MEASURES FOR THE PREVENTION AND CONTROL OF DRUG ABUSE AND DEPENDENCE

Report on a Working Group

The Hague
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Note

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1. INTRODUCTION

"Prevention is better than cure" is an aphorism of particular relevance in the case of addiction to drugs. The universal experience of very high rates of relapse among those treated for drug dependence is a constant reminder that, once established, it is extremely difficult to eradicate in the individual. At the same time, the tendency to rapid spread within vulnerable groups presents a public health problem requiring effective control from the earliest stages.

As the first of its inter-country meetings of experts on drug dependence under its long-term programme in mental health, the WHO Regional Office for Europe convened a Working Group to examine the whole problem of prevention and control in this important area. The Group consisted of psychiatrists, psychologists, sociologists, social workers, educators and public health administrators, together with representatives of other international organizations currently concerned with these matters. A list of participants is attached as Annex III to this report. The meeting was held at the Kongresscentre, The Hague, Netherlands, from 14 to 17 April 1971, by courtesy of the Netherlands Government. The agenda and a list of the documents before the participants are attached as Annex I and Annex II respectively.

The meeting was officially opened by Dr P. Siderius, Director General of Health Services of the Netherlands, on behalf of Dr R. J. H. Kruisinga, Secretary of State for Social Affairs and Public Health. Emphasizing the importance of preventive measures against drug dependence, Dr Siderius pointed to the comparative lack of information on the effectiveness of such measures as had been introduced, and emphasized the need for closer international collaboration. Replying on behalf of the Regional Director, Dr A. C. Eberwein, Chief, Health Protection and Promotion, pointed out that the Regional Committee at its twenty-first session, to be held this year at Madrid, had chosen "The prevention and control of drug addiction" as the subject for its technical discussions. This was an indication of the urgency and importance attached by European health authorities to effective action.

The scope and purpose of the meeting was then outlined by the Secretary, who described its relationship to other projects in the Office's long-term programme and indicated how the results of the Group's discussions would be utilized in other programme activities.

In the general approach to its task, the Working Group agreed from the outset that it should take account of the problems of dependence, both on drugs which were now generally socially acceptable in Europe (alcohol and tobacco) as well as other dependence-producing drugs, since the similarities in addictive mechanisms outweigh the differences in public attitudes, and the former have important implications for preventive measures.
Tobacco is known to cause serious health problems, while its repetitive use, and the difficulty in discontinuing smoking, indicate an element of dependence on it. However, it is not "psycho-toxic", in that its use does not alter consciousness or mood, and for this reason, if it were a new substance first being introduced today, it would not call for control under the proposed "Convention on Psychotropic Substances". The ill effects of tobacco primarily affect the smoker himself, and it is only indirectly that society is affected through the cost of illness and incapacity, or the premature death of the family breadwinner. Another objection to tobacco smoking is that it is seen by some as an aesthetically displeasing habit. Whatever the root of objection, health education is nowadays concerned to dissuade the public from smoking, or to reduce it. So far, however, it is mainly among doctors that there have been striking changes in smoking habits (two-thirds of the doctors in the United Kingdom used to smoke, now only one-third do). Nevertheless, although anti-smoking propaganda is not so far markedly effective, the Working Group thought that it was impossible to ignore tobacco when considering prevention, particularly when considering health education programmes.

Alcohol, which has had a much longer history of use in Europe, is a substance which, although socially acceptable, is both psychotoxic and can produce dependence in a small proportion of users (probably less than 3% of all users) though rates appear to vary from country to country. In view of the fact that alcoholism is a much larger problem than other forms of drug dependence in most European countries the Working Group saw good reasons for concentrating on this older and larger problem to the same extent as the new, though rapidly changing one, of the misuse of other psychotropic drugs (whether obtained illicitly or not).

Although methods of prevention and control differ, in some countries, for socially acceptable and for other substances, for example, in consequence of legal prohibition, in other respects there are marked similarities in the measures employed. Health education programmes in schools, for example, endeavour to dissuade young people from commencing smoking or taking alcohol, as well as from using other drugs. The educational principles involved and the methods used to alter attitudes and behaviour, may often be the same. Nevertheless, there are differences in approach to countering behaviour that is legal, though now seen to be undesirable, and behaviour that is both illegal and undesirable.

Other reasons for considering alcohol, tobacco and other drugs in this way stem from the fact that many young people point to a lack of credibility in the stated aims of drug control programmes if these ignore alcohol and tobacco. At the same time, current health education programmes dealing with tobacco and alcohol embrace aims, principles, methods and evaluation procedures which can be transposed to preventive programmes directed against other drugs.
2. GOALS OF PREVENTION

2.1 Primary, secondary and tertiary prevention (WHO, 1965)

Primary prevention aims at ensuring that a disease does not occur, or at reducing the attack rate to zero. Its success is measured in inverse ratio to the incidence of the disease (the number of new cases occurring within a given period).

Secondary prevention attempts to term inate the pathological process as soon as possible after it has become manifest. Its results are measured in inverse ratio to the prevalence of the disease (the total number of cases known at a given moment - assuming that the incidence remains unchanged).

Tertiary prevention attempts to reduce the sequelae of a disease. It aims at maintaining and restoring the potentialities of the patient which may have been threatened or impeded by his illness. Its results are measured in inverse ratio to the frequency of invalidism and long-term or so-called chronic conditions at a given moment.

It is important to be clear about the use of this classification when applied to the field of drug dependence. Primary prevention aims at ensuring that dependence does not occur, though not necessarily at the total prohibition of use of a drug. This is evident in the case of alcohol and tobacco, although, since there is a relationship between the amount consumed and the likelihood of developing alcoholism, measures to reduce consumption act towards primary prevention. With other drugs such as cannabis, which is illegal and has no medical use, primary preventive measures aim at prohibiting any use, while with drugs such as the opiates, prevention of dependence aims at controlled use in medical practice.

Secondary prevention in the field of drug dependence deals with those who are already dependent and is a matter of medical or public health concern, which should not be confused with measures to deal with drug users who are not dependent.

Tertiary prevention in the field of dependence is seen, for example, in programmes for the methadone maintenance treatment of opiate dependents which aim at restoring the potentialities of the patient and enabling him to lead a more normal life.

2.2 Goals in drug dependence programmes

Within the framework of this system of primary, secondary and tertiary prevention, the Working Group defined the goals of preventive programmes as:
(1) to prevent individual, public health and social problems associated with the use of dependence-producing drugs;

(2) (a) to reduce the availability of dependence-producing drugs for self-administration (ranging from measures designed to ensure total abstinence or prohibition to those permitting limited use and availability);

(b) to reduce unhealthy (morbid) interest in, and demand for, dependence-producing drugs;

(c) to minimize human discomfort, antisocial activity and economic loss or other social harm related to drug taking;

(d) to minimize the possibility of people beginning to use dependence-producing drugs while uninformed of their broad effects and possible complications.

The Working Group also considered that the measures taken should be genuinely effective, as there was a tendency among those who saw the danger of drugs to regard all measures against them as automatically beneficial. When new drugs are introduced, the pharmacological "benefit/risk" ratio is considered carefully, but this is less likely to be the case when social measures are being considered. For example, the risks from the total prohibition of alcohol in the United States outweighed the benefits. The risks from ill-considered health education programmes for schoolchildren may also outweigh the benefits if too sensational an approach glamorizes, and increases morbid interest in, the subject. Programmes should be judged by their effects and not by the intentions of their sponsors.

For this reason the Working Group emphasized strongly the paramount importance of evaluating the effectiveness of any programmes proposed. This is particularly necessary in a field where data are lacking, where studies of health education programmes very infrequently show benefit, where views may be strongly held without objective basis and where much activity is carried out more because the aims are seen to be desirable, than because of the certainty of their achievement.

3. METHODS OF PREVENTION AND CONTROL

3.1 Legal: limiting availability

The Working Group considered statutory and regulatory methods of limiting availability. The broad basis for the control of illicit drugs is
contained in the United Nations Single Convention on Narcotic Drugs, and in the recently proposed United Nations convention on psychotropic substances. There are, however, increasing difficulties in enforcing international controls, due to the ease and frequency of travel between European countries, to an increase in the variety of drugs, and to more widespread knowledge about their effects as a result of information available through mass media. There are also practical enforcement difficulties where a large number of young people are known to be engaged in an unlawful activity, for example, smoking cannabis, while at the same time these young people themselves do not consider their behaviour to be morally wrong or harmful to themselves or other people, and express their opinion that the law should be changed. Unfortunately statutory controls for the most part fail to prevent an increase in misuse of illicit drugs, not because of shortcomings in the laws or penalties (there is no evidence that changes in penalties in either direction have curtailed this problem) but because of increasing difficulties in implementation. Further study of the effectiveness, as well as the aims, of current controls is desirable.

3.1.1 Control of consumption

Where alcohol is concerned, taxation policies have been shown in many countries to affect consumption, the incidence of delirium tremens and chronic alcoholism. In Denmark, for example, relatively higher taxes on distilled spirits and lower on beer have led to a change in drinking habits and a decrease in occurrence of the physical sequelae of chronic alcoholism (Nielsen, 1965).

There is some evidence from France and Canada (de Lint & Schmidt, 1968; Ledermann, 1956) that per capita consumption of alcohol bears a relation to rates of alcoholism. In Finland, where the number of sources for the purchase of alcohol has been recently increased, per capita rates of alcohol consumption have similarly altered. In the United Kingdom, a commission studying the alcohol licensing laws has been considering alterations which would permit longer hours for the sale of alcohol. While this might, for example, benefit the tourist industry, the possible social implications of such a change require careful study. If increasing the opportunities for the sale of alcohol can increase consumption, and if rates of alcoholism are related to per capita rates of consumption, then any such changes should be looked at not only from the economic standpoint but also from that of their possible effect on the public health.

Bodies promulgating legislation might profitably pay more attention than is usually done to the public health implications of manipulating such controls. Health authorities are not usually in a position to advocate the use of revenue controls as a public health measure, while those responsible for taxation do not usually consider the prevention of illness to be one of their functions. Nevertheless, more consideration might be given to the public health consequences of such methods of indirect control, including, for example, taxes on alcohol and tobacco, changes in the times during which alcohol may be consumed, changes in the number of facilities for
its sale, controls on sales to minors, or the prohibition of automatic vending machines for cigarettes where it is illegal to sell them to persons under 16.

3.1.2 Control of drugs used in medical practice

One source of the drugs that appear for illegal sale is their diversion from legal channels at the stage of manufacture, distribution or supply, and when they are prescribed in excessive quantities to individuals who later distribute them to other persons. In the United Kingdom, for example, a small epidemic of misuse of intravenous methylamphetamine appeared to be due entirely to irresponsible prescribing by two doctors only. One of the practitioners prescribed 24,000 ampoules of intravenous methylamphetamine to 100 patients in the course of a month (Advisory Committee on Drug Dependence, 1970). Another significant source of illegal supply may arise through burglaries of retail pharmacies when psychoactive drugs are stolen. Measures to improve the security of these premises or reduce the stocks held will help to limit the availability of drugs from this source.

Following the above report on the use of amphetamines in the United Kingdom and one by a Working Party set up by the British Medical Association (Brit. med. J., 1968) it was generally concluded by the medical profession that amphetamines and amphetamine-like compounds were drugs with a limited use in modern therapeutics. In the British Medical Association working party's report it was noted that misuse of amphetamines could and did produce mental and physical deterioration. Following these reports, medical practitioners in various parts of England introduced a voluntary ban on prescribing amphetamines with the intention of reducing the possibility of their diversion from legal to illegal channels, and particularly to do away with the need for stocks of such drugs in retail pharmacies.

3.1.3 Control of medical practitioners

There is a possibility of drug misuse arising from improper prescribing by medical practitioners. This can be controlled in two ways: either by making specific restrictions on prescribing certain drugs or, alternatively, by leaving individual practitioners free to prescribe the drug as they wish, while ensuring the provision of methods for discovering and dealing with cases where drugs have been prescribed in such an irresponsible manner as to constitute a public health hazard. In practice, combinations of both measures are used.

The Working Group considered it was preferable to employ direct methods of dealing with poor professional practice as, for example, in Czechoslovakia, where, if a doctor is found to be overprescribing, he can be referred to a postgraduate course for re-education. It was realized, however, that in many countries the mechanism for dealing with doctors who overprescribe was often too cumbersome. For instance, the only action possible may be withdrawal of his license to practise, which is too
severe a sanction to be of use in any but a few cases of very serious professional misconduct. In regard to limitations on prescribing of certain psychoactive drugs, these may be imposed on the quantity prescribed at any one time, on the duration covered by the prescription, on the number of times a single prescription can be "repeated", on the number of drugs prescribed on a single prescription, and on the prescription of drugs by telephone, or to any "third person".

3.1.4 Monitoring

When considering the supply of potentially dangerous psychoactive drugs through normal medical channels, the Working Group stressed the need for adequate control. This may be achieved through a system of screening or "monitoring" the sources of supply and channels through which drugs are distributed in order to identify early signs of misuse. Monitoring can take place at different stages of distribution and include:

(1) supervision of pharmaceutical production, manufacture, distribution and sales;

(2) investigation of sudden unexplained changes in levels of pharmaceutical sales (as happened with intravenous methamphetamine in the United Kingdom);

(3) analysis of prescriptions as done in certain areas in Norway, Czechoslovakia and Northern Ireland (WHO, 1970; Hood & Wade, 1968; Bewley, 1970);

(4) observing changes in the type of drugs employed in attempted suicide or self-poisoning (an increasingly common type of misuse is the act of self-poisoning with drugs prescribed for some other purpose, frequently barbiturates, but in some areas other drugs such as Mandrax (diphenhydramine and methaqualone) in Scotland);

(5) noting patterns of drug misuse reported from "indirect" sources (treatment clinics, police, courts, prisons, hospitals, probation officers, youth leaders or counsellors may give the first indication of the start of a new drug problem);

(6) noting patterns in retail sales of drugs sold without prescription, e.g., analgesics, which may be abused.

3.2 Education

The Working Group defined the broad aims of health education programmes as:

(1) to reduce unhealthy (morbid) interest in, and demand for, dependence-producing drugs;
(2) to minimize the chances of someone starting to use a dependence-producing drug, while uninformed of its effects and possible implications.

There are two main target groups who may be considered likely to benefit from successful education in this field: "at-risk" groups, including teenagers, students, some therapeutic users, some health workers, etc.; and "influence" groups, including those responsible for mass communication media, those who frame legislation (e.g., politicians, statesmen), professional groups (e.g., physicians, social workers), parents, teachers, youth leaders, and so on.

3.2.1 Methods

There is very little reliable information about the effectiveness of health education programmes. The few studies which have been made fail to show any unequivocal benefits. Much health education seems to be carried out as an act of faith, rather because the ends are seen to be desirable than because their effectiveness is certain and known goals can be achieved. There is a danger that certain groups may be tempted to become self-elected health educators, whose unduly sensational programmes may produce an effect which is the reverse of that intended; on the other hand, programmes imposed by remote "authority" may prove in practice to be of limited local value. While changes in behaviour are unlikely to result from appeals to the intellect alone, changes in attitudes and feelings are not easy to produce, and are in any event difficult to measure. There is a very great need for carefully controlled trials of different educational programmes, based on careful organization and planning.

3.2.2 The role of the mass media of communication

There appear to be two ways in which mass communication media may influence knowledge about, and attitudes to, drugs:

(1) through programmes and articles specifically dealing with drugs; and

(2) indirectly, in programmes and articles (not specifically concerned with dependence) in which drug taking, drinking, or smoking, and ideas and attitudes about these, both explicit and implicit, are introduced.

A recent study of schoolchildren's attitudes to, and knowledge of, dependence-producing drugs (Wright, 1968) showed that the majority of them had knowledge of drug effects, but that much of their knowledge was factually incorrect. Most of them reported that their main source of information was from the mass media, particularly television. In the opinion of the Working Group, the mass communication media do have very considerable impact in the field of drug dependence, but although this may be educationally effective where there is already widespread use
and knowledge of drugs (for example, alcohol and tobacco), it may be less
so in the case of drugs where the amount of misuse is very limited. Prog-
grammes and articles ostensibly warning against some new drug danger may
in fact provide information to potential misusers and produce an effect
opposite to that intended.

Since the mass media do not act on target groups, the form and con-
tent of television programmes, for example, require careful thought.
The "message" should probably be simple and explicit as, for example,
in the short programmes dealing with alcohol and road safety recently
shown in France. Similar short programmes aiming to change attitudes
to tobacco smoking have been used in the United States. Films and articles
dealing with other types of drug misuse have appeared widely in many
European countries, but it would be difficult to assess whether they have
curtailed or encouraged drug use. In 1969, in Sweden, a half-day televi-
sion programme on drug misuse was presented for schools, but there was
no subsequent evaluation of its impact, though the impression is held that
it was not effective in altering attitudes.

The more difficult area to assess in regard to the mass media is the
general effects of the programme's content, such as television scenes
showing drug-taking, drinking and smoking, scenes where there are im-
plicit assumptions about drugs or alcohol, or articles or books where
various social and cultural attitudes to these are expressed.

Those in positions of influence, whether they be pop-stars or prime
ministers, undoubtedly bear an extra responsibility in the use of mass
media. The United States Federal Communications Commission has pro-
hibited the playing on the radio of certain records which glorify the use of
illicit drugs, while in Sweden, concern had been expressed about advertis-
ing which pictured drug use in the context of "pop" music.

There seems to be good cause for closer co-operation between health
authorities and those responsible for the mass media. Professional
health workers themselves, however, are not necessarily the best people
to transmit information via these media. An example of the negative
aspects of a purely scientific approach came in a series of television prog-
rammes dealing with drugs in Czechoslovakia, where doctors themselves
gave information directly, but which proved unsuccessful despite, or per-
haps because of the conscious endeavour to be factual and objective. Much
better results were obtained when the same information was edited and
transmitted by journalists, whose professional expertise lay in the field
of communications.

In Sweden a special committee had been set up to try to improve
collaboration between health authorities and the mass media. The benefits
of this are especially obvious when sensational newspaper articles about
drug use later turn out to have little foundation in fact. In this type of
situation, where inaccurate information is published without proper con-
trol, a system whereby facts can be verified before publication must be
preferable to one which requires later corrections and amendments. Since it is necessary for the mass media to cater for legitimate curiosity about new social phenomena, it is desirable that there should be authoritative sources of information in the field of drug addiction.

Even when facts are reported accurately, their presentation can be dubious. For example, when drugs are seized by the authorities, it is not uncommon to report the value of the drugs in terms of what they would fetch if they were exported, divided, adulterated, distributed and finally sold in big cities at current street prices. As a theoretical exercise this is not dissimilar to quoting the price of eggs on a farm in terms of the price that would be charged for an omelet in a city restaurant. The exaggerated prices of illicit drugs described in this way can only encourage some people to traffic in them for profit.

The examples given in this section of the report serve to emphasize the need for much closer consultation between the health professions and those working in the field of mass communication with the aim of:

(1) providing more accurate information about drugs and drug dependence;

(2) considering what attitudes should be promoted in the interest of public health rather than public excitement;

(3) considering what undesirable effects might be implicit in certain programmes or articles and how these could be counteracted;

(4) considering methods of evaluating the effects of the media, particularly in disseminating knowledge about the hazards of drug abuse and dependence.

3.2.3 Health education in schools

The effects of school health education have seldom been evaluated. Yet to be of any real value, comparison of "experimental" (exposed) with "control" (unexposed) groups of children would seem to be a minimum requirement for effective planning of programmes.

Whether health education programmes dealing specifically with drug abuse are desirable, or whether they should be incorporated in courses of general social education has been widely discussed, though there has been little attempt to measure the advantages or shortcomings of either approach. It is generally agreed that it is necessary for teachers, youth club leaders and others dealing with young people to be well-informed about these problems, and that they should themselves receive training in this field before taking part in educational programmes for their pupils.

The content of programmes for children should be related to circumstances they can comprehend and believe, in terms of their own immediate
experience, rather than concepts which seem to them remote and impersonal. An example of this is seen in attempts made to dissuade children from smoking because of the future risk of lung cancer. This had negligible effect compared with the knowledge that cigarette smoking could lead more immediately to coughing, shortness of breath and impaired athletic performance.

3.2.4 Enlightenment of physicians and persons exercising public influence

The medical profession provides a good example of the possibilities and limitations of health education. Physicians, who must be presumed to know more of the hazards and dangers of opiates than comparable non-medical professional groups, nevertheless have significantly higher rates of opiate dependence. In the USA, the incidence of morphine dependence among doctors and nurses is eight times higher than would be expected in the general population. This example illustrates that availability appears to be a more powerful factor than factual knowledge. On the other hand, the smoking habits of doctors have markedly changed, and in some countries the number who are cigarette smokers has been halved, apparently as a result of their professional knowledge of the risks to health.

Since careless prescribing indirectly affects the availability of psychoactive drugs, and can also initiate therapeutic dependence (especially where, for example, sedative or analgesic drugs are inappropriately prescribed) there would seem to be a need for postgraduate education within the medical profession. In addition, the professional organizations themselves should debate the propriety and desirability of the widespread prescribing of drugs which later turn out to have greater potential for harm than was first thought. The sources of information available to doctors concerning drugs call for consideration of ethical advertising by pharmaceutical firms, including the implications of certain advertising in professional journals. Drugs such as phenmetrazine or Mandrax have been widely promoted at times, but doctors have not always been aware of all the possible ill effects which may later appear. Advertisements may contain references to papers in professional journals which describe adverse effects, but the text of these does not necessarily appear in the advertisement. There are ethical problems for editors; if they are strict in the criteria they use for accepting advertisements, they may lose an important source of revenue for the journal. This would appear to be an area where debate in professional organizations on the "benefit/risk" rate of sounder advertising, but more expensive journals, is desirable.

The Working Group believed it was essential that health authorities should not only concentrate on "at-risk" groups but should endeavour also to educate other professional groups and leaders of opinion. Framers of policy, politicians, moulders of opinion through the mass media, teachers, social workers and parents are all important target groups, besides the general public. In many influential groups there already appears to be misinformation about dependence-producing drugs. This is an area of social concern where opinions are often strongly held for emotional reasons.
The debate on the relative dangers of cannabis and other drugs is an example of this. In several countries there are groups who underestimate its dangers, and there are other groups who overestimate them, but any dialogue between the two is often ill-informed and unhelpful. A less acrimonious, more realistic and less emotional discussion, with mutual agreement on the known facts and evidence, would be more likely to carry conviction and achieve a consensus on the most helpful approach to dissuade people from its use.

3.3 Social (community) measures

The Working Group considered social measures as a means of "secondary prevention" in the case of established drug abuse and dependence.

One important community measure is to ascertain who is already dependent on drugs, offer help and endeavour to motivate them for treatment. In Sweden, teams of social workers, psychologists and others (including the police in some instances), deliberately seek out addicts "on their own ground". Another approach, which seems more successful, is to run an "open" youth guidance clinic, to which addicts may come anonymously, giving as much of their own history as they wish. It is generally found at these clinics that clients have a wider range of problems than drug dependence alone. Thus, it seems preferable and logical to provide facilities offering help for all types of social and behavioural problems, including dependence.

In Czechoslovakia, various indirect sources provide contact with drug addicts. Thirty per cent of callers on an open telephone help service have had serious drug-taking problems and have been referred to psychiatric clinics. Routine psychiatric interviews with those who attempt suicide and those who take overdoses of drugs also bring to light many cases where dependence is a problem.

Social measures of value in secondary and tertiary prevention are illustrated by clubs for ex-alcoholics. These may be run exclusively by other ex-alcoholics, but may also provide for contact with professional health workers. Similar community facilities for drug addicts are becoming more numerous, especially in large cities.

Sports and athletics provide one avenue whereby positive leisure facilities can be offered to young people, and where desire for athletic prowess may encourage abstinence and discourage excessive consumption of alcohol or misuse of drugs (though on the other hand it might tempt the very few to experiment with amphetamines because of their effects on competitive muscular performance).

In one or two countries, social measures have aimed at the "containment" or segregation of addicts rather than at their inclusion in therapeutic programmes. In some large cities cannabis smoking, for example, though frowned upon officially, is tolerated by force of circumstances which prevent
strict control of the numbers involved. Cannabis smoking on certain premises only permits surveillance of a localized problem. It has been suggested that tolerance of cannabis reduces the availability of even more dangerous drug-dependence and discourages the inclination of young people to experiment with the opiates and heroin. Some support for this theory is given by the experience in the United States following "Operation Intercept", an intensive law enforcement activity designed to decrease the supply of cannabis (brought into the country from Mexico), which appears to have led to a rapid increase in the use of LSD, not only in the United States, but also in Canada. The philosophy behind an "unofficial tolerance" of cannabis would appear to be not so far removed from that underlying the methadone maintenance treatment of heroin addicts. In both cases a partial solution may be more realistic when total success in treatment or control is not universally possible, and where alternative measures may cause even greater difficulties.

It is essential when considering such social measures, however, to scrutinize closely the "benefit/risk" ratio to the individual as well as to society. In Basel, for example, in a similar type of social experiment, it was found that among 80 persons attending a club where cannabis smoking was tolerated, 32% were using amphetamines as well as cannabis, although two years earlier there had been no evidence of amphetamine misuse.

A further problem in assessing the effects and the value of such experiments arises from the increase in international travel by young people, many of whom come to take advantage of a local drug situation. What might appear to provide a solution, or partial solution, in the community concerned, may have unforeseen consequences. In some tourist countries, for example, up to 50% of penalties imposed for drug offences may be levied on foreigners, while clinics for the treatment of drug dependence see increasing numbers of persons from abroad seeking help.

It is clear that local or national measures must nowadays take account of the international aspects of drug addiction and drug trafficking. Local actions may have good intentions and good effects in the country in which they originated, but undesirable side effects in some other country. The partial sanctioning of cannabis use in one country may facilitate its spread elsewhere. On the other hand, lack of treatment facilities, or the strict enforcement of penalties in one country, may encourage the migration of addicts and the transference of the problem rather than its solution.

It is extremely difficult to assess the outcome of different national social policies. On an international basis, however, it is highly desirable to examine:

1. the effects of different degrees of enforcement of drug laws,
2. the degree of compatibility between countries in terms of treatment policy,
(3) the consequences of greater uniformity in national legislation on dependence-producing drugs,

(4) the repercussions of national policies and social experiments outside the country of origin,

(5) measures for improving collaboration in respect of tourist and other migrant groups.

3.4 General community planning

Overall social planning can be expected to affect the rates of incidence of alcoholism or drug dependence in the sense that anything that changes the quality of peoples' lives may have direct and indirect effects on their future behaviour. For example, there may be higher rates of drug dependence in new towns or suburbs where movement away from an old centre may have weakened traditional social controls, and where there may be insufficient outlets for creative leisure activities.

It seems probable that the social factors leading to an increased incidence of drug dependence are no different from those leading to other forms of deviant behaviour. Since the remedial measures to be employed in dealing with drug dependence are similar to those directed against other forms of deviant behaviour, it is reasonable, wherever possible, to utilize the framework of the general social services, rather than to set up counselling services for drug addicts alone.

3.5 Medical care

Besides pursuing their primary goal of curing patients of their dependence, many medical treatment programmes nowadays accept, as an alternative to cure, the modified objective of helping the addict towards improved social functioning, without complete cessation of drug taking (e.g., the methadone maintenance treatment programmes for heroin addicts). In addition, of course, it will be a medical responsibility to deal with the complications arising from drug dependence (care rather than cure) even if no improvement in social function is possible.

Compulsory treatment has been used in some countries to treat alcoholics and drug users showing symptoms of mental disorder. As a "secondary" or "tertiary" measure it has not however proved successful in the United States. Positive motivation for treatment is an essential ingredient of success, and if motivation is lacking, "compulsory treatment" may become synonymous with compulsory detention. Much of the argument in favour of the wider use of compulsory treatment stems from a desire to do something "active" when other methods have failed, rather than from any firm evidence that compulsion can provide worthwhile benefits.
4. EVALUATION

The Working Group considered that adequate evaluation for the prevention and control of drug abuse and dependence was the action that was most likely to improve the effectiveness of these measures. Without evaluation, the implementation of any preventive programme may have no real effect apart from a subjective feeling on the part of those carrying out the programmes that they are "doing something".

Medicine offers many examples of the enthusiastic endorsement of treatment as being of scientific value to patients, which has later been called in question. Nowadays we would not be convinced of the efficacy of a new remedy without an adequately controlled trial. Yet some current preventive measures, such as sensational lectures in schools on the dangers of drugs, may be of as little value as blood letting, or as prescribing inhalations of garlic for tuberculosis, though all concerned are convinced of the value at the time.

In evaluating any project, the minimum requirements for effective action should include clear operational definitions, a clear statement of the goals of the activity to be evaluated, and a statement of the criteria by which achievement of those goals should be measured.

The evaluation of proposed preventive measures should be considered from the outset of the activity and should be built in at the planning stage so that data are collected with this in mind, rather than collected retrospectively, and less efficiently. Throughout its discussions, the Working Group was constantly reminded of the lack of objective information about the effectiveness of preventive measures, and the absence of firm data by which the various national activities could be judged. A condition of financial support for programmes should be the establishment of provision for adequate evaluation at the stage when the proposals are initially submitted.

Further particulars about the aims and methods of evaluation in health services are contained in the report on the Symposium on Methods of Evaluating Public Health Programmes held by the Regional Office for Europe at Kiel in 1967 (WHO, 1968).

5. CO-ORDINATION OF ACTIVITIES

5.1 National programmes

In many countries in Europe co-ordination of national programmes for combating alcoholism and drug dependence have already been established
with collaboration between ministries. In France, an inter-ministerial committee on drug problems meets under the chairmanship of a minister. It has a permanent secretariat of officials including outside experts which meets monthly in the absence of the full committee.

In Poland, Hungary and Switzerland there are similar inter-ministerial committees, while in Belgium there is a national non-governmental body, which co-ordinates national and voluntary activities in the field.

In the United Kingdom there is a Standing Advisory Committee on Drug Dependence consisting of experts whose function is to advise the Department of Health and Social Security and the Scottish Home and Health Department. This Committee deals only with drugs and is to be superseded by an advisory council. In Sweden, in the larger cities, there are special local committees whose members include politicians, administrators and experts.

Co-ordination at national level is becoming increasingly necessary in order to avoid unnecessary duplication and because the methods and time required for much of the research are beyond the capacity of individual bodies. Most research into prevention of drug abuse needs to be multidisciplinary and of a long-term nature, if it is to produce useful results.

5.2 International co-operation

There are many organizations now involved in problems of drug dependence. Collaboration between them is desirable in order to avoid duplication of effort and ensure that the limited resources available are not squandered.

5.2.1 World Health Organization

The World Health Assembly, in its Resolution WHA 23.42, recommended further action by WHO in the field of drug dependence. The Executive Board recently discussed proposals for additional activities, the provision of reference facilities, consultations, longitudinal studies in the general population and in high-risk groups, and the provision of more detailed epidemiological intelligence (EB 47/26, 1970). The programmes proposed by Headquarters and by the Regional Office for Europe are now fully co-ordinated and collaboration between the Regional Office and other international organizations in Europe is already close and fruitful. It is hoped that the Regional Office will benefit from the provisions of the United Nations Special Fund for activities in this field.

5.2.2 UNESCO

Prevention in the field of drug dependence is a new venture for UNESCO, who wish to study educational methods and the effects of mass media. They are proposing to hold a preliminary meeting of experts in November 1971, and have appointed a consultant to make a field survey
of current health education programmes with a view to a possible conference in 1972.

5.2.3 Council of Europe

In addition to its investigations into public health implications of recent developments in drug dependence (by the Co-ordinated Medical Research Fellowships Team in 1969), the Council of Europe (1970) is arranging to hold a multidisciplinary conference on drug dependence problems in March 1972, in association with the Regional Office.

5.2.4 International Union for Child Welfare

The International Union for Child Welfare are especially concerned with preventive education among adolescents and young people and, in August 1971, are holding an international conference, in which WHO Headquarters and the Regional Office will participate.

5.2.5 International Council on Alcohol and the Addictions

The Council held an "International Institute on the Prevention and Treatment of Drug Dependence" in June 1970 in Lausanne, Switzerland, and are holding a similar meeting at Baden, Federal Republic of Germany, in 1971.

6. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

The Working Group was convinced of the need:

(1) for closer study of the effectiveness, benefits and risks of current measures for the prevention and control of drug abuse and dependence;

(2) for further consideration of measures for the indirect control of consumption through taxation and licensing regulations;

(3) for more effective control of medical practice in regard to the over-prescription of psycho-active drugs;

(4) for closer collaboration between professional health workers and the mass media of communication:

(a) to provide more accurate information to the mass media;
(b) to consider what attitudes were desirable, and likely to promote health;

(c) to consider what undesirable effects might be implicit in certain programmes or articles and how these could be influenced;

(d) to consider means of evaluating the effects of the articles and broadcasts particularly in such areas as health education and the spreading of factual knowledge about dependence;

(5) for close study of the credibility and effectiveness of current health educational programmes in schools;

(6) for better professional (including medical) education in regard to drug abuse and dependence;

(7) for further social (community) measures;

   (a) to seek out "at-risk" groups for early treatment;

   (b) to study social experiments in the "containment" of drug addicts within special community locations;

   (c) to consider specific measures for migratory workers and tourists;

   (d) to consider general measures to reduce deviant behaviour, rather than specific ones affecting only drug dependence;

   (e) to avoid measures which cause more harm than good;

(8) for much greater emphasis to be placed on methods of evaluation of the effectiveness of any remedies proposed;

(9) for close co-operation locally, nationally and internationally, in order to avoid duplication of effort and waste of scarce resources in the operation of preventive programmes.
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Hood, H. & Wade, O. L. (1968) Lancet, 2, 96


Wright, J. D. (1968) A survey of the knowledge and attitudes about drug misuse among fourth year pupils at three Wolverhampton schools, Health Department, Wolverhampton, England
ANNEX I

AGENDA OF THE WORKING GROUP

1. Introduction to the long-term programme in alcoholism and drug dependence.

2. The scope and purpose of the Working Group.

3. Legal, social, medical, educational and other measures for the prevention and control of drug abuse and dependence, with reference to international, national and local experience.

4. The evaluation of preventive measures.

5. Deficiencies in existing provisions and possible remedies.

6. Co-ordination of measures at national and international levels.

7. Proposals for the further activities of WHO in this field.
<table>
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<tr>
<th>Document</th>
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<tr>
<td>Report No. 13, April 1970</td>
<td>Consultative Assembly of the Council of Europe, 22nd ordinary session</td>
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<tr>
<td>WHO Headquarters Memorandum</td>
<td>Chart of the long-term programme in mental health</td>
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<tr>
<td>EUR/RC20/7</td>
<td>Problems relating to the misuse of psychotropic drugs: proposals for future action by the Regional Office for Europe</td>
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<td>EUR/RC20/5</td>
<td>Proposed long-term programme for the Regional Office for Europe in the field of mental health</td>
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<td>EURO 5412 IV/3</td>
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<td>EURO 4000/3 (GEN 70)</td>
<td>Report to the Regional Director on the Working Group on the Misuse of Psychotropic Drugs, Geneva, 26-28 January 1970</td>
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<td>EURO 4000/4</td>
<td>Report on Recent Changes in the Patterns of Drug Abuse in Czechoslovakia, France and Yugoslavia, by Dr T.H. Bewley</td>
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<tr>
<td>EURO 5411 IV</td>
<td>Report of the first Steering Committee Meeting on the Planning and Control of Long-term Programmes on Alcoholism and Drug Dependence</td>
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<td>Council of Europe, Information Bulletin No. 3, Directorate of Economic and Social Affairs</td>
<td>The Council of Europe and drug dependence</td>
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### Annex II

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<tr>
<td><strong>CESP(71) 4</strong></td>
<td>Consultative Assembly of the Council of Europe, 22nd ordinary session, Recommendation 609 (1970) on drug dependence</td>
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<tr>
<td><strong>Document 2815</strong></td>
<td>Consultative Assembly of the Council of Europe, 22nd ordinary session, Resolution 457 (1970) on the organization of a multidisciplinary symposium on the causes, prevention, treatment and control of drug dependence</td>
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