

PROBLEMS AND PROGRAMMES RELATED TO ALCOHOL AND DRUG DEPENDENCE
IN 33 COUNTRIES

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INTRODUCTION

The widespread problems related to excessive use of a number of dependence-producing drugs - including alcohol - are of concern to governments in many parts of the world. Interest is growing in learning more of the magnitude, nature, intensity, and duration of these problems, how they are viewed, and how they are being met in different cultural contexts, and whether effective preventive and treatment measures are available.

A WHO Expert Committee report (1967)¹ refers to "the effects of illness resulting from alcohol and drug dependence and the associated crime, accidents, family disruption, suicide, premature death, loss of productivity, as well as associated hospital, prison and welfare costs" and states that the problems involved in the etiology, prevention and control of these conditions and in the treatment of dependent persons "extend beyond the competence of any single profession or group". The Committee therefore recommended that WHO should promote multidisciplinary investigations and international exchange of information on these matters.

It became clear that an international programme should aim first at stimulating countries to study the size and nature of their own alcohol and drug dependence problems and the ways they are being met. The need was felt to devise a framework for collection of such information that would be of value for effective programme planning and, with the assistance of a WHO consultant, Dr Griffith Edwards,² a WHO Outline for National Inquiry on Problems of Alcohol and Drug Dependence³ was drafted. It was designed to bring together information on many aspects of the problems under consideration - socioeconomic, medical, educational and legal.

This instrument was tried out by Dr Edwards in England and by three other WHO consultants: Dr Bukowczyk in Poland, Dr Jongtsma in the Netherlands and Dr Skala in Czechoslovakia, with the help of many colleagues. The Outline and the four responses were reviewed during a meeting in London in 1969⁴ and revised versions were discussed at a second meeting with the consultants in the Netherlands, Poland, and Czechoslovakia in 1970. Already the international programme was beginning to stimulate interest in the compilation of information from many different sources, with interdisciplinary collaboration.

The next step was to involve a larger number of countries in the programme. This was done by organizing a three-week WHO Interregional Training Course for National Programmes on Problems of Alcohol and Drug Dependence in 1971. The sites chosen were three of the countries already engaged in the information collection - the Netherlands, Poland and the United Kingdom - where the governments were willing to act as hosts for one week each, and where the existing programmes were likely to be of considerable interest for other countries. The Training Course participants⁵ comprised public health officers, psychiatrists, and others concerned with the organization of relevant services from 17 countries in different regions of the world. Draft reviews relating to their countries were prepared by the participants in response to the WHO Outline and circulated prior to the Course.

¹ See list of references, p. 87.

² See Annex 1 for titles and addresses of consultants.

³ See Annex 3 for the final draft of the Outline.

⁴ See Annex 5 for a list of participants.

⁵ See Annex 1 for list of participants.

Follow-up inquiries showed that the participants had found the Course a rich and useful experience and several had inaugurated new activities in their own countries as a result. In view of the encouraging response, a WHO Interregional Seminar organized along the same lines as the Course¹ was held in Sweden, Yugoslavia, and Switzerland in 1972, this time bringing together 30 participants from 22 countries. Major responsibility for preparation of the main reviews and of the week's activity in each host country devolved again upon WHO consultants: Dr Kilibarda for Yugoslavia; Dr Mårtens for Sweden and Mr Wieser, with help from Dr Solms, for Switzerland.

The following review of problems and programmes related to alcohol and drug dependence in 33 countries² is based largely on the responses to the WHO Outline for Inquiry. Attention is drawn to the fact that these responses represented the views of the participants and collaborating authors, and not necessarily those of their governments.

The most detailed reviews came from the host countries and Czechoslovakia, but for many other countries extensive and useful data were gathered. As stated by a Swedish participant, despite the enormous amount of work entailed, the compilers and national authorities appreciated the importance of preparing the response to the Outline, since the information from so many sources had never before been brought together as a basis for national planning. This was true for all the countries concerned. Moreover the reviews were considered to provide valuable material for purposes of training and public education. At least one of the reviews (Zacune & Hensman, 1971) has been published, and is extensively quoted in this report. Several others have been widely distributed. For a few countries that sent participants, written responses to the Outline were not prepared, but information was supplied orally during the sessions.

Owing to the wide variations in drinking and drug-taking habits between the countries concerned, the differences in their sociocultural and economic environments, the divergence in methods of recording data, and the often incomplete nature of the response, it would not be feasible to attempt any cross-national comparisons from the data at hand - all the more so as the work required to achieve international agreement on definitions of terms to be used still largely remains to be done. This publication sets out rather to illustrate the wide range of findings among the countries, which may help persons responsible for planning to consider trends and anticipate developments in their own countries, possibly to avoid mistakes experienced in other settings, and to try out solutions applied elsewhere.

During the Course and the Seminar, sessions were devoted to detailed consideration of specific aspects of alcohol and drug dependence problems, such as approaches to prevention and treatment, legal and penal aspects, training of personnel, data collection, research and programme planning. Many of the points made have been included in the present volume, illustrated in several cases by quotations from WHO publications, or by descriptions of visits of observation in the host countries.

On the whole, the arrangement of the sections of this publication follows the lay-out of the WHO Outline for Inquiry. However, information on trends and plans in the various countries has been combined here with material on programme planning as a first section to emphasize the purpose of the meetings and the national inquiries, and to introduce the later, more detailed sections. The second section, dealing with collection, analysis and utilization of data, has also been brought forward, since this topic is closely related to programme planning and also gives the necessary warnings about the reliability and comparability of the data collected.

¹ See Annex 4 for further details about the methods used to organize the Course and Seminar for lively exchange of ideas and experience.

² A list of these countries is given in Annex 4, section 2; 28 of the responses were available in written form and five were presented orally.

In the six host countries, many persons were involved in arranging visits, giving explanations, joining in discussions and providing the warm and friendly hospitality that helped to make the visits so meaningful. Brief references to the visits are included in the present summary. It has, however, been impossible to reflect the lively give-and-take between visitors, clients, and local staff and officials that made these visits such an important learning process.

Without the interest and cooperation of the governments of the host countries, the Course and Seminar could not have been held. It is hoped that, in return, these activities provided for them, as well as for the other participants and their countries, some help and stimulation in pursuing the arduous task of organizing national programmes on problems of alcohol and drug dependence. This review has been compiled with the intention of offering some further assistance in this work. It underlines the complexity of the needs to be taken into account when establishing such programmes and draws on the experience of 33 countries to illustrate responses to the problems involved.

On behalf of all the participants, the WHO organizers of the Course and Seminar, Dr Dale Cameron and Mrs Joy Moser, wish here to express their deep gratitude to all those who contributed to make each of the meetings an invaluable experience; and particularly to the consultants, who shouldered such a heavy burden.

1. PROGRAMME PLANNING

Steps to be considered in planning programmes concerned with problems of alcohol and drug dependence could be listed as follows: definition of the problems; study of existing responses to problems; definition of programme goals; search for ways of achieving the goals; choice of means according to the resources available; implementation of choice; evaluation of results.¹ Each step is briefly considered below.

1.1 Definition of the problems

1.1.1 Nature of the problems. At the outset of programme planning, decisions have to be made as to what is to be considered a problem. Is the individual heavy drinker or user of dependence-producing drugs to be looked upon as presenting a problem for the community? If so, under what circumstances? For example, a person with a blood-alcohol level of more than 80 mg per 100 ml of blood may be considered to present a problem when driving a car, but not necessarily when sitting at home or in a restaurant. Peddling, possession and use of dependence-producing drugs may or may not be looked upon as problems, and decisions may depend on the quantities and types of drug involved. The health of the individual may be considered the main problem to be dealt with, or alternatively criminal problems associated with procuring drugs may take precedence. In all cases, valuable information for programme planning can be provided by investigations and surveys concerning the types of beverages and drugs used and the patterns of use, including quantities, frequency, duration and circumstances of use, as well as the local customs. Examples of such studies are given in Sections 3-6.

1.1.2 Severity of the problems. Attention is drawn in Sections 3.2 and 5.2 to the severity of alcohol and drug dependence problems in terms of percentages of population directly affected - by morbidity and mortality - and the repercussions on the family or close acquaintances and on the wider community. The resulting loss of productivity as well as welfare, penal and treatment costs add to the burden on the community. An indication of the size of the problems to be tackled is essential for rational programme planning, and the importance of improving the quality of the data collected is stressed in this report.

1.1.3 Population groups affected. It can be seen from the tables that some of the 33 countries have already collected information as to which are their high-risk population groups. In respect of all the problems considered, males appear to be at a much higher risk than females; heavy alcohol consumption is more frequent among older than younger age groups in some countries where, in general, the reverse is true as regards dependence on other drugs. Focus on high-risk groups in programme planning will permit limited resources to be economically used.

1.1.4 Trends. Means need to be available or established to follow the changes over time in the nature and severity of the problems under study as well as the population groups affected. Some changes in fashions of use of dependence-producing drugs have occurred rapidly and for effective action to be taken "alerting systems" based on crude information may be needed as well as more careful long-term data collection systems.

1.2 Study of existing responses to problems

1.2.1 Community attitudes. Surveys of community attitudes to alcohol and drug dependence problems are useful for revealing misunderstandings that need to be corrected through a programme of public education as well as for understanding possible obstacles to implementing

¹ This list is based partly on the outline of a talk given at the 1971 WHO Training Course by a business management expert, Mr R. J. Maxwell. His presentation was illustrated by examples drawn from smoking problems in the United Kingdom, whereas here illustrations are taken from the whole range of material covered by the report.

certain programmes. For example, in countries where daily wine consumption is considered normal, and even important for good health, an educational programme aiming at moderation, as in France, is more likely to meet with success than one exhorting abstinence. In communities where the drug-dependent person is cast in the criminal role, public education may have to emphasize his need for help rather than punishment. Several programmes outlined in this report suggest that community attitudes to problems of alcohol and drug dependence may be most effectively changed when representative groups of the community are themselves involved in developing a programme to deal with these problems.

1.2.2 Economic considerations. Section 4.3 gives some information on the extent to which a country's labour force and economy may be involved in the production of alcoholic beverages for home consumption and/or export. In some parts of the world, production and sale of dependence-producing drugs may still be important factors in national or local economy. In programmes aimed at reducing production of alcohol or other dependence-producing drugs, much ingenuity may be needed to find substitute employment possibilities and sources of income. An example is the search for substitute crops that can be grown in opium-producing areas where the soil and other farming conditions may be unsuitable for most other crops.

Taxation of alcoholic beverages may be an important source of government revenue and in programme planning such assets will have to be weighed up against the cost to the nation of dealing with problems that may in part result from high levels of availability of alcohol.

Attention is drawn to the anomalies arising from the contrary motives of advertising and public education with regard to alcohol consumption. Programmes attempting to reduce or eliminate such advertising have to take into account possible counter measures by private industry.

With respect to other dependence-producing drugs, consideration has to be given to the effects of making their use by dependent persons illegal. Rising costs of illegal purchase may be accompanied by increasing criminal activity, and by increasing wealth and power for the groups involved in the illicit trade in drugs.

1.2.3 Legal and other controls. Section 4.4 describes some of the means used for national control of production and distribution of alcoholic beverages, pointing out that the total effect may not be successful in maintaining a balance between supplying "normal" demands and limiting "abnormal use". Control measures such as prohibition, rationing, limitation of hours and places of sale, price regulation, restrictions on distilling and limitation of advertising have all been tried and their effectiveness may vary in different situations. Experimentation with various types of control may be needed and more definitive measures taken only after careful discussion and evaluation of the results.

The relevant control of other dependence-producing drugs is outlined in Section 6.3, which refers to such measures as are included under the Single Convention, as well as to the control of medical prescription practices. The report of a WHO Expert Committee on Drug Dependence (1969) set out two main conditions "at least one of which must exist for a drug to be considered in need of control":

"(1) The drug is known to be abused other than sporadically or in a local area and the effects of its abuse extend beyond the drug taker; in addition, its mode of spread involves communication between existing and potential drug takers, and an illicit traffic in it is developing.

(2) It is planned to use the drug in medicine and experimental data show that there is a significant psychic or physical dependence liability; the drug is commercially available or may become so."

Legal controls on behaviour may be instituted for the benefit of society or of the user; they may include provisions for imprisonment for public drunkenness, for drunken driving, for possession or use of drugs: but the recidivism rates suggest that such measures alone may not be helpful either for society or the individual. On the other hand, provision may be made for compulsory treatment of such offenders and/or other persons found to be dependent on alcohol or other drugs. Under some circumstances such measures have been found effective. Legislation on the establishment of specific treatment and welfare measures may reflect society's recognition of the dependent person as being "sick" rather than "bad", and therefore worthy of help. Section 7.3 gives examples of such measures.

1.2.4 Prevention and treatment policies and programmes. Sections 7.2, 9 and 10 give many examples of the wide variety of existing policies and programmes concerning prevention of problems of alcohol and drug dependence and treatment of the persons affected. Several respondents and some of the governments concerned expressed their appreciation of the opportunity provided in responding to the WHO Outline for Inquiry to bring together important information on available services that had never before been collated centrally. This, it was considered, would facilitate coordination of effort and could be used for studying what further resources would be required in programme planning.

1.3 Definition of programme goals

For effective programme planning, the main objectives need to be defined and an order of priority determined. If closely concerned members of the community are invited to help in this work, they are more likely to collaborate in implementing the decisions. As knowledge accumulates and the situation changes, the objectives or their order of priority may have to be amended. Coordinating committees, at local and national levels, have been found valuable in some countries for assuming these tasks, as pointed out in Section 8.3.

The report of a WHO Expert Committee on Drug Dependence (1970) referred to the variety of national and local responses to problems associated with drug dependence, oriented primarily towards one of the following areas: "treatment, including rehabilitation; prevention, including both the control of interest in drugs as well as their production and distribution; and profit - official and private, licit and illicit".

The Committee's report sets out (p. 13) possible ways of stating preventive and therapeutic goals in relation to drug dependence, which are, it states, for the most part, the same and largely overlap.

The precise immediate and longer term goals will, of course, have to be stated in more concrete terms for each community or nation and the decision-makers will be helped by having available the kind of information outlined in Sections 1.1 and 1.2 above.

1.4 Ways of achieving goals

Once the programme goals have been clearly enunciated, the responses to alcohol and drug dependence problems in a country can be reviewed to see whether they are consonant with the goals. An example of inconsistency was seen in England, where repeated arrest of drunkenness offenders without treatment was glaringly at odds with a therapeutic objective, so that proposals have now been made for a more appropriate response to the problem.

One of the main purposes of the 1971 WHO Course and 1972 Seminar was to provide experience of responses in other countries that might suggest to participants possible ways of achieving the goals of their own country's programme. Thus, several participants considered that the sobering-up station visited in Poland, and the system of follow-up care, provided useful models for dealing with public drunkenness and, in the case of recidivists, with other underlying individual and family problems. The discussions with drug-dependent persons under

treatment in Phoenix House in London drew the attention of many participants to a therapeutic strategy not yet known in their own countries. Many other experiences were considered in the light of their applicability in another setting: these included not only visits in the host countries but also many descriptions presented by the participants, examples of which can be found in this report. A wide variety of services exist, of course, in countries other than the 33 under review and some are briefly described in the report of a WHO Expert Committee on Mental Health (1967, p. 26 on).

In seeking ways of achieving the stated goals, programmers will wish to consider the merits of many methods that may already have been tried out in their own and other countries, and to discuss them with the persons who will be involved in their implementation. These are likely to include members of the type of bodies listed in Table 15, personnel from the various professions considered in Section 11, mass media personnel and teachers for public education programmes, representatives of the community, and persons for whom the programmes are destined.

1.5 Choice of means according to resources available

Obviously a country with few trained physicians will not plan treatment programmes that rely heavily on psychiatric manpower. On the other hand, it may well decide to establish a pilot treatment service for alcoholics in a rural health centre, like the one visited in Bjelina, Yugoslavia, which is served by professional staff from Belgrade making short visits, the main continuity being assured by social workers from the rural area. The de Laurier Centre for drug-dependent persons in Amsterdam, Netherlands, which is run entirely by non-professional personnel, might serve as another model.

The decision may be reached that no special treatment resources should be set up, but that the existing medical and social welfare facilities should be used and special training on problems of alcohol and drug dependence be provided for the staff. Where programmes of voluntary organizations are found to be effective, consideration may be given to providing subsidies so that their activities may be extended, or arrangements may be made for closer collaboration with professional bodies.

1.6 Implementation of choice

When decisions have been reached on strategies for achieving the programme goals, much time will still have to be spent on discussing with the bodies to be involved the reasons for the choice of strategies and the type of action required. The financial, manpower and physical resources will need to be defined and allocated. Further preliminary training of personnel may be necessary. An attempt should be made to foresee and overcome possible obstacles to the successful implementation of the strategy. Means should be established for ensuring that the plans made are actually put into operation. Finally, a matter of great importance, evaluation procedures should be worked into the plan.

It will probably be considered important to try out the chosen strategy on a pilot scale first, so that information can be accumulated on the best ways of implementing all the above steps.

1.7 Evaluation of results

Unforeseen obstacles, changing circumstances, lack of resources and many other factors may combine to make the best laid plans go awry. The actions taken need to be continuously checked against the detailed plans and the results measured in terms of the stated goal. Problems arising during the implementation of the plan will require frequent discussion and the planning may need revision.

Measurement of treatment effectiveness is considered in Section 9.11, which points to the dearth of careful evaluation of treatment measures or strategies so far. The examples discussed at the Psychiatric Research Centre in Uppsala, Sweden, emphasized the need for precise definition of terms, description of each step in the treatment process, and selection of cohorts and control groups. The type of careful scientific evaluation that involves detailed preparation and testing of research instruments can be used only in operations carried out on a pilot scale, but such trials may be essential if efforts on a wider scale are to be fruitful.

Attempts have been made to evaluate the effects of various measures for the control of production and distribution of alcohol and other drugs and this has sometimes led to changes in the control measures.

In Section 10.4, attention is drawn to the need for evaluation of public education and preventive campaigns, whose effects may be quite the opposite of what was desired.

There appears to have been little evaluation of the education of professional groups on problems of alcohol and drug dependence, although this is another important field for investigation.

1.8 Conclusions

Planning of programmes to deal with problems related to alcohol and drug dependence is seen to involve a number of logical steps, from defining the problems, establishing means of reaching the stated goals, to evaluating the results and adjusting the programmes accordingly. Such endeavours will involve the cooperation of persons with a wide variety of professional backgrounds and experience. This report attempts to provide examples of such cooperation and to describe how many aspects of the problems under review have been approached in 33 countries.

2. DATA COLLECTION, ANALYSIS AND UTILIZATION

Throughout this report, reference is made to the importance of careful collection of data on the availability and consumption of alcohol and other dependence-producing drugs and their correlations with problems of excessive consumption. Estimates of the extent of these problems are required as a basis for rational programme planning, for which data on existing prevention and treatment resources are needed as well. Of particular value is information on trends, which can provide clues to the efficacy of measures taken and to future requirements regarding existing or alternative preventive and treatment resources.

A session each in 1971 and 1972 was devoted to types and methods of collection of the relevant data, introduced by a consultant.¹ It was seen that a first step in data gathering is the definition of terms. The variety of existing definitions of alcoholism and excessive drinking is illustrated in Section 3.1, which also refers to the need to consider the type and quantity of the beverage used, and the frequency and duration of consumption. In Section 5.1, a definition of drug dependence is given but attention is drawn in 5.2.1 to the need to consider the type of substance used, as well as the quantity, frequency, and route of administration when judging the severity of the problem.

Wide international agreement has not been reached on the definition of terms, but efforts are being made in that direction, particularly when collaborative studies are envisaged. In the meantime, clear statement of definitions will add greatly to the value of any data gathering or investigation. In studies of trends the same definition should, of course, be used in reassessment, and this is likely to be much more important, for local and national data collection, than the establishment and use of internationally agreed definitions.

¹ Miss E. M. Brooke, now: Chef du Département de Statistiques médicales, Institut universitaire de Médecine sociale et préventive, Hôpital Sandoz, Lausanne.

Sections 3.2 and 5.2 bring together some of the information provided in the responses on the prevalence of alcohol and other drug problems in the 33 countries under review. The statistics are far from comparable from one country to another. Table 1 indicates the variety of the sources of information, such as "informal guess", data from institutions, and surveys.¹ Data on alcohol and other drug problems have been collected from statistics on morbidity and mortality, on numbers of patients admitted to hospitals and other treatment and hostel resources, and on legal offences related to alcohol and other drug use.

Many factors make these figures unreliable as indicators of the true prevalence of the problems under review but, taken together and particularly when the changes are reviewed over a period of time, such data may give a useful impression of the magnitude of the problems and the changing trends. Collection of such information from a variety of sources is likely to be more useful when related to a limited and geographically defined population, where many concomitant factors are known, than when related to a total country. Surveys of defined populations (see Tables 2 and 13) have given far higher estimates of the prevalence of alcohol and drug dependence problems than was revealed by collected data on numbers of cases coming to attention for therapeutic and legal reasons.

Section 4.2 shows that several of the countries under review produce some data on per capita consumption of alcohol. As pointed out, these figures are much more meaningful when related to type of beverage consumed and to the percentage of potential consumers (which varies between populations and is affected by age and sex distributions, but may be estimated from sample surveys). However, the average figure obtained must be interpreted with care, since it may be the result of varying ranges of consumption levels. In other words, the same per capita consumption level may be attained for 50% heavy drinkers and 50% abstainers as for 100% drinking an average quantity. The number of "problem drinkers" in each case will be very different. Nevertheless, changes in average consumption levels, along with information on other factors may give important indications of need for altering controls.

WHO will be giving increasing attention in its programmes on alcohol and drug dependence problems to questions of improving not only the collection and reliability of data but also their analysis and utilization. The possibilities and means of improving the comparability of studies will also be examined.

3. EXTENT OF PROBLEMS OF ABNORMAL ALCOHOL CONSUMPTION

3.1 Definitions and classifications of "alcoholism" and "problem drinking"

It is clear from a review of the responses to the WHO Inquiry that there is no internationally or even nationally accepted definition of "alcoholism" or of "problem drinking" but that a variety of definitions and classifications are in use for legal, insurance, treatment, and research purposes.

3.1.1 Definitions of terms

Jellinek (1960) terms as alcoholism "any use of alcohol beverages that causes any damage to the individual or society or both" and states that "vague as this statement is, it approaches an operational definition". It would appear that in most countries the term "alcoholism" is reserved for the more severe stages of damage, although the additional alcohol-related problems implied in the above definition are also of concern.

¹ See Brooke (1972) and Lin & Standley (1962) for reviews of the advantages and disadvantages of reliance on such data in epidemiological studies of mental disorders.

The second report of the Alcoholism Subcommittee of the WHO Expert Committee on Mental Health (1952) defined alcoholics as "those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their inter-personal relations, and their smooth social and economic functioning; or who show the prodromal signs of such developments. They therefore require treatment".

Excessive drinking was defined as "any form of drinking which in its extent goes beyond the traditional and customary 'dietary' use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behaviour and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physiopathological and metabolic influences." Similar definitions are used in several of the 33 countries. In Panama a definition of alcoholism based on that of the American Psychiatric Association (1968) is used.

Examples of definitions for legal use are found in Swedish temperance treatment legislation. "Alcohol abuse" is stated to exist "when someone frequently uses alcoholic beverages to obvious detriment for himself and others", whereas "addiction to alcohol" is considered to exist when the abuse has continued for an unspecified time, but is habitual, and the abuser seems to be physically and/or psychologically attached to his alcohol consumption.

Terms for symptoms of the alcoholic process, such as "craving" for alcohol, "withdrawal symptoms", "loss of control" and "alcoholic amnesias" have been described in the report of the WHO Expert Committee on Alcohol and Alcoholism (1955) and in Jellinek (1960) but, although they are widely used, there appears to be no common agreement on their meaning.

Drug dependence was defined by a WHO Expert Committee on Drug Dependence (1969) as "a state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug." The report of a WHO Scientific Group on the Evaluation of Dependence-Producing Drugs (1969) points out that "The characteristics of drug dependence show wide variations from one generic type to another, which makes it mandatory to establish clearly the pattern for each type." Alcohol is included among the generic types for which "the consistency of the pattern of pharmacodynamic actions is sufficiently uniform to permit at this time accurate delineation".

The use of the term "dependence on alcohol" appears to be gaining ground, although there is still much controversy about its significance.

3.1.2 Jellinek classification

Reference was made in the WHO Outline for Inquiry to the use of the Jellinek classification of "species of alcoholism", in which he defined five clusters of symptoms that could be summarized as follows:

Alpha alcoholism: this refers to an "undisciplined" use of alcohol to relieve "bodily or emotional pain", and "represents a purely psychological continual dependence" but no great difficulty in abstaining, although some social effects may become apparent.

Beta alcoholism: this involves physical damage resulting from alcohol use in the absence of either physical or psychological dependence.

Gamma alcoholism: the symptoms included here are craving for alcohol, loss-of-control drinking and alcohol withdrawal symptoms such as morning drinks and morning shakes; there is progress from psychological to physical dependence and marked behaviour changes.

Delta alcoholism: here the emphasis is on dependence with inability to abstain from alcohol rather than loss of control over drinking.

Epsilon alcoholism: this refers to periodic or "bout drinking".

In most of the responding countries, this classification is known and is used to some extent by research workers. It is the most widely used classification in the United Kingdom and is used in Czechoslovakia for diagnosis of dependence on alcohol in many inpatient and outpatient services. However, the statement is made in several of the responses that the alpha, beta and epsilon types are not included in alcoholism and that they do not constitute diseases *per se*, as was, in fact, pointed out by Jellinek himself. His disease concept of alcoholism and his description of stages in the development of the disease and of the physical, psychological and social concomitants have apparently stimulated clinicians and research workers in many parts of the world to study these problems more closely.

3.1.3 Alternative classifications

The classification of drinkers proposed in the report of the Alcoholism Subcommittee of the Expert Committee on Mental Health (1952) makes a division into: irregular symptomatic excessive drinkers, habitual symptomatic excessive drinkers and addictive drinkers (alcohol addicts), the last two being labelled "alcoholics". This is similar to the broad classifications in general use in some countries. The report of the WHO Expert Committee on Alcohol and Alcoholism (1955) offers a classification of disorders induced by heavy use of alcoholic beverages.

Jellinek worked in Latin America, particularly Chile, for some time as WHO consultant and his concepts concerning alcoholism became known in that region. The following is the amended version of his classification as used in Chile and, with slightly different wording, in several other Latin American countries:

- (a) Abstinence from alcohol. Absolute absence of alcohol consumption or consumption in moderate quantities up to five times a year in exceptional situations.
- (b) Moderate consumption of alcohol. Habitual consumption of less than the equivalent of 100 ml of pure ethanol in one day and/or the occurrence of fewer than 12 states of drunkenness in one year.
- (c) Excessive consumption of alcohol. Habitual consumption (more than 3 days a week), because of sociocultural and/or psychopathological dependence, of more than the equivalent of 100 ml of pure ethanol (more than 1 litre of wine, more than a 0.25 litre of spirits, more than 2 litres of beer, etc.) in a day and/or the occurrence of 12 or more states of drunkenness (with some degree of motor incoordination) in a year.
- (d) Pathological consumption of alcohol or alcoholism. An illness characterized by the regular presence of sociocultural and/or psychopathological and physical dependence on ethanol. Physical dependence is manifested as an "inability to stop or to abstain" with regard to alcohol consumption, leading to intermittent or continuous alcoholism, respectively.

It will be noted that (c) more or less covers Jellinek's alpha and beta types, and (d) comprises the gamma, delta, and epsilon types.

In France, Jellinek's classification was adapted to the local situation by Perrin. Accordingly, a distinction is generally made between:

- (i) acute alcoholism, or drunkenness;
- (ii) chronic alcoholism; and
- (iii) symptomatic alcoholism, in which patently alcoholic behaviour is only a symptom of a more or less latent psychosis.

Another French author, Pierre Fouquet, distinguishes three types of chronic alcoholism:

- (i) alcoholitis (45% of cases): heavy drinkers, late mental state;
- (ii) alcoholosis (40% of cases): neurotic episodic drinkers, tolerance for alcohol but cannot abstain;
- (iii) somalcoholosis (15% of cases): sharp but transitory craving for alcohol; zero tolerance with immediate pathological drunken bout.

In Jellinek's terms, the beta and delta forms of alcoholism are considered to predominate in France and in other countries with a tradition of wine drinking.

In the response for Spain, mention is made of a triaxial classification used in statistical work by the Programme for the Prevention and Treatment of Alcoholism and Drug Addictions of the General Directorate of Health. The three axes used are initiation or cause of the habit, manner or mode of drinking, and consequences produced.

A similar concern with co-existing etiological and psychodynamic factors in alcoholism is apparent in the scheme used in Yugoslavia, particularly in the Belgrade Alcoholism Institute.

Discontent with existing classifications is voiced in the response from Australia, which states that "the definition of misuse of alcohol in a given society depends on the group norms concerning alcohol use, that is, on the range of drinking behaviour regarded as socially acceptable. It is now generally the case in Australia that most workers in fields of alcohol and drug use problems are moving away from categorized pigeon-hole types of classification. Accordingly, Jellinek's classifications are having to be modified to accommodate the observation that the distribution of drug consumption generally approximates to a logarithmic normal curve.¹ The whole status of alcoholism disease is having to be reconsidered in the light of the behavioural sciences and modern epidemiological findings." As in the classification used in Latin America, however, the definition of excessive drinking according to quantity and/or frequency of consumption is considered of value; "The most practical approach to the problem is that of Wilkinson et al. (1969), who defined excessive drinking as an average consumption in excess of 80 grams of ethanol per day, with a particularly high risk level of drinking as being above 160 grams per day."²

For statistical purposes, many countries use the classification given in the International Classification of Diseases (World Health Organization, 1967). Proposals for amendment of the section on mental disorders have been considered during a series of International Seminars on Psychiatric Diagnosis, Classification and Statistics, the eighth of which was held in 1972. Changes were suggested for the ninth revision in relation to the classification of alcohol-related disorders.

¹ See WHO Study Group on Youth and Drugs (1973) for discussion (p. 11).

² These figures were quoted from Caroli & Pequignot (1958) who labelled consumption rates of 80-160 g per day as being in the danger zone, the high risk zone being above 160 g per day.

Discussions during the 1971 Course and 1972 Seminar emphasized the need for national concern not merely with "alcoholism", but also with many problems related to use of alcohol. These include the consequences for the individual of contaminants and intoxication, the physical and mental consequences of prolonged consumption, including dependence, and of withdrawal, as well as the socioeconomic consequences for the family, in the occupational sphere, in traffic, in the penal sphere and in treatment services.

3.2 Prevalence of "alcoholism" and "problem drinking"

In view of the considerable differences in drinking patterns and of definitions of "alcoholism" and "problem drinking", both between and within countries, little reliance can be placed on comparison of rates between areas. Moreover, except in the rare cases of special surveys, the numbers of cases found will be those coming to attention for penal or therapeutic purposes and will depend largely on the type and extent of services available. In order to provide a basis for more rational organization of services it is, however, exceedingly important for each area to collect prevalence statistics based on known definitions and to study the trends over time. Table 1, while not providing data for purposes of comparison, gives an indication of the estimates of prevalence of alcoholism and excessive drinking in many countries according to the locally used definitions.

3.2.1 Estimates in geographically defined areas

Some careful estimates of prevalence of alcoholism, using data from a number of sources, have been made in geographically defined areas.

Examples of survey results as reported in the responses are given in Table 2, which gives some evidence of the variations in definitions or descriptions of alcoholics and heavy drinkers.

3.2.2 Estimates related to demographic variables

All references in the responses relating to differences between alcoholism rates for males and females show considerably higher rates for the former. In Argentina, for example, female alcoholism is stated to be rare; in Chile, 95% of alcoholics are male. For some countries (e.g. Spain) the rate among females appears to be rising. The response relating to the Netherlands, however, suggests that an estimated "60 to 70% of the female problem drinkers remain in ambulant treatment, often by private psychiatrists", and such cases may not be included in prevalence rates. Mention is also made in some responses of increased occurrence of excessive drinking at earlier ages than formerly. Among males admitted to the Prague sobering-up station, those in the age group 15-20 years comprised about 6% of total admissions in 1955 and about three times that rate in 1964.

3.2.3 Alcoholism in industry

Some revealing studies have been carried out among industrial workers. In Zambia, for example, 30 per 1000 workers in a large mine were classified as "problem drinkers" in 1962. A study was made of a representative sample of about 2500 workers from five basic industrial concerns in Croatia, Yugoslavia. Among males, 158 per 1000 were found to be alcoholics and an additional 173 excessive drinkers. Comparative rates among females were 9 and 23.

3.2.4 Prevalence of physical and mental complications

(a) Cirrhosis of the liver. The main physical complication of alcoholism referred to in the responses is cirrhosis of the liver. A World Health Organization report (1968) shows that cirrhosis of the liver is increasing in prosperous countries. In 1969, France and Chile had the highest national rates recorded for deaths from liver cirrhosis (35.3 and 35.7 per 100 000) and New Zealand and England and Wales had the lowest rates (2.8 and 3.2 per 100 000).

TABLE 1. ESTIMATES OF NUMBERS OF "ALCOHOLICS" AND "EXCESSIVE DRINKERS" PER 1 000 TOTAL OR SPECIFIED POPULATION IN 16 COUNTRIES, FROM RESPONSES TO THE WHO OUTLINE FOR NATIONAL INQUIRY, 1971 AND 1972

Country	Population base	Rate per 1 000		Basis of estimate
		Alcoholics	Excessive drinkers	
Argentina	Total population	10-30		Informed guess
Austria	Total population	25-30		Regional inquiries
Australia	Total population	50 M. 10 F.		Rankin (1970)
	Those over 20 years	20		Sargent (1968)
Chile	Those over 15 years	50	150	Data from several epidemiological studies
Colombia	Total population	22		Informed guess
Costa Rica	Those aged 15-59 years		80	Survey of representative samples, all regions
Czechoslovakia	Total population	20	140	Known numbers of alcoholics in Prague
Finland	Those over 20 years	5.1 M. 0.9 F.		Jellinek's formula; representative sample from all regions of Finland, 1961-66
France	Total population	40	90	Jellinek's formula; results similar to Ledermann's (1956) findings
Mexico	Total population	5.5 7.0		1960 census and questionnaire to doctors. Inquiry by visiting nurses. Minimum figures
Netherlands	Total population	10		Gadourek's (1963) sociological investigation
Poland	Total population	10	80	Data from institutions throughout Poland
Spain	Total population	20-30		Informed guess
Switzerland	Total population	20 4.7		Informed guess. Surveys and administrative statistics
United Kingdom (England and Wales)	Total population over 15 years (1968)	0.2-11		Inquiry to general practitioners, 1955-6; Jellinek's formula
Yugoslavia	Total population	25		Surveys and treatment data

TABLE 2. NUMBERS OF ALCOHOLICS AND HEAVY DRINKERS PER 1 000
POPULATION IN GEOGRAPHICALLY DEFINED AREAS

Area and date surveyed	Survey reference	Population surveyed	Alcoholics or heavy drinkers	
			Rate per 1 000	Definition
<u>Australia:</u> a community	Krupinski & Stoller (1969)	Males	75	Daily consumption >80 g ethanol
			25	>80 g ethanol on at least 1 day/week
<u>Australia:</u> another community			300	At least 2-3 times per month, 5 or more drinks per session
			150	The same, at least 2-3 times per week
<u>England:</u> Country of Cambridge, 1961-64	Moss & Davies (1968)	15 years and over:		Known to any of 13 social agencies for drinking problems or various "conse- quences of drinking"
		Males	6.2	
		Females	1.4	
<u>Switzerland:</u> 10 small communes in a wine-producing canton (Valais)	Calpini et al. (1963)	20 years and over:		"Alcoholics"
		4 329 males	128	
		4 386 females	13	
<u>Switzerland:</u> one commune in another canton		About 4 000 inhabitants over 20 years:		"Alcoholics"
		Males	143	
		Females	13	
<u>Yugoslavia</u> a commune in Croatia		Representative sample of males aged 20-50 years	189	"Proven alcoholics"
			216	"Excessive drinkers"

It has to be kept in mind that alcohol consumption is not necessarily the only cause of this disorder. Separate statistics are available for some countries on mortality from cirrhosis of the liver where alcohol is mentioned as a cause (see Table 3).

TABLE 3. DEATHS FROM CIRRHOSIS OF THE LIVER PER 100 000 MALE POPULATION, WHERE ALCOHOLISM IS MENTIONED AS A CAUSE

Place	Study reference	Rate ¹
Santiago de Chile	Puffer (1968)	143.0
Mexico City		102.5
Guatemala City		26.9
Cali	Response to Outline for Inquiry	8.9
Costa Rica		88
Panama		3

¹ Female rates much lower.

Official statistics from Venezuela are stated to show that deaths from alcoholic cirrhosis accounted for only 8.7% of all cirrhosis deaths in 1969. As pointed out in the response from Sweden, it is difficult to know how many of the cases are found through improved diagnosis (Hällén & Linné, 1969).

(b) Deaths from alcoholism. Rates for deaths from alcoholism in the above-mentioned WHO report remained practically stable from 1956 to 1965, the highest being France, with a rate of 12 per 100 000 population in 1965 and the lowest England and Wales (with a corresponding rate of 0.1).

(c) Suicide. A World Health Organization publication (1968) has reviewed studies indicating the high suicide risk among alcoholics. The percentage of alcoholics among persons attempting or committing suicide in the samples studied varied from 0.5 to 32.8.

(d) Other complications. Among forms of physical damage associated with excessive use of alcohol the following are mentioned: peptic ulceration and gastritis, alcoholic cirrhosis, hepatitis and corditis, tuberculosis, damage to the peripheral and central nervous system including peripheral neuritis and dementia, and accidents (Edwards, 1967). There appear to be few statistics available on the prevalence of such complications. However, Table 4 gives an example of the more frequent medical problems among a population of treated alcoholics.

TABLE 4. PROPORTION OF ALCOHOLICS¹ TREATED IN THE INSTITUTE ON ALCOHOLISM, BELGRADE, WITH VARIOUS ASSOCIATED MEDICAL PROBLEMS

Medical problem	Alcoholics affected (%)
Serious damage to liver	17.9
Tuberculosis	10.4
Ulcer disease	8.3
Cardiovascular diseases	15.9
Polyneuritic disorders	29.1
Psychotic reactions and alcoholic psychosis	7.5

¹ Total number = 6549.

TABLE 5. ALCOHOLICS AMONG ADMISSIONS TO GENERAL AND MENTAL HOSPITALS

Country	Year	Admissions for alcoholism			Nature and place of total admissions (comments)
		Number	Primary or secondary diagnosis	Rate: percentage of total admissions (or No. per 100 000 population)	
Australia New South Wales	1969-70	3 489 males } 620 females }	Primary	25 10 5-20	Males admitted to all 10 mental hospitals All adult medical inpatients in general hospitals All patients attending psychiatrists in private practice
W. Australia	1969-70			(27 per 100 000 population)	Admitted to mental hospitals
Queensland		369 144	Primary Secondary	34.9	All admissions to mental hospitals
Austria	1961-70	29 776		(531 per 10 000 population)	(Withdrawal treatment) admissions to all hospitals
Czechoslovakia	1966	3 456 (1st admissions) 3 473 (readmissions)	Primary	13	All admissions to psychiatric institutions
France			Primary Primary	25-45 5-8 37 males 8 females	All males in medical departments of general hospitals All females in medical departments of general hospitals Admissions to psychiatric hospitals
Japan	1969			(19.2 per 100 000 population) (6.3 per 100 000 population)	In mental hospitals In general hospitals
Panama	1970	43	Primary	2.8 (3.1 per 100 000 population)	All admissions to the mental hospital
Poland	1957 1965	1 648 4 372	Primary Primary	5.7 13.0	All admissions to mental hospitals All admissions to mental hospitals
Sweden	1965 1965 1965	104		4.8 27.6 (males) 2.5 (females) 12.8 (males) 1.1 (females)	Patients over 16 years old in 57 medical and surgical clinics All admissions over 16 years old to 14 psychiatric clinics Patients in 6 mental hospitals
Switzerland	1968	1 200		22.5 (males) 4.3 (females)	First admissions to mental hospitals
United Kingdom England and Wales	1954 1967	2 359 8 066	Primary and secondary Primary and secondary	1.9 3.67	All admissions to mental hospitals All admissions to mental hospitals
Scotland	1960 1968	1 091 3 095		8.5 14.1	Admissions, readmissions and transfers to mental hospitals and psychiatric units
Yugoslavia Croatia	1954 1971	585 6 000		About 50	All male admissions to psychiatric institutions

The response from Czechoslovakia refers to an increase in the incidence of delirium tremens in South Moravia in recent years and to a high frequency of peptic ulcer among alcoholic outpatients. A report of an investigation by the Japanese Ministry of Health and Welfare in 1969 is stated to report that 39% of alcoholic inpatients suffered from complications such as diabetes mellitus, hypertension, chronic pancreatitis, chronic gastritis, peptic ulcer, alcoholic myocarditis, as well as cirrhosis.

(e) Alcoholic patients in hospitals. The response from France refers to the fact that the proportion of alcoholic patients in general hospitals is extremely high, ranging from 25% to 45% in male and 5% to 8% in female general medical departments. In many countries, such patients may appear in statistics under diagnoses other than alcoholism and may therefore not be included in prevalence figures. Statistics on admissions to psychiatric hospitals in France indicate that 37% of male admissions and 8% of female admissions are due to alcoholic psychoses and chronic alcoholism. In Victoria, Australia, of 110 000 patients admitted to hospitals (excluding obstetric hospitals) 16-20% of males and 4% of females per year, in addition to the illness for which they were ostensibly admitted, were alcoholics; admission for alcohol problems accounts for 20-30% of admissions to psychiatric hospitals. Some further examples are given in Table 5. Data on hospital admissions cannot, of course, be used alone to provide prevalence rates, since admission rates depend on the availability and proximity of hospital services, alternative forms of care and a number of other factors.

3.2.5 Alcohol problems among vagrants

In many large towns important problems of alcoholism are found among vagrants, homeless persons, or persons living in private or state-organized lodging houses. The Temperance Treatment Board in Stockholm has a special agency for homeless men. The numbers with alcohol problems registered for this group in 1970 constituted one-third of the total registration. The relevant proportion for Gothenburg in 1971 was one-quarter. A similar problem seems to occur in Helsinki. Several studies have been made of homeless persons in London. Table 6 gives some examples of alcohol problems among these groups.

TABLE 6. ALCOHOL PROBLEMS AMONG VAGRANTS

Place	Population	Percentage found with alcohol problems
Gothenburg, Sweden	165 homeless persons	95% arrested at some time for drunkenness 65% had been under compulsory institutional care for drug abuse
Helsinki, Finland	Men in rooming houses in 1969	74% had dealings with police because of alcohol consumption
London, England	837 residents in Government Reception Centres, March 1966	21% heavy drinkers 7% suspected alcoholics

A special problem among these "skid-row" drinkers is consumption of technological spirit containing methanol. There are an estimated 4000 of these drinkers in Sweden, of whom about half live in Stockholm; they are mostly middle-aged or older, socially deteriorated and usually unemployed. Of the 5000 homeless alcoholics in Finland in 1970, about 70% drank substitutes for beverage alcohol. In Helsinki, there are about 300-400 alcoholics of the "skid-row" type and it is stated that "These people live mainly in harbour areas, which provide

habitable depositories, in refuse containers, in wooded islets (where they build huts) and in dumps, where they replenish their food and clothing supplies". Their life expectancy is 50 years. Of the 250 000 persons recognized as having "alcoholism" in Australia, the "skid-row" represents some 10%.

From Czech, Polish, Swiss, and Yugoslav information, it appears that homeless persons and vagrants do not constitute an important problem in those countries.

3.2.6 Drunkenness arrest data and alcoholism among prison populations

It is clear from a number of responses that inebriation and alcoholism are very frequent causes of arrest and concomitants of criminal offences.

Arrests (sentences) for drunkenness in Sweden, for instance, affected almost 1% of the population between 1954 and 1969. In Western Australia in 1971 about 0.5% of the population served a prison sentence for drunkenness and disorderly conduct associated with alcohol use. Convictions for such offences in Victoria, Australia, leading to prison sentences account for about half the admissions to prison. Offences of drunkenness proven in England and Wales between 1950 and 1969 concerned 1-2 per 1000 of the population aged 15 years and over. In Chile, in 1969, 30% of all arrests were for drunkenness.

Several references are made to the considerable differences in the above rates according to sex. The rate of sentences for drunkenness in Sweden, for instance, was about 32 times as high for males as for females. In England and Wales, the rates were about 30 for males to 2 for females. Of all persons in prison in England and Wales in 1969 about twice as many men as women had served sentences for drunkenness offences: there were, however, far fewer total female than male offenders.

In some countries there has been a considerable increase in drunkenness arrests at younger ages. The rates in Sweden for the age groups 15-20 years in 1960-1969 were double those in 1954, although they have now started to decline. The number of convictions for drunkenness in the age group 14-16 in England and Wales trebled between 1955 and 1962.

Several studies of drunkenness offences have shown that a high proportion of arrests are made on the same men. Among offenders appearing on charges of drunkenness in two London courts, half of the sample interviewed had been arrested for drunkenness on at least one other occasion and a third three times or more. Among men in Sweden who committed their first drunkenness offence in 1959, relapses during the period 1959-1964 were more common among those who had committed their first offence at a younger age.

As regards alcohol problems among total prison populations, several responses quote figures suggesting that a third to a half may be thus affected, although much lower rates are given for Japan and for one prison in India (see Table 7).

3.2.7 Drunken driving and traffic accidents

Excessive alcohol intake is stated to be the cause of a varying percentage of traffic accidents, estimated as at least 30% in France and 3-10% in several other countries (Netherlands: 3% (1965); Japan: 4.3% (1968); Switzerland: 5-7% (1972); Czechoslovakia: 7.8% (1957-66)). It is pointed out for Australia that "the death rate from traffic crashes is now five times as great as that from all infectious diseases put together. Alcohol consumption has been shown to be the principal factor underlying at least 50% of these deaths."

Statistics from some studies indicate that the actual proportion of accidents involving persons with a high blood-alcohol level is much greater than is suggested by the above paragraph. A study in Brisbane, Australia, showed that 62% of single car accident drivers

TABLE 7. ALCOHOL PROBLEMS AMONG PRISON POPULATIONS

Country	Population or offences	Percentage with alcohol problems
Poland	Offences committed in 1966 279 persons sentenced for homicide, 1961 Recidivist prisoners convicted at least fourth time	37% due to effects of alcohol 55.6% had been drinking systematically and extensively 64.5% intoxicated at time of act 95% "abused alcohol" 5.5% often "drank excessively, e.g. 0.25 litres of vodka 3 or more times per week" 53.2% showed symptoms of alcohol dependence 50.6% had "drunk alcohol excessively before age 17 yr"
Australia (Western Australia)	Murder cases, assault and battery, rape and similar offences against persons	>50% alcohol intoxication played major role
France	Prisoners in Melun Central Prison, 1961 Recidivists in Melun Central Prison, 1955	36% alcohol to blame for offence 46% alcoholics
Netherlands	Persons aged over 18 years convicted of transgressions of Criminal Code, 1966	24% males } intoxicated at time 2.1% females } of offence
Yugoslavia (Belgrade)	Offences committed in 1971	27% under influence of alcohol
Zambia	All cases in 2 urban and 5 rural courts in 1955/66 Urban courts	24% alcohol involved 43% alcohol involved
Japan	678 522 criminals in 1964	3% committed crime chiefly because of drunkenness
India	Criminals in Central Jail, Bangalore	0.7% crimes related to alcoholism

had blood-alcohol levels higher than 100 mg per 100 ml (0.1%). In a five-year study of fatalities in Perth, Australia, 40% of traffic accident victims had blood-alcohol levels above 100 mg per 100 ml (Pearson, 1957). It is stated for Chile that acute alcoholism is the most frequent factor in traffic accidents. Among males involved in traffic accidents 70% have positive "alcoholaemia", this being higher than 100 mg per 100 ml in 56% of these cases (Vargas, 1966). In Zambia, a pathologist examined the blood-alcohol levels of traffic accident victims - mainly cyclists and pedestrians - in 1958-66. The level was at least 150 mg per 100 ml in 55% of cases. The 1967 Road Safety Act in England and Wales authorized the use of breath tests of alcohol consumption. The number of prosecutions for drink- or drug-related motoring offences in 1968 was double that of the previous year, probably largely as a result of the use of improved means of detection.

Detection and sentencing of drunken drivers may help to lower accident rates but do not necessarily prevent recidivism. A study in the Netherlands (Buikhuisen, 1968) showed that about 30% of persons convicted for drunken driving are recidivists. Of this group, 20% offended again within a year, 35% within two years and nearly 50% within three years. There was a high correlation between this type of recidivism and habitual drinking.

Not all national legislations state the alcohol level above which the detected driver is punishable, but an increasing number of countries are considering introducing such regulations. In Sweden, a driver will be convicted of drunken driving if he has been so influenced by alcohol that it can be presumed he could not have operated his vehicle satisfactorily. A blood-alcohol level of at least 150 mg per 100 ml is a sufficient reason for conviction. Legislation enacted in 1934 made imprisonment the normal penalty for drunken driving and even in 1967 nearly 1800 persons were thus punished in Sweden. The number of annual violations remained about 5 per 1000 vehicles between 1950 and 1967. Some of the violations and sentences were for so-called "unsober" driving, defined as driving with a blood-alcohol concentration of 50-100 mg per 100 ml. The punishable lower blood-alcohol limit in Sweden was changed in 1957 from 80 mg per 100 ml to 50 mg per 100 ml, but the relative number of violations continuously decreased until 1963. This may have been due to the more stringent legislation, but possibly to the fact that police resources were insufficient for a high level of surveillance.

In France, a 1970 law set a limit on alcoholaemia of 80 mg per 100 ml. Checks have shown that when alcohol tests are positive, the blood-alcohol level often exceeds 200 mg per 100 ml.

A 1961 law in Czechoslovakia completely prohibited alcohol consumption by drivers before and during driving. Despite a linear increase in the number of traffic accidents caused by drivers between 1957 and 1966, the percentage caused under the influence of alcohol decreased from an average of 11 in the four years preceding the law to an average of seven in the six following years.

In seven hospitals in different parts of Switzerland in 1964-70, over 1000 persons injured in road accidents were tested for alcohol effects and one-third were found to be under the influence of alcohol. More than half of this group had a blood-alcohol level higher than 80 mg per 100 ml, which suggests that alcohol may play a much bigger role in traffic accidents than is usually found.

4. AVAILABILITY AND CONSUMPTION OF ALCOHOLIC BEVERAGES

4.1 Drinking habits and drinking surveys

4.1.1 Types of alcoholic beverage consumed

The responses refer to a wide variety of alcoholic beverages produced and consumed, and considerable differences are noted between countries and in some cases between different parts of the same country with regard to the types of beverage most frequently consumed.

A broad distinction can be made between areas where alcohol is consumed mainly in the form of either wine, beer, or spirits. As can be seen from Table 9, Chile and France are the main wine-consuming countries of those reviewed and in Switzerland the per capita consumption of wine in the wine-producing areas is much higher than the national average. Beer consumption is particularly high in Australia, Czechoslovakia, Germany (no statistics provided), the United Kingdom, Venezuela, and Zambia, as well as in the northern parts of Switzerland. Outstandingly high consumption of spirits is noted in Yugoslavia, followed by Poland and Sweden.

In each of the countries, varied proportions of the other beverages are consumed. In France, for instance, the percentages of the consumption attributable to the main alcoholic beverages in relation to the total volume of pure ethanol consumed are: wine 70% (falling); cider 4% (falling); beer 11% (rising); spirits 15% (rising). The percentage of alcohol derived from wines is rising in several countries that do not produce wines, and the percentage derived from beer is increasing in several wine-producing countries. A number of countries refer to increasing importation of spirits, particularly whisky, brandy and gin, which in many such areas are consumed mainly by the affluent.

Increased communications and the influence of other cultures appear to be changing the types of beverage available and used in some parts of the world. The response from Australia mentions, for example, that "consumption of wine in most sections of the population is increasing and most European migrants learn to drink beer. This acculturation is illustrated by a story from a primary school of a small country town. An eight-year-old boy, the son of an Italian migrant to Australia, came to school with a small flask of wine to drink with his lunch. The teacher tried to tell him that this was unacceptable and despite the language barrier, obviously got her message through - the following day the child arrived at school with a can of beer to go with his lunch.

A number of less well-known beverages are widely consumed locally. These include maize wine and palm wine in Nigeria, home-brewed beers in Zambia, rice spirits in Thailand and rice wine (saké) in Japan, pulque and tequila in Mexico (the fermented and the distilled products of the native maguey plant). In fact the raw materials for the production of alcoholic beverages are everywhere available and every civilization learned early the necessary techniques of fermentation and developed customs and mystiques connected with consumption.

4.1.2 "Drinkers" and abstainers

In practically all the countries responding to the WHO Outline for Inquiry, it is considered "normal" for adults to drink alcoholic beverages, at least on occasion. The exceptions are parts of India, where prohibition is in force, and rural areas of Egypt (four-fifths of the population) where the religious sanction is still maintained and where wine-selling shops are prohibited.

Abstinence is particularly infrequent among adult males: fewer than 5% in Finland; few in Austria; exceptional in France; 14% in the Netherlands (Gadourek, 1963); very low percentage in Switzerland; 10% in Sweden; 20-30% in Japan. Among adult females, however, the percentages of abstainers given are higher, for example, 15-30% in Finland, 22% in

the Netherlands, about 70% in Japan. In the Philippines, only females of the "elite" class drink. Reference is made in several responses to the fact that the percentage of women and of younger people who consume alcohol is steadily increasing (e.g. in Japan, Spain, Sweden). In Australia "it is only in the past two or three years that young teenagers have started to become members of Alcoholics Anonymous and, for example, deaths are being recorded from alcohol use in children as young as 14". On the other hand, widespread education appears to have reduced the habit in some countries of providing alcoholic beverages to very young children and even infants (in France, for instance; although in certain rural areas of Yugoslavia "it is not unusual to see mothers giving their babies red wine . . . to make them sleep better").

4.1.3 Drinking occasions and places

In wine-producing countries of Southern Europe, the majority of adults commonly drink wine with meals, both at home and in restaurants, and wine is considered an ordinary component of food intake. Brandy or liqueurs are frequently taken with coffee after meals. However, drinking also takes place apart from meals to a varied extent in different wine-producing areas. In Austria, for example, "it is the custom, praised by sentimental song, and exported all over the world, to go out with friends to the 'Heuriger' in the evening. 'Heuriger' means the wine of this season's vintage, which is sold by the vintner in small quantities and drunk in little illuminated gardens". Another example is Israel, where it is customary to drink a glass of wine on Friday evening as part of religious ritual to sanctify the Sabbath.

In the major beer-producing countries, although beer may accompany meals, it is largely consumed between meals and often outside the home. In Britain, for instance, "the traditional outlet for the consumption of alcohol . . . is the public house (pub), which originated in Saxon times and has been the typical communal drinking centre for the majority of the population since then". Reference is made to a survey showing that 83% of 1 400 persons who had drunk beer during the previous year had patronized a pub regularly. The response from Czechoslovakia states that "the consumption of alcoholic beverages is accounted for mainly by the consumption of beer in restaurants and pubs . . . The beer drinker stays some hours in the typical pub and he drinks an average of five to eight glasses (half litre)". Social heavy drinking is stated to be normative behaviour in Australia for the entire adult male population of major cities, such as Sydney.

In Poland, where the main source of alcohol is vodka, alcohol consumption with meals is uncommon but social drinking is frequent. Vodka is drunk in restaurants, bars and private homes. Beer is increasingly being drunk in beer bars and street or railway kiosks. Female drinking in public places is disapproved. The Swedes, who "are still a hard-liquor consuming people", although beer consumption is also high, have frequent social occasions for alcohol consumption although it is stated that "a large part of the Swedes' heavy consumption of alcohol is associated with meals. Drinking in bars is rather limited". In one country with the highest recorded consumption of spirits, "people drink 'for health', 'for the soul', in happiness and in sorrow when someone is born and when someone dies. They drink for success and for failure, before and after meals, before work and during work". It is stated that "in many social environments, especially rural, a litre of brandy or wine is always, from the early morning till late evening, at an arm's length. Everybody can take some of it whenever he feels like it and as much as he wants". In villages in the winter "they have parties almost every night where they drink boiled brandy in great quantities".

Reference is made in many of the responses to heavy drinking on special occasions. In Chile, for example, "drinking goes on for any motive on all occasions and under all circumstances (baptisms, celebrations, quarrels, etc.) in excessive measure or in an exaggerated way" (Horwitz et al., 1969). Other responses mention increased alcohol consumption during festivities, on conclusion of business affairs and during election years!

4.1.4 Frequency and quantity of consumption

The frequency and quantity of consumption of alcoholic beverages will affect the drinker's behaviour, influence pathology, and influence other possible undesirable consequences of consumption. These aspects are therefore worthy of study in the individual as well as through special surveys. Table 8 summarizes information from a few surveys reported in the responses. Considerable difficulty may be experienced in obtaining reliable data. Schmidt (1973) refers to evidence that, with increase in level of consumption, drinkers are more likely to under-report the quantities drunk in survey interviews. More reliable data can probably be obtained when study of alcohol consumption is included as part of dietary surveys.

It is of interest that public education in France aims at reducing the quantity of alcoholic beverage consumption considered as "normal", rather than aiming unrealistically at abstinence. The response states that: "The drinking levels suggested by the National Academy of Medicine (not more than 3/4 litre of wine per day for a man in good health, not more than 1/2 litre for women and adolescents, no alcoholic beverages for children) appear, under the influence of persistent publicity . . . , to be winning over a growing proportion of the population."

4.1.5 Attitudes to drunkenness

Several responses state that drunkenness in public meets with social disapproval (France, Mexico, Sweden, Venezuela, Zambia). A Netherlands survey (Gadourek, 1963) found that 67% of respondents condemned drunkenness "but not too strongly": one in six adult Dutchmen is stated to have experienced intoxication.

In a few countries it appears that drunkenness among males is relatively frequent and is tolerated, but there is strong disapproval of female drunkenness. In Chile, for example, "among lower socio-economic strata, adult males drink outside the home with male friends, preferably on pay days, actively seeking the state of drunkenness which has a positive valuation as a sign of friendship and virility. Females . . . tolerate the male norm of excessive consumption. There is no social tolerance for female drunkenness under whatever circumstances . . . There are also the so-called 'cultural crises' of consumption which occur on occasions of national, religious and other festivities when male drunkenness of two or more days duration is tolerated". In Thailand "it is considered common to see drunken persons at parties, but the Thai society does not approve of drunken women".

There is a special attitude toward the drunkard in Poland. "He is considered a poor, unhappy man who needs care, help in getting home, or protection in circumstances of conflicts. But at the same time insensitivity to drunkards is noted. An intoxicated man lying in a public place is dealt with by the police. Wide tolerance of inebriation and insensitivity to heavy intoxication may be at least partly explained by common use of relatively large doses of alcohol by males."

The difference in frequency of and public attitudes to drunkenness between males and females indicates that social disapproval may be a strongly preventive factor for the majority and some educational programmes are largely geared to reinforcing such disapproval. The ineffectiveness of such disapproval in some cases is shown, for instance, among habitual drunken offenders in the United Kingdom, some of whom are fined or imprisoned for drunkenness time and time again. Only gradually is it becoming widely appreciated that repeated drunkenness is an indication of need for treatment.

TABLE 8. SURVEYS ON FREQUENCY AND QUANTITY OF ALCOHOL BEVERAGE CONSUMPTION

Country and reference	Population surveyed	Year of survey	Findings																								
Australia (Encel et al., 1972)	Sample of 1 000 households in Sydney: 373 males 447 females over 15 years	1968-69	<table> <thead> <tr> <th></th> <th>M</th> <th>F</th> </tr> </thead> <tbody> <tr> <td>Abstainers</td> <td>9%</td> <td>18%</td> </tr> <tr> <td>Light-infrequent</td> <td>11%</td> <td>29%</td> </tr> <tr> <td>Light-frequent</td> <td>6%</td> <td>14%</td> </tr> <tr> <td>Moderate-infrequent</td> <td>7%</td> <td>13%</td> </tr> <tr> <td>Moderate-frequent</td> <td>19%</td> <td>12%</td> </tr> <tr> <td>Heavy</td> <td>48%</td> <td>15%</td> </tr> </tbody> </table>		M	F	Abstainers	9%	18%	Light-infrequent	11%	29%	Light-frequent	6%	14%	Moderate-infrequent	7%	13%	Moderate-frequent	19%	12%	Heavy	48%	15%			
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Heavy	48%	15%																									
Japan: Japan Liquor Producers' Association	Samples of total population aged over 20 years: 5 000 males	1967 1969	Drank alcoholic beverages once or more during month preceding survey: 79.7% 72.7%																								
Japanese Medical Society for Alcohol Studies	1 000 females 1 377 males aged over 20 years	1967 1969 1968	33.0% 29.0% 88% drank 23% drank daily (a) 26% drank once or twice a week 18% drank more often than (a), less often than (b) (b) 8% drank once or twice a year																								
Poland (Swiecicki, 1963)	Male inhabitants of towns		Drink vodka 35-63 times a year, average 0.25 litres each occasion																								
Chile (Horwitz et al., 1969)	Whole population over 15 years		33.4% "abstemious" 53.7% "moderate drinkers" 7.0% "excessive drinkers" 5.1% "alcoholics"																								
Netherlands (Gadourek, 1963)	Representative sample of population	1958	>80% of a sample of people over 21 years old sometimes took a drink. Habits of regular drinking primarily among young people, the single, those with higher incomes, and those participating actively in social life																								
France (Ledermann, 1956)	Adult population		7% excessive drinkers (i.e., more than 200 ml of pure ethanol a day)																								
United Kingdom (Edwards et al., 1972)	South London sample: 408 males 520 females over 18 years		<table> <thead> <tr> <th></th> <th>M</th> <th>F</th> </tr> </thead> <tbody> <tr> <td>Abstainers</td> <td>7%</td> <td>10%</td> </tr> <tr> <td>Occasional drinkers</td> <td>17%</td> <td>36%</td> </tr> <tr> <td>Infrequent-light</td> <td>9%</td> <td>20%</td> </tr> <tr> <td>Frequent-light</td> <td>25%</td> <td>28%</td> </tr> <tr> <td>Moderate</td> <td>27%</td> <td>6%</td> </tr> <tr> <td>Heavy</td> <td>14%</td> <td>0%</td> </tr> <tr> <td>Unclassifiable</td> <td>1%</td> <td>0%</td> </tr> </tbody> </table> <p>About half the drinkers consumed the equivalent of 10-40 g of pure ethanol on each occasion. Another 30% consumed double these quantities.</p>		M	F	Abstainers	7%	10%	Occasional drinkers	17%	36%	Infrequent-light	9%	20%	Frequent-light	25%	28%	Moderate	27%	6%	Heavy	14%	0%	Unclassifiable	1%	0%
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4.2 Per capita consumption of alcohol and proportionate expenditure on alcoholic beverages

Table 9 summarizes information given in the national responses on the quantities of alcoholic beverages, by type of beverage, available and the average amount per capita available and presumably consumed each year. These figures are much more meaningful where these quantities have been also expressed as 100% ethanol, and a much clearer picture of the situation is obtained where the relative figures are given per head of potential consumers. For some countries this has been done for the population over the age of 15 years or 18 years. In the case of Venezuela, the consumers are taken to be males aged between 15 and 69 years together with 20% of the females in the same age-group. It would be highly desirable for other countries too to relate consumption figures to the section of the population considered as potential consumers.

In an analysis of consumption data, Brun-Gulbrandsen (1973) points out that "It is hard to find two studies measuring the same parameters in the same way, using the same kinds of population samples and the same kinds of statistical analysis, so that the results may be compared in a meaningful way", and he draws attention to the attempts of the Nordic Committee on Alcohol Research to plan better coordinated cross-national studies. In another analysis, Schmidt (1973) gives evidence for the assumption that the apparent per capita alcohol consumption is directly related to the proportion of heavy drinkers in the population. Several studies appear to agree that consumption of the equivalent of about 250 ml of pure ethanol a day signifies heavy consumption. However, as noted above under section 1, whether this relationship holds for the proportion of alcoholics depends on the local definition of an alcoholic.

For the purposes of the responses to the WHO Outline for Inquiry, emphasis was laid on the value not of cross-national comparisons, but of information on trends within each country.

All the responses reporting on consumption trends refer to disturbing increases in recent years in the per capita consumption of most types of alcoholic beverages and in terms of total pure ethanol. In Table 10 increases in the latter are shown as computed from the figures given in Table 9, together with other increases reported in the responses.

The big increase in alcohol consumption in Finland in recent years is particularly notable. It is mainly accounted for by a change in the law in 1969, which allowed general stores to sell light beer. This raised the number of beer shops from 500 to roughly 17 500. Beer consumption is stated to have increased by 25%, although the figures given for per capita beer consumption as pure ethanol show about a 200% increase from 1967 to 1969. However, the total per capita alcohol consumption levels are still not high compared with others recorded in Table 9. The same is true for the Netherlands, with a high recent percentage increase in consumption, the final level still being relatively low. Switzerland, with relatively high annual consumption levels, is showing only a relatively slow increase, and the increase in Yugoslavia is slowing down now that it has reached a very high recorded consumption level for the total population.

Price changes affected some consumption patterns. In Poland, for instance, for the first time since 1964, a trend towards a decrease in alcohol consumption was noted in 1970 as compared with 1969 (1.4%), and it is suggested that this may have been due to increase in prices in 1969. An increase in the price of spirits in Czechoslovakia in 1958 was followed by a notable drop in the per capita consumption (1955: 3.9 l; 1960: 2.4 l). However, the earlier level was soon surpassed (1968: 4.1 l; 1969: 5.5 l). The price of a litre of 40° rum quadrupled between 1937 and 1963, whereas the price of beer was kept constant. Per capita beer consumption more than doubled in that period to reach a level that was the highest in the world, but changed little in the following years, whereas consumption of spirits rose and doubled between 1965 and 1969. It is not stated in the response whether prices of spirits continued to increase after 1963.

TABLE 9. QUANTITY OF ALCOHOL AVAILABLE (CONSUMED) PER HEAD PER YEAR BY TYPE OF BEVERAGE AND AS PURE ETHANOL

Country	Years	Consumption per head of total population (litres)										Consumption per head of adult population		Expenditure on alcohol as percentage of total private expenditure	
		Wine		Other		Beer		Spirits		Total	As 100% ethanol	Age group	(%)	Year	
		Quantity	As 100% ethanol	Quantity	As 100% ethanol	Quantity	As 100% ethanol	Quantity	As 100% ethanol	As 100% ethanol					
Australia	1960 1969-70 1972	9.1				123.3 228.0 (adults)		1.8			13.4	Over 18 years			
Chile ¹	1960 1972	115.0				30.0		1.0			14.0 ²	Over 15 years			
Czechoslovakia	1936 1960 1969	7.2 13.2 16.0				51.8 100.1 135.1		2.4 2.4 5.5		3.4 5.5 8.0	10.3 ²	Over 18 years	7.0 8.0	1963 1969	
Finland	1960 1966 1969			"Other strong drinks"								Over 18 years	4.7 5.2	1966 1968	
			0.45 0.52		0.66 0.60		0.63 2.10		0.76 0.98	2.50 4.2	5.6 ²				
France	1960 1972	110.0				40.0			2.3	17.5	26.1	Adults	8.0	1970	
Israel	1960 1972	3.6				10.8		3.08			1.6 ² 2.4 ²	Over 15 years	-		
Japan	1960 1967		Saké	"Others?"											
		13.5		2.68		24.01		1.38		4.3	5.7 ²	Over 18 years			
Mexico ¹	1960 1967 "average"	0.1		Pulque											
				9.8		48.7		2.5					-		
Netherlands	1938 1960 1968	1.14 1.88 4.31				14.9 23.9 45.4		0.73 1.14 1.74		0.9 ² 1.5 ² 3.1 ²	4.3 ²	Over 15 years	0.08 (single) 0.09 (families)		
Poland	1938 1960 1969	0.2 5.6				4.0 3.4		3.2 8.5		1.5 5.3	7.6 ²	Over 15 years	8.5 10.5	1960 1969	
Sweden ¹	1954 1960 1970		0.39 0.61 1.05	Strong beer								Over 15 years	5.5 6.1	1965 1969	
				1.8 4.8	0.09 0.27	(?)11.3 ³ (?)49.6 ⁴	1.21 ³ 1.12 ³ 0.39 ³ 2.19 ⁴		3.32 3.0 3.34	4.82 4.82 7.24					
Switzerland	1945/49 1955/60 1966/70	36.7 34.9 40.2	3.85 3.84 4.42	Cider								Over 18 years - Over 15 years	6.7	1972	
				1.94 0.95 0.41		34.1 60.1 77.5	0.95 2.76 3.72	3.02 3.51 4.71	1.21 1.40 1.88	7.95 8.95 10.44	10.94 12.52 13.62				
United Kingdom	1960 (Over 15 years) 1969 (Over 15 years)	2.3 (3.0) 3.7 (4.8)				85.5 (111.6) 98.7 (130.0)		1.8 (2.4) 2.0 (2.6)		4.0 ² 5.2 ² 4.7 ² 6.0 ²		Over 15 years Over 15 years	3.39 3.46 4.3	1963/5 1967/8 1969	
Venezuela ⁵		3.6		"Other?"											
				8.6		114.0		1.1							
Yugoslavia	1946 1961 1971									7.2 9.9 12.4	17.3	Over 15 years	8.0 - 19.0	1972	
Zambia	1960					80.9									

¹ All figures for population over 15 years of age.

² Author's estimates.

³ Beer with 1.8-2.8% alcohol.

⁴ Medium beer with 2.8-3.6% alcohol.

⁵ Per capita potential consumers: males aged 15-69 years + 20% of females in that age group.

TABLE 10. PERCENTAGE INCREASES IN ANNUAL CONSUMPTION OF ALCOHOL PER HEAD OF POPULATION IN NINE COUNTRIES

Country	Period	No. of years	Percentage increase	
			Total	Average per year
Australia	recent	9	28	3.1
Czechoslovakia	1960-69	9	45.5	5.1
	1936-69	33	135	4.1
Finland	1966-69	3	68	22.7
	1969-71	2	46.3	23.2
Netherlands	1960-68	8	106.7	13.3
	1938-68	30	244	8.1
Poland	1960-69	9	23.5	2.6
	1938-69	31	253	8.1
Sweden	1960-70	10	50.2	5.0
	1954-70	16	47	2.9
Switzerland	1955/60-1966/70	10	16.6	1.7
	1945/49-1966/70	21	31	1.5
United Kingdom	1960-69 total population	9	17.5	1.9
	1960-69 population over 15 years	9	15.4	1.7
Yugoslavia	1961-71	10	20.2	2.0
	1946-71	25	72.2	2.9

Changes in consumption patterns may occur through the deliberate introduction of a different type of alcoholic beverage. After the introduction of medium beer (2.8-3.6% alcohol) into Sweden in 1965 the rise in the per capita pure ethanol consumption level was particularly noticeable (from 5.43 in 1964 to 6.07 in 1966). There was little change in the consumption of spirits thereafter, but the consumption of lighter beer fell and that of medium beer continued to increase. The result was, in fact, the opposite of what had been expected.

It is interesting to note the drop in cider consumption in Switzerland in recent years. This may be due partly to the fact that cider tends to be considered as a peasant's drink. However this drop has probably been more than offset by increased beer consumption.

In all countries that reported changes in expenditure on alcohol as a percentage of total private expenditure, the trend was towards an increasing proportion. This may be due to increases in taxation on alcoholic beverages as well as in consumption.

4.3 National annual production, importation and exportation of alcoholic beverages

The estimates given in Table 9 of per capita consumption of alcoholic beverages are derived from statistics on production plus imports less exports. These statistics are probably fairly carefully recorded in most countries for taxation purposes. There are, however, three main sources of error in such estimates. One is the home production of wines and beers. This has started to become popular in the United Kingdom, for instance, but is believed so far to reach only small dimensions, whereas in Australia it is already widespread. In Finland, the making of the fermented alcoholic beverages "sahti" and "kilju" (ale), as well as wines, at home is an old custom. It is estimated that these beverages account for the consumption of 750 000 litres of pure ethanol per annum, that is about 0.15 litres per head of population. In Zambia, as in a number of South American countries, homebrewed beverages are commonly used and can hardly be included in nationally collected statistics.

A second source of error is home-distillation, mainly illegal, of distilled alcoholic beverages. The response from Yugoslavia states that "almost the entire rural population and some of the urban population produces fruit, and . . . most of the fruit producers at the same time produce brandy". The domestic brandy stills are not illegal in Yugoslavia and production statistics are collected. However, it is estimated that about 35% of the total production of alcoholic beverages is not included in official statistics, and this would raise considerably the estimate of per capita consumption. In Switzerland, more than 16 000 agricultural concerns have their own distilling equipment and the response states that "the amount of spirits illegally distilled without declaration to the excise authorities is certainly large". "Pontikka" is the famous Finnish home-distilled spirit, the production of which is illegal: but only about 25 000 litres are produced per year. In France, on the other hand, it is estimated that the quantities of alcohol produced illicitly are at least as great as those openly declared by home distillers, or about the equivalent of 12 million litres of pure ethanol per year. A complication connected with illicit production is the possible presence of noxious contaminants in the spirits; this appears to be a problem for instance in some parts of India.

A third cause of error in the computation of per capita consumption is the effect of consumption by tourists which in some countries may not be offset by consumption by nationals when abroad.

One of the possible causes of rising levels of consumption of alcoholic beverages is the increasing availability in many countries, which can probably be accounted for largely by acceleration of industrialization and increase of production. Table 11 shows the trends in production of alcoholic beverages in 10 countries, as calculated from the data given in the responses. In each case the trend has been towards an increase, except as regards production of spirits in Sweden: otherwise the increases considerably outstrip annual population increases. For a number of countries not mentioned, the increase in beer production is probably very high,

TABLE 11. TRENDS IN PRODUCTION OF ALCOHOLIC BEVERAGES IN 10 COUNTRIES

Country	Wine			Beer			Spirits		
	Period	Percentage increase		Period	Percentage increase		Period	Percentage increase	
		Total	Average per year		Total	Average per year		Total	Average per year
Austria	1960-70	287.5	28.8	1960-70	40.2	4.0	1960-70	140	14
Czechoslovakia				1966-68	3.6	1.8	1966-68	29	14.5
Finland	1959-69	262	26.2	1959-69	130	13.0	1959-69	50	5
Netherlands				1967-68	4	4	1966-69	39	13
Poland	1946-49	8 947	39	1946-49	654	28	1946-69	314	13.8
Spain	1945/49- 1965/67	62.5	3.1	1958-67	224.8	24.9	1962-67	68	13.6
Sweden				1963-69	52	8.7	1965-69	-17	- 4.2
Switzerland	1961/65- 1966/70	6.8	1.3	1961/65 1966/70	11.3	2.2	1966/67- 1960/71	36.8	7.3
United Kingdom	1959-69	75	7.5	1959-69	26	2.6	1959-69	109	10.9
Yugoslavia	1960-70	27	2.7	1960-70	1 075	107.5	1960-70	58	5.8

since it is known that new modern breweries have been established in recent years in many parts of the world. Nigeria, for instance, now has four breweries, a distillery for making whisky, gin and schnapps, and bottling plants for imported brandy; foreign bottled spirits are being imported in large quantities.

In some countries, attempts to reduce the availability of alcoholic beverages are complicated by the fact that their production may constitute a major industry. The response from France states, for instance, that "France is traditionally a large-scale producer of alcoholic beverages and its products are exceptional in their abundance, variety and quality". A considerable proportion (about 10%) of the French population is engaged in the production and sale of alcoholic beverages, which are also an important export commodity. In 1970, for example, nearly half the total quantity of spirits produced in France was exported (376 000 hectolitres). In the United Kingdom, the total value of exports of alcoholic liquor in 1969 was £186 million, or about one-third of the total national export figure. Production of beer in England and whisky in Scotland are major industries. Although only a small percentage of home-produced beer is exported, United Kingdom breweries have been acquiring overseas breweries and retail outlets in recent years. In comparison, for Switzerland, where *per capita* production and consumption are relatively high, export of alcoholic beverages is negligible and, in fact, about 44% of wine and 33% of spirits available for consumption in 1970 were imported. In Yugoslavia too, nearly all the alcoholic beverages produced are consumed within the country, only about 2.7% being exported. Sweden imports most of its wine, 10% of its strong beer, and 44% of its spirits.

4.4 National control of production and distribution of alcoholic beverages

4.4.1 State monopolies

The production and distribution of alcoholic beverages are subject to a strictly organized State monopoly in Czechoslovakia, Finland, and Poland. In Sweden, a trade corporation, in which the State has a decisive influence, has a monopoly for wholesale purchase of spirits, wine, and strong beer. Retail trade is also limited to a corporation controlled by the State. Judging by the relatively high per capita consumption levels in these countries (except Finland), it would appear that the establishment of such monopolies was directed at economic interest and not at efforts to control consumption levels.

4.4.2 Controls on production

Controls on the production of alcoholic beverages are partly for economic purposes. In Switzerland, for example, "Viticulture should be adapted as much as possible to the requirements and capacity of absorption of the national market" (1971 Regulations on Wine). Directives issued concern the regions where vines may be planted and acceptable categories of vine. A law concerning the stabilization of saké production in Japan aims at protecting saké producers as well as securing the liquor tax.

However, control may be exerted for other purposes, as stated in the Swiss Federal Constitution: "legislation will aim at decreasing the consumption and consequently the importation and production of spirits". As in most countries, a permit is required in Switzerland for the production of spirits; no new equipment may be purchased by home distillers. The production of certain beverages may be prohibited by law and the production of non-alcoholic beverages may be promoted.

4.4.3 Taxation

Taxation on alcoholic beverages is an important source of State revenue. In Japan, for example, it represented 10% of the total revenue from national taxes. Taxation on beer, wines and spirits accounted for about 6% of the United Kingdom Government revenue from all sources in 1969/70. As pointed out in the response for Spain, "the so-called 'tax on alcohol' is quite effective in achieving its object, namely, to obtain a financial return". In Czechoslovakia, this return amounted to about half the population's expenditure on alcoholic beverages in 1969. The benefits obtained may be used for specific purposes. In Switzerland, for example, the "alcohol dime" is used partly for alcohol control organizations, alcoholism treatment services and benefits to the aged. In Spain, a tax on whiskies and beer is intended to subsidize some aspects of the Agrarian Social Security Scheme.

Differential taxation may be applied in an attempt to promote consumption of domestic rather than imported products: this applies to wines in Switzerland. It may also aim at changing consumption patterns, particularly to reduce the relative consumption of beverages with higher alcohol content; however, the effects may be only transitory, as shown in relation to the short-lived reduction in per capita consumption of spirits in Czechoslovakia after price increase.

4.4.4 Sale and consumption

The liberalization of numbers of places allowed to sell alcoholic beverages may affect per capita consumption levels, as already mentioned in connexion with Finland. A 1969 law allowed general stores to sell light beer, which raised the number of beer shops from 500 to about 17 580. It is stated that "If the purpose of the new law was to guide Finnish people towards more civilized drinking habits, its results have been doubtful".

"According to a consumption inventory performed by Dr Klaus Mäkelä, the law had another effect, too: alcohol consumption among women rose 38%. The percentage of female teetotallers fell by 7%. The number of drinking occasions rose by 77% among females and 64% among males. Thus, the contribution of females to the increase in consumption was greater than that of males. A new consumer group has thus entered the scene, role differences in alcohol consumption being levelled out. The role of alcohol as a prop to male identity is vanishing . . . however, beer is still widely used as a means of getting drunk. The rise in liquor consumption by 14% reveals that heavy drinking has not become more rare. In conclusion: the Finns seem to have adopted new drinking habits but have also retained the old ones."

Many countries have regulations prohibiting the sale of alcoholic beverages near certain places where large numbers of people may congregate, such as sports grounds, as well as in industrial establishments and in and near educational establishments. In Switzerland, a new café or restaurant serving alcoholic beverages can be opened only if such opening is "not contrary to the public well-being".

Hours of sale and consumption of alcoholic beverages are subject to limitations in many countries and may help to maintain public order and to reduce consumption levels.

Most of the responses refer to regulations prohibiting sale of alcoholic beverages to minors: various age-limits are mentioned. In the Philippines, for example, intoxicating beverages may not be sold to persons under 18 years of age - unless destined for some other person (a pretext not easily controlled); such beverages may not be served to or drunk by minors below the age of 21 years.

In many countries alcoholic beverages may not be sold to a person who is apparently already drunk, nor, in Switzerland, to persons on public relief or to mental patients.

In Sweden, intoxicating beverages may not be sold to persons placed on a "blocked list", either by a temperance board because of alcohol abuse, or for having been found guilty of illicit sale of intoxicating beverages, or for having been sentenced more than once in the last 12 months for drunkenness, for unsober driving or drunken driving. More than 13 000 persons were on this list in 1970. On demand, a buyer must be able to give proof of his identity. To facilitate the supervision of purchases in Finland, the alcohol monopoly at one time adopted a passbook system and the holder had to pay an annual stamp tax, but the system was no longer in use in 1972.

Little information is available on the effectiveness of these various measures in reducing excessive alcohol consumption. Several responses state, moreover, that they are not rigidly enforced: "the law is frequently infringed" (Chile); regulations are mentioned for Yugoslavia, but "in practice, however, the situation is different. Regardless of age, time of day or night, etc. alcohol is consumed in unlimited quantities even where it is prohibited by law."

When considering a coordinated national programme on alcohol and other drug problems, it would appear highly important for administrations to weigh up the advantages and disadvantages of existing national controls of production and distribution of alcoholic beverages. Is the total effect largely a promotion of both to secure increased state revenues? How far are the economic advantages counterbalanced by high costs - human and financial - associated with excessive alcohol consumption? What alternative control measures have been found successful, or partially successful, in maintaining a balance between ensuring supplies for "normal" demands and limiting "abnormal" use? The answers can be reached only through a continuous surveillance of the many aspects of the problems involved, attempts to evaluate the outcome of measures taken, and experiments with alternative controls.

5. EXTENT OF DEPENDENCE ON OTHER DRUGS

5.1 Definitions and classification

A definition of drug dependence proposed by a WHO Expert Committee on Drug Dependence (1969) is quoted on p. 10.

A WHO Scientific Group on Evaluation of Dependence-Producing Drugs (1964) considered more fully the terms of this definition and stated that "The characteristics of drug dependence show wide variations from one generic type to another, which makes it mandatory to establish clearly the pattern for each type. Even though some variations occur among individual members of each generic group, the consistency of the pattern of pharmacodynamic actions is sufficiently uniform to permit at this time accurate delineation of each of the following generic types: morphine; barbiturate; alcohol; cocaine; amphetamine; hallucinogens; and cannabis."

"Psychic dependence" was defined by this Scientific Group as "psychic drive which requires periodic or chronic administration of the drug for pleasure or to avoid discomfort. Indeed, it is the most powerful of all the factors involved in chronic intoxication with psychotropic drugs. With certain types of drugs it may be the only factor involved, even in the most intense types of craving and perpetuation of compulsive abuse."

The Group pointed out that "Some drugs also induce physical dependence, an adaptive state characterized by intense physical disturbances when administration of the drug is suspended or its action is counteracted by a specific antagonist. These disturbances, the withdrawal or abstinence syndrome, display a specific spectrum of symptoms and signs of psychic and physical nature characteristic of each drug type. This condition is relieved by readministration of the drug or by another drug of similar pharmacological action within the same generic type."

The report of the WHO Scientific Group on the Use of Cannabis (1971) refers to the need to "take into account the frequency, amount and duration of use and the relative numbers of persons conforming to various usage patterns" when evaluating the consequences of cannabis use for the individual and society. This would apply also to other dependence-producing drugs.

Apart from the classification of dependence-producing drugs according to type (morphine-type, etc.) as mentioned above, a classification into five groups has been proposed by a WHO Expert Committee on Drug Dependence (1970a) according to the level of control required, the criteria being:

- (a) the degree of risk to the public health; and
- (b) the usefulness of the drug in medical therapy.

However, as pointed out in another report of the Expert Committee on Drug Dependence (1970b), "problems of drug dependence present numerous interacting facets involving the taking of different types of dependence-producing substances in a wide variety of ways and patterns by persons with varied personal and sociocultural backgrounds throughout the world," and "in most places the pattern has become one of multiple drug use, either simultaneously or successively. As a consequence, drug dependence of a specific type is less readily identified."

5.2 Prevalence estimates

5.2.1 Drug dependence in general

No country has reliable national data on prevalence of drug dependence. Many countries collect statistics on numbers of persons contravening legislation on the prevention of misuse of drugs. These are considered to represent only a fraction of the actual number of dependent persons. Some information can be derived from records of numbers of persons treated for drug dependence, but only a small proportion are reached by treatment services. In a few countries surveys of representative samples of populations have been carried out and provide a rather more reliable basis for prevalence estimates. On the whole, however, surveys have been confined to specific population groups and the results cannot be generalized. Nevertheless, indications on broad changes in trends within populations have been sufficiently disturbing to force governments to seek better ways of controlling the problems revealed.

In many countries drug dependence has appeared almost as a new phenomenon and reactions have tended to be dramatic. Reactions of alarm and fear have resulted partly from the unexpected suddenness of the increase in extent of the problems involved, the lack of means for estimating how the trends would continue and the tendency for drug dependence to be found at increasingly earlier ages. This picture is found in several European and some Latin American countries as well as in Australia. The evidence now available indicates that in some of the more recently affected countries the problems of drug dependence, while serious, are being to some extent contained. In such countries, problems related to alcohol are still far more extensive than those related to dependence on other drugs. Moreover, several of these nations have become concerned at rising trends in the non-medical consumption of non-narcotic drugs normally destined for medical purposes.

In some of the 33 countries under review, problems related to alcohol are confined to a very small sector of the population, although they are becoming somewhat more widespread, as in Egypt, India, the Philippines, and Thailand, where problems of dependence on other drugs have long been known and are widely prevalent; yet even in these countries patterns of drug dependence are showing changes.

A new awareness has arisen that problems of drug dependence are international. Concerted attempts have to be made to keep changing fashions under review, since fashions may affect various countries in different ways or merely at different times. For the purpose of assisting authorities to forestall the most adverse consequences, it is necessary to maintain surveillance of these changes through continued collection, refinement, and analysis of information of the kind provided in the responses.

Table 12 gives some partial evidence from the responses on the prevalence of drug dependence and trends in the numbers of cases estimated or coming to attention. These figures have been related to the population aged over 15 years. Some further indications of the magnitude of the problems come from surveys, some of which are summarized in Table 13.

Several countries where problems of drug (excluding alcohol) dependence have recently become prominent emphasize that the age groups in the twenties or in some cases in the thirties are the most affected. The Australian response refers, for instance, to the marked increase in drug use by the young. In France, the age of drug dependent persons is said to range from 14 to 29 years, most being about 20 years old. An investigation of nearly 1 000 drug users in the Netherlands by Cohen (1969) showed that two-thirds were aged 18-28 years. Drug dependence in the Philippines is confined mainly to the greater Manila area among males in their early twenties. The greater Stockholm survey found that the median age of drug abusers was about 24 years, three-quarters being under 30 years old. The exception to this general trend is found in relation to the excessive non-medical use of certain drugs normally intended for medical purposes, such as aspirin, barbiturates, and psychotropic drugs, which are more heavily used by the middle-aged, and in some countries, mainly by women. Some reference has

TABLE 12. NUMBERS OF DRUG USERS AND/OR DEPENDENT PERSONS ESTIMATED
OR RECORDED FOR VARIOUS YEARS IN 11 COUNTRIES, AND RATE PER
100 000 POPULATION AGED OVER 15 YEARS

Country	Estimate			Convictions or legal notifications			Other			
	Year	No. ^a	Rate	Year	No.	Rate	Year	No.	Rate	Comment
Sweden				1970	2 200		1965 1967	828 2 476		Treated in psychiatric wards
Switzerland				1969 1970 1971	521 2 313 3 680		1955- 1969	3 500	745	First admission to all mental hospitals
United Kingdom				1965 1968	958 3 214		1935 1953 1964 1969	700 290 700 ^b 1 466 ^b		"Known addicts"
Australia	1972	F 180 000 M 90 000								
Austria	1972		75- 25				1972		7.5- 22.5	Registered
Finland							1968	932	26.6	Recorded
Israel				1967 1969 1970	872 1 535 2 353	124				
France		15 000		1971	1 944					
Philippines	1969 1970	3 000- 4 000 7 000		1970	1 620		1970	779		"Treated"
Venezuela				1965 1969	511 (?) 209 (?)					
Netherlands	1967-68	13 500- 24 000								

^a M = males; F = females.

^b Year end total of dependent persons receiving narcotic drugs.

already been made to the preponderance of males among young drug dependent persons and some further indications are given in Table 13.

Several factors influence the severity of the problems implied by the figures provided on prevalence of drug use and drug dependence. One, of course, is the type of substance used: in several of the surveys referred to in Table 13, the substance mainly used by young people was cannabis. This indicates a much less serious problem than if the drug of choice had been heroin, as was the case for 78% of the "addicts" known to the United Kingdom Home Office in 1968.

Another factor is the route of administration. In general, the use of substances by intravenous injections implies far more serious problems than oral use or use by smoking. In Sweden, 1% of the nearly 8 000 Stockholm pupils surveyed had injected narcotics at some time; for 18-year-old draftees in large cities the figure was 2-3% and up to 1% in provincial areas. The substance injected was nearly always of the amphetamine type. Heroin use in the more recent "epidemics" has been largely by injection.

The quantities of the substances used and the frequency of use will affect the severity of the problems. Very few studies refer to quantities used, although some of the responses analyse the quantities in a "usual dose". In a few cases an attempt has been made to define severity of use of a substance according to the number of times it was used over a recent period of time (for instance, 1% of children in the 1967 Stockholm schools study had used drugs more than 10 times in the last month). However, the figures for "use at any time" or "infrequent use" give no indication of the prevalence of drug dependence. As pointed out in relation to the Netherlands, "When people start using a certain drug this does not imply that they will continue to do so on a regular basis. Many people stop again for extended periods and others stop permanently. The more hazardous the drug (real or imagined) the greater the number of respondents who had stopped using it." (Cohen, 1969) The last statement will not necessarily apply to investigations elsewhere.

5.2.2 Multiple drug use

As pointed out in the response relating to the United Kingdom, "The view that drug dependence could be adequately described by reference only to the abuse of discrete psychoactive substances, such as morphine and amphetamine, is no longer tenable . . . The patterns of drug experimentation and substitution do not have any logic dictated by the pharmacological effects of the drugs . . . When a drug user cannot obtain his drug of choice or enough of that drug, he may supplement his use by what comes to hand." (Zacune & Hensman, 1971) This appears to be the situation for many of the younger drug users in the more recently affected countries, although reference is also made in the responses to considerable proportions of groups studied that use only one drug type - particularly cannabis. The pattern among some other populations with longer experience of heavy drug use may also tend towards single-drug preference.

Several of the responses refer to the more usual patterns of multiple-drug abuse and these may be different from one country to another and within countries at different times. The Cohen (1969) survey indicated that cannabis, LSD, opium, and amphetamines were the most frequently used drugs in the Netherlands. They were taken in very different combinations and frequencies by the 958 drug users surveyed and there was incidental use of some 15 other drugs. The drug user in Australia tends to use "whatever drugs are available in whatever quantities can be afforded and seem appropriate for the current social pattern and individual need". In France it is stated that "Drug dependency often involves multiple dependence; cannabis, LSD, amphetamines, heroin, opiates, barbiturates, tranquillizers, even solvents, are consumed either together or successively according to the more or less transitory fashion of the moment and the supplies available." "Liquor, heroin, and hypnotics are used together or alternately" in Thailand, and in Yugoslavia drug dependants "often use various 'cocktails' (alcohol-meprobamate-barbiturate, preludein-codein, etc.) which they make themselves, mixing various easily obtained medicaments". Many of the

TABLE 13. SUMMARY OF SURVEYS ON PREVALENCE AND
FREQUENCY OF DRUG USE IN FOUR COUNTRIES

Country and reference	Population studied			Drug use	
	Year	Type	Size	Frequency	Percentage of population studied ^a
Netherlands (Buikhuisen & Timmermans, 1970)	1968	Pupils in 156 secondary schools in 21 towns	11 659	At least once	11.15
				20 times or more	2.5
Sweden	1966	Greater Stockholm random sample aged 16-25 years		Some time	M 12.0 F 3.5
	1967	All 9th grade schoolchildren in Stockholm	7 793	Once 2-10 times >10 times >10 times in last month	M 8 M 10 M 4 M + F 1.0
	1968	Induction of 18-year old boys into armed forces		Once 2-10 times >10 times	M 5.5 M 11.0 M 9.0
	1968	Students in Stockholm University	750	Once 2-10 times >10 times > 5 times in last 2 months	M 6.0 M 9.0 M 5.0 M + F 1.0
Switzerland (Angst et al., 1973)	1971	All recruits in canton of Zurich aged 19 years	6 315	At least once	24.9
		Representative sample of Zurich girls aged 19 years	1 381	At least once	16.1
	(Weidmann et al., 1973)	1971-72	10% sample of all pupils and apprentices aged 13-20 years (a few older) in Basel	1 733	At least once Often
Finland	1970	High school students aged 15-17 years		At least once 10 times	22.9 5.2

* Includes drugs of the types listed in section 3.2.3, but in these four countries they were mainly cannabis preparations (see also Table 14)

^a M = males; F = females

reports mention concurrent use of alcohol and other drugs. The response from the United Kingdom refers to studies indicating that a young person becoming involved with other drugs may have been a heavy drinker and that a proportion of older persons treated for alcoholism had habitually taken other drugs to excess. In Prague, 2.4% of the patients hospitalized at the alcoholic department of the Psychiatric Clinic in 1958-68, had come for treatment of drug dependence, but "alcohol abuse played a significant to a very significant role in two-thirds of the cases".

5.2.3 Non-medical use of specific drugs

(a) Cannabis preparations

Nearly all the responding countries stated that, apart from alcohol, cannabis is the drug most widely used for non-medical purposes, and that its use has spread rapidly in recent years, particularly among the younger age groups. Exceptions were Poland, where the use of hashish was stated not to have been observed (1971) and USSR, where, although cannabis is grown, it is not widely used. In contrast, the response from Chile refers to "massive consumption of marihuana by adolescents" noted since the spring of 1968. Richard *et al.* (1971) estimated that nearly 6% of young people used marihuana once a week, and more than 1% daily, rates being particularly high for males in the age group 15-19 years. Examples of information from the responses are given in Table 14.

(b) Hallucinogenic type drugs (e.g., LSD)

Much less emphasis is placed in the responses on the use of hallucinogenic drugs and very little information is available on prevalence. In the United Kingdom there was "considerable reported use" and LSD has now become part of the general drug-taking "scene". The majority of users are probably under 25 years old. Limited use of LSD has been noted in Finland, Spain, and Yugoslavia, and some users have sought psychiatric treatment. The problem seems to be on the rise again in Sweden. In Australia, about 3% of a random sample of inhabitants of a Sydney suburb claimed to have used hallucinogens. In Switzerland in 1971, nearly 2 000 persons were prosecuted for use of LSD or mescaline and 72% took hashish with hallucinogens. Various hallucinogens are known to be used in several Latin American countries; they include hallucinatory mushrooms (psilocybin), fairly commonly used in Mexico, and peyotl (mescaline), rarely used.

(c) Amphetamine type drugs

Amphetamines were used in some of the belligerent countries during the Second World War to increase the efficiency of military personnel and factory workers. The first big wave of use among young people was seen to start in Japan in 1946. By 1954, there were about 200 000 amphetamine-dependent persons, mostly male and largely in the age group 21-25 years. An investigation (Tatetsu, 1956) showed that more than half were unemployed. Medical treatment was provided by law and the "epidemic" was brought under control fairly quickly; the numbers of patients receiving hospital care declined from 4 000 in 1954 to 200 in 1957, and it is stated that almost no new patients are seen now.

The fashion for oral and intravenous use of amphetamines spread to several European countries, but a rapid increase in numbers of dependent persons was not noted until the mid-1960s. In Sweden about 1-2% of young people surveyed in 1967 and 1968 (see Table 14) had experience of intravenous injections, mostly of amphetamines. Such use was found, however, to be most prevalent in asocial and criminal subcultures. Of all persons taken into custody by the police in Stockholm in the last quarter of 1968, 55% of males and 87% of females in the age group 25-29 years had needle-marks suggestive of intravenous drug use. A survey on a given day in 1969 at five youth-detention schools showed that one-third of the pupils had at some time injected central stimulants. The use of amphetamine-type drugs appears now to have declined.

TABLE 14. DATA FROM SURVEYS ON USE OF CANNABIS-TYPE DRUGS IN 16 COUNTRIES

Country	Estimated No. of users	Surveys			Comments
		Reference	Population	Users	
Australia		National Drug Information Service (1972) Le Ferre (1971) Hasleton (1971)	Sydney suburb 639 persons 2 182 drug offenders New South Wales University of Sydney students	9% 4% regularly 18% marihuana only 18%	
Chile		Richard et al. (1971)	Total youth population	39.3% 1.5% daily	Since spring 1968, massive consumption by adolescents
Finland			Regular drug users in high schools, aged 15-17 years	85.5%	Rapid increase 1968-70. Most frequently abused drug in large cities
Israel					Developing into the most prevalent narcotic drug
Mexico			High-school students	3.8%	Cannabis the main drug for middle- and upper classes, especially the young
Netherlands	20 000	Cohen (1969) Buikhuisen & Timmermans (1970)	958 drug users 1 300 school drug users	92% 88.3%	
Nigeria					Commonest narcotic drug
Philippines		Department of Education 1968-69	Greater Manila high schools 543 961 pupils	50% (marihuana)	
Poland	None				
Spain					Widespread use among young, dependence rare
Sweden		Stockholm school survey (1967) armed services survey (1968)	575 boys used narcotics < 10 times 152 boys used narcotics > 10 times 3 400: 70% used drugs a maximum of 10 times: 15% > 50 times	92% 73%	Most common abuse: sporadic use of cannabis
Switzerland		Angst et al. (1973) Weidmann et al. (1973)	6 315 recruits aged 19 years 1 381 girls aged 19 years 1 733 Basel school pupils and apprentices (10% sample)	23.3% "at least once" 5.6% "often" 13.5% "at least once" 2.3% "often" 17% 3% "often"	Most infringements of Federal law on narcotics concern cannabis
Thailand					Become very popular only during last 10 years (especially among young)
United Kingdom	30 000- 300 000				Accelerated growth since 1968; now used in all social classes
Venezuela					Most commonly used drug (especially among teenagers and delinquents)
Zambia					Sizeable problem: substantial increase among youth, especially in educational establishments

Finland was affected by the epidemic of intravenous use of central stimulants soon after Sweden. By 1970 there was a notable decrease, but there was a tendency towards an increase again in early 1971.

Surveys in the United Kingdom in the 1950s and 1960s showed that many persons were receiving regular prescriptions for amphetamines (1% of the population of Newcastle-upon-Tyne: Kiloh & Brandon, 1962) and that a relatively high proportion had become psychologically dependent upon them (an estimated 20% in the above study; mainly middle-aged women). The oral use of amphetamines obtained illicitly began to spread among young people. It was stated (Bewley, 1966) that dependence on amphetamines was probably exceeded only by dependence on cigarettes, alcohol, and barbiturates in Great Britain. The epidemic of amphetamine injection by young people reached a peak in London in 1968. In October, 1968, methylamphetamine was withdrawn from retail pharmacists by arrangement between the manufacturers, the Ministry of Health, and the British Medical Association. This curtailed the epidemic of intravenous injections and recommendations by the British Medical Association led to the voluntary curtailment of prescriptions for tablets.

The prescription of amphetamines has now been severely restricted in several other countries, for example Australia. In a survey of a random sample of the community in a Sydney suburb, amphetamine-like substances had been found in the urine of 14% of females aged over 35 years and to a lesser extent among males and younger age groups. Although the use of amphetamines derived from legal prescriptions has been drastically reduced, it is stated that there is still a considerable amount of illicit use and alternative stimulants are becoming more popular.

The response from Switzerland reports a continuing tendency to increased use of amphetamines, whereas in France the problem is stated now to be receding. Reports for Argentina and Mexico refer to increasing use of amphetamines by young people.

(d) Barbiturate type drugs

Dependence on barbiturates seems also to have developed out of overprescribing. In Australia, barbiturates account for about 10% of all prescribed drugs. In the United Kingdom dependence on barbiturates accounted for the most widespread dependence on any drug except perhaps cigarettes (Bewley, 1966): the estimated number of persons dependent on this drug in 1966 was 100 000 out of perhaps 500 000 regular users. In Thailand, barbiturates can be obtained without medical prescription and dependence on these drugs is said to be frequent among prostitutes and girls working in bars. Hypnotic drugs, notably barbiturates, are the predominant drugs used in cases of self-poisoning coming to attention in many countries. In cases of dependence, barbiturates and other hypnotics seem to be used mainly in conjunction with other drugs, for instance with heroin or amphetamines. Mass use of barbiturates with other substances, e.g., caffeine, is reported from Czechoslovakia, and use with alcohol is mentioned in several reports. The response from the United Kingdom refers to an increasing tendency for hypnotic drugs to be injected rather than taken orally, but this does not yet appear to be true for all countries reporting dependence on these drugs.

(e) Morphine type drugs

Among the countries for which responses were received, drug dependence problems of the morphine type are most prevalent in Thailand. It is stated that when the law to forbid opium smoking was passed in 1959, most of the older people accustomed to smoke opium became dependent on heroin. Over the last 10 years a considerable number of adolescents and young persons have become dependent on heroin. No statement is made about the proportion of the 300 000 registered and 600 000 - 800 000 estimated drug-dependent persons who are using heroin.

Of the estimated 7 000 drug-dependent persons in the Philippines in 1970, 779 came under treatment, 90% for dependence on drugs of the morphine type (mainly heroin).

In Japan, a rise in the illicit traffic in narcotic drugs after the Second World War led to an increase in narcotic (especially heroin) addicts, the estimated number being more than 40 000 in 1962. Severe control measures were promptly taken, including a system of compulsory hospitalization for narcotic addicts. This is said to have given successful results, and since 1966 few persons dependent on heroin have been discovered (1968, 10; 1969, 3; 1970, 6).

Information on the use of morphine-type drugs was not provided in any detail for Iran or Egypt, although it is known that they give rise to important problems in these countries.

Opium was formerly used in Israel, mainly by the Arab population and the Oriental Jews. Since 1962 its use has increased considerably and recently the intravenous injection of a solution made from opium has become popular.

Although opium is produced in Yugoslavia it is stated that drug dependence of the morphine type hardly exists, although it may be a growing problem among young people.

In nearly all the other responding countries, dependence on morphine-type drugs is limited mainly to certain professional - mainly health-related - groups and some patients who became dependent on morphine during the course of medical treatment. However, opium is eaten, smoked, or injected by a proportion of drug-users in the Netherlands (about 20% of the users studied by Cohen, (1969), and 7% of drug-using secondary school pupils studied by Buikhuisen & Timmermans (1970)). The non-medical use of opiates is now being found in groups in Sweden where formerly it was rare (1-2% of drug users in the 1967 Stockholm and 1968 Gothenburg school surveys said they had used morphine; 13% if drug users in a hospital inquiry used opiates).

A marked change in the use of opiates occurred in Britain in the 1950s. The number of persons known to be using heroin rose from an average of 54 in 1955-56 to 94 in 1960, and then rapidly to 2 240 in 1968, although this figure included a proportion no longer receiving heroin. The new computations showed that the number of dependent persons known to be still receiving heroin at the end of 1969 was 1 466. The change in the pattern of drug abuse appears to have been caused by thefts of large quantities of morphine, cocaine, and heroin from a London hospital dispensary in 1951, and subsequent trafficking at a time coinciding with scarcity of cannabis (Spear, 1969). Particularly disturbing increases in the use of heroin were seen in younger age groups after 1964. Among dependent persons known to the Home Office, the numbers in the age group under 20 years using heroin increased from 134 in 1965 to 709 in 1968; comparable figures for the age group 20-34 years were 319 and 1 390. Since the introduction of specialized treatment centres for drug dependent persons in 1968, there has been an increase in the use of methadone and a decrease in the use of heroin. At the end of 1969, more than 1 000 persons were receiving methadone on prescription; nearly a third of these were also receiving heroin, and about 200 more were receiving heroin alone or with drugs other than methadone. Several studies in defined geographical areas have indicated that the prevalence rates for heroin dependence are considerably higher - possible six-fold or more - than those obtained from the official records. Sources of information included surveys of hepatitis incidence, admissions to casualty departments for drug overdoses, questioning of known heroin users, as well as medical reports and other official sources.

(f) Cocaine type drugs

Relatively little mention is made in the responses to the use of cocaine. In Finland it is stated to be quite unknown as a drug of dependence, and in Sweden its use is virtually non-existent. In the United Kingdom, however, one-fifth of the addicts known to the Home Office in 1968 were dependent on cocaine and 29% of a representative sample of addicts prescribed heroin in London clinics had used cocaine in the preceding month (Stimson &

Ogborne, 1970). Altogether, 5% of infringements of the Swiss federal law on narcotics in 1970 related to cocaine. In the Netherlands, 3% of drug users in the school survey (Buikhuisen & Timmermans 1970) used cocaine. Arrests in Chile for the use of cocaine increased from 49 in 1968 to 129 in 1969. Where cocaine is used, it is probably taken in conjunction with other drugs, particularly opiates.

It should be noted, however, that in some Latin American countries cocaine is widely used among rural populations in the form of coca leaves. The Argentinian response states that 90% of the indigenous subcultural communities of north-western Argentina customarily chew coca leaves, and the habit has spread among the local white population.

(g) Other types of drug

In several countries a problem of dependence on organic solvents, taken by sniffing, has been noted. In Japan such use has been reported since 1950 and has gradually become a widespread fashion, especially among young people. In 13 mental hospitals in Tokyo, Osaka, and surrounding areas 328 patients were under treatment in 1970 for dependence on solvents, the majority being in the age group 15-18 years. This practice is said to be frequent also in Sweden among children aged 12-16 years, mostly in urban areas. Volatile solvents (e.g., in glue, and thinners) are the priority drugs among persons (especially young people) of the lower socioeconomic classes in Mexico.

Mention has already been made of dependence on a wide range of medicaments, such as acetylsalicylic acid and other analgesic and antipyretic drugs. The response from Chile refers to the adolescent use of a variety of drugs, including additionally some non-opiate antitussives and antidiabetics. Mention is made of the growing use in Poland in 1970 and 1971 of antiparkinsonism drugs (e.g., trihexyphenidyl hydrochloride) which caused psychiatric disturbances. Heavy use of various analgesic and antipyretic drugs has been noted in Czechoslovakia and Switzerland.

6. AVAILABILITY AND CONSUMPTION OF DRUGS (EXCLUDING ALCOHOL)

6.1 Trends in consumption of dependence-producing drugs

Countries that are parties to the Single Convention on Narcotic Drugs, 1961, provide the United Nations with statistics on the legal consumption per million population of specified narcotic drugs. Few figures on drug consumption were provided in the responses. For Finland, it was stated that there was no evidence of an increase in legal consumption of narcotic drugs in recent years. Some countries have added substances to the list of narcotic drugs, the distribution of which is strictly controlled. Hallucinogens are mentioned in this respect for Switzerland and amphetamines for Sweden.

It is very difficult to obtain any estimate of consumption of drugs smuggled into a country. Although quantities of such drugs seized are usually recorded, it is impossible to state what percentage they represent of the total quantities entering the country. Some estimates are available through collaboration between countries in controlling drug production and plotting drug smuggling routes, although the frequent changes complicate the picture. Very rough estimates of increase and decrease in drug use, related to numbers of persons coming to attention for treatment, for violation of regulations, or through surveys, are given in the sections related to separate drugs.

Records of consumption of drugs legally produced and distributed are kept for some of the responding countries. Indications are given of considerable increase in production and sales of pharmaceutical preparations: in the United Kingdom, for instance, the estimated total sales of drugs in 1968 were double those in 1958. The response from the United Kingdom notes that "it has been suggested that the vast

amount of medication being taken by large numbers of people in our society has made its own contribution towards the drug dependence problem, although the relative importance of this factor is not yet clear".

As already noted, changes in levels of consumption of drugs depend partly on fashion, which may in turn be strongly influenced by availability. In countries where supplies of amphetamines were severely curtailed, consumption levels declined rapidly, although this may have resulted partly from the widespread recognition also among users of the heavy risks entailed in intravenous use of stimulants.

For Sweden it is stated that the legal consumption of narcotic drugs "has changed remarkably over the last 10 years" thanks to collaboration of doctors in control. "Thus, in 1959 about 760 000 prescriptions of narcotic drugs were dispatched (including stimulants), in 1970 about 62 000, a decrease of about 92%." Moreover, "a calculation of the consumption in doses per thousand inhabitants of the most common drugs (dextromoramide, hydrocodone, methadone, morphine, oxycodone, pethidine and amphetamine, dexaphetamine, methamphetamine, methylphenidate, phenmetrazine and pipradol) shows that in 1959 about 5 400 doses per thousand inhabitants were consumed compared with 380 in 1970, which means a decrease of about 93%". What is not stated is the extent to which the curtailment of supply was offset by smuggled imports.

Another problem requiring urgent - and continuing - investigation is the extent to which lowered consumption of some drugs is counterbalanced by increased consumption of others, which may constitute a greater danger to the population.

6.2 Sources of supply of drugs used by drug-dependent persons

In some countries cannabis is cultivated illegally and sold locally. This occurs, for example, in Chile, Costa Rica, Nigeria, the Philippines and probably Zambia.

Opium is produced in Thailand and gives rise to local problems of dependence, but much of the production reaches the illicit markets of other countries. Yugoslavia is the greatest opium producer in the "west opium area", but drug dependence of the morphine and heroin type are said hardly to exist. On the other hand, "it is believed that 35-55% of the annual production, i.e. around 7-10 tons of raw opium, are taken out of the country through contraband and are sold in the West European and USA markets".

In most of the responding countries there is strict control over the production and distribution of narcotic drugs. However, it was stated that part of the illegal distribution of dependence-producing drugs is carried out with the knowledge of some law-enforcement and other officials in producing and receiving countries. Apart from obtaining his supplies on the black market, the drug dependent person may also resort, for example, to burglary of stores or pharmacies, falsification of medical prescriptions, or collection of multiple prescriptions. Control of such activities is increasing.

Although prescriptions are required for many of the dependence-producing drugs, over-prescribing may facilitate diversion of licit drugs into illicit channels. Several of the responses refer too to the fact that although a prescription may officially be required, it may not be requested by pharmacists for the sale, for example, of barbiturates. Moreover, many drugs that may induce dependence, such as some analgesics, are widely available without prescription.

Mention should also be made of the prescription of narcotics for drug-dependent persons by physicians, who may be required to have a special permit to write such prescriptions, as in the United Kingdom.

6.3 National control of production and distribution of dependence-producing drugs

Countries that are parties to the Single Convention on Narcotic Drugs, 1961, are obligated to control the cultivation, import, export, distribution and labelling of the opiates, cocaine, cannabis and related narcotic drugs. Such control is enforced through bodies such as departments of customs and excise, special narcotics departments, police officers who may have special training as well as national and local health authorities. Manufacture and distribution of drugs not covered by the Single Convention are frequently also controlled by health authorities in collaboration with regional and local pharmacists. In Australia, a computerized system has been developed to monitor licit transactions involving drugs of dependence. This serves to show trends in licit consumption and to minimize risks of diversion of legally produced drugs to the illicit market.

In some countries certain drugs are checked on issue by the pharmacist who records the sale. This applies, for example, to barbiturates and tranquillizers in France and in other countries for many drugs listed as poisons or dangerous drugs.

Additions are frequently made to the national lists of drugs that may be obtained only on prescription. The medical profession in several countries attempts to alert colleagues to the dangers of overprescribing. Permission to prescribe certain drugs may be limited; in Czechoslovakia, for instance, only specialists may prescribe psychostimulants and in the United Kingdom only a small number of specialists may prescribe heroin or cocaine.

Some attempts have been made to limit falsification or forgery of prescriptions. It was stated, for instance, that in the USSR prescriptions are printed on special paper, like banknotes. The number supplied to each prescriber is known and prescriptions are not renewable.

7. NATIONAL POLICY REGARDING PERSONS DEPENDENT ON ALCOHOL AND OTHER DRUGS

7.1 Official recognition of alcoholism and other types of drug dependence as illnesses

Almost all the respondents affirmed that dependence on alcohol and other drugs is recognized as illness in their country and in some cases statements to this effect are quoted from official documents. Examples include Costa Rica, where alcoholism was officially declared as a disease according to a presidential decree issued in 1954, and Sweden, where alcoholism and drug dependence are recognized as illnesses by the Psychiatric Care Act of 1966.

In many countries national and local health departments have considerable, if not primary responsibility for treatment of persons with these conditions and requirements for provision of such care are incorporated in national legislation.

The sick status of persons suffering from dependence on alcohol or other drugs is recognized through the health insurance provisions of some countries. Thus, in Yugoslavia "insured alcoholics now enjoy all rights of complete health insurance, including the right to be treated free of charge". Much the same holds good in Czechoslovakia. In Romania, dependence on alcohol and/or other drugs entitles the patient to paid sick-leave as well as free hospitalization. The pathological manifestations of alcoholism are covered by social legislation in France in the same way as other diseases.

As pointed out in the response from Switzerland however, popular opinion may still be that dependence on alcohol "is a vice, that it shows lack of control and weakness of character". This opinion is partly reflected in social legislation: the

benefits of disability, accident and health insurance are frequently reduced in the case of alcoholism or heavy drinking in Switzerland. A National Social Insurance memorandum in Sweden rules that "In states of alcoholism and drug addiction it should be a general principle that a pension will be considered only when the abuse has brought about serious and continuous physical and mental effects".

7.2 Official or broadly accepted policy on prevention and treatment

7.2.1 Prevention

Reference has already been made to policies of prevention through control of production and distribution of alcohol and other dependence-producing drugs. They rely largely on legislation, police, customs, and penal control activities, manipulation through taxation and collaboration with the medical profession in controlling prescribing habits.

Attempts at reducing private gain have included the establishment of State alcohol monopolies, but neither the purpose nor the effect appear to have been reduction of alcohol consumption. Some restraints are put on the advertising of alcoholic beverages, but these may not have resulted in substantial reductions in use. For the United Kingdom it is pointed out that "One and the same country spends £2 000 million a year on the alcohol it drinks, takes £900 million taxed revenue from those sales, and lays out over £20 million on advertising alcoholic drinks and the pleasures of the pub".

Where production of alcoholic beverages has an important place in a national economy, "any government is subject to opposing pressures", as emphasized by the French respondents, who state: "It is particularly difficult, for example, to reconcile the attitudes of the Ministries of Finance or Agriculture with those of the Ministries of Public Health or Labour."

A somewhat similar situation arises in areas where the production of opium has long been a staple source of income and where attempts are made at crop-substitution. In Iran, after a period when opium production was banned, it was resumed because of the drain on national resources caused by the illegal introduction of foreign-produced opium.

Prohibition as a preventive measure has been in force in four States in India, but has recently been lifted in two, and in one other permits to buy alcohol are easily obtained. A district national council on alcoholism in Poland introduced prohibition in part of its territory for 2 years.

Several responses refer to an accepted policy of improving the environment for groups particularly at risk as important preventive measures. Since the problems involved are so widespread, it is difficult to evaluate the results of any specific efforts made in this direction.

Emphasis is frequently laid on the preventive value of education and information on problems of dependence on alcohol and other drugs. In France, for instance, a special committee was set up in 1954 to collect information on alcoholism and pass it on to the public. As regards other drugs, "an attempt has been made to alert doctors, educators, social workers, and the police. Recently efforts have turned to parents and the general public, but here care is needed to avoid running counter to the objective."

A tendency is noted to improve the reliability of information used in educational campaigns and to select material and its presentation in view of the audience to be reached. Attempts are being made to include information on alcohol and other drugs in other parts of school and specialized training curricula, for

instance in science courses, and to discuss the available information rather than to make value judgements. Some efforts are also made to explain that data on some aspects of the problems are still insufficient to enable final conclusions to be reached, for instance with regard to the long-term use of cannabis.¹

In some countries the policy is now to establish multidisciplinary bodies of experts for the production and screening of information, which can then be passed on to persons with teaching experience for use in educational courses.

An example of the range of measures being taken with the aim of preventing alcoholism was given by the participants from the USSR at the 1972 WHO Seminar. These measures include lowering the production of beverages containing more than 30% of alcohol; increasing the production of beverages with a low alcohol content; making home-production of all alcoholic beverages, except wine, illegal; limiting the hours of sale of alcoholic beverages to 11.00-19.00; restricting sales on Sundays in some cities; restricting the sale of spirits in restaurants to 100 ml per head; prohibiting the employment of persons under the age of 23 in any areas of the liquor trade; punishing the encouragement of drunkenness in young people by a 3-year prison sentence.

Examples of the implementation of preventive policies are given in Sections 4.4, 4.3, and 10.

7.2.2 Treatment

According to most of the responses, national policy has veered towards increasing emphasis on medicosocial measures in dealing with alcohol problems and away from the former repressive measures. This movement is also apparent with reference to the non-medical use of other drugs, although it may be occurring more slowly.

Several responses refer to the policy of integrating early diagnosis and the treatment and rehabilitation of persons dependent on alcohol - and in some cases other drugs - with the general national and local health programmes, and particularly with the mental health programmes. Health ministries are taking increasing responsibility for the development of such provisions.

Although dependence on alcohol does not seem to be considered a crime in the countries under review, the response to public drunkenness is frequently imprisonment and/or a fine. Several countries have made, or are considering, changes in the relevant legislation, since in a high proportion of cases persons found drunk in public are in need of treatment and other assistance and the legal sanction does nothing to alleviate their condition, except that they may be provided with temporary shelter. In Poland and Czechoslovakia, persons found publicly drunk are taken to "sobering-up" stations, where medical examinations and assistance are given: recidivists are followed up and may be advised to seek further treatment or committed for care.

Emphasis on commitment to treatment is tending to change in favour of voluntary treatment in some countries. The Swedish response states that drug abusers, formerly committed to treatment through the Child Welfare and Psychiatric Care Acts, "shall as far as possible be treated on a voluntary basis, according to the proposals of the Committee on Drug Abuse. . . . A 'treatment chain' of field work: inpatient treatment - outpatient treatment - aftercare, is being organized". Most of the alcoholics are also treated on a voluntary basis, but there are legal

¹ See WHO Scientific Group on the Use of Cannabis (1971).

provisions for commitment to treatment, and the legislation is to be reviewed. The response goes on to state that "The idea that no treatment should be enforced on social criteria only is gaining ground, so it is likely that this special temperance treatment legislation will be abolished and drastically changed."

There are indications that official policy in several countries fosters efforts to rehabilitate persons treated for dependence so that they can return to a role in the family and community, including the work environment. This is stated policy in Chile, for example.

Increasing attention is being given to evaluation and improvement of treatment. The response from Australia states, for instance, that "At present, a certain degree of flexibility is deemed necessary because of the changing pattern and volume of drug-dependent persons presenting for treatment. An eclectic approach has been adopted and attempts are being made to evaluate different methods of treatment, to work out criteria for successful administrative and preventive action, and to establish what modalities will be adequately utilized by the drug dependent population."

In several countries the so-called "British approach" to treatment of persons dependent on opiates is being studied with a view to its application elsewhere. This approach has to be seen within the framework of the sociocultural patterns of the country and the National Health Service, which provides special inpatient and outpatient facilities for treatment of persons dependent on drugs. Compulsory treatment can be effected only under the general provisions of the 1959 Mental Health Act. The response from the United Kingdom refers to a memorandum circulated throughout the National Health Service in 1967, which points out that "Some addicts will not accept withdrawal treatment, at any rate to start with, and complete refusal of supplies will not cure their addiction - it will surely throw them on the black market and encourage the development of an organised illicit traffic on a scale hitherto unknown in this country. The aim is to contain the spread of heroin addiction by continuing to supply the drug in minimum quantities where this is necessary in the opinion of the doctor, and where possible to persuade addicts to accept withdrawal treatment. For these purposes the medical supervision of addicts is necessary."

The report of a WHO Expert Committee on Drug Dependence (1970b) notes that "in several countries the free and permissive prescribing of drugs of dependence has led to the development of an increase in the incidence of drug dependence. No method of maintenance on dependence-producing drugs should be undertaken without strict controls and strict supervision by trained medical personnel."

"The Committee was of the opinion that great caution is advisable in connexion with the possible use of a maintenance method for sporadic users of drugs or for young persons who have only been using drugs for a short time."

"It was noted that, in a very few countries, opium is provided through governmental channels to selected, long-term opium users. The Committee hoped that information could be obtained to indicate the impact of this programme on the total pattern of use of morphine-type and other dependence-producing drugs in those countries. The goals of this approach were 'problem containment' and 'minimization of illicit drug traffic', as in the case of the two maintenance programmes just discussed" (in the United Kingdom and the USA).

It is clear from most of the responses that dependence on alcohol and other drugs is now looked upon as deriving from, and giving rise to, complex medical, psychosocial, and economic problems often with legal implications. Some countries have therefore established special bodies to investigate and coordinate activities that aim to respond to these problems, as set out in Section 8.

7.3 Extent to which the above policies have been incorporated into legislation

Although most of the responses refer to specific legislation on the control of production and distribution of alcohol and certain other dependence-producing drugs, little mention is made of legal provisions for preventive activity through education. One exception is Chile, where the 1969 Law makes it compulsory for primary, secondary, and special schools to provide teaching on alcohol problems. Another exception is Poland, where such provisions are stipulated in the Anti-Alcoholism Act.

Considerable attention is being given in many countries to the redrafting of legislation on prevention of drug dependence and treatment of persons who have become dependent. In Switzerland, for instance, a proposal has been made to introduce preventive measures and provisions for the treatment and rehabilitation of dependent persons into the Federal law on narcotics.

Legislation in some countries requires the provision of treatment facilities. As regards alcoholism, this applies, for instance, in Chile under the 1969 law and in Poland, where local authorities and national committees are obliged to set up institutions for alcoholics in towns and counties under the Anti-Alcohol Act of 1959.

Legislation has been enacted in the United Kingdom concerning the establishment of special treatment centres for opiate addicts, as well as for restrictions on prescribing heroin and cocaine, and the compulsory notification of addicts.

The Law on Social Assistance in Sweden states that "The Social Welfare Board shall make itself well acquainted with the need of the private citizen for care and shall strive to satisfy this need." Persons whose need for care is caused by drug dependence come under this Act, except that those under 20 years of age come under the purview of the Child Welfare Act. The aim of the Temperance Treatment Act is "to bring any person who abuses alcoholic beverages back to a sober way of life". The Temperance Board investigates reports of alcohol abuse, carries out suitable welfare measures, and may persuade the alcoholic to undergo treatment.

Some of the Swiss cantonal laws stipulate welfare measures for alcoholics: for example, the "law on prevention and control of alcoholism" of St. Gall and two enabling laws in Berne on "welfare measures for alcoholics".

In several countries, legislation provides for compulsory treatment of alcoholics. In Czechoslovakia, the order may come from the Department of Health of the District National Committee when outpatient treatment is considered insufficient or the patient either does not collaborate or is unwilling to be treated. Although chronic alcoholics may be forcibly committed to disintoxication establishments according to some Swiss cantonal laws, such provisions are used only as a last resort.

Provisions under the Penal Code enable the Temperance Board to enforce referral to treatment in Sweden. Commitment to treatment may depend on special circumstances. In Finland, for example, these exist when the abuse is connected with one or more social disorders; when the person is violent or a danger to himself or his environment, has been convicted for driving a motor vehicle while intoxicated, has caused an obvious disturbance, is neglecting to provide care and maintenance for his dependents, needs public aid.

Most of the responses refer to legislation concerning public drunkenness. The response from the United Kingdom states, "Legislation governing public drunkenness is complex and in part of long standing. Some of the laws on the Statute Book have fallen into total disuse, and the overall position has ... been described as 'unsatisfactory, illogical and confusing' (Napley, 1969)". This probably applies also to some other countries. Repeated public drunkenness may lead to commitment to treatment.

Intoxication may aggravate or mitigate criminal liability, depending on circumstances, as in the Philippines. On the other hand, the intoxicated offender may be considered fully liable, as in Poland or Sweden. However, the decision about the sanctions to be applied may depend on whether the criminal was intoxicated.

Legal provisions exist in some countries for placing an alcoholic under guardianship (e.g., some Swiss cantons), and in others, e.g., the Philippines, contracts agreed upon when either party was in a state of drunkenness may be voidable.

Although drug dependence is generally not considered a crime (though it is in Thailand, for example), the acquisition, possession, and/or use of specified drugs are illegal in most countries. However, the sanctions may be suspended in favour of treatment, as in Thailand and in France, in certain cases laid down by law, "particularly if drug-dependent persons undergo complete courses of treatment". The addict coming before the courts in Sweden may be remanded for psychiatric treatment, but the response states that this does not often occur: "In 1968, out of 1 427 persons convicted of drug crimes, only 18 were remanded to psychiatric treatment, much to the surprise of the Committee on Drug Abuse which had recommended that treatment should be given some priority." In Mexico, addicts are required by law to submit to treatment by doctors in federal rehabilitation hospitals or privately if the facility satisfies requirements laid down for treatment. In Spain, drug-dependent persons may be required to undergo treatment in pursuance of a recently promulgated Law on Dangerous Conduct and Social Rehabilitation: although detained in health institutions they remain the responsibility of the Ministry of Justice. Both alcoholics and drug-dependent persons are obliged by the Public Health Code to undergo special treatment in Panama.

In Finland, experimentation with or use of illegal dependence-producing drugs incur no sanctions but the person involved may be interrogated by the police to uncover the links in the illegal trade. "No law in Yugoslavia", it is stated, "has ever foreseen punishment for those who use drugs for the purpose of 'enjoyment'."

The response concerning the United Kingdom points out that "The abuse of drugs is now characterized by rapidly changing fashionability of many different types of substances which cut across the discrete categories of old legislation. In some cases very different types of drug offences were subject to the same maximum penalties, such as possession of small quantities of cannabis and the possession of large quantities of heroin. . . . The proposed Misuse of Drugs Bill is designed to deal with new patterns of drug abuse as they arise and to provide penalties for drug offences according to relative harmfulness of different drugs. The Bill distinguishes between unlawful possession and trafficking."¹

8. RESPONSIBILITIES AND ACTIVITIES OF NATIONAL BODIES

8.1 Government departments

Nearly all the responses mentioned the over-riding importance of a Ministry or Department of Health (in some cases combined with Welfare or Social Security) in dealing with problems of dependence on alcohol and in certain countries also of other drugs, with particular reference to establishment of treatment and rehabilitation facilities, sometimes with development of treatment methods and organization of relevant health education for the public, with or without the assistance of a Ministry or Department of Education. Such preventive and treatment responsibilities may devolve largely on a Mental Health Department, as in Japan and Costa Rica. A special subsection may deal with surveillance of pharmaceutical and narcotic drugs, as in France.

Questions of drunken driving, public drunkenness, and illegal use of, or traffic in, drugs are generally the concern of Ministries of Justice, Security, Defence, the Home Office,

¹ The bill has since been enacted.

etc., although there may be collaboration with the Ministry of Health, for example in organizing treatment for persons serving a prison sentence.

Customs control may come under one of the above-mentioned Ministries or under a Ministry of Finance and/or National Economy, which may also deal with questions of taxation.

A Ministry of Agriculture may be concerned with the control of, or improvement in, the production of alcohol and/or other drugs, or with crop substitution.

8.2 Other national bodies

In many countries national bodies have been established to deal specifically with problems of alcohol and/or drug dependence. Some of these have been set up by, or have a close link with, governmental bodies. A list of the main national bodies mentioned in the responses is given in Table 15. In addition, a number of voluntary organizations have extended their activities and now have national coverage. This applies to Alcoholics Anonymous in many countries, to a number of church-sponsored or lay temperance societies, and to parents' or other lay associations for giving assistance to drug addicts. Certain other national bodies are concerned with problems of alcohol and drug dependence as part of a wider programme. This applies, for example, to National Institutes of Mental Health and to Red Cross organizations.

8.3 Coordination

The range and variety of the various national bodies give an indication of the need to coordinate their activities. Most of the bodies listed in Table 15 carry out some coordination activities, mainly in a limited field. Examples of bodies established for the purpose of more comprehensive coordination in relation to alcoholism are to be found in Czechoslovakia, Poland, and Sweden, and in Australia and Sweden in connexion with dependence on other drugs.

In Poland, for example, the Parliamentary Commission of Health is the highest control organ in the field of alcoholism. The Deputy-Ministers of Health and Social Welfare, Justice, Internal Affairs, Education, Food Industry, Trade, and the State Attorney and representatives of social organizations together form the Permanent Commission of the Council of Ministers to Fight Alcoholism. The efforts of the Civic Committee to Fight Alcoholism led to the adoption of the 1959 law which sets out a detailed programme for the prevention and treatment of alcoholism. This Committee has branches all over the country that carry out educational and preventive activities.

The Swedish Government Co-ordination Agency for the Control of Drug Abuse brings together the Heads of the Office of the Chief Public Prosecutor and Prosecutor of the Supreme Court, the National Correctional Administration, the National Police Board, the National Board of Health and Welfare, the Swedish Board of Customs, the Office of the Chancellor of the Swedish Universities, the National Board of Education, the Swedish Association of Local Authorities, the Association of Swedish County Councils, and a member of Parliament.

The Council on Alcoholism and Drug Dependence in Austria brings together representatives of the Ministries of Justice, Defence and Education, the Home Office, trades unions, social insurance bodies, temperance organizations, and scientific specialists.

In the United Kingdom, "the need for close collaboration among all organizations treating alcohol dependence has been emphasized by the Committee on Habitual Drunken Offenders (1971), whose recommendations include advice that central government departments should consider what further steps can be taken to improve liaison among such bodies. . . . The need for elaboration and coordination of services is emphasized by the Ministry of Health memorandum in that the absence of a reliable cure for alcoholism requires that treatment facilities should be organized so as to permit flexibility, experiment, and research."

TABLE 15. NATIONAL BODIES CONCERNED WITH ALCOHOL AND/OR DRUG DEPENDENCE

Country	National body	Comments
Argentina	<ol style="list-style-type: none"> 1. National Drug Dependence and Narcotics Commission (CONATON) 2. Standing Committee on Drug Dependence Prevention & Treatment 	<ol style="list-style-type: none"> 2. Part of National Institute of Mental Health
Australia	<ol style="list-style-type: none"> 1. National Standing Control Committee on Drugs of Dependence 2. Sub-committee on drug education 3. Australian Foundation for Alcoholism and Drug Dependence 	<ol style="list-style-type: none"> 1. Senior officials from Commonwealth and State Departments: Government budget 3. Group of affiliated organizations from all States
Austria	Council on Alcoholism and Drug Dependence	Advises Minister of Health; representatives of various governmental, trade union, and scientific bodies
Chile	<ol style="list-style-type: none"> 1. National Commission for the Control of Alcoholism and Problems of Alcohol 2. Union for Rehabilitation of Addicts 	<ol style="list-style-type: none"> 1. Proposed to include reference to other drugs 2. Voluntary body, 130 branches
Costa Rica	Commission on Alcoholism	Semi-autonomous
Czechoslovakia	Central Anti-Alcoholic Committee	Established in 1958; attached to Ministry of Health; branches in all regions and districts
Finland	<p>Bodies under Ministry of Health and Social Welfare:</p> <ol style="list-style-type: none"> 1. Expert Committee on Drug Dependence 2. National Commission for Alcohol and Drug Affairs 3. National Expert Committee for Care and Rehabilitation of Vagrant Alcoholics 4. National Expert Committee for Alcohol - Substitute Affairs 	<ol style="list-style-type: none"> 1. 15 members; governmental and other bodies 2. 3 sections dealing with different aspects of treatment policy
France	<ol style="list-style-type: none"> 1. High Commission for Study and Information on Alcoholism 2. National Committee for Defence against Alcoholism 3. Interministerial Narcotics Commission 	<ol style="list-style-type: none"> 1. Established in 1954; attached to Prime Minister's Department 2. Established in 1872; 80 county branches and numerous local ones 3. Under the Ministry of Public Health
Israel	Two interministerial committees	One deals mainly with hashish, the other with prevention of drug problems

TABLE 15. NATIONAL BODIES CONCERNED WITH ALCOHOL AND/OR DRUG DEPENDENCE (contd.)

Country	National body	Comments
Mexico	<ol style="list-style-type: none"> 1. Mexican Association of Alcoholics under Rehabilitation 2. National Council on Problems of Drug Dependence 	<ol style="list-style-type: none"> 2. Co-ordinating Body between Secretary of Health and Welfare, Secretary of Public Education, National Academy of Medicine, pharmacologists, penologists, social services, national universities, etc.
Netherlands	<ol style="list-style-type: none"> 1. Federation of Institutions for Care of Alcoholics (FZA) 2. National Commission against Alcoholism (NCA) 3. The People's League against Alcohol Abuse 	<ol style="list-style-type: none"> 1. Established in 1953; subsidized by the Government 2. Established in 1908; teetotalers' organizations 3. Established in 1875; a sobriety movement
Nigeria	Inter-departmental Committee on the Control of Narcotics	Established in 1966; deals with control, public education and training of personnel
Philippines	<ol style="list-style-type: none"> 1. Narcotics Foundation of the Philippines 2. Ad hoc Committee on Narcotics 	<ol style="list-style-type: none"> 1. Established in 1968, deals with education, treatment, rehabilitation, and job placement
Poland	<ol style="list-style-type: none"> 1. Permanent Anti-Alcoholism Commission of National Councils and Government 2. Civic Committee to Fight Alcoholism (SKP) 	<ol style="list-style-type: none"> 1. Representatives of several ministries 2. Supported by Polish United Workers Party; links with Government and research institutions; branches throughout country
Romania	Proposal to establish inter-departmental commission	

TABLE 15. NATIONAL BODIES CONCERNED WITH ALCOHOL AND/OR DRUG DEPENDENCE (contd.)

Country	National body	Comments
Sweden	<ol style="list-style-type: none"> 1. Swedish Council for Information on Alcohol and Other Drugs (CAN) 2. Government Co-ordination Agency for Control of Drug Abuse (SBN) 3. Government Co-ordination Agency for Alcohol Questions 4. Working Group of the National Board of Education for Alcohol, Narcotics and Tobacco Questions (SANT) 5. Swedish Medical Association Committee on Drug Dependence Problems 6. Swedish Medical Association Committee on Alcohol Problems 	<ol style="list-style-type: none"> 1. Consultant organ for Government, which subsidizes its activities 2. Heads of various governmental, university, and local authority boards 3. Established in 1957; representatives of governmental, research, trade, temperance, and sports boards 4. To supervise relevant programmes in educational system 5. Research, therapeutic advances, policy 6. Established in 1955; research, therapeutic advances, policy
Switzerland	<ol style="list-style-type: none"> 1. Federal Commission against Alcoholism Subcommittee on Scientific Research 2. Federal Alcohol Administration 3. Swiss Central Office of Education on and Prevention of Alcoholism, Lausanne 4. Swiss Federal Bureau for the Repression of Illicit Traffic in Narcotics 	<ol style="list-style-type: none"> 1. Advisory body to Federal Council; established in 1964 2. Public health concern, promotion of non-alcoholic beverages, grants for prevention. Established in 1885 3. Established in 1902; prevention, sociological and psychosocial research 4. Attached to the Department of the Federal Public Prosecutor
United Kingdom	<ol style="list-style-type: none"> 1. National Council on Alcoholism 2. Medical Council on Alcoholism 3. Standing Advisory Committee on Drug Dependence 4. Association for the Prevention of Addictions 	<ol style="list-style-type: none"> 1. Established in 1963; affiliated to local councils, mainly for education of public 2. Scientific and research body 3. Established in 1967; governmental
Yugoslavia	League on Alcoholism and Drug Dependence	
Zambia	Former National Council on Alcohol and Addictions	Established in 1966, now dissolved. Meeting in 1972 of Department of Social Services and Mental Health Association to consider programmes.

9. TREATMENT AND AFTER-CARE SERVICES

9.1 Principles

The report of a WHO Expert Committee on Mental Health (1967), convened to consider services for the prevention and treatment of dependence on alcohol and other drugs reviewed existing types of service and made the following statement:

"The treatment of persons dependent on alcohol, with the best methods available, has produced encouraging results. Marked improvement or social recovery has been reported in up to 50-70% of cases, depending mainly on the underlying personality of the person treated. The proportion of therapeutic failures is generally higher among abusers of other drugs, but social and cultural factors and the extent of dependence on a particular drug within the population also affect the treatment results."

"There are many principles that are equally valid in the treatment of persons dependent on alcohol and those dependent on other drugs. An important fact, often overlooked, is that detoxification of the dependent person is only one aspect of the total treatment process. Indeed, this measure is less time-consuming and difficult than the other essential therapeutic steps. Intensive treatment of psychological dependence and of drug-induced and other physical disorders, social and vocational rehabilitation, and long-continued follow-up through supportive and consultative services are all needed in the majority of cases if the dependent person is to have an optimum chance of living his life free of drugs as a productive citizen. Nor must non-relapse into dependence on alcohol or other drugs be considered as the sole criterion of effectiveness of the therapeutic regime. Improved interpersonal relations, working patterns and satisfactions in living must also be used as criteria in judging therapeutic results."

The Committee stressed the need for the development of comprehensive programmes to meet the physical, psychological, social, economic, and other problems arising in relation to the drug-dependent person, his family, and society in general. This would entail close cooperation between various disciplines, organizations, and facilities. It was recommended that, wherever feasible, such facilities should be closely integrated with other health and welfare services.

More detailed attention is given to the principles of management of drug dependence problems in the report of a WHO Expert Committee on Drug Dependence (1970b). Questions of withdrawal from various drugs, maintenance on narcotics, and the use of antagonists are discussed, as well as the role of compulsion in treatment and treatment in self-regulating communities.

9.2 General structure of services

In countries with an organized pattern of health services, treatment for somatic complications of alcohol use is usually available in general hospitals, but the psychological complications may be overlooked and left untreated. Admission to mental hospitals may be limited to patients with serious psychiatric complications, particularly alcoholic psychoses. Increasingly, however, specialized treatment and specialized wards or centres are becoming available in, or attached to, or separate from general and mental hospitals, for the treatment of alcoholics at both the earlier and later stages of their disorder. Provisions for outpatient treatment, before, after, or instead of, inpatient hospital care have expanded rapidly in recent years. There appears to be a tendency in some countries to forego the establishment of institutions for long-term internment of "chronic" alcoholics in favour of community-based hostels and halfway houses where support is given for re-establishing a role in society.

Similar provisions may be available through the health services for persons dependent on other drugs, who are in some cases treated along with alcoholics. More frequently, however, separate treatment facilities have been established, often on an experimental basis.

Social welfare or probation services have played a leading role in certain countries in providing assistance to alcoholics and sometimes to persons dependent on other drugs. In such areas the health professions may be awakening only gradually to their responsibilities, or may already be cooperating closely in the established programmes.

Voluntary organizations, including those comprising mainly former alcoholics or drug-dependent persons, appear in some countries to be the main source of support - psychological, social and sometimes medical - for these people. Here again, there is increasing collaboration with the health services.

Although all the responses indicated awareness of the need for treatment and after-care, many emphasized the inadequacy of the provisions available in terms of accommodation, therapeutic personnel, and treatment. In some areas, and for some groups of persons, the response has been largely repressive, and therapeutic requirements have been left out of account.

However, throughout the responses there are indications of an awareness that a network of treatment and other supportive facilities is required; that long-term follow-up of the persons treated is frequently necessary; that collaboration between many agencies, specialists, and local citizens is important in establishing and running treatment services; that greatly increased attention should be given to the evaluation of treatment measures and structures; and that alternative methods and approaches should be tested in view of the relative inefficiency of the measures currently employed. For all these purposes, knowledge of experience in other countries may be found valuable.

A synopsis of the services and facilities in the responding countries is given below, with some illustrations from the countries visited by the participants in the training course and seminar.

9.3 Counselling and outpatient treatment

9.3.1 Case-finding and motivation

In many countries, rough and cheap accommodation is made available by private bodies or health authorities for vagrants, of whom a considerable proportion may be alcoholics or drug dependent persons. Attention is being given in some areas to means of gaining the confidence of people in such refuges and motivating them to seek treatment where necessary. A centre of this kind was visited in Stockholm ("Alltinget"). It was run by an untrained staff paid by the local authorities. Beer and cheap meals were obtainable and clothing was provided in cases of dire need. A hobby room was available and concerts and other attractions were arranged weekly. The guests remained anonymous and were free to discuss problems with the staff, but were not forced to do so. "Skid-row" alcoholics and drug peddlars frequented the place. The centre has since been closed, partly because it attracted too many vagrants, and smaller centres have been opened. It was of interest to learn that the sample of men approached in Alltinget with an invitation to stay at Krukmaårgatan Lodge (p. 66) all accepted, indicating that the possibility of finding a more permanent home may be acceptable to the "skid-row" population.

Some of the Alltinget guests were contacted through an advisory bureau in Stockholm and motivated for treatment. This bureau was opened in 1969/70. There are 30 staff members comprising a psychiatrist, trainees, psychologists, and social workers. The programme includes field work, which involves becoming acquainted with drug dependence problems in

Stockholm, making contacts with drug users, and attempting to motivate them to go for treatment. Guidance, including individual and group therapy, is carried out and referrals may be made to three special wards for drug dependent persons or to an emergency ward of a general hospital.

In Uppsala, a Swedish town of 100 000 inhabitants, a start was made to contact drug users in 1966 when officially no problem of illicit drug use was known there. By 1972, about 1 300 drug users had been contacted by a small group of voluntary workers and about 90% had visited an advisory centre. Assistance was given with daily problems, referrals were made to treatment on request, and post-treatment help was offered. Similar "Outreach" services are now to be found in a number of countries.

As regards the United Kingdom, a report of a Home Office Working Party on Habitual Drunken Offenders (1971) draws attention to the severity of the homeless alcoholic problem in an area of London (Southwark). It recommended the establishment of an experimental shop-front centre whose function would be "to reach out with a helping hand again and again, to attract the man who has not sought help before but also to maintain contact with, and tempt back, those who have tried before and failed." The Alcoholics Recovery Project, established in 1966, had set up three such centres by 1970. They provide, in an informal atmosphere, personal contact, general advice and information, and specific information, and encouragement about treatment, and they have been particularly valuable as a resource for integrating existing services and for referring the men to appropriate accommodation and treatment facilities. The Recovery Project is also responsible for two of the experimental hostels for alcoholics mentioned on p.65. A 12-month study (1971-72) focused on the subculture of the homeless alcoholic and the whole project is now being evaluated.

Assistance to heroin users was started in London (Soho) in church premises before official treatment centres were established. The house is still used as a meeting place for drug users, many of whom are contacted in clubs and bars in the district, together with social workers, doctors, and parents. Discussion groups are organized and lectures are given. Liaison is maintained with many church and voluntary groups concerned with preventing and treating drug dependence, as well as with individuals willing to provide emergency assistance and with the staff of prison services and treatment centres.

Another "pre-treatment facility" visited in London was the Community Drug Project, accommodated in part of an old house in a London street. The purpose of the project is to make contact with drug users who have not yet sought treatment, in the hope that they can be motivated to do so. As stated in the Community Drug Projects Third Report, "The day centre sets out to provide the first stage of a programme that we hope in time will enable the drug user to discover and achieve a new way of life that does not rely upon drug taking for its satisfactions....Through our knowledge of the individual and our relationship with other treatment facilities and rehabilitation programmes we can direct people to the most appropriate kind of help.... We follow people through as many stages of rehabilitation as possible offering our encouragement, and practical help when needed. As well as helping the individual the knowledge of his progress can often stimulate others to take this step."

Young people from many parts of the world flock to Amsterdam in the summer. A certain proportion are attracted by the knowledge that the municipality shows a certain tolerance towards drug use in the hope that problems of drug dependence will not go underground and thereby deteriorate. Two centres where young people congregate in the evenings were visited. In both, drugs were known to be used and sold. Voluntary workers and social workers got acquainted with the clients and were available to help with problems and, if possible, to motivate some towards treatment. One of the centres, "Paradiso", which attracted large crowds, has now been closed. The other, "Cosmos", offers opportunities for discussion, meditation, listening to music, eating "macrobiotic" food and using a sauna. Some of the clients "drop in" at the Jellinek Medical Consultation Bureau for Alcoholism and Drug Abuse (MCB) in the evenings, where psychiatrists and social workers are available to provide help.

A Youth Advisory Centre (JAC) was opened in Amsterdam in 1969. It opens in the evening until early morning and provides assistance, advice, and information to any persons who wish to drop in. A proportion of the clients are drug users (10% of the 8 000 cases in 1970) who can be referred for treatment. Similar "crisis centres" have been opened in other towns in the Netherlands and in a few other countries.

Centres known by such names as "Drop-ins" and "Release" have sprung up in many countries as contact points and helping centres, mainly for drug dependent persons who find there some acceptance and human warmth. The organization of such groups varies from place to place and time to time. Some appear to be carrying out an important function as a pre-treatment or even treatment facility, often mainly run by other dependent or previously dependent persons. Examples of such centres were seen in several cantons in Switzerland.

9.3.2 General medical and psychiatric services

(a) General practitioners

Although several of the responses point to the important role that can be played by general practitioners in the treatment of alcoholics and drug dependent persons, it is recognized that they frequently have little interest in these problems, which they may not consider to be illnesses; they may have had little training to prepare them for this task; and they may consider that such work would take up too great a proportion of their time. However, in areas where general practitioners function as "family doctors" their knowledge of the family situation should enable them to assist with treatment and after-care even where they are unable to accept full responsibility.

(b) General hospital outpatient and emergency services

As pointed out in the United Kingdom response, "it is not uncommon for alcoholics to attend casualty departments in general hospitals as the result of injuries, traffic accidents, collapse, or suicidal attempts" and it is suggested that such attendance could provide an opportunity for early case-finding and referral to specialist services. Similar opportunities for diagnosis occur in the general outpatient services. The response from Chile refers to a focus on outpatient treatment provided by "a team of the General Health Department of the general health station corresponding to the place of residence and centres on the community. These teams have the possibility of carrying out follow up of patients, particularly through the staff of the programme of sociocultural development of health which was initiated in 1971."

(c) General psychiatric outpatient departments

In some countries, persons with alcohol problems are most often treated through general psychiatric outpatient clinics attached to general or psychiatric hospitals or to local mental health centres. In France, for example, nearly 1 000 mental health units arranged sessions during 1970 at which alcoholics as well as other mentally ill persons were seen. Community Mental Health Clinics are used for this purpose in Australia, Mexico, Panama, and a number of other countries.

Persons dependent on other drugs may also be treated through such facilities, but where the problem is increasing the tendency is to establish specialized services.

(d) Specialized outpatient care

The responses give numerous examples of specialized outpatient care, for persons with alcohol and/or other drug problems, within the framework of general health and welfare and

psychiatric services. Czechoslovakia, for example, had 214 outpatient clinics for alcoholics with 28 000 first examinations and 110 000 registered in 1971. Such clinics have been established in all districts and form part of the psychiatric outpatient services.

In the United Kingdom a certain number of medical practitioners (545 in 1968) were licensed to provide heroin and cocaine to persons under treatment by them and diagnosed as dependent on these drugs. Notifications must be made to the Home Office. The treatment is carried out mainly through specialized clinics and aims at motivating the drug dependent person to accept withdrawal or at least to assist those on a regular maintenance dose to live as normal and useful a life as possible. To a large extent, methadone for oral use is now prescribed instead of heroin. In 1970, there were 14 such specialized treatment centres for opiate dependent persons attached to National Health Service Hospitals in London, and 13 others outside London.

In several countries, family case-work is considered to be an important part of the medicosocial services for alcoholics. This applies, for example, to Switzerland where much of the work of the welfare services consists of inducing the family to participate in treatment. In France, such work is carried out through the general social services under the Ministry of Public Health. Quite extensive family case-work is undertaken in Zambia by psychiatric social workers and the social welfare service.

An interesting experiment in Czechoslovakia has proved well worth continuing and trying out elsewhere. Alcoholic patients with their families and therapists from Prague are given an opportunity to spend a fortnight camping in the country. The programme focuses on the needs of the children, the wives, the patients, and the family as a whole.

9.3.3 Other specialized systems of outpatient care

Apart from the facilities provided within the general health and welfare services, other types of specialized outpatient counselling and care are available in several countries, as illustrated below.

(a) Medical Consultation Bureaux (Netherlands)

In the Netherlands, outpatient treatment is available mainly through the Medical Consultation Bureaux for Alcoholism and Drug Abuse (MCBs), of which there were 19 in 1971 giving fairly good national coverage. Treatment is open to all and free of charge. About 11.5 thousand persons (128 per 100 000 population aged over 15 years) were under treatment in MCBs on 1 January 1968. Roughly two-thirds are referred by the courts.

Each MCB has one or more consulting psychiatrists to interview every new patient. A part-time psychologist is attached to some of the bureaux. The main load of the work is carried by social workers and nurses with social psychiatric experience, who receive the patients at the bureau, make home visits, work with the spouse and families, give advice about work and family problems, consult authorities, report to courts, and carry out group therapy. The director of the bureau is usually a social worker or sociologist. By 1971, six of the MCBs had developed special clinics for providing inpatient treatment.

(b) Sociomedical commissions and advisory centres (Poland)

Sociomedical commissions are in existence all over the country; in Warsaw, for example, there are seven. They comprise a chairman (lawyer), a vice-chairman (physician: psychiatrist or doctor with training in alcoholism), and members from social (civic) organizations. Their duties are laid down by the law of 1959. They operate within public health administrations of local People's Councils and can order the submission of alcoholics to compulsory treatment in outpatient care. The physician is the only member of the commission who may diagnose alcoholism and he has the final word about treatment. The commission is in

continuous contact with advisory centres and inpatient facilities. About 5% of patients coming before the commission are sent by the courts and 70% by their families. Others are reported by the "sobering-up" stations. Trade Unions send alcoholics to advisory centres, but may direct them to the commissions if they avoid treatment. About 1 000-2 000 persons are seen annually in Warsaw by the commissions, about 5% being female. There is a possibility of appeal within 14 days against the commission's decision to the Health Department of the People's Council. About 20% of patients under treatment are sent by the commissions. They also keep data on the patients' background and control the continuation of treatment and can permit the conditional discharge of patients under compulsory treatment. The commission also decides whether the patient's wages should go to his spouse and can provide extra financial assistance for the family. In 1969, one commission visited in Warsaw ordered outpatient treatment for about 400 persons, whereas court decisions for inpatient treatment were made for 89 persons from the same district. The courts have their own expert physicians.

Advisory centres for alcoholics have been set up in nearly every district and in major sectors of large towns. The number increased from 79 in 1955 to 406 in 1969. About 29 000 new patients were treated in 1969 and attended an average of 10 times, the total number treated being about 70 000 (274 per 100 000 population aged over 15 years). Some 40% of the patients come on compulsory order of the sociomedical commissions.

These centres are managed by general physicians (about two-thirds) or psychiatrists (about one-third) with the help of a nurse who is involved also in social work. In some cases assistance is provided by psychologists and neurologists.

(c) Counselling agencies, alcoholism policlinics, and centres for drug abuse (Sweden)

Sweden has about 15 counselling agencies for persons with alcohol problems. They are generally independent sections of the temperance boards. Both social and medical care are provided and regular discussions and group therapy may be provided for clients and their spouses. Some agencies conduct a continuous temperance information campaign.

A system of alcohol policlinics was developed in the 1950s and in 1970 there were 125, mainly attached to a general or psychiatric hospital or, in smaller communes, connected with the offices of community physicians. The personnel include physicians, nurses, and some social welfare staff and psychologists. Smaller clinics may receive patients during only a few hours a week, but others are able to provide advanced medical as well as social therapy; an example is the Maria Clinic in Stockholm, which provides a 24-hour service. Some of the clinics are managed partly by local temperance boards.

Drug dependent persons are treated in some of the alcohol policlinics, but there are also 10 outpatient clinics specifically for those using other drugs. The staff comprise social workers, psychologists, and physicians, and, in some cases, former drug dependent persons. The treatment is founded entirely on the voluntary cooperation of the patients.

(d) A-clinics (Finland)

The A-Clinic Foundation, established in 1955, is a private organization set up by bodies concerned with social welfare, public health, temperance work, alcohol policy, medical associations, the church, and municipalities. It establishes and maintains outpatient clinics (13 clinics and 1 projected in 1971). They are staffed by one or two general practitioners or psychiatrists as well as by nurses and social workers. In 1972, one of the clinics visited had a clientele of 2 000 persons. A "hang-over" station is attached to each clinic and some have "sobering-up" stations with beds for stays of up to one week. The Foundation also organizes public information, carries out research, and trains staff for its clinics.

(e) Medicosocial and welfare centres (Switzerland)

Switzerland has some 115 medicosocial and welfare centres for alcoholics, most of which are private institutions receiving government grants. About 20 are directed by the Blue Cross temperance society. The services are run in cooperation with social welfare physicians or general practitioners and with the communal authorities. Some organize courses or week-end meetings for patients and their families.

(f) Outpatient departments of alcoholism institutes (Yugoslavia)

Institutes and centres for the study and treatment of alcoholism have been established in several of the Yugoslav republics. The one visited in Belgrade during the 1972 WHO Seminar has a very active outpatient department linked with centres for social work and hospitals in the city. The staff of the treatment centre includes general practitioners who have undergone a special course of training on alcoholism, psychiatrists, and specialists in internal medicine, ophthalmology, neurology, and electroencephalography as well as psychologists and social workers. Treatment consists of 10 days of daily attendance for detoxification followed by attendance twice weekly for 6 weeks then every 2 weeks for 2 years. If the patient does not keep the appointment a social worker visits him the next day to induce him to return to treatment. About 15% of the patients drop out of treatment within the first 3 months. Many return for repeated courses. Treatment includes somatic measures, psychotherapy, social assistance, and aftercare.

Outpatient treatment centres have been established in some rural areas surrounding Belgrade, physicians from the Belgrade institute taking turns to spend 2 weeks there, whereas the social worker staff remains at the rural centre. Such a centre with a very active programme was visited in Bjelina, Bosnia, where a high proportion of the population is engaged in the production of slivovic.

(g) Alcoholism Commission centres (Costa Rica)

This Commission has its headquarters in the capital city and there are 17 branches throughout the country. Each branch has a social worker who promotes meetings with alcoholics and their families, organizes group therapy, carries out social welfare work, and refers patients to the headquarters or to hospitals for medical and psychiatric assistance. There is an information centre dealing with dependence on other drugs.

(h) Outpatient clinic of the Central Committee for the Prevention of Intoxication and Combating of Narcotic Drugs, Cairo (Egypt)

This Committee comprises physicians, psychologists, lawyers, police officers, judges, social leaders, teachers, political officials, and religious leaders. It was responsible for establishing in 1969 the first clinic of its kind in the country, situated in an ordinary building in the centre of Cairo. Two psychiatrists, two social workers, a religious man, two nurses, and a pharmacist make up the professional staff, who dealt with 1 540 patients in 1971; the patients were mostly working class and 95% were dependent on opium. Each patient is assessed by a psychiatrist and social worker and the treatment regime is outlined. The religious man plays an important role in patient management. Admission is voluntary and patients are expected to attend the clinic each afternoon (except Friday) for treatment and relaxation in the club, and are encouraged to resume work in the mornings. Modified insulin treatment and antidepressants are used. A study is being made to follow up patients dependent on opium one year after treatment. The cost of the treatment is stated to be about US\$ 2 per head.

(i) "Sobering-up" stations (Poland, Czechoslovakia, Mexico)

Although not strictly for outpatient care alone, most "sobering-up" stations provide

for only one night's stay. This system of emergency care has spread rapidly in Poland, where by law such stations should be established in all towns of over 100 000 inhabitants. There were 27 stations with 1 181 beds in 1970. At a station in Warsaw, which was visited by the WHO Training Course participants in 1971, about 90 patients are brought in daily by the police or by ambulance: about 30% are "chronic alcoholics". Of the nearly 30 000 persons seen in 1969, about 5% were female and about 1.5% young drug addicts. On arrival, the patient's valuables are removed and listed in the presence of a policeman. He is undressed, showered, given a medical examination and put to bed; if thought necessary he is strapped down. He stays 8-24 hours and is observed during the night. For certain occupations, the place of work is notified of the admission: this is obligatory if he comes more than twice in one year. A person brought in more than twice in a month has to go before a sociomedical commission which may order treatment. A payment of 215 zloty has to be made for the service. To run this service, there is a staff of 116, one-third being physicians. An average daily shift is 4 doctors, 10 male nurses, 4 deposit clerks, and several additional hands. About 75% of the persons detained at "sobering-up" stations are there for the first time, but about 1.5 thousand persons per year are detained from 50 to 100 times.

Similar emergency care is organized in Czechoslovakia, which in 1969 had 51 "sobering-up" stations with 457 places and dealt with 30 000 persons.

In Helsinki, a "sobering-up" station ("Arkadia") has been run since 1969 by a voluntary organization for young clients. Three experimental units to be run by the State will open in early 1974.

Following the 1971 WHO Course, a similar unit, but for emergency treatment of both alcohol and other drug dependence problems, was established in Mexico at the National Psychiatric Hospital, on the basis of the experience in the above-mentioned countries.

(j) Clubs for treated alcoholics (Yugoslavia)

A widespread network of clubs for treated alcoholics has been established in Yugoslavia. In Croatia alone there are 130 clubs with about 20 000 members, including alcoholics, family members, and therapists.

The clubs are stated to constitute therapeutic communities whose main aim is to keep their members sober. Regular meetings are held weekly and monthly about 500-800 club delegates come together for a county meeting. There is an annual Congress. Usually, a social worker is in charge of organizing activities, which include assistance to families of alcoholics, sometimes with special social and educational help for children. Among the staff of the clubs are 15 psychiatrists, 34 other physicians, social workers, nurses, teachers, psychologists, and a sociologist.

9.4 Inpatient treatment in general and mental hospitals

As noted on p.18 and in Table 5 a considerable proportion of the patients in general medical wards may be alcoholics, although they are often admitted to treatment for another condition. The somatic complications of dependence on alcohol and other drugs may be treated in the general wards and withdrawal treatment may be given.

Increasingly, however, psychiatric departments are being set up in general hospitals and may provide treatment for alcoholics and drug dependent persons along with other mentally ill persons, as is done also in many psychiatric hospitals. An example was seen by the WHO consultants in the State Psychiatric Hospital of Cracow, Poland, where 25 places are reserved for alcoholics in an 80-bed psychiatric ward. The director considers that the rehabilitation of alcoholics is more effective when carried out in a ward with mental patients. An example of the treatment of alcoholics along with other patients in open wards was seen in the University Psychiatric Clinic in Groningen, Netherlands, where treatment is carried out on therapeutic-community lines.

Where an active treatment programme is being developed, the tendency seems to be, however, to provide special wards or clinics, either for the treatment of alcoholics or persons dependent on other drugs, or both.

An example of a specialized treatment centre for alcoholics attached to the psychiatric department of a general hospital was visited in the Institute for Alcoholism Study and Control in Zagreb, Yugoslavia. This centre has 45 beds for inpatient treatment as well as 50 day-hospital places and an outpatient department. The inpatient department is "open". Patients have some degree of self-government and carry out work connected with running the community. There is a daily group meeting and individual and group therapy sessions are organized. While following treatment, all patients are invited to join one of the clubs for former alcoholics, described above. Dependence on other drugs is as yet a relatively small problem in Croatia, but a unit for drug dependent persons with 15-20 beds has been established in conjunction with the centre for alcoholics.

Czechoslovakia has 20 specialized wards for alcoholics with about 800 beds in psychiatric clinics and hospitals, though it is suggested that 2 000 places are required. Persons diagnosed as alcoholics represent 13% of all admissions to psychiatric clinics, but only 3.6% of the wards are specialized for the treatment of alcoholism. An example of a specialized unit is the Apolinař, which is connected with the Psychiatric Clinic of the Medical Faculty in Prague. It has 50 beds and receives patients from all over the country who come voluntarily for treatment (about 80%) or from the outpatient centres on compulsory orders. A treatment régime has been worked out and has to be adhered to strictly; 15 thrice-daily sessions of apomorphine administration are given for groups of 6-8 members. Lectures are given on alcoholism and an examination has to be passed. The patients assist with the work of the "sobering-up" station, where they observe the manifestations of intoxication and the sobering-up process. The régime also includes a week's stay in the closed department of the psychiatric hospital at Bohnice, where the patients see very serious cases. Weekly group therapy is carried out mainly in closed groups of five persons, and patients are also members of groups set up for specific purposes (work, sports, etc.) and of the total patient group which assembles daily for the morning report and lectures. They may also meet weekly with the group of "stabilized" alcoholics. Treatment lasts 3 months and is followed by prolonged follow-up care and Antabuse (disulfiram) administration. At intervals, the patient returns for a 2-day cure. After discharge from hospital treatment, the patient becomes a member of the club KLUS, which holds weekly meetings with doctors and inpatients. The treatment programme in this centre has now been adapted for use in a number of countries.

It is the stated policy in Sweden to organize care for persons dependent on drugs within the general health and mental health services. A group of the 1972 WHO Seminar participants visited the drug dependence ward in Rålambshov Mental Hospital. A close link is maintained with the field activities of the local advisory bureau, the same physicians working in both. Since there were no models on which to base a programme when this ward was established in 1958, it was set up as an experimental unit and has a high staff/patient ratio. The patients come voluntarily and can leave at any time. The programme includes plenary discussions, group and work therapy (patients and staff working together), and occupational and cultural activities. Patients stay 14 days before being allowed out alone. If they bring in narcotics they have to leave the programme, but some have been back for treatment 4 or 5 times.

In England and Wales, 1 in 6 alcoholic patients in psychiatric hospitals was in a special alcoholism treatment unit in 1967. By 1970, there were 14 specialized treatment units in 10 of the 20 hospital regions. The WHO consultants visited the specialized unit in St Bernard's Hospital, just outside London. This unit admits both alcoholics and persons dependent on other drugs. There are 40 beds in the male ward and 30 in the female ward, serving a population of 4-5 million. The sexes mix for discussions and other ward activities.

Each patient is seen by a psychiatrist on admission, and an attempt is made to follow up those who leave. Three mornings a week are devoted to discussion groups. New patients prepare a life history, which is read in public and discussed. The wards are run as "therapeutic communities".

In the Chilean national programme for control of alcoholism, it has been calculated that an alcoholism treatment centre integrated with general medical services is needed for 100 000 inhabitants, which would mean that 97 centres were needed for the population in 1970. In fact, there were only 46, not all of which were functioning fully. There are two specialized centres in Santiago for treating adolescent drug dependent persons.

9.5 Specialized institutions

(a) Treatment homes and disintoxication institutions (Switzerland)

Several of the responses refer to such long-stay institutions. In Switzerland, for example, there are 8 treatment homes ("maisons de cure") for alcoholics with a total of about 300 beds (50 for women) which admit persons who volunteer to undergo treatment for a year, as well as persons officially ordered to accept treatment. At present an attempt is being made to adjust the length of stay to individual needs. Some of the homes have a very active programme of work therapy (agriculture, carpentry, etc.) and attempt to arrange for suitable employment and living conditions in the community before the patient leaves the institution. Trial leave periods may also be granted. At one home visited in Berne, wives could be invited to stay for short periods in the institute and join in discussion sessions. In addition to these open homes, there are 5 disintoxication centres, with a total of about 400 beds, attached to penal establishments for compulsorily committed alcoholics.

(b) Sanatorium for alcoholics (Hoog Hullen, Netherlands)

This sanatorium is situated in a small farming community outside Groningen and takes patients mainly from the northern provinces, usually sent through an MCB which continues after-care supervision when the patient leaves Hoog Hullen. The staff includes five psychiatrists, and nurses who receive on-the-job training. Apart from the 35 beds there are a few apartments for married couples. Individual and group psychotherapy, as well as work and social therapy, are provided. After the early period of treatment, visiting by family members is encouraged and family problems are discussed with the therapeutic team. Special attention is paid to the preparation of the patient for his return to the community. Some drug dependent persons are now accepted for treatment. There is one other special sanatorium, the "Huize Henriette", which has 18 beds for women.

(c) Woskowice Institution for Alcoholics (Poland)

This is one of nine long-term institutions for alcoholics in Poland. It houses 100 patients, mainly on compulsory treatment. Cooperation is maintained with 22 advisory centres and a mental hospital ward for alcoholics. The staff includes one physician, three nurses and two social workers. Every other week one social worker collects information on the patients under his care from his community and family and follows up patients previously treated in the institution. Much stress is laid on work therapy (Buxakowski, 1973) but there is frequent contact with the physician and voluntary participation in evening group psychotherapy. Another such institution, Zimnowoda, in Poznan, has patient government and stresses small-group psychotherapy.

(d) Closed care temperance treatment (Sweden)

About 5 700 patients are admitted annually to institutions run by the temperance boards.

These are not medical institutions, though some have "admission wards" staffed by a nurse. Generally a social worker is in charge of the institution, and physicians may be employed on a part-time basis, including psychiatrists in about half the institutions.

The response states that the time during care should be used to strengthen the patient so that he can continue rehabilitation in open care. Attempts are made to enable patients to participate in the activities of the surrounding community. Some experiments are conducted in the running of modified forms of therapeutic communities.

(e) Therapeutic communities for drug dependent persons (Sweden)

Two after-care institutions for drug dependent persons were opened in 1971. They are self-governing communities in the mountains, run with the help of social workers, and intended for a six-months stay prior to return to the community.

(f) Featherstone Lodge Project (England)

The Community Drug Project (see section 9.3.1) established the Featherstone Lodge Project in 1970 to provide an opportunity for former heroin users to learn to live without drugs. A drug dependent person may enter the programme via a hospital, a treatment centre, the courts, or the street. He must first attend an induction centre for "Encounter" sessions every afternoon for about 7-10 days, where he learns about the project and becomes aware that he needs help with the problems underlying his use of drugs. The ex-drug dependent staff in the centre assist with this work.

The drug dependent person may then apply for admission to Phoenix House, the conditions being that he has been free from drugs for 5-7 days and is willing to accept the conditions outlined and the help offered. Some addicts may be taken initially for a trial period on release from prison. Phoenix House is a therapeutic community based on the experiences of Synanon, Daytop and Phoenix House in the USA and on the theories of Maxwell Jones. Some of the staff are recovered addicts, who worked with trained professionals having consultative and administrative functions.

The 1971-72 Annual Report of the project states that "The Phoenix House programme is based on the premise that drug taking is a symptom of underlying problems. An individual's reliance on chemical substances prevents him reaching solutions to these problems. Therefore withdrawal from drugs is only a preliminary to tackling the problems themselves. The concept of self-help is vitally important in the process. We believe it is essential for the ex-addict to be given ample opportunity to help himself in his recovery and to re-assume responsibility for his own life.

The house is therefore organised in such a way that there is a highly structured hierarchy to create the maximum number of responsible posts, and there is constant pressure on residents to seek responsibility and exercise it with self-awareness and concern for others. Such a programme would of course only be tolerable within a community where every member feels free to express deep concern for the others."

During the final stages of rehabilitation, the addict spends an increasing amount of time outside the House; he may return to his studies, undergo training, go out to work, and may assist the staff in their therapeutic work with other drug addicts. Residents have no contact with their family for the first three months, but the latter are contacted by the staff and may participate in groups arranged for them.

Alpha House, in Portsmouth, is run on similar lines to Phoenix House. Government funds have been made available to evaluate these two programmes over a period of three years.

(g) De Laurier Centre (Amsterdam, Netherlands)

The Laurier centre in Amsterdam was set up in 1970 as a kind of emergency sleeping place, used by young people, and some of the more regular residents became involved in a drug-help programme. When visited in 1971, about 30 young people were living there in a communal way, the majority being former addicts or persons still using drugs. Attempts were being made to turn this into a rehabilitation centre, mainly run by ex-addicts, but with consultant help from psychiatrists and other professionally trained persons.

9.6 Half-way houses and hostels

In many countries the need has been felt to make provisions for facilitating the social rehabilitation of certain groups of alcoholics and drug dependent persons before they return to a fully independent role in the community. Some examples of hostels and half-way houses set up for this purpose are reviewed below.

9.6.1 Half-way houses and hostels for alcoholics(a) United Kingdom

A 1968 Ministry of Health memorandum in England and Wales stressed the value of hostels for alcoholics with varying needs, providing for a stay of a few weeks up to an indefinite period. The management should range from "conventionally authoritarian" to "varying degrees of permissiveness". A scheme introduced in 1965 provided for grants to subsidize places in hostels for offenders, including those formerly addicted to drink or drugs. Five experimental hostels for treated alcoholics were started on a two-year basis (Cook & Pollak, 1970). At the end of 1970 there were about 25 hostels taking alcoholics in London and 35 elsewhere in England and Wales.

Giles House. This was one of the experimental hostels visited by the WHO Course participants in 1971. It is a spacious old house with a garden in a London street of similar houses. Male alcoholics who have been referred to the house, either direct or after inpatient treatment, can apply for admission to a committee of the residents, who are all former alcoholics. Most of the residents find full-time work and assist in running and decorating the house; they may cook meals if they wish and may invite visitors. Regular attendance at Alcoholics Anonymous (AA) meetings is fostered, but is not compulsory. Weekly house-meetings are held at which the residents attempt to assist each other with their problems and the self-made rules and regulations for the house are discussed. Some flats are available nearby where residents who feel able to attempt a more independent existence may live for a limited period before finding their own accommodation. The only resident staff for the house is a warden. Some contact is maintained with psychiatrists and social workers. Most of the residents met by the participants had been at a very low level of physical and social deterioration previously but were enthusiastic about the hostel experience and its value in assisting their rehabilitation. Some had relapsed but had been readmitted. One former resident, who attended the meeting with the participants, had been an alcoholic and had then become seriously addicted to other drugs, but was now working again as a physician in a unit for treatment of addicts.

(b) Sweden

Half-way houses have existed in Stockholm for more than 45 years, run under the auspices of the temperance board. Originally they were established as sheltered living accommodation for 10-15 ex-alcoholics with a full-time job, and staffed by a married couple. There are now 8 half-way houses with 385 places and with different programmes, some run like hotels and others more like nursing homes. In general, there are now one or two social workers on the staff. The present trend is to offer more active treatment in these houses,

so that they can accept clients with greater need for care who might otherwise be placed in larger residential institutions.

A high percentage of vagrants and homeless men are found to be alcoholics. Several national responses refer to reception centres, lodging houses and other shelters intended for temporary stay, but the majority appear to provide little in the way of counselling, referral to treatment or resettlement.

Krukmakargatan Lodge. This socio-medical centre for research on and treatment of homeless men was established in 1967 in a residential district of Stockholm. The house has 20 places for residents and 21 staff, and another unit, more like a hostel, with a lower staffing ratio, has been established with 10 places. The 45 men treated from 1967-69 were a random sample of those applying for common lodgings and their status after two years was found to compare favourably with controls as regards rates of criminality, rehospitalization, etc. Although at first attempts were made to run the house as a self-regulating community, this approach was unsuccessful and an increased amount of assistance from the staff was found necessary. Most of the men had always lived outside society and had continuing conflicts. The majority were heavy drinkers, and continued to consume on the average the equivalent of 40 litres of pure ethanol per year, although they agreed to a rule not to bring liquor into the house. About 60% had temporary work while in the home, compared with 25% of the controls who had work. The residents were informed that they could, if they wished, stay in the house for the rest of their lives, and many looked upon it as their home, although some moved out to flats. The cost was estimated at about 20 Swedish kronor per head per day, which was considered to be less than for the various types of care and stay in penal establishments for the control group.

(c) Other countries

The Finnish review refers to a number of half-way houses established in Finland, mainly by the A-clinic Foundation and other voluntary organizations, totalling 13 with 381 places in 1971 and 21 with 590 places in 1973. Switzerland has 13 half-way houses with some 350 places. In France, there are about 30 half-way houses with 1 500 places. Zambia and Spain each have one such house.

It would seem that there is a widespread need for establishment and evaluation of the activities of rehabilitation facilities of this kind.

9.6.2 Hostels for drug-dependent persons

There appears to be little experience of running hostels for other drug dependent persons, and in some areas there has been considerable resistance on the part of the local community to their establishment. In 1971 there were several hostels in London and one in Stockholm.

9.7 Treatment within the penal system

Although it is known that a high proportion of prisoners have drinking problems (see Table 7) only a few of the responses referred to special provisions for treatment of alcoholics within the penal system.

In Czechoslovakia, nine therapists from Prague clinics for alcoholics carried out two courses of 5 months duration each time for 20 sentenced alcoholics during their imprisonment. On release, the alcoholics could voluntarily stay at a night hospital for follow up, while working during the day. Proposals were made for extension of such treatment on a compulsory basis to all sentenced alcoholics while in prison.

Group and family therapy for alcoholics are available in three penal institutions in the Netherlands, where there is also extensive use of the probation officers who assist with the treatment of alcoholics and may refer them for further care (e.g. through the Medical Consultation Bureaux).

In the United Kingdom, too, offenders may be placed under the supervision of the Probation Department for 1-3 years. Long-term support and social help are offered, as for all offenders, but consideration is being given to provision of special facilities. Within the prison system, special units, such as Grendon Underwood, have been established to deal with psychiatrically disturbed prisoners, and may include care for alcoholics. Some treatment is also available for drug dependent persons in prisons (James et al., 1970).

About a quarter of the inmates of correctional institutions in Sweden in 1971 had a background of drug abuse, and the same was true for about a tenth of those in the extramural corrective system. Proposals for setting up special treatment were unacceptable because of the high budgetary and manpower demands. An alternative policy was adopted for greater utilization of outside medical and social services in the prisons and the granting of furloughs to prisoners for treatment outside the institution.

Group therapy is spreading in prisons in Finland, and information provided after the Seminar referred to the encouraging results of the work of two social workers with young drug addicts committed for trial.

A few other responses refer to treatment within the penal system. The Spanish review mentions a section for 65 alcoholics and drug dependent persons started in 1971 in the General Psychiatric Penitentiary Hospital in Madrid, under the aegis of the Ministry of Justice. In Costa Rica, a centre for treatment of alcoholics has been set up by the Alcohol Commission in the National Central Prison. The response for France states that treatment for alcoholics is given in some penal establishments.

9.8 Programmes within industry

Alcohol problems are an important cause of absenteeism and accidents in industry, and in some cases programmes of early case-finding and help have been established in conjunction with industrial health services. Notable examples are found in France (Godard, 1966), where there is also an important programme for railway workers. The Swiss Federal Railways employ two social workers to deal exclusively with alcoholics among railway workers.

In Sweden, an Alcohol Problems Committee of the Board of Industrial Safety has worked with various bodies in developing guidelines for collaboration in dealing with alcohol problems in industry. It is proposed that working groups, comprising employees and employers, should carry out informative, counselling and supportive activities in relation to alcoholism. An Alcohol and Narcotics Council has been formed in Greater Stockholm with similar objectives, including drawing attention to available resources for prevention and treatment of dependence problems. The 80 companies represented in this council have about 120 000 employees.

The two major labour organizations in Finland have worked out an agreement whereby workers showing symptoms of alcoholism or drug dependence are not dismissed but are first referred for treatment.

A large company in the Netherlands has a programme for alcoholics, providing information for executives and treatment in the industry's clinics, which are run by nurses and social workers. Attempts are being made to detect alcoholism at an early stage during regular medical examinations.

The Costa Rica Commission on Alcoholism started a programme in industry in 1969. More than 1 000 industries were visited by social workers, who referred more than 50 employees to the Commission for treatment.

In agreement between the Central Union of Workers and the National Health Service in Chile, a programme is being worked out to promote the improved treatment of alcoholics and excessive drinkers in industry.

The system of clubs for recovered alcoholics in Yugoslavia has many branches in industrial enterprises.

9.9 Part played by voluntary organizations

Most of the responses emphasize the valuable role of voluntary organizations in the treatment and rehabilitation of persons dependent on alcohol and, in some cases, those dependent on other drugs.

Of outstanding importance in the European and Latin American countries and in Australia are the Alcoholics Anonymous (AA) groups. In El Salvador, for example, one group was started in 1958 and there are now 525 with about 15 000 members. From there the movement spread to Guatemala and Honduras. Argentina, Colombia, Costa Rica, Panama, and Venezuela all have active groups. In Mexico, AA works closely with the Ministry of Health and Welfare and the Social Security system and has recently given assistance to persons dependent on other drugs. In Finland and the Netherlands AA groups have been operating since 1948. In the United Kingdom, AA groups had about 3 000 "regular attenders" in 1970. The response states that "Alcoholics Anonymous" undoubtedly provides a service for continuing follow-up and support of hospital treated patients, as well as getting patients to accept initial hospital treatment. The organization has, in its own right, a high degree of therapeutic success."

Specific AA services for family groups (Al-Anon) and for teenage sons and daughters of alcoholics (Alateen) are developing in some countries.

Some AA groups function within penal institutions (e.g., 15 in El Salvador, 40 in the United Kingdom and others are active within industries.

In addition to AA, Sweden has another widespread voluntary movement, the Link, which carries out organized care in outpatient departments, half-way houses, and convalescent homes. The society now gives some help to other drug dependent persons as well as alcoholics, and government subsidies are provided for the activities.

Similar activities are carried out in Switzerland through the Blue Cross temperance society, which employs 50 full-time social workers and runs some 20 welfare centres for alcoholics and 6 information centres for young people. The temperance societies, which have a total membership of about 20 000, are making efforts to organize jointly with the social welfare services voluntary aid groups to take over post-treatment assistance and help the families of alcoholics. The Swiss AA has its own centre for meetings, courses and treatment at Walzenhausen.

The Salvation Army has many branches in Australia, the United Kingdom and some other countries. Apart from providing shelter it also runs some outpatient services.

In Japan, a number of voluntary organizations were associated in 1970 in the "Japan Council on Alcohol Studies". It is stated that "a large part of the work of prevention and after-care with alcoholics has been carried out by these organizations, whereas psychiatrists, mental health officers and other medical specialists have given only poor attention to the problem."

The role of voluntary organizations in the treatment of drug dependent persons is developing. Sweden, for example, has a National Association for Help to Abusers of Medical Drugs (RFHL) which took part in the Swedish debate on drug abuse and now carries out treatment in contact groups. There are eight branches, and the Stockholm branch now employs social workers and physicians. Government subsidies are available for such voluntary work.

In many countries "drop-in" centres and "communes" for drug dependent persons are run by volunteer groups, sometimes including persons who were formerly dependent on drugs.

9.10 Collaboration between facilities

Now that dependence on alcohol and/or other drugs are seen as problems requiring long-term treatment, increasing attention is being given to collaboration between facilities to provide coordinated care.

The work carried out in Prague is an example of an integrated treatment service. Of the population of 1 million, about 20 000 (i.e., 1 in 20 aged over 15 years) has been notified as having an alcohol problem. The alcoholism treatment facilities comprise a "sobering-up" station, 10 outpatient clinics for the city and 1 for the region, 3 inpatient facilities (Apolinař, attached to the University, with 50 beds for treatment lasting about 3 months; one in Lojovice for the compulsory treatment of alcoholics and recidivists, with 35 beds for treatment lasting 4-11 months; and one in Bohnice (the Prague Psychiatric Hospital) with 70 beds for treatment lasting 4-11 months of patients sent by order of a judge or for those unable to cooperate in open wards), and a club for former alcoholics. Apart from the male unit, Apolinař has a centre for women, a unit for patients up to 18 years of age and for preventive care of children of alcoholics, and an addiction research unit. Treatment of alcoholics in prison has started. Problems of dependence on other drugs are not severe, though there are problems of dependence on psychostimulants and barbiturates, often combined, in 40% of patients with alcoholism. Persons with these dependence problems are treated together with alcoholics but receive separate psychotherapy.

A Swedish Royal Proposition of 1968 stated that "Care and treatment of drug abusers are socio-medical complexes of problems. It will be necessary to co-ordinate the medical and social actions which are needed for detoxification and for rehabilitation." The Swedish Committee on Drug Abuse has stressed the importance of establishing a continuous chain of treatment consisting of fieldwork, open treatment with treatment centres or outpatient clinics, inpatient care, and after-care. Coordination agencies, comprising politicians and administrators, were set up in many parts of Sweden in 1968 when the problem of drug abuse came to the forefront of attention. In 1969, there were 250 such coordination groups.

The response relating to the United Kingdom states that "Evans et al. (1966) have demonstrated that effective collaboration can be achieved between hospitals, local authorities, and voluntary services, and that this has resulted not only in more efficient treatment and after-care for the alcoholic and his family, but also proved useful for research and education of the public."

During the 1971 WHO Course, the Community Drug Project (CDP) in London was visited and discussed. The introduction to its 1968-69 report states that: "The CDP has had the happiest working relationship with hospitals, and could not exist without the ready support offered by local specialized Drug Treatment Units. Day centres such as the CDP, hospital clinics and inpatient units, rehabilitation hostels of the type which the CDP plans, all have to be a part of an integrated service. A city such as London has not made a satisfactory response to its drug problems unless the whole range of these services is provided in proper and planned balance."

9.11 Measurement of treatment effectiveness

There has been little careful evaluation of the effectiveness of treatment measures or strategies in any of the responding countries. As pointed out in the review relating to the United Kingdom, "Few investigations have attempted to include control groups, define carefully characteristics of the population which they were treating, or give a complete description of the type of treatment employed. The validity of data is often not thoroughly checked and reports of outcome are frequently limited to considerations of abstinence or not adequately specified." Several assessments of treatment results are outlined and the response concludes: "These English studies of treatment for alcohol dependence do not indicate any major difference in results between the two main types of inpatient care, that is, group therapy in a specialized unit or selective therapy in a general psychiatric hospital. There is no evidence that inpatient care is necessarily better than outpatient. The studies have emphasized that prognosis is determined to a great extent by the previous personality and social stability of the alcoholic and that this may be more relevant to prognosis than the particular treatment given." Walton et al. (1966) found that only slightly better results were obtained with inpatients than with outpatients, but that better results were obtained with "loss of control" drinkers than with "inability to abstain" drinkers.

Evaluation of the work of the inpatient treatment in Apolinař, Prague, is being undertaken by research staff not previously associated with the unit. The project includes (a) a process study of all voluntary patients admitted to Apolinař during 1970, and (b) an outcome study based on a one year follow-up of the total sample included in (a).

Kurihama National Hospital in Japan was trying in 1971 to make a follow-up survey of discharged alcoholic patients, with defined standards of assessment. Of 720 hospitalized patients, 560 were successfully located and followed up, the longest period since discharge being 9 years.

In the Psychiatric Research Centre of Ulleråker Hospital, Uppsala, Sweden, a clinic for drug addicts with a 7-bed detoxification unit and a 15-bed treatment unit has been established for research and evaluation. Patients are selected and classified according to the degree of their addiction. Groups are formed according to 40-50 variables, such as degree of contact with society, number of friends, duration of abuse. A treatment model has been set up in which one variable is changed each year to simplify evaluation. The patient's performance is evaluated in the programmes of physical activity, vocational training, self-selected programmes, etc. Follow-up examinations are made at predetermined intervals, beginning with 2 weeks and becoming longer. Each patient chooses a person who can assist with follow-up, and other sources of information are used, such as temperance board records and police reports.

In the United Kingdom most of the reports on treatment of drug addicts, are stated, to deal with the characteristics of the patients and methods of treatment used. A Drug Dependence Clinical Research and Treatment Unit has been set up by the Joint Bethlem Royal and Maudsley Hospital specifically to evaluate treatment measures (Connell, 1970). Research has been initiated also to evaluate the two rehabilitation programmes, one in London and one in Portsmouth, based on the Phoenix House type of programme.

10. PREVENTION PROGRAMMES AND EDUCATION OF THE PUBLIC

10.1 Responsibility for, and scope of, education programmes

Other parts of this report have discussed the implementation of national policies on prevention of alcohol and drug dependence problems through legislative, economic, and social controls; in this Section, programmes aimed at prevention through education of the

general public and of special groups, particularly school populations, are reviewed. Information on national and local bodies concerned with these programmes is summarized in Table 16.

10.2 Nature and extent of use of mass media

In a number of countries there has been a trend towards improved collaboration between the mass media and the national and local bodies concerned with public education on alcohol and other drug problems.

A Seminar was organized in Australia in February 1972 by the Commonwealth Department of Health aimed at strengthening cooperation with the mass media. Representatives from television, radio, magazines, and newspapers attended. Subsequently, most of the States reported increased liaison with representatives of these media and reported that action had been taken to include them in State Drug Education Advisory Committees. A further conference for top-level management representatives and editors was planned for 1972/3.

On request from the Swedish Broadcasting Corporation, the Swedish National Board of Health and Welfare appointed an expert group to advise on the "drug message" in the programmes and the evaluation of its effects on various groups.

The radio, press, and television cooperate with the work of the Civic Committee in Poland.

In Costa Rica, the Commission against Alcoholism gives frequent radio broadcasts (daily in December) on alcohol problems.

Several other countries report extensive use of mass media for public education on questions of alcohol and drug dependence. The French response, referring to the press, states that "the tone of articles on addiction has developed favourably over the past two years; it is now more scientific and is less prone to seek the sensational"; some of the other responses, however, draw attention to the fact that mass media do not always produce their articles or programmes on these topics with the requirements for preventive effects in mind.

TABLE 16. NATIONAL AND LOCAL BODIES CONCERNED WITH EDUCATION OF THE PUBLIC ON PROBLEMS OF ALCOHOL AND OTHER DRUGS

Country	Body	Scope and activities
Australia	Drug Education Subcommittee of the National Standing Control Committee Queensland Health and Education Co-ordinating Committee on Alcoholism	Established in 1970; developing a National Drug Education Programme. All States are actively involved, and the programme is being implemented through established Drug Education Centres, workshops, and seminars for parents, teachers, youth leaders, etc. Education programmes in secondary schools School education on alcohol included in above, except in Queensland
Argentina	National Institute of Mental Health; Toxicology Department, University of Buenos Aires	A few lectures and special courses; campaigns on juvenile drug problems
Austria	Ministries of Education and Health	Arrange annual week of information on alcohol and drug problems
Costa Rica	Commission on Alcoholism Department of Mental Health National Committee of Mental Health	Educational campaigns through mass media Conferences for the public; professional training
Czechoslovakia	Red Cross Socialist Academy Some alcoholic commissions	Limited activity
Finland	Expert Committee on Drug Abuse	Produces printed information for schools and the public; training seminars for school, health, and welfare authorities and for local and police authorities throughout Finland
France	High Committee for Study and Information on Alcohol National Committee for Defence against Alcoholism	Established in 1954; collects data on alcoholism and disseminates information through publicity campaigns in cooperation with national associations Provides information on alcoholism and available treatment facilities through its 80 departmental branches and numerous local committees

TABLE 16. NATIONAL AND LOCAL BODIES CONCERNED WITH EDUCATION OF THE PUBLIC ON PROBLEMS OF ALCOHOL AND OTHER DRUGS (contd.)

Country	Body	Scope and activities
India	Medico-Pastoral Association, Bangalore	Held a seminar and arranged a few lectures for university students on alcohol and other drug problems
Israel	Ministry of Education Kibbutz movement Sick fund (Kupot Holim)	Prepared document on hashish for educators Symposia on drugs for instructors, counsellors, etc.
Japan	National Institute of Mental Health	Consultation and information through mental health clinics Professional training
Mexico	Ministry of Health and Welfare	Educational campaigns, e.g., a day devoted to alcoholism in "mental health week" 1962
Netherlands	National Commission against Alcoholism People's League against Alcohol Abuse	Provides widespread information; employed a school visitor for 2 years to give information. Edits quarterly factual periodical; sends representatives to summer schools Provides extensive information and documentation on alcoholism, recently also on other drug problems
Nigeria	Narcotic Control Board	Responsible for policy on education of the public on dangers of drug dependence
Panama	Department of Transport	National Educational Travellers' Campaign; courses given to the National Guard and to educators included use of alcohol and other drugs, drunken driving
Poland	Civic Committee to Fight Alcoholism	Study of alcohol problems and production of informational material: brochures, journals, books, films, and material for lectures and discussions, training of lecturers; educational campaigns by local branches throughout Poland
Sweden	Hygiene Educational Delegation (HVUD) in the National Board of Health and Welfare Swedish Council for Information on Alcohol and other Drugs (CAN)	Publications and conferences on alcohol and other drug problems Courses and conferences for general public and special groups, particularly schools and other educational establishments

TABLE 16. NATIONAL AND LOCAL BODIES CONCERNED WITH EDUCATION OF THE PUBLIC ON PROBLEMS OF ALCOHOL AND OTHER DRUGS (contd.)

Country	Body	Scope and activities
Switzerland	<p>Swiss Central Office of Education on and Prevention of Alcoholism, Lausanne</p> <p>French-Swiss Group for the Study of Alcoholism and Drug Dependence</p> <p>Swiss Association of Pharmacists</p>	<p>Periodicals and brochures on alcoholism and drug dependence; campaigns, exhibitions; research on prevention</p> <p>Courses and symposia for the public; professional training; publications</p> <p>Mobile exhibition on drug problems</p>
<p>United Kingdom</p> <p>(England and Wales)</p> <p>(Scotland)</p>	<p>National Council on Alcoholism</p> <p>Medical Council on Alcoholism</p> <p>Christian Economic and Social Research Foundation</p> <p>Association for the Prevention of Addiction</p> <p>Society for the Study of Addiction</p> <p>Drug Dependency Discussion Group</p> <p>Health Education Council</p> <p>Teachers' Advisory Council on Alcohol and Drug Education</p> <p>Scottish Health Education Unit</p> <p>Scottish Council for Health Education</p>	<p>Founded in 1963; publications; local councils and information centres throughout the United Kingdom</p> <p>Publishes <u>The Journal on Alcoholism</u>, mainly for general practitioners</p> <p>Information about changing patterns of alcohol consumption; analyses advertising trends</p> <p>Educational material for the public</p> <p>Scientific investigations, meetings; publication: <u>British Journal of Addiction</u></p> <p>Meetings for doctors, nurses, and social workers concerned with drug dependence</p> <p>Supplies factual information to teachers</p> <p>Promotion of research on formation of attitudes to use of alcohol among school children and young people</p> <p>Poster campaigns, conferences, and courses</p>
Yugoslavia	<p>League of Organizations on Alcoholism and Drug Dependence</p>	<p>Material on causes, prevention, and treatment of alcoholism, produced in collaboration with other bodies; annual month (November) dedicated to campaign against alcoholism, with lectures, conferences, exhibitions and educational material; campaign covers whole country, through branches in republics and localities</p>

TABLE 16. NATIONAL AND LOCAL BODIES CONCERNED WITH EDUCATION OF THE PUBLIC ON PROBLEMS OF ALCOHOL AND OTHER DRUGS (contd.)

Country	Body	Scope and activities
Yugoslavia (contd.)	Railway Workers' League on Alcoholism Red Cross Federal Union for Traffic Safety Institute on Alcoholism and Drug Dependence (Belgrade); Institute for the Study and Control of Alcoholism and Addictions (Zagreb)	Campaigns against driving under the influence of alcohol Information and educational material for general public, schools, and professional groups; conferences and seminars

The review relating to Switzerland notes that the prohibition of any kind of publicity on the Swiss radio and of publicity for tobacco and alcohol on Swiss television may be regarded as general prevention. The British Broadcasting Corporation does not allow any direct advertising of alcoholic drinks or any other product; advertising is permitted, however, by the Independent Television Companies Association, although certain constraints are imposed. In many countries alcoholic beverages are widely advertised in the mass media, particularly on public posters and in the press and it has been argued that this more than counteracts all other preventive activities. On the other hand, one might draw attention to the situation in countries such as Poland, where there is no advertising, but where alcohol problems are serious and widespread. Here the counter-argument might be that such problems would deteriorate even further if advertising were permitted.

10.3 Programmes in Schools

The responses refer to a variety of programmes for education on alcoholism and other drug problems in schools. In Australia, the Health and Education Departments of New South Wales are aiming at having at least one appropriately trained teacher in each high school by the end of the 1972/73 school year. In some of the schools an experimental programme with direct participation of students has been initiated. South Australia is developing programmes for all secondary school children and three schools have started pilot programmes to assist in planning.

Alcoholism is dealt with in France in all classes as an option (civic education) and in the national science programme for pupils aged about 10 years and again at 14-15 years. In technical schools, the hygiene programme includes a section on alcoholism that is compulsory material for the certificate of vocational skill (taken at about age 18 years). Information for teachers is provided annually by the National Committee for Defence against Alcoholism during a publicity week.

School programmes in Switzerland vary according to canton. In the Canton of Geneva a group of physicians in the Youth Health Service give to all pupils from the age of 13 years an extensive health education course that includes information on alcohol problems and drug dependence.

In Chile, the Ministry of Public Education's programme on prevention of alcoholism is used in all primary schools.

In Costa Rica, programmes on alcoholism are given for 1 hour a week for 6 years in primary schools and about 4 lectures a year are given in secondary schools on other drug problems.

In England and Wales, a Health Education Council carries out educational work on alcohol and drug use for the Ministry of Health. It concentrates on supplying the teachers with information such as bibliographies and lists of films and film-strips. The Department of Education and Science (1968) has produced a Handbook of Health Education with a chapter on education on alcohol, drugs and tobacco. This states that: "While objective, scientific information about the dangers of drug taking may protect pupils, the subject should not be handled in such a way as to lend unnecessary glamour or to encourage its concealment. Thus, drug taking should be discussed in its proper context as an aspect of health education, the proper use of medicaments and the solving of social problems ..."

"Health education should attempt to inform young people about the risks of misuse of both tobacco and alcohol and, even more important, should try to impart attitudes which allow

young people to make independent decisions and free them from the necessity of always following the social group ..."

"Teaching about alcohol should, as with drugs, be put into its proper context, in order to avoid the 'limelight' treatment as in the delivery of special lectures on the dangers of alcohol and its improper use."

An inquiry among school medical offices indicated that many local authorities were providing education on drugs by various means to teachers and pupils.

10.4 Evaluation of public education and preventive campaigns

There is little reference in the responses to investigations on the effectiveness of educational efforts and special campaigns for prevention of alcohol problems and drug dependence.

The response from the United Kingdom states that "The hope is frequently expressed that simple educational programmes disseminating factual information about the dangers of particular substances will be sufficient to prevent alcohol or drug dependence. However, there is little evidence that this is so. Knowledge in itself is not necessarily protective and sophisticated approaches to health education are needed to place drug and alcohol use in its proper perspective. Debate and discussion are often more appropriate than rigid lecture methods ..."

"Especially advanced techniques will be needed to influence groups in the population who might be particularly at risk, such as adolescents or children of alcoholics. These 'at risk' groups may include persons with delinquent or sociopathic tendencies who have already resisted attempts at formal education in other contexts. Unfounded scare or fear techniques tend only to discredit information and may therefore be more harmful than helpful."

Some experimental educational campaigns have been set up and attempts made at evaluating their effects.

In Australia, evaluation studies are being undertaken in relation to the National Drug Education Programme.

Several opinion polls carried out in France have shown that social tolerance of alcoholism (once very widespread in France) is lessening, and that the public considers alcoholism a real danger for the country. A recent survey indicated that more than half of the population consider that the consumption of alcoholic beverages in France is too high.

Some attempts have been made to measure the effectiveness of campaigns against driving with high blood-alcohol levels. In the United Kingdom the Road Research Laboratory of the Ministry of Transport commissioned an independent market research board to evaluate the effects of a big Road Safety Campaign in 1964. Among the findings was the assessment that people were more intolerant towards drinking and driving after the campaign than before it; although there was no evidence that the campaign led to any overall reduction in the proportion of men who sometimes have a drink before driving. The responses relating to France and Switzerland note that, despite several campaigns, the numbers of road accidents in which heavy alcohol consumption has been involved do not seem to have been reduced.

11. PROFESSIONAL EDUCATION AND TRAINING

In general, the responses point to the limited nature of most courses on problems of alcohol and drug dependence in professional curricula, the considerable variations in content and length of courses, and the need for better organized and more extensive training. Some examples are given below of courses included in the training for various professions.

11.1 Medicine

(a) Undergraduate training. Nearly all the responding countries state that some attention is given to alcohol problems in most of the undergraduate medical curricula, though fewer references are made to drug dependence problems. Frequently such training is included in courses on pharmacology, social and preventive medicine, and psychiatry and may be limited to a few hours of lectures. The response relating to France, for instance, states that medical students are given one lecture on alcoholism during their fifth-year course on hygiene, although some clinical instruction is given on organic and psychological complications. In Israel, the 6-week course in psychiatry includes a lecture on problems of addiction and one case presentation. Information on alcohol and narcotics is given in the pharmacology course in Sweden and the 3-month psychiatry course includes 8 hours of lectures on alcoholism, 2 on narcotics, and some practical work, which may be done in a clinic treating alcoholics. The relevant training in 22 medical schools that responded to an inquiry in the United Kingdom varied from one or two lectures to a much more comprehensive programme, including additional training for those who wished it.

(b) Postgraduate training. Only the responses from Israel, the Philippines, and the United Kingdom mention that physicians specializing in public health may be given a few lectures on problems of alcohol and drug dependence. During the 3-year specialist training for general practice in Sweden, 6 months are devoted to psychiatry, and systematic training is given on alcohol and drug dependence problems. In Chile, it is proposed to provide training on alcohol problems for general practitioners through departments of psychiatry, internal medicine, preventive medicine, and rural internships. Special courses would be given also to specialists in internal medicine. Otherwise, specialist training in these subjects is mainly directed to psychiatrists, and even for them it may be very limited. For general psychiatrists in Sweden, a maximum of 1 year out of the 3-1/2 years' practice is spent at an alcoholism clinic, and alcoholics and drug dependent patients are contacted in the psychiatric hospitals: the theoretical training on dependence problems is not compulsory.

At the Institute of Psychiatry, University of London, psychiatrists in training work under supervision in the outpatient clinics and wards of the Joint Bethlem Royal and Maudsley Hospital. A weekly case-conference is held in the alcoholism inpatient unit. Some students choose alcoholism or drug dependence as the subject of their required research project. This Institute has an international role in training of psychiatrists: for instance, the 2 559 postgraduate students training there in 1949-67 came from 77 countries.

11.2 Social work

Training in dependence problems is regularly included in the curriculum for social workers in the Netherlands, Sweden, and Switzerland, and in some courses in other countries, such as the Tampere University training in social welfare in Finland. In the United Kingdom such training is likely to be included in curricula for medical and psychiatric social workers and probation officers.

11.3 Nursing

Information on alcohol and drug problems is given to nurses in Sweden during courses on hygiene, on the clinical and toxicological effects of drugs, on sociology and social medicine, and on mental health care. Several other responses mention that some such training is given, particularly to psychiatric nurses.

11.4 Law and law-enforcement

Little mention is made in the responses of training for the legal profession, although the reply relating to Sweden refers to information on legal aspects of alcoholism and drug dependence given during courses on public, international, and criminal justice. A 3-day course on narcotic problems was organized by the Chief Public Prosecutor of Sweden for prosecutors and judges. In Israel, Criminological Institutes in Jerusalem and Tel Aviv give seminars and lectures on drug addiction and alcohol to law students and to psychologists and sociologists who study criminology.

Policemen are given training in several countries on problems of alcohol and drug dependence from both the medical and the penal aspects. In Costa Rica, for example, the police are given 5 hours of instruction per year on alcohol problems and how to deal with inebriates.

Japan, Nigeria, and the Philippines have special courses for training narcotic control officers. In Nigeria, for example, the courses aim at enabling the students to recognize the common drugs of abuse by inspection; to carry out simple chemical tests to establish preliminary identification where physical inspection is inadequate; to know the more usual methods of administering drugs of abuse and their more usual effects; to recognize the common symptoms of a person under the influence of drugs; and to be familiar with the general characteristics of the illicit traffic in drugs in their area of operation.

11.5 Teaching

The response relating to the United Kingdom refers to a questionnaire sent to Institutes of Education and teacher training colleges in Britain. About one-third stated that they had no specific training for teachers on problems of alcohol or drug dependence, about one-third gave one or two lectures on these topics, and one-third gave more intensive training. A few local education authorities stated that some in-service training was being provided for teachers. In Sweden, an 8-hour course on problems of alcohol and narcotics is included in the year of training at teachers' colleges and other courses are provided during compulsory continued education for teachers.

11.6 Other professions

The response relating to Sweden mentions special training for a number of other professions: the clergy (Swedish State Church) - a 4-hour course; psychologists - an 8-week elective course with study visits; work therapists; social educators; driving instructors; youth counsellors; managers of homes for the aged; attendant personnel in youth detention schools.

11.7 Special courses

In order to supplement the training available in the usual curricula, a number of private or State bodies have organized sporadic or recurrent courses, sometimes for training several disciplines together.

An official 3-month course was organized in Spain in 1969 and 1970 by the National Psychiatric Care Foundation for several hundred medical and social work personnel. Training was given in prevention and treatment of alcoholism and other drug dependence by a faculty representing several disciplines.

The Finnish A-clinic Foundation has trained its own social workers since 1955 and since 1972 has organized courses for the staff as a whole (nurses, secretaries, social workers, etc.). Clients and families of clients have participated in some of the courses.

The Belgrade Institute on Alcoholism started in 1963 to organize 2-week seminars for physicians, clinical psychologists, nurses, social workers, teachers and policemen, providing a theoretical background and enabling them to take part in the practical work of the Institute.

The National Federation of Mental Health in the Netherlands twice organized one-week courses on problems of drug dependence for specialized personnel, mostly from the MCBs, as well as shorter courses for physicians.

The French-Swiss Study Group on Alcoholism and Drug Dependence (GREAT) plays an important role in the training of physicians, social workers, and nurses through its annual courses, including practical exercises. In the German-speaking part of Switzerland, the Swiss Association of Social Workers for Alcoholics gives its members a basic training and refresher courses.

Various seminars and training courses have been organized for physicians and social workers in France, including a one-week seminar on drug dependence for physicians. The National Committee for Defence against Alcoholism arranges courses for its own staff.

In Costa Rica, a number of seminars and congresses have been organized by the Commission on Alcoholism, in some cases with the help of the Association of Psychiatrists, Psychologists, and Neurologists.

Individual treatment centres in some countries have played an important role in providing information, experience, and training not only to nationals but to foreign visitors. Some examples are the Jellinek Clinic in Amsterdam, and the Kalksburg Clinic in Vienna.

Valuable training of participants from a variety of disciplines has been carried out through the Summer School on Alcoholism, organized annually for one week under the aegis of the Camberwell (London) Council on Alcoholism since 1969. The teaching staff come from universities, research institutions, and alcohol units and the methods employed include lectures, videotape recordings, and group discussion.

12. INVOLVEMENT OF PROFESSIONAL MEDICAL BODIES IN PREVENTION AND TREATMENT

As shown in Table 15, professional medical bodies in some countries have established their own committees on alcohol and/or other drug problems (e.g., the committees of the Swedish Medical Association and the Committee on Alcoholism of the French Academy of Medicine). In many other countries, medical bodies are largely represented on governmental and other committees dealing with these specific problems. Some medical bodies have been concerned with improving education and training on these subjects both in medical curricula and as separate activities. The Finnish Medical Association, for instance, has arranged courses for physicians on drug dependence problems; the Costa Rican Association of Psychiatrists, Psychologists, and Neurologists organized a symposium on drug dependence; the Polish Psychiatric Association has held a series of meetings and congresses on various aspects of alcoholism.

A few scientific journals specifically devoted to alcohol and/or other drug problems are produced by medical bodies. These include the Japanese Journal of Studies on Alcohol, produced by the Japanese Medical Society for Alcohol Studies, and the quarterly Revue de l'Alcoolisme, produced by the French Medical Group for Studies on Alcoholism. The Institute on Alcoholism and Drug Dependence in Belgrade publishes Alkoholizam, a professional quarterly journal on both alcoholism and drug dependence. The corresponding institute in Zagreb produces a similar quarterly journal in English and French, with contributors from all over the world. Many medical bodies and their members contribute to specialized journals, such as the British Journal of Addictions, but an increasing number of articles on alcohol and other drug problems are published in medical and psychiatric journals.

Medical bodies have an important rôle to play in alerting their members to their responsibilities with regard to over-prescribing of certain dependence-producing drugs. A Working Party on Amphetamine Preparations, established by the British Medical Association in 1968 recommended voluntary measures for control that were rapidly followed both by the medical profession and the manufacturers. Agreement on the need to cut down on barbiturate prescriptions has not been so clear-cut and discussion continues.

13. RESEARCH

Table 17 shows that several countries have established institutes or foundations specifically devoted to research on problems of alcohol and/or other drugs. Most of the bodies listed are concerned with several aspects of research including epidemiological, clinical, behavioural, socioeconomic, and in some cases biochemical and genetic.

Departments of psychiatry, pharmacology, and preventive and social medicine of many universities include research on alcohol and drug problems in their programmes and clinical research is carried out in numerous hospitals and treatment units.

Some other bodies with broader research, medical or social interests have contributed to research on the subjects under review. An example is the Swedish Social Science Research Council. Another is the British Medical Research Council, which established three working parties in 1969 to study various aspects of drug dependence: biochemistry and pharmacology, epidemiology, and treatment. The French National Institute of Health and Medical Research has carried out important studies on alcohol consumption and on the use of drugs among young people. National institutes or departments of mental health may perform or promote research on alcohol and drug dependence, as in Chile, Japan, and Yugoslavia.

Some governmental bodies have their own research departments and may be concerned with specific aspects of the above topics: some ministries of transport, for example, carry out research on the effects of alcohol and drug use on road safety. In certain countries governmental bodies finance and/or review and evaluate research and its application. The British Home Office, for instance, through its Standing Advisory Committee on Drug Dependence, reviews research and makes recommendations on the utilization of findings. In Israel, the government appointed a special research committee in 1970 to set up a master plan for research on drug dependence. Research may be among the activities of other national bodies, such as the Swiss Central Office for Education on and Prevention of Alcoholism.

Several of the bodies mentioned above are concerned with dissemination and sometimes evaluation of research results. In Australia, seminars are organized usually at least once a year in each State for presentation and discussion of specific issues concerning drug use and alcohol related problems. The St Vincent's Hospital in Melbourne holds annual summer schools for presentation, discussion, and coordination of studies on alcohol and drug dependence.

The response relating to the United Kingdom emphasizes the importance of relating research to the formulation of policies on these problems. This would be an important task of the Advisory Council proposed in the Misuse of Drugs Bill, 1970, and of some other national bodies considered under Section 8.

Several research centres were visited during the 1971 Course and the 1972 Seminar and reference is made below to some of their programmes.

TABLE 17. RESEARCH INSTITUTIONS AND FOUNDATIONS CONCERNED SPECIFICALLY WITH PROBLEMS OF ALCOHOL AND/OR OTHER DRUGS

Country	Institute or foundation
Costa Rica	Department of Research, Commission on Alcoholism
Czechoslovakia	Department for Study of Drug Dependence, Psychiatric Clinic, Charles University, Prague
Finland	Finnish Foundation for Alcohol Studies
France	High Commission for Study and Information on Alcoholism
Mexico	Research Centre on Drug Dependence
Netherlands	Foundation for Alcohol and Drugs Research
Philippines	Philippine Institute of Scientific Studies for Prevention of Alcoholism
Poland	Scientific and Research Section of the Civic Commission against Alcoholism
Sweden	<p>Alcohol Research Council of the Swedish Medical Research Council</p> <p>Drug Dependence Clinic, Psychiatric Research Centre, University of Uppsala</p> <p>Department for Theoretical Alcohol Research, Karolinska Institute, University of Stockholm</p> <p>Collaboration in: Nordic Council for Alcohol Research</p>
Switzerland	<p>Institute for Research on Alcoholism and Drug Problems, Friedmatt University Psychiatric Hospital, Basel</p> <p>Subcommittee for Scientific Research of the Federal Committee against Alcoholism</p>
United Kingdom	<p>Addiction Research Unit, Institute of Psychiatry, London</p> <p>Clinical Research and Drug Dependence Treatment Unit, Joint Bethlem Royal and Maudsley Hospital, London</p> <p>National Addiction and Research Institute, London</p>
Yugoslavia	<p>Institute on Alcoholism and Drug Dependence, Belgrade</p> <p>Institute for the Control and Study of Alcoholism, Zagreb</p>

(a) Drug Dependence Clinic, Psychiatric Research Centre, University of Uppsala

This clinic is outstanding in that every step of its operations is subject to research and evaluation (see p. 70). Apart from the treatment facilities, the clinic has a 4-bed metabolic ward and a pharmacological laboratory. The research programme (Götestam, 1971) includes biochemical and neurophysiological studies of drug effects in animals and humans, investigation of possible narcotic antagonists, and mental disorders associated with use of dependence-producing drugs.

(b) Department for Theoretical Alcohol Research, Karolinska Institute, University of Stockholm

This department is an internationally renowned centre for research on the physiological effects of alcohol and other drugs. A method of predicting whether a new drug will be dependence-producing is being tried out through studies of the temperature response to drug administration in rats. The phenomena of tolerance, abstinence, withdrawal, and use of antagonists are also being studied in rats. Other studies have been concerned with the etiology of alcoholism and an investigation of the nature and extent of alcohol problems in the community.

The Department of Alcohol Diseases in the same institute, apart from its clinical work, carries out research on problems and disorders related to alcohol consumption and on evaluation of treatment measures.

(c) Scientific and Research Section of the Governing Board of the Civic Committee against Alcoholism, Poland

Studies carried out by this body are mainly sociological and economic. They include investigations on alcohol consumption and attitudes to drinking based on a nation-wide survey; studies of the need for, and organization of, care for families of alcoholics; and studies of alcohol consumption by young persons.

(d) Institute on Alcoholism and Drug Dependence, Belgrade

The research department of this Institute has carried out studies on the rehabilitation of alcoholics into the community; conditioning and aversion in the treatment of alcoholics under artificially induced sleep; and a cost-benefit analysis of the Institute's operations.

(e) Institute for the Control and Study of Alcoholism, Zagreb

A number of epidemiological investigations on alcoholism, particularly in Croatia, have been carried out by this Institute. In collaboration with the Department of Public Health, a register of all inpatients treated for alcoholism has been built up to cover the whole Republic and the possibility of recording outpatients is being investigated. Another register has been started to record all traffic accidents due to alcoholism and a third to record the effects of alcoholism on working capacity.

(f) Department for Study of Drug Dependence, Psychiatric Clinic, Charles University, Prague

This department is situated in the Apolinař (see p. 62). Research topics have included drug-induced experimental psychoses in alcoholics and healthy volunteers; LSD-treatment of alcoholics; and tryptophane metabolism, sleep-deprivation, learning, and memory in alcoholics.

(g) Institute for Research on Alcoholism and Drug Problems, Friedmatt University, Psychiatric Hospital, Basel

This Institute has carried out a number of studies on consumption of various types of drugs in Switzerland and admissions to mental hospitals consequent to excessive drug use; and the characteristics of drug users in Basel. In collaboration with the Karolinska Institute, it has investigated the decrease in driving ability of persons under the influence of alcohol, of alcohol associated with certain medicaments, or under the influence of other drugs.

(h) Addiction Research Unit, London

This unit is a section of the Institute of Psychiatry, University of London. It has a research group on drug dependence as well as on alcoholism. The professional staff comprises psychiatrists, psychologists, a statistician and research workers with training in, e.g., social work. In addition to their research activities, the staff have treatment responsibilities for alcoholics and drug addicts and have helped develop several community projects. Some of the staff have consultant positions at the above Institute. An attempt is being made to develop a coordinated alcoholism treatment service with concomitant evaluation. Collaboration is maintained with treatment and research programmes of the Drug Dependence Treatment Unit at the Joint Bethlem Royal and Maudsley Hospital.

Research projects carried out include studies on prevalence and incidence of problem drinking in urban areas; long-term follow-up of alcoholics; studies on drunkenness offenders in court and alcohol problems among recidivist prisoners; study of young people's drinking; and evaluative studies on treatment and rehabilitation measures and strategies.

14. TOBACCO SMOKING

14.1 Health and dependence problem

Although tobacco is not considered everywhere to fall within a category of dependence producing drugs, some authorities state that the dependence mechanisms are similar to those leading to other problems discussed in this report, and certain national bodies, treatment centres, and research institutions deal with problems of tobacco smoking along with dependence on alcohol and other drugs. The WHO Outline for National Inquiry therefore included, as an annex, a rubric on tobacco smoking and about half the responses gave some information on this subject.

In recent years, WHO has shown considerable concern about the health hazards of tobacco smoking. The Executive Board, at its forty-seventh session, adopted a resolution (World Health Organization, 1971) requesting the Director-General "to continue to assemble information on the effects of smoking and the results of action taken to reduce the habit", and "to seek the assistance of the United Nations and the specialized agencies in promoting the social change required and in studying the economic consequences, actual and anticipated, of the change."

In the meantime, the report of a WHO Study Group on Youth and Drugs (1972) has stated, after listing the dependence-producing drugs already mentioned, that tobacco "clearly is a dependence-producing substance with a capacity to cause physical harm to the user, and its use is so widespread as to constitute a public health problem. However, unlike the types of dependence-producing drug just noted, it produces relatively little stimulation or depression of the central nervous system, or disturbances in perception, mood, thinking, behaviour or motor function. Any such psychotoxic effects produced by tobacco, even when it is used in large amounts, are slight compared with those of the types of dependence-producing drugs listed above".

An article by Russell (1971a) included in the review relating to the United Kingdom states: "Whether or not the smoking of cigarettes is harmful to health is no longer at issue. The emphasis has now shifted to assessing the extent of this damage." Among the more moderate estimates quoted by him is that by Lowe (1970) who calculated that some 38 000 men and 4 000 women in England and Wales die prematurely each year as a result of smoking. Russell adds: "this is over five times the death rate due to road accidents and more than eight times the suicide rate".

Evidence is given in the national reviews for increasing awareness of the health hazards of smoking tobacco, particularly of cigarettes. Considerable publicity was given to a report of the British Royal College of Physicians (1962) on Smoking and health, which was updated in 1971. In Sweden, 25 doctors and scientists petitioned the Swedish Government in 1963 for governmental action to control smoking. Yugoslavia produces 13% of the total world tobacco output and consumes two-thirds within the country. Ten years ago information on the harmful effects of tobacco began to be publicized and more recently a petition signed by 1 400 outstanding persons was sent to the government to initiate a campaign against smoking.

14.2 Campaigns to diminish the habit

In several countries, educational campaigns have been initiated, providing information on the dangers of smoking to health. This has been done at government level in Poland, by the National Health Service, with the help of the mass media and the Polish Medical Society. In Sweden, a National Smoking and Health Association works closely with the National Board of Health and Welfare in establishing an educational programme. It provides an information service to the public and the press, assists local leaders with information activities, and provides teaching aids for the preventive programmes in schools, including material for "motivation lessons" to start group discussion, which has given promising results. Educational programmes on smoking hazards are carried out in every State and Territory of Australia. A recent survey of Sydney schoolchildren indicated that there had been a 30% decrease in smoking compared with a national survey undertaken 4 years previously. The Austrian Medical Association has recently organized a broad information and deterrant campaign with the help of mass media. Institutes of social and preventive medicine and leagues against cancer have done much to spread information on the effects of smoking on health.

Unfortunately, attempts to evaluate such campaigns indicate that they may have been largely ineffective. In many countries this may be due partly to the fact, as Russell (1971a) points out, that the prevailing social climate "is one of approval and tolerance of smoking", cigarettes being "perhaps the most readily available of all commodities", and partly to the counter-effects of other influences: "£100 000 a year of Government funds to persuade people not to smoke is unlikely to achieve much in the face of the £17 million spent annually by the tobacco companies on advertising." Russell goes on to propose that "future anti-smoking campaigns should employ some of the methods of commercial advertising. This would be expensive as it would involve frequent, persistent, and widespread exposure of propaganda messages as well as sophisticated application of the principles of communication theory. It would also involve continuous monitoring of public response to allow feed-back control and adjustment of both form and content of the propaganda message."

14.3 Other measures

A few countries have attempted to restrict commercial advertising of cigarettes. In Sweden, where there is no such advertising on the radio or television, discussions are focusing on restriction in the press. Advertising in or on public conveyances and in hospitals has stopped. In the United Kingdom, a ban was imposed on the advertising of cigarettes on commercial television. "The tobacco industry responded with the massive proliferation of gift coupon schemes." (Russell, 1971a). In Poland, the production and distribution of tobacco are in the hands of the State and there is no advertising, but in 1969 the output of tobacco and its products was 2.7 times as high as in 1950.

Increase in taxation may lead to reduction in consumption of tobacco. Russell (1971b) produces evidence in favour of this assumption in the United Kingdom, the effect being largely a tendency to reduction in the recruitment of new male smokers.

The printing of health hazard warnings on cigarette packages has been advocated widely and implemented in some countries. The effect of this measure does not seem to have been evaluated, and may in fact lead to increased consumption.

A high proportion of smokers are well aware of the danger of their habit and wish to stop. Russell (1971b) found that this applied to three out of four smokers studied, though "less than one in four ever succeed". Clinics have been established for treatment of the dependence involved, but so far only limited long-term success has been registered. Of some 30 anti-smoking clinics opened after the 1962 Royal College of Physicians' report, only one remained open after 5 years. Three smoking withdrawal clinics are functioning in Sweden.

Several responses reported on research endeavours. The Swedish National Smoking and Health Association has appointed a scientific committee charged with stimulating further research. Investigations are carried out in various centres in Poland and the Polish Academy of Sciences has a special team to study the problems involved. The relationships between tobacco smoking and diseases are continuing to be investigated in a number of countries (e.g., cancer, by an epidemiological research group, in Japan). Little research seems to have been done on the causes and cure of dependence on tobacco.

A preventive step which has had some measure of success is the public example of the medical profession in giving up smoking, or at least abstaining from smoking in public. A move to this direction was made in January, 1970, when the WHO Executive Board requested unanimously those attending its meetings to refrain from smoking. This was followed by a similar request at the World Health Assembly in May, 1970.

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ANNEX 1

PARTICIPANTS, WHO SECRETARIAT, AND OBSERVERS AT THE
1971 COURSE AND 1972 SEMINAR

WHO Inter-Regional Training Course for National Programmes on Problems of
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WHO Inter-Regional Seminar for National Programmes on Problems of Alcohol and
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ANNEX 2

SELECTED PUBLICATIONS DISTRIBUTED TO THE 1972 SEMINAR
PARTICIPANTS AS BACKGROUND DOCUMENTATION

American Medical Association (1968) Manual on alcoholism, Chicago

Cameron, Dale C. (1971) Abuse of alcohol and drugs: concepts and planning, WHO Chronicle, 25,
8

Eddy, N. B., Halbach, H., Harris, I. & Seveers, M. H. (1965) Drug dependence: its significance
and characteristics, Bull. Wld Hlth Org., 32, 721

Kalant, H. & Kalant, O. J. (1971) Drugs, society and personal choice, Ontario PaperJacks

WHO Expert Committee on Drug Dependence (1969) Sixteenth report, Geneva (Wld Hlth Org. techn.
Rep. Ser., No. 407)

WHO Expert Committee on Drug Dependence (1970) Eighteenth report, Geneva (Wld Hlth Org. techn.
Rep. Ser., No. 460)

WHO Expert Committee on Mental Health (1967) Fourteenth report. Services for the prevention
and treatment of dependence on alcohol and other drugs, Geneva (Wld Hlth Org. techn. Rep.
Ser., No. 363)

WHO Scientific Group on the Use of Cannabis (1971) Report, Geneva (Wld Hlth Org. techn. Rep.
Ser., No. 478)

ANNEX 3

PROBLEMS OF ALCOHOL AND DRUG DEPENDENCE:
OUTLINE FOR NATIONAL INQUIRY

Introduction

The fourteenth report of the WHO Expert Committee on Mental Health¹ states that: "Dependence on alcohol and dependence on other drugs create or contribute to major public health problems and should therefore be of concern to all public health organizations and administrations" and that "WHO should provide further leadership in the development of coordinated multidisciplinary, international research programmes and the stimulation of international cooperation and exchange of information on the problems under consideration".

As a basis for implementing these recommendations, there is need for national reviews of the situation.

The following outline for inquiry is intended to serve as a guide for reporting on many aspects of problems of alcohol and drug dependence and of the ways these problems are being met.

Reviews based on this outline were compiled for 15 countries in preparation for the WHO Inter-regional Training Course for National Programmes on Problems of Alcohol and Drug Dependence, 12 September - 2 October 1971. Copies of the reviews were circulated and used as background documentation for discussions on planning the relevant national programmes. Examples of such programmes were seen in the three host countries for the course: Poland, the Netherlands and the United Kingdom. Within each of these countries there had been extensive multidisciplinary collaboration in drawing up the reviews, which underwent several revisions over a period of three years.

During the course it was generally agreed that this outline is of value for promoting the collection of information required for effective national planning of a coordinated programme to meet problems of alcohol and drug dependence. It is therefore now being circulated to the proposed participants in the WHO Inter-regional Seminar for National Programmes on Problems of Alcohol and Drug Dependence, to be held in September 1972.

This outline reflects the need for a multidisciplinary approach to the problems under review. The main purpose of the inquiry will be to promote the collection of data required for effective national planning of coordinated services.

I. Extent² of problems of abnormal alcohol consumption

1. Meaningfulness of Jellinek classification of "Species of alcoholism"³ as applied to this particular country.
2. Definition of alternative terms as used in this country.
3. National prevalence estimates of "alcoholism" and/or "problem drinking", according to the terms used in this country.

¹ WHO, Expert Committee on Mental Health (1967) Wld Hlth Org. techn. Rep. Ser., No. 363.

² Here and throughout the inquiry, emphasis is laid on the need for information on trends rather than simple one-point statements. Comments on the reliability of data provided would be valuable.

³ Jellinek, E. M. (1961) The Disease Concept of Alcoholism, New Haven.

4. Above prevalence estimates related to demographic variables (including any racial or religious groupings and notes on "drinking problems" among adolescents).
5. Prevalence of physical complications (in particular alcoholic cirrhosis).
6. Extent of abnormal alcohol consumption among vagrants: the "skid row" problem and drunkenness arrest data.
7. Rate of alcoholics among criminal and prison populations.
8. Drunken-driving data.
9. Notable changes in above problems in recent years.

II. Extent and nature of problems of dependence on other drugs

Seriousness and nature of problems posed by the following types of drug dependence, with information where possible on special characteristics of groups of drug users, including their age, criminal involvement, etc.; drug of choice and method of administration (e.g., intravenous, oral) for each type of dependence; and, where possible, prevalence data, especially in relation to demographic variables.

1. Morphine type.
2. Cocaine type.
3. Amphetamine type.
4. Barbiturate type.
5. Cannabis type.
6. Hallucinogen type (e.g., LSD)
7. Other types (specify).
8. Notable changes in above problems in recent years.

III. Interrelations between above problems

1. Trends in abuse of several drugs simultaneously, or in sequence.
2. Trends in interchange between dependence on alcohol and on other drugs.

IV. National policy regarding persons dependent on alcohol or other drugs

1. Official recognition of alcoholism and other types of drug dependence as illnesses (i.e., presenting medical as well as socio-economic and legal problems).
2. Official or broadly accepted policy (goals and methods) for preventing and treating alcoholism and other drug dependence.
3. Extent to which the above have been incorporated into legislation:
 - (a) Legal status of persons dependent on alcohol or other drugs, e.g., criminal sanctions, compulsory treatment, competency issues.

(b) Legislation on prevention of dependence on alcohol and other drugs and treatment of persons who have become dependent.

V. Responsibilities of national bodies

1. Responsibilities and activities of various government departments in relation to alcohol problems and/or other drug problems.
2. Responsibilities and activities of other national bodies in relation to these problems.
3. Coordination of activities mentioned under 1 and 2.

VI. Availability and consumption of alcoholic beverages

1. National annual production, importation and exportation of alcoholic beverages.
2. Illicit production of alcoholic beverages: probable extent of problem.
3. Methods of national control of production and distribution of alcoholic beverages, e.g., taxation, licensing laws, regulations on places of sale and consumption, minimum age for purchase or consumption, with notes on effectiveness of measures employed.
4. Per capita quantity of alcohol consumed, by beverage categories.
5. Per capita expenditure on alcohol, related to information on per capita income
6. "Normal drinking" survey data: proportion of alcohol drinkers and non-drinkers in the community and relation to demographic variables.
7. "Social drinking" occasions and situations: where and when is alcohol generally consumed? When is it socially permissible for a man or a woman to take alcoholic beverages or get drunk?

VII. Availability and consumption of other drugs

1. Trends (if available) in per capita consumption, for all purposes, of dependence-producing drugs, by types of drug, as in II.
2. Sources of supply of the various drugs used by drug dependent persons.
3. Any information available on recent changes in costs of obtaining various dependence-producing drugs illegally ("black market").
4. National control of production and distribution of dependence-producing drugs (excluding alcohol).

VIII. Treatment and after-care services

1. General pattern, availability and adequacy of treatment and after-care services: policies regarding voluntary versus compulsory treatment.
2. Numbers and rates (e.g., per 100 000 population aged over 16, by sex) for patients with alcohol and/or other drug problems treated per year (e.g., for last 10 years).
3. Characteristics of treated population, related to supposed characteristics of total population with alcohol and/or other drug problems.

4. Types of services and facilities for patients with alcohol and/or other drug problems.

- (a) Counselling and outpatient treatment, e.g.,
 - consultation bureaux,
 - information centres,
 - general practitioner services,
 - sobering-up stations,
 - outpatient services attached to general or psychiatric hospitals,
 - specialized outpatient units.
- (b) Specialized unit inpatient care.
- (c) Inpatient care within general and mental hospitals.
- (d) Industrial rehabilitation.
- (e) Half-way house care.
- (f) Family case-work.
- (g) Treatment within the penal system.
- (h) Programmes within industry.

The information should include, where possible: description of the characteristics of the type of patients likely to be served by each of these facilities, and criteria for exclusion from treatment; personnel providing treatment (non-medical or untrained social work staff, professional staff, the role of voluntary workers); types of treatment given; and, where available, summary statistics on numbers of persons treated and duration of treatment.

5. Collaboration between facilities: possibility of long-term follow-up of persons coming to treatment.

6. Part played by voluntary organizations, e.g.,

- temperance and church organizations,
- Alcoholics Anonymous and similar organizations,
- prison after-care associations,
- national associations for mental health,
- national councils on alcoholism and/or drug dependence.

7. Plans for development of treatment services.

8. Measurement of treatment effectiveness.

- (a) Information on which treatment centres within the country are able to furnish data and which are not.
- (b) Criteria employed for assessing outcome, tests used to check reliability of data, completeness of sample follow-up and length of follow-up.

IX. Prevention programmes and education of the public

1. Nature and extent of implementation of national policies on prevention, with particular reference to legislative control, school and public education.
2. Information on effectiveness of particular campaigns, including drunken-driving campaigns.
3. List of national and local bodies concerned with education of the public on problems of alcohol and/or other drugs, with notes on their scope and activities.
4. Nature and extent of use of mass media.
5. Availability, duration and methods used in teaching school children about problems of alcohol and/or other drugs.

X. Professional education and training

1. General pattern, availability and adequacy of professional education and training on problems of alcohol and/or other drugs.
2. Inclusion of education and training on problems of alcohol and other dependence-producing drugs in curricula for the following professions: medicine (undergraduate, post-graduate - e.g., public health, psychiatry, general practice), social work, nursing, law, law-enforcement (police, probation officers), teaching, other professions: with notes on amount of training and methods by which such training is given (e.g., special courses, incorporation into other courses, clinical experience, courses with trainees from other professions).

XI. Involvement of professional medical bodies in prevention and treatment

1. Committees.
2. Publications.
3. Statements.

XII. Research

1. Specialized research institutions and foundations concerned with problems of alcohol and/or other drugs, with notes on their scope and activities.
2. Professional bodies concerned with such research.
3. Specialized journals devoted to such research.

XIII. Trends and plans

1. Changes in size and/or awareness of problems.
2. Importance of problems of alcohol and drug dependence in the context of the country's total health situation.
3. Trends in attitudes towards problems and ways of meeting them.
4. National plans for improving prevention and treatment of dependence on alcohol and/or other drugs.

XIV. Other comments

ADDENDUM

Tobacco smoking

1. Extent to which tobacco smoking is considered an important health and dependence problem in this country.
2. Existence of any local or national campaigns to diminish the habit.

ANNEX

Data collection

1. Methods used for collecting the data in response to the outline.
2. Problems encountered in above data collection.
3. Present or planned feedback of information.
4. Interpretation and utilization of collected data.
5. Plans for on-going data collection and use.

ANNEX 4

ARRANGEMENTS MADE TO PROMOTE EXCHANGE OF KNOWLEDGE AND EXPERIENCE
AT THE 1971 COURSE AND 1972 SEMINAR

1. Statement and main purposes. The following main purposes of the 1971 Course and the 1972 Seminar were stated in the invitations to Governments to nominate participants:

- (a) to enable public health officers, psychiatrists, and others concerned with organization of the relevant services to study and exchange experience on practical aspects of the development of local and national services for the prevention and treatment of dependence on alcohol and other drugs;
- (b) to stimulate local and national compilation of information to provide an adequate basis for development of services;
- (c) to stimulate research on evaluation of preventive and treatment measures.

2. Multinational participation. As requested through the WHO Regional Offices, participants were nominated by their governments because of their present or anticipated responsibility in their own country for programmes dealing with alcohol and drug problems. The participants for the two meetings came from countries within all six of the WHO Regions, as listed below:

<u>African Region</u>	<u>European Region</u>	<u>Eastern Mediterranean Region</u>
Nigeria *	Austria *	Egypt *
Zambia *	Belgium	Iran *
	Czechoslovakia *	Israel *
<u>Region of the Americas</u>	Finland *	
Argentina *	France *	<u>South-east Asia Region</u>
Chile *	Germany, Federal	India *
Colombia *	Republic of	Thailand *
Costa Rica *	Italy	
El Salvador *	Netherlands *	<u>Western Pacific Region</u>
Mexico *	Poland *	Japan *
Panama *	Romania *	Philippines *
Venezuela *	Sweden *	
USA (observers)	Spain *	
	Switzerland *	
	United Kingdom *	
	USSR	
	Yugoslavia *	

3. Programme. During each week of both the Course and the Seminar, about one-third of the time was spent on each of the following activities: (a) visits for observation of programmes in the host country and discussion of its programmes; (b) reviews of responses to the WHO Outline for Inquiry; (c) general consideration of means of improving national responses to problems of alcohol and drug-dependence. These programmes were discussed between the WHO staff and consultants during the preliminary meetings in 1969 and 1970, and detailed timetables were established later for each country.

* Countries providing a written response to the WHO Outline for Inquiry.

(a) Visits of observation

In each of the host countries, the consultants and their colleagues had spent much time and effort in planning visits of observation for the course and seminar participants. An attempt was made to select examples of facilities so that the range of services available could be understood. Wherever possible, the participants were split into small groups to provide greater opportunity for discussion with persons using the facilities, staff involved in organizing the services, and, in some cases, the local community. Thus, in the Netherlands in 1971, after a preliminary plenary session at which the programme of the country was presented and discussed, staff from 16 Medical Consultation Bureaux in different parts of the country each took one or more participants to visit services in their area for a day and a half. On their return, the findings were discussed in plenary sessions. Similarly, in Switzerland in 1972, small groups were taken to visit services in five different cantons. In other countries the visits were spread over the week and often included lunch-hour and evening visits, when the users of the services were most likely to be present.

In all the countries many opportunities were provided for considerable discussion with alcoholics and other drug-dependent persons themselves and in some cases with members of their families. In Poland and Yugoslavia, where questions of language were most likely to create an obstacle to understanding, excellent arrangements were made for interpretation. Several times during the visits, panel discussions were arranged between a group of persons interested in various aspects of alcohol and drug problems, and the WHO participants were invited to cross question them.

In London in 1971, for instance, this method of demonstrating and examining the complex issues at hand was used on several occasions to great effect. On the first day, devoted to alcoholism, a visit to a Magistrates' Court, where several cases of public drunkenness were heard, was followed by a panel discussion with two magistrates, a community liaison officer, a police officer, and a probation officer. Following a visit to a shop-front office for homeless alcoholics, a panel comprising a clergyman, a community worker, a local counsellor and other local residents discussed how the local community responds to the problem of the homeless alcoholic. In the afternoon there was a very lively exchange of opinions between a Member of Parliament, two staff members of the Department of Health and Social Security, one from the Home Office, a consultant psychiatrist in charge of an alcoholic unit, a lecturer on social studies, and a secretary of the Brewers' Society. The third day was devoted to drug dependence and visits were similarly interspersed with panel discussions.

An outstanding panel of decision makers with high levels of responsibility was brought together in Stockholm in 1972 to summarize and discuss the Swedish response to problems of alcohol and drug dependence. It comprised a Cabinet Minister, Coordinator of the Government Drug Dependence Committee; the Directors-General of the National Board of Health and Social Welfare, the National Board of Prisons, and the National Board of Schools; a Chief of Section of the National Police Board; the Chief Prosecutor; and the Permanent Secretary of the Ministry of Health and Social Security. Again, there was animated interchange of question, answer and comment between the panel members and between participants and panel.

(b) Review of responses to WHO Outline for Inquiry

Nearly all the responses to the Outline were received in time for circulation to participants prior to the Course or Seminar. Each participant, or pair of participants, then had an opportunity to present a summary of this material for discussion on the relevant country's programme. This was done in plenary session in the Course, but in the Seminar the presentations were made in smaller groups according to language - English, French, or Spanish - and subsequently reviewed at a plenary session. This gave increased opportunity for lively discussion.

(c) General considerations

During the planning, it was arranged that each of the following items should come under special scrutiny during at least one session, and if possible two, in the course of the three weeks:

- (i) behaviour associated with the use of alcohol and other drugs;
- (ii) public attitudes and responses to use of alcohol and other drugs;
- (iii) approaches to prevention; treatment, including rehabilitation, of persons with alcohol and drug problems;
- (iv) legal and penal aspects;
- (v) training of personnel dealing with alcohol and drug problems;
- (vi) data collection, analysis, and use for planning programmes;
- (vii) research on alcohol and drug problems; evaluation of preventive, treatment and rehabilitation measures and of total programmes.

These topics were, of course, considered in the responses and were frequently under review during the visits and panel discussions. The special sessions were intended to review the knowledge and experience on each subject and to point to areas of ignorance and oversight. Various techniques were employed for this purpose. In some cases, one or two brief presentations were made and points were added by the participants, so that a blackboard summary could be produced. In 1971, the first item was dealt with by a non-expert questioner eliciting information and experience from the participants. An impromptu drama was built round the first two items, in which the participants in the roles of alcoholics, drug addicts, and community members illustrated the wide variety of behaviour and responses. Public attitudes and responses were examined also through an exercise where the participants in small groups chose community roles to express reaction to an alarming (fake) front-page article in the press on the spread of drug addiction. The advantages and disadvantages of various methods of prevention, treatment, and rehabilitation observed during the visits were discussed in plenary sessions. In connexion with discussions on prevention through public education, exhibitions of posters, pamphlets, books and other teaching devices were shown in Poland and Yugoslavia, and educational methods were presented and demonstrated in London. Opportunities for professional training at a summer school on alcoholism were considered. Examples from the national responses were used to illustrate a presentation on data collection. Questions concerning research were illustrated by presentation of the programmes of research centres, outlines of specific research projects and discussion of the pitfalls encountered and the possible utilization of results.

At the end of the three weeks in both years, special sessions were devoted to the planning of national programmes on problems of alcohol and drug dependence. In London, the topic of principles of programme planning and evaluation was introduced by a specialist from a firm of business consultants who is particularly concerned with the organization of health services and examples of programme planning were described. Finally, each participant or pair of participants from a country outlined the steps that could be taken to improve the relevant programmes. Follow-up of the Course and Seminar has revealed that a number of the proposals have been implemented.

FIRST CONSULTATION ON NATIONAL RESPONSES TO PROBLEMS OF ALCOHOL AND DRUG DÉPENDENCE
London, 19-24 May 1969

Organized by WHO
and
ADDICTION RESEARCH UNIT, INSTITUTE OF PSYCHIATRY, London

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