WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

WHO Inter-Regional Workshop on
Prevention and Treatment of Drug Dependence

Alexandria, 16 - 21 October 1978

Public Health and Policy Perspectives

Consultant's* Background Paper 1

*Prepared by WHO Consultant, Dr Sten Mårtens, Lecturer in Psychiatry, University College, Cork, Ireland

Policy Development

It may seem trivial to say that every programme planning and development must be preceded by the development of a policy But the somewhat disturbing fact is that most programme developments in most countries have not followed this simple logic. The concept of policy is closely related to that of politics, which might be part of the explanation why drug control policies are so rarely developed and, even more rarely, clearly spelled out. Undoubtedly there is a strong element of politics in policy making because policies will inevitably bind decision makers to certain costs and priorities. Sometimes political decision makers are criticised for not issuing policy guidelines in time but it must be said in their defence that it is far from easy to develop sensible and realistic policies within the field of drug abuse prevention, treatment and rehabilitation Because, in order to develop such policies one has to have a realistic assessment of the problem and such assessments are always hard to get, and decision makers hardly ever get them in time As a consequence policy making frequently follows after programme development instead of the other way around which has led to confusion in many places Surely most of us know of concrete examples of this state of affairs . It is also possible that decision makers may shun away from policy making because it seems complicated and difficult There is fairly much written about it, but in our daily life we seldom find time to read as much as we ought to and, besides, much of the literature on policy development may initially seem like theoretical desk products.

But, in actual fact, what is policy development, basically, other than sitting down with the relevant facts and figuring out the most realistic and productive way to deal with the situation? But in order to be able to do so, it is imperative to have all essential facts If one does not, it may be the best policy to do nothing until they have become available.

Unfortunately drug issues often tend to be dramatised or emotionally charged and sometimes politically inflammable

Exaggerated statements are common and the fear and sometimes mystery that is attached to drug issues have sometimes been used by the media to create pressure or sensation. There are also remarkably many self-styled experts who are only too happy to give their unsolicited "advice" which is often contradicting. It is not surprising, then, that policy makers often find themselves in a quandary. Governments and Health and Social Welfare Departments are known to have made mistakes in the past because of lack of policy and such mistakes have at best been costly, or may even have contributed to aggravating a situation rather than alleviating it. One of the main objectives of this Workshop is to exchange experience which will help decision makers not to repeat mistakes which have been made by others in the past

The policy makers' first concern is to obtain an assessment of the drug abuse situation in the country or area which is as accurate as possible Area or province assessment is specifically mentioned here because it is very rare indeed that any one country has a drug abuse problem which is uniform or generalised. Probably, in all countries represented at this Workshop there is very considerable variation of the problems between different provinces, between rural and urban areas etc. In fact, in a number of developing countries there is good evidence that in some areas there are no drug abuse problems at all whereas in others there are very serious ones. And those are not merely quantitative differences, but to a very large extent qualitative as well. We need only to think of countries which have a moderate traditionally based opium problem in certain remote rural areas, and at the same time a rapidly increasing and serious intra-venous heroin problem in the larger cities. Naturally, policy makers must take such local differences into account.

It is quite clear that sound assessments cannot be based on hearsay, news media articles or programmes or similar information. However, that is not to say that such information should be neglected. There is usually some truth in such information but it is often based on indirect knowledge, or it represents extreme views or is biased one way or the other.

The difficulties associated with obtaining accurate assessments of drug abuse situations are well known and often lamented upon. It is a well known fact that it is a treaty obligation for Government Parties to the Single Convention on Narcotic Drugs, 1961, and the Convention on Psychotropic Substances, 1971, to send annual reports on drug abuse to the United Nations Division of Narcotic Drugs Those who have participated in the annual meetings of the Commission on Narcotic Drugs will remember that no such meeting during the last ten years at least, have passed without criticism of the quality of drug abuse reporting by Governments We shall return later to the question of assessment of drug abuse problems. At this point it may suffice to say that it is equally important for national policy makers as for the international control agencies

The next step following assessment of size and type of the problem, is to try and determine the seriousness of it. This involves analysing the nature of the problem in public health and social terms. This is necessary in order to form realistic and sensible intervention policies The first question may well be is the problem serious enough for the Government or other authorities involved to spend funds and manpower to intervene specifically against it?. For it is not self-evident that a drug problem per se requires specific intervention. This point may be illustrated by the following example

It is well known that the rural population in certain areas use opium fairly extensively as a quasi-medical remedy Because of the difficulty in controlling this opium use, some of it develops into abuse or non-medical use which is harmful, and, in itself, constitutes a problem In the same areas there may be little or no primary health service and no medical service to speak of Should or should not a Government interven. specifically against this problem? This is an important question policy makers will have to ask themselves. Perhaps their answer will be that the best way to intervene against such a drug abuse problem is to spend a good deal of the available funds and manpower on developing primary health services in the region, rather than to launch

an expensive specific drug abuse programme?

But the same policy makers may have information indicating that, in the larger cities of the country, heroin abuse, while not yet widespread, is in fact occurring and the incidence is increasing. At the same time, there is more and more non-medical use of hypnotics, sedatives and tranquillisers. The policy makers would then probably find that what may be a good policy for the rural areas will be a fairly meaningless one in those big cities. In such a situation it is unlikely that one single policy will be sufficient as a basis for programme development - probably it would become evident that the fairly rapid spread of heroin abuse and non-medical use of psychotropic substances does constitute a serious, although thus far fairly limited, social and public health problem, and therefore special measures will have to be taken to intervene against it. Those drugs are not taken for the same reasons as opium in the rural areas, and furthermore, the public health and medical services are probably more developed in the cities. In other words, the nature of the problem is different.

When the size, nature and impact of the problem or - as in the quoted case - the problems, have been assessed, the policy makers will have to formulate the main goals of their intended policy or policies. In doing so they will have to consider not only what is ultimately desirable but, more important what is realistic and, most important, what is feasible within the limits of available funds, manpower and possible international or other external assistance. The feasibility will have to be seen not only against the resources available within the Health and Social Welfare area, but also in other departments and agencies with which collaboration has to be established.

For to-day, it is universally recognised that there is a constant interplay between demand and supply of drugs of abuse. The characteristic dynamics of this interplay is that one tends to enhance the other. Experience in many places have shown that ever so ambitious programmes to reduce demand were quite unsuccessful because nothing was done to reduce supply. Certainly, also the reverse is true, and there is perhaps even more evidence to show that efforts to

reduce supply and illicit traffic failed because nothing was done to reduce demand, i.e. there was no programme development within the area of prevention, treatment and rehabilitation.

The policy, officially adopted by international drug control agencies, is quite clear in this context Supply, demand and illicit traffic problems must be tackled simultaneously and in concert if any tangible results are to be achieved. Obviously, national policies must also adhere to this principle. This raises the issue of co-ordination between various departments and agencies involved in drug control. Policy makers will have to negotiate with all parties involved and take their evaluations, attitudes, resources and limitations into consideration before formulating a policy. There is plenty of experience in many countries of efforts to obtain good inter-agency or inter-departmental co-operation in the drug abuse control field. But as is well known, that experience was not always positive. The general consensus, however is that it is necessary to have some sort of national co-ordination body. There are examples of various types, compositions and administrative localisations of such bodies, which will be discussed later. But one thing is certain and that is that unless this co-ordinating body is formed at the very onset, and allowed to participate in policy development, the results will not satisfactory. The conclusion is that it is very unlikely that a programme of prevention, treatment and rehabilitation of drug dependent persons will function successfully unless it is in harmony with other programmes of drug control.

The products of policy development are goals , viz. what policy makers expect intervention programmes to achieve, Practically without exception, policy development is not initiated until there are some signals that a problem already does exist. Contingency drug abuse control policies do not seem to exist. As previously mentioned, more often than not, there is already a fulminant drug abuse problem in existence and some more or less well planned actions have already been taken. It is therefore necessary to set short-term as well as long-term goals. It may be useful, at this stage to consider the difference between

policy goals and programme objectives. Logically, a policy goal should be independent of programme objectives. This may be illustrated by concrete examples

One commonly expressed policy goal is to eradicate non-medical use of opium. Needless to say, before setting up such a goal the realism of it has to be carefully weighed. Undoubtedly there are countries or areas in which such a goal is a realistic one. But it is equally true that there are countries and areas where non-medical use of opium has such a long tradition and is nourished by prevailing socio-economic conditions, and so wide-spread that the goal is not realistic, at least not within foreseeable future. A more realistic goal, then, would be to substantially reduce non-medical use of opium Such a goal may well be set irrespective of what methods are to be used to reach it. After careful consideration of the size and nature of the problem and of what public health and social impact it has, the policy maker is not only entitled, but may in fact be required to set it. Once it is set, the ways and means by which to reach it will be technical questions and questions of financial and manpower resources. The setting of policy goals will require realistic estimates of what technical and other resources are available or may be made available within reasonable future.

It is also unavoidable when such a policy goal is to be set, to consider national or local traditions and attitudes towards the phenomenon of non-medical opium use. Policy goals which are contrary to, or at odds with, deeply rooted traditions and attitudes will most probably be very hard or even impossible to reach There are a number of concrete examples from which we may learn In one area a clear and fairly short term goal was set, namely to stop completely opium poppy cultivation. This case was unusual because there was no non-medical use of opium in the area. The produced opium found other ways and uses. It happened that opium poppy cultivation had very old traditions and it was a major agricultural product with many different uses. Therefore, the local attitude towards continued cultivation was very positive. It was considered a useful and good thing

to do. Accordingly there was a strong negative attitude against stopping the cultivation. Many sophisticated and well thought out methods were used to attain the goal, very much money was spent and a great number of experts and other manpower was used, but it ended in failure.

There are similar examples from which we also may learn which do not necessarily concern opium. In several western countries, in the fairly recent past, the policy goal of complete stopping of the use of alcohol was set. Those were the well known prohibitions of alcohol in some European countries and in North America The failures were disastrous not only because the goals were not reached, but they undermined public confidence in the policy makers and they promoted crime and other social ills of which the consequences are still apparent

There are yet other examples of policy goals which have in fact been reached while the consequence was that one problem was replaced by another, and a worse one. Thus, in one country a policy goal was to prohibit all use, even medical, of amphetamine and related psychotropic substances because there was an epidemic spread of abuse of such drugs. The goal was reached in the sense that doctors could no longer prescribe central stimulants. They were not manufactured, imported or sold legally anywhere. But in less than one year pure chrystalline amphetamine was introduced in the illicit market. Although much more expensive to buy, it was easier to dissolve and inject intravenously. The consequence was that the abuse of amphetamine not only increased further, but it became predominantly intravenous with all the secondary ill effects related to that kind of abuse. Further, because of the illegality and high costs of the substances in the street, the abuse became strongly associated with criminal activity. In another country, drastic interventions were undertaken against non-medical use of opium. The policy goal in that case was nearly reached, but instead heroin was introduced and the abuse is still a very malignant problem associated with serious organized crime. There are many other examples which could be quoted and the common lesson to be learned from them is that it is imperative for policy makers to try and analyse what consequences the ultimate reaching of a policy goal might have. Admittedly, policy makers cannot be

expected to be prophets but they can be expected, like doctors are by old tradition, to try and act according to the ancient Hippocratic rule "Primum est nil nocere" (The foremost concern is not to harm").

The examples quoted have dealt with broader and more general policy making in the drug abuse control field. The principles and issues which have been discussed, however, are applicable also for policy development within the more limited areas of prevention and treatment and rehabilitation of drug dependent persons. It has been frequently pointed out, and is still worthwhile emphasising, that there is no such thing as a generally accepted or even recommendable treatment method. Consequently it can never within foreseeable time be the task of a policy maker to issue guidelines or to set goals which are bound to certain methods. And what has been said about treatment methods is even more true with regard to methods of prevention. Obviously, the methods used in those areas are the concern of technical and scientific experts whose job it is to use methods and develop programmes designed to reach the set policy goals. It follows from this reasoning that in order to be able to set realistic goals, policy makers must acquire a fair knowledge of existing approaches and methods and what to expect from them. If they do not have this knowledge or are unable to acquire it - which may often be the case - they will have to establish good communication with, or include, the experts in the early stages of policy making. Thus, the logics of policy goals being independent of programme objectives can, in practical life not be strictly adhered to. There has to be a constant communication and feed-back between policy makers and expert programme developers.

If, for instance, a policy maker were to set as policy goal that all drug dependent persons in a given area will be cured by going through a treatment and rehabilitation programme, it may be safely predicted that the goal will never be reached. The two simple reasons are that all drug dependent persons will not come to treatment, and there are no known treatment and rehabilitation methods which are even remotely that effective. In this extreme and unlikely case

anybody with minimal familiarity with treatment and rehabilitation would have been able to advise the policy maker of this at an early stage. But, incredibly, policy goals of similar although not as extreme kind still are set here and there, presumably due to lack of communication between policy makers and experts

Another and more likely variation of policy making of this kind would be to set as a goal that every drug dependent person in a certain area should have gone through treatment and rehabilitation at a certain point in time. The policy maker would know the basic fact that only a certain proportion of the treated persons will benefit from the programme but he feels, understandably, that everyone should have the chance. As there is in most countries, particularly in this region of the world, no legislation which may force a drug dependent person to treatment and there is no safe method to determine who is a drug dependent person, such a policy goal would also be meaningless A policy maker, then, who is aware of the necessity to take legislation aspects into consideration also when planning treatment and rehabilitation policies might, if he is in such position, set as a goal to promulgate legislation for compulsory treatment He may succeed in this, but probably only if it is in line with the political and/or the public attitudes which are based on socio-cultural tradition There are examples of situations where such legislation has been passed against the general attitude that a drug addict is a sick person who should be helped on a voluntary basis. The result was that the hospitals used for the treatment programmes had to adopt prison-like rules, and experienced similar problems as prisons do. As the staff were medically trained and did not like their new role, recruitment became a problem, and the necessary collaboration by patients and their families failed It is fair to state that in practically all countries in which treatment and rehabilitation programmes have been planned there have been vivid discussions if treatment should be compulsory or voluntary. Unfortunately there is not enough scientific evidence to tell which policy gives the better results. On the other hand there is evidence enough that where the general attitude is against compulsory treatment

results tend to be poor. But the poorest results of all are seen where programmes have been developed without any clear policy regarding the very important question of voluntary or non-voluntary treatment.

Yet another important policy issue in this context is whether or not prevention, treatment and rehabilitation programmes are exclusively public health and medical responsibilities Experience shows that although no specific policy guidelines have been issued, it is taken for granted in many countries that they are more or less only a medical concern. There is general consensus in most parts of the world today that drug dependence is a typically multi-factoral problem which requires a broadly based multi-disciplinary approach. There are even countries in which it is more or less officially stated that drug dependence is only to a very minor part, if at all, a medical concern or responsibility. In this Workshop we are not concerned with extreme views and, besides, there is not enough scientific evidence to show that the one approach is better than the other. But, in reality in a number of developing countries, the Departments of Health or Health and Social Welfare (they are nowadays mostly merged) are the only ones that have the necessary motivation, resources, expertise and know-how to start treatment and rehabilitation programmes. In the longer term, however, it is unlikely that such programmes will continue to be mainly medically orientated. The need to associate educators, psychologists, sociologists, social-workers and other professional categories will most probably be evident as time goes on and a better balance will be required. But, again, policy making must be realistic, and most developing countries today cannot afford what might still be considered the luxury of having the few existing representatives of non-medical professions engaged in drug dependence programmes. But if this is the case, why not state it in the policy, and include further multi-disciplinary development in the long term goals?

As previously stated, policy making means financial commitments and such commitments require setting of budgetary frames which in turn requires determination of priorities

Policy making bodies in the area of drug abuse control, in developing and developed countries alike, have limited budgets at their disposal, at least in a relative sense Policy development, therefore, requires careful and realistic analysis of how and where best use can be made out of the limited resources over one budget period. However, it also requires projecting and forecasting for the longer term In this context, a warning may be justified. The extent and patterns of drug abuse and dependence in recent years are known to have gone through surprisingly rapid changes, the causes of which are not sufficiently known. It is therefore probably not prudent to fix policies for longer periods than three years at a time. As it were, things have been known to change radically during such short time periods. In a recent concrete case, in the developed world, the drug abuse problem changed almost completely from one of predominantly amphetamine abuse over opium, morphine base to heroin within three years. Consequently, by the end of that period, previous policy goals and priorities had to be radically changed.

Priorities regarding prevention, treatment and rehabilitation in the drug dependence area will have to be established not only in terms of funds and timing, but also with respect to problem areas. Policy makers will have to decide which drug dependence problem or sub-problem can and should be dealt with immediately and which may wait till later. Such choices are not easy to make. In some countries there may exist a wide-spread social and recreational use of cannabis which in some area or among some groups may have taken relatively large proportions. At the same time there may be, in fairly limited areas, a serious opium smoking problem which is on the increase. Quantitatively the cannabis abuse may be far greater than the opium abuse. According to existing national legislation and international treaties, both would be equally illicit and undesirable and all efforts would be expected to be made to reduce them. On the other hand, available funds, manpower and other resources would be far from sufficient for tackling both problems with equal urgency and vigour. Because of the illegality of the abused drugs

and the implications the abuse might have in terms of law enforcement activities, public attitudes, relations to neighbouring countries, national image and international relations etc., there might be strong pressure with political overtones through mass media or other channels to go ahead and do something comprehensive about the total drug abuse problem. This would be a potentially dangerous situation because it constitutes the typical setting for misdirected policy. In such a situation, which has been experienced in many countries in the past, probably the most important of all policy development issues will present itself. That issue is the technical and scientific objectivity and integrity of the policy making body. Presuming that policy makers have been able to receive all available information and advice by experts, it is of decisive importance that they will be able to present their policy proposals in such a manner that they will be accepted and respected by higher level decision makers. Admittedly this is a very sensitive and not so tangible policy issue, but it is essential for the establishment of priorities and it will have to be recognised and faced.

The importance of communication and co-ordination with other interested agencies at an early stage of policy development was discussed above. The need for such co-ordination extends to the stage of priority setting. It would not be sufficient for each party to concur in a common broad policy. Specific goals and priorities must be set for each agency involved. Those goals and priorities may or may not be identical.

Assessment of Problems

Early awareness of a drug abuse problem is often derived from knowledge or experience of traditional drug use or from scattered routine observations by public health, medical or law enforcement agencies. Such observations, although of considerable importance, are frequently transmitted to responsible authorities through second hand sources and may therefore have become distorted or biased on the way. It may be expected that reports from law enforcement agencies are the more accurate ones because of the obligatory recording and reporting duties inherent in law enforcement work. Nevertheless, experience has shown that law enforcement reporting alone mostly does not accurately reflect the drug abuse situation in a given country or area.

Reports on illicit production, smuggling and drug seizures may give a good picture of the illicit traffic situation which is valuable as such. But there are a number of countries known in which there is a considerable illicit production and trafficking, but virtually no drug abuse. The drugs illicitly produced and trafficked are obviously intended for other markets than the domestic one. Hence the need for effective regional and international co-operation.

This discrepancy is usually not recognised by e.g. representatives of the mass media who may tend to equate seizure figures and similar data and the drug abuse situation. This may have adverse consequences if decision and policy makers do not have more accurate sources for their assessment of problems. Health and Social Welfare agencies, institutions and personnel are usually not obliged to report on drug abuse and therefore information from such sources, although not necessarily inaccurate, are usually scattered and uneven and therefore tend to give a distorted picture of the situation. Moreover, if draconic legislation against drug abuse and/or possession of drugs for personal use is prevailing, it is quite conceivable that Health and Social Welfare Personnel will avoid reporting in order to protect their clients from law enforcement intervention. Obviously such a situation not only makes it difficult to obtain realistic assessments, but may also seriously jeopardise the implemention of subsequent treatment programmes.

It is now universally recognised that one has to go about drug abuse assessment in a systematic and scientific manner. But, unfortunately, despite the wide acceptance of this fact, problem assessment is almost everywhere one of the weakest links in the chain of actions taken by Government authorities against drug abuse. This is the case even in the majority of developed countries with well built up administrations and full access to financial and other necessary resources. Some possible explanations for this common short-coming have been briefly touched upon above, but the most important one is probably the simple fact that it is very difficult to obtain accurate information on drug abuse. Because of the mostly negative social attitude against

stigma attached to it, drug abusers do not readily present themselves for recording. In many societies they are also afraid of legal sanctions and therefore actively try to conceal the fact that they are abusers. It is, for instance, very common that drug dependent persons seek medical or social welfare assistance for other ailments and problems that the dependence itself. This is obviously very easily done, as drug dependence leads to so many secondary disorders and social problems for the individual. A number of studies have been devoted to this problem and it is estimated that the so called "dark figure" is very high in many countries. This means of course that, in the subsequent planning process, an estimated "dark figure" will have to be added to the presented assessment figure. Thereis substantial variation of this "dark figure" between countries and areas, and the size of it is probably related to such factors as social attitudes, prevailing legislation, efficiency of law enforcement, availability of effective help etc.

Inadequate problem assessment in development countries is, in addition to the above mentioned factor, naturally also caused by lack of resources, not necessarily in terms of finance - because it is comparatively inexpensive - but expertise and trained personnel. However, this certainly does not exclude that excellent and hard work has been done in some places by devoted officials and their teams.

As it is an international treaty obligation to report on drug abuse the UN Division of Narcotic Drugs, financed by UNFDAC is presently giving assistance to Governments to assess the extent and patterns of drug abuse. Likewise, the WHO as is well known is since several years conducting a comprehensive collaborative epidemiological research programme on drug abuse and dependence. Several of the countries represented at this Workshop are involved in it and have already produced interesting and valuable results. It is expected that these efforts, within foreseeable future, will remedy some of the weaknesses in problem assessment. The conclusion is that developing countries are well advised to seek assistance from the international agencies when they plan to initiate drug abuse problem assessments. Such assistan is available, but, like other international assistance, it presumes that the major effort is made by the country itself. The assistance is only meant to cover such areas and items that the country

cannot manage on its own. Another important aspect of this issue is that no outside experts will ever be able to collect the essential information as well as the people who know the areas and populations, and without the experience of national experts the gathered information is unlikely to be accurately interpreted.

Drug control legislation has already been mentioned several times as a factor which may influence the possibilities to make accurate problem assessments The deterrent effect which too severe legislation may have on the drug abusers incentive to present themselves to assessment teams has already been mentioned. There is a number of countries in which certain types of narcotic drugs possession, use and abuse are prohibited by law, but not others. Such differential legislation, although probably well motivated for various other reasons, does not make the task easier for assessment makers Obviously, if only one type of drug abusers will come forward during an assessment research programme, the resulting picture will be askew. There is no generally applicable solution to this particular complication because its characteristics will vary from country to country . But it is very essential that assessment makers are clearly aware of it, and that ways and means are devised to compensate for it.

Keeping these general considerations regarding drug abuse assessment in mind, information should be sought on what drugs are abused, where, how, and with what consequences. This may be done by means of two main approaches, namely by <u>using already existing data</u> and /or by the technique of <u>sample surveys</u>. Either or both of these general approaches may be used in most countries.

Obviously, the use of existing data is limited by the extent to which such data are available, if indeed they exist at all. In developing countries there is often poor supply of any data, but there is very rarely a complete lack. Possible sources for such data collection are hospitals, out-patient services, emergency services, law enforcement services, penal institutions, schools, and universities, armed forces or other public institutions where a certain amount of registration normally takes place. If registration is not done in such institutions there may be

possible. The advantage of using already existing data, are obvious. It does not require the same scientific sophistication as other data collection methods may do, and it is less costly. Further, it may cover a whole country or area and yield a fairly good picture of the diversity and distribution of the problem or problems. As previously mentioned there is seldom or never a homogenous problem in a country and the extent and patterns tend to vary over time. The use of existing institutions also yields the desirable side effect of raising the level of awareness among the professional staffs of drug abuse problems in their populations.

The principle of the sample survey approach is that a selected number of people (a sample) is identified from a specified population, using scientific sampling methods to assure that the sample will be representative of that larger population Information is then gathered from the sample, usually by way of self-administered questionnaires or face-to-face interviews. The advantages of this approach and method is that it is more scientifically accurate than most other data collection and that it allows a more detailed and in-depth study of a given population. It may also be repeated and thus give a good picture of changes of the same population over time.

Most sample surveys concerned with the assessment of drug use and abuse focus on particular types of questions. Such questions concern drug use, what kind of drugs ever used in life time, in the previous twelve months, in the previous thirty days. Questions of age at beginning of drug use and at beginning of regular use are important. The methods by which the drugs are administered are also of great interest for assessment of the seriousness of the problem. A sample survey should include demographic variables such as sex, age, type of society, level of education, study status, employment status and socio-economic level In some countries it may also be useful to include questions of ethnic group, religion, history of immigration, size and composition of family and related questions. Questions on other drug related variables would include law enforcement interventions. Exposure to drug use, attitudes to drugs and drug use, expected social

attitudes towards drug use, risks believed to be associated with drug use etc.

Sample surveys have been used extensively in some countries and there are standarised instruments available. The United Nations have published a Manual on Drug Abuse Assessment (1978) which is easily available, and a technical report of the World Health Organisation (Smart, Hughes and Johnston) was published the same year. The advantage of using such generally accepted instruments, is among others, that survey studies carried out in different countries in a given region will be comparable which is of key importance for policy making and planning on the regional level.

It should be kept in mind that the use of such survey instruments require a fair amount of skill on behalf of the field workers which will use them Experience, and sometimes bitter experience, has shown that such skill will not be acquired without quite intensive training by experts.

Definition of Objectives

When drug abuse problems have been assessed and it has been decided how society will endeavour to cope with it, i.e. when the policy goals have been defined and stated, the time has come to establish programme objectives. Provided this logical sequence of events has been followed it is now up to technical and scientific expert programme planners to propose the ways and means by which the policy goals are most likely to be reached Thus, the policy makers being the strategists of society's reaction to a drug abuse problem, the tactics of implementation are for the programme developers to propose.

As previously noted, in most cases, unfortunately, there is usually a fairly serious drug abuse problem already in existence by the time society begins to react with interventions. Such a situation would call for short-term as well as long-term programme planning. Ideally, an intervention programme against drug abuse would begin with primary prevention, i.e. to try and reduce the incidence of drug abuse. But as there is a considerable prevalence already in existence, this ideal sequence of events is not likely to be followed in practical life. Usually, the immediate interventions will have to be made on the level of secondary prevention. The objective of secondary prevention is

to reduce prevalence, i.e. to reduce the number of already existing drug abusers and/or drug dependent persons. This is done by means of treatment and rehabilitation and it is within this area short-term objectives have to be established. Such objectives should be simple and capable of being measured permitting an objective evaluation of their successful accomplishment. Examples of short-term objectives might be as follows

(1) To bring drug dependent persons into continuing contact with helping staff personnel.
(2) To encourage drug dependent persons to enter into a treatment situation.
(3) To reduce the number of medical and psychological complications associated with the abuse of drugs.
(4) To improve the personal and social functioning of drug dependent persons
(5) To reduce illegal and criminal behaviour associated with abuse of drugs.
(6) To help prevent the development, or reduce the extent of black-market activities in illicit drugs by reducing the demand for them.

The therapeutic objectives noted above would lend themselves to objective measurement. To help in formulating evaluation objectives in quantifiable terms, it is necessary to identify the broad criteria and the specific measures that are to be used, Such criteria and specific measures will be discussed in a later section.

Examples of long term objectives within the area of prevention, treatment and rehabilitation may be

1. To reduce the personal and social costs of dependence on illicit drugs
2. To reduce the incidence of drug dependence.
3. To develop a system of continuous planning and evaluation of programme activities modifying them as necessary according to the evaluation of their effectiveness and the changing needs of the drug situation.

It is possible to measure objectively the degree to which all the objectives mentioned above have been achieved at a certain point in time This can be done by collecting data

from persons in treatment, the drop out rates, employment or school records, arrest lists, statements of family and friends, hospital admissions, self-report information and related data.

When substantial numbers of drug dependent individuals are brought into a treatment setting, they will reduce the demand for illicit drugs by becoming non-consumers. Even if help and care measures are unsuccessful, a temporary reduction of demand occurs. People who are detoxified and then relapse will require less of the drug for the weeks thereafter because they have lost their tolerance. Every successfully treated person also reduces demand for drugs because he no longer persuades non-users to try the drug. In fact, he may become a resource in preventing drug involvement by uninvolved persons.

In addition to broader programme objectives, individual objectives must be set down at the onset of treatment. This is ideally a decision made by both the patient and the staff. The personal objectives must not be unrealistic, otherwise failure is assured. Wide experience in most countries has shown that future unconditional abstinence from drugs as a single objective is not realistic. It may be reached in a limited number of cases, but if there are no alternatives the majority of treated persons will be discouraged and less inclined to re-enter treatment. Inevitably, staff personnel will be disappointed and frustrated and eventually this may lead to programme failures. This in turn may discourage policy makers from relying on treatment and rehabilitation as a means to reach their policy goals. They may then be tempted to place law enforcement and similar measures higher on the priority lists at the cost of treatment and rehabilitation. However, this does not exclude that abstinence and a more acceptable life style is the ideal and may be set down as an individual treatment objective, as long as it is recognised that there have to be other and less ideal alternatives. Abstinence, of course, has the extra advantage of being easily measured

Examples of alternative treatment objectives are the following.

(1) Maintenance of supervised drug use with achievement

In this instance the person is unable to achieve abstinence to opiate after efforts to do so. A programme of maintenance on an opiate may be required for a prolonged period or - exceptionally - permanently for physical or emotional reasons. Nevertheless, he has altered his manner of living so that it conforms more closely to the social norms of the community Criminal activity, arrests, drug related illnesses and unemployment may have ceased or been gradually reduced In setting down this objective it must be realised that it involves serious risks which have to be weighed against the advantages. Those risks are, firstly, that it may meet with great difficulties for the patient eventually to discontinue the maintenance drug. Secondly, unless a maintenance treatment is very meticulously monitored and supervised, the maintenance drug will leak out into the illicit market and thereby worsening the illicit drug problem of the area.

(2) Abstinence without substantial changes in life style

It is known that certain individuals can lose their dependence on drugs without particularly changing their anti-social patterns of behaviour. They might have been involved in criminal behaviour already prior to their drug involvement. Others are obviously unable to learn appropriate ways to function in society. Certainly, the achievement of abstinence is a gain in terms of the general policy goals, but additional measures would have to be taken to improve the anti-social tendancies of the individual.

(3) Reduction in the use of illicit drugs and anti-social or illegal activities.

As already pointed out, the majority of drug dependent persons are unable to remain completely abstinent While therefore not being complete treatment successes, they need not be considered complete failures Their drug requirement will be reduced and their illegal activities to obtain drugs may also be considerably decreased Also, their physical and mental health and social functioning may be considerably improved Follow-up studies of drug dependent persons who have, in the shorter term, been unable to remain abstinent and therefore have undergone multiple short courses of detoxification during some years, have shown that there is a remarkably great chance of becoming abstinent in the long term. The conclusion is that relapses followed by

previously assumed - waste of time and resources.

Preventive measures should, as already mentioned, logically precede measures of treatment and rehabilitation. But for reasons already explained, in practice, prevention in the public health area will mostly be part of the long-term planning. Preventive intervention of other kind such as enactment of new and up-to-date legislation and launching of more effective law enforcement programmes might well take place already in the short-term in order to curtail supply If immediate preventive measures of such kind are to be taken, however, it must be made sure that they will not counteract the objectives of treatment and rehabilitation This is an important co-ordination issue which has already been touched upon and will be further discussed below.

Primary prevention, i e. efforts to prevent the occurrence of a problem or to prevent incidence of drug abuse and dependence is universally recognised as a very complex task. The main reason is that the problem to be prevented is a typical multi-factoral one which has its roots in the very socio-cultural, ideologic/ religious, economical and political fabric of the society in which it occurs. It is therefore not surprising that it will take long time to plan and develop, and its objectives are long term ones. In planning primary prevention and formulating its objectives it is useful to apply the ecological model. In this model the drug abuse problem is seen as an inter-action between the individuals and the drugs in a given type of environment. If primary prevention is going to be even moderately successful, those three determinant factors will have to be dealt with simultaneously and in harmony. Preventive measures and interventions, then, will have to address themselves to the individuals, the drugs and the environment alike. Obviously, such disciplines as sociology, psychology, pedagogics, law, public administration and management, national economics and others will have to be engaged in such a major operation. Above all it takes a truly multi-disciplinary approach, and a well functioning inter-departmental co-ordination. These are difficult things to achieve and that may be the reason why primary preventive programmes against drug abuse have not so often

had to be suspended altogether for complete review of policy and objectives. And this has been very costly.

In stating objectives for primary prevention it is essential to differentiate between drug information on the one hand and drug education on the other. Drug information is a form of communication which simply imparts factual knowledge or transmits learning. It is a fairly limited process in which the main elements are usually information concerning the drugs themselves and their (harmful) effect on people, along with instruction regarding specific drug control legislation and other forms of social control

Drug education on the other hand is a broad range of concerted activities relating to teaching/learning situations and experience which attempts to maximise opportunities for the intellectual, emotional, psychological and physiological development of young people. It involves a total educational process and its general objective is to strengthen the individual's capacity to cope with a situation in which they are running the risk of becoming drug abusers and eventually drug dependent persons An important element in this resistance is the formation of a realistic, well founded and acceptable negative attitude against drug abuse. Ample experience has shown that mere drug information is not sufficient to achieve this desirable attitude formation or change of attitude. From the preventive point of view, then, it is not enough to view illicit drug use or abuse as an isolated facet of behaviour. It comprises patterns of behaviour integrated into a whole set of values , beliefs and behaviours which takes place in the social network of family and friends, as well as against the broader socio-cultural background of the society. Concentration upon only one of those factors, even within the general educational sphere is likely to produce little effect

In primary prevention it is perhaps more important than in any other area of drug abuse control to formulate clear and realistic objectives which can be evaluated. The type of programmes employed to try and change attitudes or even behaviour depends entirely on the nature and extent of those objectives In setting down primary prevention objectives it has to be decided which drugs or types of drug abuse which are most necessary and feasible to concentrate on Should all [illegible] be included or only the ones that are considered to be the

most dangerous? Another important question will be to what extent to reduce drug demand. The objective of reducing to nil the demand for an illicit drug which is already being abused is probably not realistic. If a drug is already being widely used, particularly in societies where drug use is a common phenomenon, the demand for even recently introduced drugs is likely to increase because drug taking is a pattern of behaviour, and a specific drug is only one means of maintaining the pattern. The risk of another and more dangerous type of abuse taking over as a result of the elimination of the target abuse must also be taken into account

A further issue is the choice of target audience for an intended preventive programme. In the past drug users and abusers were considered the main audiences However, education should also be aimed at those who are likely to influence the behaviour of this group. They are at least an equally important audience which must not be neglected This audience includes not only parents and teachers, but people who likely to come into professional contact with drug users such as police, social-workers, the medical profession as well as those who formulate rules, regulations and policies which determine the means of control of drugs by allocation of resources to demand and supply reduction.

Resources and Costs.

It is a fact of life that resources allocated to drug abuse control programmes are, in relative terms, very limited. This is true in the developing as well as in the developed world As noted previously, high level decision makers are inclined to place such programmes rather far down their priority lists. It is not for this Workshop to take issue with decisions made by Governments or Government Administrations or to voice criticism for it is recognised that, particularly in the developing world, there are a host of other priorities within the Health and Social Welfare sector. But it might not be entirely out of place for experts in the field of drug abuse and dependence to do some soul-searching and see if, to some extent, we may have ourselves to blame for the low priority rating. Do we always present our case in such a manner that high level decision makers will realise how important d-

drug abuse problems are still prevailing, and it may take special efforts to overcome them One such attitude might be that drug abuse is mainly a problem of the developed countries and do therefore not need to have high priority in developing countries. Suppression of supply and illicit traffic, if possible with external assistance is seen as the main concern, and developed countries will have to solve their own drug dependence problems. Such an attitude may have been justified some decades ago, but it is clearly obsolete today. Illicit drug demand is a serious problem in very many developing countries, and where there is demand there will always be supply and illicit traffic Thus, almost every country has within its own borders the notorious problem triad of supply, demand and illicit traffic which will have to be dealt with simultaneously Furthermore, all societies in today's world are developing in a broad sense The traditional division of the world in a developed and developing part is disputable as the difference between them lies rathern in what stage or face of development they are at present. Although there may be marginal dissent about the dangers to society of certain drugs, there is global unanimity that drug abuse is a very potent inhibitor of development at any stage Drug abuse means escaping reality to the artificial anaestesia of a dream world and it deprives people of the incentive, drive, goal-orientated activity and tenacity which is necessary to achieve any development. These are qualities which are not immediately tangible and which are not readily evaluated in terms of cost-benefit, but nevertheless they are of primary importance Thus, it may well be that the most important issue concerning resources and costs is how to present these important facts to the ones who are responsible for allocation of resources and costs.

When a drug abuse problem presents itself in a country it often causes anxiety and frustration. The general attitude is frequently that there are no resources at all available to cope with it. In reality, what seems to be the case is that there are no <u>special</u> resources available to deal with it The primary concern of the planners, then, will be to see how already existing resources may be re-allocated and

[illegible] and rehabilitation programme, provided

it is apparent that a special programme is necessary. It is fairly common, in developing countries, that the relatively few cases of drug dependent persons who actively seek treatment are being treated in acute admission units of general hospitals or in regular psychiatric institutions, hospitals or departments As far as short-term detoxification is concerned, this may or may not be satisfactory depending on the number of patients undergoing or in need of such treatment in a given area. Although, from a technical point of view, it is desirable to have special units for drug dependent persons, it is by no means an absolute necessity. As psychiatrists and psychiatric para-medical personnel are used to treating drug dependent persons along with other psychiatric patients, this modality may well be the most practical one in the beginning By and by drug dependent patients may be systematically channeled to one part of a ward or unit, and certain personnel may be specially assigned to look after them. Thus the staff will gain more and more practical experience in managing such patients.

If case finding and special efforts are being directed towards the treatment of drug dependent persons such an arrangement may soon lead to a specialised unit within an already existing hospital or treatment insitution In this way a gradual evolution of a special treatment programme will be feasible without a great deal of additional personnel, localities, equipment or costs. Another advantage with this "organic evolution" is that the drug dependence treatment programme will not stand out as something exclusive and separate from the regular medical services. Experience has shown that this aspect of resource allocation is an important one. Given all other pressing priorities in most developing countries, a negative attitude towards a specialised and exclusive programme is easily built up and it will adversely affect further programme development. This general policy of non-exclusivity is applicable to all aspects of resources and costs of drug dependence programmes in the developing world. A balance has to be struck between non-exclusivity and specialised programme contents. Also, from the point of view

of general medical support services, consultations by other disciplines, laboratory services and logistics, it is practical to run a treatment programme as closely as possible to existing services. The setting up of new and independent units and/ or construction of new blocks or buildings should be avoided for economical and many other reasons. Accordingly, it has been a consistent policy of the international organisations not to assist in institution building There is usually no desperate lack of buildings and/or localities which may, with fairly modest alterations and improvements, be used for drug dependence treatment purposes This is in fact the way such programme have usually started in developed countries, and many successful programmes are in operation in such premises today. What is most important in a drug dependence treatment programme is its content and the experience, devotion, skill and endurance of the staff. Therefore the question of resources and costs are closely related to planning and setting down treatment objectives. If this is done in a realistic manner, taking into account existing resources and possible resource development , there will be no need to state that resources do not exist.

In this context manpower development is of key importance and therefore the subject will be discussed as a separate agenda item of this Workshop. There are, however, a few important points of general interest which might be mentioned already at this juncture. Evidently, in all developing countries, there is a tremendous lack of trained and qualified personnel not to mention specially trained personnel. This is the case at all levels along the line from top administration officials, the medical profession and all categories of para-medical personnel It is self-evident, therefore, that any programme planned on the basis of full staffing by specially trained personnel will be impossible to implement The fact that a few have had the opportunity of studying abroad, in developed countries, or have been awarded fellowships to see programmes elsewhere is obviously a very good asset, and their experience and know-how should be made use of But, at the same time, it should be recognised that this type of training has its limitations, or even serious disadvantages unless it is used very judiciously Experience does show that some people educated

and trained abroad will have a tendancy to over-estimate the importance of the material standards they have seen This may give rise to an "all-or-nothing" attitude, viz either a full blown technically perfect programme run by fully trained and qualified staff, or else no programme at all. The result of such attitude, should it still exist, will be no programme at all in that country or area If a programme is started at a modest scale using available resources with some necessary extra additions and improvements, it will fairly soon have gained enough experience to start practical training of new personnel Key persons in the programme may be given the opportunity to see other programmes, preferably in countries with similar technical development and socio-economic and cultural settings, and exchange experience with their colleagues there In this important context, regional co-operation is of key importance and this is one of the main reasons why we are gathered here this week The openness, understanding and hospitality of our present host country is an excellent example of such co-operation.

It is well known that an important concern of the WHO today is manpower development This policy stresses the importance of using to a much larger extent than before the services of para-medical personnel It also emphasises the need to include, if possible, in programmes important non-medical persons in whom the population has faith and confidence. They may be community leaders, religious people, practitioners of traditional healing methods etc. It should be admitted that occasionally this approach has met with fairly feeble response or has even been found unacceptable by professional groups It is important to emphasise here that the quality and quanity of such personnel vary greatly between countries and areas What is possible and acceptable in one country is not in another. Therefore no generalisations should be made. But it is probably fair to state that there is in those categories a substantial reserve of manpower which has not been sufficiently exploited. With additional training, guidance and sometimes attitude formation, the importance of such

accessory manpower with their special experience and knowledge of people's wishes and needs should not be under-estimated, particularly in a situation where the strictest economy with qualified personnel has to be exercised.

As far as financial costs of drug dependence programmes are concerned, there are no "shopping lists" showing the actual cost of individual programmes It goes almost without saying that financial costs vary immensely, and accurate comparisons between programmes and countries are very difficult to make. To this should also be added the constant inflation which is afflicting the whole world The costs estimates of a programme last year are sure to be obsolete today Some fairly trivial observations may of course be made The simpler the design of a programme, the less expensive it will be. And there is no evidence to show that complicated, exclusive and elaborate programmes are any more effective than simple ones. Programmes which emphasise out-patient care and community care are always less expensive than ones based on institutionalisation and in-patient care. Elaborate technical equipment is expensive to buy, run and maintain But elaborate equipment is not necessary in drug dependence treatment programmes. Almost invariably, there are requests for elaborate laboratory equipment, e g. for analysis of drugs in body fluids etc which may be necessary for the monitoring of treatment programmes Advanced laboratory technology has now developed methods which are surprisingly cheap and accurate and which may be used in very primitive settings by people with fairly modest special training Whatever else is needed in terms of medical equipment may well be fitted into the routine equipment of a general hospital or treatment centre.

In a drug dependence treatment programme which relies heavily on out-patient and community care - which is desirable - travelling is unavoidable It is decidedly wiser to spend a little more funds on simple vehicles which can be locally maintained, and travelling costs, than on buildings and equipment The personal presence of leading persons of the

programme in various parts of the area is of great importance. In conclusion, in comparative terms, it may be truthfully stated that drug dependence treatment programmes are not the most expensive. There are indeed many other health programmes which require higher costs

Legislation.

Some aspects of legislation have already been discussed in the previous sections dealing with Policy Development, Assessment of Problems and Development of Objectives, because all these activities are influenced by or may require special legislation or changes of legislation To summarise briefly, there are three main categories of legislation which are of special importance for the successful planning and implementation of treatment programmes These are the following -

Legislation concerning drug related crime,

Legislation concerning compulsory and/or voluntary treatment, and

Legislation on drug control

The point has already been made that if drug dependent persons who, because of the nature of their condition, will be handling and possessing illicit drugs, are considered as criminals (rather than sick persons in need of help and care) and legislation to that effect is strongly enforced, they will show up neither for assessment nor for treatment Thus, draconic, rigid and indiscriminate legislation in this area may be deterrent rather than conducive to treatment Without going into details, there are plenty of examples in the world today where a reasonable balance has been struck between the need to deter from crime and invite to treatment Legal advice in these matters may be obtained through the international organisations, in particular the UN Division of Narcotic Drugs.

The importance of the issue of compulsory vs. voluntary treatment has also been discussed The importance of cultural social and political background as well as public attitudes are obvious In most countries with experience of drug dependence it has become clear that there is need for the provision of both types of treatment. Whether or not a drug dependent person needs compulsory treatment is not only a legal issue. It is to a large extent a medical and social

issue as well, and it has to do with the type of dependence, the seriousness of it and the patient's attitude and, last but not least, what resources are available for effective treatment. It has been proven to satisfaction that just locking up drug dependent persons in an institution does not give good results. The majority of them will relapse almost immediately after discharge and virtually no institution, including maximum security prisons, have been able to stop the smuggling in of drugs. A compromise which has been found useful in many countries is to have voluntary treatment as the normal procedure, and reserve the possibility of compulsory treatment as exception in specially difficult, complicated or dangerous cases.

Finally, drug control legislation is of considerable importance with regard to treatment programmes There is no need to speak to this audience about control legislation related to illicit drugs as defined by the international treaties Such legislation exists almost everywhere and it is usually in line with the existing conventions. The problems usually lie in their effective enforcement.

But the importance of the closely related type of legislation which deals with control of licit drugs in general is rather frequently over-looked There is enough evidence to suggest a close relationship between illicit and licit drug demand. The most obvious evidence of this is that multiple drug abuse is rapidly spreading almost everywhere This creates very difficult problems at the planning as well as the implementation levels. As already pointed out in the section on Policy Development there is ample evidence that one type of drug abuse may be replaced by another if the first is eliminated or strongly reduced It is therefore necessary to control as effectively as possible the handling of licit drugs. Unfortunately, in many countries today, the control of production, import, trade, sale and administration of regularly used medical drugs is far from satisfactorily controlled. Regulations and habits related to drug prescription are usually too lenient. It takes not only effective legislation but much insight, goodwill and collaboration from the part of the pharmaceutical industry as well as the medical and

pharmaceutical professions in order to create the basis for such control. Experience also shows that it is not possible to exercise effective control of dependence producing drugs only. No Government can afford to have a special administration for that sole purpose. It has to be integrated with the general drug control administration which will have to be strengthened In short, it is not possible to exercise any appreciable control of dependence producing psychotropic substances, e.g barbiturates and tranquillisers, in a country where anyone can buy any type of antibiotic over the counter in a drug store. This might well be one of the most important legislative issues which public health officials will have to deal with in the area of drug abuse control

National Advisory Boards and Co-ordination Bodies.

It is apparent already at the policy making and planning stage that there has to be effective co-ordination between a number of agencies and departments in order to implement a successful drug dependence prevention, treatment and rehabilitation programme. In previous sections a number of concerned disciplines, agencies, and authorities have been mentioned. Besides Health and Social Welfare there are Administration, Planning, Development, Education, Justice, Law Enforcement, Foreign Affairs, and not least Finance It is highly desirable, and expected, that all these authorities are involved in a nation-wide effort to contain drug abuse. But if each one of them has its own policy, planning and implementation, the results will probably be confusing, Although , there is consensus today that there has to be inter-agency co-ordination in the drug abuse control field, the co-ordination problem has usually not been solved to satisfaction There are very strong traditions of independence in the various departments and ministries, and communication is often poor. Whereas it is easy to state that a national co-ordination body should exist, it is very hard to make any generalised prescription as to how such a body should be composed and how it should function in the individual case. The reason is the vast differences in concept, history, tradition, constitution, political background and development of national administrations An administrative co-ordination problem

in a highly centralised national state is bound to be very differen from that of a federation of a number of culturally and ethnically different states or provinces. But whatever the structure of the national administration there is one element which is of key importance in achieving reasonable co-ordination and that is finance. Every programme planning and implementation needs special financement. The agency or body which is responsible for co-ordination must have access to this tool It must be made possible to decisively influence the allocation of funds, affording of grants etc Without the use of this steering mechanism a co-ordination body might well become a "paper tiger" Budgets must be built into programmes and conditions of co-ordinative nature must be attached to the financement of the budgets.

In recent years a number of structures, national or regional, have been developed which may provide guidelines regarding what systems might be considered, taking an account of political, constitutional and other factors. The order in which they are presented here should not be taken as preferential or as reflecting successes or failures in the experience with them since a number of quite different variables have shaped the work of these various organisational structures.

In countries where drug programmes are to be administered by a single level of Government, co-ordination is frequently effected through inter-ministerial, inter-agency or inter-departmental committees. On such committees sit the permanent heads (or their designates) of each ministry, department or other Government agency involved in administering programmes related to the reduction of illicit demand for drugs The composition of such committees will be determined by the terms of reference of the committee but it is normally assumed that its membership will be broad enough to ensure co-ordination of at least the major programmes related to drugs.

It is worth noting that while such a committee structure can make co-ordination possible, it cannot ensure it absolutely, since it lacks fiscal control other than the control each member of the committee has over the resources of his own agency. That is, the committee itself normally has no power

to exert financial control as means of ensuring co-ordination. The committee mechanism can, however, make possible at least some level of co-ordination through timing the stages of programme development.

A second, more typically co-ordinating structure, takes the form of a national commission. These are presently constituted in a number of countries. Normally, the function of such a national commission is to plan, organise and co-ordinate the relevant efforts at the national level Its membership can be drawn from any number of concerned Government Agencies or from agencies outside Government The national commission differs essentially from the inter-agency committee described above in that while committee members report to their individual agencies, the commission as a whole usually reports to the Government - in some cases directly to the head of state or his designate. Unlike, most committees, the commission is usually provided with a core staff and secretary who are responsible for carrying out such programmes as research, training and the day to day co-ordination among the various other agencies involved in the programmes. Many national commissions also utilise the services of outside expert advisors from time to time.

It will be obvious from the above that the national commission structure can ensure a more viable and effective form of co-ordination than the inter-agency committee It is, however, a more costly structure since it must be given its own operation budget and full time core staff - expenditure not usually encountered by the inter-agency committee. It becomes important therefore to determine whether the tighter co-ordination achieved through the national commission structure makes possible efficiencies which exceeds the operating costs of the commission.

Another structure employed particularly by countries having a federal form of Government is the national institute, national centre or similar agency. The institute/centre structure can function in any of a number of ways. It can serve exclusively as a resource centre, providing finances and guidance to other jurisdictions and, through the impact it makes in this role, can effectively co-ordinate at least

the major trust of programmes in those jurisdictions and in the country as a whole. It can also function as a large programme agency, itself engaging in research, re-production of documentation, evaluations and providing administrative counselling to other levels of Government. This structure can function, evidently, only where quite large financial resources are available and might therefore not be the choice of most developing countries.

Identification of Ministerial Responsibilities

It is obviously not within the terms of references for outside advisers to set criteria for the responsibilities of various ministries. It may however be legitimate to propose that those responsibilities must be clearly identified and spelled out. It is a fact that in many countries there is unnecessary duplication of effort between ministries or departments. In certain countries, for instance, drug control administration orginated and grew out of the Department of Revenue because the production and sale of narcotic raw material was an important source of revenue. Another control administration developed in the Ministry of Justice or the Interior because of the importance of the illicit traffic problem Most Governments have found it natural to let the Department of Health, nowadays frequently merged with that of Social Welfare, be responsible for drug abuse control programmes. In the case of treatment and rehabilitation this would seem to be a logical solution. But whatever responsibilities the respective ministries may have it is strongly recommended that a good look is being taken at them already at the planning and policy making stage. It is of course equally necessary that everybody concerned in the ministries are fully informed about their own as well as the other ministries' responsibilities The best form for such communication is a co-ordination body as discussed in the foregoing section.

Role of Non-Governmental Organisations

What has been discussed so far have been activities and responsibilities on Governmental and Ministerial levels. But prevention , treatment and rehabilitation programmes

they need as broad public support as possible. It has repeatedly been pointed out that policies, objectives, and programmes which are foreign to, or even at odds with deeply rooted tradition and public attitudes run a high risk of failure. Therefore it is wise to engage non-Governmental voluntary organisation in the programmes. In countries where such organisations as youth organisations, labour organisations, sports organisations, religious ideological or political organisations exist, their support is very essential because they have knowledge, experience and insight into the every day life style of their membership. They may play an important role, particularly in attitude formation and in social re-integration of treated persons. There are a number of examples of countries in which voluntary non-Governmental organisations are given Governmental financial support for including drug abuse prevention work in their programmes. Provided there is good policy guidances this is usually well spent money and because of the voluntary element involved it does not need to be expensive

In many countries the most important non-Governmental organisations are the religious ones

Evaluation

Evaluation has become more than a household word in national as well as international programme planning. It is taken for granted today that there is a built-in evaluation element in every programme of prevention, treatment and rehabilitation. In fact, this is usually a condition for obtaining grants or having funds allocated. Furthermore, it is a universally accepted fact that it is possible, although by no means easy, to carry out scientifically acceptable evaluations.

Specific issues related to evaluation of treatment and rehabilitation programmes will be dealt with during the discussion of the second background paper to this Workshop. A detailed discussion of evaluation will therefore not be needed at this point. There are, however, some general considerations which should be observed by those who plan the strategy and tactics of programmes. It was pointed out in a previous section of this paper that it is essential that policy goals and programme objectives are set down in such a way that they can be subject to evaluation

it is important to keep in mind the seemingly trivial truth that it is no use trying to evaluate objectives which are not possible to evaluate.

In broad terms, programme evaluation has two main purposes, namely -

(1) To determine how successful the treatment has been in order to justify continuation of the project.

(2) To inform the programme direction of short-comings and deficiencies so that adjustments and improvements can be made.

The minimum requirements for evaluative studies are -

(1) Clear operational definitions,

(2) A precise statement of the programme objectives to be evaluated,

(3) The criteria and particular measures to be used.

A somewhat controversial issue which has been the subject of much discussion in the past is who should make the evaluation. The difficulty encountered here is to strike the delicate balance between maximum objectivity and the experience and knowledge of the programme under study which is necessary to make an evaluation study meaningful In this context it has also sometimes been observed that the attitude of the programmes staff towards outside evaluation is not always a positive one This in itself is perfectly understandable as the staff may fear that their efforts and engagement in the programme may not be fully appreciated in an evaluation study. Also continued jobs, grants, etc will, as a matter of course, be at stake when the results of an evaluation will be reviewed at higher administrative levels In the past it was almost taken for granted that evaluation should be entirely carried out by outside experts or evaluation teams However, such studies were often criticised for their lack of insight in the practical everyday programme work and the criteria and values upon which the programmes were based. The consequence was that the results were seriously questioned and even challenged, which made their interpretation difficult. In some countries the pendulum swung to the other extreme, viz. programmes could and should only be evaluated by the ones involved in it, sometimes also including the treated persons. Evidently, the

lack of objectivity often invalidated such studies, and there were sometimes difficulties in having them carried out at all. The most generally accepted approach today is to have collaborative evaluation, i.e. the studies are carried out in close collaboration between an outside expert or evaluation team and key representatives of the programme staff.

In the debate on evaluation the issue of "hard" vs. "soft" data has also frequently been brought up. "Hard" data would imply strictly objective quantified data of the type required in research within the natural sciences. The nature of drug abuse and dependence, however, is undoubtedly such that it is difficult and very expensive, if not impossible to arrive at such data in an evaluation study It might be somewhat easier in treatment programmes than in prevention programmes. In later years it has become apparent and accepted that unconditional insistance on "hard" data is counterproductive. The methods used in evaluative research are closely related to sociological and psychiatric research and within those disciplines so-called "soft" data are almost universally accepted. The most illustrative example of "soft" data are data derived from self-administered questionnaires by persons who have undergone treatment.

In conclusion, then, whereas evaluation certainly is a pre-requisite for programme continuation, it is no use having such requirements on the studies as to deter people from carrying them out properly.

Constraints and Future Needs

Many of the issues discussed in previous sections have given ample illustrations of the constraints which public Health and Social Welfare authorities in developing countries are faced with. The most obvious and over-riding constraint is the general lack of resources. The second most important restraint is probably the low priority rating usually afforded drug abuse programmes in the developing world, because of the host of other important priorities in the Health and Social Welfare area. Those two factors in combination do indeed constitute very formidable constraints in planning, implementation and continuation of programmes.

The most serious among all the lacks of resources is

The most important problem to be faced by planners and decision makers is how to use the few experts they have at their disposal in the most economical way. And that is usually not by having them doing every day routine work in programmes. It is probably far more more economical to engage them in Government work, against remuneration which will at least compensate them for loss of other income, and let them be in charge of planning, co-ordination, monitoring and the training of others. It has to be accepted that, in the beginning, programmes will be carried out by relatively unqualified personnel. But under the guidance of a few highly qualified leading persons there is already convincing evidence of good results of programmes in some countries High level planners and decision makers, in this respect as well as in all others, may be expected to see beyond the immediate obstacles of such a policy

The major constraint of low relative priority rating has already been discussed and it is of course the hope that a workshop like the present one will contribute to change the situation It may be useful in this context to make a few observations regarding outside assistance and aid, be it bilaterial or multilaterial. Given the present, and probably future, policies and resources of assistance-providing organisations and agencies it would not be realistic to expect that outside assistance will ever be of such magnitude that it can entirely support programmes. It does not do it today and it is hard to believe that it ever will. International experience to-date has clearly shown that programmes which have been initiated and started irrespective of outside assistance are the ones which have been most successful and therefore the most interesting in the eyes of assistance-giving organisations.

In planning this Workshop a special meeting convened in Geneva in the early part of 1978 In his opening address to this meeting the Director of Mental Health in WHO Headquarters summarised briefly the WHO policy on which international and particularly regional collaboration in mental health is based. The present policy is characterised primarily

by the concept of co-operation between countries and the main role of the World Health Organisation is to facilitate such a policy. This pertains to drug dependence programmes as well. The Workshop would be an example of this policy where participants are expected to take an active part and contribute substantially. He expected that the participants would not only consider the Workshop as a temporary event but would follow up its conclusions and recommendations in their respective countries in collaborating with each other. The most important future need, then, besides increased resources, higher priority and integration in existing health programmes, would be better internal and external co-ordination particularly on the regional level. Initiative and active contributions by individual Governments will then be facilitated and supported by the World Health Organisation.
