Coping with substance abuse: a many-sided task

Steady progress is being made towards understanding the use of drugs for non-therapeutic purposes. The associated problems are increasingly regarded as having psychological, biological and social dimensions. There is a growing acceptance that the hazardous consumption of alcohol and other drugs can both result from and exacerbate poor socioeconomic conditions. Sustained action to combat drug-related problems is needed on a broad front; there is no panacea.

Once considered a scourge of only the industrialized countries, drugs are now recognized as having severe effects not only on health but also on the social and economic fabric of many developing countries. During recent decades, alcohol consumption has been declining in most Western countries but increasing rapidly in many developing countries where there has been a concomitant rise in alcohol-related problems. The realization that the spread of HIV infection is being accelerated in various Asian and South American countries by the sharing of injection equipment has led to an increased awareness of problems resulting from the use of illicit drugs in the developing world.

In February 1990, the United Nations held a Special Session on Narcotics which adopted a global plan of action (including reorganization of the United Nations drug agencies) and a political declaration. A ministerial summit dealt with demand reduction and cocaine in April of the same year in London, and in the following September the World Health Organization established its Programme on Substance Abuse.

As used in the present article, the term “drugs” refers to psychoactive or mood-altering substances that tend to be consumed for pleasurable rather than therapeutic purposes. Acute effects are associated predominantly with intoxication and often manifest themselves as behavioural problems, such as violence; chronic effects often involve physical damage to body organs. Acute effects are
determined by the type of drug, the dose ingested, the mode of administration, previous experience with the drug or drugs of the same or similar groups, the frame of mind of the person taking the drug, the ambience where the drug is consumed and other factors. Acute harmful effects usually result from pharmacological actions that have been exaggerated because of the ingestion of a large dose. Chronic effects depend not only on the individual's history of drug consumption—dose, frequency, duration, mode of administration and pattern of use—but also on the toxicity of the drug or of impurities associated with it.

**Types of drug**

Although drugs are sometimes classified according to their legal status, those that are legal in one country may be illegal in others; furthermore, the legal status of a drug in a particular country may change. In many countries, alcohol and tobacco are legal drugs and treated quite separately from illicit drugs, while in others the drinking of perhaps the most widely familiar drugs are the sedatives or depressants, of which alcohol is probably the best known. Drugs derived from the opium poppy or synthetically manufactured to resemble them are depressants, as are the barbiturates and the benzodiazepines. They act on the brain, causing sedation. If taken in very large quantities, they can cause profound sedation or unconsciousness. Their effects are additive so that sedative action is increased if different substances are taken together. When the taking of sedative drugs is stopped after a period of consumption, a withdrawal syndrome may develop. There are similarities in the withdrawal syndromes associated with different types of depressant drug. Alcohol is sometimes incorrectly thought to have stimulant properties because of the association of drinking with aggressive behaviour, which actually occurs because alcohol depresses the inhibitory centres of the brain before the excitatory centres.

Stimulant drugs include the amphetamines and cocaine, which are relatively powerful, and weaker substances such as caffeine. The psychoactive ingredient in betel nut, which is consumed widely in the Western Pacific region, is achrecholine; this has stimulant and mild hallucinogenic properties. Drugs in this group all have an excitatory effect on the brain. Stimulant drugs in large doses can cause coma but the effect of small doses is mild excitement. The discontinuation of stimulant drugs after they have been taken for a period does not result in a stereotyped withdrawal syndrome, as is common with depressant drugs. However, the sudden cessation of psychostimulants may be unpleasant and lead to a strong desire to resume consumption.

The hallucinogens cause hallucinations or disorders of perception or sensation. Lysergic acid diethylamide (LSD),

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even small quantities of alcohol is unacceptable socially whereas cannabis is regarded as relatively innocuous. The classification of drugs according to their pharmacological mode of action is a more helpful way of understanding them.
mescaline, peyote, and cannabis are members of this group. MDA (3,4-methylenedioxy-amphetamine) and some of the drugs referred to as designer drugs have both stimulant and hallucinogenic properties. There is no true withdrawal syndrome when the taking of hallucinogenic drugs is suddenly stopped although this is still a subject of debate where cannabis is concerned.

Tobacco is probably one of the most widely taken drugs. Its psychoactive component is nicotine, which either stimulates or sedates, depending on the way it is smoked. Sudden cessation after several years of smoking may result in withdrawal symptoms of variable intensity. Most of the complications of tobacco smoking are caused by tars and other noxious compounds rather than by nicotine. However, the desire to continue smoking is largely determined by the nicotine content.

In many parts of the world, prescription drugs of various kinds are obtained improperly and used for their psychoactive properties rather than for therapeutic purposes. Many other drugs taken around the world are harder to classify. Kava, a mild hallucinogen and sedative, is often consumed during rituals in Polynesia. Khat, a mild stimulant, is taken in some parts of the Middle East.

**How drugs act**

Alcohol acts on fat-filled membranes in nervous tissue in the brain. Drugs derived from the opium poppy, such as morphine, heroin and codeine, act on a family of specific receptors in the brain. The human body produces its own chemical messenger substances, resembling opioids, which act on the same receptors. The benzodiazepines and cannabis act on their own specific receptors in the brain although no endogenous substances comparable to the human opioid messengers have yet been identified in respect of these drugs. The effects of cocaine and other stimulants are mediated through several types of neurotransmitters rather than specific receptors.

**Individuals with a history of psychiatric disorders are more likely than other people to develop drug problems.**

The intensity of action of a drug is influenced by, among other factors, its pharmacological nature and the rate of increase of its concentration in the blood reaching the brain. This in turn depends on the quantity ingested, the route of administration, the absorption characteristics of the drug which are affected by the way it is taken, and the way the individual handles it. The effect of drugs is influenced by the individual’s sex, weight, state of health, previous experience of taking drugs, and the type and quantity of other drugs recently consumed. Psychological factors are at least as important as pharmacological ones in determining a person’s reaction to a drug. The expected effect is one of the most important psychological factors, and to a large extent this is determined by social and cultural influences.

**How drugs are taken**

Drugs may be taken by swallowing, smoking (on their own or with tobacco), inhalation of vapour, snorting through the nostrils, and injecting. With swallowing, the concentration of a drug in the blood stream
rises relatively slowly. Usually, the drug has to leave the stomach before maximal absorption can take place; by the time it reaches the brain it has been greatly diluted in the blood.

Drugs are sometimes self-administered into veins or muscles or under the skin. Intravenous injection is probably the most common form of nonmedical drug injecting, the veins on the inside of the elbow being the most frequently used. A drug injected into a vein of the arm takes about 20 seconds to reach the brain. The increase in concentration of a drug in the blood reaching the brain is much greater following this kind of administration than when the same drug is taken by mouth. A drug injected subcutaneously or intramuscularly is absorbed much more slowly than when injected directly into a vein.

Drugs may be heated to achieve vaporization and then inhaled. The lungs have a very large surface area and so the absorption of inhaled or smoked drugs is very efficient. Following inhalation the delay between ingestion in the lungs and arrival at the brain is about seven seconds. There is very little opportunity for drugs to mix with blood from other parts of the body and the concentration of drugs reaching the brain is very high. Consequently, the inhalation of drug vapour or smoke produces a far more pronounced effect than other modes of administration. However, if drugs are perceived to be expensive, smoking or inhalation may be regarded as wasteful in comparison with injecting, since some smoke or vapour inevitably escapes.

**Effect of long-term drug use**

The effect of a drug is influenced considerably by the individual’s experience of it or similar substances. The first encounter with a drug is often unpleasant. Following a period of regular consumption, metabolic tolerance may develop. This means that the drug may be broken down more rapidly and exert less of an effect than when consumed by someone for the first time. Alternatively, prolonged exposure may damage certain organs so that drugs are metabolized less efficiently and consequently have enhanced effects. Neurological tolerance can occur following prolonged exposure to some drugs, whereby they exert a smaller effect than expected because the brain becomes used to them. However, reverse tolerance also occurs, in which exaggerated effects are produced in individuals who have had extensive exposure to a drug. Tolerance occurs to some extent even on first exposure. Thus individuals drinking alcohol for the first time may demonstrate a greater effect at a given blood alcohol level when the concentration is rising than when it is falling.

The state of mind of people who consume drugs has a very powerful influence on the effects of the drugs. If a person who is about to take a drug is anxious, or fearful of the consequences, the likelihood that the experience will be unpleasant is heightened. Expectations of drugs are strongly influenced by a person’s peers and by the attitudes in society. On the other hand, the consumption of a drug by an individual who is feeling cheerful and has pleasurable
Substance abuse: the global situation

Substance abuse has become one of the most widespread and serious public health problems this century. Involving an increasingly broad spectrum of drugs and alcohol, the epidemic of substance abuse is affecting countries everywhere, both developed and developing. As both a health and social problem in its own right, and also as a major underlying factor in a range of other physical and psychosocial health problems, substance abuse is currently influencing more people and broader age groups than ever before.

The escalation in the abuse of drugs such as cocaine and heroin has occurred in addition to an already high prevalence of other psychoactive drug abuse, involving cannabis, tranquillizers, depressants, stimulants and solvents. In many countries these are now being used in various combinations and are often associated with the use of alcohol, itself a major cause of morbidity and mortality. The excessive use of alcohol is also becoming more prevalent, especially in developing countries, where its health and social effects have become a major economic drain on both health and social services.

Substance abuse, including single episodes and occasional intoxication, affects health and social well-being in a variety of ways. Some have been more clearly described than others, but all are pervasive and a serious threat to national health and welfare. In recent years the relationship between drug injecting and HIV transmission has become a major concern in many parts of the world. Less well recognized, but statistically and medically more significant in terms of its overall societal impact, is the relationship between substance abuse and hepatitis, tuberculosis, cardiovascular diseases, cirrhosis and neuropsychiatric disorders; disinhibition and sexually-transmitted diseases; unwanted pregnancy and complications in pregnancy including fetal distress; and violence and suicide.

The abuse of drugs and alcohol constitutes one of the main causes of impairment of social competence and performance. In the case of otherwise healthy young people, for example, behavioural problems associated with substance abuse are currently among the most important reasons for interrupted social and intellectual development. In the industrial and educational sectors, substance abuse accounts for more workdays lost than any other single disease and is a major cause of poor performance at work; just as on the road and in the home, it has become the leading cause of accidents and injuries. It has also become a critical factor in family disorganization and breakdown where the economic and social costs involved in chronic substance abuse are a major burden on family finances for food, education, and welfare.

Although the problem is a universal one, developing countries and poor communities, where economic resources are already scarce, are often the worst affected. The combined, and often synergistic, effects of substance abuse and poverty have proved to be a major impediment to socioeconomic development, contributing not only to the emergence of new health and social problems, but also to the institutionalization of old ones.
associations with it is likely to result in an enjoyable experience.

The ambience where psychoactive substances are consumed has a considerable bearing on the effects produced. If the consumption of a drug is sanctioned by the society where it occurs, the individual is likely to experience the effects that the community associates with the drug in question. Illegal drugs consumed in a sordid environment under unhygienic conditions are likely to have a very different effect from the consumption of a legal drug ingested in attractive surroundings where it is an accepted part of social rituals.

Problems arising

The use of drugs may have serious consequences for both the individuals directly involved and society in general. The behavioural problems associated with acute consumption are usually very conspicuous and disruptive. Medical complications linked to chronic consumption are often insidious and may not become apparent until

| Whether the consumption of a drug is hazardous depends largely on its pharmacology and toxic effects. |

irreparable damage has been done. Many of the physical sequelae of illicit drug use are caused by the mode of administration. For example, in the Andean mountains there are relatively few side-effects associated with the consumption of cocaine in the form of the coca leaf. However, when the same active ingredient is injected or a free-based vaporized form of the drug is inhaled, compulsion to use the substance repeatedly and other complications are far more common.

Some individuals continue to consume drugs despite suffering severe illness, loss of relationships and family, unemployment, financial insecurity, loss of liberty, and other dire complications. This happens because of their pleasurable effects, the deeply ingrained habit, and a fear of withdrawal symptoms and other possible consequences associated with cessation. Drug-seeking behaviour can perhaps be understood when it is appreciated that the individual often balances the virtual certainty of gratification in the short term against the slight possibility of negative consequences in the more distant future.

Dependence, which is particularly associated with the use of depressants, has both subjective elements such as a compulsion to consume a drug, and objective characteristics such as withdrawal symptoms following abrupt cessation of consumption. Drug-taking by dependent individuals often varies little from day to day. Usually a particular variety of a drug is preferred. The daily routine may be planned to ensure that the drug is always available, sometimes by concealing supplies. For many years it was thought that dependence was an all-or-nothing phenomenon, but it is now increasingly seen as having a scale of severity. This has profound implications for both prevention and treatment. A knowledge of dependence is vital if the behaviour commonly seen in persons seeking depressants is to be understood.

One of the most perplexing aspects of drug consumption is the phenomenon of relapse: a formerly drug-dependent individual may, after abstaining for many years, return to uncontrolled drug use without any obvious reason or precipitating factor. Relapse occurs
with all types of drugs but the risk of it doing so declines over time.

Research into drug use mainly involves clinical populations. However, community samples may provide a very different picture. In clinical populations it is often the case that relatively few people have a problem with a particular drug, yet afflicted individuals may be burdened with complications of great severity. Community studies indicate that problems are much more diffusely spread throughout populations, many people experiencing minor difficulties. When a community study is repeated in a given population after an interval of some years, it is often found that most of the individuals experiencing problems are not the same ones as previously did so, and that people who continue to experience drug-related problems over a long period may suffer in different ways as time proceeds.

### Antecedents

The factors that lead to experimentation with and hazardous consumption of drugs are poorly understood. If the public health model of agent, host and environment is followed, drugs are the agent, the consumer is the host, and the myriad cultural, political, religious and historical aspects of society are the environment.

Whether the consumption of a drug is hazardous depends largely on its pharmacology and toxic effects. Weak intoxicants such as achrecholine (in betel nut) are unlikely to be associated with adverse outcomes following acute exposure. Relatively powerful intoxicants such as alcohol are more likely to have problems associated with them. The probability that a drug will give rise to complications following chronic exposure depends on its inherent toxicity, whether it is taken repetitively, and the route of administration. Compulsive and repetitive use is unusual following initial exposure to most drugs. In general, people who drink alcohol for the first time at an early age continue to consume moderate quantities throughout life and are capable of deciding when and when not to drink. Chronic excessive drinking, periodic bouts of heavy drinking, and pathological secretive drinking are uncommon. On the other hand, most people who become regular cigarette smokers consume a fixed quantity every day and show evidence of dependence on nicotine. Heroin is probably somewhere between alcohol and nicotine in that most persons injecting the drug do so intermittently rather than in a dependent manner. The addictiveness of drugs can be tested with laboratory animals and human ex-addicts, although the interpretation of this kind of research is anything but straightforward.

It is not known why some individuals are desperate to try drugs and then go on to consume them dangerously, while others are content to lead safer lives or perhaps try different risk-taking pastimes. The addictive personality is firmly entrenched in folklore but less well supported by scientific evidence. Numerous studies, backed by clinical experience, suggest that many people with severe complications resulting from alcohol or other drugs have psychological or...
WHO’s Programme on Substance Abuse

The overall goals of WHO’s Programme on Substance Abuse are to reduce the impact that existing substance abuse has on the health and welfare of populations everywhere and to prevent new substance abuse in all its forms. Specifically the objectives are:

- to reduce the demand for addictive substances;
- to reduce the impact of substance abuse on the health and welfare of individuals and families;
- to develop effective approaches to the treatment of substance dependence and associated diseases;
- to collaborate in controlling the supply and use of licit psychoactive substances; and
- to integrate relevant health components into all development programmes designed to reduce the supply of illicit narcotic drugs.

The Programme aims to stimulate innovative thinking on this problem and to coordinate new research and interventions that respond to national needs and benefit from the experience and support of international scientists and institutions.

psychiatric problems. Whether these are the cause or the result of prolonged excessive drug consumption is difficult to know. However, there can be little doubt that individuals with a history of psychiatric disorders are more likely than other people to develop drug problems.

To have suggested that alcoholism was an inherited disorder would have been heresy only a few years ago. But research on twins, siblings and half-siblings, the non-drinking sons of male alcoholics, and laboratory animals has shown that the probability of developing alcohol-related problems is affected by genetic factors. Furthermore, people who break down alcohol in a particular, genetically controlled, way—resulting in the production of large quantities of an unpleasant metabolite—are less likely than others to develop drinking problems. The observation that drinking and drug problems tended to run in families was made in clinical practice long before these insights began to accumulate as a result of research.

In recent years, increasing attention has been paid to the possibility that drinking problems have much in common with learned behaviour. The desire to consume alcohol is understood to be triggered by external cues, such as the sight of beverage alcohol, or internal ones, such as depression or anxiety. It is likely that many of the findings relating to the importance of the consumer’s attitude and environment apply to other drugs in addition to alcohol.
The striking differences in drug consumption and in the prevalence of problems resulting from it between different countries or within countries at different times show that, however powerful biological and psychological determinants may be, social factors are also of critical importance. Attitudes to the consumption of particular drugs or to particular drug-related problems range from intolerance to permissiveness in different countries, and views may change with the passage of time. For example, in some countries the smoking of opium is accepted while the consumption of alcohol is regarded with concern; in others the reverse is true.

**Prevention of drug-related problems**

The harmful consequences of drug use can be diminished by reducing consumption and making it less hazardous. Consumption can be made less dangerous without reducing it. Thus the compulsory wearing of safety belts by drivers and passengers in cars in some industrialized countries has helped to reduce alcohol-related road deaths even though average alcohol consumption has remained static.

Drug consumption can be reduced at the societal level by both restricting the supply and decreasing the demand. The former may involve reducing the cultivation of the plants such as opium and coca, decreasing the production of drugs such as heroin and cocaine, and interrupting their transportation, distribution and sale. The use of legal drugs such as alcohol or tobacco can be limited by, for example, controlling the number and type of outlets and banning consumption below a certain age.

Reducing demand requires changes in social attitudes. This can be achieved through mass campaigns, school education projects, special attention to high-risk populations, and so on. Alternatives to drug use have been promoted among young people, alcohol and tobacco advertisements have been regulated and otherwise restricted, and the young have been encouraged to resist peer pressure. The substantial changes in patterns of smoking seen in many Western countries in recent decades would not have been possible without major changes in public attitudes to the habit.

Patterns of drug consumption in society frequently change. It is often difficult to ascertain whether this happens because of fluctuations in supply or demand. In recent years greater efforts have been made to reduce demand than to restrict supply. Not only are the consequences of drug use more widely appreciated than formerly, but it is increasingly recognized that the benefits of measures introduced to restrict supply are often difficult to demonstrate while their costs are substantial and rising. It is estimated that global opium and coca production increased significantly in each of the last ten years except 1991, when a slight decrease occurred due largely to adverse weather. The proceeds of the global illicit drug trade is estimated to exceed US$ 300 000 million annually, over half of which is assumed to be profit.

The consumption of alcohol and tobacco usually declines following an increase in price or a decrease in availability. If such changes are introduced suddenly, ways of circumventing legal channels may be employed, including smuggling and domestic production. It is generally accepted that achieving a sustained reduction in average alcohol and tobacco consumption is an important element in the prevention of problems related to these drugs. The demand for alcohol and tobacco is also influenced by social attitudes, and public opinion can be swayed by government
advertising campaigns warning of the consequences of drug use. On the other hand, advertising by the alcohol and tobacco industries may cause the public to become more permissive in respect of the consumption of these drugs and help to develop a climate of opinion less receptive to effective prevention policies.

Drug use has become a sensitive issue in many communities, and sometimes severe penalties have been introduced to deter people from starting to take drugs or increasing their intake. Measuring the benefits and costs of intervention is usually difficult and scientific evidence of the effectiveness of responses to drug-related problems is often meagre. The issue of drug-taking is often bound up with that of personal values. There is relatively little disagreement about the toxicity of individual drugs but the ways of responding to them remain controversial. The control of responses to drug use can be at least as difficult to achieve as keeping a grip on consumption.

Caring for the victims

The task of caring for persons with drug-related problems is shared by many. Help is often provided by relatives, friends, neighbours and community agencies with their health and welfare professionals. Sometimes only accommodation is required; however, intensive help may be needed for a period, and long-term or intermittent assistance of variable intensity may be necessary in some cases.

Treatment should be considered as part of a spectrum of health and welfare services meeting diverse needs rather than as a sharply focused provision of a particular professional activity. The commitment by persons experiencing even severe drug-related problems to abjure psychoactive substances indefinitely is often ambivalent or fluctuating. Drug treatment services need to be flexible and closely integrated in order to meet the widely varying needs of persons seeking assistance. A capacity to cope with wavering motivation is desirable. An awareness of costs is important as the number of persons who could benefit from treatment is usually too large for the available resources. The needs of persons with advanced and often intractable problems have to be met; treatment services should also be mindful of the many people consuming alcohol or other drugs hazardous but thus far without complications. Intensive treatment for the few is giving way to relatively minor intervention at an early stage for the many.

Detoxification is the first stage in many forms of treatment for people who are intoxicated with or withdrawing from a drug. The aim is to allow the drug to be excreted and to bring about more normal functioning. Assistance may consist simply of non-specific encouragement and reassurance in tranquil surroundings. Detoxification may be accomplished quite satisfactorily at home. Alternatively, it may be carried out in institutional surroundings with professional staff and medication. If additional progress is made it should be regarded as a bonus. Detoxification is commonly seen as a prelude to rather than as a specific form of treatment.

Whether treatment is provided within a broad framework of health care or as a specialist service, the first step is to clarify the objectives. Although choosing the aim of treatment is often regarded as the prerogative of the health professional, the likelihood of any decision being implemented is enhanced if the patient has a say. If a patient firmly decides to return to drug use, it is unlikely that attempts to
persuade her or him to make a different choice will be successful.

The diverse approaches to treatment are more a reflection of cultural realities than of the range of methods known to be effective. The personal values of researchers and policy-makers significantly influence the development of national responses to drug problems. However, most of the approaches adopted have elements in common. This is particularly true of initial assessment, involving the taking of a comprehensive drug history. During assessment it may become clear that referral to another health or welfare agency is appropriate. Until recently, most treatment was given in residential settings but today outpatient treatment is increasingly regarded as no less effective and more cost-efficient. In many countries, treatment is based on local customs and religious practices, while elsewhere it is more influenced by the behavioural sciences. Sometimes treatment consists of administering the drug the patient has been taking, although in a different form, or a similar product, in what is known as substitution therapy. The giving of methadone to heroin injectors or nicotine-containing chewing gum to cigarette smokers are examples of this. When a therapeutic programme has been completed, follow-up is advisable because a return to drug use is very common. A relapse is better regarded as an important learning experience than as a reason for recrimination and feelings of guilt.

Voluntary caring organizations have been established in many countries by people who themselves have experienced difficulty in controlling consumption of alcohol or other drugs, with the aim of helping former substance abusers to maintain their resolve. Meetings are arranged at no charge and no records are kept of sensitive information. There can be little doubt that these organizations have benefited many millions of people.

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Although the consumption of alcohol and other drugs, and the resulting problems are increasing in many parts of the world, there is room for cautious optimism. Steady advances are being made in the understanding of drug problems. More realistic and more cost-effective preventive responses are emerging and knowledge of effective interventions is accumulating. Drug-related problems are regarded increasingly as having psychological, biological and social components. Responses in each of these areas are required with reference to the drugs themselves, the persons at risk, and community attitudes. There is a growing acceptance that the hazardous consumption of alcohol and other drugs can both result from and exacerbate poor socioeconomic conditions. An increased awareness of the magnitude of the actual and potential consequences of drug consumption has resulted in a long-term commitment to sustained action. Also noteworthy is the widespread realization that there is no panacea for drug-related problems.
Virginia Berridge

– The what, where and when of drug problems

As Dr Wodak states, attitudes to the consumption of particular drugs or to specific drug-related problems range from intolerance to permissiveness in different countries, and views may change with the passage of time. In the matter of drug use, what is regarded as a problem varies between countries and historical periods. What counts as a problem differs according to the cultural background. The toleration of some drugs and the prohibition of alcohol in Muslim countries contrast with the Western acceptance of alcohol and banning of certain other drugs.

In the nineteenth century, opium and opiate-based preparations were commonly consumed in England both for pleasure and to ease the pain of various illnesses. Opiates were freely available, being sold in grocers’ shops in the back streets of industrial cities. The use of opium was not perceived as a problem. Problems indeed there undoubtedly were, such as overdosing on the adulterated drug, dependence and addiction, but they were not recognized at the time.

Some people have seen the situation in nineteenth-century England as a blueprint for drug legalization today. Society managed to operate informal controls in the nineteenth century, so the argument runs, and could do so again. Another view is that an examination of the situation in the nineteenth century indicates how far we have advanced by learning the lessons of that period relating to drug abuse and misuse.

However, both of these views distort the historical perspective. The first tries to use the past in a very simplistic way to justify a particular stance in the present. The second is equally flawed: we cannot assume that there is a direct line of progress from past to present. The misconceptions and prejudices of the past are easily exposed; those of today may remain largely unperceived.

The past can be used, however, in trying to understand how and why problems were identified in a social and historical context. By studying the factors that helped to define the drug problem in nineteenth-century England we can perhaps arrive at an assessment of issues that still exist, although in changed forms. Let us consider, for example, the role of the medical profession in the drug area. In the first half of the nineteenth century no regular drug user would have thought of asking a doctor for treatment. But gradually doctors became involved not only in treating users but also in the regulation of drugs and the definition of problems associated with them.

Policies, as well as problems, are defined historically and socially. Dr Wodak says that the personal values of researchers and policy-makers significantly influence the development of national responses to drug problems. But the translation of problems into policies is more than a matter of
personal predilection. The social and structural context of policy development has to be taken into account. It is necessary to consider not only the influence of the medical profession in its relationship with the state, but also such issues as the impact of war and international power politics. With regard to alcohol, the brewing and distilling industries have played their part in determining different forms of control policy. Where tobacco is concerned, it is appropriate to look not just at economic and political interests but also at the role of the medical profession in defining the problems and the role of epidemiological research in legitimizing public health policies on smoking.

As Dr Wodak rightly says, problems are not just waiting to be discovered. Nor are policies necessarily the automatic and rational response to problems. Sometimes, policies emerge when the problems are at their least severe. Contemporary definitions and policy responses can only be understood in terms of the complex matrix of social, cultural, political and organizational factors from which they have arisen.

Ho Lin-lik

– Deep-rooted differences in outlook demand mutual respect

Dr Wodak’s remarks on attitudes to the consumption of particular drugs or to particular drug-related problems raise a variety of practical issues. Most importantly, perhaps, they touch on the sensitive area of cultural values and cross-cultural awareness.

The rapid development of communications technology and the facilitation of meetings between professionals from various regions of the world serve to demonstrate perceptual differences between cultures. Despite the shared aim of solving common problems, misunderstandings can arise from a failure to appreciate these differences.

Even though drug abuse seldom respects national or cultural boundaries the responses to it vary considerably.

The situation is reflected in laws and practices, and more especially in policies that provide the foundation for them. Most governments represent the collective will and see the welfare of the people as their main obligation.

Perceptual differences arise from many elements; some of the most powerful influences reach back over several millennia, whereas others have taken root in our own lifetime. Geographical, socioeconomic and political experiences also have a profound effect on the cultural identity, values and perceptions of people.

It would be unrealistic to think that the present situation could easily be altered by international agreements or even national legislation. The day may come when there is a universally accepted value system; until it does, however, we have to recognize, accept and manage our differences as best we can.

International meetings dealing with drug abuse and related problems frequently bring together representatives from widely
different cultural, socioeconomic and political backgrounds. Even though drug abuse seldom respects national or cultural boundaries the responses to it vary considerably. Furthermore, the very nature of the matters under scrutiny raises issues of substantial sociopolitical content. Discussion inevitably touches on concepts of the state

We do not belong to a universal culture and should accept the diverse realities of the global family.

and the individual as well as on the duties and responsibilities of government in relation to the state and the individual.

The questions that arise can no doubt be answered by every individual with absolute conviction. However, the answers can be expected to differ between colleagues with diverse cultural backgrounds. For example, what is judged to be intolerant or permissive depends on the cultural values of the observer. Both intolerance and permissiveness can be seen as manifestations of bad or good government.

Since we do not belong to a universal culture and are unlikely to in the foreseeable future, we should accept the diverse realities of the global family. We should recognize that different situations call for different practices, and that some practices are not universally applicable and may be at variance with values held by people around us.

It is as well to remember that possibly the greatest strength of humanity is its diversity and that its strongest bond lies in mutual respect.

K. E. Voronin

– The treatment of drug dependence merits closer attention

In his comprehensive account of the difficulties encountered in tackling drug abuse, Dr Wodak should, perhaps, have referred to a wider range of hallucinogens, including psilocybin and morning glory seeds. It is also worth pointing out that mescaline is obtained from peyote, a cactus; mescaline and peyote are, in effect, the same thing. Cannabis, although hallucinogenic, is usually considered separately from the hallucinogens because it has other important effects as well.

It should be noted that certain psycho-stimulants, among them cocaine and amphetamine, produce a high degree of psychic and psychological dependence, and that relapses are consequently a particular problem with these compounds.

It would have been useful if Dr Wodak had indicated the stages in the treatment of drug and alcohol dependence, which are outlined below.

- Detoxification and treatment of withdrawal, including normalization of physical and neurological disorders and correction of acute behavioural disturbances.
- Overcoming metabolic disorders and behavioural disturbances, and normalization of the psychic condition, including sleep.

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Coping with substance abuse

- Identification of the main symptoms of psychic dependence and administration of specific therapy; consideration is given to psychopathological characteristics, the frequency of presentation, and whether psychic dependence is periodic or persistent. This is the most important stage in the therapeutic process, as it practically determines the duration and characteristics of remission.

- Identification of circumstances associated with previous relapses, and administration of preventive treatment or maintenance therapy. Special attention is given to factors exacerbating drug addiction, to the identification of situations resulting in actualization of the syndrome, and to internal factors producing symptoms spontaneously.

- Most abusers first receive drugs from friends, and the imitation of older children, adults and rock stars is of significance, as is peer pressure.

- Hallucinogens, painkillers, stimulants and other substances are frequently used to counter fatigue in religious ritual dances and in connection with notions of divinity.

- Cigarettes, alcohol, hashish and other drugs may be offered to friends and visitors as part of the socializing process.

Addiction has been known to result from the medical use of morphine, heroin and other drugs, particularly in war situations.

Combinations of colonial and economic factors can lead to drug dependence on a massive scale. Thus, having lost the Opium War of 1840–42, China was forced to import opium in exchange for silk and tea and to liberalize its use. The consequence was that the number of addicts in China grew from about a million in 1842 to 100 million at the end of the nineteenth century. The Indians of Bolivia, working in the country’s silver mines, were forced by the Spanish colonists to chew coca leaves in order to alleviate their thirst and hunger and increase their work capacity.

Drug dependence can have dire consequences throughout society: conflict, violence and theft may occur, and the families of addicts may become desperate.

Milka Maurer

- The medical approach is insufficient

Dr Wodak describes the problems of drug abuse largely from the medical standpoint. Important though this is, one has to acknowledge that drug abuse can be mastered only by the coordinated efforts of many disciplines and of society as a whole.

It is often said that people become dependent on drugs because of curiosity, despair and failure, but these factors do not necessarily have such a consequence. The following social factors have a much greater influence.

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and depressed. Drug abusers become inefficient in their work. Large amounts of money, which would ordinarily go into the general economy, are instead spent on drugs, trafficking activities, and so on; tax revenue is lost, and expenditure is incurred on the general population, which, indeed, is the most powerful force that can be deployed against drug abuse and in favour of rehabilitation.

Continuing research is needed into the social causes and consequences of drug abuse and into multidisciplinary interventions that might be used on the demand side. Among the areas meriting particular attention are:

- education (only 1% of students abuse drugs in Japan);
- organization of activities for young people in their free time;
- development of social responsibility through lectures in sociology, moral education, cultural tradition and religion;
- detection of drug abusers at an early stage, at work, school, sport and elsewhere, and notification of the health authorities;
- treatment of dependence, involving hospitalization, psychotherapy and social support;
- rehabilitation and prevention of resumption of drug-taking;
- social and moral support for rehabilitated drug users.

On the supply side there is a need to consider multifaceted preventive, therapeutic and rehabilitative matters: the control of gang members and their rehabilitation and the control of firearms, production and trafficking.

Doctors have the daunting task of curing individual drug abusers and are also engaged in protecting their rights, as are the civil rights organizations. But society also has rights, notably to defend its social and economic value systems. Confronted by the
challenge of drug abuse and associated decadence, social rights must take precedence because, in the final analysis, they are the guarantor not only of society as a whole but also of the rights of each and every citizen.

Josette Poujols

— Medical care is essential, but so too is the work of remotivation and reintegration

Publications relating to drug abuse fall into two categories:
— those concerned with medical aspects of the problem;
— those dealing with the experiences of young addicts or their parents.

Dr Wodak’s article is of the first kind. It tries to remain neutral but contains little that is new. Specialists have not paid sufficient attention to the changes that have occurred in the drug addiction scene since the 1970s. Before 1970 most drug patients were adults, often classed as intellectuals, each using a single substance. When they sought treatment they wanted discretion and confidentiality. Addicts were relatively few in number and virtually unknown to the rest of society. During the 1970s, however, drug addiction appeared among adolescents and subsequently developed into a mass phenomenon.

In France during 1980 I learned of my daughter’s drug addiction, and in an instant I changed from being indifferent to being greatly concerned about the problem. I decided to tackle it on a wide front, and my family doctor soon began sending other parents to see me. This led to the founding of the Comité national des Familles pour l'Aide et le Sauvetage des Adolescents et jeunes Toxicomanes (CNFASAT, National Committee of Families for Assisting and Rescuing Young and Adolescent Drug Addicts) in 1981. At that time the typical attitude in France was that parents were to blame because they were too soft, too strict, divorced, alcoholic, or on tranquillizers. This placed a heavy moral burden on parents, some of whom were even driven to suicide.

The aims of CNFASAT are to enable young people to escape from the trap into which they have fallen and to help them and their parents if they approach the organization. It soon became clear that there were important differences between the real situation and established interpretations of it.

• The problem affects all strata of society, not just people from underprivileged backgrounds.
• One drug addict is much like another. Drug addicts tend to have the same attitude, the same way of testing how to exploit other people, and the same or very similar behaviour in given situations. It is not true that each case is unique. Only when freed from drugs can patients return to being their true selves.

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• Although the law stipulates compulsory treatment there are not enough places in convalescence centres. Withdrawal alone is not enough.

It appeared that no information was available on the number of drug addicts in France. Clearly, this made it impossible to estimate the financial resources needed to deal with the problem, and so in 1983 we investigated the matter and came to the conclusion that roughly 60,000 young people were on hard drugs. This produced an unfavourable response, even among specialists. The feeling appeared to be that the situation should not be dramatized, and that case-finding was undesirable. Such negative views, which still seem to hold sway in France, fail to take account of the fact that drug addiction is linked to hepatitis, sexually transmitted diseases, and AIDS.

We also need to estimate the impact of drug addicts on society:

— deviant behaviour, including crime;
— real total cost, including the direct and indirect social cost and the loss of productivity.

This allows the appropriate level of intervention to be defined. For example, an amount could be allocated to the control of drug addiction which was equivalent to the economic cost of the problem.

Complete rehabilitation may take several years. It involves withdrawal, convalescence, and consolidation through training or employment, together with critical intermediate stages. In 1983 we set up a chain of therapy incorporating all these stages. The sequence of activities is essential, and the objective placed before a young person going through a given stage is not just to complete it but to move on to the next stage as well. This may seem insignificant but in fact the patient’s mental outlook is of vital importance.

Since 1984 we have developed a withdrawal method involving the use of internal medicine at the Cochin Hospital. The treatment, in which no psycholeptic drugs are employed, takes seven days and includes a medical examination. It is painless, easily followed by young people, and has a success rate of over 95%. It is a direct outcome of the approach used in the preparatory stage, when the decision on treatment is being made. Before admission to hospital, arrangements are made for prompt transfer to a convalescence centre. The day of admission is intended to mark not merely the start of withdrawal but also the permanent break with addiction and the beginning of an overall plan resulting from the young person’s psychological preparation. It is pointed out that:

— when someone is addicted to drugs the problem is less to want treatment than to find out how to obtain and persevere with it;
— people cured of the drug habit resume their former mentality and morality.

It is wrong that children should be confined in a kind of chemical straitjacket and deprived of their freedom of action. It
would also be wrong to legalize the consumption and sale of drugs: this would be to connive at the destruction of young people.

Drug abuse is not inevitable, and there is no reason to accept it. Moreover, this field is not the exclusive domain of specialists. One of our studies has shown that medical care, essential though it is, accounts for less than 10% of the tasks that have to be performed to enable young people to overcome the drug habit. The lion’s share of effort should go into remotivation and reintegration into society.

Peter Vamos

— Individuals should be held responsible for their actions

Dr Wodak provides a comprehensive overview of the impact of drug abuse on the fabric of society. He defines drugs broadly as mood-altering substances and points out that their legal status varies from country to country. The effects of the drugs on users are said to be influenced by the social context in which they are consumed.

Clearly, community resources should be brought to bear on the treatment of drug dependence in a coordinated fashion. Dr Wodak is right to recommend a broad-spectrum treatment network, but the importance of treating the most severely addicted should not be minimized. These people, comprising no more than 10% of the drug-abusing population, are often heavily involved in trafficking and are believed to be the perpetrators of the majority of crimes associated with drug usage. Their effective treatment could significantly reduce the demand for drugs.

Detoxification is an important first step in recovery but without subsequent treatment it is counterproductive and can contribute to the perpetuation of the addiction cycle.

Addicts may use detoxification to lower their thresholds so as to achieve better "highs" with smaller amounts of drugs. Effective counselling at the detoxification stage is critical. Dr Wodak is correct in advocating the involvement of patients in the setting of goals for their own treatment. Self-help is a powerful therapeutic tool in the addiction field and could be used to advantage with most treatment approaches.

As Dr Wodak says, a wide range of treatments should be available, many of them capable of being administered on an outpatient basis. However, it should be emphasized that residential treatment is essential for certain hard-core, asocial drug users, who would not acquire the necessary social learning and cooperative living skills through outpatient treatment.

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In its various forms, self-help is the most effective tool in the fight against addiction.

The impact of cultural norms on treatment is immense. When psychosocial treatment modalities are transferred from one culture to another a process of adaptation by the host culture is required. For example, approaches that are effective in Western
“guilt” cultures may prove counter-productive in Eastern “shame” cultures unless significant adjustments are made.

Dr Wodak’s view that relapse is better regarded as a learning experience than as a reason for recrimination is consistent with most current thinking on the subject. The importance of after-care and follow-up cannot be emphasized enough.

Well-structured support networks, responsive to clients’ needs, significantly enhance treatment outcomes. Treating families and other people close to clients increases the probability of success.

Dr Wodak’s enthusiasm for the self-help movement is undoubtedly justified. In its various forms, self-help is the most effective tool in the fight against addiction. Although drug-related problems have physiological, psychological and social components, the importance of individual responsibility must not be overlooked. Difficult socioeconomic conditions do foster drug abuse but clients should not be encouraged to feel that they are simply the victims of circumstances.

Effective treatment requires efficient evaluation, appropriate matching of clients with treatment modalities, and extensive and comprehensive follow-up. The network of social services available in a community should be mobilized to aid clients in their recovery, and the notion of individual responsibility should be maintained. Treatment modalities should be seen as points on a continuum of care rather than as all-encompassing solutions.

Saul Levine

— Combat the true causes of substance abuse

Dr Wodak’s coverage of a wide range of issues related to substance abuse is admirable. He does not, however, deal with the more philosophical or existential aspects of the subject. Even in the more technical, academic and clinical journals, certain troubling questions are but seldom addressed, among them the following.

• Why are the medicine cabinets of the world filled with sedatives, tranquillizers and stimulants?

• Why does substance usage occur among people of all cultures, ages, ethnic groups, religions, races and socioeconomic classes?

• Why do we pretend that it is “their” problem (youth, psychiatric patients, dysfunctional individuals, criminals, and so on) and not our own?

• Why do we imagine that arrests, search-and-destroy operations, and comparable actions are going to eradicate drug abuse?

• Why do we forget that human beings want or need some placebo or panacea to provide respite, solace or escape in the face of painful reality?

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• Why do we treat street drugs, other than alcohol, as the major culprits in substance abuse, when over-the-counter and prescription drugs are an even greater hazard?

• Why do 40% of elderly patients who are admitted to general hospitals for medical and surgical reasons have problems of substance abuse, dependence, overusage, addiction or withdrawal?

• Why do we act as if substance abuse were an illness, a moral issue or a crime?

• Why do we ascribe repetitive behaviour that is deemed defiant, such as sexual activity, overeating and gambling, to a dependence/addiction model of causation and treatment?

These and other questions have probably been neglected for the following reasons.

• Substance abuse affects, or has affected, virtually all of us personally, either directly or through people we love or are close to.

• The stress of contemporary life leads us to seek easy ways of achieving inner peace. There is a vast array of substances used for calming anxiety, easing pain, or escaping from reality: tobacco (nicotine), coffee (caffeine), cocaine, valium, marijuana, scopolamine, codeine, lycerig acid, hashish, amphetamine, alcohol, heroin and mescaline are but a small sample of the naturally grown or artificially synthesized chemicals that are introduced orally or by injection into many millions of people every day.

The users may be labelled as sad, sick or weak. There have been many attempts to identify types of people who are particularly likely to become substance abusers. In fact, however, all types of people are involved, and narrow stereotyping is of no value. Some individuals may be particularly vulnerable to some chemicals in certain circumstances, but there is clearly an enormous number of possible combinations of personality types, circumstances and substances which can lead to problems. Why is it that the so-called 12-step programmes seem to have considerable success in the control of substance abuse? Obviously, detoxification and the treatment of physical and psychiatric disorders are absolutely necessary. But it is also clear that attention to individuals and their relationships, values and spirituality has had most success in respect of chronic and/or heavy users. Is this because the elements most lacking in many contemporary lives —self-esteem, belief and belonging— are the very ingredients of the 12-step programmes, or variations on them?

Certain treatment programmes are effective only in so far as they fulfil particular needs, or are ineffective because they fail to address them, as with conventional medical approaches.

We should help people towards relief from low self-esteem, social isolation and spiritual emptiness if these ills help explain why substance abuse arises.

We should help people towards relief from low self-esteem, social isolation and spiritual emptiness (demoralization) if these ills help explain why substance abuse arises.
Eddy Engelsman

-To reduce drug abuse the fight should be against underdevelopment, deprivation and low socioeconomic status

Dr Wodak makes it clear that substances may have various adverse pharmacological effects but that the degree of damage they produce hinges largely on psychological, social and cultural factors. There are no universal solutions to drug problems. The approaches adopted should be appropriate to the problems as they occur in particular societies. Any attempt to bring about a single international approach would be ill-advised.

Factors determining the extent of adverse effects.

The basic aim of drug policy should be to reduce the harm associated with drug use. Drugs are harmful in the following two ways.

- They cause primary physical health problems.
- When the supply is restricted, secondary problems arise: drug-related crime, social ostracism, AIDS, and so on.

The effects of drug use can become confused with those of drug policy. This has made the fight against trafficking seem to be the main focus of international policies on drugs.

The sociocultural circumstances in which drugs are taken, their users’ expectations, the reasons why some people take them, and the reactions of other people are the major factors determining the extent to which drug use may be a problem. Repressive drug policies may actually encourage deviant life-styles, since an important “meaning” is attached to drug use. Such disapproval by society transforms drug abuse into a significant phenomenon. The less drugs are seen in this light, the less attraction there will be in society, particularly among the young.

Aiming at demand reduction, many countries pay exclusive attention to substance abuse. However, the factors causing it include the gap between rich and poor, a lack of access to social and health services, and the dilapidation of many residential areas. If these matters are not taken into account, efforts to reduce demand can have little chance of success. Instead of conducting a war on drugs it is preferable to combat underdevelopment, deprivation and low socioeconomic status.

Regrettably, the above factors are not prominent on the international political agenda. Drug policy appears to rest on knowledge gathered in particular clinical situations rather than in the field.

The Netherlands approach

To recognize certain unintended consequences of drug policy is to open the way for pragmatic aims and feasible prevention and treatment approaches. In the Netherlands the social security and general health care systems contribute to the effort made to contain addiction. Drug abuse is regarded as a social and public health matter rather than as a problem for the police and courts. Drug laws and their enforcement are meant to reduce the supply of drugs, not to criminalize their use. Clear distinctions are

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made between drug takers and drug traffickers, and between cannabis and other drugs. The prime aim is to protect health in general and reduce the risks and harm associated with drug use.

Much attention is paid to drugs in health education and promotion programmes in schools. Young people learn to cope with the risks of life, including those presented by drugs, and to take responsibility. Not only illicit drugs but also those that are accepted legally, such as alcohol and tobacco, are taken into consideration. To do otherwise would undermine the credibility of the education programmes if not of the entire drug abuse policy.

The discretion available to the police and the prosecution department allows for the setting of priorities in the detection and prosecution of offenders. National guidelines have therefore been established. Action against international trafficking is accorded the highest priority. Under certain conditions no special action is taken by the police to detect the possession of drugs for personal use or the selling of up to 30 grams of cannabis products, although selling is prohibited. Criminal proceedings against consumers would aggravate rather than solve the problem. The policy in force prevents users from going underground and sliding into the fringes of society, where the risks may increase.

A wide range of treatment, counselling and rehabilitation services is available. Treatment is primarily concerned with improving the addicts' physical and social functioning; immediate conversion to abstinence is not required. Methadone maintenance is one of the modalities. Failure to provide this type of care would make matters worse and increase the risks to individuals and society. This approach allows many addicts to give up their habit in drug-free facilities. In general, care precedes cure.

In order to bring about behavioural changes with a view to the prevention of AIDS, it is essential to make and maintain contact with as many drug users as possible. This requires accessible health services with feasible treatment aims, namely to reduce harm or minimize risk. Addicts can exchange used needles for clean ones and obtain condoms at no charge. Assistance may take the form of field work, walk-in centres for prostitutes, the provision of substitute drugs, material support, and opportunities for social rehabilitation.

To advocate the free provision of condoms and clean needles is not easy. Politicians who do so may be accused of condoning or even promoting illegal and unhealthy behaviour. Needle-exchange programmes, however, do not lead to more drug use but to less sharing of needles and increased health consciousness.

Most young people in the Netherlands are not interested in experimenting with drugs. Among those aged 10–19, 2.7% had used cannabis (preceeding month prevalence in 1989); under 0.5% had used heroin and cocaine. In Amsterdam 0.4% of the total population had used cocaine (preceeding month prevalence in 1990), which was the same as in 1987. Nationally, the number of drug addicts has stabilized at about 21 000, 70% of whom do not inject.
The aid network is capable of reaching 70–80% of addicts in Amsterdam and almost 100% in some smaller cities. The average age of drug addicts is rising and the number of new addicts is falling.

Many addicts are willing to change their behaviour in the interest of AIDS prevention. In 1991 the known prevalence of HIV infection among injectors in Amsterdam was 24% (8% of drug users). Of the AIDS patients registered in the Netherlands, 10% are intravenous drug users.

There is no prospect of eradicating drug abuse but it can be contained through demand reduction and realistic approaches to treatment.

Diyanath Samarasinghe

— Drug abuse and related problems can be tackled by acting to change social attitudes

Dr Wodak’s article encompasses the range of issues involved in dealing with drug problems and provides a theoretical framework in which to place the possible responses to them.

Of the many ways in which substance abuse can be tackled, attempting to change attitudes has not been adequately exploited. This approach is recognized as a necessary component of demand reduction programmes but hardly ever forms part of treatment programmes. This is unfortunate, since the very decision to seek treatment is strongly linked to attitudes prevailing in the individual’s immediate environment, just as relapses into drug use are influenced by how socially comfortable it is to sustain an abstinent life-style.

Much education on drug prevention has been based on the premise that the use of drugs is inherently pleasurable but that caution is needed because of attendant risks. According to this view a primarily pharmacological process leads to changed behaviour, such as the disinhibition following alcohol use, and to the subjective experience of pleasure or euphoria.

However, there is cogent evidence from laboratory studies and anthropological sources that social or cultural influences are the prime determinants of the perceived pleasure of drug use. Dr Wodak rightly highlights the primacy of the effects of expectation and ambience in determining whether the drug experience is felt to be pleasurable. Yet in most of the literature on drug prevention the allegedly pleasurable effects of alcohol and other drugs are taken for granted. Too little attention is given to environmental factors that can make an aversive or neutral chemical experience feel pleasurable. These influences can be challenged or undermined in order to expose the true nature of the drug experience when shorn of the magic of social ritual and circumstance.

Aggression following alcohol use, like other forms of drug-induced behaviour, is also attributed too readily to such effects as the suppression of the inhibitory centres. Explanations of this kind are the result of attempts to understand social phenomena in terms of neurochemical mechanisms. Alcohol hardly ever disinhibits beyond the level that the immediate social environment is willing to tolerate, and there is no convincing neuropharmacological evidence.

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of selective suppression of specific pathways or centres, yet the neural disinhibition theory persists. Here too opportunities exist for social interventions aimed at discrediting notions of magical drug effects.

The removal of the social mystique and of the sanction for transgression of behavioural norms accorded to drug use is of considerable value in both demand reduction and treatment activities. Attempts are made to engage people, especially the young, in campaigns to remove from the use of alcohol and other drugs the socially bestowed magic. Young persons are involved as active agents in challenging and reversing the positive social attributions made to the use of alcohol and other drugs, rather than being passively targeted for interventions designed to help them to resist social pressures encouraging drug use. Their efforts help to modify the general social perception of the drug experience while giving them a better understanding of the truth concerning the allegedly positive effects of the substances in question. Involvement in demystification campaigns also helps people to resist social pressures that favour experimentation with drugs.

Part of the demystification process involves contesting false attributions made to drug use, such as the claim that alcohol helps people to forget enmities or the contrasting assertion that it causes the revival of old grudges. It is worth pointing out that people who are aggressive or disinhibited in one setting may behave with great decorum in another, despite having consumed the same amount of alcohol.

In order for social perceptions to be changed and for the social sanction for violation of the norms of decency by drug users to be removed, it is necessary for entire communities to initiate a process of questioning, challenging and changing the social rituals and symbolic meanings attached to drug use. Society should cease to tolerate and excuse antisocial acts perpetrated by intoxicated individuals.

Changes in the way a community perceives drug use powerfully affect the number of new users. When the gloss is removed, the drug experience offers little. Many people have discontinued the practice of social drinking on discovering that the alcohol experience is in fact unpleasant.

There is now a tendency for some regular drug users to seek assistance in discontinuing the habit. When a community ceases to regard drug use as an enjoyable or valued activity and refuses to countenance drug-induced misbehaviour, users seem to be increasingly inclined to view their experience in a new light. There is also a beneficial effect on people who used to be dependent and are now attempting to remain abstinent. In a community that no longer sees alcohol in a positive light or as a necessary part of social ritual, the individual who has given up drinking is less likely to resume the habit than would otherwise be the case.

Reductions in drug abuse are more beneficial to health in poor countries than in rich ones, because the monetary savings among the people affected are proportionately greater in the former, leading to better nutrition and other gains. In poor communities the use of alcohol tends to become the only leisure activity, restricting perceptions of enjoyment, even among the very young.
Learning from the historical and international experience of drug problems

— Final comments from Dr Wodak

The health, social and economic consequences of mood altering substances impose a burden of suffering in many countries of the world today which is unacceptable. In recent decades, hazardous consumption of drugs and problems resulting from their use has affected an increasing number of countries including especially many developing countries. Responses to drugs in a growing number of countries are increasingly benefiting from a greater awareness of the magnitude of these adverse consequences. In addition, insights gained from biological, psychological and social disciplines are steadily improving our understanding of the nature of drug problems and helping to fashion more effective responses. The nine authors responding to my overview of global drug problems demonstrate that the commonalities of approaches in this area are beginning to outweigh the differences.

Dr Berridge reminds us of the importance of considering the historical dimension of drug problems. As she points out, however, the historical process can all too easily be distorted. One of the recurring themes from any historical review of psychoactive drug use is the ever changing nature of drug use and drug problems. Drugs preferred by a community constantly change. Consumption levels wax and wane. Problems encountered and attitudes to these problems within a community are subject to poorly understood fluctuations. As Dr Berridge rightly emphasizes, one of the few constants over time and in varying cultures is the lack of sustained scrutiny of the industries which produce mood altering substances.

Just as we can learn from other historical epochs, so too can we learn from the rich diversity of global experiences of drug problems. Dr Ho reminds us of the immense diversity of cultures in the family of nations.

Although historical, religious, cultural, linguistic, political and economic differences make it difficult to generalize from one country to another, this diversity also allows countries to learn from one another. Countries which have experienced high levels of problems can learn from other countries which have managed to sustain lower levels of problems.

K. E. Voronin and Peter Vamos both draw our attention to the importance of developing comprehensive therapeutic plans. Treatment approaches vary in different countries not only because countries experience differing kinds of drug problems but also as a result of a multitude of cultural factors and differences in the availability of resources. Studies evaluating the effectiveness of interventions to reduce drug problems involving several countries are still comparatively rare in this field.

The importance of prevention of drug problems through social controls and particularly the need to develop community attitudes which discourage drug problems is emphasised by Milka Maurer. Her recommendation that societies should simply say “no” is a controversial suggestion. Some countries have adopted a belligerent attitude to drug use which over time has transferred to the consumers of drugs. Whether this has resulted in a decrease or an exacerbation of drug problems remains a subject of great contention.
As Mrs Poujols rightly affirms, community groups have considerable potential power to reduce the magnitude of drug problems. Unfortunately, this power is all too infrequently exploited. Her moving words also remind us that drug problems involve real people and real families and that injecting drug use has been changed irrevocably by the spectre of AIDS.

Saul Levine’s commentary directs our attention to the many areas of this subject which are still poorly understood. His plea for a better understanding of why psychoactive substances are so widely desired is shared by many. However, it is possible that more effective methods of reducing the number and severity of drug-related problems in a community could be developed without major advances in our understanding of the causes of experimentation and subsequent repetitive consumption of drugs.

The association of social disadvantage with drug use and the need to ameliorate these situations of deprivation to reduce drug-related problems is rightly highlighted by Dr Engelsman. In addition, he warns us not to ignore the major negative consequences of attempts to restrict the supply of drugs although accepting a place for such efforts in a comprehensive approach. In the Netherlands, national policies are directed at containing rather than eradicating drug problems. He presents impressive evidence that this approach has paid dividends in his own country but advises against assumptions that policies found to be effective in one country will necessarily work in other contexts.

Although many of the commentators equate drug abuse with illicit drugs, Dr Samarasinghe places considerable emphasis on alcohol. This is a most important point as the Director-General of WHO noted recently when he commented that “of all the so-called drugs of abuse, alcohol is the most frequently abused ... and alcohol remains the cause of the greatest number of health and social problems.” Dr Samarasinghe argues powerfully for more acceptance of the notion that individual and community attitudes to drugs are important determinants of drug problems. It would be folly to ignore this counsel. However, we have still much to learn about how to convert attitudes permissive to drug problems into responses which result in more responsible drug consumption.

Drug use and drug problems both have a long history in most countries. A willingness among nations to share experiences and to subject national and international approaches to independent scrutiny are recent developments. Attempting to develop and maintain rational approaches to this subject can be as difficult as attempting to control drug use.