

# **Public Health Aspects of Alcohol and Drug Dependence**

Report on a WHO Conference

Dubrovnik  
21–25 August 1978

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# CONFERENCE ON PUBLIC HEALTH ASPECTS OF ALCOHOL AND DRUG DEPENDENCE

*Dubrovnik, 21–25 August 1978*

## 1. INTRODUCTION

A Conference on Public Health Aspects of Alcohol and Drug Dependence was held in Dubrovnik from 21 to 25 August 1978, at the invitation of the Government of Yugoslavia. The Conference was attended by psychiatrists, psychologists, sociologists, social workers and public health administrators from 24 of the 32 countries of the European Region of the World Health Organization.

In addition to staff members of WHO, participants also included a representative of the International Council on Alcohol and Addictions (and the Narcotic Drug Division of the United Nations). Observers from psychiatric and other services concerned with alcoholism and drug addiction in Yugoslavia also attended. A list of participants is provided in the Annex.

The Conference was opened by Mrs Neveaka Novakovic, Vice-President of the Federal Committee of Labour, Health and Social Protection. In welcoming participants to Dubrovnik she expressed the happiness of the Government of Yugoslavia in being able to participate with WHO in holding such a meeting. She emphasized her country's concern with the problem of increasing alcohol consumption and pointed out that annual per capita intake of alcohol in Yugoslavia had increased from 6 litres before the Second World War to 14 litres today. Her country's interest in the health and social welfare of its people had given rise to a growing concern about the problems created by the indiscriminate use of alcohol and drugs. It was against this background that the Second Yugoslav Conference on Alcoholism and Drug Addictions had taken place in 1977. Further activities of a similar nature would form a continuing feature of health care in Yugoslavia in the future.

Dr M. Postiglione, Director, Disease Prevention and Control, of the Regional Office for Europe, welcomed participants to the Conference on behalf of Dr Leo A. Kaprio, Regional Director of the WHO Regional Office for Europe. He explained that the present Conference was taking place in the setting of the Regional Office's long-term mental health programme extending from 1970 to 1983, which had been approved by the Regional Committee.

Professor V. Hudolin was elected Chairman of the Conference, with Dr A. Sippert and Professor J. Skala as Vice-Chairmen. Dr D. Walsh was elected Rapporteur and Mr J.U. Hannibal, Technical Officer, Mental Health unit, acted as Secretary.

Dr A.E. Baert, Regional Officer for Mental Health, reminded participants of the diversity of cultures and drinking habits in the 32 countries of the European Region, where differences in annual per capita alcohol consumption were as great as 32-fold, ranging from 0.5 litre to over 16 litres. Alcohol and drugs made a substantial contribution to the 1 000 000 psychiatric beds occupied in the Region, as well as to the 100 000 deaths each year because of road traffic accidents and to the 100 000 deaths by suicide. He spoke of the growing awareness in the Region of the need to stop the increase of alcohol and drug consumption through health education and through promoting control measures on the production, distribution and availability of them.

Representing the Division of Mental Health of WHO in Geneva, Mrs J. Moser described how the Division, which had worldwide responsibility for alcohol and drug abuse problems, worked together with the six WHO regional offices in activities devoted to curbing the rising tide of alcohol- and drug-related problems. She emphasized the broad nature of the concept of "alcohol-related problems" reflected in the substitution of the term "alcohol dependence" for "alcoholism" in the 9th Revision of the International Classification of Diseases. To illustrate the diversity of national approaches, she commented that some countries approached alcohol and drug addiction as one subject, while others dealt with them separately.

Of the many WHO activities in this field, she mentioned particularly the Expert Committee meeting in 1966 and the 1977 Convention on Psychotropic Substances as evidence of the broader approach to those two problems and the growing awareness of the complexity of their origins in medical, social and economic terms. Since their roots and origins were complex and diverse, so too must be the approaches of prevention and treatment.

She informed the Conference of two recent activities at WHO headquarters of particular relevance to the subject under discussion. The first was a publication entitled *Prevention of alcohol-related disabilities*, a compilation of information on the nature of problems in various countries and on the means being employed to prevent them. The first part had already been published and the second was concerned with individual country profiles, setting out the problems and policies of prevention, together with the resources deployed towards them.

The second activity was called *Community response to alcohol-related problems*, a research project designed to stimulate countries to look at drinking habits and the resulting problems in their own communities. By inducing countries to examine their own situation it was hoped that they would take responsibility for their own alcohol problems and begin to develop and direct resources towards dealing with them effectively.

The project also had a comparative dimension as it examined countries varying greatly in their state of development and in their use of alcohol. Two of the countries being investigated were undergoing rapid economic and industrial change, and the opportunity existed to learn about the impact of those factors on alcohol consumption and problems. The latter aspect was particularly important as there was evidence that alcohol abuse may become a major public health problem in countries with hitherto low consumption rates but now undergoing rapid economic change.

Mr J.U. Hannibal briefly described two further relevant activities of the European Regional Office. First, the Office was collaborating with the Finnish Foundation for Alcohol Studies in the International Study of Alcohol Control Experiences project. That project was designed to investigate the methods of curtailing alcohol consumption and had, as collaborating agencies, the Addiction Research Foundation of Toronto, Canada, and the Social Research Group, School of Public Health of the University of Berkeley, California. From the European Region, Finland, Ireland, Poland, Switzerland were participating, and possibly the Netherlands.

Secondly, he described the series of training courses in the epidemiology of alcohol and drug addictions being organized by the Regional Office to educate professionals working in relevant health, social and administrative fields. The first of a new series would be held in 1979 in the USSR.

## 2. TRENDS IN ALCOHOL CONSUMPTION AND DRINKING PATTERNS IN EUROPE

Since the findings of Ledermann in 1956<sup>a</sup> and later of de Lint and Schmidt<sup>b</sup> that there was a close relationship between annual per capita consumption of alcohol and the extent of alcohol-related problems, there had been keen interest in the differences in consumption between countries and in longitudinal trends in consumption within countries. There was also a growing interest in patterns of beverage preferences both within and between countries. Epidemiologists were examining trends which indicated that changes in consumption were affecting different subgroups disproportionately, e.g., rising consumption in young people, women and immigrants, and also

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<sup>a</sup> Ledermann, S., *Alcool, alcoolisme, alcoolisation*. Données scientifiques de caractère physiologique, économique et social (Institut national d'Etudes démographiques, Travaux et Documents, Cahier N° 29). Paris, Presse universitaire de France.

<sup>b</sup> de Lint, J. & Schmidt, W. The distribution of alcohol consumption in Ontario. *Quarterly journal of studies on alcohol*, 29: 968-973 (1968).

the populations in developing countries. Finally, there was evidence that traditionally established patterns of national drinking, such as drinking with meals, drinking heavily at weekends, and episodic heavy drinking among males, were being augmented by drinking patterns more characteristic of other national groups. In that way the characteristic national drinking pattern of a country had evolved into a more "international" style of heavier overall consumption.

Dr Ruth Mattheis introduced the consideration of those issues by presenting consumption data for the European countries from 1950 to 1976. Those data, together with the percentage consumption changes between 1950/52–1968/70, 1950/52–1975/76 and 1968/70–1975/76, are presented in Table 1.

The most important point to note in the table was that consumption of alcohol had increased considerably in most countries of the European Region in the last 25 to 30 years. Highest consumption was still, as it was 35 years ago, in the wine-producing countries. In 1950 only two countries, France and Portugal, had passed an annual per capita intake of 10 litres of pure alcohol, whereas by 1975 the number of countries exceeding that limit had risen to 10.

Within that overall increase there was a narrowing of the dispersion of national consumptions from 16.5 litres of pure alcohol in 1950/52 to 12.8 litres of pure alcohol by 1975/76. Some countries such as the German Democratic Republic and the Netherlands, had shown rises of well over 300% while others, notably those at the head of the consumption table in 1950/52, had shown smaller percentage increases and in one case – France – even a decline. Some of those features were illustrated in Table 2.

It might be argued that countries with the highest initial consumption level would in any case show the smallest proportional increases. Looking at recent years it could be seen that whereas consumptions since 1950/52 had risen, there had been more recent declines in some countries, e.g., in Italy since 1969, Portugal since 1971 and Switzerland since 1974. In Austria and Sweden the position was almost static between 1968 and 1970, with only very small increases.

Most of the consumption increases seemed to have occurred between 1950/52 and 1968/70, although varying in time and scale. The increase in Ireland occurred somewhat later than in other countries. The relationship between increases and national economic circumstances was sometimes suggestive and merited further investigation.

The three main groups of alcoholic beverages, i.e., spirits, beer and wine, had shared disproportionately in the increased per capita consumption of pure alcohol during the past 25 years. The consumption of beer and spirits had risen faster than that of wine, particularly in the wine-producing countries, with a trend towards heavier beer consumption in France, Italy, Portugal and Spain. On the other hand, Belgium, the Netherlands and the countries of Scandinavia had shown a relatively steep increase in wine consumption.

Table 1. Per capita consumption, 1950/52, 1968/70, 1975/76

Country	Per capita consumption (in litres pure alcohol)					
	1950/52		1968/70		1975/76	
	Absolute	Absolute	Change 1950/52 = 100%	Absolute	Change 1950/52 = 100%	Change 1968/70 = 100%
<i>Wine countries</i>						
France	17.6	16.1	- 8.5	16.5	- 6.2	+ 2.5
Hungary	4.8	8.9	+ 85.4	10.7	+ 122.9	+ 20.2
Italy	9.4	13.7	+ 45.7	12.7	+ 35.1	- 7.3
Portugal	12.9	15.2	+ 17.8	14.1	+ 9.3	- 7.2
Spain	8.1	11.9	+ 46.9	14.0	+ 72.8	+ 17.6
Switzerland	6.6	10.3	+ 56.1	10.3	+ 56.1	0.0
<i>Beer countries</i>						
Austria	5.4	10.8	+ 100.0	11.2	+ 107.4	+ 3.7
Belgium	6.6	8.4	+ 27.3	10.2	+ 54.5	+ 21.4
Czechoslovakia	4.9	8.2	+ 67.3	9.2	+ 87.8	+ 12.2
Denmark	4.0	7.0	+ 75.0	9.2	+ 130.0	+ 31.4
Germany, Federal Republic of	3.6	10.1	+ 180.6	12.5	+ 247.2	+ 23.8
Ireland	3.4	4.4	+ 29.4	8.7	+ 155.9	+ 97.7
Luxembourg	6.8	9.4	+ 38.2	13.4	+ 97.1	+ 42.6
United Kingdom	4.9	6.2	+ 26.5	8.4	+ 71.4	+ 35.5
<i>Schnapps countries</i>						
Finland	2.2	4.4	+ 100.0	6.4	+ 190.9	+ 45.5
German Democratic Republic	1.9	6.0	+ 215.8	8.3	+ 336.8	+ 38.3
Iceland	1.1	2.8	+ 154.5	3.7	+ 236.4	+ 32.1
Netherlands	1.9	5.3	+ 178.9	8.3	+ 336.8	+ 56.5
Norway	2.1	3.5	+ 66.7	4.3	+ 104.8	+ 22.9
Poland	3.1	5.5	+ 77.4	8.2	+ 164.5	+ 49.1
Sweden	4.0	5.8	+ 45.0	5.9	+ 47.5	+ 1.7
Yugoslavia	2.7	7.8	+ 188.9	8.9	+ 229.6	+ 14.1

Sources: (1) **Kettil Bruun et al.** *Alcohol control policies in public health perspective*, Finnish Foundation for Alcohol Studies, WHO Regional Office for Europe, Addiction Research Foundation of Ontario, Helsinki, 1975. (2) *Produktschap voor gedestilleerde dranken*. Schiedam, Netherlands, 1977.

Table 2. Per capita consumption of pure alcohol,  
1950/52 and 1975/76

<i>Heaviest consumption</i>			
1950/52		1975/76	
Country	Litres	Country	Litres
France	17.6	France	16.5
Portugal	12.9	Portugal	14.1
Italy	9.4	Spain	14.0
Spain	8.1	Luxembourg	13.4
Luxembourg	6.8	Italy	12.7
Belgium	6.6	Germany, Federal Republic of	12.5
Switzerland	6.6	Austria	11.2
Austria	5.4	Hungary	10.7
Czechoslovakia	4.9	Switzerland	10.3
United Kingdom	4.9	Belgium	10.2

Country	Per capita consumption 1975/76 litres	Increase over 1950/52 %
<i>Sharpest increase</i>		
Netherlands and German Democratic Republic	8.3	337
Germany, Federal Republic of	12.5	247
Iceland	3.7	236
Yugoslavia	8.9	230

*Least increase*

France	16.5	- 6.2
Portugal	14.1	+ 9.3
Italy	12.7	+35.0
Belgium	10.2	+55.0
Switzerland	10.3	+56.0

An explanation for those changes was not readily available, but a growing "internationalization" of the alcohol industry in the direction of supranational corporations with monopolistic interests in many aspects of the alcohol production and distribution trade was perhaps paramount. But tourism, international labour migration, the increasingly international flavour of advertising and the mass media must also have led to changes in the type and scale of alcohol consumption, and to an erosion of national and regional differences. One factor that might be relevant was the growing acceptability, from the social point of view, of buying alcohol in off-licences, together with the anonymity which those large distribution outlets conferred on the purchaser. That impression was supported by evidence from several studies showing that alcohol sales were higher in self-service shops than in retail stores.

Some evidence of the extent of change of beverage types came from recent consumption data in France. Here, although wine consumption as a whole had declined, there had been a tendency to substitute wine of higher alcohol content to replace less potent wines. Data given to the Conference indicated the increase in spirit and beer consumption in France. Consumption of aperitifs anisés had increased from 385 000 hectolitres of pure alcohol in 1970 to 528 000 in 1975: of whisky, gin and vodka from 66 700 in 1970 to 103 117 in 1975, of liquers from 60 000 in 1970 to 97 000 in 1975, and of beer from 35.4 litres per person in 1960 to 45.2 litres in 1975.

The Conference also considered changing habits and patterns of drinking within European countries. Stereotypes of traditional national drinking behaviour tended to persist, even against substantial evidence indicating change. It was still customary to think of France or Italy as countries where wine was a usual component of meals, and where, as a result, large sections of the population consumed alcohol every day and where the heavy drinker very seldom appeared drunk. That pattern of drinking was sometimes, in traditional spirit and beer drinking countries, represented as being "civilized", contrary to the considerable evidence that many members of wine drinking populations with heavy intake were incapable of abstaining from alcohol, the withdrawal of which would lead to serious symptoms. On the other hand, the Scandinavian countries were perceived as regions of intermittent drinking to excess with loss of control as a primary problem.

Currently there was growing evidence that those traditional patterns of alcoholic usage were being complemented by habits of alcohol use imported from other countries, thus leading to the "internationalization" of drinking styles. For example, in northern Italy traditional wine drinking habits were changing sharply under the impact of rapid industrialization and urbanization. Wine drinking was being complemented by heavy spirit and beer consumption. In brief, in many countries of the world the traditional type of drinking behaviour was not being eliminated as newer types of drinking habits appeared, but newer habits were being grafted on to older ones.

A further clearly identified trend was of heavier drinking among certain groups who might as a consequence be recognized as "high-risk groups". In Berlin (West), for example, in 1960, 22% of the alcoholics treated by the sociopsychiatric services were women, but that figure had now risen to 32%. The reasons why women were drinking more were manifold but included, as a generality, their emancipation. That implied fewer social restrictions on their drinking behaviour so that they were freer to drink in places, at times and to an extent that formerly would have involved social disapproval. Perhaps just as important was their improved economic circumstances; they were more economically independent and had greater spending power than previously. Also relevant was the trend towards a one- or two-generation nuclear family, particularly for those women of late middle age whose children had become independent and whose husbands were out working all day, leaving them lonely and often socially isolated. There were also, sometimes, spinsters and widows, whose life by middle age might seem to them to lack further purpose.

Concern was expressed by participants about the irrefutable evidence of growing consumption and problems among young people. Survey evidence quoted by participants from a number of countries indicated clearly that many children were drinking alcohol at a very early age. In Austria, the Federal Republic of Germany and Portugal up to 80% of those aged 15 years had already begun drinking. Among the factors leading to the lower age of commencing drinking, one of the most powerful was the striving by young people for earlier individual and adult identity. They were following, in many cases, the bad example of their elders, and also had more spending money, coupled with the falling cost of alcohol in real terms. The children of known alcoholics or heavy drinkers and migrant workers, were also designated as high-risk groups.

In conclusion, Dr Mattheis stated that the overall alcohol consumption of a country depended on numerous factors including:

- the scale and type of national drink production;
- traditional drinking patterns and types of drink;
- taxation, import and export policies in the alcohol sector;
- type and scale of demand and advertising;
- purchasing power of the public, and
- sociocultural influences.

In almost all countries the annual per capita consumption of the entire population was estimated as comprehensively as possible. Some inaccuracies were likely if per capita consumption was computed as per *total* population. A more appropriate denominator would be the population aged 15 and over, as some countries, such as Ireland, had a comparatively high proportion of

their population aged under 15 years, thus giving rise to consumption figures per adult that were a good deal lower than in reality. The resulting data, however, in all countries provided little information concerning the proportion of consumers to the total population and the way the amounts of drink were divided among different consumer groups. However, it was clear that the number of abstainers in most European countries had declined substantially and that overall alcohol consumption was a valid indicator of the incidence of alcohol-related problems in any given population group.

The most striking example of the diminution in extent of alcohol-related problems in the face of consumption decline was perhaps that of France during the two world wars. When, in the 1940s, annual alcohol consumption fell by between 10% to 20% compared with earlier figures, mortality from cirrhosis of the liver showed a corresponding 20% decline. Similar evidence came from a psychiatric clinic in Berlin (West) where delirium tremens was an unknown diagnosis in the war years and those immediately following, compared with one sample day in 1978 when there were more than 200 patients under care with the diagnosis of delirium tremens or Korsakov's psychosis.

In the light of all that evidence the Conference affirmed that the level of alcohol consumption in any given society was a matter of considerable public health importance because of the proven close relationship between the degree of consumption and the extent of associated problems.

### **3. EPIDEMIOLOGY OF ALCOHOL-RELATED PROBLEMS**

The Conference next reviewed the extent and growth of alcohol-related problems. Miss M.R. Mamelet introduced the subject by recalling that the use of alcohol was very old in man's history. Because of that there had been a tendency to separate use from abuse and to deny any logical link between the two. Accordingly the concept of the "alcoholic" had become institutionalized and he was regarded as sick and alienated from other drinkers. For example, in France a man might be a very heavy drinker and in the dependence category but provided he did not disturb those around him too deeply, he was not categorized as having a problem and might even command high social prestige.

That dichotomy between "alcoholism" and drinking created great problems for epidemiology, making it difficult to identify, study and apply preventive measures to high-risk groups. A further difficulty was that in some countries wine was regarded as a food and an essential part of "alimentation"; as a consequence it had been difficult to think of and legislate for it as a substance with toxic properties rather than as a commodity "like any other commodity". Statistics classically used to highlight the extent alcohol

problems had, in France, been mostly medical, i.e., deaths from cirrhosis, deaths from alcoholic psychoses and numbers of admissions to psychiatric institutions. In France, the Federal Republic of Germany and Ireland admissions for alcoholism to psychiatric hospitals now constituted between one quarter and one third of all psychiatric admissions.

That manner of estimating the extent of alcohol problems had led to a predominantly psychiatric approach and had caused an absence of interest in assembling social statistics concerning the far greater social ill-effects of alcohol abuse. Thus, although everyone was aware that the alcoholic's family was one where problems were particularly common, there was very little attempt to calculate systematically the exact cost in terms of human unhappiness of alcohol-related strife within the drinker's family. Financial difficulties within families due to alcoholic drinking were well known to social welfare and social work agencies but were seldom tabulated; the incidence of wife beating was, at least to some extent, known to the police and social agencies, but once again no country was able to provide reliable statistics on the matter. Some attempts had been made to assess the effect of excessive drinking on children in those families but usually the groups were small and it was difficult to extrapolate national situations from them.

Statistics relating to crime were difficult to come by but there had been some studies of the drinking habits of prisoners that indicated the substantial role of alcohol in much criminal activity. Caution was needed, however, in making "cause-effect" interpretations of such data. The role of alcohol in suicide and attempted suicide was also worthy of mention; many surveys had shown that a considerable number of people who either committed or attempted suicide had taken alcohol immediately beforehand.

The role of alcohol in road traffic accidents was well known and estimates provided by the participants of many countries suggested that as much as 40% of road accident fatalities, both drivers and pedestrians, could be attributed directly to alcohol. The epidemiology of such fatalities indicated clear "risk" groups among drivers who drank. Thus fatality rates were much higher among young drivers in their teens and twenties when they had taken alcohol. Research studies showed clearly that the increase in consumption of alcohol by young people was closely related to the increasing number of road accident fatalities among them. Persons known to be "alcoholic" or to have received treatment for alcoholism were another high-risk group, yet it was common to see no long-term preventive action taken against such people when they appeared in court. Thus neither in the case of the young person nor the alcoholic was there any assessment of his fitness to drive in relation to his drinking habits, once the period of driving suspension (if it occurred) was completed.

Alcohol problems in industry could be defined in both economic and medical terms. In economic terms the cost to industry because of absenteeism and decreased productivity was widely acknowledged. Death or injury because

of intoxication or "hang-over" effects were well recognized. Although certain industries had rigid rules concerning those who were detected by medical departments as heavy drinkers or who were actually suffering from the effects of drink at work, in many cases there was a resistance on the part of management and trade unions to do anything effective about the problem.

From the point of view of physical medicine the role of alcohol, in addition to its cirrhotic effect, was responsible for countless other forms of death or permanent incapacity. There were known associations between alcohol consumption and cancer of the oesophagus, buccal cavity and larynx, in spirit drinkers and of cancer of the large bowel in beer drinkers. The neurological damages caused by alcohol, ranging from the picture of total dementia and Korsakov's and Wernicke's syndromes to peripheral neuritis were well recognized. In addition, the cardio-toxic effect of alcohol also had to be borne in mind, and there was increasing international concern about the incidence and prevalence of the fetal-alcohol syndromes. In the wider perspective alcohol made enormous contributions to hospitalizations for apparently non-alcoholic reasons. They ranged from accidental injury to pneumonias contracted by inebriated persons exposed to adverse weather conditions. It was estimated in France that up to 40% of all hospitalized patients were suffering from a condition associated with alcohol or were excessive drinkers. It was therefore important that physicians treating patients in general hospitals should be aware of the possible underlying contribution of alcohol and should have easy access to specialists in the management of such problems. At the same time, social work services should be altered to bring help and support to drinkers and their families.

Legislation and services in France were showing a growing awareness of the need for a multidisciplinary and comprehensive approach to the problems of alcoholism rather than an exclusively medical one. Twenty-five years ago a law had been introduced to deal with alcoholics who were "dangerous" because of alcohol-induced violence to their families or others but who refused treatment. That law allowed a dangerous alcoholic to be brought before a medical board, following social and medical examinations. The board then decided whether or not he should be hospitalized in a rehabilitation centre for alcoholics. Every year 10 000 were dealt with in this way, and 1 000 voluntarily agreed to accept treatment, lasting from one to three months. That treatment remained largely psychiatric.

Another social measure was a law of 1970 covering drunken driving. Some 100 000 persons were screened in 1976. In 1978 that law had been extended so that police could spot-check drivers in designated areas, whereas before they had power only to test drivers involved in accidents. That had led to a dramatic decline in consumption, and as a result cafe proprietors had been protesting about lack of customers.

The prevalence of cirrhosis of the liver was known to be mostly due to alcohol and its extent fluctuated closely with consumption. Thus it fell

dramatically during the world wars when alcohol availability was severely restricted. Currently, it was rising in most European countries but recently, in line with decreased consumption, had down-turned in France.

Unfortunately, the characteristic situation was for cirrhosis to be treated vigorously by physicians in general hospitals, without any consideration being given to the fundamental pathology — excessive alcohol intake.

Recently, in France, the approach adopted towards alcoholics or drivers apprehended with excess alcohol in their blood was to refer them to centres of food hygiene (Centres d'hygiène alimentaire). Here care was provided by gastroenterologists or general practitioners and, if required, by the sector psychiatrist acting as consultant. By removing the care of those problem drinkers from the psychiatric services it was hoped to treat more people earlier and more effectively. Such centres were being made available throughout France, with the intention of bringing a much wider medical and social approach to the alcoholic.

Other aspects of alcohol-related problems were being increasingly recognized, quantified and studied, including social aspects. Disturbances in family life and functioning, including child battering, because of alcohol, were being researched in a much more scientific fashion than previously.

#### **4. COMMUNITY RESPONSE TO ALCOHOL- AND DRUG-RELATED PROBLEMS**

The Conference spent some time in group and plenary sessions in discussing the most appropriate manner for the community to approach problems created by alcohol and drugs. It became apparent, given the wide differences between countries in the extent and characteristics of the problems, that it was not possible to lay down a general approach that was valid for all countries. To begin with there were considerable differences between countries in the relative dimensions of alcohol and drug problems, although it was generally agreed that for most, alcohol presented the quantitatively greater problem. Furthermore, trends in the extension of drug problems varied greatly. In some countries illicit drug consumption had levelled off but in others with, until recently, low consumption, it was rising rapidly.

A problem recognized as fundamental by the Conference was whether alcohol and drug problems should be approached on a unitary basis or whether sharp distinctions should be made in relation to those two problems. That was not as simple a question as appeared at first sight, because approaches had to be made at many different levels, i.e., prevention, including controls and education, treatment and after-care. Once again it was apparent that each country, in the light of the size and characteristics of its problems, the public

attitudes and traditions of its people and the prevention and treatment resources that it possessed, would have to choose the most suitable approach for itself. There even might not be a unified approach within a country through all phases of dealing with the problems. Thus, health education might cover both alcohol and drugs from a common basis of "education for living" and include information on the two substances in the light of their relevance to taking responsibility for one's own health. On the other hand, many countries would see two conditions as being quite separate, and as there were considerable epidemiological differences in the persons likely to be affected by either problem, the approach and treatment would be different. Even allowing for the fact that there was in many countries a good deal of cross-dependence on both alcohol and drugs, it was recognized that the majority of people had problems mainly in one or other area and should be treated separately.

Most European countries had responded at the national level to the problems created by alcohol abuse. In the USSR a national programme was conducted by the Central Scientific Research Institute for Health Education. In Czechoslovakia, Hungary and Poland, national committees were responsible for providing public information, organizing centres and coordinating activities. In Finland, Norway and Sweden, in addition to the state monopoly of control of alcohol sales, the Ministries of Health had organized local preventive services and treatment centres. In Switzerland, programmes were implemented by public and private agencies joining together in a federal commission, and prevention and control measures also operated at cantonal level. In the Netherlands, alcohol control was the responsibility of private medical and social agencies, subsidized and controlled by the state. In France, the multiple activities of the national committee against alcoholism were subsidized by the Government. In the United Kingdom there was both a council on alcoholism and a medical council on alcoholism, while in Ireland a national council on alcoholism worked towards prevention, education, advice and referral.

It could be seen therefore that there were a variety of approaches in operation in various European countries. Some efforts were entirely government-based, others came from voluntary organizations with government or local authority subsidy, others were private agencies sometimes set up by state funds, while in some countries there was a combination of such approaches. Where voluntary or private agencies were active their composition was usually multidisciplinary, being made up both of professionals working in the field of alcohol and drug abuse, and of personnel of voluntary organizations such as Alcoholics Anonymous and other groups of ex-drinkers.

Professor V. Hudolin introduced the topic of community response to alcohol-related problems. He outlined the necessity of a social as well as a medical approach to alcohol- and drug-related problems in the light of the increase in their numbers, in consumption of alcohol and in the number of alcoholics and of the services provided for them.

Stressing that the majority of problems caused by alcohol were not medical in nature, and that many physicians, as a recent survey in Yugoslavia showed, perceived alcoholics in a negative fashion, he urged that the approach to the problems created by alcoholism as well as their prevention must be multidisciplinary. Accordingly, a community-oriented approach was essential for early detection and intervention. The philosophy behind such a conceptualization recognized that alcohol-related disturbances could not be regarded only as problems of individual persons but must be seen in a family and community context. That meant that any pre-existing or resulting disorder within the family must be attended to, as it was useless to treat problem drinkers without looking also at coincident family disturbance. He stressed the complexity of the interactions between members of a drinker's family and elaborated in some detail on the possible interaction of disorders that arose within such families. The treatment of an alcoholic in a disturbed family situation would prove more effective if the whole disturbed system was dealt with. Treatment should be given not only to the family member who was drinking, but also to the family group to re-establish a proper balance. This required a multidisciplinary approach involving both professionals of many backgrounds and the community itself.

The Conference then spent some time debating the degree of specialization necessary to deal with alcohol problems. There was general agreement that the more serious alcohol-related problems such as alcoholic psychoses required specialist medical intervention; there was less unanimity about the heavy drinker or even the alcoholic. It was pointed out that in France, with an estimated one to three million heavy drinkers, specialist psychiatric attention was clearly impossible for the majority of cases because of the sheer size of the problem. There was therefore a need to involve many different kinds of health and social professionals such as general practitioners, social workers, and even voluntary organizations in the community itself in the early diagnosis, treatment and support of the problem drinker.

A need for specialization within the medical field in the treatment of alcohol problems was also debated. It was clear that within the European Region the majority of people with alcohol dependency problems were treated in psychiatric hospitals, sometimes in special units and sometimes not. In some countries, however, there were independent hospitals and units for alcoholics which had developed a highly specialist approach to the alcoholic. Some of those services, however, were selective and treated only those patients who were highly motivated and most likely to respond. That begged the question that from the public health point of view those with poor prognosis were most in need. Thus the Conference emphasized the need for more critical evaluation of community responses to alcohol and drug problems.

Ultimately, within any community, the degree of enlightened response to problems was related to the ability to recognize their extent and cost, economically and socially. That in turn was dependent on education, not just

of the public but of all persons involved in the health and social services, so that a greater and heightened awareness would be created of the detection thresholds of problem drinking and an earlier utilization of intervention and prevention techniques. In that respect it was recognized that adequate education programmes for physicians, psychologists, social workers and nurses were often lacking, and even more so in self-help agencies whose deployment and use in the community was of such great potential value both for detection and prevention. That was particularly important as the early diagnosis of problem drinking rested on the identification of social rather than medical problems. Multidisciplinary education must therefore have a role in training professionals in that field.

The need to concentrate on certain community subgroups thought to be at high risk for alcohol- or drug-related problems was something that each society would have to consider in relation to its own particular situation. Countries with high proportions of migrant workers, possibly formerly unused to exposure to alcohol but suddenly finding themselves in situations of high environmental exposure, should seriously consider mounting programmes to reduce the risk for those people, together with more fundamental social support for them.

## 5. CONTROL POLICIES

Dr K.E. Bruun introduced the topic of control policies. In discussion of the issues raised, the Conference acknowledged the clear distinctions at present made regarding policies of legal restraint affecting the consumption of alcohol and illicit drugs; for the latter, restrictive measures had been legally imposed nationally and internationally long ago whereas, apart from isolated incidences of prohibition, the usefulness of legal restrictions on alcohol consumption had not been widely explored. The Conference therefore agreed to concentrate its discussions on control measures as they applied to alcohol rather than to drugs. It was true that some restrictions existed in every country, but in recent years there had been a relaxation of legal controls of production, distribution and availability of alcohol together with the coincident increase in consumption. At the same time, most of the countries of Europe had seen a decrease in real terms in the price of alcohol. France, however, was one exception where rising costs had been associated with a decrease in consumption.

It should be immediately recognized that the purpose of control measures in relation to alcohol was not prohibition, but rather the exercise of some control on consumption in a fashion and to an extent that was possible and feasible in the country under consideration.

In the political sense "control" is a pejorative word, but in a technical sense as utilized by the Conference it was conceptualized as a tool in public health policy capable of influencing consumption trends. It was acknowledged that rising consumption levels implied an increasing number of persons whose intake was above a certain level, thus increasing the risk of certain health problems, both physical and social. Therefore level of consumption had a bearing on public health.

It was important to have a realistic level of aspiration in relation to control policies, which might best be expressed as "through control measures one may postpone or diminish an increase in problems". Control measures were not a substitute for other actions in controlling consumption. They were ancillary to them, adjunctive and complementary, and formed only part of the totality of any national alcohol strategy from the public health point of view.

Groups reporting back to the Conference in plenary session stressed the need for control policies to take cognizance of existing sociocultural and economic attitudes and realities. Since those varied greatly from country to country, so must the nature of policies and their application. Above all, control policies must be seen to be reasonable and form part of existing legislative procedure, not as new impositions perceived as a burden or limitation of personal freedom. For that reason "control policies" was not an ideal term, but no suitable alternative could be easily found. The reasons for the need for control policies should always be carefully explained to the public before their introduction, so that they were thoroughly understood by the community to which they applied and were seen to be reasonable in the light of the growth of alcohol problems. They must also form part of a general policy of positive health and not be seen as negative and as aimed at alcohol alone for moralistic reasons. Above all they must be acceptable to the community towards which they were directed.

There appeared to be considerable variations in the levels of control in the European countries. In the USSR there was a committed policy of control. For example, the sale of spirits was restricted to the hours of 11 to 19 and was forbidden in certain environments such as near youth facilities. Production and sale were a state monopoly and all advertising was forbidden. In Spain, new legal restrictions were being considered but, if they became law, enforcement would be important. In Poland, because of increasing problems, there was now some control, particularly in relation to spirits. In the Federal Republic of Germany there was concern that lack of restrictions had led to rising problems. In that country there were 100 000 beds in psychiatric institutions and 30% of all admissions to them were related to alcohol misuse. In urban areas alone, the figure was as high as 50%. In Denmark there had been high taxes on spirits in 1974 and 1975, resulting in declines in consumption. In Italy, traditional consumption patterns were changing, spirit consumption was rising and recent years had seen a 300% increase in the importation of spirits.

Various types of controls were utilizable to halt or at least decrease consumption rises. There could be restrictions on availability through the control of places and hours of permitted sale, control of outlets in relation to beverage types that may be sold such as restriction on sale of spirits in supermarkets, price control through taxes thereby ensuring that alcohol did not continue to become progressively cheaper in real terms and lastly through control of advertising. To promote the effectiveness of control measures there must be an acknowledgement of the need for self-control, giving rise to community control which in return influences self-control, all of this through educational processes.

Studies concerning the situation in member countries of the European Economic Community showed that certain states had been relatively passive over alcohol policies. In France, however, a number of measures had been taken to cope with alcohol problems; it was also the only EEC country to have shown a decrease in alcohol consumption in the 1960s. In most other EEC countries alcohol had become cheaper, agricultural and industrial interests had been given great prominence and as a result alcoholic beverages had become more readily available.

The Conference unanimously agreed that existing control policies should never be relaxed without very careful consideration of the possible public health consequences. Finland could be cited as a country where alcohol control was traditionally rather strict but became more relaxed with the introduction of a new law in 1969.<sup>a</sup> That new legislation had a dramatic effect on alcohol consumption, which went up from 2.9 litres of pure alcohol per capita in 1968 to 4.2 in 1969. The upward trend had continued and in 1976 the consumption was 6.3 litres. In the same period the incidence of a number of alcohol-related problems rose steeply: arrests for drunkenness, for drunken driving, for personal violence under the influence of alcohol and alcohol-related deaths.<sup>b</sup> That Finnish example offered clear-cut evidence of the harmful effects of a relaxation of legislation leading to an increase in consumption and problems. In fact the Finnish laws had been relaxed in the belief that their strictness was responsible for the extensive problems existing prior to 1969, but that "natural experiment" proved the belief to be quite erroneous. Additional evidence of the need for great care before the relaxation of any control measures came from Africa and Greenland, where social controls in particular were being eroded by the increased "westernization" of traditional culture and the promotion of an alcohol culture by the industry.

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<sup>a</sup> Sulkunen, P. Availability of alcoholic beverages and alcohol policies in EEC countries 1–11. *Alkoholipolitiikka*, 42: 241 (1977).

<sup>b</sup> Ahlström-Laakso, S. & Österberg, E. *Alcohol consumption and consequences of drinking in Finland, 1960–1975*. Paper presented at the 23rd International Institute on the Prevention and Treatment of Alcoholism, Dresden, German Democratic Republic, 6–10 June 1977.

The growing "internationalization" of the European and indeed the international scene had favoured the growing consumption of alcohol. Tourism, duty-free outlets and international marketing policies of alcohol had all worked towards the relaxation of restraints.

Dr K.E. Bruun reminded the Conference that economic interests often ran counter to those of public health and said that the alcohol field was a very good example of that. He pointed out that the exclusion of alcohol issues from the programme of the League of Nations had been related to the economic interests of the most influential nations, and the fact that alcohol was still not an issue in the United Nations was an indication of the strong economic interests involved.

## **6. HEALTH EDUCATION FOR ALCOHOL AND DRUG ABUSE**

Professor J. Casselman led the discussion on that subject. He pointed out that a survey carried out on behalf of the WHO Regional Office for Europe on health education programmes and activities involving alcohol and drugs for young people in the countries of the Region had covered some 50 programmes and activities under the following main headings:

- (1) aims and objectives
- (2) content
- (3) feasibility and implementation
- (4) methodology
- (5) existence of evaluative procedures
- (6) availability of data concerning results and effects.

It emerged that all countries conceptualized health education similarly. In general their perception of health education might be defined as "the plan of formal efforts to stimulate and promote experiences at times and ways through situations leading to the development of the health knowledge, activities and behaviour that are most conducive to the attainment of individual group or community health".

Despite agreement as to the nature of health education in relation to drugs and alcohol there was wide variation as to methodology and content. Most of the programmes appeared to be traditional but new ideas and approaches were becoming apparent. They included the realization that behaviour could not be altered by the provision of information alone, that the

approach must be health- rather than disease-orientated, that an authoritarian approach must be avoided, that an attitude of the “knowledgeable expert” talking down to the “ignorant client” and all other forms of paternalism in the delivery of information were outmoded. It was also now widely acknowledged that a fragmented approach, with health education being packaged and delivered in some circumscribed and discontinuous instalments, was counter-productive, and that uncritical and total reliance on the mass-media, particularly television, attempting to sell health education like any other commodity, was inexpert and unrealistic. On the other hand, health education through the media should bring to bear all the sophisticated expertise and techniques of media usage so as to reach its target population most effectively.

In place of the outmoded approaches of the past there must be multi-lateral and multidisciplinary development of health education for children of school age. “Multilateral” meant that the education must come from many sides, i.e., from the school where the child was for some of the day, from the family where he spent another part of his life and from the wider community where he spent the remainder. Furthermore, the messages that came from these three different environments must be consistent and coherent and there must be no sense of contradiction between them. The education must be multidisciplinary so that every discipline in which the child was involved helped him to form his precepts of what healthy living was all about. Health education was now seen as part of the self-actualization and self-realization process, stressing the importance of individual choice in behaviour relevant to health. Thus an individual, through education in the context of his society, became equipped for rational decision-making in health matters.

Effective health education should have clearly defined goals and objectives, should have a content that takes its origin from knowledge of its purposes and the population at which it is aimed and should develop that content on the basis of scientifically evolved expertise and techniques. It should commence early in life; recent sociological and psychological evidence indicated that children as young as eight years or even less already knew a great deal about alcohol and drinking and had internalized attitudes and beliefs even before that age. Health education on drugs and alcohol should form part of a continuous educational process helping individuals towards self-realization, developing their coping and adaptive mechanisms and decision-making, thus helping them to make healthy choices.

For successful health education programmes all educators and health service personnel must themselves be trained and educated in health education. Non-specialist personnel delivering health education to children should themselves have been trained by specialists, both in education and in the problems of alcohol and drugs. Education must always be delivered in an unbiased and objective fashion and above all there must be a realization that “shock” tactics may be counter-productive.

The Conference also concurred in the view that health education for children and adolescents must not be a passive process and that active participation on the part of the pupil was essential. The means by which that could be brought about were numerous and included such techniques as quizzes, educational programmes in such matters devised by the children themselves, debates and even plays and dramatic entertainment. As the peer-group influence might be more important in older, teenage children it was important to ensure that participation in health education programmes became part of the normal curriculum involving all children and not merely the interested few.

However, the matter of health education in relation to alcohol and drugs was not merely that of children or indeed those who were perceived as fully informed adults. The greatest educational task of all in that field was perhaps to convince the mature public and those who governed them in the political field, of the real and urgent need, from the public health point of view, to do something effective to curb rising consumption of alcohol and associated problems. It was logical that that effort should march forward with education given to children. If there were a contradiction or dichotomy between what children were taught and what adults felt and did, then the child would quickly perceive the inherent dishonesty of such a situation, come to his own conclusions and make his own choices independently of health and social considerations. Learning comes not only from educators but also from the community, with the sanctions and controls that it imposes, and if early educational experience is ill-adapted to the prevailing cultural and social mores then it is naturally cast aside. That was why health education of children could only be successful in a milieu of responsible example-giving by adults, i.e., their families and communities.

The education and training required for those working in health and social services, whether at undergraduate or postgraduate level, was a task that in some countries still remained to be done. In the field of undergraduate and postgraduate medical, social work and psychological training there was heavy competition for available curriculum time, and therefore health education content had to compete with other subjects for space. That implied that the designers of educational curricula should be committed to preventive aspects of health and social care rather than simply, as so often in the past, to the treatment of existing pathology. Furthermore, the practitioner in the field, adequately educated in alcohol and drug problems, must, if his education was to be of any practical value, have appropriate services to turn to when he does detect a problem. He must therefore have access to specialist services for help, advice and support.

Participants in the Conference, realizing the fragmentary and uncertain position of much of health education in some countries in relation to form, content and organization, expressed the need for some international clearing house or agency which could provide them with essential facts relating to the

delivery of effective health education. Thus, research findings hitherto not very widely disseminated could be made accessible to a wider group of people working in this field.

Because it was still a relatively new science with many uncertainties in relation to the most effective application of its principles in a variety of differing sociocultural settings, there was an obvious crucial need for the evaluation of health education programmes. The Conference recognized that there was a danger that health education might become the popular catchword of the future and that therefore some degree of critical appraisal was necessary as to what it comprised, in content and objectives, in each particular setting. Accordingly, evaluative pilot research was absolutely necessary. Simple "before and after" surveys, not just of information received through educational programmes but of the impact that such programmes had on behaviour, were examples of the type of research that was fundamental to evaluating the usefulness of educational programmes. In that context the Conference's attention was drawn to an evaluative research project on education in the alcohol and drugs field — unfortunately one of the few endeavours of its kind. It was a joint Danish/United Kingdom project in the drug field, and focused on situational evaluation and very broadly surveyed the dissemination of information on drugs to children and then the experimental study of their responses and the reasons for their reaction, when they were actually exposed to a drug situation.

The Conference agreed with the statement that as the principles of health education with respect to drugs and alcohol were now quite clearly defined and accepted as valid, the questions raised by the actual implementation of health education for the young, though many in number, were mainly functional: when, how, by whom, with what means it would be provided, and whether the target group would be considered in a social, economic or political context.

There were several solutions, each of which might be valid for a specific situation. Fruitful comparisons could be made of the experiences and results of programmes and activities in different countries as regards the promotion of health education for the young, which was so essential to the future of every individual.

## **7. CERTAIN PROBLEMS IN TREATING ALCOHOLICS AND DRUG ADDICTS**

Dr E.A. Babajan highlighted the main issues involved in the treatment of alcoholics and persons with problems related to the use of alcohol and illicit drugs.

The question of the unitary versus the dualistic treatment approach to those problems, which had been discussed earlier, was taken up again from

the point of view of treatment. The principal point was whether drug-dependent persons should be treated by the same team and facilities as those with alcohol problems. Dr Babajan pointed out that in the USSR chronic alcoholics and those addicted to narcotics were not treated in the same department. They required different regimes and periods of hospitalization before transition to outpatient care. He stressed that the overall system of management of alcoholics and drug addicts should be a combination of in- and outpatient treatment.

In relation to drugs Dr Babajan stressed that the term "narcotic substance", from the point of view of national and international treaties and conventions, embodied different criteria and conceptualization, depending on whether the term was used in a medical, social or legal context. Thus, before a substance could be regarded as being "narcotic" it had to fulfil criteria in each of those three dimensions. First it had to have a specific effect on the nervous system (stimulation, sedative, hallucinatory, etc.) which was the reason for its nonmedical (i.e., self-administered) use. Then that nonmedical use must lead to social problems and constitute a legal transgression. When those three criteria had been met one could speak of *narcomania*. It was in the context of that description and within the framework of the Single Convention on Narcotic Drugs of 1961 that the United Nations acted on questions of production, consumption, export and import of "narcotic" substances.

On the basis of those considerations the term "narcomania" in the USSR was reserved for substances recognized by law to be narcotic. However, there were substances which brought patients under social and medical care which did not fulfil all three criteria and it was therefore necessary to use a clinical definition of abuse of such substances which have not been recognized by law as being narcotic. In those cases another concept, that of *toxicomania*, was employed.

In relation to alcohol and its problems Dr Babajan divided society into five groups. First, there were those people who do not use alcohol at all. They were a heterogeneous group comprising children and in the USSR most of the female population and some men. Secondly, there were people who very occasionally took alcohol, out of curiosity or for the occasional celebration but otherwise did not use alcohol. There was a third group who regularly took alcohol but in such moderate amounts that they never created any problems for themselves or anyone else by their very limited consumption. The fourth group was made up of abusers and the fifth group of chronic alcoholics. It was with the fourth and fifth groups that the psychiatrist or therapist worked.

The Conference then considered some points relevant to the treatment of alcoholics. As regards the composition of the treatment team, it was agreed that a psychiatrist was a key element in treatment, particularly as alcoholics were known to have a high incidence of serious physical conditions produced by their excessive drinking. Furthermore, it was recognized that in some

alcoholics, at least, there were underlying psychiatric disorders which needed psychiatric intervention. However, the Conference agreed that the overall treatment programme must be very broad and based on multidisciplinary concepts. In addition, treatment must also be multilateral and at several different levels: community, outpatient and inpatient. Throughout those different levels of therapeutic activity many disciplines would be involved, i.e., treatment must be simultaneously multidisciplinary and multilateral.

Some participants in the Conference felt that whenever possible outpatient treatment was to be preferred to inpatient as they believed that research findings did not indicate any greater success rate of inpatient over outpatient therapeutic settings. However, there was not total agreement on that point and some felt that for severe cases, i.e., chronic alcoholics, an intensive inpatient regime was necessary. That would involve, following detoxification, individual and group psychotherapy, treatment with appropriate psychotropic drugs when there was reason to suspect underlying psychiatric abnormalities, and intensive courses of work or occupational therapy. The latter, of course, would be on a paid basis and would involve, for those who were unskilled or who had lost skills through their drinking, retraining courses. Gradually thereafter, depending on response, treatment would be moved towards outpatient settings. But there was a recognition of the usefulness of partial hospitalization, including the use of hostels and halfway houses.

All participants stressed the importance of rehabilitation and many suggested that help with job finding was extremely important. Employment agencies should be altered to the special needs for re-employment of alcoholics. Help in job finding was a crucial step in the rehabilitation of alcoholics at a stage when disillusionment could so easily lead to a relapse.

Dr Babajan referred to small groups of alcoholics whose drinking was of such dimensions that not only were they endangering their own health but were bringing social destruction and unhappiness to their families, and who would not accept treatment voluntarily. Although in general compulsory treatment was undesirable, there were cases where it was necessary and essential. Many countries had mental health or other legislation to make that feasible. Examples of such procedures were given from both France and the USSR.

The Conference again stressed that treatment of the family and the social circumstances of a person with alcohol- and drug-related problems was an essential ingredient of the multilateral approach. Furthermore, treatment of psychosocial malfunctioning within the family of problem drinkers must proceed from a multidisciplinary base, using techniques from many different professions to disentangle problems and give vital support to such families.

Much emphasis was placed on the need for evaluation of various treatment measures. That was particularly necessary as the treatment of alcoholics, in numerical and economic terms, was now one of the most important components of the workload of psychiatric services. Nevertheless it was

generally the case that services were provided on "inspirational" grounds rather than designed from a background of scientific findings relating to need and effectiveness.

## 8. RESEARCH

Whereas new knowledge leading to new orientations and approaches had been accumulating in the field of alcohol- and drug-related problems in recent years, it was apparent, from the contributions of many Conference participants, that there were still many gaps in current knowledge of the medical, social and economic circumstances surrounding alcohol and drug problems. They existed at every single level of the multifaceted settings in which those problems arose.

It was clear that the level of research activity varied greatly from country to country. Whereas some, albeit a small minority, of countries had established and satisfactorily funded specialist research groups to study alcohol and sometimes drug problems, the majority of countries had no adequately staffed research centres to enquire into alcohol problems. That was all the more surprising in view of the enormous national cost of those problems. It contrasted, too, with the approach of the industry where market research was generally highly developed. Indeed in some countries the totality of knowledge of drinking patterns and habits came from the industry which often generously made such materials available to researchers. The prevailing situation in most countries was that there may be, within university or health service departments, a few people interested in the alcohol or drugs problem field who carry out individual and somewhat isolated research projects without any substantial financial support or backing.

That was in general a very unsatisfactory state of affairs, considering the extent of the problem, and it was felt that governments should be urged to fulfil their responsibilities in relation to researching alcohol and drug problems in their own countries. The Conference frequently stressed that the approach to alcohol problems must be that of a total package devoted to activity in every relevant area. One of the relevant areas was research because if little was known about consumption patterns or trends, the efficacy of various prevention programmes, and the usefulness of educational and treatment programmes, their aims and objectives, target populations, content and applications, could not be rationally decided.

National research must be complemented by international research. Since the Conference had recognized the growing "internationalization" of trade activities in the alcohol field, of drinking patterns and styles, of the narrowing gap in national consumptions as well as of beverage types, together with the

need for an international pool of expertise concerning programmes of education and control measures, the case for international research collaboration could not be overstated. Coordination and collaboration in research activity also facilitated similar combined activities in other areas of alcohol and drug problems. A promising example of international collaboration was that of the International Study of Alcohol Control Experiences referred to in the opening meeting.

The Conference then identified the following broad areas as research priorities:

- (1) trends in the consumption of alcohol and illicit drugs;
- (2) the epidemiology of alcohol- and drug-related problems;
- (3) the study of control measures and their effectiveness;
- (4) the evaluation of health education programmes in this field;
- (5) a critical appraisal of treatment measures.

## 9. CONCLUSIONS

1. Evidence indicated a picture of increasing consumption of alcohol and of licit and illicit dependence-producing drugs in most countries of the European Region. There was a clear trend towards similarities of types of alcoholic beverages consumed. Most of the increases in alcohol consumption which had taken place seem to have occurred between 1950 and 1970, although varying in time and scale. The relationship between increased consumption and national economic circumstances was suggestive and merited further investigation.

2. The view was generally accepted that there was an association between increasing per capita consumption of alcohol and growth in related problems.

3. There was a need to involve many different types of health and social professionals as well as voluntary organizations and self-help groups within the community in the prevention, early diagnosis, treatment and support of those harmed by alcohol and drugs. There was agreement that a comprehensive range of services, with particular emphasis on community facilities, should be available.

4. Much emphasis was placed on the need for improved education, not only of the public and the patient, but especially of all persons involved in the health and social services, in order to ensure greater recognition of the need for earlier detection of the problem and the utilization of techniques of early intervention.

5. It should be recognized that the purpose of control measures in relation to alcohol and drugs was the promotion of health through restriction of consumption to the extent that was feasible in the country under consideration. Control measures should not be changed or relaxed without consideration of the possible public health consequences.
6. Control measures were not a substitute for other actions in limiting problems. They were ancillary to them, adjunctive and complementary, and formed only part of the totality of any national strategy from the public health point of view.
7. Public support was necessary for the successful application of control policies. Governments as well as the public must therefore be made aware of the size and nature of the economic and social costs of alcohol- and drug-related problems. Key figures in the community had a particular duty to exhibit responsible attitudes and behaviour in relation to alcohol and drugs.
8. A need was recognized for multidisciplinary programmes of health and social education for children and adolescents. They should be developed within the community and involve the participation of the school, the health services and especially the family. Health and social education was now seen as part of the socialization process stressing the importance of individual responsibility in behaviour relevant to health.
9. Research was urgently required on the economic and social consequences of alcohol- and drug-related problems. The effectiveness of control policies in restricting consumption should be carefully examined. In addition, health education programmes should be critically evaluated in relation to methodology, content and results.

## 10. RECOMMENDATIONS

1. Governments are urged to monitor the level of consumption of alcoholic beverages and to develop national strategies in order to prohibit further increases of alcohol consumption or if possible to effect a decrease. Among other measures, steps should be taken to moderate the extensive promotion of alcoholic beverages, by restricting or banning advertising. The possibility of international cooperation in the field of control measures should be explored.
2. The value of national coordinating mechanisms for monitoring and investigating alcohol and drug problems and for the development of policies and programmes to deal with them is emphasized. Governments not having such mechanisms are urged to consider their establishment.

3. Graduate and postgraduate education and training of all health workers in the field of alcohol- and drug-related problems should be established. The international exchange of experiences in the field of education and training should be encouraged.

4. Agencies, whether national or regional, dealing with the problems induced by alcohol and drugs have a responsibility to inform governments and the public of their extent and the need to do something about them. At the same time governments should ensure that there are adequate programmes of education for children and adolescents in the field of alcohol and drug use.

5. Research is required on many aspects of alcohol and drug problems. Areas urgently in need of research include trends in the consumption of alcohol and illicit drugs, the epidemiology of alcohol- and drug-related problems, and the evaluation of the efficacy of control policies, of educational programmes and of treatment measures.

## Annex

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