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GLOSSARY OF SOME KEY TERMS

Many definitional problems exist in the field of narcotic and psychotropic drug misuse. Key terms, related to health planning generally and to drugs specifically, need to be clarified for the purposes of useful discussion.

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INTRODUCTION: PURPOSE AND SCOPE

The purpose of this document is to provide a set of definitions of some terms that are likely to be in frequent use during the London Conference of Ministers of Health. The list is selective rather than all-inclusive, being intended specifically to meet the need for a common language of communication on this particular occasion and the definitions are not necessarily valid for other purposes.

The first section deals with background concepts relating to health planning. The aim here is to set out in brief form the framework for health strategies in support of the key declaration of the Alma-Ata Conference of 1978:

"A main social target of governments, international organizations and the whole world community should be the attainment of all peoples of the whole world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".

Such an approach to health issues forms the necessary framework within which national and international responses to drug misuse can be discussed. With that framework established, the second section deals with terminology relating to drugs, drug misuse, and drug dependence.

1. TERMS RELATING TO THE HEALTH PLANNING CONTEXT

Health for all. In 1977 the Thirtieth World Health Assembly decided that the main social goal of governments and WHO in the coming decades should be the attainment by all the people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This goal is commonly known as "health for all by the year 2000". "Health for all" is a process leading to progressive improvement in the health of people not a single finite target. It will be interpreted differently by each country in the light of its social and economic characteristics, the health status and morbidity patterns of its population, and the state of development of its health system. However, there is a health baseline below which no individuals in any country should find themselves; all people in all countries should have a level of health that will permit them to work productively and to participate actively in the social life of the community in which they live.

Primary health care. The key to attaining the goal of health for all by the year 2000 is, in the view of the Alma-Ata Conference, primary health care. This term implies essential health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound, and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Related sectors should also be involved in it, in addition to the health sector.

Community involvement implies the active involvement of people living together in some form of social organization and cohesion in the planning, operation, and control of primary health care, using local, national, and other resources.

Community health workers. To carry out primary health care community health workers are needed, that is to say, trained health workers who live within the community and work with other health and development workers as a team. They provide the first contact between the individual and the health system. The types of community health worker may vary between countries and communities according to their needs and the resources available for meeting them.

Intersectoral action is action in which the health sector and other relevant sectors collaborate for the achievement of a common goal, the contributors of the different sectors being closely coordinated.

Health promotion is an evolving concept that encompasses fostering lifestyles and other social, economic, environmental, and personal factors conducive to health.

National health policy. Each government needs, for the task of improving the people's health, a national health policy, that is, a set of decisions to pursue courses of action aimed at achieving defined goals for improving the health situation.

Goal. A goal is a general aim towards which to strive, for example, to have an environment that is conducive to health or to have primary health care available to everybody. A national policy, which presupposes a political will to commit a nation's resources to the achievement of these goals, also determines the priorities among the goals and the main directions for achieving them.

National strategy. The decisions which make up a national health policy are usually couched in general terms. The policy is the basis of a national strategy, which lays down the broad lines of the action required in all the sectors concerned to give effect to the national health policy and indicates the problems and ways of dealing with them.

Programmes. A national strategy usually includes specific programmes for delivery by the health system infrastructure, for example, a programme of health education, a programme being an organized aggregate of activities directed towards the attainment of defined objectives and targets, which are progressively more specific than the goals to which they contribute.

Objective. An objective is the end result a programme seeks to achieve; for example, the objective of health education can be defined as ensuring that people will want to be healthy, know how to stay healthy, do what they can individually and collectively to maintain health, and know how to seek help when required.

Target. A target is an intermediate result of a programme, marking a stage in the achievement of the programme's objective.

National plan of action. The national strategy having been defined, a national plan of action is drawn up, that is, a broad intersectoral master plan for implementing the strategy in order to attain the national health goals. It specifies in operational terms the steps to be taken in accordance with the strategy, keeping in mind the various objectives and targets to be attained and the programmes for attaining them. These steps include political, economic, financial, social, legislative, administrative, scientific, technical, and managerial measures.

Monitoring is the term used for the continuous follow-up activities to ensure that they are proceeding according to plan.

Evaluation. This is another essential part of the managerial process for national health development, and is the systematic assessment of the relevance, adequacy, progress, efficiency, effectiveness, and impact of a health programme.

Technology transfer. Part of WHO's task is to support technology transfer, that is, the process of ensuring the wide application of scientific discoveries, and of methods, procedures, techniques, and equipment that will promote health and socioeconomic development. The concept includes the export of technology and its exchange among and introduction into countries.

Regional strategies, which vary widely according to the needs of countries in any given region, have been formulated to help countries within the region overcome obstacles to the fulfilment of their national health strategies and to give effect to regional health and related socioeconomic policies. For this purpose, the exchange of information and experience is essential.

The Global Strategy for Health for All brings together regional and national strategies in an integrated world strategy fostering the development of regional and national policies, strategies and plans of action, and supporting countries, both in regional groupings and individually, in their preparation and implementation. The Global Strategy was adopted by the World Health Assembly in 1981. It describes the broad lines of action to be taken at policy and operational levels, nationally and internationally, in the health sector and in other social and economic sectors, to attain health for all by the year 2000.

WHO's General Programme of Work. This constitutes WHO's support for national, regional, and global strategies and plans of action for the attainment of health for all by the year 2000. Each Programme covers a period of six years. The Seventh General Programme of Work, for the period 1984-1989 inclusive, contains an analysis of the health situation in the world and defines the objectives, intermediate targets, and approaches that will be adopted to support Member States of WHO in attaining the long-term goal for the year 2000.

WHO's medium term programmes. These are prepared on the basis of the General Programme of Work and specify the types of activities to be carried out by WHO for the six years covered in order to maintain the objectives and targets of that General Programme.

2. TERMS RELATING TO DRUGS

Drug. A drug is a chemical substance of synthetic, semisynthetic, or natural origin intended for diagnostic, prophylactic, therapeutic, or palliative use, or for otherwise modifying physiological functions, of man or animals.

A psychoactive drug is one that is capable of altering mental functioning. For present purposes the word "drug" may be taken as indicating "psychoactive drug", which will be taken to include both narcotic drugs and psychotropic substances.

Drug dependence. A state, psychic and physiological, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.

Psychic dependence. A condition in which a drug produces a feeling of satisfaction and a psychic drive that require periodic or continuous administration of the drug to produce pleasure or to avoid discomfort.

Physical dependence. A state of physiological adaptation of the organism to regular intake of a drug, such that manifests itself by intense physical disturbances when the administration of the drug is suspended. These disturbances, i.e., the withdrawal or abstinence syndromes, are made up of specific arrays of symptoms and signs of psychic and physical nature that are characteristic for each drug type.

Dependence-producing drug. A drug having the capacity to interact with a living organism to produce a state of psychic or physical dependence or both. Such a drug may be used medically or nonmedically without necessarily producing such a state. The characteristics of a state of drug dependence, once developed, will vary with the type of drug involved.

Dependence potential. There are differences between individual dependence-producing drugs in relation to their potential to produce dependence. The greater a drug's dependence potential, the greater the risk that the individual using this drug will develop dependence on it. Assessment of dependence potential through animal experiments in a preclinical phase of drug testing is of considerable public health importance.

Drug-related problem or drug problem. This term is used, in the first place, in relation to the individual. An individual may be deemed to have a drug problem when his use of a drug is causing or threatening to cause significant impairment of his mental or physical health or social adjustment. At times, the drug may be only contributing to such impairment, rather than being the sole causal agent, e.g., use of hallucinogens may contribute to the precipitation of onset in schizophrenia. Within the public health context, a drug problem may be deemed to exist in relation to a particular drug if the health authorities judge that it is causing significant harm to a significant percentage of the population, or threatening so to do.

A drug problem may result from the use of a dependence-producing drug or from one without this property (e.g., LSD), or from the use of a potentially dependence-producing drug before the individual has progressed to dependence (e.g., accidental overdose at an early stage of heroin use). Conversely, dependence may occur without any obvious immediate drug problem (e.g., dependence on caffeine). In practice, many people who misuse drugs will both develop dependence and incur accumulating drug-related problems, but conceptually "dependence" and "drug problem" are distinct.

Drug misuse or drug abuse. Of these two terms, "drug misuse" is generally preferred in health discussions as being free from judgemental connotations, but the terms are virtually synonymous. A drug may be considered to be misused if its use is unlawful, if it is a licit pharmaceutical substance used other than for acceptable medical purposes, or in the context of licit prescribing used in excess or contrary to medical direction, or inappropriately prescribed.

Classes of drugs. Despite the multitude of individual drugs that are capable of misuse, there are relatively few classes of drugs of misuse, and within one class all drugs have considerable family resemblance. The general characteristics of the major drug groups are as follows:

(i) Opiates (or opioids). The prototype drug for this group is morphine, the major active ingredient in opium. Opium is the resinous exudate of the capsule of the white poppy, Papavar somniferum (hence the origin of the name opiate for this family of drugs). Opium contains, as well as morphine, other psychoactive substances that can be extracted in pure form, including codeine, a commonly used drug for relieving pain and cough. Morphine can be converted by a relatively simple chemical process to heroin (diacetylmorphine or diamorphine). Besides these plant products, there are many entirely synthetic opiates, such as methadone (a drug used widely in the treatment of heroin dependence), pethidine (meperidine or Demerol), and dipipanone. All the opiates share a capacity to relieve pain and produce a pleasant, detached, dreamy euphoria, and the capacity to induce dependence. Withdrawal from the opiates can be very distressing, but will not be fatal unless the patient is otherwise severely ill or debilitated.

(ii) General brain-depressant substances. This drug group includes alcohol, the barbiturates, and an enormous variety of synthetic sedatives and sleeping tablets. These substances have in common the ability to cause a degree of drowsiness and sedation or pleasant relaxation, but may also produce "disinhibition" and loss of learned behavioural control as a result of their depressant effect on higher centres of the brain, a property that accounts for the seemingly "stimulant" effects of alcohol. These drugs all have the potential to induce cross-tolerance and changes in the nervous system that lead to withdrawal syndromes. The possible seriousness of these withdrawal states needs to be emphasized - withdrawal from severe physical dependence on alcohol or barbiturates can be life-threatening. "Minor tranquillizers" of the benzodiazepine type, such as diazepam (Valium) or chlordiazepoxide (Librium), are probably best placed in the general depressant group, although they also have some distinctive features: the benzodiazepines have less potential to induce serious withdrawal states (possibly because they are much longer acting) and are generally far safer drugs in clinical practice than the barbiturates, although their dependence potential should be borne in mind.

(iii) Stimulants. Cocaine is the psychoactive ingredient of the coca leaf. It produces a sense of exhilaration and a decreased sense of fatigue and hunger. Similar effects are produced by a number of synthetic substances, such as the amphetamines and related substances, including phenmetrazine, methylphenidate, and various drugs that have been marketed for the treatment of obesity. Khat is a shrub, the leaves of which are chewed in the Middle East. The active ingredient is cathinone, which has actions that are similar to those of amphetamine.

Cocaine, the amphetamines, and some of the other synthetics can cause excitement in extreme degrees and can cause psychotic illness. These substances have a high potential for dependence, although the withdrawal symptoms seem to be limited to temporary feelings of fatigue, "let down", and depression.

Millions of people all over the world consume coffee and tea containing caffeine (tea also contains some theobromine). These substances tend to be stimulants in that they alleviate mild degrees of fatigue, but they have a mechanism of action in the body that is quite distinct from that of cocaine and the amphetamines. Generally, they produce very low levels of dependence, and withdrawal, if any, seems limited to some headache and fatigue.

(iv) Psychotomimetic (psychedelic or hallucinogenic) drugs. This group includes LSD (lysergic acid diethylamide), mescaline, peyote, and many other plant-derived or synthetic substances. These drugs have the capacity to induce highly complex psychological effects, including transcendental experiences of other-worldliness, hallucinations, and other types of perceptual distortion. Sometimes this experience becomes bizarre and frightening, producing what is commonly known as a "bad trip". Psychotomimetics do not induce physical dependence.

There are also a few drugs that are relevant to the concerns of the present Conference but that do not fit satisfactorily into any one of these four major categories or families. These include:

Cannabis. This is the generic name given to the drug-containing plant products of Indian hemp: this plant material offers an extraordinary array of psychoactive chemicals, the most important of which is Δ^9 -tetrahydro-cannabinol, or THC. The dried leaves or flowering tops are often referred to as marijuana or ganja (although ganja may also have a generic meaning), and the resin of the plant is referred to as hashish or "hash". Bhang is a drink made from cannabis. Cannabis appears to have some depressant qualities, but it can also have psychotomimetic effects. Until recently, it was believed that cannabis was innocent of dependence potential, but recent evidence throws some doubts on this belief. Research is now under way on possible harmful effects of cannabis on the brain.

Nicotine. This is another drug that merits a separate category. Nicotine can have a calming and sedative effect, but it is also capable of causing a degree of stimulation - it is a drug that can have a dual action. Nicotine readily induces a degree of dependence, but withdrawal symptoms are more a matter of restlessness and irritability than acute physiological disturbance.

Volatile inhalants. These include: anaesthetic gases, glues, lacquers, paint thinners, and so on. There is some doubt as to where to place these substances. They may have some depressant and anaesthetic effects, but they also seem capable of producing perceptual disturbances. The chief danger is their physical toxicity. Solvent sniffing can become a frequently indulged habit, but it is unclear whether in practice any severe degree of physiological or psychological dependence develops.

Miscellaneous intoxicants. There are a few other drugs that do not fit neatly into any of the drug categories mentioned. Included here are Kava, a substance used in some islands of the Pacific, and betel nut, which contains the drug arecoline and is widely used in Asia and the Pacific basin. Still another is the synthetic drug phencycline, currently popular among some groups of young people in the USA; in comparatively low doses it causes a mixture of drunkenness and anaesthesia, but in higher doses it causes psychotic states that may resemble schizophrenia.

Polydrug misuse or multiple drug misuse. In many countries, a long-established traditional pattern of drug use that centres exclusively on one substance (e.g., cocaine in the Andes region or opium in certain Eastern countries), is being replaced by mixed and often rather chaotic patterns of use where different drugs are used. This is occurring, in particular, among young people living in urban areas. Use patterns in cities may be influenced by fluctuations in fashion or availability. The polydrug misuser may, for instance, begin by smoking cigarettes and drinking alcohol and then may combine these at any given time with other drugs, such as amphetamines, cannabis or heroin.

Narcotics or narcotic drugs. As with "psychotropics" (see below), this is a term of administrative convenience rather than one of precise scientific meaning. The word "narcotic" is enshrined in such official titles as the United Nations Commission on Narcotic Drugs and the International Narcotics Control Board, and it has meaning within the United Nations Single Convention (as embracing opiates, cocaine, and cannabis). The

term is sometimes used as loosely synonymous with "opiates". The term thus has a formal meaning in relation to certain organs of the international control system and to international and some national legislation. For discussions of health-related issues, it is usually better to designate the class of drugs under discussion more precisely, as under the glossary entry "Classes of drugs".

Psychotropics or psychotropic drugs. This term has come into use to describe a range of drugs of varied pharmacological type that have, or have had, legitimate application in medicine (particularly psychiatry). The term is generally taken to embrace antidepressants and major tranquillizers: these two groups of drugs have negligible dependence potential and are unlikely to be of much concern to the London meeting. The psychotropics also include stimulants (such as amphetamines), sedatives and hypnotics (such as barbiturates), and minor tranquillizers (such as the benzodiazepines), and all these classes of substance have some potential for misuse and dependence. Thus, although the term has no precise scientific meaning, and puts together under one heading what the pharmacologist would consider to be a very mixed collection of substances, it is none the less a concept that is administratively useful. For instance, it defines the concerns of the Convention on Psychotropic Substances.

Recreational drugs. The use of some drugs, such as alcohol, is culturally approved and legally permitted in certain societies, not for a medical purpose but simply for a pleasurable or convivial effect. The "recreational" concept is useful within this restricted meaning but from the health perspective it carries no assumption that the designated "recreational drug" is free from health dangers or dependence potential. It is unsatisfactory, though, to extend the concept to include the illicit use of certain classes of drug (e.g., cannabis, intermittent use of heroin) just because the users themselves claim that personally their drug use is harmless fun and hence "recreational". Illicit use of drugs is by definition drug misuse.

Routes of drug administration. There are several different ways in which a drug may be taken into the body - drugs may be swallowed (eaten or drunk), chewed and absorbed through the lining of the mouth, sniffed and absorbed through the lining of the nose, inhaled through the lungs, or injected, either beneath the skin, into the muscles, or into a vein. Some drugs can be taken in several different ways - tobacco may, for instance, be chewed, sniffed as snuff, or smoked, while cocaine may be chewed in coca leaves, sniffed, smoked, or injected.

These different methods for introducing drugs into the body have important implications for drug effect, risk of dependence, and risks to health. The history is often of traditional cultures supporting or approving the use of a swallowed or chewed drug (opium eating, for example, or cannabis when drunk or eaten, or cocaine when chewed), showing rather more disapproving attitudes towards the smoking of a drug (smoked opium or smoked cannabis, for example, and initially, smoked tobacco), and absolutely disapproving the injection of drugs (heroin injection as supplanting indigenous opium use).

Such instinctive cultural appraisal seems generally to be based on a fairly accurate assessment of relative risks. A substance that is eaten will produce effects that are far less rapid in onset and less intense than those produced by the same drug when injected (with inhalation usually giving an intermediate effect, but with some smoked drugs providing much the same rapid impact on the brain as intravenous injection): opium when eaten gives nothing like the "buzz" or "rush" of heroin injection, but a much steadier level of intoxication. Methods of administration at the traditionally more approved end of the spectrum will then carry less risk of rapid dependence. Again, taking the opiate example, opium eating certainly implies risk of dependence, but it may be possible to eat opium over a fairly prolonged period without necessarily becoming dependent; smoked opium is likely to cause more major social incapacity and more rapid and less tractable dependence; intravenously injected heroin is not readily compatible with normal social functioning and carries risks of fatal overdose and of speedy and major dependence.

As regards risk to health, the potential damage associated with a given drug relates partly to the possible inherent toxic actions of that drug once it is circulating within the body and whatever the route of administration by which it gained entrance, but there are frequently also health risks related specifically to the route of administration. Inhaled drugs carry particular risk of damage to the lungs (cigarette smoking and bronchial cancer or chronic bronchitis), while intravenously injected drugs offer considerable risks of an infection being introduced - generalized infection of the bloods, for instance, or tetanus, hepatitis, malaria, or AIDS.

3. SOURCES

(a) Terms relating to the health planning context. The text in this section relies entirely on the Glossary of terms¹ published by WHO in relation to WHO's "Health for All" series. Quotations are verbatim, except that some have been shortened, a process that has necessitated a few minor editorial amendments.

(b) Terms relating to drugs. The entries relating to "drug", "drug dependence", "psychic dependence", "physical dependence", "dependence-producing drugs" are verbatim or near-verbatim quotations from definitions employed in WHO reports.² All other entries have been prepared specially for the present document or in the case of entries for "classes of drugs" and "routes of drug administration", are abbreviated extracts from a report based on a Collaborative Study by the World Health Organization.³

¹ Glossary of terms used in the "Health for All series", No. 18, Geneva, World Health Organization, 1984.

² WHO Technical Report Series, No. 551, 1974 (Twentieth report of the WHO Expert Committee on Drug Dependence).

³ Edwards, G. et al., ed. Drug use and misuse: Cultural perspectives. Beckenham, Croom Helm, & New York, Park Press, 1983.