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PROGRAMME ON
**SUBSTANCE
ABUSE**

Action to
reduce
substance
abuse

A framework for
developing national
programmes on health
and social problems
associated with alcohol
and drug abuse



WORLD HEALTH ORGANIZATION

There is a growing recognition throughout the world that alcohol and drug abuse are creating major social and health problems. Fortunately, there is also growing evidence that trends in these problems can be arrested and even reversed, provided that timely action is taken. The purpose of this document is to provide decision takers, policy makers and interested bodies and individuals with a framework for short and longer term action to reduce the harm caused by alcohol and drugs. It sets out the benefits of taking such action, and the costs of allowing the situation to deteriorate. It proposes a series of activities that can be undertaken immediately, with limited financial or manpower resources. It provides a more detailed outline for a comprehensive plan of action in the longer term, involving not only the health sector, but also other sectors of government as well as nongovernmental organizations. It identifies obstacles and suggests ways of overcoming them. Although the focus of this document is on action at the national level, it is important to recognize that much can be achieved at local and provincial levels as well. Other WHO documents address these issues, and can be used in conjunction with the framework for action set out here.

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ASSOCIATED WITH ALCOHOL AND DRUG ABUSE.

1. TOWARDS ACTION

There is a growing recognition throughout the world that alcohol and drug abuse are creating major social and health problems. Fortunately, there is also growing evidence that trends in these problems can be arrested and even reversed, provided that timely action is taken.

The purpose of this document is to provide decision takers, policy makers and interested bodies and individuals with a framework for short and longer term action to reduce the harm caused by alcohol and drugs. It sets out the benefits of taking such action, and the costs of allowing the situation to deteriorate. It proposes a series of activities that can be undertaken immediately, with limited financial or manpower resources. It provides a more detailed outline for a comprehensive plan of action in the longer term, involving not only the health sector, but also other sectors of government as well as non-governmental organizations. It identifies obstacles and suggests ways of overcoming them.

Although the focus of this document is on action at the national level, it is important to recognize that much can be achieved at local and provincial levels as well. Other WHO documents address these issues, and can be used in conjunction with the framework for action set out here.

Alcohol and drug abuse can undermine the health of individuals, of families, of communities or of whole nations. A coherent response to alcohol and drug abuse therefore requires the involvement of many different individuals, groups and sectors of government. Some measures that need to be taken relate to controlling the supply of psychoactive substances, whether licit or illicit. In this document, however, the major emphasis is on measures to reduce demand, through the development of effective approaches to prevention, treatment and rehabilitation.

In this context, it is important to ensure that services to combat alcohol and drug abuse are not developed in isolation. The programme of action set out in this document needs to be firmly anchored in other national programmes. It will relate to the mental health programme of a country and will often rely upon the expertise of those with mental health skills. Coordination of activities on the prevention of alcohol and drug abuse and activities on the promotion of mental health will strengthen the capacity of those working in all relevant fields to benefit from the widest range of experiences. Beyond that, it will be linked to the overall health programme of the country and to the many entry-points which exist for promoting healthier lifestyles.

It is also particularly important that a campaign dealing with drug abuse (specifically intravenous usage) should be seen within the context of the individual country's programme for tackling the issues of HIV and AIDS. Collaboration and coordination in undertaking this aspect of prevention and treatment activities is essential to achieve optimum effectiveness. In addition, the importance of other health consequences, such as the spread of hepatitis B infection, means that national control strategies with respect to drugs need to be kept under continual review.

Although special attention is given to the key role of the health sector in stimulating and sustaining action to reduce alcohol and drug abuse, it is clear that the health sector alone cannot achieve all that is desired. Effective coordination may often be achieved more easily at local than at national level and in this regard the principles and practices of community organizing may prove useful. Both locally and nationally, the health sector can play the key role in stimulating better coordination. In addition to strengthening coordination between sectors of government and creating opportunities for collaboration with nongovernmental organizations, there is a need to ensure that measures to reduce alcohol and drug abuse are seen as integral to a country's programme of national economic development. In this way, efforts to combat alcohol and drug abuse become part of a nation's positive drive to achieve its full potential. Those who are committed to promoting the development of the nation are thus naturally enlisted as allies in a common enterprise.

2. BENEFITS OF ACTION

The financial gains that can be achieved by adopting more effective national drug and alcohol policies include improved industrial and agricultural output, more effective use of education and health care services, reduced expenditure on law enforcement and greater family well-being. In addition health benefits will result from reduced levels of injury and enhancements in the length and quality of life of citizens which can be achieved by efficient policy interventions to tackle alcohol and drug abuse.

Why invest in national action programmes aimed at preventing the abuse of alcohol and drugs and treating those who have used these substances? It is only rational to undertake such investments if the rate of return, in terms of cost savings and reductions in avoidable mortality and morbidity, is sufficient to vindicate the outlay of scarce economic resources.

Gains from action will be apparent in a number of different areas.

2.1 Financial gains

The abuse of alcohol and drugs has serious financial consequences for a variety of institutions in any society. Taken together they can have a grave and disadvantageous impact on a national economy and its development.

i) Industry and agriculture:

If workers abuse addictive substances the quality and quantity of their work will be reduced. These effects will manifest themselves in reduced work effort and an increased probability of industrial injuries and damage to valuable equipment which will also affect future productivity. In some specific industries such

as nuclear fuel and power, oil production and transport, the potential damage and harm to others which can result from mistakes can be enormous. Additionally, use may increase absenteeism, leading to reduced output and under-utilization of scarce capital equipment, and dismissal, with consequent unemployment because of justified concern about the quality of the person's work effort. Furthermore it is not only the abuser who requires consideration here. Because alcohol and drug problems impact on family members their productivity and performance can also be affected. All these costs, which arise from the misuse of scarce skilled human resources, can be mitigated by cost effective prevention and treatment programmes.

ii) Education and health services

If the use of alcohol and drugs can be reduced amongst the young, investments in education would be more effective, both because of the reduction in immediate disability amongst young people themselves and because of the avoidance of longer term costs associated with chronic disability.

The impact of reduced substance use on the health care system will be double edged, especially in the short term. Improved screening to identify and help users may initially create demands for increased funding for care and cure. In the longer term, however, with reduced levels of use, these costs may be reduced. Of course, these reduced costs will need to be set against projected loss of government revenue (with respect to licit drugs, including alcohol) resulting from the implementation of more effective programmes.

iii) Law enforcement system

The systems of police, customs and excise, justice and prisons are very expensive. These expenses arise from the high cost of enforcing legal constraints (e.g. preventing illegal importation or production of drugs and alcohol) as well as dealing with breaches of the law (e.g. individual and group violence or theft arising from and/or necessary to fund the use of addictive substances).

Many societies have increased investment in these areas, but the cost effectiveness of these expenditures has been very limited. If substance use can be reduced, the rate of growth of these costs could be curtailed.

iv) The family

The individual user of drugs or alcohol can impose significant costs on other members of their family. These costs may be financial, requiring others in the group to earn to sustain the family's living standards, or non-pecuniary, if the user is violent or abusive. Children in particular may suffer severely from the effects of a parent's alcohol or drug abuse both in a physical sense (child abuse) and in terms of their own personality development.

2.2 Health gains

In addition to the financial benefits resulting from the reduced use of alcohol and drugs, there will be a parallel reduction in death injury and infirmity associated with such use and an enhancement of the length and quality of life of members of the population. In particular, significant improvements could be expected in relation to the following:

i) Injuries

Many injuries in the workplace, the fields and at sea are associated with substance use. In addition, use can lead to road traffic injuries, injuries in the home, injuries from street and other violence, and leisure injuries (e.g. mountaineering accidents and drownings). A reduction in alcohol and drug use will consequently lead to a reduction in the potential for such injuries.

ii) Diseases and premature death

Substance use leads to avoidable premature death from, for instance, liver cirrhosis for those using alcohol and the overdoses of drug addicts. Indeed, a wide range of debilitating diseases, including hepatitis B, are associated with the consumption of alcohol and drugs. The severity of the impact of these diseases upon populations is often directly related to the level of consumption of these substances. If, therefore, the consumption of alcohol and other drugs is reduced the risk of early death will diminish.

iii) Quality of life

Survival both for the user and for their relatives may be at reduced quality of life (in terms of physical, social and psychological well-being). Users may lose their job, indulge in criminal activity to finance their addiction and have few resources to maintain nutrition, cleanliness, clothing and housing. The effects of using these substances may be translated into effects across generations with the babies of users having reduced physical and social well-being. A reduction in use will offer the potential for improvement in the quality of life for all in the family group. Recovered abusers will generally discover new potential for personal development and will frequently experience a total change in their way of life. Such changes are very personal to the individual concerned and his or her family. They may be difficult to quantify precisely but should not be ignored when identifying the major benefits to society of dealing with alcohol and drug abuse. An improvement in the quality of life of a significant problem group can have a consequential beneficial effect on that of the wider society.

The existing levels of substance use impose considerable burdens, both in financial outlays and avoidable reduced health. As use increases, these costs expand. The potential gains from carefully articulated and implemented treatment and prevention programmes are considerable. For instance nationally coordinated policies can be seen to have reduced alcohol use and consequent harm to users. The management of drug use can reduce the spread of AIDS

resulting from the multiple use of needles. Whilst policies will vary from country to country, such potential gains make it rational to invest in prevention and treatment activities.

3. SHORT TERM ACTION

After identifying the individual or body that will have responsibility for the campaign, there are five factors which will determine the scope and direction of short term activities: issues already identified; observations by key individuals and organizations; findings of existing studies; limited investigations; and international experiences. It is possible to initiate immediate action using these determinants and achieve quantifiable results.

Some of the problems posed by alcohol and drugs are urgent, and require urgency in action. Some problems change suddenly, demanding quick changes in response. In any case, given current levels of concern relating to the growing seriousness of alcohol and drug problems, it is worth taking immediate action. In order to prevent the worsening of already damaging situations, the time to begin is now.

The first step in any national plan of action must be to designate a body or individual to oversee its operation. In many countries such a person or body already exists. They must have a clear mandate both in terms of expectations placed upon them in respect of achievements and the time to be taken in realizing these. They must also be provided with adequate financial resources to carry out their task. If no obvious body exists, then it is extremely important that the responsibility for setting up the action plan should be placed firmly with one individual. Failure to make these decisions can very quickly lead to serious problems.

ACTION:

Assess the potential for existing bodies or individuals to take on the responsibility for coordinating activities and ensure that a report back structure is established.

Short term activities, besides responding to urgent needs, bring about quick responses, are generally easily evaluated, sensitize governments and create community awareness of issues. They can also commit individuals, offer training opportunities thereby strengthening the national resource pool, and can attract national and international attention. In addition those individuals and bodies engaging in them can often improve their own status and image because of the impact resulting from such action.

Short-term action can also improve intersectoral relationships and joint activity. Where problems are shared with other countries, collaboration at this stage introduces the prospect of improved

international relations and the potential for joint campaigns in the future.

Short-term activities are not miniature long-term ones; they are specific entities, and have specific roles and functions. They may at times pilot long-term activities, and dictate the direction of future policy. Their precise nature will vary from country to country but they might include such functions as general awareness stimulation, limited testing of prevention or treatment options and the generation of political decisions relevant to the issue. Above all short term action must be visible.

Determining the scope and objectives of short term activities

Short term action should not be taken to mean "ad hoc". It is designed to achieve clear and predetermined objectives, should be planned accordingly, and incorporate an evaluation process. Although this implies a significant amount of background investigation prior to initiating short term activity, it does not under any circumstances mean that exhaustive research must of necessity precede it. There may even be occasions when opportunities arise, because of local political considerations. Whilst such opportunities may provide the impetus for a line of action that would otherwise have been difficult or impossible, caution needs to be exercised to avoid dissipating limited energies on activities which, though easy to launch, are not necessarily of highest priority.

There are five considerations which will assist in determining the pattern of short term action.

i) Issues already identified

Sometimes, particular problems arising from alcohol and drug abuse are well known but no action may have been taken to deal with them. Such instances may be generally known, professionally highlighted as existing fact, referred to by socially recognized individuals, exposed by responsible media or identified by nongovernmental organizations.

An advantageous position is where a given short term activity in the field of drug abuse prevention can be related to an expressed policy of a government. For instance, where poverty eradication is a government policy, this would include almost any activity designed to reduce the level of consumption of alcohol.

ACTION:

Identify existing issues and policies that have relevance to alcohol and drug problems. Include relevant government policies on issues such as economic development and AIDS that are supportive of short-term action to address alcohol and drug abuse.

ii) Observations by key individuals and organizations

Sometimes, responsible and knowledgeable individuals and organizations make their observations on relevant alcohol and drug related health issues known to the government, other interested persons, or to the media. They may in their conclusions associate factors as cause and effect. Such observations whilst not always scientific often give a general impression of the problem and may well be worthy of consideration as starting points for planning action. Picking up on the opinions of key people, or bodies such as social leaders, professionals etc., has the advantage that activities related to them often draw support.

ACTION:

Identify key individuals and bodies (including nongovernmental organizations) knowledgeable about alcohol and drug abuse, interview those persons to obtain their ideas about what short-term and long-term actions should be taken, sort those ideas by type and frequency, prioritize by feasibility, and summarize in report to decision-making group for action. Enlist the support of such individuals for the action plan.

iii) Findings of existing studies

Many societies already have an accumulation of relevant data although this may not be readily available or directly tied to alcohol or drug problems. It may be found in the research findings of academics and professionals on subjects which have relevance to alcohol and drug issues; or be retrievable from reports on matters directly connected with the subject. Sometimes, analysis of reports from government departments can reveal useful information. Whatever the source, such documents may well offer a baseline on which to plan useful activities. (See Annex 1 for further information on conduct of an inventory of existing resources.)

ACTION:

Identify potential sources of such study reports, including libraries, universities, and government agencies; request studies from potential sources; prepare inventory and review reports received; identify key findings from reports that are of immediate relevance to a short-term action plan.

iv) International experiences

From time to time, certain issues related to alcohol and drug consumption are brought to light at a global level. They are either of major potential impact on the human race or are of universal relevance. Since no nation can afford to ignore such issues they can offer an important starting point for the initiation of short-term activities. The association of HIV infection and drug use is a particularly important example of such an issue.

The priority attached to preventing the spread of HIV and AIDS throughout the world makes it imperative that consideration is given both to the nature and spread of drug use and its prevention.

There are also instances of national experiences which need to be tested in other sociocultural settings. Often, exhaustive original work has been done by the first country, and all that is required is a limited replication. When culturally applicable, such activities are easy to handle (because of the experiences of others), and often highly cost-beneficial.

Although every nation has its own unique problems, work carried out in other countries may well be relevant and offer ideas in respect of a whole range of matters ranging from questionnaire design or study methodology to the relative effectiveness of different educational or treatment programmes. Discussion with other nations may also open up opportunities for effective international cooperation.

ACTION:

Identify those international organizations (such as WHO) and other nations who have relevant expertise and interest in alcohol and drug abuse; request documents, reports and materials that may be beneficial; review such materials and, as appropriate, request further information or technical assistance.

v) Limited investigations

Sources of information referred to under i., ii., iii. and iv. above are likely to have produced many ideas which could provide a basis for action. Some of them, particularly those involving "cause and effect," may require further small-scale investigations to confirm their validity prior to further action although it may well be that the evaluation of the action programme itself may be the best way of testing the initial hypothesis. This can sometimes have significant drawbacks but it has the benefit of learning by experience.

ACTION:

Based on reviews of concepts and ideas generated by items i.-iv. above, identify opportunities for follow-up tasks, including both those suitable for immediate widespread application as well as those requiring more substantial investigation such as long-term research. (See Annexes 2 and 3 for further information.)

4. LONGER-TERM ACTION

Short- and long-term activities are clear and separate entities. If a short-term activity is found ineffective, much money and effort may be saved, and crippling frustration avoided by not embarking on any long-term activity which incorporates elements that proved to fail.

Although the actions described under the short-term category can be expected to produce some short-term results and to enhance the visibility of efforts to combat drug and alcohol abuse, they do not in themselves constitute a national programme. For that, a commitment is required to a more integrated series of longer-term actions. It is at this stage that it will be possible to establish priorities, and to plan ahead on a long-term basis.

In the following pages, longer term action is reviewed under five headings:

- identifying priorities
- establishing the programme
- maximizing service take-up
- training
- effective coordination.

4.1 Identifying priorities

It is necessary to establish an explicit system of setting priorities, to relate these to activities by service providers and available budgets, and to review continuously the performance of the programme. Priority setting will reflect political imperatives and those investments which are likely to generate substantial financial and public health benefits.

The first task is to identify goals of policy and rank these to form a set of priorities. These priorities will reflect public and political imperatives, "the felt necessity of the time", and what can be demonstrated to be good value in terms of producing health and financial benefits at least cost. Decision-makers will require a framework for identifying and monitoring performance in relation to agreed, explicit priority goals (such a framework is outlined in Annex 2). In order to ensure an ongoing commitment to priorities, they could be agreed to by all decision makers involved in the programme. Obviously priority setting must be realistic and avoid the adoption of unachievable targets.

In some circumstances an emphasis on preventive campaigning should be a first priority, while in others treatment services will be paramount due to the level of visible problems in a society. Neither approach is mutually exclusive - preventive work may well generate a demand for treatment amongst existing users by awakening a level of self awareness. If demand increases, it will be necessary to have services in place.

Some treatment services are preventive in that they not only act as vehicles for the dissemination of educational material but also, by intervention in the user's problem at an earlier stage, reduce the requirement to provide more expensive resources later on in their using "career".

Not all countries will have the same needs and priorities. Different stages of development in health care will lead to a variation in targeted goals, as also will cultural differences and the relative level of other problems, e.g. AIDS. Thus the prevalence of AIDS associated with drug use varies enormously, being a major problem in some countries and, as yet, a relatively minor one in others. Such factors will influence attitudes to and behaviour towards intravenous drug users and the identification of policy goals.

The establishing of priorities will serve as the baseline from which the development programme's success can be judged. Priorities will alter during the course of a programme as a result of changed user behaviour, changed distribution of the substances, pricing changes or some other modification to the user group or the substances concerned.

Once agreed, it may be desirable to publicize widely the agreed priorities for action as this will create a fertile constituency within which the prevention and treatment campaign can operate.

The development of any programme will depend on the financial resources made available. It is important that the instigator of any initiative is in a position to either make an agreed call on these resources or to bid for their allocation in accordance with expert criteria.

The results of short-term action, the analysis of the preliminary surveys and identification of needs will create a debate. It is important to limit this, if possible, to a period of consultation which is short (e.g. three months). It should be possible to start on-the-ground action to plan and implement services in a continuous, rolling process soon after the consultation period. This process will be informed by continuous monitoring of performance in relation to agreed policy goals.

ACTION:

Within a maximum of three months, identify priorities, identify budgets and devise management systems which relate budgets to goals in manner consistent with the achievement of priorities.

4.2 Establishing the programme

Prevention campaigns and service development are not mutually exclusive. Every action plan will include elements of both and each component will serve to enhance the other. The process of development must take account of local factors but should aim to generate both a basic awareness of drug and alcohol related health matters and provide at least some opportunities for assistance with individual problems arising from substance use.

Whilst needs and requirements will vary according to the priorities identified by different countries and to the relative state of development of existing specialist and other relevant services, there are a number of features which should be regarded as common to all plans and which encompass the wide range of treatment model options.

The actual implementation of any of these will also be determined by a number of other factors, e.g.

- the view likely to be taken by potential service users;
- the developing of joint or single substance services;
- cash availability;
- cost effectiveness of various levels of intervention.

4.2.1 Prevention campaigns

The format and content of a prevention campaign is extremely important and it is essential that the following should be considered prior to its initiation:

- (a) Education and information programmes should contain appropriate and relevant messages, i.e. succinct and to the point, aimed at a particular target audience or group of audiences. There exist varied opinions about the desirability or otherwise of some of the more sensational messages intended to inculcate fear. These can sometimes encourage rather than discourage use.
- (b) The message should be widely distributed using all available sources of dissemination including television, radio, press, advertising, posters, printed material and word of mouth transmission. If a number of different messages are being promulgated, it is important that these should be harmonized, so as to avoid confusion that might arise from apparently conflicting statements. Above all, the campaign theme must be visible and understandable, and should be supported by the widest range of relevant services.
- (c) It can be further backed up by utilizing other agencies, where appropriate, to pass on the message. These may include religious bodies, employers or managers, health care agencies.

- (d) It should contain some information about where to go for treatment or advice.
- (e) It should be sustained. Although there may be a limited life to any campaign, the message (perhaps in another form) will require regular repetition. It cannot under any circumstances be assumed that the simple receipt of the message after a short time will result in permanent mass behaviour change.

The organization and operation of the prevention campaign will depend on the level of development and the organizational structure of the particular country concerned. Given however, that the brief for developing the campaign should as far as possible be placed with the authority responsible for health matters, the main differences will be in the resources (both human and otherwise) and communications facilities available to the organizer.

Countries will vary in their level of infrastructural development and other characteristics. These will include:

i) Literacy level

Where national literacy levels are low or the problem is seen to be established among societal subgroups where illiteracy is common, the operation of the campaign will largely depend on the spoken word both via such communications methods as exist together with the use of local opinion leaders. Obviously in such a situation primary health care workers will play a significant part and it is extremely important that they and other key individuals should be both fully briefed and involved in drawing up campaign objectives. There will still be a requirement for visual image and written word back-up material. The use of high impact simple message posters with minimal word use, in such situations is likely to be extremely advantageous in getting a message to a wide audience.

ii) Education system

The level of development of a country's education system can have a profound impact on the potential for dissemination of the prevention campaign message. Schools of course offer an opportunity to direct the programme towards a specific audience which in many countries is shortly to become the age group most at risk. Within schools, factors such as class size, number of teachers and the breadth and content of the educational curriculum will have an effect on the potential for using this medium.

iii) The extent of development of mass communications systems: Radio, TV and Press

The existence of key communications systems which reach a larger part of the population either directly or, via onward verbal transmission indirectly, means that greater attention can be devoted to targeting the campaign towards individual risk groups. In states where such systems are highly sophisticated, it becomes possible to introduce a prevention campaign which makes use of all established advertizing and marketing techniques. Even where ownership of the appropriate receivers for radio or TV is low,

the use of this method of disseminating programme objectives is still important.

iv) The structure of communities - whether urban or rural

The extent to which a country has become urbanized will affect the means by which a prevention programme is disseminated. Where populations are concentrated, the use of mass systems such as posters, billboards, public transport and utilities as methods by which the targeted group may be reached, becomes possible. The programme's message can be highly visible to a significant number of people.

Dispersed rural communities require a different approach. Here more results may be achieved by concentrating resources on word of mouth transmission.

v) The extent of development of health care facilities

The more developed the health service, the greater the potential for both disseminating the prevention message and, at the same time, providing assistance for those with problems who are encouraged to seek help as a result of the prevention campaign. Even in relatively underdeveloped situations, however, the health worker's role in prevention is extremely important, both in ensuring that the message reaches the target audience, and in providing immediate advice.

vi) Nongovernmental organizations

Nongovernmental organizations can play a significant role in prevention and their potential contribution should be considered at an early stage in campaign formulation. Not all countries will have the same type or number of NGOs but most will have some which could be involved in the programme both at national and local levels. Sports, religious, educational and charitable bodies may all be able to assist, as will trade associations, professional groups and many other clubs and societies.

vii) Transportation services

Where transportation systems are well developed, they can be used both as a means by which people and hence the campaign message is taken out to the target group, and because they allow access to urban areas or other concentrations of population, e.g., markets, as a method of bringing this group in touch with the preventive message or services.

viii) The extent to which sub-national administrative structures exist

Where local or regional government structures are established, these provide an ideal point of message dissemination i.e. taking responsibility for ensuring that the nationally derived prevention campaign is initiated and maintained at a more local level. This increases the potential for market penetration.

ACTION:

Identify the target audiences and the means of message distribution most appropriate to local conditions.

Secure the cooperation of others likely to be of assistance in furthering the prevention campaign.

Set achievable goals for the campaign ensuring that unrealistic expectations are not raised.

Seek advice from international agencies and where possible professional communicators about the achievements of prevention campaigns carried out elsewhere and then identify the key message for the action programme.

Plan for monitoring of campaign impact and prepare for second stage activity.

4.2.2 The pattern of services

It is desirable that, where possible, at least some elements of the following types of services be included in any action plan. The degree to which these can be established will, of course, depend on the extent to which the country concerned has already established its generic health care provision. In cases where resources are very limited, it is not recommended that considerable attention be devoted to setting up specialist provision in advance of establishing generic systems. Here it is suggested that the focus of the action plan should be on equipping the appropriate non-specialists to provide a level of cover for alcohol and drug problems.

i) Non-specialist intervention - primary care

This must be undertaken by informed and trained persons whose normal work function could bring them into contact with individuals misusing drugs or alcohol. They include general medical practitioners, community based nurses, social workers, probation workers and non-specialist nongovernmental organizations. In some cases it may be possible for the problem to be handled as part of the routine work plan of these bodies or individuals; in others, it may require referral to a specialist person or agency, where they exist.

It is of extreme importance that this group of personnel is sufficiently aware of the nature of alcohol and drug problems to be able to make some judgement as to the appropriate course of treatment to be followed. In some countries the non-specialist will initially form a basis for the only available service.

ii) Intervention/easy access

It is desirable that there should be an easy access contact point for self or family referrals. Such an operation can offer both advice about treatment programmes available and possibly community-based counselling. This has the added benefits of potential for early intervention and the maintenance of the individual in the community, thereby enabling existing strengths

and links to be built upon. The skill to assess the desirability of a particular treatment option and to make onward referral where appropriate is important. The service can also provide a focus for the work and/or establishment of self-help groups.

Additionally, where there exists a tradition of voluntary (i.e. non-employed) service this can be harnessed to provide a trained counselling back-up to the activity undertaken by key staff. The issue of confidentiality, mentioned previously, is important in this element of service provision and the potential use of the service as a preventative base also requires mentioning. Such an agency may also be able to fulfill a role in providing aftercare and follow-up. Services of this type may sometimes be more effective when operated by nongovernmental organizations.

iii) Treatment services

The nature and level of sophistication of treatment services will vary from country to country. In some countries, a complete specialist team will include psychiatrists, social workers and psychologists operating in a specialized facility. In others, this will not be possible. Whatever the level of development of a particular country, there should be an attempt to provide at least some elements of both in-patient and out-patient care.

The available expertise and treatment facility will differ from place to place, but it should certainly offer both detoxification where necessary and initial rehabilitation. Where it is felt to be acceptable and appropriate in client care terms, the means to stabilize a person on a substitute drug may also be provided here.

Out-patient care may include the operation of day treatment programmes or other non-residential schemes. Where sufficient resources exist to administer it, home detoxification may be an option. The medical service also offers an opportunity to deal with other health matters affecting the user.

Where a specialist treatment facility does exist, it can also serve as a focal point for all involved in work with alcohol or drug problems, particularly for primary care workers who can use it as an advisory or support agency.

iv) Rehabilitation and aftercare

This may involve both residential and non-residential components geared towards relocating the individual in society. A number of highly developed programmes exist in this category and all have validity as treatment regimes.

In some cases these programmes will involve the acquisition of skills or participation in employment schemes, in others they will be more intensely therapeutic, and in some they may have a spiritual component. It is important, where a variety of approaches exists in one place, insofar as is possible, to locate the patient in the type of programme which best meets his needs.

In the early stages of setting up a treatment service a less sophisticated rehabilitation scheme could be introduced focusing on the user's future needs and providing aftercare and follow-up.

In many cases this will also be required for the individual's family. Self-help groups, where they exist, can be extremely effective in ensuring the continued well being of the ex-problem user.

One of the most essential messages to be conveyed to ex-users during this period is how they should deal with situations in which they run the risk of relapse.

4.2.3 Other factors in service provision

The location of services is a factor in determining both the take up of the facilities and their ability to penetrate the user population. Even in advanced countries, with highly developed transport systems, the distance which a potential service user must travel has frequently proved a disincentive to entering treatment. It is important, therefore, in planning services that there should be a rolling development programme to establish a geographical pattern of services that will eventually maximize the level of client take up.

In drawing up the service plan, attention must be paid to ensuring that appropriate referral links, procedures and coordination are maintained. The multi-disciplinary approach should be fostered.

Back up materials for the service will be required. These may include posters, leaflets, and other means of disseminating information about the service's availability.

The decision to implement a particular service approach will highlight further training or educational needs.

It may also have implications insofar as the provision of other health care services, e.g. sexually transmitted disease services, are concerned.

It is desirable that a comprehensive evaluation of any new service should be undertaken from its start date in order to provide some indication of its effectiveness.

All services established should be kept under regular performance review.

ACTION:

Since the stage of development attained by countries varies considerably, it is important that targets for service development should be attainable within the overall national context. The following are suggested as possible objectives. The objectives listed in (a) to (c) below form a sequence, related to the availability of current resources and facilities. It may often be appropriate to select objectives from all three categories, since countries will all have particular needs.

- 1) Basic objectives relevant to the needs of countries even where existing resources and facilities are very limited:
 - (a) All primary health care workers should receive basic training in alcohol and drug abuse matters.

- (b) A number of individuals amongst this group should receive more intensive specialist training in the care of people with alcohol or drug problems. Attention should be given both to the geographical coverage and to the possible establishment of a small central core team of practitioners with extended knowledge. This will then enable the country concerned to move to the next stage of development.
 - (c) The development of self-help groups should be stimulated.
- ii) Objectives relevant to the needs of countries where resources and facilities, though limited, are nevertheless constrained:
- (a) the basic training in alcohol and drug abuse issues of all primary care workers;
 - (b) the establishment of area teams of specialists to provide back-up services to primary workers;
 - (c) ensuring the provision by such teams of a generally available specialist advice service;
 - (d) the development of a hospital-based treatment service with a core team of specialist practitioners;
 - (e) the setting up of a pilot treatment and rehabilitation service for those persons receiving treatment (this may mean the allocation of additional staff and property depending upon local circumstances);
 - (f) the encouragement of self help groups.
- iii) Objectives relevant to countries where adequate resources and facilities are or are likely to be available:

The establishment of all elements of the recommended primary and specialist care services, i.e.:

- (a) trained primary care workers;
- (b) specialist intervention service;
- (c) specialist back-up workers;
- (d) community-based specialist services;
- (e) hospital-based specialist care;
- (f) rehabilitation and aftercare schemes;
- (g) self-help groups.

The level to which these will be developed will depend upon the existing pattern of specialist services but even where none or few are currently operational it is recommended that an attempt should be made to ensure that all elements are at least in place.

4.3 Maximizing service take up

New prevention and treatment services must be coordinated and promoted to make best use of resources. Typical reasons why services are not fully utilized include lack of awareness, stigma, cost and difficulty in getting to the service. Most barriers can be overcome with careful promotion and monitoring.

It is not sufficient just to open up a service and expect it to be used. Experience indicates that services must be promoted for them to be used as intended. If they are not promoted properly, officials may see low use of the facilities as reason to eliminate such services before they have a fair chance to work. Potential users must be aware of what services are offered and how they fit the particular needs as the user perceives them to be. There will often be a lag time before any new service is fully used, no matter how great the need. Further, there may be barriers to use, such as stigma (see section 5) or transportation problems, that can not be overcome simply by providing a new service. Strategies therefore need to be developed to reach those who could benefit from services, but are not currently making use of them.

With treatment facilities both potential users and primary care workers should know what service is available, should believe that the treatment can be effective, and should be satisfied that it will be confidential. Training programmes for primary health care workers may include information on overcoming barriers to the use of services. The potential service users may need encouragement to deal with their problems and it is thus desirable to ensure that a sympathetic, caring image of the service is conveyed.

The methods of communicating with drug and alcohol users will vary according to prevailing local culture and availability of communications resources. This should include both mass media and interpersonal methods, such as radio and television, leaflets and posters, and word-of-mouth communication from religious and cultural leaders, educators, recent users of the service, and others considered to be opinion leaders. It is crucial that all information transmissions, whether visual or verbal, should present as user-friendly.

The need for coordination between preventive and educational programmes and the provision of treatment services is of paramount importance in ensuring the effectiveness of both of them.

ACTION:

Determine expected level of service utilization at various time points, interview service providers and service users to identify major barriers to service utilization (such as lack of awareness, stigma, transportation, cost, etc.), and develop specific action plan with timetable to overcome such obstacles.

4.4 Training needs

An inventory must be made of the required level of competence that various categories of health professionals need to acquire in the context of a national alcohol and drug abuse programme.

Training institutions have a responsibility to make the necessary changes to meet the new educational needs. More importantly, they should take the lead in coordinating research and development activities on a community-wide basis.

The content of undergraduate, postgraduate and continuing education courses for healthcare professionals may require revision to ensure the acquisition of appropriate skills to deal with the comprehensive health needs of individuals, families and communities affected by alcohol and drug abuse problems.

The decision to set up prevention and treatment programmes inevitably raises the question of whether existing professionals, statutory and nongovernmental agencies are equipped with the specialist knowledge or skills required to make a contribution to the programme's operation. In those countries where it has not been a serious issue in the past or where existing health care services are limited, there will be a pressing requirement to identify the skills that health professionals need to acquire and the means by which these might be obtained.

Training both at undergraduate and postgraduate levels, as well as continuing education, needs to be considered in this context.

Undergraduate curricula for medical, nursing or social care practitioners should be reviewed to help ensure that trainees acquire the necessary skills to understand and tackle the complex needs of individuals, families and communities affected by alcohol and drug abuse problems.

The time allocated to training should vary with and relate to the level of specialist skills assessed as being appropriate to each category of health care professional.

The nature of alcohol and drug abuse makes it important that the training of health professionals takes into account the need for multi-disciplinary thinking and action. It is therefore desirable that training should, where possible, take place in teams composed of students or practitioners from different professional backgrounds.

The learning process which would facilitate best the acquisition of the required skills is based on problem-solving principles and methods. Trainees should be faced by actual and simulated situations to analyze and suggest alternative courses of action.

In some specific cases, for instance those medical workers specializing in mental health, there should be an enhanced training in alcohol and drug problems provided in their specialist education.

Social work qualification courses and those for similar professions should also include instruction in substance abuse as an integral part of that course. Requirement levels will vary, but should be similar to that recommended for medical personnel. In some cases (e.g. social workers associated with the criminal justice system), there is a strong case for suggesting a significant increase in specialist training. Social worker training should be particularly focused on developing the ability to identify problems and providing the family care requirements which may result.

Continuing education programmes for those key agencies where no formal qualification exists should be dealt with by a programme of regular seminars and technical skills training courses. In such cases, it is important to capitalize upon the existing skills, experience and enthusiasm of volunteer workers and not to attempt to over-professionalize them. Instead, it is necessary to identify opportunities to strengthen links between professional and voluntary services.

The objective of training programmes should be to ensure that all medical practitioners and nursing staff likely to come into contact with substance abuse problems and all social workers and welfare staff are provided with the skills necessary to recognize, assess and, where appropriate, treat problems when they appear. Some non-specialist nongovernmental workers that encounter the problem may also require appropriate training.

Training for both specialists and non-specialists should cover the following areas:

- (a) illustrative case histories;
- (b) the nature of drug and alcohol problems and their effects;
- (c) characteristics of users, including social and demographic variables;
- (d) the identification of problems, assessment and goal setting;
- (e) treatment methods and options available;
- (f) sources of specialist advice and guidance;
- (g) the family dimension to alcohol and drug problems;
- (h) associated health issues (e.g. HIV and AIDS, liver cirrhosis; hepatitis B);
- (i) prevention and education programmes;
- (j) legal and ethical implications;

For those who are specializing in working with alcohol or drug problems, a more specific and intensive training programme to develop appropriate skills will be necessary. Regular refresher courses should also be included in the training plan.

Regular updates on developments in the field (e.g. through news sheets, regular discussion groups and follow-up meetings) should be established to ensure that awareness levels remain high.

Three groups outside the health sector should also receive some basic training in the nature and treatment of drug and alcohol problems.

- (a) The role of school teachers in communicating messages about alcohol and drugs is potentially very important. It is therefore essential, where a prevention campaign is envisaged, that they should be fully informed and able to pass on their knowledge to others. In societies where the educational system is highly developed, it may well be appropriate to provide specialist educationalists to train school teachers in substance use matters.
- (b) The judiciary should be provided with seminars similar to those provided for non-specialist health workers.
- (c) The law enforcement personnel should receive education on the nature of drug and alcohol problems during their initial training and this should be followed up with seminars for key officers.

Whilst training is a necessary prerequisite to developing a service, it also has long-term implications and will require regular enhancement. Work-based training to ensure that workers both keep abreast of new developments and learn additional skills is highly desirable.

The participation of training institutions including universities is essential to the success of both prevention and treatment programmes. In addition to their educational activities, they should also undertake research and evaluation, and contribute to the planning, implementation and monitoring of intervention programmes. They should be encouraged to develop partnerships with health professionals, health authorities and representatives of nongovernmental agencies and health consumers in order to ensure that action on alcohol and drug abuse is able to maximize its effective potential.

ACTION:

1. Undertake an exercise to identify (a) the responsibilities and skills required by each profession concerned and the training and educational initiatives required to achieve this.
2. Design problem-solving learning packages to suit each health professional's needs and to train trainers for that purpose, taking into account the multidisciplinary nature of the problem.
3. Encourage and support universities and other educational institutions to plan, implement and evaluate community-based intervention programmes.

4.5 Effective coordination

To achieve success, intersectoral coordination based primarily on agreement about objectives and actions is paramount. Coordinating bodies at national level will bring together both statutory bodies and non-governmental organizations. These bodies should include persons of authority, national leadership, finance providers, and in addition to the health ministry, other relevant departments of state.

The need for coordination will become apparent as soon as the process of identifying priorities begins. Such coordination will be required between different parts of the health sector (for example, between preventive and treatment services), between health and other sectors (for example, education, justice, finance and others), between state sectors and NGOs, and between NGOs themselves.

In this context, it is important to ensure that services to combat alcohol and drug abuse are not developed in isolation. The programme of action set out in this document needs to be firmly anchored in other national programmes. It will relate to the mental health programme of a country and will often rely upon the expertise of those with mental health skills. Coordination of activities on the prevention of alcohol and drug abuse and activities on the promotion of mental health will strengthen the capacity of those working in all relevant fields to benefit from the widest range of experiences. Beyond that, it will be linked to the overall health programme of the country and to the many entry-points which exist for promoting healthier lifestyles.

It is also particularly important that a campaign dealing with drug abuse (specifically intravenous usage) should be seen within the context of the individual country's programme for tackling the issues of HIV and AIDS. Collaboration and coordination in undertaking this aspect of prevention and treatment activities is essential to achieve optimum effectiveness. In addition, the importance of other health consequences, such as the spread of hepatitis B infection, means that national control strategies with respect to drugs need to be kept under continual review.

Although special attention is given to the key role of the health sector in stimulating and sustaining action to reduce alcohol and drug abuse, it is clear that the health sector alone cannot achieve all that is desired. Effective coordination may often be achieved more easily at local than at national level and in this regard the principles and practices of community organizing may prove useful. Both locally and nationally, the health sector can play the key role in stimulating better coordination. In addition to strengthening coordination between sectors of government and creating opportunities for collaboration with nongovernmental organizations, there is a need to ensure that measures to reduce alcohol and drug abuse are seen as integral to a country's programme of national economic development. In this way, efforts to combat alcohol and drug abuse become part of a nation's positive drive to achieve its full potential. Those who are committed to promoting the

development of the nation are thus naturally enlisted as allies in a common enterprise.

In developing a programme on substance abuse, it is important that national leadership should be provided. This would help enhance coordination at all levels.

The first task in establishing coordination is to obtain agreement with the defined aims of the proposed action plan, its time scale and its constituent parts. It is necessary, having regard to the resource implications of the programme, that there should be appropriate involvement, at all stages, of those responsible for financial allocations.

ACTION:

Identify sectors/organizations that need to be coordinated for a given activity/activities. Identify authorities/national leadership that should be represented on them. Assess the feasibility of using in its present form/modifying an existing coordinating body, or setting up a new one. Define the role of the coordinating body, particularly with regard to accountability/review/evaluation of activity coming within its purview. (Refer Annexes 1 and 3).

5. **OVERCOMING OBSTACLES AND PITFALLS**

Major barriers and pitfalls can threaten the success of an action plan but there are ways to overcome them. Obstacles to even the best of plans will always exist, but by anticipating such problems and developing alternatives, the chances for both short term and long term success can be improved.

No matter how well-prepared an action plan is, there will be some barriers to its implementation. These may take several forms: a lack of understanding, natural inertia, or active opposition. The better these obstacles are understood when preparing and justifying the action plan, the more likely it is that they can be dealt with successfully. Just as no plan will be perfect in its first draft, no plan will get everyone to understand and agree to it right away, regardless of possible objections and difficulties, it may be possible to preempt delays which would otherwise occur and to expedite the development of the programme activities.

(a) **Decreasing stigma and denial**

The stigma associated with alcohol and drug abuse and the denial that the problem really exists in the individual, the family, the community and the society are frequently barriers to success. Alcohol and drug use is heavily stigmatized in some societies because of historical, religious, social and legal reasons. This often results in lack of attention to the problems because some people believe that alcohol and drug users should simply stop using these substances, and

that resources should not be "wasted" on those whose illnesses are "self-inflicted" or who are simply "criminals". This view ignores the reality that such substances are highly addictive and therefore it is not easy to just stop using them. It also does not take into account the broader social and economic costs of the use of such substances, and the benefits to all of reducing such problems.

A frequent consequence of stigma is denial. This means that individuals, families, and communities do not admit that a problem with alcohol and drugs exists whereas in reality it does. No one likes to admit to problems, especially when such problems are viewed by many in society as caused by a personal weakness rather than as a "real" health or medical problem. Therefore, addicted individuals may refuse to get help, families may not get an addicted family member into treatment, the community may not provide enough treatment facilities, and the society may not devote sufficient resources to the overall alcohol and drug problem, or may decide to affix the blame for such problems somewhere else, such as on a drug-producing nation. This also may result in severe under-reporting of numbers of problems or persons in treatment, thus artificially limiting resources by even the most responsive of health organizations.

ACTION:

Decrease stigma and denial by making it more acceptable to admit to a substance abuse problem, perhaps through media coverage of celebrities entering treatment; educating both opinion leaders and the public about the causes and symptoms of alcohol and drug abuse, and increase public belief in the benefits of treatment; inform health care workers about available prevention and treatment services.

Denial of the problem can be addressed by reducing stigma, thereby making it more socially-acceptable to admit to alcohol and drug abuse. Some approaches include increasing media attention about famous personalities who have been treated successfully, more public discussion of the causes and symptoms of alcohol and drug dependence, and building public confidence in the benefits of treatment. Public information and training of care-givers such as doctors, nurses, and social workers is necessary over a period of time. While these efforts eventually will help reduce denial, they do take time. Unfortunately there is no quick way to reduce the denial that has built up over generations.

(b) Negotiating cooperative arrangements

In some countries, there will exist organizations that have been involved in working with alcohol and drug abuse for years and which will be resistant to sharing this task with others. Such groups may oppose a dynamic action plan, and this should be anticipated.

The action plan may call for more of a balance between prevention and treatment services. This may mean that treatment-oriented groups oppose the plan because they see themselves losing scarce resources, and might argue that no funds should be spent for prevention when there is still one person left untreated. However, it is only when we begin to prevent as well as treat alcohol and drug abuse can we expect to reduce such problems overall. An action plan that is not criticized by

someone probably has failed to be strong enough to achieve real results when implemented.

Other organizations may object for other, including political, reasons. For example, an action plan that calls for reduced availability of alcohol may be opposed by those who make their living from sales of alcohol. This may include government agencies that tax and sell alcohol. Nevertheless, this may be a very sound strategy to reduce alcohol problems in a particular society. Likewise, a measure aimed at reducing production of an illicit drug may be opposed vigorously - if indirectly - by those who profit from the sale of that drug.

ACTION:

Anticipate objections that might be raised by various groups who would be threatened by the action plan, develop counter-arguments, provide data (if available), and be ready to suggest alternatives such as further study, a pilot project, or deferral of an action until a later phase of the programme.

(c) Avoiding the temptation to fix blame

One common pitfall that can become a barrier to success is affixing blame for the problem. It is a temptation, especially when alcohol and drug abuse has increased dramatically, to transfer the blame to someone else - either a group or another society. This too often either blames the victims - dependent persons - for their addictions, or blames the drug producers exclusively. Neither message is particularly useful in reducing problems, as it increases the stereotypes about alcohol and drug abuse without addressing solutions, and may set up further barriers to success by alienating some groups.

ACTION:

Develop positive messages about alcohol and drug problems to channel energy into prevention and treatment; avoid creating adversaries, especially among those persons for whom services are designed to help.

(d) Avoiding "quick fix" solutions

Some elements of the action plan need to demonstrate quick response and success to become visible and build confidence. However, such activities cannot substitute for long term efforts and achievement of results over time. It may be a temptation to launch a single, highly visible effort, such as a media campaign, and then fail to implement other action. While such efforts can be important, they should not take the place of longer-term efforts. Building public and opinion-leader awareness of the nature and extent of alcohol and drug problems is just the beginning, and urging users and potential users to "just say no" is not very effective. Early efforts to address the problems may well increase the visible problem by making it more acceptable to admit to one, thus building demand for treatment. So the most effective short term actions may demonstrate that alcohol and drug abuse is more extensive and problematic than was at first believed.

ACTION:

Develop a visible, credible programme element to achieve visibility for the alcohol and drug problem, but avoid "quick fix" solutions that may create new problems; anticipate and plan for visible programmes creating a greater demand on existing new services.

(e) Countering arguments about lack of apparent harm

Some critics may argue that alcohol and drugs can be used by some persons without harm to anyone but themselves, and therefore prevention of use is not necessary. Alternatively, it may be said that the family may be sustained by trade in such substances, and the reduction of these earnings may have deleterious effects on the group's ability to subsist. This concept can be a major barrier to addressing the problem as it ignores the fact that most people live in communities where the consequences of such use affect virtually everyone in some way. For example, a person who becomes dependent on drugs may spend large sums of money, thus depriving the family of food and shelter, as well as causing them to be a less productive household. The costs to society of medical care, lost work production, support of a family and life-long support of a child of a substance abuser, are considerable. Thus the community has a financial stake in its members as well as compassion for their individual well-being. As little alcohol and drug use is without risk, this provides the community with a reason to try to reduce harm and suffering caused by use.

ACTION:

Identify all types of harm related to alcohol and drug use, such as economic, health and social costs, and including other visible problems such as AIDS and crime to demonstrate the full harm to society; present information showing that there are circumstances where even occasional experimental use of alcohol and drugs can lead to addiction and other problems; identify particular harm to children caused by alcohol and drug use.

The planner should expect to receive some criticism of the action plan, and should be ready to address such obstacles as opposition to part or the whole of it. The process of debate is however an important part of any planning effort which should be viewed as an opportunity to educate organizations who will be active in the implementation of the plan, in both the long term and short term. Conflict may develop, be disruptive and block certain essential parts of the action plan in the short run. However, over the long term, the ownership of the plan by a broader constituency will probably serve to increase the chances of truly reducing alcohol and drug abuse. Planners should not become discouraged by such obstacles, but instead should be stimulated by them.

6. ENLISTING FURTHER SUPPORT

The impact, success potential and credibility of any action programme will be enhanced if other significant agencies and individuals at international, national and local levels are involved at an early stage, and attention is paid to maintaining their commitment.

(a) International level

The support of recognized international agencies such as WHO and ILO for the development of a prevention and treatment programme can both enhance the status of that campaign and act as a source of professional help and advice.

Where a country is involved in a regional grouping of states, fellow members may be able to assist by sharing their own experiences or offering their expertise. Since the problems caused by alcohol and drugs transcend national boundaries, there may well be enthusiasm for joint simultaneous action in neighbouring countries.

(b) National level

At a national level a wide range of bodies and individuals can be identified as having an interest in the reduction of alcohol and drug-related harm. In some cases their cooperation will be critical to the campaign's success (e.g., the most senior government figures and law enforcement bodies), and in others their cooperation in the campaign will enhance its status and help in ensuring that it maximizes its effectiveness. In securing support it is essential that all potentially interested parties understand what benefits will accrue to themselves, and when these are likely to occur.

The following organizations or individuals may be of considerable assistance in developing a widespread support network:

- government ministries and senior administrators responsible for law and order, finance, social welfare, employment and education.
- associations of industrialists and employers;
- trade unions;
- commercial companies with a direct interest in reducing harm, e.g., insurance, banking;
- the media (both written and broadcast);
- national organizations of health care professionals and other professional bodies with an interest in the issue (e.g., planners);
- religious leaders;

- nongovernmental agencies;
- national figures (particularly from entertainment and sport) who provide role models for the young.

This list is not exhaustive and attention will need to be devoted at country level to ascertain which groups are likely to be most critical to the campaign's success.

(c) Local level

The support at local level of significant opinion leaders and those controlling locally distributed financial resources will be beneficial to the campaign. They should include as appropriate, political decision makers and local officials as well as those prominent in commerce, trade unions, the medical professions, local associations and local media.

ACTION:

1. Contact all potentially interested organizations and individuals as soon as possible, and elicit their support for the action programme.
2. Ensure a mechanism for coordinating their activity and establish effective communication links to ensure that their interest is maintained.
3. Develop a method by which all supportive bodies or individuals can feel involved in the programme, even though the key task of ensuring implementation of the action plan remains with the body responsible for health matters.

<u>Immediate</u>	<u>Short-Term Planning</u>	<u>Outputs</u>	<u>Short-Term Action</u> (Sample priorities)	<u>Longer-Term Action</u> (Sample priorities)
Designate individual or body	1. Identify key issues and policies relating to the key problems		1. Prepare/promote national action plan (Both short- and long-term)	1. Establish national coordinating body
Describe key problems	2. Interview key individuals to obtain their perspectives and ideas, and to enlist their support		2. Develop/strengthen linkages with key organizations - existing mental health organizations - existing nongovernmental organizations - other key sector organizations	2. Inventory prevention/treatment services
Identify and involve key individuals and institutions	3. Gather and review available studies for ideas, recommendations, and sources of data relevant to action	1. Brief status reports 2. Goals and priorities for national action plan 3. Pilot project opportunities	3. Develop/strengthen prevention services - identify key messages and channels - promote service availability - etc.	3. Conduct prevalence study
	4. Identify international organizations and other nations who might provide ideas, approaches, methods, technical assistance or resources		4. Develop/strengthen treatment services - prepare list of treatment facilities - improve access to care - etc.	4. Evaluate prevention services
	5. Identify immediate needs for limited investigations in response to above steps		5. Train prevention providers at community level	5. Evaluate treatment services
			6. Train treatment providers at PHC level	6. Evaluate training programmes
			7. Seek additional technical and financial resources	7. Analyse public policies for improvement
			8. (Other)	8. Provide for regular review of national action plan
			9. (Other)	9. (Other)
				10. (Other)

ANNEX 1

The Inventory of Existing Responses and Resources

- 1.1 As part of the initial information gathering exercise and before embarking on any preventive or treatment service development programme, an inspection of existing activities, both specialist and relevant non-specialist, can be undertaken in order to ascertain:
 - (a) those which do not need replication;
 - (b) those which could provide models to be used elsewhere;
 - (c) those components which are capable of further expansion;
 - (d) those which, with additional training or orientation, could increase their contribution to the field of work.
- 1.2 Where a subject focused prevention programme already exists or has until recently been in operation, an attempt should be made to assess its effectiveness. Where no formal evaluation has been undertaken it should be appraised in terms of its direction, operational practice, instigation of programme, methods used, materials, target audience and geographical spread.
- 1.3 Non-specialist prevention programmes may deal with alcohol or drug issues as part of a general spectrum of health matters. Where this is so or where the potential for doing it exists, the overall operational effectiveness of the programme requires appraising in the same way as specialist operations.
- 1.4 Services are delivered in both specialist and non-specialist forms. They should be appraised in terms of the effectiveness of existing activity and in particular the extent to which they identify problems and are dealing with them.
- 1.5 Specialist services may fall into the following categories:
 - (a) Medical - treatment units, detoxification units, in-patient, out-patient;
 - (b) Community-based - advisory services, counselling, day programmes, detached operations, rehabilitation centres, residential care, telephone counselling, befriending schemes, family care, activities schemes, skills training;
 - (c) Self-Help Groups - international bodies, e.g. Alcoholics Anonymous, Narcotics Anonymous, local mutual support operations;
- 1.6 In appraising specialist services and, for that matter, in planning new developments, it is important to remember that there are many different models and philosophies of treatment. It is necessary, however, to make some judgement about the appropriateness of the existing treatment philosophy in relation to the prevailing needs identified in the assessment exercise and the particular social environment of the country.
- 1.7 In any field of care there exist a number of bodies purporting to provide specialist treatment services who are either fraudulent or of questionable motivation, some of them being international in their sphere of operation. If doubts exist about whether an organization is reputable then appropriate checks should be made.

1.8 Non-specialist services include:

- (a) Medical - accident and emergency, liver specialists, general psychiatric, general practitioners and community medicine specialists. Of these, the last three in particular could play a significant expanded role in the development of specialist service provision.
- (b) Community-based - social workers, welfare centres, adolescent centres, marriage guidance counsellors, night shelters or resettlement units for the homeless, probation service, education welfare practitioners, youth organizations, occupational health workers. Whilst all of these agencies would benefit by specialist training in most instances they would not see their main task as dealing with the substance abuser per se. Their contribution could, however, be important particularly where specialist resources are not present or are at an early stage of development. Social workers and probation officers in particular are well placed to develop a special interest.

In the development of community services for problem alcohol and drug users, the role of the experienced non-specialist, both as trainer and as a potential recruit to a specialist task team, cannot be overemphasized.

- (c) The police - all police forces have a role in the process of dealing with drink or drug problems. However, their task is one of law enforcement not treatment and they should not, therefore, be considered as part of the health care process or its administration. Where cautioning policies exist, however, they may provide a means for putting potential service users in touch with treatment agencies.

- 1.9 When an appraisal of existing action is being undertaken, some attempt should be made to ascertain the nature of treatment path (if any) of the user coming into contact with a particular agency, e.g. does it lead to care and rehabilitation, criminal conviction and prison, assistance with other presenting problems.
- 1.10 The identification of specific individuals with the existing skills (or potential for acquiring them) to participate in the developing programme can also be carried out at this time. This will include people from all disciplines - doctors, social workers, educators, nurses, nongovernmental organizations.
- 1.11 As part of the exercise it will be useful to collate information on backup services which can be utilized by a specialist facility. This includes the identification of family support provision and long term community follow-up.
- 1.12 The orientation of existing treatment services is important, i.e. are alcohol and narcotics problems dealt with together or separately? Increasingly, it is being suggested that the former is appropriate in treatment terms but perceptions will vary from country to country.

- 1.13 The degree to which separate bodies and agencies are integrated is highly relevant to the development of a specialist service. Where this does not take place it is very easy for individuals to slip through the treatment net. It is desirable, therefore, to establish whether facilities exist to permit cross referral, case conferences, and information exchange between different treatment agencies.
- 1.14 The rules for dealing with confidentiality need to be identified and monitored. In places where simple possession of a substance constitutes an offence in law, it is important that the person seeking help can do so without fear of arrest or having information about them being passed beyond the specialist treatment network. If this fear exists people will not come forward for treatment.

ANNEX 2

Monitoring Programme Performance

2.1 In a world in which resources are generally scarce, it is necessary to justify their use and demonstrate that they provide good value for money. This monitoring can be done at a variety of levels.

2.1 Monitoring inputs

The monitoring of inputs requires the identification, measurement and valuation of all costs associated with the activity, regardless of whether it is preventive or curative. Some of these costs are easier to identify than others. The costs of producing interventions, both capital and current, are never easy to identify because most systems have poor management information systems. Even when costs have been identified their apportionment across joint activities is never uncontentious e.g. how much of the cost of a hospital portering system or of a capital asset such as a building should be apportioned to a drug clinic?

The acquisition of cost data about patients and their carers is not easy either. For instance if carers give up work or leisure to look after addicts, how are these foregone activities to be valued? Crude methods exist to value these effects and, similarly, the indirect effects such as those arising from industrial restructuring arising from, for instance, reductions in brewing capacity.

2.3 Monitoring processes

This requires that activities or processes of prevention and cure are identified and, where possible, quantified in terms of costs and volume. In general, this requires that efforts are made to record what has occurred in the initiation, implementation and development of particular activities and of the programme as a whole. This is both a descriptive and an evaluative enterprise and needs to be taken seriously as an inherent component of monitoring.

2.4 Monitoring outcomes

The desired effect of these inputs and activities is improvements in health. These improvements may manifest themselves in financial benefits such as reduced use of services, increased productivity at work and the growth of new industries resulting from consumer expenditure being switched out of alcohol and drug expenditure and into the consumption of other goods and services.

Another aspect of the outcome of these activities will be enhancements in the length and quality of life. Whilst avoided mortality (i.e., lives saved or gains in life years) is possible to identify, there is no agreed method for valuing improvements in the quality of life. However, crude explicit estimates of such attributes of outcome are useful if the full effects of preventive and treatment interventions are to be identified and given due weight.

ANNEX 3

Assessment of the Nature and Extent of Drug and Alcohol Problems

- 3.1 The collection of information is a preliminary to the instigation of a prevention or treatment programmes. This should not be a detailed and long term research exercise, but an attempt to gain a broad overview of prevailing trends in substance misuse.
- 3.2 All forms of data collection will give incomplete estimates of the numbers involved in the misuse of alcohol or other drugs. The collation of existing information will underestimate the true level of the problem. There is significant evidence that, only when specialist services are established, does its actual extent of use become apparent. This is due to the fact that the abuse of alcohol or drugs will generally be either illegal or have attached to it a high level of stigma and denial.
- 3.3 Despite its incompleteness, such data gathering will enable a first attempt to be made to direct preventative and treatment programmes towards identified problems, presenting groups or localities. The information obtained can help in gaining the support of key decision takers; a necessary prerequisite for successful action. Finally, with resources always scarce, the data produced can provide a justification for the setting up of an action programme.
- 3.4 Even if the initial assessment does not indicate the existence of an extensive problem with alcohol or drugs, international experience shows that it does not follow that a problem does not exist or is not likely to exist in the future.
- 3.5 The exercise should, ideally, attempt to obtain information in the following categories:
 - (a) characteristics of the users - sex, age, marital status, parental responsibilities, employment status, criminality, social categorization, associated medical, health or social problems, membership of societal subgroups, ethnicity;
 - (b) location of the users - urban, rural, sectors of urban areas, regional variation in prevalence, type of housing;
 - (c) drug of choice - alcohol or other drugs, singly or in combination, substance substitution, extent of cross usage;
 - (d) level of drug use - quantity, frequency, quality of drug of choice, relative strength (alcohol);
 - (e) cost of use - price of drug, levels of individual expenditure on drug of choice as a percentage of income;
 - (f) financing of expenditure - employment, welfare benefits, crime, dealing in illicit substances, prostitution;
 - (g) environment of drug use - using alone, group usage, sharing of equipment of using, legal setting (where licit substances are misused), place of use;
 - (h) administration of substance - oral, injection, inhaling, other;
 - (i) length and pattern of use - months, years, continual, bout, sporadic, recreational, social, indications of decline in personal control of use;
 - (j) existence of previous problems - same substance, other substances;

- (k) reasons for use - where any assessment of these has been made;
- (l) current disposal of clients - treatment, counselling, probation, prison, death, nothing.

3.6 A number of agencies or organizations are likely to possess data which will be useful. Some of this will be scientific and some will be anecdotal material. In attempting to gauge the extent of use, this latter information can be extremely valuable. Amongst the bodies who should be approached are:

- (a) health managers responsible for records maintenance;
- (b) health care professionals (doctors and nurses) with specialist interest;
- (c) any existing specialist agencies;
- (d) other health care professionals likely to have contact with substance misuse problems. These will include: accident and emergency personnel, sexually transmitted diseases clinics, liver units, gastroenterologists, neurologists, general psychiatrists, community medicine specialists, health visitors, general practitioners;
- (e) social care or welfare professionals and their administering authorities;
- (f) the police, other law enforcement agencies and the customs authority;
- (g) prison administrations, who will frequently have contact not only with recognized admitted users but who will also have information relating to illicit use within the prison setting;
- (h) probation services;
- (i) court records administration and, where appropriate, the judiciary for information on sentencing policies;
- (j) generalist nongovernmental organizations, especially those where their work is primarily in the orbit of social welfare or aid. Also temperance bodies;
- (k) education administrations and teachers, also, where they exist, education welfare officers;
- (m) employers may frequently have had to deal with issues of alcohol or drug abuse impacting upon the work place.
- (n) armed forces records may give indications of the level of problems amongst military personnel;
- (o) the local coroners or other individual responsible for compiling mortality figures;
- (p) local opinion leaders or persons of importance in any community may be able to give advice on their perception of the problem;
- (q) self-help groups, where these exist, will provide a significant indication of the nature and extent of misuse. Examples of such bodies are Alcoholics Anonymous, Narcotics Anonymous, and their various offshoots;
- (r) users themselves are often one of the best indicators of the level of alcohol or drug problems, particularly where the activity is illegal. The soliciting of information from users about the people they are aware of who share their problem is perhaps the most useful way of doing this.

N.B. All of these potential respondents will only be able to provide information about those who have actually had contact with them. There may also be some overlap in the figures, i.e. one individual may show up on police records but also have been seen in a hospital setting and be receiving assistance from a social care agency. The consequent risks of double counting must be guarded against.

3.7 When making approaches to potential information givers it is worth bearing in mind that certain specific data, where they exist, could be useful. This includes:

(a) Medical and associated data

- (i) accident and emergency data where alcohol/drugs have been identified,
- (ii) drug overdose figures,
- (iii) diagnoses of primary alcoholism, alcohol dependence, drug addiction,
- (iv) toxic effects of alcohol/drugs,
- (v) cirrhosis of the liver,
- (vi) HIV/AIDS data related to drug use.

(b) Law enforcement and associated data

- (i) drug/alcohol related road accidents,
- (ii) drug/alcohol driving convictions,
- (iii) alcohol/drug related convictions for violence,
- (iv) alcohol/drug related convictions for theft or burglary,
- (v) thefts from pharmacies,
- (vi) drunkenness convictions or cautions (where appropriate),
- (vii) convictions for the possession of illicit substances,
- (viii) convictions for illicit dealing,
- (ix) other alcohol/drug related crime,
- (x) drug seizures statistics, quantity and type (numbers, volume and values).

3.8 As a background to the study, the gathering of certain additional information relating to trends in legal use will also be advantageous. This information may be available from legal producers (especially of alcohol), government trade bodies and revenue/taxation authorities and should include volume and value characteristics, e.g.:

- (a) trends in the quantity produced nationally and imported, and the estimated consumption levels over time;
- (b) type of substance used - spirits, beer, wine and other substances;
- (c) perceived changes in the user groups, e.g. by age and sex;
- (d) types, levels and yields of taxes levied on the product;
- (e) cost estimates of the damage caused by substance use.

3.9 Information gathering will provide a basis for determining the nature of the response and obtaining the support of key figures. It can be used as part of the preventative campaign itself. By making the report widely available and by the general use of press and media to highlight its findings it can set the scene for an increase in interest in the whole area of drug and alcohol use.

This can then lead to increased involvement by decision makers and wider dissemination of the findings.

- 3.10 As the preventative treatment programme gets underway it is important that plans be made for a follow-up study of the same data and information providers at regular (e.g., 12 month) intervals.

ANNEX 4

References

Arif, A. & Westermeyer, J. (eds) (1988) Manual of Drug and Alcohol Abuse: Guidelines for teaching in medical and health institutions. New York and London, Plenum Medical Book Company.

Denniston, R.W. (ed.) (1991) Guidelines for Assessing Health Promotion Approaches to the Prevention of Alcohol and Drug-Related Problems. Rockville, Office for Substance Abuse Prevention (ADAMHA), and Geneva, World Health Organization (unpublished document WHO/PSA/91.4).

Farrell, S. (1985) Review of National Policy Measures to Prevent Alcohol-Related Problems. Geneva, World Health Organization (unpublished document WHO/MNH/PAD/85.14).

Grant, M. (ed.) (1985) Alcohol Policies. Copenhagen, World Health Organization Regional Office for Europe (WHO Regional Publications, European Series No. 18).

Grant, M. & Gossop, M. (eds.) (1990) Preventing and Controlling Drug Abuse. Geneva, World Health Organization (Non-Serial Publication).

Grant, M. & Hodgson, R. (eds.) (1991) Responding to Drug and Alcohol Problems. Geneva, World Health Organization.

Jayasuriya, D.C.; Arif, A.E.; Khan, I. & Gulbinat, W. (1987) Drug Abuse: Guidelines for national policy formulation, implementation and evaluation. Geneva, World Health Organization (unpublished document WHO/MNH/PAD/87.7).

Moser, J. (ed.) (1985) Alcohol Policies in National Health and Development Planning. Geneva, World Health Organization (Offset Publication No. 89).

Rootman, I. & Moser, J. (1984) Guidelines for Investigating Alcohol Problems and Developing Appropriate Responses. Geneva, World Health Organization (Offset Publication No. 81).

Walsh, B. & Grant, M. (1985) Public Health Implications of Alcohol Production and Trade. Geneva, World Health Organization (Offset Publication No. 88).

World Health Organization (1988) Consensus Statement, prepared by a WHO expert working group during meeting on Health Policies to Combat Drug and Alcohol Problems: a satellite conference to the Healthy Policies Conference, Sydney and Canberra, Australia, March 1988. Geneva, World Health Organization (unpublished document MNH/PAD/88.4).

World Health Organization (1989) Options for the Use of Methadone in the Treatment of Drug Dependence. Geneva, World Health Organization (unpublished document WHO/MNH/DAT/89.2).

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