Investigation Into Drugs and Alcohol 1971: Final report

Dr AS Ellis
Director Mental Health Services

Public Health Department of Western Australia
February 1972

THE HON. MINISTER FOR HEALTH:

Sir:

I have the honour to present a Report on an overseas visit made on behalf of the Government of Western Australia to investigate drug and alcohol problems.

Between July and November 1971, I discussed these matters with authorities in nine countries, and with those at the World Health Organisation in Geneva. I also attended the first Conference of the European Association for Special Education, at Norrköping, in Sweden, and the Eighth Annual Congress of the Australasian and New Zealand College of Psychiatrists in Auckland, in October.

I received great courtesy and co-operation everywhere, and Australian embassies, particularly in Greece, Italy, Sweden, and Holland, were most helpful, as was Australia House in London.

An interim Report has already been submitted, summarising my findings and recommendations. A detailed account of the discussions held in each country follows. Most of the interviews were recorded on a portable tape-recorder; otherwise, this Report is compiled from notes taken at the time, from personal observation, and from literature obtained from the persons interviewed.

A. S. ELLIS.
DIRECTOR,
MENTAL HEALTH SERVICES.

Perth,
February, 1972.

ACKNOWLEDGEMENTS

This Report could only have been prepared with the co-operation of very many people. Acknowledgement is made to the Government of Western Australia, to the Ministers of Health who authorised this visit, and to those who arranged a lengthy and complicated itinerary. Prominent among the latter are the Secretary of the Mental Health Services in Western Australia, Mr. K. T. Cadee, and the Administrative staff at this Office.

I would like to express my sincere gratitude to Dr. F. Bell, the Deputy Director of the Mental Health Service, whose efficient administration of the Department during my absence enabled me to devote my energies to the task in hand, knowing that matters on the home front would be dealt with capably and expeditiously.

Thanks are due also to the Officers of Australian embassies, and of Australia House, who were most helpful in arranging interviews and transport; and to the people in many countries who not only provided a great deal of information, but who were uniformly courteous, helpful, and most hospitable. Their names are recorded in the body of the Report.

My typist, Miss R. F. Tomlinson, carried out an unusually difficult task most painstakingly and competently. In addition to dealing with strange names and titles, she had the added burden of extracting meanings from taped material which was often presented in foreign accents, and with back-ground noises varying from air-conditioners to city traffic. She was ably assisted in the latter stages by Mrs. June Smith of this Office.

It is not usual to introduce a personal note into material of this nature, but in fairness I must acknowledge the great help and support given to me throughout a most strenuous exercise, by my wife, whose assistance was of incalculable value, particularly when it was necessary to return hospitality, whose retentive memory frequently supplemented the recorded interviews, and who throughout helped to keep the work in proper perspective.

A. S. ELLIS,
DIRECTOR, MENTAL HEALTH SERVICES,
WESTERN AUSTRALIA.
26th January, 1972.

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Figures given for populations and currencies are approximate.

ISRAEL

Population: 3,000,000

Currency: Israeli Pounds
IL.1 = 29 cents (Aust.)
$A1 = IL.3·36

Information from:

Dr. R. R. Mayer, Director, Government Mental Hospital, Beer-Yaacov.

Professor S. Shoham, Professor of Criminology, Department of Law, University, Tel Aviv.

Dr. L. Tramer, Director of Mental Health Services, Jerusalem.

Medical Students at "Ness Ziona" Hospital, Rehovot.

Dr. Mayer is in charge of the 300-bed long-stay psychiatric hospital at Beer-Yaacov. The Hospital is a government institution, and caters for approximately equal numbers of men and women.

The alcohol problem in Israel is not great; of 71 admissions to Beer-Yaacov in the previous year, only 20 were for alcoholism; there seem to be no special facilities in the country for the treatment of this condition. Dr. Mayer considers that treatment should be based on out-patient clinics, and the Israeli Mental Health Service had planned such clinics with a skeleton staff; however, they were unable to find a social worker prepared to do this work, even on a part-time basis.

In Israel there is hardly any street drunkeness; the police arrest alcoholics only when they are a public nuisance or a danger to their relatives or to others. When this happens the offender is brought before a magistrate, who treats the case on its merits. The Magistrate in Dr. Mayer's area does not accept the view of alcoholism as an illness, and seldom refers people to hospital. Twelve of the twenty admissions mentioned above were detained against their will. Security was the same as that afforded to other patients in the hospital.

Treatment is on traditional lines, with full physical and psychiatric examinations followed by strenuous efforts at social rehabilitation, often with the aid of "Antabuse". "Alcoholics Anonymous" is seldom used. The Israelis think that this method is not particularly well suited to their culture and to their environment.

Even in the prisons alcohol is not a great problem. There are about 3,000 persons in prisons, and an annual turnover of between 1,000 and 1,500. There is an average of only 20 alcoholic offenders in prison at any one time. Dr. Mayer has discussed the matter with the police who arrest troublesome alcoholics, and has frequently suggested an order for detention in hospital which would be current for 14 days. He agrees that compulsory treatment is of little use, but thinks—as do many others—that if a patient stays in hospital for a fortnight it is easier to convince him that he has a problem with alcohol, and to stimulate his desire for recovery.

The drug problem in Israel is increasing, and the authorities are as concerned about the increasing use of Barbiturates as they are about Heroin, Morphine and Hashish. The latter is brought from Lebanon by Arab fishermen. Police estimate that there are about 10,000 drug addicts in the country, of whom over 9,000 use Hashish. About 800 use other drugs either separately or in addition, and some inject "cooked" Opium intravenously.

In 1966, 582 offenders were arrested for breaking the law dealing with the sale and use of narcotic drugs; in the first quarter of 1967, 125 persons were tried for drug offences. In 1966, 111 kilogrammes of Hashish were seized, and 20 kilogrammes of raw Opium; but in 1967, with the opening of the bridges across the Jordon, the amount increased greatly; in that year 275 kilogrammes of Hashish were confiscated in Acre (a town of some 12,000) alone. One of the reasons for the great increase in Acre (in the North) was thought to be that with the establishment of Israeli check points in the Sinai, smuggling from Lebanon to Egypt had become difficult and expensive. The United Nations had given authority for planting 1,500 hectares (3,750 acres) with sunflowers in Lebanon, but the estimate of the area actually under cultivation is 150,000 acres.

There is no difficulty in obtaining Hashish. It is sold openly on the streets. Dr. Mayer believes that much of what is sold as Hashish contains very little T.H.C. (Tetra-hydro-cannabinol, the active ingredient). It sells currently at about IL.600 per kilo., i.e. approximately $A80 per pound. In the year 1971 about 4½ tons of Hashish was taken from the Fateh—the Arab "Freedom Fighters". Police are on the lookout mainly for pushers, and magistrates are lenient where the offence is possession only. An example is that of some 70 people who bought Hashish in Israel, paying $U.S.120 for 43 grammes (about 1½ ozs.),

with the intention of smuggling it into Canada and Europe. Because they were not "pushers", and had taken it only for their own use, they were fined only about $A580 and given a six-weeks prison sentence.

Morphine, Heroin, Cocaine, and L.S.D. are still rare in Israel, but several types of Hashish are in use. The most expensive brand of Hashish is named after Abdul Nasser, and costs the equivalent of $A200 a kilogramme, i.e. about $A90 a pound. The most popular brand, which is also the cheapest, costs only $A53 a pound. Hashish is usually brought into Israel through Jordan, Syria and the Lebanon. An account of the traffic can be found in Professor Shoham's book "Israel Studies in Criminology Volume I" (Gomeh Publishing House, Tel Aviv, 1970). A copy of this book was presented to me by Professor Shoham, and is now in the Mental Health Library.

Between 1949 and 1956 the Bureau of Health allocated drug dosages (except for Hashish) to registered addicts, the object being to free addicts from exploitation by black marketeers, and to save them and their families from impoverishment and "moral deterioration". This method apparently failed to achieve its objective, and was dropped in 1956. At that time a 20-bed ward was set up in the Mental Hospital at Bat Yam for detoxification treatment. Some group therapy and Occupational Therapy was also given, but follow-up services were inadequate. The situation now is, that although there is no official drug allotment, if there is a medical indication the Regional Psychiatrist may prescribe drugs which can be obtained through the Regional Pharmacist. There are about 400 addicts registered at present in Israel, and between 6 and 10 are added each year.

Marihuana is considered a dangerous drug because although it may do little harm to experimenters, or to those who smoke it occasionally, about 20% of the experimenters do graduate to more dangerous drugs. Furthermore, even the casual user tends to become apathetic, and although some people can take Hashish and continue to work efficiently, studies have shown that about 20% of these eventually "drop out" from society. My informants consider that legalising Marihuana in Australia would merely add another problem to that of alcohol. Legalising would mean standardisation of the active ingredient, and the maintenance of standards of purity. (For example, no admixture of Heroin, pure Opium, Cocaine, Strychnine, etc.); but a black market would still exist to sell the drug to young people, who would not be allowed to purchase it legally, and who would thus be even more likely to graduate to more serious addictions. They believed that any change in legislation would need very careful consideration indeed.

TREATMENT

No specific treatment is given to those dependent on Marihuana, other than an attempt to encourage them in a more socially acceptable and useful way of life. The standard treatment for Heroin addicts is the substitution of a sedative during the acute withdrawal period, followed by tranquillisers. There are too few trained social workers to do adequate follow-ups. There are 6 social workers at Beer-Yaacov, and these work in out-patient clinics as well. There are also voluntary workers, but their role is confined to befriending patients who have no family. They are not, and do not pretend to be, trained social workers. Dr. Mayer himself has tried some group psychotherapy, but his results have not been good. He thinks it may not always be possible to wean people completely off drugs, and that a more realistic goal is to help the dependent to live a useful life within the community, possibly while taking drugs or substitutes under supervision. In Israel they have had no experience of "Phoenix" or "Synanon" groups.

An interdisciplinary committee consisting of Dr. Mayer as Chairman, together with a scientist from the Weizmann Institute, who is studying the physiological basis of motivated behaviour, the Professor of Criminology at Tel Aviv University, a sociologist, and a psychologist, has been set up by the Government to study the drug problem, and recently held its first meeting.

NOTE ON THE HOSPITAL BENEFITS SYSTEM

As well as private hospitals, there are government hospitals and those administered by the Union "Sick Funds". All workers (there is compulsory Unionism) pay between 7% and 8% of their monthly salary as dues to the Sick Fund. The Government subsidises the Sick Fund hospitals as well as supporting its own Government hospitals.

The Government subsidy for treatment in Sick Fund psychiatric hospitals ceases after two years, and the patient may then be transferred to one of the Government hospitals. As one would expect, the Sick Fund psychiatric hospitals tend to be selective, and to take the more acutely ill. There are many geriatric patients in government hospitals, and Beer-Yaacov, with a total bed-strength of 300, has a ward for 40 geriatric patients, of whom 30 are women.

RESEARCH

At Tel Aviv University, some basic research on the effect of raw T.H.C. is being carried out on volunteers. The dosages have not yet been finally standardised. The T.H.C. is synthesized by a chemist at the University. Professor Shoham is also conducting a survey of the drug situation in the University. He said, "Not everyone agrees with this, but by being drugged you are basically assuming that the other part of society is functioning. You want to lie there with euphoria, but you want the milkman to bring fresh milk, you want the drivers to drive buses, you want the aeroplanes to take you places, even to Katmandu. If you have to go there, the one that takes you there should not be under the influence of drugs"; and again, "If you're in you're in, and if you're out you're out; if you do a thing, you should be responsible for the logical outcome. Everyone should make his own choice, and when it is made the person who makes it should be responsible for it." I found this view common, not only in Israel.

Professor Shoham holds very strongly to the belief that people do graduate from Marihuana to narcotics such as Heroin, and cites the large number of Americans returning from Vietnam who are solidly "hooked" on Heroin. He says that there is simply no doubt that most of these addicts started with Marihuana or other non-narcotic drugs, and graduated to Heroin.

Professor Shoham presented me with a copy of the book which he edited, and which has already been quoted. Both he and Dr. Mayer asked for copies of our Senate Special Committee Report on Drug Dependence and Drug Abuse, which I have sent to them. They also asked to be kept informed on developments in Australia, particularly in this State.

Dr. Tramer is the Director of Mental Health Services in Israel. It was somewhat difficult to locate his office, but when I did so we had a most cordial discussion on mutual problems, many of which, such as shortages of nurses and other skilled people, we had in common. Although Dr. Tramer is, as Director of Mental Health, intimately concerned with drug and alcohol problems, and is most concerned about the drug situation, he has delegated most of his authority in this field to Dr. Mayer and to the Committee of which the latter is Chairman (see above). There is no special unit for the treatment of drug dependency in Israel, and at present they treat this condition along with general psychiatric illnesses.

DISCUSSIONS WITH AMERICANS

In late July, I took some leave in Greece and Italy, and during this time took the opportunity to discuss the problem of drugs with various Americans I met on the Continent.

Several professional men I spoke to considered the drug situation in New York particularly serious. Apparently people are not infrequently held up at knife-point for drugs. The offenders are mainly Negroes and Puerto Ricans, but some white criminals are also involved. Some members of the Government are said to have suggested the wholesale buying of drugs from traffickers, on the understanding that more drugs would not be smuggled into the United States. I could not find out if this has actually been done.

Another professional man—a dentist—said that his house had been broken into five times in the past seven weeks by people looking for drugs. Another told me that he had an intercom. system installed between his front door and his surgery; no one was allowed in without positive identification.

This seemed to apply more particularly in New York. However, in discussion with high-school pupils and teachers from the Mid-West, one got the impression that the drug situation there, although increasing, was not considered really dangerous. Here, by "drug situation" they meant Marihuana. In the country towns it seems that Cocaine and Heroin are rare. The Professor of Criminology at Tel Aviv (q.v.) was convinced that American society was about to collapse—telephones did not work, essential services were inefficient, and in general the whole place was deteriorating. (Since returning home I have heard the same criticism from other reliable visitors to the United States). Professor Shoham had been to America some ten times in the last few years, and was convinced that there was no future for that civilization. However, in discussion with the students and teachers I mentioned, the situation did not seem so serious. I spoke with an intelligent group of students while I was travelling by train from Florence to Rome. These students were all in their second or third year at the University, and one of them had already majored in Economics. Another member of the party was a Canadian Professor of Archaeology. They were all disturbed about the drug situation (Marihuana) in the Universities and High Schools. One of the students had a sister aged 13, and he said: "This kid can tell me more about drugs than I ever knew." He said that this was because of the excellent education programme in their town of Houston, Texas.

Most of these students believe that education is the only possible answer to the drug problem. When I outlined our own drug education programme in Western Australia (that is, as a part of a Modern Social Issues programme of education), they agreed that this was

the proper way to tackle it. They were very keenly aware of the dangers of "education" provided by unskilled persons.

These boys also suggested that parental influence was a major factor in producing drug-dependence—particularly the pressure to reach a higher standard than the parents themselves had done. I suggested that this might have been a function of the children's thinking, rather than of the parents. They did not disagree with this, but thought that the discrepancy between the parents' apparent ambitions for their children, and the children's inability to meet them, caused many of the difficulties. Perhaps the children, being unable to meet parental aspirations, became disappointed and depressed, and then took drugs as a method of self-satisfaction.

In these discussions very little was mentioned about legal implications, or the right of the individual to "opt out" of society should he so desire. Professor Shoham's ideas on this have already been mentioned, and this type of thinking is by no means uncommon.

In Greece I met a party of American high school teachers and students on a ship cruising around the Greek Islands. Most of the teachers were from high schools in the Mid-West. They were adult, intelligent women, and in discussion agreed that Marihuana was smoked in the high schools, and perhaps in the upper levels of the "grade schools". Although they said that they considered this was a "menace", when they were pressed it seemed that this did not really create much of a problem. They felt that alcohol was a far greater problem, particularly in the high schools, and for this they blamed solely the example set by parents. I asked if they thought any particular drug seriously affected student performance; they said that they thought this was not necessarily so.

Some of these teachers had been able to follow the progress of their pupils into College (University), and felt that although they might have experimented occasionally with Marihuana their performance had not been seriously affected. This suggestion, however, was strongly negatived by others, and by other students with whom I had discussions. In the Mid-West and in the country areas there did not seem to be the problem with Cocaine and Heroin that there was in New York. The students I met in Greece were of high school age—a little older than we see here—but intelligent, concerned, and pleasant to talk with. They themselves certainly showed no indication of any drug dependency, but all said that they knew friends and colleagues who were taking Marihuana regularly. The teachers with them were of high calibre, and seemed somewhat older and perhaps more experienced than many of those in our own State and High Schools.

In general, the opinion among these young people was that Marihuana was dangerous because of the possibility of psychological addiction, and that governments were wise in refusing to liberalise its use. They quoted cases where previously good students had dropped out of school or college because they had become apathetic as a result of using this drug, and were spending their entire time either smoking it, or discussing it, or working out ways to get it, and, as Professor Shoham had described, "lying there in euphoria", lacking in self-respect, and completely neglecting their work, their responsibilities, and their own physical and mental welfare.

SWEDEN

Population: 8,000,000

Currency: $A1 = SKr.6 (approximately)
SKr.1 = 16 cents (Aust.) (approximately)

Information from:

Dr. Malcolm Tottie, Head of Division of Information and International Co-operation of the National Board of Health and Welfare, Stockholm.

Mr. Daniel Wilklund, Assistant Head of the National Board of Medical and Social Health Questions. (Mr. Olin assisting).

Inspector Rosengren, Senior Social Worker, Mariapolyklinik, Stockholm.

Professor L. Goldberg, Karolinska Institute, Stockholm.

After I had been to the Congress of the European Association for Special Education at Norrköping, I went by train about 150 miles north to Stockholm. Dr. Maguire, of the Australian Department of Immigration, had made arrangements for me to meet the Swedish authorities, and I called first on Dr. Tottie. This officer has a great deal of experience, and is highly regarded throughout Europe. He told me that in Sweden, with a population of just over 8,000,000, it was reliably estimated that there were some 60,000 to 70,000 persons "out of action" because of alcohol, and that about 200,000 more had problems in which alcohol certainly played some part.

Dr. Tottie believes that effective treatment can be carried out only within the community, and that special institutions are of little value. Indeed, he thought that separate institutions for the treatment of alcoholism would shortly disappear altogether.

He estimated 10,000 drug-dependent persons in Sweden, which would give a comparable figure of about 1200 for Western Australia. If this is restricted to Marihuana and the narcotics, it is considerably higher than we know of at present. However, narcotics from subsequent conversation, it seemed that this figure referred to those involved with Barbiturates and Bromides as well. This estimate was arrived at by counting the numbers of people in hospitals, prisons and other institutions, who were actually being treated for drug dependence.

My attention was drawn to the problem of drug "misuse" as opposed to "dependence", and I was told that the Swedish figures showed a consumption of between 30 and 35 doses of tranquillisers and sleeping pills per person per day. This is an economic problem which costs the State the equivalent of about $A166,000,000 a year. Dr. Tottie believes that this problem is due largely to over-prescribing. ("To say 'yes' takes 10 seconds: to say 'no' takes half-an-hour"). He thinks there is an increasing tendency to get away from life's problems by taking drugs, especially tranquillisers and stimulants. He considers that a good education programme is most important, and was very impressed when I told him how our Health Education Council here was approaching such matters. He gave me a number of relevant papers which I sent home and have placed in the Mental Health Library.

Mr. Wiklund is the Assistant Head of the National Board of Medical and Social Health Questions, and I discussed the problem of legislation with him.

In Sweden, legislation to control alcoholism and narcotic drug addiction was first brought forward in 1916. It has been changed materially twice since then. Under the Common Law there is power to put people in mental hospitals for treatment against their will. Such admissions are not regulated by the Mental Health Act. Seventy-five per cent of the patients in institutions are voluntary, and usually have undertaken to stay from 3 to 4 months. After discharge, they can, of course, be re-institutionalised if necessary; but compulsory treatment is not favoured; except for reasons of safety. An order for compulsory admission can, if necessary, be made by the Governor of a Province acting on a medical report. On compulsory admission, a person may be forced to stay for up to one year or more, but most patients are discharged on probation after three or four months. The police are empowered to return them to the institution if necessary, but, as in Australia, there is a widespread dislike of bringing in the police, and it is said that persuasion is usually enough.

A drunken driver, if he has a blood alcohol of over ·05%, is brought before the ordinary Courts, where he loses his licence and may also receive a prison sentence of up to one month on an open prison farm. If the blood alcohol content is greater than 0·15% there is always a prison sentence of up to three months as well as the loss of driving licence. Details of these penalties and their application are contained in the Report of the late Sir Philip Phillips, which he wrote for the Victorian State Government in 1969. Copies of

this report are available from the Mental Health Services Library or from the Public Health Library.

Mr. Wiklund told me that there were some experiments in treatment going on within prisons, but there were not enough psychologists and psychiatrists. There are psychologists in some of the bigger prisons, but more are needed. In the prisons there are also "Information Groups" in which people are told the facts about alcohol and its effect on the body, but there is some doubt about the effectiveness of merely transmitting factual information.

"Alcoholics Anonymous" is not much used. It is thought that the average member of A.A. in Sweden is a different type of person from the one in the United States—the average Swedish alcoholic is said to be not quite so intellectual as his American counterpart, and he belongs to a lower socio-economic group. However, there is an organisation called "Links", whose members visit prisons in groups, and tell of their experiences with alcohol. They are not trained to give information, or in public speaking, but they are all working class people, and can explain in simple language the dangers and disabilities resulting from excessive use of alcohol.

Amphetamines were the main problem in Sweden when I visited. Mr. Wiklund gave me two papers, one entitled "Drug Addiction and Drug Abuse in Sweden"—published in March 1970, and another one on "The Abuse of Central Stimulants by Young People in Sweden", dated 9th November of the same year. These papers are available in the Mental Health Services Library. They can be summarised by saying that intravenous Amphetamine is at present the main drug problem. There is not a great number of Heroin or Opiate addicts, but the Swedes consider that the seriousness of intravenous Amphetamine has been greatly understated by international authorities.

As far back as 1965 the "National Organisation for the Help of Addicts and Drug Abusers" was formed. This is a private organisation, subsidised by the Government. The object of the Organisation is to stress the increasing importance of the Narcotics problem, and to demand government action for prevention and treatment. An expert group on drug dependence was appointed by the Government in 1966, and named the "Narcotic Drugs Committee". It had sub-committees on legislation, therapy, diagnosis, social problems, and methods of prevention. The Committee had 10 permanent members, a secretary, and about 20 expert members of sub-committees. It published its first report in February 1967, and in this estimated that there were about 5,000 Narcotic drug abusers, concentrated in three large cities. The Committee rejected the idea of treatment through law enforcement, and also opposed the building of large special treatment units for addicts. They recommended that instead there should be units for 10 to 12 addicts, and that these should be placed at existing mental hospitals. Rehabilitation should also be provided, they said, by municipal social units. They also emphasised the abuse of drugs such as Barbiturates and Tranquillisers, which they regarded as a growing problem, and quite as serious as any other kind of drug-dependence. They suggested computerised registration of all prescriptions, and a continuous follow-up of those drugs which appeared to create problems.

In June 1967, the Committee's second report recommended heavier penalities for professional smuggling and pushing of Narcotics, suggesting that the maximum penalty should be raised to 4 years' imprisonment.

They recommended also that users of Hashish should not be prosecuted for minor offences. A good deal of tension had been caused by newspaper reports and growing public controversy, and the Cabinet called a special meeting in December 1968 to discuss the situation. From this meeting a Ten-point Programme following the recommendations of the Narcotic Drugs Committee was published.

The third and fourth reports of the Committee, in December 1969, recommended that it should be replaced by a standing Expert Advisory Group which was, in fact, appointed in March 1970. Much more detail can be obtained by perusing the paper in the Mental Health Services Library which has already been referred to.

In the paper "The Abuse of Central Stimulants", recommended preventive measures included drug education in schools. They point out the importance of factual information; frightening or biased information has little effect on potential drug users except that of widening the "credibility gap" between the generations. Again, our own Health Education Council in Western Australia is certainly following approved and correct lines in its approach to the problem. Rehabilitation is dealt with in more detail in the summary of my interview with Inspector Rosengren (see below).

RESEARCH

Studies are being made in Sweden, Norway and Denmark upon school children, i.e. teenagers up to the age of 16. There are about 8,000 of these in Stockholm and 4,000 in the

smaller Swedish cities. The study is made by a questionnaire which is said to be fairly reliable; because such a large number of persons are being investigated, it is statistically significant. Many young people are said to be experimenting with Cannabis; I was told that approximately 3% got "hooked", and went on to hard drugs. This figure is a good deal lower than estimates in some other countries, where up to 33% was sometimes given as the approximate figure of those who go on to Narcotics after using Hashish.

The Swedes continue to stress the problem of Barbiturates, which they say is largely the result of over-prescribing; they are trying to improve this by better education of doctors. Between 1967 and 1969 the number of legal prescriptions rose from 270,000,000 to 350,000,000 doses.

LEGAL

There is no special institution for treating any form of drug dependency, but there is considerable discussion going on at present as to how to deal with the problem. The treatment of drug addicts is in principle, voluntary, but there is still discussion as to whether compulsory treatment is needed or not. At present there are two laws, one for children—the Child Welfare Act—which makes it possible for the Authorities to take a person up to the age of 20 for compulsory treatment, and the Mental Health Act, which has recently been amended, and allows for compulsory treatment of those over 20.

The responsibility for social welfare in Sweden is located in small communities like County Councils or Local Authorities, of which there are about 600. These areas have populations varying from 800,000 in Stockholm, to 2,000 or 3,000 in smaller areas, and consequently the facilities vary greatly in quality. The Councils are subsidised by the Central Government which, in the case of alcoholics, pays 75% of all the costs for treatment. I was told that the type of institution needed to treat drug dependency is more expensive, and the treatment more complicated than for alcoholism. The 75% subsidy from the Central Government depends on the amount paid by the Councils to the local institutions for alcoholics, and this subsidy cannot be used for treatment of drug dependency. Drug addicts are regarded as trouble-makers in institutions, and not infrequently are refused treatment in the more traditional psychiatric hospitals unless they are under compulsory order.

For 8,000,000 people, Sweden has about 30,000 psychiatric beds. 2% to 3% of the patients are said to be drug addicts, which means a total of about 500 addicts in the whole country at any given date. In addition, about 40% of the youngsters who are being compulsorily treated under the Child Welfare Act in reformatory schools are said to have had some connection with drugs prior to their arrest.

SOCIAL WELFARE

There is integration throughout the community, down to local levels, of the Social Welfare Board, the Child Welfare Board, and the Temperance Welfare Board. These three together make up the "Committee for Prevention of Alcoholism and Treatment of Alcoholics". All alcoholics are known by the Social Welfare Board, and if the alcoholic has to go to hospital or to prison, the Board immediately take steps to see that the man's family does not suffer financially.

There is also a system of home visiting, which is concerned particularly with juvenile offenders. Providing the parents agree, offending children may be sent home, and followed up by home visitors in much the same way as probation officers do.

MARIAPOLYKLINIK

Inspector Rosengren (although his title implies it to us, he is not a police officer), told me about the social welfare situation concerning drug dependency. The Mariapolyklinik works with children under 20. These under-twenties are brought to the Clinic either by the police or by social workers. The adolescents picked up in this way are not from any particularly under-privileged group, but come from all strata of society. The police have the power to pick up these adolescents if they are under the influence of drugs or alcohol, and to bring them to the Clinic for assessment. At the Clinic they "dry out", and stay for up to a week, or a maximum of six weeks; during which time plans can be made for their future job, housing, and education.

Inspector Rosengren has a staff of some 16 assistants, who are not trained social workers in our sense of the word, but who have had some grounding in psychology, sociology, and allied subjects. These people go around Stockholm and the larger cities, visiting "pads" where adolescents are known to congregate. They are available for discussion and help; on occasions they bring children into the Clinic.

The drug problem is regarded essentially as a social problem, and one requiring long-term planning for the addict's future. The basic problem is to make stable, positive contacts with adults which can last many years. The adult concerned may be a social worker,

a doctor, or a family member, but the Clinic also has lay supervisors of its own. There are some 6,000 foster homes in private families, and about 200 children are placed in these each year. The aim is to provide an ordinary family setting for these children, to accustom them to normal family routines, and to get them away from the destructive milieu of the big cities. It is essential to have some sort of emotional contact, and to make the addict responsible to another person, in the same way as the other person is responsible to the addict.

I was advised that we in Perth should not necessarily imitate the Stockholm organisation of a large centralised clinic, because to work with drug addicts it is essential to form small, intimate media. The Mariapolyklinik has asked the Stockholm City Authorities to develop small units within the suburbs around Stockholm. These would be established near schools, factories, youth hostels and so on, but at present finance is not available. Their main problem is that the boys and girls who come to the Clinic have to travel distances of from 10 to 15 miles to get there. It is thought essential that if there are to be contact facilities they should be actually within the community where the addict is, i.e. in the suburbs, much the same as our own Child Welfare Department has its Contact Centres throughout the suburbs here. There should be 4 or 5 social workers, together with 3 or 4 physicians or psychiatrists available for each Contact Centre. These people should be on duty up to midnight; after dark they will get help from adult ex-alcoholics. There is one such Clinic working in Stockholm at present, but they were unable to form others before the Service was centralised at Mariapolyklinik.

TREATMENT

Methadone treatment is controversial in Sweden, as it is in other countries. In any case, Methadone alone is of little value unless it is combined with social therapy and proper after-care. There is a tendency among doctors to over-prescribe Methadone, and to attribute any improvement to this alone.

In Sweden they have neither the resources nor the knowledge to set up "Synanon" or "Phoenix" organisations. They talk a good deal about it, but say that nothing is really being done. It is difficult to make contact with young drug addicts, and the social workers prefer to get them away from the cities into a "normal" environment.

The Inspector quoted to me a family that lived in North Sweden, about 250 miles from Stockholm, who took in 6 addicts—boys and girls—together with 4 of their own children aged between 5 and 15 years. The group of 6 addicts has the opportunity to make lifelong contacts, and they have security from the very beginning. This procedure brings the addict into the family group, where he is introduced to a new way of living. He works in the garden and on the farm from 8.30 to 10.30 in the morning, from 11 till 1, and from 2 to 4 in the afternoon. The addicts go on vacations with the family in the ordinary way—they go for excursions to the mountains, and for picnics and so on. The family is subsidised by the State, receiving SKr.125 (about $A20.00) a day. Although this sound rather lavish, it is certainly less than the average daily cost in a hospital. For the first three months of the time that the addict lives with the family, he does not go out alone, but after that the therapeutic situation must be translated into reality. They then go out dancing etc., and as my informant said "You have to have contact with girls or boys without being drugged, without smoking Hash, without beer; they have to learn, and you have to train, and train, and train, again, and again, and again, like rebuilding the personality. You have to do in one to one-and-a-half years what you would normally do in a lifetime." These patients must remain in a setting where close emotional ties can be formed and kept. The City is not good for them; they must be removed from this "hot" media and they must learn not to run away when they are confronted with reality. As Mr. Rosengren said: "Here you belong to a family, you can live with us as long as you want, but we have our rules". This is why the Swedes are not particularly keen on "Synanon" or "Phoenix"; they say that those organisations isolate the individual from reality, and tend to produce a sort of sub-culture allowing the individual really to "opt out" from ordinary society.

KAROLINSKA INSTITUTE, STOCKHOLM

Professor Leonard Goldberg is in charge of the Karolinska Institute, which is part of the Government Medical School. Six of his staff are paid from ordinary government funds, and five others from a special Government Research Fund. When more money is needed for research, the Institute looks for it elsewhere, e.g., from private funds set up by bankers etc.

Professor Goldberg is a world authority on the physiological effects of alcohol and drugs, and has an excellent laboratory occupying three or four floors of a large building. Apart from being the leading authority in his field, the Professor is a highly cultured and charming person, interested in all aspects of modern living. He was most hospitable, adding considerably to the pleasure of my stay in Sweden. I was also fortunate to have an introduction to Dr. Th. Ehrenpreis, a senior paediatric surgeon, and a world authority on Hirschprung's disease, who likewise gave much of his time and was equally hospitable.

Professor Goldberg took me on a tour of his laboratory, and explained various current investigations. He has a special temperature-controlled room in which the effect of drugs on the metabolism of rats is being studied. It seems that the body temperature of rats shows a specific change according to the particular drug with which the rat is injected, and that if injections are given every day, the initial temperature response changes. The change in response during chronic administration is specific for Opiate-like drugs. Therefore, if you inject with non-Narcotic, non-dependence-producing drugs, the temperature change can be compared with that produced by dependence-producing drugs; hence a screening test for dependency can be developed, which can be applied to any new drug before it is placed on the market, or, as Professor Goldberg said, "At least we can make an intelligent guess". This work is still at the testing stage. Its importance is obvious.

The Professor agreed that the development of drug dependence is a result of the reaction between a drug and the individual. So far he has been more interested in the "non-individual" part of this work, with normal rats. It is possible, however, to train monkeys in self-administration, so here we can examine the individual reaction to drugs. A monkey can be trained to press a pedal if it desires an injection, or to avoid pressing if it does not want the injection; it is thus possible to test an individual response to an injection. This, however, is the second stage of Professor Goldberg's present investigations. It is already possible, however, to show by means of the temperature variations mentioned above, the effect of tolerance, abstinence, withdrawal, and Morphine antagonists in rats. This work is to be published in the very near future.

DENMARK

COPENHAGEN

Population: Denmark 5,000,000 (Copenhagen 1,000,000)

Currency: Danish Kroner (DKr)
DKr.1 = 12 cents (Aust.)
$A1 = DKr.8 (approximately)

Information from:

Dr. Borup Svendsen, Senior Forensic Psychiatrist to the Ministry of Justice.
Dr. Frits. Schjøtt, Assistant Psychiatrist to the Ministry of Justice.

Dr. Schjøtt is a medical graduate of ten years'standing who is in psychiatric training and is working at a youth advisory clinic in Copenhagen. The Health services are administered by a Medical Director who seems to occupy much the same position as our Commissioner of Public Health. This officer is responsible for public and mental health throughout the country.

Dr. Schjøtt estimated that there were 50,000 alcoholics, and between 1,000 and 2,000 drug addicts in the Danish population of 5,000,000. He considers that the drug problem is over-stated by newspapers and by public opinion, and that it is being made a "politcal football". There are severe clashes between those who regard addiction as criminal and those who regard it as an illness. Most of the addicts come from underprivileged groups and many are psychotic.

In Denmark there had been a wave of Amphetamine abuse which has now declined. The main problem now is opiates, more especially a refined preparation of raw opium called "morphine basis", which is sold in sterile packs complete with needle. Each pack contains about 800 mgms of a mixture of substances of which 80% to 85% is pure morphine, and about 20% "dirt". Raw opium is imported from the Middle East, and refined in Marseilles or Hamburg. The refined product is imported into Denmark, and sells at about the equivalent of $A12 for 800 mgms, which contains 700 mgms. of morphine, equalling about 1 day's supply for a medium to heavy addict. Depending on how much he has, he will use it in two or more "fixes".

The penalties for smoking only, are light; but penalties for pushers and traffickers are up to six years' imprisonment. So far, the maximum penalty has not been inflicted, the usual penalty being from 2 to 3 years' imprisonment with or without a fine. Usually the fine is nominal, because small peddlers do not have the money to pay large fines. It is thought that the really "big" people often do not know where their money is going. They are said to be aware that their money is in some kind of business which pays about 20% per annum, so they ask no questions.

The Youth Clinic at which Dr. Schjøtt works is a semi-private institution which began as a research project; after the specific research was finished the offices and staff were used as a Youth Advisory Centre. The staff received some training in group therapy, and with the recognition of the increasing drug problem, a Government subsidy was granted. The Centre is now administered by the National Institute of Mental Health. An old house in a slum area of the city was taken over, and various therapies were tried. The present policy is that of "country trips". Treatment commences at a "Contact Centre", where a social and medical history is taken. Groups are formed at the very beginning, and when 6 or 7 suitable people have been collected, they go together into the country for about three months. During that time, attempts are made to detoxify them and wean them off drugs by means of Methadone. This drug however, is not used as a long-term maintenance treatment, nor is the "blockade" method followed. As a rule, Methadone is not given to addicts who are not active members of the group. If they want Methadone, patients receive it only in the group setting. Many who are sincerely motivated are often under-privileged and sick, and relapse as soon as the Methadone is stopped. The Danish experience has been, however, that if these people are taken into the country away from the city milieu, even if they have the tendency to relapse, it is difficult to get back to the city, and easier for social workers and others to form lasting relationships with them. With each group of six patients in the country there are two health workers who are not trained social workers, and spend about six weeks each with the group.

Country houses are rented; usually only one group lives in a house unless it is large enough to accommodate more. While groups are at the Contact Centre waiting for a house to become available, they are accommodated in rooms at the Centre. Dr. Schjøtt says it is not difficult to maintain contact with them because most of the addicts have nowhere else to go, anyway. If there are more than about ten, the rest (perhaps up to 40 or 50) take small four-roomed flats which apparently are very primitive. Some of the addicts just

"hang around", and Dr. Schjott says; "they have one toilet where we know that they 'fix'. Of course it's prohibited, but nobody interferes, because then they will just leave us."

"Country trips" scheme is not yet fully implemented, and calls for further follow-up. For example, it is hoped that they may eventually have a country high school or some sort of integration with other social groups. All this is still "on the planning table".

After the three months in the country, attempts are made to get the ex-addicts into halfway houses in the city and to help them get jobs. The Centre thinks that after three months off drugs, providing the patients are well motivated, they can avoid slipping back, although a few may need ambulatory treatment for some months or years afterwards.

I asked about "confrontation therapy", but Dr. Schjøtt said that it was not done at the Contact Centre; "it would be absolutely impossible because of the whole turmoil there". So far as he knows, it is not carried out in the country groups either. The programme in the country involves physical rehabilitation by adequate food and rest, and at the same time the houses that the Centre rents are usually in such a state that it is necessary to paint and furnish them; this is good therapy for the group. Dr. Schjøtt says; "this would all be very good if we had a good cure rate, but that we have not". It is in any case impossible at present to give figures, although it is felt that the relapse rate is lower than with the more traditional treatments in prisons or hospitals.

HOLLAND

Area:	13,000 sq. miles
Population:	12,000,000
	(Amsterdam: 1,000,000)
	(The Hague: 620,000)
Currency:	1 Guilder = 24 cents (approximately)
	$A1 = 4·3 Guilders

Sources of Information:

Dr. J. Van Londen, Director of the Department for Community Health of the Municipal Health Service, The Hague.

Dr. Waffelbakker, Youth Inspector of the Health Inspection Branch of the Department of Health and Environmental Hygiene, Leidschendam.

Dr. Dekker, Inspector for Mental Health, Department of Health and Environmental Hygiene.

Mr. Krauweel, Director of the Jellinek Clinic for Alcoholism.

Dr. Van Londen, as the Head of the Department for Community Mental Health in The Hague, is responsible to the Director of Public Health of the Municipal Health Service. The Agencies for Mental Health in Holland are organised on a denominational basis—Catholic, Protestant and others—and there are, therefore, Boards with denominational representation. The whole set-up seems rather complicated, but it does ensure that all groups have a say in the running of the Health Service, and that Mental Health is constantly in the public consciousness as an important area of the Public Health Administration.

The Federal Government subsidises a Bureau for Alcoholism and Drug Dependence in The Hague. On this Bureau there are representatives from private psychiatrists, general practitioners, Courts, the Mental Health Services, and the Churches. The Bureau undertakes out-patient screening and in-patient treatment for alcoholics and drug-dependents. Dr. Van Londen considers it not feasible to treat alcoholics and drug-dependent people together (this was the general opinion in Holland), and finds it unsatisfactory to place drug-dependent persons or alcoholics in psychiatric hospitals. At present there is a clinic for 16 in-patient male alcoholics in The Hague, and 6 other clinics in other parts of the country.

The Hague Municipal Service is building a unit for drug addicts in the grounds of a psychiatric hospital. There are to be 12 beds, male and female together. There will be liaison between this Unit, the Bureau, and the Psychiatric Hospital which will supply the staff. Dr. Van Londen considers that such a Unit should have not more than 12 beds, because of the explosive nature of the psychopathology involved. The idea is to detoxicate the patient, and then send him to an in-patient follow-up centre for longer stay and rehabilitation. The long-stay unit is to be organised between the mental hospitals and the city Social Psychiatric Services. However, as in Copenhagen, this set-up is still on paper, and at present a room in the building which houses Dr. Van London's office, is used for "screening" drug addicts. Neither addicts nor hospital staff like treating drug dependency in the wards of psychiatric hospitals.

Throughout Holland there are six special clinics for alcoholics. In most cases these are Government-subsidised, and in order to qualify for the subsidy the Clinics have to conform to certain rules and conditions laid down by the Federal Department of Health. The Hague Clinic of sixteen beds is too small to qualify for this subsidy.

Again, there is reluctance to treat alcoholics in mental hospitals. One of the reasons (apart from the mutual antagonism between alcoholics and staff) is the too rapid discharge rate—10 to 14 days. These problems are identical with our own in Western Australia.

The Hague Department had been running the Clinic for 6 or 7 years, and claimed 35% of all admissions had been completely abstinent after a 5-year follow-up period. Dr. Van Londen, however, was not overjoyed with this figure, and thought that it might represent a natural remission rate (irrespective of treatment). He pointed out that there was a fairly strict selection of cases, so that when this factor was considered together with the natutal remission rate, the efficacy of the special clinic might well be queried.

Leidschendam is some ten miles out of The Hague. Here there is a very large multi-storey complex of Government buildings, one of which houses the various health instrumentalities. My informant here was Dr. Waffelbakker, who is not a psychiatrist; he is a physician specialising in youth health. In each of the eleven provinces in Holland there are Public Health Inspectors who have the general responsibility for the health of their province. At Leidschendam however, there are specialised Inspectors who cover the whole country, and Dr. Waffelbakker is a Youth Inspector who is responsible for child and youth health throughout the country. Dr. Dekker is the Inspector responsible for Mental Health

throughout the country;and there is also an Inspector of the Pharmacy Department who deals with the narcotics law etc. These three work together with the Department of Justice where drug problems are concerned.

It is estimated that from 20,000 to 30,000 people in Holland are using hashish. Despite the fact that usage is illegal, the penalties inflicted are very small. There is a maximum penalty of three years' imprisonment for association with hashish, but users never receive such a sentence. No penalty is enforced for smoking in private; but if it is smoked "defiantly", the person may be sentenced to one or two weeks in prison. Some Magistrates fine an offender half a Guilder (about ten cents) for smoking. It is difficult to catch the "big people" who traffic in, but do not use, drugs. Between these traffickers and the occasional user is a large group who both use and sell it.

Raw T.H.C. has been synthesised in America, and this is a powerful hallucinogen quite as potent as L.S.D.

The principal drugs used illicitly are Hashish and Marihuana, Opium, L.S.D., and Heroin. Most constant drug users are polyaddicts.

Drug abuse began between 1960 and 1962 in all cities, not only in Amsterdam. According to a questionnaire circulated in 1969 by Dr. H. Cohen of the National Federation for Community Mental Health, the average age of 958 drug abusers was 23 years; two-thirds of them were aged between 18 and 28; drug usage showed a sharp decline after the age of 30. Of those who replied to the questionnaire, 54% were University students. I was given a copy of Dr. Cohen's paper, which is now in the Mental Health Library and is recommended for perusal by those interested in more details of drug usage in Holland.

There is said to be a considerable amount of L.S.D. all over the country, but mostly in Amsterdam. Opium from Hong Kong can also be obtained in the Chinese quarters of Amsterdam and Rotterdam at a price of approximately $A2 to $A3 per "slice". The Jellinek Clinic treats some drug abusers along with alcoholics, but the "de Lauryer" is an alternative clinic for drug-abusers, which is administered by ex-users, rather like "Phoenix". Dr. Waffelbakker says this is "working". There are 40 to 50 drug users at "de Lauryer" with 40 to 50 drug-free persons.

The newspapers are said to play a large part in producing or increasing the drug problem; another factor is "pop" music. Dr. Waffelbakker thought that about one-third of the "pop" music played was in fact propaganda for drugs. (The B.B.C. has recently banned certain "pop" records on these grounds, e.g. "Lucy in the Sky with Diamonds"(L.S.D.)). "Puff, the Magic Dragon" was an early record of this type, extolling Marihuana. Youngsters listening to this music think they are, in Dr. Waffelbakker's words, "Very old-fashioned if they don't know what's going on". He thought that few people recognised the significance of this sort of "infection". Peer groups play a very large part in spreading it.

SOCIAL FACTORS:

Amsterdam is at present the European centre for youth from all countries. The City Council obviously has difficulty in coping with the great summer influx of hippies, drop-outs, drug addicts, and normal tourist youth traffic.

Largely because of the cheap "Eurorail" fares between European capitals, and reduced trans-Atlantic air fares, central railway stations throughout Europe in summer are crowded with young people standing, sitting, or lying about, or seeking accommodation from the bureaux at the stations. Sanitary provisions seem inadequate. Most of the youngsters were well enough behaved. Some were seemingly under the influence of drugs, shown by the vacuous stare and apparent lack of desire to move—even from a sitting or lying position on the station concourse or in the street outside. Most of them seemed to be in need of a good wash and brush-up.

For some months many used to sleep on the "Dam", the City Square of Amsterdam, but this is now forbidden; the alternatives are parks, canal houseboats, or "sleep-ins". The latter are buildings where up to 500 people can sleep in bunks. There is a charge of about 60 cents a night for accommodation. The Amsterdam City Council provides two "sleep-ins". Each is staffed by 10 to 15 half-time students, a Council Nurse is in attendance daily, and a doctor is on call. The object is to provide some night shelter, and as far as possible to safeguard the physical health of the young people. Those who do not spend the nights in sleep-ins camp in one of the parks, or simply roam the streets in an aimless and apparently harmless way. One park near my hotel was notorious for "pot". The smoke could be smelt in the open air on a calm evening.

While I was in Amsterdam, two free markets were opened, where youngsters could sell their own products, e.g. paintings, wood carvings, embroidery, etc. Sale of manufactured goods such as cameras, binoculars, transistors and so on is forbidden. The idea behind this is to prevent the youngsters begging, but it is too early yet to say how it will work.

Last year in Rotterdam there was a "Pop" festival attended by 60,000 young people. My informant, Dr. Waffelbakker, was the leader of the medical team there, and said that he spent "four very, very happy days". There was no trouble like there was at "Woodstock". I felt that to enquire too closely about venereal disease, skin disease, gastroenteritis, or the infection of "clean-skins" by the drug sub-culture would have been impolite. Some sociological research was carried out there by the Ministry of Culture together with the University, but all I could find out about this was that the people attending the Festival were said to belong to a higher-than-average intelligence group.

As Dr. Waffelbakker said, this is a new way of living. "There is", he said, "some smell of freedom in our country and I am more or less a little proud of that". My own brief experience of Amsterdam at this time provided more smells than that of freedom. That this happy picture of permissiveness run riot is perhaps not always entirely acceptable, is suggested by the answer to my question "What happens to these people in winter?" "In winter? Everybody is very happy. The rain starts, and they leave the parks, and they leave the "Dam", and the sleep-ins are closed, and then they have to find other places . . . ."

Dr. E. Dekker is Head of the Department of Mental Hygiene in the Inspectorate of Mental Health, and advises the Minister for Health on national policy. He regards Marihuana as an important "stepping-stone" to the narcotic drugs.

He told me about the "Walk-in" Clinic (Youth Advisory Centre) in Amsterdam which is staffed by a psychiatrist, nurses and social workers. This is open all night, and staff is available for consultation. About one-third of the enquiries deal with drugs. The Centre is a non-government organisation subsidised by the City Council and by the Ministry for Social Affairs, but at present is in financial difficulty, and facilities are being curtailed. Apart from the reduction in finance there is also, apparently, difficulty in co-ordinating the activities of the Clinic with hospitals and other agencies, but it is hoped that this will shortly be overcome.

JELLINEK CLINIC

The Jellinek Clinic is on the Kaisersgraacht, which is a tree-lined canal in Amsterdam. The Clinic itself is a 17th Century house which at one time belonged to Kruger, the "Match King". There is a panelled entrance hall, and a beautiful oak staircase. At the rear of the house is a charming, old-world garden, where traffic noise does not penetrate.

The Director of the Clinic is Mr. Krauweel, who had a long association with the late Dr. Jellinek.

HISTORY

The Clinic started over 25 years ago with the two Directors, (Mr. Krauweel and Professor Jellinek), a charwoman, and a "rouseabout". In 1947 Mr. Krauweel examined their alcohol treatment results, and considered them very poor, mainly because at that time they had no after-care service. As a result. he considered that it would be more efficient to have a small detoxification unit and to establish large out-patient facilities.

He obtained a house and rebuilt it, "begging" the money from the Province and the City Council and from private sources. He insisted on detoxification followed by rehabilitation and with a very good selection of cases he had a 90% success. This, of course, brought about its own downfall because everyone came to his Clinic. Fifty more beds were added and the place began to get too big.

In the early 1950's, he admitted a few drug-users; he had no trouble when there were only a few, but as soon as the numbers grew, he found that it was impossible to mix alcoholics with drug addicts. They belong to different age groups, and Mr. Krauweel found that the addicts became very aggressive towards the alcoholics, because the latter were "father-figures"; the alcoholics disliked the drug addicts because they were a younger and much noisier group. The result of mixing the two groups in any numbers was chaotic.

Another problem is the difficulty of recruiting highly qualified staff of stable character who can work in harmony with psychiatrists, psychologists and social workers.

Mr. Krauweel emphasised the importance of poly-addiction, and also the extremely large financial interests involved in drugs. He mentioned also that there was considerable political agitation in Holland to legalise the use of Cannabis, and said that there was a cigar factory that was known to have a Marihuana cigar ready for sale as soon as the Government should legalise the drug.

All the ambulatory work at the Jellinek Clinic is paid for by a State subsidy, and in-patients are paid for by the Sick Fund Insurance Companies. The Clinic takes the insurance policies, and informs the company concerned. Everyone is entitled to State Social Insurance, which covers hospitalisation costs for up to one year. The contribution takes about 5% of one's salary, and insures against medical, hospital, and dental expenses of all sorts.

Hospitalisation costs about 90 Guilders (something over $A20) a day. After a year in hospital with chronic illness (even Korsakoff's Psychosis) there is a further insurance provision for which one can pay a little extra. Provisions are made for mental illness and mental retardation, and Mr. Krauweel says, "You could be hospitalised to all eternity without further payment".

The Clinic has 87 beds and will soon have 99. Patients may stay for up to 89 days, and are all voluntary. The average length of stay varies between two weeks and two months or more. There is no way of forcing people to stay; they are allowed to leave if they want to, but if they come back they must enter a "gentleman's agreement" under which they must stay as long as the doctor thinks it is necessary.

It is more difficult to deal with drug addicts than with alcoholics; addicts are more difficult to discharge. Many drug addicts are psychopaths who want to stay much longer than is really necessary, and these waste the professional resources of the Clinic. When news arrives that a new group of "hippies" is coming to town, some patients leave, and interrupt their treatment. All that can be done is to let them go, telling them to come back when they are better motivated. Conditions of the "gentleman's agreement" include that there should be no "stuff" in the house, and that the patients should cooperate in group therapy, the daily routine, and other treatment provided.

The difference between "de Lauryer" and the Jellinek Clinic is that in the former the patients "do it themselves". The Jellinek Clinic is said to be "full of doctors", and it can give better physical treatment, and skilled group therapy, but for certain types of young people "de Lauryer" is more attractive.

Many alcoholics, of course, never reach the Jellinek Clinic. Some get "Antabuse" from their family doctor, but may continue drinking if they are not properly supervised. Such cases may eventually come to the Clinic for more adequate treatment.

The treatment of drug dependents is made more difficult than it might be, by young people who want to be thought "progressive", and who imitate a certain type of "intellectual". There is also the stimulation by press and radio publicity, and by speeches from those politicians who want to get on the bandwaggon, and who profess to regard drug-taking as a sign of intellectual freedom and of great sophistication.

The Jellinek Clinic has a Club associated with it. (Mr. Krauweel does not like the name "Half-way House"). There are 20 beds at the Club, and the Clinic employs a paid Manager there; he is in fact regarded as a servant of the Club, not of the Clinic. He is a former patient who used to be a hotel-keeper. Doctors are not allowed in the Club except by special invitation, or as ex-patients of the Clinic. The house used to be owned by the Dutch Women's Club, and there are several small rooms for groups, where ladies used to meet when they came to town for shopping, and so on. The Clinic took over the whole building, which badly needed renovating. Mr. Krauweel arranged for the patients to do it up themselves, and consequently they take a great pride in the place. The Clinic recently authorised a credit of 4,000 guilders for the Club for a new television set.

Membership of the Club is by ballot; as one might expect, the type of person who resides there is usually an ex-patient who is unable or unwilling to go home, or who has no home to go to. He pays 2 guilders 50 (about 60 cents) as a joining fee, and can stay indefinitely. However, he must take part in club activities, and in maintenance of the buildings and grounds. Mr. Krauweel himself visits once a week—he is a member by invitation. No records are kept at the Club. It has plans for a small, select, restaurant; I was given to understand that because of this a number of "friends of the Club" wanted to become members—some of them being magistrates in the City. Like everyone else however, they have to be balloted for.

CZECHOSLOVAKIA

Area: 49,000 sq. miles
Population: 14,000,000
Prague: 1,000,000
Currency: $A1 = 19·35 Czech. Korona
CsK1 = 5 cents (Aust.)

Information from:

Sister O. Velkova, deputising for Dr. J. Skala, and in charge of St. Apollinaris Clinic for Alcoholism, Prague.

I visited Prague to discuss with Dr. Skala treatments for alcoholism. Dr. Skala is a European authority on this subject; unfortunately he was unexpectedly on vacation when I arrived but had kindly arranged for his senior Nursing Sister, Miss Velkova to show me the Clinic and answer queries. Miss Velkova is a very energetic woman who speaks and understands English well, and has been associated with the Clinic since it began. Most of our travelling in and around Prague was done by public transport and on foot.

Alcoholism is as great a problem in Czechoslovakia as in Australia and is treated at three levels, namely:

1. Alcoholism Sections in Psychiatric Departments of Hospital Polyclinics (Out-patient Departments)
2. Detoxification Units
3. Alcohol In-patient Wards at Psychiatric Clinics, Psychiatric Hospitals, and Institutes.

There are Psychiatric Departments at 267 Polyclinics throughout the country—80% of these Departments have sections for the out-patient treatment of alcoholism. The total number of alcoholics registered in these Sections at the beginning of 1970 was 110,230; over the previous five years the case load was increasing by an average of 14,000 per annum. About 15% of these were voluntary registrations, the others had been referred from Detoxification Centres or by the Police or Courts. The greater number of the registrations are merely records—about 7% are under active treatment at any one time. About 4% were receiving maintenance "Antabuse", and 3% either voluntary or compulsory out-patient clinical treatment.

Nearly 12% of first registrations at the Psychiatric Polyclinics (apart from those who are registered in the Alcohol Sections) are either alcohol-or drug-dependent persons. The proportion of drug dependents to alcoholics is about one to twenty-five.

The detoxification centres take as in-patients, persons with acute alcoholism who are dangerous to themselves or to others, or who "cause public offence, or transgress or disturb traffic regulations".

There are 51 detoxification centres throughout the country, with a total capacity of 457 beds. About 30,000 persons are detained annually in these Centres. Women account for 4·5%, and adolescents up to 18 years for 4%, of the total. The number of recidivists varies between 26% and 30%. One reason for these Centres is that they allow some sort of register to be compiled of actual and potential alcoholics—for example, in Prague alone there are said to be 20,000 persons registered in this way.

ST. APOLLINARIS CLINIC

This Clinic which I saw in Prague, is a highly specialised Clinic for the treatment of alcoholism. It was started in 1948, and has developed an intensive programme for groups of about 9 members each. It is associated with the Charles University of Prague and "feeds" a long-stay unit in the country where there is accommodation for 35 persons who may be compulsorily detained for a year or more.

There are 10 beds for detoxification, and 51 places for longer treatment, up to about 3 months. The results of the 3 month intensive therapy have been followed for two years by specialists from the Research Institute of Psychiatry, and it is claimed in a long-term study that 60% ex-patients remain "dry" at the end of one year. the percentage decreasing to 25% over the following four years.

Briefly, the hypotheses upon which treatment at the Apollinaris is based are:—

1. The patient is exposed to conflicting situations with psychological and physical stresses, and learns to face unpleasant events without using alcohol or other drugs.
2. By completing difficult and unpleasant tasks, the patient gradually develops a sense of responsibility, self-confidence, and self-respect.
3. A new system of values is developed.
4. Re-socialisation is attempted by living in small groups where communal and group pressure is brought to bear in managing everyday situations.

5. Intense physical activity improves physical condition, which in turn is said to facilitate psychotherapy.
6. A scoring system keeps the patient aware of his progress. Successful progress is rewarded by the privilege of unaccompanied walks.

The programme consists of small group psychotherapy meetings, psycho-drama, interaction between patients and therapists in community activities, participation in the patients' and ex-patients' club, etc. Yoga, gymnastics, and intensive physical training are also used. Details and results of the programme can be found in a paper which I have placed in the Mental Health Library. In summary, a long-term review showed that of 100 patients who finished the treatment, 53 abstained from alcohol for at least one year, 40 for two years, 30 for five years, and ten for ten years. Fifteen patients were not improved after one year, and thirty-five were unimproved after five years.

The staff for the Detoxification Centre, the Alcoholism Unit, and the Long-stay Unit in the country, consists of three Social Workers possessing a B.A. with one or two years post-graduate experience, four Psychologists, one of whom is stationed permanently at the country centre, a Head Nurse, two Staff Nurses and eleven Sisters. Dr. Skala is in overall charge, and is assisted by a doctor from the nearby Psychiatric Clinic.

Nurses take blood samples and give First Aid to patients, most of whom have been brought to the Centre by the Police.

The Centre is in a converted monastery, occupying a basement and two upper floors, which are reached by flights of wide stone steps. There is a lecture room, a dining-room, and a garden where patients exercise daily, commencing at 6.30 a.m. A daily inspection is carried out at 7 a.m. Patients are allotted to groups—about 9 to each group—each of which is responsible for cleaning, and does general duties under supervision. The Group relies on "group pressure" to keep patients at the allotted work and is responsible for its own discipline.

Patients receive aversion therapy with Apomorphine, intensive vitamin therapy, and "Antabuse" treatment at the Unit; they also attend lectures on the effects of alcohol, and so on.

Voluntary patients stay from three to six months; others are referred from the Courts with a six-months' sentence or longer, and may be transferred to the country annexe.

Social rehabilitation is encouraged by a patients' Club, and by groups in the country towns consisting of drinkers associated with equal numbers of cured alcoholics. Recidivist drinkers are urged to attend the Club once a week. The Club holds New Year festivities without alcohol, and there used to be an exchange with patients from Yugoslavia, but the Government no longer allows this. The main idea is to give alcoholics some sort of aim and object in life. The programme has a superficial resemblence to A.A., but lacks the religious colouring and the emotional overtones of the latter.

The Alcoholism Unit takes drug dependent persons also. It is said that there is little difficulty in mixing the two groups, but in any case there are no facilities for segregation; alcoholics and drug-dependents receive much the same treatment. The drugs most used by addicts in Czechoslovakia are L.S.D., Barbiturates, Ephedrine, and a drug called "Yastril" which contains Stramonium. It is said that the Czechs do not like Hashish.

As previously mentioned, there are alcoholism wards at psychiatric centres, hospitals, and institutes. These wards represent less than 5% of the total psychiatric bed capacity, although 12% of all patients are said to be alcoholics. It is estimated that throughout the country there is a shortage of about 1600 beds for alcoholism, and there is also the universal complaint that treatment is too short. The total capacity of the 20 specialised alcoholic wards is 850; the size of the wards varies from 10 to 100 beds.

For many years there have been efforts to classify patients according to how willing and how able they are to cooperate in treatment. This has resulted in a sort of 4-tier classification, from the voluntary patient who is willing and able to cooperate and whose length of treatment is usually about three months, to the non-voluntary patient who is neither able nor willing to cooperate, and who stays six to twelve months, or longer.

There are plans for more intensive treatment, particularly of the alcoholic in prison. At present, treatment of prisoners is usually carried out at an out-patient centre after release, but it is hoped that in future, treatment will be given during the period of imprisonment. It is being recommended that units of 20 to 30 beds should be established in the prisons, in charge of medical staff from outside. It has been possible to do this in selected areas, and an assessment of this type of treatment in prison was carried out between 1967 and 1969 in 50 alcoholic prisoners. The therapy was said to have been very effective. It has been further suggested that one prison might serve exclusively for treatment of alcoholics. 4,000 alcoholics were sentenced to imprisonment in 1967, but only 500 of these received any treatment during detention.

ANTI-ALCOHOLIC CONSULTING CENTRE FOR UNDERAGE ADOLESCENTS

This Centre is described in detail in papers in the Mental Health Service library. Under-age adolescents are between 16 and 18, and are referred by parents, employers, Courts, or public health organisations. Very few attend voluntarily. Most are totally uninterested in any sort of physical activity, in culture, or even in reading "thrillers". Most patients come on the recommendation of the out-patient hospital departments of districts or suburbs; the papers referred to above were written by social workers, and contain details of investigations on 290 of these young patients.

Another paper, by Dr. J. Mecir, the Assistant Professor at the Child Psychiatric Department of the Psychiatric Clinic at the Charles University of Prague, describes experiences at that Centre, and reviews 800 patients between the ages of 16 and 18 over the last ten years.

Everyone in the country is compulsorily insured, so alcoholics receive State Insurance. There are two views on the wisdom of alcoholics receiving insurance money, but they are legally entitled to it. The State subsidises the Apollinaris Clinic to the value of approximately $A10 per patient per week.

GENEVA

World Health Organisation

Sources of Information:

Dr. D. C. Cameron, Chief Medical Officer, Drug Dependence, W.H.O.
Mrs. J. Moser, Drugs and Alcohol, W.H.O.
Miss E. Brooke, Consultant Statistician, W.H.O.
Mme. Muelenthaler, Psycho-social Clinic, Geneva.

I discussed with Dr. Cameron the facilities needed for the treatment of drug-dependency and alcoholism, starting from the premise that what was needed depended on the size of the problem, and the type of approach planned. There is no point setting up special services unless you are going to give some treatment which is different from that elsewhere, or unless there is some reason for separating certain patients from others. Dr. Cameron was at one time on the staff of a mental hospital which had an admission rate of about 1800 acute alcoholics a year. With such an intake, it was necessary to set up a special ward for detoxification. This ward was supervised, not by a psychiatrist, but by a specialist in internal medicine, who could deal with the physical problems of fluid balance, mineral balance, and so on. Another special unit was set up for the alcoholics, within the mental hospital, but apart from the rest of the patients, because the programme for them was different, and was much more intensive than that for others. Dr. Cameron said; "they didn't have a spare minute a day, until 10.0 o'clock at night. They were really busy throughout the entire period". It is impossible to carry out this sort of treatment on a ward where there are acute psychotic patients.

The limiting factors, then, are the numbers of patients, and whether any specialist treatment is being provided. With a small number of patients, it is usually uneconomic to run special programmes.

Where drug addicts are concerned, one must consider the type of addiction as well as the numbers involved. For example, there is no reason to bring Cannabis dependents into hospital at all. If the drug of dependence is Amphetamine, it may be necessary to have the patient in hospital for a very short time, until the risk of suicide is over. This can be adquately handled on ordinary psychiatric wards.

It takes from 10 to 14 days to withdraw addicts from Opiates. Such people are a very disruptive influence on a psychiatric or general hospital ward, and if there are more than about half-a-dozen of them at any one time, some special facilities should be provided for their management during the withdrawal stage. For a maintenance programme, it is not necessary to have the patients in hospital.

More research is needed on Methadone maintenance treatment. The views of the World Health Expert Committee on drug dependence, of which Dr. Cameron is Secretary, are set out in detail in the Eighteenth Report of that Committee, published in Geneva in 1970. A copy is in the Mental Health Library. Although Methadone can be useful in selected cases, it is necessary to consider psychological, legal, and socio-economic factors as well, if permanent gains are to be made.

Therapeutic communities such as "Phoenix" and "Synanon" have only limited appeal. Only a small, self-selected group of persons makes contact with such organisations; of these, about two-thirds actually become residents. Of those who become residents, one-half to two-thirds stay less than a few months, and leave without the approval of the Community. It is estimated that if long-term improvement does occur, it is limited to less than one-third of those who make initial contact. These programmes, however, do show that some former drug users can live together in an orderly society.

An education programme is most important, but it must be carried out by mature, experienced, people. I was told of an education programme carried out in a part of England away from London, where there was at that time essentially no drug problem, but where it was thought to be a good idea to help parents know the signs and symptoms which might indicate that their children were using drugs. "So they filled parents full of all these signs and symptoms. Well, you know, some of these are fairly general, and what they succeeded in doing was to create mistrust between parents and children, in the face of no drug problem". Dr. Cameron was interested in our programme in Western Australia, and fully approved the approach being made by the Health Education Council.

I spoke also with Mrs. Joy Moser, who is on the Committee for Drugs and Alcoholism. Experts believe that at the national level, these problems should be considered together, for several reasons; one being that a person often takes both drugs and alcohol, or moves from alcohol to other drugs. Furthermore, the pattern may change over a whole country, as it has in Japan. Previously, alcoholism there was not a problem, but now it overshadows the drug problem. It seems important, therefore, that there should be persons

at top level in Governments, who are aware of these problems and of their interdependence. Whether the persons suffering from these conditions are best treated together, is a matter different for each area, and depends on the person and on his particular addiction.

Most of the discussion I had with Mrs. Moser concerned drug education. With the development of community health services, it is important that there should be mutual understanding between psychiatrists and public health officials, that there should be more social psychiatry in the medical curriculum, and that general practitioners should receive better post-graduate training in community health.

Mrs. Moser is also particularly concerned with serious mental retardation, especially with the difficulties of families who have such members. She was interested to learn what we were doing in this field in Western Australia, and of our activities in epidemiological research. My offer to send information on this was eagerly accepted. (The work that we are doing in the Narrogin area in co-operation with Princess Margaret Hospital and the local doctors, is of especial significance in this field.)

I was told of a three weeks' European Seminar on aspects of drugs and alcoholism, which was to be held later in 1971. There are 22 participants, including three consultants from World Health. They are spending one week in Poland, one in Denmark, and the final week in the United Kingdom. During the final week in England, there is to be emphasis on research, conclusions, and a statement from each person about future plans and follow-up. When asking Governments to send representatives, World Health asked specifically for people who held positions of importance in organising services in their own countries, so that the Seminar should not be an isolated event. The participants from each country will have to know exactly what their own problems are, and what local facilities they have for handling them, so that when the team reaches, say, the Netherlands, they will have a day-and-a-half discussion on local problems and what is being done about them; then the participants will give a synopsis of what happens in their own areas, and what their particular problems are. After these discussions the groups split up, and nineteen clinics throughout the Netherlands act as hosts for one or two members each, so that each sees something slightly different. They then come back, together with the Directors of the particular clinics, for further discussion. In this way information is disseminated to others besides the actual participants.

I was told that the West Pacific Regional Office for World Health (which is in Manila) had written to Canberra, asking if they could send one or two participants. A World Health Fellowship, however, could not be provided, so that whoever came would have to come at Government expense or at his own. I was told that they had had no reply. Next year (1972) this interchange of ideas will be held again in different countries.

I was given a copy of the World Health Questionnaire "Concerning Procedures for Investigating Suicides", and a paper outlining a national enquiry into the problems of alcohol and drug dependence. This follows a recommendation of the Fourteenth Report of the World Health Expert Committee on Mental Health, which states:—"Dependence on alcohol and dependence on other drugs create or contribute to major public health problems, and should therefore be of concern to all public health organisations and administrations", and:—"W.H.O. should provide further leadership in the development of co-ordinated . . . research programmes". A copy of this Report is in the Mental Health Library.

W.H.O. also has a programme called "Estimation of Mental Health Resources", covering more than 20 countries. The object of the programme is to discuss differences, to exchange ideas, and to reach some common ground for recommendations for improvements to individual services. The Directors of Mental Health in Australia provided information along these lines to Canberra some two years ago.

It was suggested that in Western Australia we might give a week's course on modern aspects of Mental Health Services, to the medical practitioners in outlying areas. I think this should be done by the University, but in the absence of a Professor, it is unlikely that anything of this sort will be carried out in the immediate future, apart from the visits already paid to the North-West by the Mental Health Services Director, and the Mental Health Out-Patient Clinics at Kalgoorlie and Geraldton.

In Geneva I visited a "Psycho-social" Centre, which had been set up with the aid of the City Council. It was in temporary premises, and was not yet working fully. There was an Analytical therapist (Mme. Muelenthaler) in charge, who was assisted by a social worker. The arrangement seems to be more in the nature of a Consultation Centre for people with problems; they deal, however, with a number of alcoholics, who may be referred by doctors in the City. There is also an association with the Professor of Psychiatry at the University of Geneva. Readers of this report who want more information should get in touch with Mme. M. Muelenthaler at the Centre Psycho-social Universitaire, Boulevarde St Georges, 16-18, Geneva.

UNITED KINGDOM

Population:
Greater London 9,000,000
Birmingham 1,200,000
Portsmouth 215,000

Currency: £1 = $A2·13
$A1 = 50 new pence

Sources of Information:

Inspector C. G. Jeffery, H.M. Chief Inspector, Home Office, Drugs Branch, London.
Dr. A. Sippert, Senior Medical Officer, Department of Health and Social Security.
Dr. M. R. Glatt, In charge of Drug and Alcohol Dependency Ward, St. Bernard's Hospital, Middlesex.
Dr. J. Willis, In charge of Saint Giles Centre, Drug Maintenance Clinic, Camberwell.
Dr. D. Hawks, Alcohol and Drug Research Centre, Maudsley Hospital, London.
Dr. G. B. Oppenheim and Staff, Charing Cross Hospital Out-Patient Psychiatric Clinic Annexe.
Dr. J. Owens and Mr. Nyman, All Saints' Hospital, Birmingham.
Dr. D. Brough, Superintendent, St. James' Hospital, Portsmouth.
Dr. I. Christie, Psychiatrist "Alpha House", Portsmouth.
Dr. J. Brunning, i/c Alcohol Programme, St. James' Hospital, Portsmouth.
Dr. S. A. MacKeith, Consultant Psychiatrist, West Sussex Region.
Dr. J. K. Hewat, Senior Consultant Psychiatrist, Knowle Hospital, Fareham, Hampshire.
Professor F. C. Camps, Professor of Forensic Psychiatry, Middlesex University.
Sister Joan Elizabeth (and others), St. Mary Spelthorne, Egham, Surrey.
Colonel Baker, acting for Colonel W. McAllister, Salvation Army, East London
Mr. Henderson, Social Worker i/c Reception Ward, Salvation Army, East London.
Miss Green, Psychologist, "Alpha House", Portsmouth.
Residents of "Alpha House", Portsmouth.
Mr. Holland, Senior Psychiatric Nurse, i/c "Alpha House", Portsmouth.

A very extensive programme was arranged by Dr. B. Welton of Australia House, and Dr. Sippert of the Department of Health and Social Security.

HOME OFFICE

I spoke first with Mr. C. G. Jeffery, who, as Dr. Snow found earlier in 1971, was extremely helpful.

Inspector Jeffery considered that Cannabis did not at present constitute a major problem. He said that Police could produce no evidence of criminal actions as a result of use of Cannabis, so that in general, apart from the fact that it is something that is against the law, and on present evidence, one does not want to encourage, it is not seen as anything like the problem that intravenous Heroin or intravenous Methedrine are.

Mr. Jeffery told me that there had been a marked down-turn in the use of intravenous Heroin in the last two or three years. He could give no definite reason; he said that the epidemic had appeared in 1960 for no apparent reason, and could disappear just as readily without any particular action on the part of the authorities. Although the authorities did in fact take action to control the situation, Mr. Jeffery would not say that the improved position was due to this alone.

In America an addict is entirely dependent on illicit supplies; in the United Kingdom there is no evidence of illicit supply. Recently there have been hardly any deaths from sepsis or overdose, and there is no evidence of any increasing number of addicts who are unknown to the authorities.

Doctors have a statutory obligation to notify cases of addiction to the Chief Medical Officer of the Department of Health and Social Security. They are under no obligation to inform the Police, but in some towns e.g. Birmingham and Bradford, there is very good cooperation between doctors at the local addiction treatment centre, and the drug squad. In these towns it is accepted that the drug squad comes and discusses any information of value with the staff of the centre, and the doctors in charge make it quite clear that while they will not give information which will result in the prosecution of any of their patients,

they will pass on information they receive from their patients about traffickers; the drug squad informs doctors of any indication that patients might have been "cheating" and, say, getting Heroin from alternative sources. There is thus in effect a very good working relationship.

There are thirteen or fourteen addiction treatment centres in London. These are scattered, because the original idea of the Department of Health was that the centres should be based on teaching hospitals. A couple of non-teaching hospitals have been brought into the scheme, but there is no planned distribution of centres. Neither is there any staff establishment laid down for the centres—each one is administered by its own hospital and has its own particular approach.

Mr. Jeffery said that there was a general feeling that even the use of Amphetamines was decreasing in the United Kingdom. In 1968, immediately following the restrictions on Heroin, there was an epidemic of intravenous Methedrine; two of the "rogue doctors" who had been involved in over-prescribing Heroin and Cocaine, switched to prescribing Methedrine ampoules when their licences to prescribe Heroin and Cocaine lapsed. By certain methods of checking, the drug squad was able to show that one of these doctors had certainly prescribed just on 25,000 ampoules of Methedrine in the month immediately after the licence to prescribe Heroin had lapsed, that is, over 800 ampoules a day. This doctor continued to prescribe more than 400 ampoules a day until October 1968, when he was struck off the Register.

So far as intravenous drugs are concerned, there is no major problem outside London, except occasionally in the larger cities within easy reach, e.g. Birmingham, Manchester, Liverpool, and Newcastle.

Cannabis and L.S.D. on the other hand, are penetrating into all sorts of unexpected areas. It is quite common for Cannabis to be available at local dances, in rural church halls. There is some drug misuse in schools and some indication that nearly all the University students who are addicted to drug-taking had started before they came to the University. There is, however, certainly no problem like the Americans say they have, with ten-and twelve-year olds taking Cannabis. In England it is more common among the sixteen-and seventeen-year olds.

Over the last three or four years, the peak age for narcotic addiction has advanced each year, which suggests that there is a "hard core" of cases who are getting older, and perhaps a fringe of users who appear and disappear. The basic problem is the "hard core" of maybe eleven or twelve hundred cases. The peak age went from nineteen in 1967 to twenty-two in 1970, and it appears to be the same population that is involved.

The "British method" of control and treatment is dealt with in discussions with Dr. Sippert, Dr. Oppenheim, and others.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Dr. A. Sippert is the Chief Medical Officer of the Department of Health and Social Security. He told me that £2,000,000 had recently been allocated by the Government for research into, and treatment of, alcoholism; information is being gathered from local authorities about their own alcoholism units, the number of patients and staff, present treatment methods, and future proposals. The voluntary organisations, of which there are very many, are also being consulted because of their extensive experience with the problem. The local authorities, who are now responsible for the after-care services and social casework, have little or no practical experience of this sort of work with alcoholics. A.A. is very active, and so are other organisations such as the Salvation Army and the Churches. There is also the National Council for Alcoholism, and the more important of the Regional Councils, which do a lot of the counselling, information, and early identification of cases. There is a Medical Council on Alcoholism, which is responsible mainly for educating practitioners and for promoting research; another voluntary organisation, the Alcoholics' Recovery Project, deals primarily with the "Skid Row" group of alcoholics in London.

Information is being collected from all these organisations, and the hospital planning authority has proposals for further expansion of the hospital treatment of alcoholism. Attention is also being paid to the "habitual drunk", looking at the problem posed by alcoholics who are picked up "drunk and disorderly", taken to court, released from court or taken to prison, discharged from prison, found drunk again, etc. The report of the Working Party on Alcoholism (published by H.M. Stationery Office) recommended a great increase in hostels, and the provision of experimental detoxification centres. The recommendations of this Working Party are being considered in the plans that are being made for the comprehensive service for treatment and rehabilitation. There is a need for counselling or information centres where distressed people can go to seek information,

and the Department is experimenting with alcohol addiction units combined with detoxification units. There are not enough hostels where alcoholics can be supported until they find new jobs and places to live, and accommodation is needed for those who are going to be supported indefinitely, or who are attending for day- or out-patient treatment.

(There is a move in England to explore the treatment of the alcoholic as a day-patient or out-patient, rather than the more traditional in-patient approach.)

Alcoholic units where possible should be associated with general hospitals, but if there is a great need in an area, and if there is no alcohol unit handy, it may be necessary for it to go on the site of a psychiatric hospital. The Department would agree to this only as a temporary measure, and providing the unit is put up in such a way that it does not extend the life of the psychiatric hospital. (These hospitals are being "run down" as quickly as possible.) The alcoholism service should preferably be closely associated with a University Department, so that it can become a focus for teaching doctors, psychiatrists, D.P.M. candidates psychiatric social workers, probation officers and so on.

The Department encourages detoxification centres in association with hospitals, and a built-in evaluation programme. One of the hospitals that is being considered for this type of unit is St. James' Psychiatric Hospital at Portsmouth, which I visited, and where I discussed the plan for the unit with the doctor who is going to run it.

Dr. Sippert pointed out how difficult it is to do an incidence or pattern survey of alcoholism; because not only is it necessary to define the term, but it is well known that the majority of people who are drinking too heavily or who have lost control of their drinking are loath to admit that they are ill, or that they are alcoholics, and are unlikely to come forward. Generally speaking, however, Dr. Sippert believes that most of the experts would set the figure of alcoholics in the country at about 300,000—that is, using the definition in a narrow sense.

We discussed the question of compulsory treatment. There seemed to be mixed feelings about this in the U.K., and a lot of psychiatrists say that the Mental Health Act of 1959 can be used to detain alcoholics compulsorily. Some are not in favour of compulsory treatment at all, but others, like Dr. Glatt, (see page 27) are strongly in favour of compulsory treatment in selected cases. They believe that both addicts and alcoholics reach a stage in their illness where they are not in a position to decide whether they would benefit from treatment, and they feel that these patients should be detained compulsorily. However, this is an open question at the moment.

Detoxification centres should be closely associated with general hospitals. A link is needed between the Detoxification Centre and the Accident Emergency Section, because it is sometimes difficult to tell whether one is detoxifying an alcoholic, or detoxifying some other medical emergency who just happened to have a drink; therefore one needs the cover of specialists. Another difficulty in planning a detoxification unit is the question of demand, which usually increases at weekends and decreases during the week. There is a need for supporting facilities, and patients must be able to move either to an alcohol unit or elsewhere for accommodation. Medical and nursing staff are often inexperienced in these matters, and will have to be specially trained.

The plans to integrate psychiatric with general hospital work are quite well advanced. There are two types of units under consideration. The first one is termed a "satellite unit". This is at the site of a district general hospital. There are four sizes, viz:—60 beds and 80 day places, 90 beds and 120 day places, 120 beds and 150 day places, and 150 beds with 160 day places on the site, and forty places at day hospitals in the area. Together with these larger units there are plans for what is called a "ten-bed annexe". This is a self-contained ten-bed ward with day area, dining area, interview rooms and quiet rooms which can be used for alcoholics or for drug addicts, and is attached to the psychiatric unit of the general hospital.

The other type of unit planned as a link with the psychiatric unit of the general hospital is to be in charge of psychiatrists, with psychiatric nurses, and will provide training facilities for psychiatric and general nurses together.

The setting-up of these facilities will be funded by the Department. It is assumed that once units are set up there will be a certain amount of revenue, and estimates would be provided with this in mind. The money that the Government provides for alcoholism must be used for that purpose only, and the Department wants to ensure that it is spent in the most economic and efficient way. This is why there is so much activity at present getting ideas from hospitals, voluntary organisations etc. as to how the allocated money can be best applied.

I asked about treating alcoholics and drug addicts in the same unit. Dr. Sippert told me that although he felt some would prefer not to, there were units at Birmingham, Notting-

ham, and Saint Bernard's in Middlesex, treated them together. I later saw the unit at Saint Bernard's, with Dr. Max Glatt.

It is said that younger drug addicts can develop a close relationship with the older alcoholics. In some units they have meetings where an alcoholic may be chairman one day, and a drug addict the next, and so on, and they have individual therapy meetings. Despite the insistence of some persons in continental countries, it does seem feasible to treat the two groups in one area.

The drug problem, Dr. Sippert felt, was closely allied to over-crowding. He said "it seems to be the problem of so many rats in a tiny hole—the more rats you get they begin climbing over each other; where you've got freedom—and you have freedom in Australia—it's easy to get into the country—it's easy to go and find things to do without treading on somebody's toes". "This", he said, "is half the problem here, and this is why I myself live fifteen miles out—because I live in a village where I am an individual". Nevertheless, this can hardly be the whole problem, because there are still a number of individuals living in crowded circumstances who do not resort to drugs.

The history of Heroin dependency in the U.K. is an interesting one, and can be read in many reports. When the first Brain Report came out in 1961, it was said that there was no problem of Heroin dependency; by the time the second Brain Report came out in 1965 there was indeed a problem of rapidly increasing numbers of young people dependent on Heroin. Hitherto it had been the "therapeutic addict" who was dependent on Morphine or Heroin, and the Brain Reports stated that the problem was due mainly to injudicious prescribing. Many of their thirteen or fourteen recommendations were translated into action.

Addiction is treated as a general medical problem. If you have a definite problem, one tries to meet it by the general provisions available; if the general provisions do not adequately solve the problem it is necessary to meet it by special facilities. What happened in England is, that where the numbers did not justify providing special facilities, the general psychiatric service provided them, and certain doctors were licensed, to make sure that they could provide the proper prescriptions. Patients may go into a psychiatric hospital, into the out-patient clinic in a psychiatric unit, or may be treated at the general hospital itself. In London, where the numbers certainly warranted the setting up of special facilities, it was necessary to decide whether there should be four or five major centres, or whether they should be dispersed. It was eventually decided to disperse the facilities, mainly because it was thought undesirable to bring together a lot of addicts, and so provide a focus of drug culture.

After a great deal of consideration, they paired teaching hospitals or regional hospitals, and eventually arrived at about fourteen treatment units, which have already been very well described in the C.M.S. report of 1966. I spent some time at one of these units at the psychiatric out-patient annex of the Charing Cross Hospital. This is described in a later section of this Report.

At first, the units catered for young people dependent on Heroin and Cocaine, but since then they have evolved, as one would expect, because the idea of an addict wedded to one drug is no longer valid. Most addicts are in fact poly-addicts. Many, for example, are misusing Heroin but a lot of them are also misusing Methadone as well. They have probably been taking barbiturates and stimulants, and also using barbiturates intravenously. Dr. Sippert thinks that instead of the traditional "hard" and "soft" drugs, a better division might be a division into intravenous and oral "use".

Heroin addicts in England are not involved in a great deal of crime, because with the "British system" of licensing the treatment centres, an addict can get the drugs, and be maintained. Crime associated with drug dependency is mainly that of illegal possession, or perhaps of pushing; but barbiturate "mainliners" are at present a very great anxiety. These addicts go through all the phases of alcoholism in an accelerated way. They become drunk and disorderly when they "mainline", and they become aggressive and difficult. They then of course become "dead drunk", then unconscious; and they can eventually kill themselves with an overdose. There are about fourteen million prescriptions for barbiturates and hypnotics written each year, and some of this material inevitably falls into the wrong hands. Other addicts "mainline" "Tuinal" and "Seconal". They obtain the tablets or capsules, and mix them with water, forming a highly caustic solution. They then inject this, and if they miss the vein there is "a very bad mess". The whole of the tissues slough out, and they have a very bad ulcer which takes a long time to heal. After a time the vein becomes thrombosed anyway, and gangrene, as well as septicemia, is not uncommon. In England they have also found that "Mandrax" is "a terrible nuisance" in this way.

I discussed "Phoenix" and "Synanon" with Dr. Sippert, and he told me that an evaluation of "Phoenix" was starting at Portsmouth. This unit is described below. It is accepted that this programme is suitable only for a certain type of addict, and that drug dependence treatment should involve other facilities also.

Maintenance treatment in the U.K. is moving more towards Methadone, which at first was given intravenously. It is claimed that 40% of Heroin addicts are now in some form of work, and 40% are living in the community in a well-adjusted way. These groups are receiving either Methadone or maintenance Heroin.

Methadone is given under close supervision; its advantages are said to be that it does not interfere with the patient's work, and that it is clean and does not produce sepsis or ulcers, once patients are taught how to inject themselves.

For further rehabilitation of addicts there are four hostels in the London metropolitan area, with a total of 40 places. These are voluntary organisations subsidised by the local health authotities. "Phoenix House" in London, "Alpha House" in Portsmouth, and another hostel in Manchester, are also subsidised by local authorities. At Esher, in Surrey, there is a hostel occupied by people who are undergoing Methadone maintenance treatment and are also working.

An organisation which well might be imitated here is the Drug Dependence Liaison Committee. There are a number of these in the United Kingdom; they are composed of local doctors, probation officers, pharmacists, directors of education, social workers, churches, a medical committee of local general practitioners, etc., in fact, anyone with a vested interest in the control of drug-dependence. These Committees are mainly for exchange of information, but the principal difficulty in Australia would probably be that of getting enough involved people together at any one time.

ST. JAMES' HOSPITAL—PORTSMOUTH

St. James' Hospital is the mental hospital which serves the Portsmouth area. The Superintendent, Dr. Douglas Brough, took me to the new "Solent" wards, which cater for day-patients, out-patients, and in-patients. The main feature of the arrangement is that patients have a team consisting of a psychiatrist, psychologist, social worker, and occupational therapist, attached to them. Whether they are day-patients or in-patients is irrelevant. Patients move quite easily from one status to another, and the same team continues to look after them. Another feature is that the out-patients and day-patients have to pay for any medicines they get. They put 40 n.p. (80 cents) into a machine, which thereupon produces a ticket which is presented to the Pharmacy with the prescription before the patient can obtain his medicine. Patients have to pay 40 n.p. for each item on the prescription.

Details of the staffing and administration of these wards do not directly concern drugs or alcohol, and will not be presented in this Report.

ALCOHOLISM UNIT, PORTSMOUTH

This is the Unit referred to by Dr. Sippert (page 22). When I was at Portsmouth, the Unit was still in the planning stage, waiting for a ward at St. James' to be remodelled.

Dr. John Brunning will be in charge of the Unit. He has already outlined the policy to be followed, which is based on physical and psychological treatments. It is proposed that from 2 to 6 weeks will be the ordinary length of stay. Dr. Brunning will exercise consultant supervision, and four sessions a week will be worked by two Clinical Assistants.

Patients will be assessed by a staff member prior to admission. Admissions will usually be at a fixed time (11 a.m. Monday to Saturday), so that patients will not be admitted without previous notification to the Unit. It will be noted that the Unit is for treatment, not for detoxification.

The patient's motivation will be assessed at the time of admission, and patients who drink while under treatment, or who bring liquor into the Unit, "will need to leave while they reconsider their future".

Group therapy plays a large part in the treatment programme, and the initial phase of treatment will be an introduction to the Group, and lectures, tape-recordings, and films on alcoholism. There are to be family group meetings once a week (on Saturday mornings), and out-patients will be seen weekly at follow-up sessions, at a time which will enable them to attend the "weekly tea" which is held late on Wednesday afternoons.

If a patient relapses after discharge, or if he has been discharged for not co-operating in his treatment, he may be re-admitted by arrangement with the Charge Nurse or a Medical Officer.

The administration of the Unit is planned along rational lines; it is flexible enough to allow the patient to work in the community, and if necessary, to return to the Unit each night.

Dr. Brunning believes that in many alcoholism units "Success is measured too closely on a scale of teetolalism; loss of dependence on alcohol is only part of recovery". This accords with the "British approach" to drug-dependency, in which cure is not necessarily associated with total abstinence.

A Unit of this type could well be set up in Western Australia, providing an interested physician or psychiatrist could be found to run it. Progress will be watched with interest.

ALPHA HOUSE—PORTSMOUTH

This is an organisation along "Phoenix" lines, where treatment for drug-dependency is based on "Confrontation" technique. This method is of limited application, but its adherents have a somewhat evangelistic approach. The opinion of the Chief Medical Officer, Drug Dependence, at W.H.O. is quoted at page 19. He believes that a relatively small group of addicts makes contact with such Organisations, and that long-term improvement is limited to less than one-third of that Group. However, as there are no valid statistics about the method, it is impossible to evaluate it at present.

"Alpha House" in Portsmouth started in June 1968. It describes itself as "A medically directed therapeutic community based on the American "Synanon" and "Phoenix" programmes for the rehabilitation of drug addicts". The official pamphlet issued by "Alpha House" goes on to say "Although Alpha is directed and controlled by Professionals as a research project in the field of Drug Misuse, its Policy is in no way influenced by Orthodox Psychiatry".

"Confrontation Therapy" is described in the pamphlet as "A crash course in maturation". The booklet describing "Alpha House" and Confrontation Therapy as practised there, is in the Mental Health Library.

The project is an attempt to produce statistically valid data about this method. It is set up in two houses in a middle-class suburban street in North Portsmouth, and is under the direction of Dr. Ian Christie, a psychiatrist who has been seconded from St. James Hospital for this purpose. Dr. Christie, together with a psychologist, a senior psychiatric nurse, Mr. Holland, and one other, were sent by the Local Authority to the United States to study the problems involved. Earlier this year the Rev. George Smith of the Church of Christ in Perth, received a Churchill Fellowship to study this method, and spent 12 weeks undergoing the same discipline as patients, at the "Phoenix" organisation in London. He has written a full and frank account of his experiences in London and also in America, where he spent six weeks studying the procedure. Although the Rev. Smith is undoubtedly sincere in his enthusiasm for the "Confrontation" method as practised in "Phoenix", and has studied it fully, I am not convinced that this is a project which would be economic here, or that the Government should subsidise it from limited resources, to the exclusion of other methods of treatment. Even Dr. Christie himself says that American problems are not the same as British ones, and that it is not possible to engraft methods from one country to the other.

When I visited the Portsmouth Unit there were 6 residents. The Unit accepts only drug-dependent people, who must not be taking drugs when they apply for admission. Residents at "Alpha House" had at one time been taking Heroin, Amphetamines, or L.S.D.; sometimes more than one drug.

The houses provided by the Council need renovation, and, as is the usual practice in such units (cf. "de Lauryer" and the Jellinek Clinic Club, in Amsterdam), residents were engaged in painting, paper-hanging, and carrying out improvements to the houses.

The rent is paid by the Local Authority, which is financing the project on the understanding that some valid statistics are to be produced at the end of a three-year period. The brochure on "Alpha House" states that "Alpha" is a "self-supporting, independent unit", but as the Local Authority is financing it on a trial basis for three years, I am not quite clear how this statement ties in with the facts.

The staff consists of an Administrator (Mr. Holland), two female Nurses seconded from St. James Hospital, and the Psychologist. General supervision is provided by Dr. Christie.

The project is said to be advancing better since the Group moved into the houses. Before that, there was difficulty with accommodation, but the Organisation now appears to be accepted locally, and is considered fairly well grounded.

This is another project which is of considerable interest, because it is one of the few attempts to produce statistics about the method, and differs from similar units in that it has psychiatric affiliations, even if it is "influenced in no way by Orthodox Psychiatry".

SALVATION ARMY—EAST LONDON

I visited the Salvation Army Referral Centre at "Booth House" in East London, and spoke with Colonel Baker, deputising for Colonel McAllister, and with Mr. Henderson, a trained Psychiatric and General Nurse who is in charge of the Centre.

The Referral Centre has 11 beds and is attached to the William Booth Hostel of some 300 beds.

Professor Desmond Pond, who will be remembered as the H. B. Williams Travelling Professor of 1969, did a survey from the London Hospital, of alcoholics in East London.

The Referral Centre accepts alcoholics and people with other social problems. It is staffed by a secretary, a social worker and the Officer-in-charge (Mr. Henderson). I was told that the drug problem they see is infinitesimal compared with the problem of alcohol.

The Unit is financed by a grant from the Department of Health and Social Security, and by the Local Authority. The full-time Social Worker is paid by the Salvation Army.

All referrals are voluntary. They are often "skid-row" type alcoholics who "dry out" for a few days under medical supervision, and after investigation may go on to other Salvation Army Units in the country for long-term rehabilitation. At one unit they may stay for up to six months, attending Occupational Therapy or a sheltered workshop. A Committee there studies all aspects of each case, a doctor attends on request, and Colonel McAllister, who is himself a doctor, visits once a month. Patients are supported during this period by weekly payments by voucher from the Department of Health and Social Security. The Army deducts all except £1 a week pocket money, and puts it in a fund for the patient, who may draw it on discharge.

It is estimated that the Army in London provides shelter for 10,000 men nightly. Colonel McAllister has surveyed this population, and finds that a considerable number have psychiatric disabilities or mental deficiency. Mr. Henderson at the Referral Centre, estimated that there were "maybe 400" schizophrenics among the 500 population of Blackfriars Hostel, but I am not sure how he made this estimation, and I think his criteria for a diagnosis of schizophrenia may have been somewhat elastic.

The main reason for including a brief account of this visit is to draw attention to the fact that the Salvation Army does a great amount of work in this field, more particularly with alcoholics, and that for this purpose it is subsidised to some extent by the Government.

ALCOHOL UNIT, ST. BERNARD'S HOSPITAL, MIDDLESEX.

St. Bernard's Psychiatric Hospital is a considerable distance from Central London, necessitating a long tube journey followed by a 20-minute bus ride.

The Specialist in charge of the Alcohol Unit is Dr. M. R. Glatt, who has worked with alcoholics for many years, and has written a great deal on the subject. When I visited, he was experiencing difficulties because the Administration wanted to move his patients to another part of the Hospital. This illustrates a difficulty which is not infrequent when alcoholics or addicts receive special treatment in a psychiatric hospital. Furthermore, if the nursing staff is on roster to the "Alcoholic" wards, the constant changes make it difficult for patients to establish a good rapport with the nurses, and for nurses to get worthwhile experience in handling alcoholics.

Dr. Glatt has two open wards where he treats alcoholics and addicts together. Theoretically, the staff on duty for the two wards, which accommodate a total of 48 male and 24 female patients, consists of 2 charge nurses and 2 junior nurses on each shift. At night there is a patrol nurse. Even this very small staff is not always available; to me it appeared an impossible situation.

As long ago as 1962, Heroin addicts were placed with the alcoholics, mainly for administrative reasons. It was found that the alcoholics befriended the addicts, to the mutual benefit of both, so the arrangement was allowed to stand; although Dr. Glatt, who prefers to treat alcoholics on an open ward, thinks that drug addicts should in the early stages at any rate, be on a closed ward so as to reduce the possibility of outside contacts. Dr. Glatt was worried about the abuse of Methadone, which is said to be available on a black market; other drugs abused are Chinese Heroin, L.S.D., Hashish, Amphetamines, and "Mandrax".

A government grant had been made to start a halfway house for addicts, but this project had been set aside for the time being. St. Bernard's would probably share in the £2,000,000 Government grant for Alcoholism (see page 22), but detailed plans for its use had not yet been made.

As Dr. Glatt's writings testify, he has had some success in treating alcoholics, but I believe this is due to his own personality and dedication rather than to the superiority of any special line of treatment.

This visit strongly confirmed my opinion that it is extremely difficult, if not impossible, to provide really suitable treatment for alcoholics at traditional psychiatric hospitals.

ST. GILES' MAINTENANCE CLINIC FOR DRUG-DEPENDENTS

This is one of the 14 drug-dependency clinics which have been set up in the London area. It is administered by Dr. J. H. Willis, who is the Consultant Psychiatrist in Drug-dependence at three of the main London hospitals. St. Giles' Clinic functions in association with King's College Hospital. They are registering about 30 cases of drug dependency each month, but most of these are addicts who have been taking drugs for some time; they are not new recruits.

At St. Giles Clinic, drug abusers attend by appointment, and receive maintenance doses of Heroin, together with sterile syringes and needles for injecting. They are taught how to inject the drug so that there is no sepsis or extravasation. Physical checks are also carried out.

The rationale of this approach is that the primary treatment needs of each patient vary, and that total abstention is extremely difficult to maintain.

A study of addicts after hospitalisation, made in the United States in 1962, indicated a relapse rate of 90% in the first six months after discharge. What is aimed at in the "British approach" (so called to distinguish it from the American and other treatment methods) is not total abstention, but rather controlled, supervised, dosage. The addict must attend the Clinic regularly to get his prescription, and during this process (hopefully) forms a meaningful personal relationship with a member of the Clinic staff—the doctor or a social worker. The Heroin dosage may be gradually reduced over a long period: (an account of this is given in the section of this report headed "Charing Cross Clinic").

For some years the complications of self-injection such as abcesses, septicaemia, syringe-transmitted jaundice, overdosage, and so on, were major factors in causing the hospitalisation of addicts; with instruction in how to give their own sterile injections, these complications have practically disappeared.

Addicts frequently overstate their requirements for drugs. While I was visiting the Clinic, a young woman presented, saying that ther handbag containing her weekly dosage and her syringe, had been stolen. She was subjected to a very searching enquiry indeed before the doctor would order an "emergency" injection, or provide another syringe and needle. This woman was aged about 30, and said that she had been taking drugs of one type or another for some 15 years. She appeared well-groomed and adequately nourished, showing none of the signs popularly supposed to indicate drug-taking, such as a dirty, unkempt, or dishevelled appearance, malnutrition, etc. She was living with a male companion, who was also an addict; neither was working, and their lives seemed to revolve around Heroin and the Clinic. The Department of Health and Social Security apparently provided enough money for them to live at slightly above subsistence level.

I asked Dr. Willis his opinion of the "Phoenix" Organisation. In one of his articles (in "Practical Treatment in Psychiatry", Ed. Crammer, Blackwell Scientific Publications 1969), he had suggested that the "Day Top Lodge" setting, where group interaction similar to that in "Phoenix" was practised, was "a model that one would like to see copied"; it was interesting to hear from him that the estimated cost of keeping an inmate at a "Phoenix" House was $U.S.10,000 a year, that there was a drop-out rate of about 80% and 18 "cures" in 18 months. These figures were based on "Phoenix House" in London; Dr. Willis also mentioned the well-known dislike that "Phoenix" has of independent investigators, and its anti-medical attitude. "Phoenix", "Synanon", "Day Top", and similar organisations, all practise "Confrontation Therapy" in one form or another; in the absence of proper investigation it is impossible to say what differences between them might be significant for therapy. Possibly the "Alpha House" project in Portsmouth (see page 26) may eventually give some indication. Several papers which Dr. Willis gave me have been placed in the Mental Health Services Library.

CHARING CROSS HOSPITAL PSYCHIATRIC CLINIC ANNEXE FOR DRUG DEPENDENCY

This Clinic is under the supervision of Dr. G. B. Oppenheim, who was closely associated with Dr. Owens of Birmingham in the early days of treatment of drug-dependency by maintenance methods. The Charing Cross Clinic is situated behind St. Martin's-in-the-Fields, close to Trafalgar Square. Its "catchment area" covers the entire British Isles—Dr. Oppenheim says: "We will take practically anyone who can commute". No rigid criteria are laid down for acceptance.

When a patient first presents himself, he is given an appointment for a week or ten days ahead. This is really a rough test of motivation, and excludes those who come to the Clinic in the hope that they will receive a free injection of Heroin without "strings".

If the individual keeps his appointment, a full history is taken, and a specimen of urine to check whether he is still taking drugs, and if so which ones.

The Clinic gets in touch with the Home Office to see if the person is registered elsewhere. The name given is not regarded as very important; identity can be more accurately checked by means of personal description, especially including tattoo marks or scars.

If the patient is accepted, the doctor and social worker make a treatment plan with him. The immediate programme deals with food and accommodation; the long-term plan involves drug needs, work, health, personal relationships, recreation, and general activities.

The Clinic has a list of places prepared to accept drug-dependent persons; an attempt is made to get the addict to identify with a particular place.

It is realised that in the early stages motivation towards cure is low; many addicts come only to register for Heroin. The aim then is to give the patient an experience of a life without drugs. Most histories show that at the point where a person became involved in drugs, further education stopped. The individual is immature, and has probably had a breakdown in family relationships. He is introduced into a community group which is " 'Christian-based' without thrusting Christian doctrines at them".

The patient must be brought to realise that drugs are facts of life; that a Utopia—where there are no drugs and no temptations to take them—does not exist. Consequently, attempts are made to treat patients in their ordinary city or suburban setting (cf. the Swedish method or removal to country families—page 8). Few addicts are living in their own homes; some are in foster families, others are married, and the Clinic gives a lot of emotional support to young wives of addicts. This work has increased over the last three years.

As far as possible, the patient must be kept working, and he must go to the Chemist every day for his drugs. This gives him less time to exchange drugs, to add to them, or to manipulate them. He also has to come to the Clinic to get his prescription weekly, and this is an exercise in punctuality and regularity. All this activity is deliberately contrived to give the patient a replacement for drugs—so that eventually drugs become *boring*.

The patient eventually becomes to believe that he is capable of working consistently, and of holding a job. The Clinic does nothing for the addict that he cannot do for himself. The Clinic will provide the main direction, but the patient must actually do the work himself.

The philosophy of this Clinic is that drug-dependency is a self-limiting condition, and that the function of treatment is to keep the patient alive and interested in reality until he matures. They have only 3 or 4 patients on maintenance Heroin who are over the age of 40, and one couple on Heroin maintenance who are stable, working members of the community, and leading reasonable lives.

The Clinic does not see many new Narcotic addicts, but there is a group of persons addicted to non-Narcotics, most of whom are poly-addicts; the group changes every 4 to 6 months in both its composition and in the type of drug used.

For maintenance treatment patients must pay 40 cents (Aust.) for each prescription, and must buy their own syringes and needles from the Chemist. (At St. Giles' Clinic they are given these; but Dr. Oppenheim says that these are saleable or exchangeable commodities and should not be provided for nothing.)

Patients should be working, but if they are not, the Department of Health and Social Security will pay £7 ($A14) per week, out of which the patient may pay up to £3 rent.

The prescription the patients get from the Clinic can only be drawn on daily from the approved chemist; the patient can only attend the Chemist where the Clinic and he have agreed that he should go. Most Clinics send the prescriptions by post to the Chemist; however, during the postal strike the Charing Cross Clinic found that they could give the patient the prescription, provided it was endorsed: "Only to be dispensed at . . . . . , no alteration valid". There have been no errors, and the right amount of Heroin goes to the right person. There were more delays and errors in sending the prescription to the Chemist by post than there were when it was given to the patient himself.

Usually patients are weaned off Heroin fairly quickly, and Methadone replaces it. (This is not the "blockade" method of treatment used in the United States, New Zealand, and Australia). The dose of Methadone is gradually reduced. When the patient reaches a minute dose, e.g. 8-10 milligrammes of oral physeptone (Methadone) daily, it becomes very difficult to withdraw the drug completely. It may be necessary to reduce dosage as slowly as by 1 milligramme every fortnight.

When the patient is free from Narcotics, the urine is clear, the patient is working, and perhaps married, he may come once every three months or so for a check, or a social worker may occasionally call on him. There is no intensive follow-up.

SPELTHORNE ST. MARY, THORPE, EGHAM, SURREY

Information from: Sister Joan Elizabeth and Others.

This is a treatment centre for alcoholics and drug addicts, administered by an Anglican Order of Nuns, the "Community of St. Mary Virgin of Wantage". The Order provides schools, homes for babies, care for the sub-normal, for geriatric patients, and others, in many places throughout the British Isles.

The Home at Egham is in an old manor-house, set in most extensive and beautiful gardens with well-trimmed lawns, flower-beds, hedges, and stately trees. To walk into this setting was like stepping back 300 years.

This particular House was opened in 1879 for "the Reformation of Women who have Fallen into the Habit of Intemperance". In 1900, the words ". . . through the Misuse of either Drugs or Alcohol" were added to the original statement of aim. Obviously the Order realised the need for action in this field some years before legislators and administrators. They have been accepting drug-dependent people as well as alcoholics, since the 1890's.

Sister Joan Elizabeth said that usually a quarter to one-third of the 50 inmates were female drug addicts of all ages. There are a few young female addicts, but there has been a great increase in alcoholism in young women over the past five years; many are spirit-drinkers.

The usual charge for a paying patient is 14 guineas (under $A30) a week; some patients may pay more. If a patient cannot pay, and has been referred by a Court, she pays what she can, or else the Home Office accepts responsibility for payment. In such cases, or where a patient has perhaps been referred by a Local Authority, the charge will be only 10 guineas a week. It seems that this might have to increase. St. Mary's does not receive a Government subsidy, but all patients are insured under the National Health, and receive medicines and treatment on National Health terms.

There are 15 Sisters when there is a full staff; usually they have about 12. Ex-patients help with domestic tasks, and there are six sub-normal girls who live around the compound and do domestic chores. They have their own living room and a Sister to "mother" them. There is no special type of treatment laid down; the tradition is purely oral, being handed down from one generation of Sisters to the next, and being changed or modified according to current knowledge.

Patients may be referred by doctors, hospitals, social workers or psychiatric social workers, clergy, or by a Court. St. Mary's will accept an application for admission from any responsible person, but in all cases require a full medical report, and any other information, such as a probation officer report or remand reports.

There are no compulsory admissions, but some who are admitted under probation have a condition of "residence at Spelthorne St. Mary's" inserted into the Order. Magistrates will refer patients on a social worker's report, or on a medical report from Holloway Prison; patients are admitted only if they freely accept the conditions that might be laid down. Very few abscond; it surprised me that any would wish to abscond at all from such surroundings.

On admission, a patient goes first to the Infirmary wing. This consists of eight private rooms and a private hospital ward; drug withdrawal is carried out here, in bed, and under close medical supervision. One of the Sisters is a doctor, and two are State Registered Nurses (they work full-time, being patient-oriented rather than dedicated to a "shift" system). A local doctor who visits fortnightly will also attend in case of emergency.

After the patient has "dried out" she enters the every-day life of the House. There are two "People's Sisters" who arrange rosters and activities, and allocate patients to various Departments of the community. When a patient is allocated to a certain Department, the actual work she does there is the responsibility of the Sister in charge of that Department. The "People's Sisters" arrange other activities for patients, such as shopping expeditions, visits to the near-by village, hair appointments, and so on. Visitors to patients are kept at a minimum during the early days, especially for drug addicts; the Sisters are quite rigid about this, and have no compunction about turning away any visitor who might appear questionable.

The Sister Superior is trained in group therapy and group counselling; she and one of the other Sisters hold group therapy sessions. There is also a great deal of individual counselling on an "ad hoc" basis.

There is "a certain amount of to-ing and fro-ing" with A.A. The local A.A. group frequently refers patients to St. Mary's, and the Home will put a discharged patient (she is

described, perhaps more happily, as a "leaving" patient) in touch with A.A. if she is thought likely to benefit.

They prefer all alcoholics to make a minimum stay of six months. For many, this is long enough; but if a patient comes via a Court, and has a bad history of recidivism, Saint Mary's will usually ask for a condition of 12 months' residence to be inserted into the Probation Order. They may not be kept 12 months, but it is better to have this condition than to have to ask the Court for an extension of a shorter period.

Although the Sisters accept drug addicts, they find that the younger patients do tend to "gang up" on the older ones. This is not regarded as of great significance. They say:— "a family doesn't consist of a single age-group"; and they insist that all inmates play their part in communal activities.

The Sisters told me that they did not think that their statistics were really valid, and I did not obtain any there. However, of all the residential facilities I have seen, this one impressed me most. It overcomes the difficulty of the dislike that drug and alcohol addicts have of being regarded as "mental"; there is no taint of "psychiatry" in the atmosphere; there are no "mental patients" in the next room or ward. There is good medical cover; there is no starry-eyed sentimentality, and certainly no harshness. This is a realistic approach to a problem of which this Group has had nearly 100 years' experience; the whole is tempered with dignity, and with a great deal of genuine kindness, warmth, and humanity.

ALL SAINTS' HOSPITAL, BIRMINGHAM

At this Hospital I had interviews with Dr. John Owens, who is credited with initiating the "British Method" of treatment of Heroin addiction by maintenance doses, with his Senior Social Worker, Mr. Nyman, and Senior Psychiatric Nurse, Mr. Hill.

Dr. Owens was treating alcoholics until 1965, but when the second Brain Report was published, in that year, he included drug addicts, "almost by accident". There are many immigrants in the Birmingham area, and it is a fertile field for drug addiction and for "pushing".

Twelve beds in an old T.B. ward were allocated for drug users; there is still the same number. Within twelve months after it became known that drug abuse was being treated at "All Saints", the Unit was swamped by Heroin abusers. The caseload of addicts reached 75, all of whom were actively engaged in "main-lining" Heroin.

Control by maintenance dosage was initiated more or less for want of any other method. Addicts were carefully assessed as to their drug needs. It is noted elsewhere, that they usually overstate the amount of drug they require; each new patient is seen by two members of the Clinic separately, with an interval of some hours between the interviews. The clinical condition is assessed at both interviews, and the patient is finally seen a third time, to work out his maintenance dosage, (a rough method is to "divide the dose first asked for by two, subtract half the remainder, and then bargain"!).

The routine is much the same as that at the Charing Cross Clinic (qv). Dr. Oppenheim, who is the Superintendent of that Clinic, worked for some time with Dr. Owens at Birmingham, and carries out his methods in London.

In Birmingham, patients are seen weekly, and receive prescriptions. Prescriptions can be filled only by two named Chemists in the town, and only at 8.0 a.m. and 10.0 a.m. on week days. Patients must attend the Chemist daily to receive their scheduled maintenance dose; special arrangements are made on holidays and at weekends. The chemists concerned report to the Clinic on the behaviour of the addict when he comes for his ration, and do a great deal of "unofficial social work".

Dr. Owens and his Social Worker lecture to Magistrates and others; drug addicts are frequently placed on probation, on the understanding that they receive treatment from the Clinic. Cases are usually discussed with the Magistrate and the Probation Officer.

We have remarked before (page 21) that there is in Birmingham a good relation between the drug squad, the city Police Authority, and the Clinic, so that there is an interchange of information.

I was told that at present there is no illicit Heroin in the West Midlands; known cases of addiction are receiving treatment, and the condition does not seem to be spreading. Despite a high immigration intake from Pakistan and India, the Heroin situation seems to be under control, and Marihuana was not even mentioned. However, they are anxious about Amphetamine and L.S.D. There is an illicit source of these drugs, and there is proof that some L.S.D. is being "laced" with strychnine, resulting in a powerful and murderous combination.

JAMAICA

Area:	4,000 square miles
Population:	2,000,000
Kingston—	
Population:	390,000
Currency:	Jamaican Dollars
	$J1 = $A1.08

In Kingston, I interviewed Dr. M. H. Beaubrun, the Professor of Psychiatry at the University of the West Indies, and his Senior Lecturer, Dr. Frank Knight.

This island is particularly interesting because of the wide-spread and endemic use of Cannabis there. It is estimated that 50% of all male Jamaicans use Cannabis in some form or other, and that 20% are regular heavy users, i.e. up to five cigarettes a day.

The lower-class Jamaicans have been smoking Cannabis for a long time; particularly the religious sect known as the Ras Tafarians, who worship Haile Selassie (the Emperor of Ethiopa) as God. This Sect preaches that Marihuana is a "holy grass" given to them by God, and they smoke it from childhood. An infusion of Marihuana leaves, known as "Ganja tea" is fed to infants from the time they are weaned. These lower economic groups of Jamaicans believe that Marihuana has magical and medicinal properties. It is supposed to protect a child from evil spirits; to give energy; to promote sexual vigour, and to be as effective against all ailments as "Tiger Balm" is said to be in South East Asia.

Despite the drug's wide-spread consumption, its use in Jamaica is illegal. The penalty for possession of Marihuana is a minimum 18 months' imprisonment. This penalty is mandatory; magistrates have no discretion. Furthermore, smoking is equated with possession.

Professor Beaubrun says there are strong moralistic tendencies in the Jamaican middle and upper-classes; politicians therefore react unfavourably to any suggestion for reduced penalties.

I was told that those who smoke "Ganja" regularly, do not take much alcohol; some are total abstainers. A local research project showed that 50% of 17-year-old Jamaicans smoke Marihuana; by the age of 19 this has dropped to 40%; but alcohol-takers have increased to 6%. Of the over-twenties, only 30% smoke "Ganja"; about 20% take alcohol. It was shown that, as the use of Marihuana declines, the consumption of alcohol increases, reaching a fifty-fifty proportion at about the age of 30. There is a suggestion that as people become more affluent, they adopt middle-class standards, and begin to take alcohol instead of Marihuana. In the figures quoted it is assumed that the same population is concerned, but this has not yet been proven.

There is little Marihuana in the High Schools; pupils who do use it are usually "experimental" smokers. There is no Heroin problem in Jamaica although it is severe in neighbouring countries, viz: Cuba and Puerto Rico. An article by Professor Beaubrun entitled "The Pros and Cons of Cannabis Use in Jamaica" was published in the Newsletter of the Caribbean Psychiatric Association in August 1971. A copy of this paper is in the Mental Health Library. It sets out both sides of the question very clearly.

Professor Beaubrun considers that the "stepping-stone" theory (that Cannabis leads young people to "harder" drugs) is a red herring. He says: ". . . there is no need for Cannabis to lead on to Heroin or other hard drugs. This phenomenon is clearly the product of social, legal, and economic factors". The phrase he uses is: "There is no **need** for Cannabis to lead on . . .", but he does not deny that it **can** do so. Contrasted with this opinion, we have those of Professor Shoham, of the University of Tel Aviv, who is convinced that Cannabis can, and does, lead to more dangerous drugs; of the Swedish Authorities, of the Inspector for Mental Health in Holland, of Inspector Jeffery of the British Home Office, and others.

Probably the truth is that some people who smoke Cannabis regularly, do (but need not inevitably) go on to use narcotic drugs. It seems that in our Society (which is very different from the Jamaican), the danger is that the use of Marihuana places a young person in a milieu where he may more easily be led on to narcotics; he tends to become part of the drug sub-culture, and he is exposed to the very real danger of taking Marihuana which may be adulterated with other far more dangerous drugs.

Professor Beaubrun's paper raises interesting and controversial questions, but anyone who wishes to use his arguments to reinforce a movement to liberalise the use of Cannabis should note that this paper discusses only one section of a society which is very different from our own; extensions of some of his arguments to our own situation could be fallacious. The Ras Tafarians who use the drug in Jamaica are "trying to cope with a dual degredation —the being black, and the being the most impoverished of the blacks". Sections of the

Professor's paper could be used to bolster arguments either for or against the liberalisation of the use of Cannabis.

In another paper, also now in the Mental Health Library ("The Diagnosis and Management of Acute Psychotic Reactions Due to Alcohol and Drugs", read in Curacao in June 1971), Professor Beaubrun describes panic reactions and a toxic psychosis due to Cannabis. He says, inter alia, that "There seems enough evidence now to support the view that persons who would not otherwise show psychotic symptoms may develop . . . short-lived reactions" (Compare Spencer, Bahamas).

It is perhaps not out of place to warn those who may wish to read the papers I have mentioned above, to do so carefully and critically. These are scientific articles, setting out many aspects of controversial questions. Quotations from these papers, taken out of context, could be misleading to un-informed or un-critical minds.

BAHAMAS ISLANDS

Area:	700 islands over 80,000 square miles of Atlantic Ocean.
Total Population:	150,000
Nassau— Population:	50,000
Currency:	Bahamian Dollars $B1 = $US1 = approx. 90 cents (Aust.)

I spent some time at Sandilands Mental Hospital near Nassau, in the Bahamas, and discussed alcoholism and drugs with the Superintendent, Dr. Podlewski, with Dr. D. J. Spencer, and with members of the staff. This Hospital takes about 250 psychotic patients, and has a turnover of about 1,000 patients a year. There is an alcoholic unit of 26 beds, with male and female patients and staff, attached to, and a physical part of, the Hospital. This is not favourably regarded by either patients or staff; they think such a Unit should be "down town".

Dr. Spencer estimates that over 40% of the hospital admissions are due to alcohol. "Of 119 patients on the medical and surgical wards of the General Hospital, 30% were ill either totally or partially as a result of chronic alcohol poisoning." From his own discussions with patients, Dr. Spencer estimates that the average patient has been drinking between 2 and 4 pints of spirits daily. Even in hospital, patients are "frequently found brewing their own liquor from tobacco, sugar, and coffee". It is also reported that "Drinking, drunkenness, and excessive use of alcoholic beverages are so common as to be a norm"; it seems that the problem is basically socio-cultural.

There are parallels between the drinking pattern of the native Bahamian, the Eskimeaux, and the American Indian in British Columbia and in California. It seems likely that alcoholism among our own Aborigines may stem from similar roots, i.e. the social pressures to which the "fringe population" of Aborigines is subjected, the difficulties of acculturation, and the struggle for identity in an essentially 20th-century European Society.

No alcohol is produced locally in the Bahamas. There is a tariff on imported liquor, and over the past 10 years there has been a great increase in the consumption of beer, cider, and whisky. Rum used to be drunk a great deal, but recently has diminished in favour of whisky.

The average Bahamian native is very dangerous when driving a car under the influence of alcohol—far more so than if he were taking Marihuana. It seems that alcoholism is the major public health problem in the Islands. It results in a shattered family group, within a matriarchal society. Most of the men are said to be incapable of forming stable sexual relationships. There seems to be no cohesive cultural pattern, but only a vague sort of tradition.

Symptomatically, patients often present violent and uncontrollable psychotic episodes, with visual and auditory hallucinations. I was also told of four cases of "alcoholic foot", in which peripheral neuropathy is severe enough to warrant amputation. This condition has also been described in France; there is a suggestion that it may be due to a fault in pyruvate metabolism.

Treatment of alcoholism is mainly symptomatic. There is some occupational therapy, and some group aversion therapy with Emetine and Mist. Ipecacuanha. Apparently 6 to 8 patients sit around a table, undergoing this treatment together. This sounds most unpleasant, but the rationale is that "With an emotional people, you have to give emotional treatment".

A.A. does play some part in rehabilitation, but there is only one trained psychiatric social worker, who has some assistance from some untrained female staff; follow-up is, therefore, considered inadequate.

Marihuana in the Bahamas comes from the outlying islands, from Mexico, and from Jamaica; at Easter, college students come to Nassau from nearby Florida, and push a good deal of Marihuana on to the local population.

The penalty for the possession of Marihuana is from $B300 to $B1,000 ($A270 to $A900); the usual sentence is a fine, with one month's imprisonment. A chronic offender might receive 3 months' imprisonment together with a fine of $B300.

Dr. Spencer described a psychotic reaction associated with Marihuana. The signs are clear, visual hallucinations, with bizarre delusions, and a great deal of violence and agression. There is amnesia for the onset, and for events leading up to the illness. The episode lasts only about a week, and there is not the relapse that might be expected if

the condition was one of schizophrenia. There have been 30 such cases over a two-year period. Similar cases have also been reported from France.

Recently two cases of Amphetamine addiction and one of Heroin, were seen in the Bahamas, but the patients came from the United States and there is no other drug problem in the Bahamas than that of alcohol.

SAN FRANCISCO

Population: 2½ million (San Francisco-Oakland urban area)
San Francisco City: 750,000
Currency: United States Dollars
$US1 = approximately 90 cents (Aust.)

Information from:

Dr. Barry Ramer, in charge of Drug Dependency Treatment Programme, City and County of San Francisco.
Dr. R. S. Shore, Director, Bureau of Alcoholism, Community Mental Health Services, San Francisco.

The main reason for visiting San Francisco was to see the Mental Health Services there, which are generally considered to be the most comprehensive in the United States. I discussed drugs and alcohol with Dr. Ramer and with Dr. Shore, who are in charge respectively of these programmes.

In San Francisco there are five Mental Health "catchment areas", each with its own Mental Health Centre, Director, staff, and treatment programme. Dr. Ramer, who administers the drug treatment programme for the City as a whole, has facilities in each catchment area. (Other specialty services which are "city-oriented" in this way are geriatrics, youth guidance, child psychiatry, and alcohol.)

There are about 130 people on the staff of the Drug Dependency Service—26 or more are physicians, and 40 are State registered nurses. Dr. Ramer supervises 6 clinics in various parts of the City, each of which is headed by a full-time physician, a psychiatrist, and a part-time physician who is responsible for the medical care of patients. There are from 3-6 registered nurses, about 6 "rehabilitation workers", a secretary, and a porter, to each clinic. Such a staff can handle up to 200 addicts a day.

Dr. Ramer estimates that there are about 5,000 Narcotic addicts in San Francisco. This figure is based on a formula worked out by Dr. Michael Barden in New York City, where each Quarter has a narcotics registry. In New York they recorded every known death from narcotic overdose, and found that only half the people who died from this cause in a particular period of time were on the Narcotics Registry. It was therefore assumed that the Registry represented only half the addicts. The Registry in New York totalled 50,000; this is how the figure of 100,000 addicts in New York was arrived at. For 8,000,000 (the population of Greater New York), this is equivalent to about 1 per cent. Hence the statement that "One per cent of the population in an urban community has serious narcotic addiction problems" has become entrenched in the literature (or what one might call "folk-lore"), of drug dependency. For Dr. Ramer's San Francisco community of 700,000, this would mean 7,000 hard-core narcotic addicts; this is considered "a bit high—we are not in New York City, and we don't have these huge ghetto populations"—the estimate has been scaled down to 5,000. For Perth, the figure based on the Barden formula should be 5,600; this number would be **seriously addicted** to narcotics—seriously enough to cause death from overdosage. A problem of such magnitude could hardly be overlooked in a city of this size. I do not know the figures from narcotics deaths in Perth, but if they were one-hundredth of those estimated by this formula, they could not have escaped being brought to the active notice of the Public Health or the Mental Health Departments. Transposition of a figure alone can be dangerously misleading.

I was told that Americans see drug addiction (here we are speaking mainly of Heroin) as an epidemic disease. Certain predispositions are required. These are poverty, crowded living conditions, and "oppression", either political or socio-economic. Narcotics diminish pain, hunger, sexual drive, and aggression; slum and ghetto populations use narcotics for these reasons—as an escape from an otherwise dreary existence. In the middle or upper-class white society, the people who use these are thrill-seekers, and "The thrill-seeker is often someone who has substantial social problems, and so for a programme that is for the wealthier area of town you require a different kind of staff, and a different kind of set-up than is required for a ghetto. In other words, with the ghetto we shrug our shoulders and say 'Really there isn't much we can do except to raise them from the Ghetto', whereas in the wealthier areas, it's more traditional psychotherapy. The kids that come for help have usually got their heads screwed on backwards, so what we do is help screw it on properly. That's the psychiatry you feel more comfortable with".

It is thought that the problem in the middle-class areas has grown during the last five years, and that this will possibly happen in most other Western-oriented communities.

There is in the Mental Health Service Library a Report on the Community Mental Health Services of San Francisco for the year 1969/1970, and this gives a very good overall view

of the facilities and services available. The figures show that of 6,500 odd patients treated in "publicly operated facilities", nearly 4,500 were treated at the Centre for Special Problems (Private facilities in the area accounted only for 1,850 patients). The Methadone maintenance programme was initiated at the Centre for Special Problems, and the alcoholism programme was also commenced during 1969/70, but in a separate clinic. Those interested in details are referred to this Report.

One of the big problems with Marihuana is that of the Courts. The Courts are said to be "choked with thousands of cases all in the dock for Marihuana consumption. It is literally ruining the legal system. You can't get a criminal to trial, because there are 19 Marihuana cases in front, and those cases take time. They require jury selection, and jury trial in each case". Possibly there is a lesson for Western Australia here. The Magistrates have discretion; for a first offence the sentence may be anything from probation to a year in gaol. The second offence may attract from 6 to 12 months' imprisonment; for the third offence there is no probation; the offender goes to gaol for 12 months.

The general opinion is that children who take Marihuana do it either for thrill-seeking or because it is an exciting, illegal, peer-group activity:—("There is a taboo attached to it. They all go down to their basements and say 'Let's organise a party'—pull down the shades, and lock the doors, and form a little huddle—it brings about a good deal of closeness if they are doing something bad together . . . We're driving our children to be criminals, and giving them a marvellous education in criminology. The moment you put them in gaol and expose them to those people who are already there, you educate them in criminology and in criminal behaviour, so that if they weren't criminals when they went in they're sure to be well educated when they come out. Our whole system is just falling apart"). Statistics on the San Francisco Methadone Programme for Narcotic Addiction show that with Methadone and some psychotherapy, 85% can be rehabilitated. It is said that, of those who have been two years in the Methadone Programme, 95% are gainfully employed. Of those who have been only six months in the Programme, 40% are in employment; of those who have been on the Programme for a year, 75% are working.

There are in-patient programmes run by the Mental Hospitals, but the trend in California is away from these institutions, which are being closed down at the rate of one every three or four months. Patients are being transferred back to the community. Recent legislation makes it mandatory for communities to provide comprehensive, total Mental Health Services on a local basis.

Dr. Ramer thinks that there has been a recent increase in the use of Marihuana, with a corresponding decrease in Amphetamines and Barbiturates; L.S.D. and Mescaline have "just about disappeared from the scene". He thinks that "Most of the kids in America who are in urban communities are giving up drugs, and going in a new direction. The big thing now is ecology, and so all the youth who were before doing things like L.S.D. and other drugs, are now in the High Sierras picking up trash on the camping trails. They are just redirecting their energies into something else".

He predicts that in four or five years there will be a fixed number of the population taking narcotics and alcohol. Marihuana will be legalised, taxed, controlled, not advertised, and available probably at drug-stores, but it will be necessary to educate people thoroughly to recognise the dangers of abuse of the drug. "We hope that eventually we will have a more legitimate and more reasonable approach to the whole scene."

BUREAU OF ALCOHOLISM, SAN FRANCISCO

Dr. R. S. Shore is the Director of the Bureau of Alcoholism in San Francisco. Their treatment facilities for alcoholism had only really just got going during 1970. The Bureau had formed a broad-based Community Advisory Group, which helped to prepare a staffing grant application. (This is a form of community-government co-operation which could well be adopted here.) Details of the work of the Bureau in combating alcoholism can be found in the Summary of the San Francisco Community Mental Health Services already referred to (page 54 et seq. of that Summary).

There is a 20-bed, medical detoxification ward at the San Francisco General Hospital, staffed by a clinical psychologist, a neurologist, and two psychiatric social workers. There are two "Interns" (R.M.O.'s), one Registrar, and several medical students; Dr. Shore himself, and one other psychiatrist teach there. The average length of stay is from 3 to 5 days. Patients are admitted through all sorts of agencies; the Police take some there instead of to the Courts, and all admissions are voluntary.

Next, there is a 45-bed Convalescent Care Unit at Laguna Honda Hospital, which had had vacant beds following a drop in the numbers of geriatric and chronically-ill patients: some of these beds were made available for alcoholics. The average length of stay here is 2 weeks; under the same roof there is an out-patient clinic. Treatment includes family therapy, group therapy for spouses, groups for recidivists, lectures, behaviour therapy,

etc., as well as A.A. and its offsprings "Alanon" and "Alateen". Dr. Shore has mixed feelings about A.A. This is discussed later in this section. The staff at "Laguna" includes a psychologist, a psychiatrist, and a general medical physician.

A "Recovery House" or "Half-way House" is now functioning in Mission district. This takes about 15 people, and is staffed by a psychologist and two recovered alcoholics.

The Bureau also sponsors a case-finding programme for employees of City Departments. This is modelled on similar industrial schemes elsewhere. Signs which may point to alcoholism (actual or latent) in employees may be, for example, undue absenteeism, accidents, over-long periods spent in toilets, coming late on Monday mornings, and so on. Cases can be detected early, prevented, evaluated, and referred. This Service is run by three full-time non-medical employees, with one secretary.

A great deal of attention is also being devoted to community organisation, community liaison, and inter-agency collaboration; one doctor, a physician, has a part-time job working with the Courts, police, and various agencies, trying to create a unified comprehensive programme throughout the entire community, and to encourage other people to take on responsibility for treating some alcoholics, where previously they had refused to care for them.

Dr. Shore's opinion of in-patient treatment of alcoholics agrees with that of Dr. Tottie, in Sweden, viz: that it is a "carry over" from the old days, making little sense. All agree that the results are unimpressive; nevertheless, there is a great pressure in the community **not** to deal with alcoholics; to take them out of the community, and to "ship them out of town". This tendency should be counteracted; people should be treated where they live, and their families should be involved as much as possible. It might perhaps be necessary to take the alcoholic out of the family group for a very brief "cooling-off" period, but unless there are very good reasons against it, treatment should take place within the community itself.

Dr. Shore is a strong supporter of the theory that alcoholism is fundamentally a psychological problem, not a physiological one. This is why he has some reservations about A.A. There are other forms of treatment that are equally effective, and he says: "It seems to be helpful to many, but it only reaches 5% or 10% of the alcoholics in the country. There is a revolutionary fervour about it all which I think one should be careful about. Everybody who is a recovered alcoholic is, so far as I am concerned, **not** a therapist. There is a sort of movement to support the theory that if you are going to treat Chinese, you should have a Chinese to do it; if you are going to treat alcoholics, then it should be an alcoholic; if you are going to treat blacks, then it should be a black. I think there is some sense to that, but it's overdone. In alcohol, one of the dangers is that recovered alcoholics are given a great deal of sanction to treat." He went on to say that there is some suggestion in the research today that A.A. is being more helpful to middle-class working people than to some lower-class people, but not to many of the upper-class. This is interesting in view of the Swedish theory that the adherents of A.A. there are less "intellectual", and of a lower socio-economic group, than the ones in the United States.

In San Francisco they do not use much aversion therapy with alcoholics. It is thought preferable to supply positive reinforcement (i.e. "stars" for good things) instead of negative ("shocking them with electicity for bad things").

"One of the most unfortunate things in the whole state of our psychiatry", says Dr. Shore, "is that we just don't know how to pick the patients to send them to the right therapist. We try to have a lot of different things going because we believe that this is probably where the answer is".

SYDNEY

WISTARIA HOUSE

Director—Dr. Stella Dalton.

One of our senior Officers (Dr. D. H. Prentice) visited Wistaria House in Sydney during 1971, and his report is available in the Mental Health Library. I had discussions with Dr. Dalton in Auckland, and also in Sydney.

Dr. Dalton uses the "blockade" method of Methadone treatment. This is different from substituting Methadone for Heroin, and from using Methadone to keep addicts on addictive doses so as to maintain a psychotherapeutic relationship.

The blockade method depends on the fact that if you give an addict more than about 80 mgms of Methadone daily, he no longer suffers from a hunger for narcotics. On such doses, addicts can live normally except for their daily dose of Methadone.

Dr. Dalton has been using this method since 1969; after two years, 75% of those treated are said to be taking no drugs, and to be leading normal lives. Figures were produced which showed, that of a properly-matched and statistically valid series of patients, 25% of those treated by other methods than blockade, died. These figures and their background will be published shortly in the Proceedings of the Eighth Annual Congress of the Australian and New Zealand College of Psychiatrists. Of the blockade group, 86% improved; of the control group only 24.5% improved. Dr. Dalton currently has 35 patients being treated by this method.

Briefly, the method is to increase the daily dose of Methadone from 15 to 120 mgms. over a period of 67 days. By the 27th day patients are up to 80 mgms., and are out of the "addictive zone". By the 35th day, they are receiving three daily doses of 35, 30, and 35 mgms. respectively; by the 43rd day they are on three doses of 40 mgms. daily; the rest of the time, to the 67th day, is spent gradually reducing to one dose a day.

Along with this physical treatment, there is group psycho-therapy. Much of this work is actually done by the group itself; it is carried out on "confrontation group" lines, but is professionally supervised. After the patients have left hospital, they are followed up by social workers or other officers from Wistaria House.

It is preferable for patients to come voluntarily, but Courts refer patients on probation, with the proviso that the patient "shall accept the conditions and obey the orders of the Director". This obviously allows a great deal of flexibility in treatment, with the sanction of a prison sentence if the patient does not cooperate.

The voluntary admissions are "vetted" by the resident Group, who claim to be able to assess motivation, and to detect when a patient relapses or is not cooperating in treatment. The Group is also responsible for general discipline in the Unit. The doctor in charge has the right to veto a Group decision, but seldom does so.

This method is perhaps of limited application, but is a useful addition to the armamentarium.

CONCLUSIONS AND RECOMMENDATIONS

1. MARIHUANA

This is used in all countries, but no Government yet feels that it is in a position to "legalise" it, that is, to place the drug under government control regarding conditions of manufacture, strength, purity, distribution, and use.

Many authorities believe that the use of Marihuana predisposes to the use of narcotics. Certainly a great number of narcotics abusers started their career with Marihuana. Whether they would have used narcotics anyway, without first resorting to Marihuana, is an open question.

Most Marihuana-smoking among High School and University students is experimental and short-term, but psychological dependence can occur, introducing the user to the drug-sub-culture, and placing him at risk concerning narcotics.

There is no specific treatment for Marihuana users. Persistent use of Marihuana is usually the symptom of a personal problem of adjustment to society.

Penalties for possession vary greatly, from a nominal fine in Holland, to 18 months' imprisonment without the option, in Jamaica. Generally, magistrates have discretion. Some United States psychiatrists suggest that the drug will eventually be placed under government control, and taxed. It would not be advertised, and dealers and purchasers might be licensed. Similar controls (except for advertising) have not prevented alcohol becoming a major problem. There is some merit in the argument that we do not need a second drug which can produce comparable demoralising effects. A brief discussion on the question of the "legalisation" of Marihuana can be found in "Drug Misuse: A Psychiatric View of a Modern Dilemma", published in June 1971 by the Group for the Advancement of Psychiatry.

The Australian penalty of $4,000 fine, with or without a lengthy prison sentence is in line with world trends for those convicted of "pushing" this drug. Magistrates here should continue to exercise their discretion, with a general tendency to lower the financial penalties for smoking in private. Prison sentences for Marihuana smokers are useless as a deterrent or as a removal from drug sources. It is far more "criminal" to place a first-or second-time Marihuana smoker in prison (where he will obtain an excellent grounding in practical criminology) than it is to smoke the drug itself. Furthermore, such wholesale incarceration chokes the prisons, and tends to bring the Penal System to a shuddering halt.

Authorities in Sydney, San Francisco, and London, say that Marihuana is now being adulterated with Heroin, Strychnine, or L.S.D.; and a cigar-manufacturing company in Holland is said to have stocks of Marihuana cigars in store, waiting for the drug to be "legalised".

2. AMPHETAMINES

The use of intravenous Amphetamine seems to be the major drug problem in most Western countries at present. Although most chemical firms have ceased to produce Amphetamine, the drug can be manufactured illegally. Treatment (which consists mainly of withdrawal and an attempt at reorientation) can be given in ordinary medical or psychiatric facilities. Removal from drug sources is important after medical treatment, and requires follow-up supervision. This condition does not yet pose a problem in Western Australia, and the few cases met with can be dealt with in our hospitals.

3. L.S.D.

This is reappearing in some areas and can easily be manufactured privately. The position here should be closely watched.

4. HEROIN AND OTHER MORPHINE DERIVATIVES

The "British approach"—namely, the restricted prescribing of Heroin to known addicts—seems to be paying off. There has been a marked down-turn in the use of intravenous Heroin in the U.K. over the past two years. There are few new users, and lately there have been no deaths from overdosage, sepsis, or liver failure. There is no evidence of illicit supply, and authorities are hopeful that the epidemic has passed its peak.

Methadone systems of treatment as used in the U.K., United States, and in Australia at Wistaria House in Sydney, are also of considerable value. It is claimed by the Department of Health and Social Security in London that 40% of Heroin addicts are now in some form of work, and that another 40% are stable members of the community, being supported by gradually decreasing doses of Heroin, or by Methadone. Those under treatment are taught how to inject themselves so that no sepsis or extravasation results.

Local drug dependence liaison committees have grown up in the United Kingdom. These are composed of local doctors, probation officers, pharmacists, local directors of education, social workers, voluntary agencies, church groups, etc. These Committees meet frequently, exchanging information and formulating action on the local scene. Something similar could well be adopted here with value.

Heroin abusers can obtain treatment at one of the drug dependency clinics in London or in other big cities. In-patient treatment in mental hospitals is not regarded with any favour, but is sometimes administratively necessary. Compulsory treatment is of little value, but there is not much difficulty in getting users to go voluntarily to the Clinics.

The addict is encouraged to seek his own job, and to look for accommodation away from the area of Heroin supply. The Clinics prefer to do nothing for the addict that he is able to do for himself.

The Scandinavian method of placing young addicts on farms in the country might have some application here, if there were enough addicts.

In Europe, the U.K., and the United States, "Phoenix" type institutions using "Confrontation" therapy were discussed. Most authorities in the United Kingdom have considerable reservations about their value. It is estimated that these Institutions cost the equivalent of $US10,000 per inmate per annum to administer. There is an estimated "drop-out" rate of 80%, and they claim 18 "cures" in 18 months. They are anti-research, and do not usually admit independent investigators. However, a unit has recently commenced at Portsmouth, U.K., which is supervised by a psychiatrist, and has an inbuilt research programme conducted by a psychologist. The Regional Hospital Board is sponsoring this experiment for a three-year period. It will be watched with interest. At present there are no reasons for believing that this approach is of greater value than any other, and if it is of any worth at all, it applies only to a minority. To outlay limited Government funds in subsidies for this form of therapy, is not warranted at this time.

5. BARBITURATES AND TRANQUILLISERS

This problem is increasing, and is primarily one of over-prescribing; the solution rests mainly with the medical profession itself. Suicide with Barbiturates is not uncommon; all those who attempt suicide in this way—or in any other way—should at least be seen by a psychiatrist before discharge from the Casualty Unit, if not actually referred for treatment. I think this is a routine in most large general hospitals today, but a Report of this nature would be incomplete without mention of the practice.

6. REFERRALS FOR TREATMENT

Congestion in prisons and hospitals could be eased if magistrates referred cases on probation to out-patient departments or to hospitals (general or psychiatric), not with an order for admission or assessment, but, as is done in New South Wales, with a condition that the Parolee "... shall accept the conditions and obey the orders of the Superintendent". This allows flexibility of approach by doctors, while retaining the sanction of fine or imprisonment if the conditions are not observed.

7. EDUCATION

Our present Health Education Council is undoubtedly using the correct approach in treating drug and alcohol dependence in the wider context of modern social issues. Overseas opinion agrees emphatically that we are right to ensure that only properly accredited representatives should give information on these matters to the young. Support of the Health Education Council will pay dividends in minimising or preventing the spread of drug and alcohol dependency among young people in Western Australia.

In almost every country—with the exception perhaps of Czechoslovakia—the Press was regarded as a potent agent of morbid interest in drugs, sensationalism in reporting leading to increased interest and consumption. If the reporting of drug offences could be curtailed in the same way as has been done with divorce and matrimonial causes reporting, the Press would be performing a major public service. In a small community such as ours, private approaches to local newspaper proprietors should not be impossible. Generally, better information and a less hysterical approach to drugs, was believed to be the best way of combating the growth of this menace.

8. UNIFIED APPROACH

Drug-dependence and alcoholism are social problems, and concern not only the medical disciplines, but social, legal, and educational ones as well.

An inter-disciplinary committee should be set up to integrate the present activities in these fields, and should include representatives from the appropriate government depart-

ments, from churches, and from voluntary bodies. Sub-committees dealing with legal, therapeutic, preventive, social, research, and educational aspects, should report regularly on the progress of joint action.

9. GENERAL

Figures for drug-dependency from other countries should be looked at very critically before translating them into Western Australian conditions. The fact that narcotic drug addiction is not a problem in Western Australia at present, should not lead to complacency. Facilities for the treatment of such few cases as we have, exist already in general and psychiatric hospitals and clinics, but should it be necessary to set up special facilities at some future date, we will not be completely unprepared.

Compulsory treatment of drug-dependency or of alcoholism is of little benefit to anyone except the immediate contacts of the affected person. Such compulsory provisions as we possess in the Mental Health Act should, however, be retained, because in a minority of cases early compulsion can lead to later acceptance of voluntary treatment, e.g. where detoxification takes place in a setting of compulsion, the person may, in his "right mind" be brought to accept that he has a problem needing help. I am still of the opinion that a separate Act to cover these matters is unnecessary. It may perhaps be advisable politically, but I would welcome informed discussion.

10. ALCOHOLISM

Compulsory treatment has been discussed above. It has its place, but it is generally agreed that it is of limited value.

The setting up of a treatment unit for the long-term treatment of alcoholism in Western Australia is long overdue, and has been deferred only because of other priorities. However, the success of such a unit depends on the personality of the individual who runs it, and I would be reluctant to advise spending a considerable amount of public money on a building which might stand for years unused for its original purpose. It must be accepted that psychiatrists and their ancillaries dislike treating alcoholics as much as alcoholics resent being included with the mentally ill. However, abuse of alcohol is regarded by World Health and other authorities as an illness which "substantially impairs mental health", but its ramifications are so wide that the mental components are often overshadowed by social and economic ones. A detoxification unit of 20 to 30 beds is urgently required in the metropilitan area. This should be set up in close association with a general hospital, preferably one which has teaching affiliations. Provision for smaller detoxification units should also be made at Geraldton and Kalgoorlie. The Units should operate as part of the General Hospital, and should be in charge of general physicians.

In Perth, psychiatric consultation could be provided by staff psychiatrists; in the country towns, by the visiting Mental Health Psychiatrist, and motivation towards recovery would be assessed at this stage. Separate buildings would not be required; such a unit could function adequately in a ward of the hospital, as occurs in San Francisco, Melbourne, and many other cities.

Facilities for follow-up from the Detoxification Centre should be provided elsewhere for up to 40 alcoholics. We are inclining to the belief that alcoholics may be better treated on an out-patient basis; but an in-patient stay of up to 6 weeks, with an intensive programme of activity, and of group and family therapy, supported by visiting community workers, would be of benefit to adequately-motivated patients.

What is most urgently needed in this State, however, is an assessment of the present facilities available, governmental and other. Inter-professional and inter-departmental rivalries cannot be allowed to inhibit action on this problem. Like drug-dependency, alcoholism is a community social problem, and cannot be considered solely on a medical basis. The co-operation between medical, social, legal, correction, voluntary, and research agencies, which is so important, could be implemented by the setting up of the Committee suggested above. Such co-operation, is well advanced in Scandinavia, Holland, England, and the United States, and with a little goodwill and energy could easily be undertaken here.

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