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INVESTIGATING DRUG ABUSE

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INVESTIGATING DRUG ABUSE

A Multi-national programme of pilot studies into the
non-medical use of drugs

by James J. Moore

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PREFACE

Among the United Nations agencies and secretariat bodies concerned with the drug problem UNSDRI has played the rôle of a somewhat iconoclastic outsider. This posture was not intended to detract from the efforts of those who bear specific responsibilities for planning and for action with regard to illicit drug production, traffic and consumption. It does, however, reflect a series of perplexities relating to UNSDRI's own limited institutional perspective.

UNSDRI is in fact concerned primarily with the study of crime and the operation of criminal justice systems. There exist obvious correlations between drug traffic, drug abuse and other forms of criminality. However, we do not believe that the drug problem should be considered essentially as a crime problem, to be solved by criminal justice measures, or by criminal justice alone — just as a purely medical/epidemiological, mental-health or cultural/anthropological perspective would be insufficient to explain and cope with the phenomena involved.

Starting from that premise, the pilot studies initiated by UNSDRI with assistance from the Ford Foundation and the International Research Group on Drug Legislation and Programmes, and continued with the support of UNFDAC and various national authorities, deliberately suggested an integrated approach to research, planning and action. Specifically, the proposed country studies would encompass and correlate phenomenological data, attitudinal data and

data on educational, law enforcement and treatment programmes.

While such an integrated model did in fact serve as a conceptual framework for all the research described in this publication, initial emphasis was placed on the problem of consumption — either by so-called epidemiological studies or, more often, by simpler magnitude and trend assessments of the demand for illicitly procured drugs. There were in fact clear indications that as long as there existed a strong illicit demand, production and traffic control would remain problematic — especially as illicit production could demonstrably be shifted from one area to another, and consumption turn from one drug to another drug, alone or in combination.

It is of course evident that this emphasis on the demand side should not be exclusive, or deflect from efforts to curb traffic and illicit production. Especially at action level, the latter may be more feasible and as urgently needed as long-term measures to cope with demand for illicitly produced drugs. We are referring specifically to crop substitution programmes that offer real and lasting economic alternatives to the communities concerned (as currently demonstrated under UN auspices in several countries), and to a variety of efforts by UN and affiliated bodies to strengthen the law enforcement potential, nationally and internationally. Studies such as those described in this publication are intended to reinforce and orient contextually, and not to inhibit action. This naturally means that research must often be quite simple, that it must be realistically timed, and that it should be related to issues which the policy-maker can understand and address.

This also explains why UNSDRI's efforts focussed at least initially on a national rather than international context ("country"-studies). It is in fact primarily at national level that policy action is taken, and support for international programmes generated. Also, since the quality and quantity

of available data vary greatly from country to country, research models may have to be hand-tailored to fit local conditions. Cross-cultural studies, comparisons and conclusions are generally possible only in a second phase. Of course global surveys and universal research models may also have a certain value, but the picture they convey is often shallow and at times a distorted one.

The present volume contains the first results of a few of the country studies stimulated by UNSDRI. A second volume will consider the nature and policy impact of drug abuse research in some countries that have experienced serious drug abuse problems in the past. Our thanks go not only to James Moore, who has been responsible for this publication and for the underlying research, but also to all those within and outside the United Nations family who have collaborated in our efforts. We would like to express our particular gratitude to the United Nations Fund for Drug Abuse Control: its action may be expected to add co-ordination, a sense of priorities and concrete operational impact to the efforts of the international community in coping with a problem far too complex and serious to be solved by bits of knowledge and fragmented programmes — however well-meant — reflecting limited professional perspectives and institutional biases.

Peider Kőnz
Director

CHAPTER ONE

BACKGROUND

It is now more than 60 years since the signing of the first treaty intended to control the distribution of drugs through concerted international action. In the intervening period, a number of new accords have been developed and implemented, each one a step towards recognition that the supply of illicit drugs cannot be contained solely by unilateral action, since profitable criminal activity seldom respects national boundaries.

At this point in time one cannot reliably quantify the impact of these international efforts on the supply of illicit drugs, although it is generally assumed that a vacuum in international action would inevitably have spawned a more dangerous and unacceptable availability of harmful substances in many parts of the world than exists even at present. There is also general agreement that the effectiveness of international drug control treaties derives from the persistent efforts of individual states to implement the control measures specified in the treaties. Without this commitment on the part of individual countries, controls would be fragmentary and inefficient at best, or non-existent at worst.

As the activities of states to cope with the social and medical problems arising from drug abuse are intensified, there has been concurrent recognition of the need to better understand the nature and dynamics of the phenomenon,

not only for the purpose of controlling supply, but also to initiate programmes of prevention and treatment. And as the investigation of drug abuse has advanced in varying degrees in many parts of the world, so too has the identification of certain characteristics of the phenomenon. One of these characteristics is the apparent cultural specificity both of the phenomenon itself and of the variety of social responses which can be brought to bear on it in attempting to achieve effective controls.

By cultural specificity we refer to those characteristics of a behavioural phenomenon which derive from such specific factors as commonly held values, traditions, political structures, and the range of social responses evoked by particular behaviours. In the case of non-medical drug use these cultural specificities will determine, among other things: the types of drugs used; the ways in which drugs are used; the levels of acceptance or non-acceptance of particular forms of drug use; and the form the response of the larger society takes to an individual's use of drugs.

Against this background it becomes apparent that any investigation of drug abuse cannot be conducted on the basis of general assumptions. Characteristics of the phenomenon which prevail in one country need not necessarily characterize the phenomenon in another jurisdiction. Acceptance of this principle underlies the approach taken in the programme of country studies which forms the substance of this report.

The UNSDRI Approach

The rôle of the United Nations Social Defence Research Institute (UNSDRI) in fostering this series of studies on the characteristics of drug abuse in a number of individual countries began in 1972. Essentially, the programme was based on two assumptions: first, that if this phenomenon

were to be successfully contained or checked through international efforts it would be necessary not only to attack production and supply sources, but also to become familiar with the characteristics and dynamics of drug abuse in individual countries; and secondly, that these characteristics could only be investigated, identified and validly interpreted by research teams indigenous to the individual countries affected by the phenomenon.

The first purpose of the UNSDRI programme has been to initiate and facilitate studies of drug abuse in a number of individual countries which would yield information for the guidance of policy planners and operators of social control systems. In line with this objective, three areas of investigation were advanced. They were:

- 1) Studies of the incidence, prevalence and characteristics of drug use and drug using populations in individual countries;
- 2) Studies of public and official attitudes as these affect the nature of individual and social responses to drug abuse;
- 3) Preparation of an inventory of the various social mechanisms for intervening in drug-related problems.

A secondary goal was to ascertain whether there are characteristics of drug use which transcend its cultural nature. It was felt useful to investigate this possibility, even though, as noted above, the general nature of the phenomenon is specific to individual cultures.

As a preliminary step during 1972, the research staff of UNSDRI prepared a " Programme Outline and Guide " * which was distributed to selected social scientists and government experts in a number of countries for their

* Cf. Appendix A. to this volume.

information and comment. This document was not intended as a definitive research programme, but rather as a kind of "shopping list" of subject areas which might be investigated, depending on local conditions, either in entirety or selectively. The three parts of the programme guide corresponded to the three study areas listed above.

More intensive analysis of the programme outline was made at a workshop held in Frascati, Italy, in December, 1972. Experts and officials from 14 countries* attended the five-day workshop, focussing on ways in which dual goals might be achieved: namely, the refinement of the programme guide and, at the same time, agreement on a degree of flexibility that would permit individual country teams to develop a research programme and instruments adequate for their own needs and circumstances. In this task, the participants were aided at the workshop by the presence of representatives of all of the major international organizations — both United Nations and non-governmental — active in the field of drug control.

At the conclusion of the Frascati workshop it became evident that for a variety of reasons not all countries which expressed interest in the programme were in a position to participate in it. In some cases, adequate funds were not available; in others, government priorities did not permit a commitment at that time. In sum, however, four agreed to proceed with the full programme: Indonesia, Italy, Mexico and the Commonwealth of Puerto Rico.

During 1973 a Report of the Frascati Workshop and Programme of Country Studies was published and distributed widely¹. Essentially, this publication remains the main instrument for the overall programme of country drug studies.

* Afghanistan, Brazil, Egypt, Hong Kong, Indonesia, Iran, Italy, Lebanon, Mexico, Norway, Panama, Puerto Rico, Singapore, Yugoslavia.

¹ U.N. Social Defence Research Institute. *A Programme of Drug Use Research*, Rome, 1973.

Underlying Philosophy

Some reflection on the philosophy underlying the programme can be useful to those planning programmes of a similar nature. The first publication adequately touched on the core problem:

"Experience with social science research programmes carried out simultaneously in a number of countries has amply demonstrated the difficulties and, often, dangers that arise from the use of a single research instrument. Cultural and linguistic differences make such an approach precarious at best. In an investigation of drug use, such an approach might well reduce the reliability of the findings to a level that would jeopardize their utility and their credibility. This is not to say that compatibility of approach is not essential. Obviously, unless the participating countries can agree on a number of common areas of investigation and common information goals, then no comparisons are possible. But the manner in which information can be collected and measured may well vary from country to country and region to region for a variety of reasons. In summary, it was the intent of the proposed research programme to gather information in several countries to at least a commonly agreed level; the manner in which it was to be gathered would necessitate individual judgements in individual countries. The workshop, hopefully, provided the forum for discussion of possible research approaches and a setting for achieving some agreement about common goals".¹

Several weeks prior to the workshop, UNSDRI provided to prospective participants a list of items about which information was requested prior to the discussions at Frascati. These items were devised to yield information regard-

¹ U.N. Social Defence Research Institute. *A Programme of Drug Use Research*. Rome, 1973, p. 2.

ing the current state and availability of data and resources. The advantages of this process were considerable since it provided a base on which judgements could be made about the feasibility and scale of individual projects.

Equally important was the selection of the individual experts and officials who attended the workshop. Of necessity, any investigation of the many factors related to drug abuse requires the application of the techniques and skills drawn from many of the social and behavioural sciences and the bio-medical field. At another level, however, the utility of the research findings in the drug abuse field involves matters of social policy, such as the legal status of drug-related behaviour, the use of social programmes for intervention, treatment and social reintegration of the drug user. From the perspective of the UNSDRI programme, the nexus of these factors — scientific and political — was of paramount importance. Against this backdrop, the participants in the workshop were invited with the objective of melding sound, reliable investigative research techniques with the needs of the officials and administrators who are confronted with the implementation of programmes of public policy.

It might be asked why UNSDRI, a small institute in Rome, concerned with research into the causes and prevention of crime and delinquency, should involve itself in the development of a pluri-disciplinary programme of investigation into a phenomenon as multi-faceted as drug use. The motivation for the country studies programme arose, essentially, from a recognition of drug abuse as one other form of behaviour that correlates with social and psychological factors which may or may not be related to either delinquency or crime. In many countries, however, drug abuse is regarded as deviant behaviour although this view will often be conditioned by either the drug abused or the form of drug use. Whatever the situation, the UNSDRI

programme typifies one approach to studying the phenomenon. Many other approaches to investigating it are being taken by other national and international organizations. Throughout the period since the research programme commenced, UNSDRI has appreciated the counsel, co-operation and encouragement of these organizations and has endeavoured to keep them apprised of the progress of the studies.

Expectations

One hoped-for by-product of the studies is, of course, the improvement of national systems of reporting on drug abuse to the United Nations. This is a specific requirement addressed to parties to the Single Convention on Narcotic Drugs; in recent years various bodies of the United Nations have been attempting to find ways of improving both the form of reporting as well as the representativeness and reliability of the data reported to the UN each year. It is hoped that through the impetus of the country-studies programmes individual governments and the UN can be assisted in efforts to improve reporting, and, consequently, to deepen their understanding of drug abuse and its associated problems.

An important limitation of investigation into any social phenomenon is that the information yielded relates solely to the status of the phenomenon at a single point in time. The studies reported and analysed in this publication have that limitation, but it need not diminish their value. Their findings, on analysis, make important statements about the characteristics of drug abuse among the populations studied. They can provide important insights to those practitioners and administrators responsible for planning and implementing programmes to combat the undesirable social and personal effects of drug abuse, particularly by identifying problem areas for which solutions have not

yet been found. At the same time, there must be a commitment to further research along similar lines if social policy with respect to drug abuse is to respond to the changing nature of the phenomenon.

In this connection, it has been heartening in recent years to witness the establishment and growth of research programmes implemented by well-structured institutions, most frequently under governmental auspices, rather than on an *ad hoc* or one-time-only basis. In the studies reviewed here, we could refer to the programmes conducted (and still in progress) at the Centro Mexicano de Estudios en Farmacodependencia (CEMEF), the Department of Addiction Control Services in Puerto Rico, and the leadership and co-ordinating role in Italy of the Centro Nazionale di Prevenzione e Difesa Sociale. Experience suggests that only through longer-term monitoring and research can planners and policy-makers hope to deal effectively with so diverse and ever-changing a field.

Organization of the Materials

Some explanation is in order regarding the organization and presentation of the materials in this report. To a large degree, this was determined by the objectives and initial conceptualization of the country studies programme which, it will be recalled, was designed in three general parts to cover the areas of epidemiology, attitudinal studies and control and intervention mechanisms. The presentation follows that structure, although it will be evident at times that in a dynamic sense these are not discrete areas but often inter-related. Consistent with the purpose of this report — an elaboration of the planning, research philosophy, methods pursued and experiences and outcomes of each of the studies — we have not set out to present all of the findings of the research programme, but rather to

use some relevant findings in an illustrative manner. It is our hope that in the long run planners and researchers will be better served by learning of the experiences of those in parallel roles in other countries.

Finally, some critical comment will be offered, based on our own analysis of the programme. The comment is intended to be of constructive utility. The country-studies programme has been a beginning only, although we believe its value is evident and positive. We hope that by sensible assessment and evaluation it will be possible to construct a more useful, congruent relationship between research into the complex phenomenon of drug abuse and the formulation of programmes and policies that will prove more effective in meeting problems than in the past.

Definitional Clarifications

In this report, all possible efforts are made to avoid ambiguity, although it must be recognized that many of the definitional difficulties that have troubled scientists in this field remain unsolved. To minimize the confusion, some clarification is needed.

The terms *drug use* and *drug abuse* are used in literature to convey a variety of meanings. In the context of this report, however, an attempt is made to convey uniform concepts. *Drug use* is used here to refer to all forms of consumption of psychotropic drugs, legal and illegal, whether medically prescribed or not. The term *drug abuse*, although etymologically imprecise, will be used interchangeably with *non-medical drug use* to refer to all drug use which is not indicated on generally accepted medical grounds.

A considerable amount of confusion also arises over the use of the term *drug user(s)* which occurs frequently in the research literature. In this report the term is used (with some sacrifice of consistency) to refer to persons

engaging in *illicit* drug use. A second consideration relative to the use of the term arises particularly from the findings of survey research. It will be noted that in a number of the studies described in this report the terms *drug use* and *drug user* are employed to characterize any and all illicit drug use, regardless of the frequency or intensity of that use. Thus, for example, the term *drug user* may be applied in some survey research to a subject who has used a drug only once, or it may apply to long-term chronic use. This distinction should be borne in mind as an important qualification when interpreting survey findings.

Likewise, the terms *addict* and *addiction* appear in some of the studies with less than adequate precision. Wherever possible, the term *physical dependence* is preferable, since it characterizes more accurately a condition that must be present when referring to either addicts or their addiction. Strictly speaking, there cannot be addiction without physical dependence and, normally, withdrawal syndrome. Thus, the use of these terms should exclude such substances as cannabis and LSD, and be reserved to those substances, which, in fact, can and do produce physical dependence, e.g., the opiates and barbiturates.

A few other terms occur which give rise to some semantic confusion. One is the term *control* which in the context of this report refers to the goal of the programme rather than to an assumed outcome. Likewise the term *treatment* is used to refer to a particular form of social response, without assuming a particular outcome, such as a cure.

Reference has already been made to the use of *epidemiology* as one form of research that can yield important and useful information about the nature of non-medical drug use in a society. This application of the term is not, admittedly, strictly accurate, since in the literal sense it is a field of science restricted to the application of medical principles in public health. As used in this report, however,

it enjoys the advantage of aptly describing one conceptual approach well suited to studying the dynamics of non-medical drug use in a population; namely: the agent (the psychotropic substance), the host (user) and the environment (set, setting, etc. of non-medical drug use).

Finally, with regard to the substances subsumed under the term *drug*, reference will appear to the use of materials over which minimal or no legal controls are imposed. These include, for example, alcohol and a range of volatile solvents which, while their use may not be illicit, are nevertheless the source of problems and concerns in a number of countries. Thus, at times, the term *drug(s)* is used in this report to refer to substances which may not appear in a number of pharmacopoeiae.

Acknowledgements

Throughout the course of the pilot phase of this country studies programme on drug abuse research, collaboration and support were both essential and forthcoming from many sources, and these many contributions are gratefully acknowledged.

Finances to meet a significant portion of the UNSDRI operating costs were provided by the United Nations Fund for Drug Abuse Control. The start-up costs of the programme, incurred in the sponsorship of the Frascati workshop and the earlier preparatory work, were met in part through the financial support provided by the International Research Group on Drug Legislation and Programmes of Geneva, and by the Centro di Prevenzione e Difesa Sociale of Milan.

The Centro Mexicano de Estudios en Farmacodependencia (CEMEF), the entity by which drug-related programmes are co-ordinated and administered for the Government of Mexico, has been of very great assistance to this programme, not only through the implementation and co-ordination

of research projects in that country, but also through its generous co-sponsorship, with UNSDRI, of research workshops in 1974 and 1975 for countries in the Latin American region.

In Puerto Rico, the programme has received outstanding support from the Research Institute as well as other branches of the Department of Addiction Services.

Progress would not have been possible from the initiation of the programme without the willing and helpful co-operation and interest of all those experts and officials who contributed to the discussions at the Frascati workshop, on behalf of both individual countries and a number of international organizations.

Special mention must be made of the advice and consultation made available by the World Health Organization, particularly through the co-operation of Dr. Dale C. Cameron and Dr. Patrick Hughes.

Finally, throughout the pilot programme, UNSDRI has enjoyed the benefits of consultation with the United Nations Division of Narcotic Drugs in Geneva.

CHAPTER TWO

ESTIMATING THE SIZE AND NATURE OF THE PHENOMENON

The purpose for which research is conducted and the intended end use of the product will dictate to a large extent the approach taken in an individual research programme. This is especially true when the programme is designed to provide guidance for policy planning. Thus, a variety of methodological approaches can be employed in the development of individual country studies, depending on a number of factors. The particular policy requirements of the country in which the studies are to be conducted is one factor. The prevailing cultural and social characteristics of the country represent another set of factors. But because the research design will also be shaped by the canons of sound social science practice, a further conditioning factor will be the need for reliability in the data and data-gathering methods and for validity in drawing conclusions.

In estimating the size and nature of the phenomenon of non-medical drug use, the research teams employed a variety of techniques, yielding data of varying degrees of reliability and 'hardness'. All the approaches used were listed in the research outline and guide developed by UNSDRI and its collaborators at the 1972 research workshop in

Frascati. To recapitulate, the methods of data collection proposed were:

1. Reviews of recent literature, including surveys of unpublished, current or projected research projects.

2. The identification and assessment of sources of systematically gathered data. These included official government statistics on drug use, police and court records, public health and vital statistics records and hospital admission records.

3. Surveys of informed opinion, using structured and uniform interview formats with individuals whose information, although perhaps partial, was nevertheless related to direct experience with non-medical drug use and drug users. This group included physicians, psychiatrists, social workers, police officials, social scientists and educators.

4. Structured surveys in scientifically selected population samples, including, so far as possible, control groups for purposes of comparative analysis.

5. Analysis of case histories, either through the examination of records or through standard interviews or tests with individuals drawn from drug-using populations.

6. Participant observation studies for purposes of constructing ethnographic profiles of drug-using populations.

It is evident that the data yielded by each of these research methods will not be uniform with regard to quality and reliability. The use of participant observation techniques will not provide accurate quantitative data regarding the number of drug users in a population, although it can yield qualitative insights into the life and dynamics of drug-using groups which cannot be gleaned from analysis of the information derived from surveys of scientifically selected population samples. It must also be kept in mind that while

survey research is more quantitatively precise, it has the limitation of characterizing a situation in a particular population at one point in time only, and the longer-term utility of this information will require replication of the survey in order to discern changes and trends.

In the UNSDRI programme, country research teams utilized a number of these methods, either singly or in combination, in order to ascertain, to the degree possible, the size and characteristics of non-medical drug use in particular regions of their countries. The information thus provided (and, at times, supported by other data not drawn from the immediate studies in progress) formed the raw materials for an initial sketch of the non-medical drug use picture in these countries, or particular regions of them. The studies described below are not, as already noted, a final, definitive representation of the phenomenon. In every case, through the research infrastructure and accumulated experience born of the UNSDRI programme, a programme of monitoring through continuous research is in progress. These programmes and institutional structures will be described at appropriate points in this report.

Puerto Rico

All drug-related programmes in the Commonwealth of Puerto Rico are operated and/or co-ordinated by the Department of Addiction Services (Departamento de Servicios contra la Adicción), which was established in 1973. In addition to its role of providing treatment and rehabilitation services and programmes of prevention, the department also has the responsibility for conducting research and evaluation. These latter functions are the specific concern of the Research Institute of the department, which has a staff of research specialists and, on occasion, commissions special studies to independent researchers or research groups.

Although some epidemiological studies of non-medical drug use had been conducted in Puerto Rico prior to the establishment of the department, the highly mobile nature of drug use patterns made further studies necessary.

Non-medical drug use in Puerto Rico is presently characterized by rapid and profound change, brought about in part by a reversal in the flow of migrants. That is, migration is currently flowing chiefly from the mainland of the United States of America back to Puerto Rico, an important and significant change from the migration pattern that prevailed there for many years. This current wave of migration has inevitably brought with it migrants whose non-medical drug use began chiefly in the megalopolis centres of the United States, but whose addiction continues after resettlement in Puerto Rico.

In the view of some Puerto Rican officials a second significant factor influencing the incidence of non-medical drug use at the present time is the severe economic conditions that have prevailed on the island since 1974. In spite of government efforts to ameliorate socio-economic conditions, it is estimated that 60 per cent of Puerto Rican families still live in poverty. The consequences of this situation, as stated in one government document, are serious.

"The United Nations, among others, has pointed out that economic crisis situations tend to correlate positively with social unrest as manifested through increased indices of delinquency, violent confrontations, alcoholism and drug addiction. All of these conditions were dramatically present in Puerto Rican society"¹.

The presence of these two factors, and others, dictated the need for a comprehensive plan of epidemiological research in Puerto Rico if planners and programmers were to be kept abreast of the dynamics of the drug abuse phenomenon.

¹ Department of Addiction Services, Commonwealth of Puerto Rico, *Drug Abuse Prevention Plan for Puerto Rico*; San Juan, 1975.

In attempting to estimate the incidence and prevalence * of non-medical drug use, the Research Institute of the department first reviewed the existing data on the phenomenon which had been compiled by various researchers in recent years, including various estimates of the magnitude of the phenomenon. These, with the dates on which the estimates were made, appear in Table 1.

An analysis of the merits and limitations of these estimates at various points in time was then prepared. The situation was summed up as follows in a recent report¹.

"In spite of the lag in scientific sources of information on the incidence and prevalence of drug abuse in Puerto Rico, the studies done thus far do in fact provide a general indication of the drug abuse scenario in Puerto Rico. One of the often-cited studies is the study by García and Roselló, on the *Magnitude of the Drug Problem in Puerto Rico*². Generally, it is considered as a preliminary research effort towards a scientific approach to the problem. The authors establish a total of 6,794 known addicts, for the period of January 1964 to May 1969. Included in this count are all clients known by the various agencies, medical, psychiatric, correctional, penal and legal, such as government and volunteer institutions.

This study reveals that the majority of the addicts reside in the metropolitan areas (74.4%) and that the majority of users are male (92.5%). Age of addicts and users by type of drug used were other aspects mentioned in this study.

* In this report, as in a significant proportion of the literature on the subject, an adaptation of the public health medical model is employed to describe the dynamics of drug abuse. Hence, *prevalence* is taken to refer to the degree to which something (in this case, harmful drug use) is present in the population being studied at a given point in time. *Incidence* refers to the rate of occurrence of *new cases* of a particular disorder (drug abuse) in the population studied.

¹ Department of Addiction Services, Commonwealth of Puerto Rico, *Drug Abuse Prevention Plan for Puerto Rico*, 1975, pp. 71 et seq.

² García, C.S.; Roselló, J.A. *Study of the Magnitude of the Drug Problem in Puerto Rico*. Department of Psychiatry, University of Puerto Rico, 1970.

TABLE 1: ESTIMATED NUMBER OF ADDICTS
(Various Sources)

SOURCE	Date	Number of addicts
Department of Treasury, Office of Special Investigations . . .	1970	18,132 known addicts
Department of Treasury, Office of Special Investigations, after taking into account non-identified users	1970	36,000 known and unknown
Formula of Dr. Baden: *	1965	4,400 known addicts
(annual drug deaths \times 100 = known drug addicts)	1970	16,000 known addicts
(annual drug deaths \times 200 = total drug addicts)	1971	—
Macro-System	—	25,000-30,000 users
Department of Addiction Services	1970-1971	20,000 users
Study of García and Roselló ¹ . .	1964-1969	6,794 known addicts

* Application by Dr. Ernesto Colón Yordan of Dr. Baden's Formula to Puerto Rico.

¹ García, C.S.; Roselló, J.A., *Study of the Magnitude of the Drug Problem in Puerto Rico*. Department of Psychiatry, University of Puerto Rico, 1970.

There are, however, limitations in the García-Roselló work. For instance, the unknown number of addicts was not considered. The count was based on those who had registered at treatment centres or had been identified by other agencies such as the Police and the Department of Justice. The estimate has a further limitation in that it does not eliminate those cases in which the addicts were rehabilitated, or those cases in which the addicts died.

"In spite of the drawbacks of the García and Roselló study, it does provide a general estimate of the known addicts for those years. Moreover, it helps to document the fact that heroin is the main substance abused. García and Roselló find that at least 60% of the known addicts use heroin, while in a later study Mrs. Martín found that 83-95% of addicts were heroin users¹.

Another factor which has restricted the usefulness of the data in previous studies is a counting of only those who use habit-forming drugs. Usually those who use barbiturates and other sedatives, amphetamine, and hallucinogen drugs are not included in the enumeration.

The figures of drug abusers would undoubtedly be higher if such persons were included.

A more accurate accounting still of the entire drug problem in Puerto Rico would be obtained if those who use "soft" or medicinal drugs were to be identified and tabulated. For instance, there are those who sniff paint thinner, gasoline, and other industrial solvents. In some instances common medicines such as aspirin are mixed with soft drinks, tobacco and alcohol. Nor do the figures include persons who use potentially addictive medicines such as tranquilizers (Equanil, Librium, Valium, etc.).

Future research is needed on the abuse of multiple substances in the Puerto Rican population. Many

¹ Negrón de Martín, I. *The Magnitude of the Drug Problem in Puerto Rico*, College of Pharmacy, University of Puerto Rico, 1972.

questions remain unanswered and above all there is a serious need to examine the role of the use of multiple substances in providing a point of entry into the world of heroin addiction. At present, the results of a study on heroin addiction by Professor Vales¹, suggest that marijuana, as well as other "soft" substances, were the first contacts of the heroin addicts with the psycho-social milieu of addiction.

Against this complex background of a wide range of estimates based on a variety of methodologies, the Research Institute attempted to calculate a new set of estimates, testing a number of different methods. By the Institute's own reckoning², very specific problems had to be overcome and, in some cases, certain methods could not be utilized. Determining the empirical base for drug programmes in any given area is a difficult and investigative task. Social prejudice against the addict, fear on the part of informants, and repercussions from law enforcement units are obstacles which have prevented efforts, such as census-taking of drug addicts, to obtain a more accurate picture of the extent of the drug problem in Puerto Rico.

"Based on three different methods of establishing the total number of drug addicts, the Research Institute estimates that there were approximately 70,000 drug addicts at the beginning of the planning year 1974-75. Although this figure was derived under certain constraints, it is the operational number used as the basis for the planning of drug programmes in Puerto Rico.

Method 1

One of the methods used by the Research Institute is based on the number of drug addicts identified

¹ Vales, P. *Socio-Cultural Alienation and Heroin Addiction*. Institute of Social Research, University of Puerto Rico, 1975.

² Commonwealth of Puerto Rico. Department of Addiction Services. *Drug Abuse Prevention Plan for Puerto Rico*, San Juan, 1975, p. 249 et seq.

or treated in the various treatment programmes in Puerto Rico during 1973-74.

<i>Centre or Agency</i>	<i>Number of addicts identified or treated</i>
Public Treatment Centres .	2,613
Private Treatment Centres .	2,107 (approx.)
Veteran's Hospital	71
Penal Institutions	2,031
TOTAL	6,822 (estimated)

The Research Institute also developed a method for estimating the total number of drug addicts in Puerto Rico.

In order to use this method, several assumptions were made after preliminary appraisals of the drug scene in Puerto Rico and after consulting with independent researchers in the field. One basic assumption was that for each known addict there are 10 other unknown addicts.

This approach, developed by Leon Gibson Hunt¹, is in use in some states. Hunt's hypothesis is that drug addiction is like an epidemic and that any one addict introduces non-users to addiction who in turn introduce others, in a contagious fashion. On the basis of the preliminary results of Vales² sociological study, this way of estimating the number of unknown addicts seems applicable to the addiction process in Puerto Rico.

Using the figure of 6,822 known or identified drug addicts and multiplying this by 10, 68,220 persons were estimated drug addicts at the end of 1973-74, or at the beginning of the year under plan 1974-75.

¹ Hunt, L.G. *Heroin Epidemics. A Quantitative Study of Current Empirical Data*, Drug Abuse Council, 1973.

² Vales, P.A., *Op. Cit.*

Method 2

The Research Institute, in the development of its Evaluation Project, has compiled a list of clients who have been part of the public treatment programmes covering the period from 1959 to 1973. The list of persons totals 8,872. Subtracting the approximately 800 clients who are double counted, the estimated number of drug addicts based on those who joined treatment over the past 14 years is 7,982.

The multiplying factor of 10 is again applied, to render an estimated total of 79,820 drug addicts at the end of calendar year 1973. An analysis of chemotherapy programme clients indicates that 81% were drug users for one to ten years before joining the programme. On these grounds, albeit indirectly, the figures point to a number close to 70,000.

Method 3

The third and most recent estimate is based on the results of a *Survey of Active Clients* administered by the Evaluation Project of the Research Institute.

One of the purposes of the study is to find out, by interviewing active clients, the number of those addicts who they knew were not receiving any kind of treatment. A sample of 10 percent of the clients of the drug-free and chemotherapy modalities were interviewed. The respondents indicated that they knew collectively 31,919 addicts who were not receiving treatment. Therefore, every active client claimed to know an average of 114 non-identified addicts. Assuming that the total of active clients is acquainted with the total of non-active clients, an estimated figure of 125,840 addicts who are not in treatment can be computed. As of December 1973 there were 1,100 persons who were active clients. That total (1,100) multiplied by the factor of 114 (114.40 is the statistical computation) gives

a total of 125,840 persons. After this estimate was adjusted by eliminating the responses in the extreme upper limits of the range, the estimate yielded 69,883 addicts who did not receive treatment as of December 1973, which accounts for a total of 70,983 drug users in Puerto Rico (judged by the clients to be mostly heroin addicts).

In addition to the estimates of the number of addicts in Puerto Rico made by the Research Institute of the Department of Addiction Services, there are some direct and indirect indicators that may help to explain the magnitude of the drug addiction problem on the island.

Direct Indicators

Direct indicators include all those factors which could be considered as *exclusive* consequences of the drug problem. Some examples of direct indicators are: deaths, drug seizures, and arrests due to drugs. The Department of Health offers information on mortality as a consequence of drug usage, whether by accident or by suicide, distributed by sex and geographic areas (see Table 2).

On analysing the data presented in this table, we may note that the increase in deaths related to drug use has augmented steadily, from 14 deaths in 1962-64, to 106 deaths in 1970-73. These deaths have been due mainly to suicides related to drug use. During this same period 89 suicides were reported, in comparison with 51 deaths caused by accidents.

In continuing to analyse this data by area, specifically the San Juan Metropolitan Area against the rest of the island*, we find that there are more deaths due to drugs (52.1%) in the Metropolitan Area than in the rest of the island (47.9%). From

* The Metropolitan Area includes the municipalities of San Juan, Carolina, Bayamón, Cataño, Trujillo Alto and Guaynabo. The island includes all of the remaining municipalities, including Vieques and Culebra.

TABLE 21: MORTALITY DISTRIBUTION BY DRUG USE *

Not Determined		Accidents			Suicides			Metropolitan Area			Island		
		Males		Females	Males		Females	Total		Accidents	Suicides	Total	Accidents
		Total			Total			Total					
118	1962-1964	51	39	12	89	46	43	73	26	47	67	25	42
	1965-1967	5	53	92	9	4	5	5	2	3	9	3	6
62	1968-1970	25	21	4	17	10	7	20	14	6	22	11	11
	1971-1973	10	9	1	24	11	13	23	6	17	11	4	7
56		11	6	5	39	21	18	25	4	21	25	7	18

1 Commonwealth of Puerto Rico, Department of Addiction Services, *Drug Abuse Prevention Plan of Puerto Rico*, San Juan, 1973, p. 255.
 * Barbiturics and Opiates.

SUMMARY

	1962-1973	Metropolitan Area			Island		
		Deaths		Per cent	Deaths		Per cent
		Total			Total		
Accidents	.	51	26	51.0	25	49.0	
Suicides	.	89	47	52.8	42	47.2	
Total Determined	.	140	73	52.1	67	47.9	
Not Determined	.	118					
Grand Total	.	258					

1969 to 1972 there was a marked rise in the number of arrests of drug pushers, from 401 arrests in 1969 to 697 arrests in 1972.

Interventions with minors in drug-related cases also grew during this same period, from 112 in 1970 to 195 in 1972. This may indicate a larger drug market.

Concerning the types of drugs most commonly used since 1972, there has been an increase in arrests for marijuana, cocaine, LSD and methadone. Heroin arrests, however, have been decreasing rapidly. The data offered by the Puerto Rico Police Department and the Investigations Office of the Department of the Treasury, give an idea of the area of the island where the largest number of arrests due to drugs are made, and which sex is most affected. According to these statistics, for each female arrested, 16 men are arrested, and for every two drug-related arrests made in the San Juan Metropolitan Area, one is made on the rest of the island.

The accumulated data was analysed to provide other indications of the characteristics of the drug-using population in Puerto Rico, relying chiefly on treatment data. It was possible, for example, to analyse the data on patients treated during the 1973-74 year by areas in which they resided, thus identifying locations where high prevalence and incidence persist. In this regard, the area of Metropolitan San Juan proved to have the highest concentration of drug users, although there were also high concentrations in six other smaller urban centres.

By analysis of the treatment clientele, age characteristics could be identified. Sixty-six per cent were between the ages of 19 and 30, although the highest incidence (30% of the total) was in the age group between 21 and 25.

A breakdown by sex showed that in the 19-30 year-old category, 93% were males, or a ratio of approximately 10 males to each female treated.

Indirect Indicators

Indirect indicators are those which divulge information related in some way to the problem of non-medical drug use, but which are not an exclusive result of it. One such indicator is the number of property crimes, such as car thefts, breaking and entering and robbery, some of which correlate with areas known to have a high prevalence of criminal addicts.

In 1973, a study of the correctional system in Puerto Rico was conducted by Technical Services Inc.¹. It focussed on the populations in penal institutions on the island and provided considerable indirect information about the magnitude and characteristics of the addict population and correlations between addiction and criminality. The data collected in this study also served to elucidate some reasons for the commission of property crimes by addicts as well as some of the background characteristics of the addicted prison population.

For example, it will be noted in Table 3 that ages of confined addicts are lower than those of confined alcoholics. It is also interesting that the age distribution of confined addicts is almost identical with that of the addict population in the treatment programme, i.e., in the 20-29 year age group, 66 % of the treatment population, 67 % in the confined addict population; in the 20-24 year age group, 30% for the treatment population, 31.6% for the confined population.

The prison survey also indicated that approximately 90% of the confined addicts were born and/or raised in urban centres, a finding that parallels the survey of the treatment population.

The data contained in Table 4 indicate that just over one-third of the confined addict population had held

¹ Technical Services, Inc., *Study of Addiction in the Penal Population in Puerto Rico*, 1973.

TABLE 3: AGES OF CONFINED ADDICTS

Ages	% Addicts	% Alcoholics	Ages	% Penal Population
15-19	3.3	2.2	17-21	14.52
20-24	31.6	17.9	22-30	47.98
25-29	35.4	14.2	31-40	21.77
30-34	13.7	15.7	41-50 *	7.66
35-39	5.2	11.9	50 +	4.43
40-44	4.2	14.2	No Response	4.84
45-49	2.4	8.2	—	—
50-54	1.9	6.7	—	—
55 or over	2.4	9.0	—	—

TABLE 4: EMPLOYMENT HISTORY OF CONFINED ADDICTS

Previous Employment Condition	% of addicts
1. Had permanent employment	37.2
2. Changed jobs, but employed	21.9
3. Employed at times	19.5
4. Unemployed	21.4

permanent employment. The remainder showed either instability in their employment situations or under-employment or unemployment. It should be noted, however, that a considerable proportion of the population believed that trafficking in drugs constituted employment, so that the actual employment figure might be remarkably lower when considered in a more conventional sense.

Further information can be gleaned from the data in Table 5 which illustrate the age at which the addicts in the prison population first engaged in the use of any psychotropic substance. It will be noted that about two-thirds of these addicts began using drugs before the age of 17, and one-half of these latter before the age of 14.

TABLE 5: AGE OF INITIAL DRUG USE

	% of addicts
1. Over 20 years of age	11.9
2. From 18 to 20 years old	16.4
3. From 15 to 17 years old	36.8
4. Less than 14 years old	29.9
5. Not applicable	5.0

Further information about this aspect of drug abuse can be drawn from the data in Tables 6 and 7, based on populations of addicts under treatment. Again, it is noteworthy that in the San Juan treatment population, 71 per cent began drug use before the age of 19, and in the population in the Pavillon B study, 52 per cent at age 14 or less, and 85 per cent below the age of 21.

TABLE 6: AGES AT WHICH CLIENTS OF THE CHEMOTHERAPY PROGRAMMES OF THE METROPOLITAN AREA OF SAN JUAN (1973-74) BEGAN USING DRUGS

AGE	Number of clients	Per cent
12 or less	81	15.2
13 - 18	303	56.0
19 - 25	106	19.9
26 or more	13	8.0
Total . . .	503	99.1

TABLE 7: AGES AT WHICH 100 CLIENTS TREATED IN PAVILLON B OF THE DRUG FREE PROGRAMME BEGAN USING DRUGS

Age of Commencement of Drug Usage	Number of Clients
14 or less	52
15 - 20	33
21 - 25	5
26 - 35	1
No answer	9

Source: Social characteristics of clients treated in Pavillon B.

Information about the drug preferences of addicts in Puerto Rico was further developed by the use of data contained in surveys of both treatment and prison populations of addicts.

The data in Tables 8 and 9 were obtained from the study of the addicts in penal institutions in Puerto Rico, but unfortunately the way in which the data are presented do not make it possible to be precise in determining whether one specific drug (e.g. marijuana or barbiturates) was preferred or whether the pattern was, in fact, that of poly-drug use. It is of interest, however, that the lists include not only the traditional and pharmaceutical substances, but also household and commercial volatile solvents.

Other evidence about the preferred drugs of addicts, drawn from prison population surveys conducted earlier, indicate that more than 80 per cent preferred heroin above all other drugs. Marijuana or a combination of heroin and marijuana were the second choices. This is borne out by

TABLE 8: FIRST DRUG PREFERENCE

SUBSTANCE	% Addicts
1. Uses nothing	4.0
2. Minor tranquillizers, thinner, glue	4.5
3. Marijuana, amphetamines	44.9
4. Hallucinogenic (LSD, STP)	1.0
5. Barbiturates, Cocaine, Heroin whatever is available	40.4
6. Liquor	5.4

TABLE 9: SECOND DRUG PREFERENCE

SUBSTANCE	% Addicts
1. Uses nothing	12.0
2. Minor tranquillizers, thinner, glue	1.7
3. Marijuana, amphetamines	17.1
4. Hallucinogenics (LSD, STP)	5.15
5. Barbiturates, Cocaine, Heroin whatever is available	62.9
6. Liquor	1.1

police data of illicit drug seizures which suggests that the majority of drug trafficking is in heroin, marijuana and hashish.

Other evidence of drug use patterns was drawn from an examination of the results of urinalysis conducted in conjunction with treatment programmes during 1973 and 1974, as demonstrated in Table 10.

The information contained in Table 10 indicates a reduction in amphetamine use in the last six months of 1974 and a consequent increase in heroin use among the samples tested. It must be noted, however, that these samples were not screened for evidence of marijuana and so yield no information about the prevalence in the samples of this drug.

Earlier studies of addict populations in Puerto Rico have concluded that certain sectors of the population are more at risk to non-medical drug use than others. These included school dropouts and the unemployed. In investigating these factors, Table 11 provides for the scholastic

TABLE 10: DISTRIBUTION OF RESULTS OF URINE TESTS AND POSITIVE FINDINGS; 1973-74, and July December, 1974

Type of Drugs	1973-74	1974 (Jul-Dec.)			
	Positive Findings	Quantity	Per cent	Positive Findings	Quantity
Heroin	2,907	900	30.9	2,565	1,103
Amphetamines	2,907	1,066	36.6	2,565	666
Barbiturates	2,907	831	28.5	2,565	759
Cocaine	2,907	107	3.6	2,565	30
Others	2,907	3	.4	2,565	22

Source: Admission Office of Department of Addiction Service.

TABLE 11: ENROLMENT AND PERCENTAGE OF DROPOUTS IN PUBLIC SCHOOLS, 1971-72 and 1972-73

LEVEL	ENROLMENT		DROPOUTS		PER CENT OF DROPOUT	
	1971-72	1972-73	1971-72	1972-73	1971-72	1972-73
Elementary	423,672	423,644	17,592	17,463	4.2	4.1
Junior	138,960	164,113	11,370	11,459	7.1	6.9
High School	104,292	111,525	7,832	8,810	7.5	7.8
10-12						
Total	678,924	700,282	36,794	37,732	5.4	5.3

Sources: Statistics Division Department of Education.

years 1971-72 and 1972-73, indicating that the dropout rate is highest in the adolescent years, the years in which, according to other evidence, many addicts begin their non-medical drug use. If these data are correlated with the employment history of dropouts, a picture of the population at risk comes into focus. Information gathered by the Statistics Division of the Puerto Rico Department of Education indicates, for example, that in May 1972 there were 194,436 dropouts between the ages of 14 and 19 years. Of these, 56,581 were unable to find work and another 39,102 were not even seeking employment. Thus, in this age group, the population at risk could be calculated at more than 95,000.

By relating the legitimate income of addicts with estimates of their expenditures on drugs, it is possible to indirectly learn something about the place of criminal activity through property crimes in maintaining a drug habit. The data in Table 12, gathered in the survey of the penal population, indicates the monthly incomes reported by the confined addicts, while the data in Table 13 shows their reported *weekly* financial requirements to maintain their drug habit.

Possible limitations of the significance of the data reported in both these tables should be taken into account. As noted earlier, many of the addicts in the prison survey listed as employment their involvement in the illicit traffic of drugs. Earnings from this trafficking may be included in reported income in Table 12, thus accounting for income levels well above the skills and earning capacities of most of the addicts.

It is difficult to interpret these reported data. On the one hand, it could be argued that so long as the incomes derived from trafficking were used for the purchase of drugs, then there would be correspondingly less need to obtain money through the commission of property crimes. On the other hand, other studies reveal tendencies on the part of traffickers to exaggerate their income from these enterprises.

TABLE 12: MONTHLY EMPLOYMENT INCOME
OF CONFINED ADDICTS

SALARIES	First Employment	Second Employment	Third Employment
1. Under \$99.99	5.7	1.9	1.3
2. 100-199.99	11.4	3.8	3.9
3. 200-259.99	20.7	18.5	14.5
4. 260-324.99	19.7	15.9	13.2
5. 325-429.99	17.1	15.3	17.8
6. 430-649	7.8	8.3	7.9
7. 650 or more	2.1	1.3	2.6
8. an imprecise large quantity	0.5	—	—
9. an imprecise small quantity	2.1	0.6	0.7
10. not applicable	13.0	34.4	38.2

TABLE 13: AMOUNT OF MONEY NEEDED WEEKLY TO MAINTAIN
THE HABIT

	% Addicts
1. \$ 1,000 or more	3.6
2. \$ 999 - 500	6.6
3. \$ 499 - 200	16.2
4. \$ 199 - 100	21.0
5. \$ 99 or less	33.5
6. Very much - entire earnings	7.2
7. Whatever was available	4.2
8. Not applicable	7.8

If this latter situation prevails, then, as noted above, the gap between income and perceived requirements would be even greater than indicated in the two tables and one could consequently expect a high level of property crime to meet the disparity.

Other data were analysed in the hope that they might throw light on the relationship between addiction and crime, but the findings are generally inconclusive. While there was a marked increase between 1965 and 1974 in the percentage of addicts serving sentences for property crimes (robbery and burglary), there has been a marked decrease in the number of addicts institutionalized for drug offences. The increase in the percentage of addicts serving sentences for property crimes may simply be a function of the reduced number of drug offenders in prison due to a policy which now refers many drug offenders to treatment facilities rather than penal institutions. Likewise, the increase of 16.9 per cent in total property crimes reported in 1974 above those reported in 1973 may or may not be related to increasing non-medical drug use. As noted earlier, the effects of economic recession have been quite severe in Puerto Rico during this period.

The objective of the Puerto Rican analysis was to identify the population at risk to harmful drug use. Based on evidence derived from analyses of the identified population of addicts in Puerto Rico, the Research Institute was able to construct a composite profile of the known characteristics of this population group. The analysis demonstrated that a large number of the identified addicts were dropouts from the formal school system, unemployed and, generally, possessing a low level of employable skills. Of equal importance was the prevailing number of addicts who had begun their non-medical drug use in adolescent years and who predominantly came from metropolitan or rural areas of the island.

By analysis of the available data regarding the population of Puerto Rico as a whole, it was possible to specify the

population at risk, i.e., those in the general population showing a higher probability to exposure to non-medical drug use. This group, the Research Institute concluded, was comprised typically of adolescent males between the ages of 13 and 18, living in Metropolitan San Juan or the communities of Ponce, Caguas and Mayaguez.

Mexico

Although studies of the extent and characteristics of non-medical drug use were conducted sporadically in Mexico over a period of years, the first systematic, co-ordinated programmes of drug abuse research began in 1972 with the establishment by the President of Mexico of the Centro Mexicano de Estudios en Farmacodependencia (CEMEF). This autonomous entity is responsible for maintaining a continuous flow of scientific information to those engaged in drug abuse programmes throughout Mexico, as well as for establishing programmes of research, prevention, treatment, personnel training and for providing specialized information needed to help resolve problems in this field.

In examining the terms of reference of CEMEF, it is clear that its mandate extends well beyond the sphere of research. But, as a matter of policy, research has been accorded a high priority by CEMEF in the formulation and operation of many of its programmes. Of major importance in the research programme are the epidemiological studies which have been designed and implemented since 1973, following development of the basic UNSDRI Programme Outline and Guide, and supplemented by information on sampling procedures and survey techniques. The findings of all of these various epidemiological studies are not presented in this report. Rather, it has been judged more useful to review the substance of a manual and guide prepared by CEMEF in 1974, providing details of epide-

miological instrument design and a sample pre-coded instrument (cf. Appendix 1 to this chapter)¹. We will also review the design, testing and application of a pilot study in Mexico City.

Epidemiology of Drug Dependence

For purposes of studying and understanding it, drug dependence has been regarded as a communicable condition which can be transmitted from one individual to another. In this way an epidemiological focus is made possible.

On the other hand, we know that the "drug dependent" as such does not exist, but rather that we encounter a great variety of persons who abuse drugs, who have different psychological and social characteristics and who vary in age, socio-economic status, occupation, area of residence or who may belong to different subcultures. These variations point to the need for studies to assist us in determining the existence of all these factors, the correlations among them, and their influence on the use and abuse of drugs.

Advantages and Disadvantages of Various Research Techniques

One of the major problems in the social sciences arises from the difficulty of conducting research on a large number of persons in a relatively short period of time. In this connection, the following observations are relevant.

1. Anonymous questionnaires, used especially with students in classrooms, have the advantages of low cost and are easy to administer. When the results of these are

¹ Gómez Colmenares, A.; Medina Mora Icaza, E. *Manual Sobre Investigación Epidemiológica en Farmacodependencia*, CEMEF, 1974.

compared with the results yielded by group discussions, the outcome has proven to be very similar. It should be remembered, however, that these represent only a small part of the population.

2. Questionnaires distributed through the mail are normally unsuitable for research purposes since the percentage that will be completed and returned is so small as to be unrepresentative of the population to which they were directed and, in addition, the returns will be weighed in favour of only one component of the sample. For example, in one survey in which questionnaires were sent to householders, a high proportion of those who did not respond were later found to be persons experiencing problems of drug abuse with their children.

3. Although individual interviews can yield much valuable information, many difficulties are encountered in attempting to interview groups, whether comprised of drug users or the general public. Problems arise from the sample design, including a certain number of persons who refuse to reply, and the time and effort required to trace all those persons selected for the sample. Frequently, a sample will under-represent certain groups, such as persons with no fixed address, those in hospitals or other institutions, or those belonging to some youth sub-cultures, many of whom it would be desirable to include in the sample.

4. There are other indirect ways of obtaining information, such as analysing records of the production and sale of drugs distributed legally, or using police records to develop statistics on arrests for drug offences and drug seizures. Hospital records of patients treated for drug-induced conditions can also provide information. This type of analysis, however, covers only very limited

segments of the general population. More direct research methods, such as interviewing, appear to be best for collection of primary data regarding non-medical drug use and its related problems. Such research can be implemented through a variety of approaches, depending on the objectives of the research and the resources available to conduct it.

In Mexico, CEMEF employed both research approaches, direct and indirect, in order to obtain more reliable and complete data to ensure that in their epidemiological studies account was taken of the more representative characteristics of the population. In the description of epidemiological studies which follows, it will be noted that there is reliance on some existing data sources as a basis for further work designed to provide more precise data in a more scientific framework.

The Pilot Study

Essentially, a pilot study is a test of the methodology to be employed in a subsequent study or studies and no attempt should be made to generalize from its findings. The CEMEF pilot survey was thus designed to evaluate the following factors:

1. The sample, with particular attention to its representativeness, the ease or difficulty of the sampling method employed, and other related problems.

2. Interviewers and supervisors, focussing on how the system of supervision functions, the adequacy of the number of interviewers employed, their qualifications, and possible problems of organization and co-ordination of staff.

3. The questionnaire, particularly with regard to its validity and reliability, comprehension, or the complexity of its contents, the rate of refusals by prospective

interviewees and any other difficulties encountered in applying it.

4. Processing and handling of the data and the time required to analyse them.

5. Indicators of prevalence and incidence obtained in the pilot survey to assist in designing the definitive study.

The categories of psychotropic substances covered by the CEMEF survey were: narcotics, cocaine; depressants (barbiturates, tranquillizers, etc.); analgesics; anti-depressants, anorexiant and other stimulants; marijuana; LSD and other hallucinogens; alcohol; solvents and inhalants (e.g., glue, thinner, etc.).

Description of the Studies

The studies described here were designed in two phases: the first a pilot phase; the second the definitive study, modified in the light of the findings of the pilot research. They are the first of a series of such studies conducted to determine both the extent and characteristics of non-medical drug use as well as prevailing attitudes among the public regarding the phenomenon.

It was envisaged that the results of these studies would serve as a basis for elaborating working hypotheses to be tested in subsequent studies, once areas had been identified which required more careful analysis and after priorities had been established regarding future activities. At the same time, the findings would make possible the design and implementation of programmes of prevention, education, treatment and rehabilitation and, generally, better use of the resources available.

But some limitations of these studies had to be recognized at the outset. Although an attempt was made,

for example, to cover the total population in the surveys, it was nevertheless likely, as noted earlier, that some groups of persons would be excluded from the study, such as those with no permanent residence, persons travelling or living in hotels, hospitals, clinics, etc., at the time the study was being conducted. Another limitation arose from the voluntary nature of the information provided by the interviewee. It was possible that in a survey of drug use lower estimates would result which are not entirely reflective of the phenomenon as it occurred in the population. It was therefore necessary to complement these data with the findings of other field studies.

The survey was to yield not only epidemiological information, but also information about public attitudes towards the use and abuse of various substances, towards drug users, towards programmes of prevention, treatment and rehabilitation and towards the authorities and the legal control system.

The geographic area covered in the pilot survey was the Federal District (Mexico City), although subsequent studies would cover other urban centres as well as rural areas (including a community on the US - Mexican border).

Pilot Study Methodology

The pilot study took as its base the population 14 years of age and older of persons living in the Federal District, including foreigners who normally resided there. The questionnaire was administered to a selected sample of 595 persons by social science students. Interviewers worked in teams of five and their work was co-ordinated by a team supervisor. A specific geographic area was assigned to each group.

Statistical management and data processing were the responsibility of the Centre for Applied Mathematics and Systems Research (CIMAS) of the National Autonomous

University of Mexico. The quantitative and qualitative analyses of the data during and after administration of the questionnaire were also conducted by this Centre.

Sampling: As noted above, the sample for the pilot study was drawn from the population 14 years of age and older of the Federal District. A system of stratified sampling was employed in which numerically larger economic strata were sampled with greater intensity than the smaller strata. Three economic levels were established, according to the income level of the head of the household — a classification developed by the Market Research Bureau (BIMSA) and based on 1970 census data. In the three strata shown below — high, medium and low — the low stratum corresponds to Levels I, II and III of BIMSA classification, the medium stratum to Levels IV, V and VI and the high stratum to Levels VII and VIII.

<i>Stratum</i>	<i>Monthly Income</i>	
	<i>Pesos</i>	<i>\$ (US) approx.</i>
High	5,000 +	415 +
Medium	1,000 to 4,999	85 to 414
Low	0 to 999	0 to 84

A number of city blocks were then selected on the basis of the proportion of the population in each of the three economic strata. A number of blocks in the industrial zone were also included, yielding a total of 459 city blocks.

The blocks were chosen randomly, using the map of Mexico City as the sampling frame. The sampling unit was the residence-household.

In order to determine the number of families to be interviewed in each block, the total number of families in the block was divided by a constant numerical factor determined by the population density in each economic

stratum. Since the number of families per block would be lower in the high economic stratum (fewer or smaller multi-family dwelling units) than in the other strata, different constants were used. In the sampling, therefore, one family in thirty was selected for interviewing in the high economic stratum and one family in fifty in the medium and low strata and the industrial zone. Where the quota of families was less than 5.0, the block was eliminated from the sample (87), as were blocks uninhabited by any family (7). Thus a total of 94 blocks was eliminated, yielding a sample of 365 blocks with 595 interviews, distributed as follows:

<i>Stratum</i>	<i>Families Interviewed</i>
High	128
Medium	367
Low	100
Total sample	595

Families sampled in the industrial zone were distributed among the strata according to income.

After determining the quota of families to be interviewed in each block, families were selected by tables of random numbers. Then one member (14 years or older) was selected for interviewing from each family, again using tables of random numbers. It was assumed that by using this selection process the sample would be representative of age and sex in the general population 14 years and older.

The decision to exclude from the sample those under 14 years of age was based on two reasons: first, the desire to avoid arousing in this group curiosity about the subject of drugs; secondly, it was assumed that a different research instrument would have been required, adapted to the comprehension levels and language skills of this age group.

The Questionnaire

The questionnaire designed for the pilot study was comprised of three sections. The first sought information about the respondent, such as age, sex, education, income and religion; the second sought information about the respondent's use, or non-use, of illicit drugs and alcohol; the third section solicited the attitudes and opinions of the respondent towards non-medical drug use. Evidently, the second section would provide the epidemiological information needed about the prevalence of drug use in Mexico City, while the third section would provide some insights into possible guidelines for education and prevention with regard to drug abuse.

The majority of the questions were of the multiple-option type, although there were five "open" questions in the section dealing with attitudes, in order to provide more amplitude to the interviewee in responding.

Evaluation of the Pilot Study

The findings of a pilot research, particularly those resulting from survey research, are of limited value except as a guide to the internal validity, consistency and reliability of the instruments used and the degree to which the sample selection represents the population from which it is drawn. In the case of the pilot project in Mexico City, the data were compared to the data drawn from the 1970 official census of the city. Following are some key characteristics of the population surveyed as yielded by analysis of the data, with a brief commentary, where relevant, on its implications for modification of the project before the final, definitive study is designed.

Sex: Among those actually surveyed, 41% were male, 59% female; according to the 1970 census data, the proportion of those over the age of 14 were 47% male and 53% female.

Age: The following breakdown demonstrates the distribution of age groups across the sample surveyed and the actual age distribution based on the census.

Age Groups	Frequency Expected (1970 Census)	Frequency Obtained Pilot Survey
	N	N
14 - 17	90.5	98
18 - 24	141.4	169
25 - 34	133.3	139
35 - 49	131.1	94
50+	98.5	95

Chi-square tests were applied to determine the significance of these differences *.

From this it is evident that the age group 18 to 24 was highly over-represented in the sample, compensated for by a low representation of the age group 35 to 49. In general, the younger population had greater representation than the older population.

The evaluators pointed out, however, that these two areas of variation from the census distribution (sex and age) might have been due to the size of the pilot sample, which is one-fifth of the size of the sample selected for the definitive study **.

These discrepancies arose, the evaluators felt, from the difficulties encountered by interviewers in establishing contact with the type of individual previously selected for

* $\chi^2 = 15.9$ d.f. = 4 .001 p. 01

** A description of the methodology employed in designing the sample for the definitive study appears in Appendix II to this chapter.

the survey and the possibility that the interview was conducted with whomsoever was available in the household at the time of his visit in order to avoid having to make a return call for the interview.

Economic Strata: The levels of family income by which economic strata were established in the pilot study also revealed discrepancies. Here the differences arose between the number of interviews originally selected in each income level (by city blocks) and the actual distribution of the interviews. The following tabulation demonstrates the differences:

	<i>City Blocks Selected by Income Level</i>		<i>Interviews Conducted by Income Level</i>	
	N	%	N	%
High	50	11	128	21.5
Medium	153	33	367	61.5
Low	241	53	100	17.0
Industrial Zone	15	3		
Totals	459		595	

It is evident from the foregoing that in the population actually sampled in the pilot study the upper and middle family income groups were greatly over-represented and that the low income group was significantly under-represented. There are two possible sources suggested for the discrepancy: 1) the zones designated by BIMSA were not homogeneous with respect to family income; 2) the criteria employed by BIMSA in establishing economic levels did not correspond to the criteria applied in the pilot study.

Education: The foregoing discrepancies also seemed to be reflected in data on the educational background of the subjects interviewed. While the 1970 census data revealed that 28.7% of the Federal District population 14 years of age and older had received an education beyond the primary level, the findings of the pilot survey yielded a proportion of 57% for the same level of education, almost double the census figure.

Questionnaire: In order to determine how the questionnaire functioned in the pilot study, the experiences of the interviewers and coding staff were examined. Some of the difficulties identified were:

1. Instructions to the interviewer were very sophisticated and lacked clarity.
2. Because some respondents provided the same replies for both drugs and alcohol, it was suggested that interference could be avoided either by interspersing these questions throughout the questionnaire or by standardizing the questions in order to simplify the questionnaire.
3. Some questions did not measure only the phenomenon being examined (e.g., drug abuse), but also reflected attitudes towards some of the characteristics mentioned in the questionnaire. One such case involved responses to the question of social distance, in which there also appeared attitudes towards nationality or other relationships (e.g., friendship, family ties).
4. Some irrelevant responses seemed to result from a lack of information on the part of the respondent. It was suggested that an item might be included in the questionnaire which would help to detect such cases.

5. Both in the open-end questions and in those multiple-choice questions which were too extended, the fatigue of the respondent was evident in mechanical replies to the various options offered, even though there were few difficulties with the language used. In some cases, especially in the low income group, it was found that persons associated the term "take" ("tomar") with getting drunk ("emborracharse").

6. Three problems were identified related to the multiple-choice questions:

a) Difficulty in remembering all the options offered in the questionnaire and therefore choosing to reply with the word having the greatest impact, e.g., "dangerous" and "excessive use" ("uso exagerado");

b) Lack of options to match unforeseen responses;

c) An excess of unnecessary options.

7. Speculative or hypothetical questions were inoperative especially in the low income group.

8. Interviewers reported difficulties in interviewing persons of advanced age who had serious difficulty in understanding the questionnaire and in selecting options.

9. Some questions did not clearly differentiate between the present and the past.

10. The questionnaire was difficult to handle because of its volume and structure, making it awkward to record responses.

11. The questionnaire was not pre-coded, resulting in loss of time in coding it subsequently, and greatly increasing the probability of errors.

12. The wording of the questionnaire in general did little to improve rapport between the interviewer and the

respondent. This problem was particularly acute when moving from one part of the questionnaire to the next.

At the time of this writing, the results of the definitive epidemiological study in Mexico City were not available. However, the experience and analysis of the pilot study have been presented as one example in structuring and analysing a pilot study in a particular setting. Other aspects of the CEMEF research programme will be described in the chapter on attitudinal studies.

Italy

During 1972, contemporaneous with the drafting of the UNSDRI country study programme, a group of medical and social scientists began the planning of a research programme in Italy, using the UNSDRI framework and under the auspices of the Centro Nazionale di Prevenzione e Difesa Sociale (National Centre for Prevention and Social Defence), located in Milan. The five-phased research programme included components for epidemiological studies, as well as studies on attitudes, pharmacology, treatment and the role of the media.

The description of the epidemiological study which follows¹ is drawn from a project carried out by three scientists on a group of students at the State University of Milan during the 1972-73 academic year. Its purpose was not to determine the prevalence and incidence of non-medical drug use among the 30,000 students enrolled at the university, but rather to determine the feasibility of conducting epidemiological studies on small, discrete groups — in this case, a group of 249 students who were members

¹ Andreoli, V.; Giannelli, A.; Morselli, P. "Rilevamento Epidemiologico di sostanze stupefacenti in un 'microambiente' mediante uso di questionario", *Droga e Società Italiana*, Giuffrè Editore, Milano, 1974.

of a cultural association ('Cineforum') interested in concerts and films. This group was in no way representative of the university population in Milan nor of the student population in Italy as a whole. Rather, it was generally viewed as a group more tied to traditional values, less revolutionary (in the Marxist sense) and more committed to scholastic pursuits rather than to political activities. Following are some characteristics of the sample.

Of the 249 students, 64.6% were male, 35.4% female. More than 73% of the sample were under the age of 25. All faculties of the university were represented, although the largest single faculties represented were Medicine and Pharmacy (22.1%) and Letters and Philosophy (22%). Besides, 23.7% of the sample were employed in addition to their academic efforts.

The questionnaire, which appears as Appendix 2 to this chapter, was sent to those students who were members of the 'Cineforum'. The questionnaire was completed by the individual students themselves and was, in effect, their ticket of admission to the showing of a film. It sought information about the frequency of their drug use — if any — as well as possible cultural or political motivations for drug use, psychological factors, the type of information they had about drugs and, finally, possible relationships between drug use and sexual behaviour. This latter subject was introduced in order to examine the often stated opinion in Italy that a relationship existed between drugs and sex.

Survey Findings

1. *Drug Use*: Of the sample of 249 students, 16.08% (40) had ever used drugs. This group represented 18.1% of the females in the sample and 16.8% of the males. It is noteworthy, however, that at the time of the survey,

only 4% of the total sample (i.e., 10 students) continued to use drugs, the remainder having given up the practice after initial experimentation. The most frequent drug use occurred in the age group over 25 years (21.3%); in the age group under 25, 15.9% had had a drug experience. Analised by faculty, 24.6% of those who had ever used drugs were enrolled in Letters and Philosophy and 29.4% in Engineering and Architecture.

2. *Drugs and group influences*: The findings demonstrated the influence of informal group pressures, particularly of friends, in initial experimentation with drugs. In the drug-using group, 41.5% had their first drug offered to them by friends; after accepting it they became members of the group. This characteristic is much more evident among the males (48.1%) than among females (30.8%). Only 22% of the drug-using group acquired it themselves the first time, most particularly among males and the over-25 age group.

Among those who never used drugs, 39.2% had friends who did so. Almost one quarter of the non-users had had drugs offered to them at least once.

3. *Counter-motivations to drug use*: Among the group that had not used drugs, a variety of reasons were given, some of which were:

Fear of intoxication	24.9%
Saw no need for them	20.4%
An alienating act	14.4%
Not socially useful	14.9%
Political convictions	4.4%
Lack of opportunity	2.8%
Others	27.1%

4. *Motivation for drug use:* Among those who had ever used drugs the following motivations were given:

To learn the effects	39.0%
Curiosity	34.1%
To know myself better	29.0%
To escape from reality	7.3%
Lack of self-confidence	7.3%
To be part of the group	4.9%
To search for artistic inspiration	4.9%
Not indicated	24.4%

It is evident from the above that almost three-quarters of the drug-using group were motivated by curiosity about the drugs and their effects.

Other findings of the survey indicate that there is less acceptance of family and educational authority by the drug-using group (22%) than among those who have never used them (49.7%).

5. *Perceptions and reality:* In a number of areas, there is concordance in both groups regarding the motives which impel a young person to become intoxicated by drugs, as reflected in Table 14.

An interesting exception to the general agreement reflected in Table 14 is the difference in the perceived role of depression in youthful drug use. It will be noted that almost three times as many who had had drug experiences described depression as a motive as among those who lacked drug experience.

6. *Relationship between drugs and sexual behaviour:* As noted earlier, this part of the questionnaire was designed to probe the possibility that non-medical drug use was somehow linked to lack of sexual satisfaction. The survey findings showed that about 85% of the subjects in both

TABLE 14: MOTIVES FOR DRUG INTOXICATION BY YOUTH

	Non-Using Group %	"Have used" Group %
Rebellion	40.9	48.8
Family Crisis	33.7	31.7
Group phenomenon	28.7	24.4
Imitation	22.1	24.4
Publicity	19.9	19.5
Ignorant of dangers	19.3	17.1
Self-examination	18.2	24.4
Depression	4.9	14.6
Curiosity	1.7	7.3

groups considered themselves to have normal sexual impulses. The incidence of homosexual experiences was, however, more than three times as high among the drug-using subjects (26.8%) as in the other group (8.3%). In addition, the drug-using group had had significantly more sexual experiences — and at an earlier age — than the non-using group.

In summary, 1) no correlations — either positive or negative — could be established between the instrumental use of drugs and lack of sexual satisfaction; 2) where there is psycho-physical disequilibrium resulting from lack of achievement, drug use is only one possible solution that may

be sought; 3) since no clear-cut agreement was forthcoming from the respondents on the effects of drugs on sexual behaviour the authors concluded there was no basis for linking the two.

7. *Inter-relationships between drug and alcohol use:*

The survey revealed that the drug-using subjects made greater use of alcohol than those who did not engage in drug use. Of the former, 41.4% drank periodically or habitually, compared with 18.2% in the latter group. Although wine consumption patterns were about the same for both groups, the drug-experienced subjects made greater use of stronger alcoholic beverages (39% to 29.2%).

8. *Types of drugs used:* The drugs used by the subjects in their first experience were:

Hashish	53.7%
Marijuana	22.0%
Oral Amphetamine	12.2%
Injected Amphetamine	2.4%
LSD	2.4%
Opiates	2.4%
Cocaine	2.4%

It is evident from the above that over three-quarters of initial experimentation was with cannabis derivatives (hashish and marijuana). Analysis revealed that a very similar pattern prevailed for those whose drug use continued after the initial period.

9. *Drug Information:* Analysis of the survey data revealed that 77% of the information sources of the sample were newspapers, films, television and friends, and only 21% obtained information from books and conferences. But in

the drug-experienced group, friends were the main information source (almost 83%), compared with 53.6% in the non-using group.

The respondents also indicated the subject areas they felt should be dealt with in programmes of drug information:

Psychological effects	59.8%
Clinical effects	45.4%
Toxicological aspects	31.7%
Descriptive monographs	18.9%
Legal information	13.7%

Generally, the response patterns to the above query were similar for both groups of respondents, although in the drug-using group a somewhat higher proportion were interested in legal information and facts on the psychological effects of the drugs.

CUESTIONARIO

NO MARQUE EN ESTE ESPACIO

* de Entrevista

Puntaje de muestra

9 10 11

A B C

1ra TARJETA

FECHA:

No. de Entrevista:

Entrevistador:

Hora de inicio de la Entrevista

..... A.M. P.M.

Visita	Fecha	Hora	Resultados
1			
2			
3			

INTRODUCCION

Buenos (días, tardes, noches) Pertenezco a un centro de estudios que está realizando una encuesta sobre la opinión de las personas acerca del uso de medicamentos, bebidas y sustancias. Nos interesaría mucho saber lo que usted piensa al respecto, para lo cual pedimos su cooperación. Su nombre y dirección no son de interés para el estudio y toda la información que usted nos proporcione será considerada en forma confidencial.

1. Casi todo el mundo emplea diferentes clases de drogas y medicamentos por varias razones a lo largo de su vida. Voy a leerle una lista de las razones por las cuales la gente toma medicinas, drogas o sustancias, para que usted me diga si las ha usado en algunos de estos casos: (Entr.: encierre en un círculo el número correspondiente. Marque una o más opciones).

a) Ha usado b) Nunca usado E (no sabe o no contesta). Esta opción no se le pregunta al entrevistado

1.1. Para curar o prevenir alguna enfermedad grave de cualquier tipo	12-1	2	3
1.2. Para aliviar un dolor de cabeza, espalda o muscular	5	6	7
1.3. Para calmar los nervios o aliviar la tensión nerviosa y sentirse tranquilo	9	0	X
1.4. Para no estar deprimido o quitarse lo triste	13-1	2	3
1.5. Para poder dormir	5	6	7
1.6. Para bajar o no subir de peso	9	0	X
1.7. Para quitarse el cansancio o proporcionar energía para «seguir trabajando»	14-1	2	3

2.1. Le voy a hacer algunas preguntas respecto a su opinión personal en relación al uso de sustancias o medicamentos.

Considera usted que en nuestro país el uso habitual de medicinas como por ejemplo: pastillas para dieta, pastillas para dormir, tranquilizantes, etc. sin receta médica o usadas en forma diferente a como la receta el médico: (marque abajo en 2.1, drogas legales).

	2.1. legal	2.2. ilegal	2.3. alcoholismo
1. es un problema muy grave	15-1	15-7	16-1
2. es un problema algo grave	2	8	2
3. es un problema insignificante	3	9	3
4. no es un problema	4	0	4
no sabe o no contesta	5	X	5
(no preguntar esta opción)			

2.2. Y en relación al uso de sustancias como: marihuana, peyote, cocaína, LSD, etc. piensa usted que en nuestro país: (marque la respuesta arriba en 2.2., drogas ilegales).

2.3. Y qué piensa usted acerca del alcoholismo? (marque la respuesta arriba en 2.3., alcoholismo).

3. Aquí hay una lista de medicamentos y sustancias con algunos ejemplos de cada uno. ¿Ha usado, tomado o probado alguno (s) de estos? (pregunte para cada diferente clase de droga)

(Encierre en un círculo la categoría que se señale «sí» usadas y encierre en un círculo también el nombre del medicamento usado, si no está en la lista anótelo a la derecha, y anote también para qué dijo la persona que lo usaba)

	Si	No	NO	
1. Analgésicos (para el dolor como: aspirina, mebolal, saridon, prodolol, optalidon, etc.)	17-1	2	3	.....
2. Hipnóticos (para dormir como: Dori-den, Noctec, etc.)	5	6	7	.....
3. Barbitúricos (como Seconal, Tuinal, Luminal, Nembutal, Amytal, Cyclopal, etc.)	9	0	X	.....
4. Otros Sedantes (mandrax, Qualude, Revonal etc.)	18-1	2	3	.....
5. Sedantes (tranquilizantes) como: Equanil, Apascil, Librium, Pacedrim, Valium etc.)	5	6	7	.....
6. Antipsicóticos (como: Largatil, Haldol, Artane etc.)	9	0	X	.....
7. Antidepresivos (como: Tofranil, Anatanil, Norpramin, Nardil etc.)	19-1	2	3	.....
8. Píldoras para dieta (como: Redotex, Preludin, etc.)	5	6	7	.....
9. Estimulantes (como: Cafeína, Benzodrina, Dexedrina, Aktedron, Ritalin, Captagón, Ionamin, Dexamil, etc.)	9	0	X	.....
10. Jarabes para la tos (Codeína como: Percodán Percobar, Hicodán, etc.)	20-1	2	3	.....
11. Opiáceos (morfina, Demerol, Sosisgón, etc.)	5	6	7	.....
12. Marihuana o Hashish	9	0	X	.....
13. Otros alucinógenos (Peyote, Mescalina, Hongos, Psicocibina)	21-1	2	3	.....
14. Solventes o inhalantes (pegamento: Flexo, Duco, Thinner, gasolina, resistol 5000)	5	6	7	.....
15. LSD	9	0	X	.....
16. Cocaína	22-1	2	3	.....
17. Heroína	5	6	7	.....

Marque de este lado el nombre del medicamento si no está en la lista y si no lo recuerda señálelo y apunte para lo que la persona dijo haberlo usado

INSTRUCCIONES:

Cada tipo de droga alguna vez usada en la pregunta 3, enciérrela en un círculo en la parte de arriba de las páginas 7 y 11 y pregunte la serie de preguntas de la 4 a la 13 acerca de cada tipo de droga encerrada en círculo.

Si en la pregunta 3 no usó ninguna droga pase a la pregunta 14, página 73.

[illegible]

4. Dice usted que ha usado (mencionar la droga encerrada en círculo), ¿La ha usado usado en los últimos 6 meses?	6 meses																		
1. Sí	22-1	28-1	34-1	(preg. 5)	40-1	46-1	52-1												
2. No	2	2	2	(preg. de sig. droga)	2	2	2												
- No sabe ó no contesta	3	3	3		3	3	3												
5. ¿En qué forma la ha utilizado? untada, fumada, inyectada, inhalada ó tomada? (marque una o varias)	Forma																		
1. Untada	5	5	5	(preg. sig. droga)	5	5	5												
2. Fumada	6	6	6		6	6	6												
3. Inyectada	7	7	7	(continua)	7	7	7												
4. Inhalada	8	8	8		8	8	8												
5. Tomada	9	9	9		9	9	9												
6. ¿La ha usado en los últimos 3 meses? (90 días)	3 meses																		
1. Sí	23-1	29-1	35-1	(preg. 7)	41-1	47-1	53-1												
2. No	2	2	2	(pase a preg. 9)	2	2	2												
- No sabe ó no contesta	3	3	3		3	3	3												
7. ¿La ha usado en el último mes? (30 días)	Ultimo mes																		
1. Sí	5	5	5	(preg. 8)	5	5	5												
2. No	6	6	6	(pase a preg. 9)	6	6	6												
- No sabe ó no contesta	7	7	7		7	7	7												
8. ¿Qué tan seguido las ha usado en el último mes? diariamente, de 3 a 5 veces por semana, 1 vez a la semana o menos de una vez a la semana?	Usada																		
1. Diariamente	24-1	30-1	36-1		42-1	48-1	54-1												
2. De 3 a veces por semana	2	2	2	(pase a preg. 10)	2	2	2												
3. 1 vez por semana o menos	3	3	3		3	3	3												
- No sabe ó no contesta	4	4	4		4	4	4												
9. ¿Ha usado alguna vez (mencione la droga encerrada en círculo) diariamente por un período de 1 semana?	Diariamente																		
1. Sí	6	6	6	(preg. 10)	6	6	6												
2. No	7	7	7	(preg. de sig. droga)	7	7	7												
- No sabe ó no contesta	8	8	8		8	8	8												
10. ¿Ha intentado dejar de tomarlas, pero volvió a tomarlas?	Intentado																		
1. Sí	25-1	31-1	37-1	(preg. 11)	43-1	49-1	55-1												
2. No	2	2	2	(pase a preg. 13)	2	2	2												
- No sabe ó no contesta	3	3	3		3	3	3												
<table> <tr> <td></td><td>12 * Marijuana Hashish</td><td>13 * Otros all genos</td><td>14 * Solvente Inhalante</td><td></td><td>15 LSD</td><td>16 * Cocaína</td><td>17 * Heroína</td><td></td><td></td></tr> </table>											12 * Marijuana Hashish	13 * Otros all genos	14 * Solvente Inhalante		15 LSD	16 * Cocaína	17 * Heroína		
	12 * Marijuana Hashish	13 * Otros all genos	14 * Solvente Inhalante		15 LSD	16 * Cocaína	17 * Heroína												
11. Cuando dejó de usarlas, tuvo molestias especiales?	Molestias																		
1. Sí	5	5	5		5	5	5												
2. No	6	6	6	(continue)	6	6	6												
- No sabe ó no contesta	7	7	7		7	7	7												
12. ¿Recibió usted ayuda de alguien para poder dejarlas? ¿de quién? ¿Médico, hospital, ayuda de tipo religioso, familiar o maestro, usted mismo?	Ayuda																		
1. Médico u hospital	26-1	32-1	38-1		44-1	50-1	56-1												
2. Ayuda religiosa	2	2	2		2	2	2												
3. Familiar o maestro	3	3	3	(continue)	3	3	3												
- Usted mismo	4	4	4		4	4	4												
- No sabe ó no contesta	5	5	5		5	5	5												
13. ¿A qué edad la empezó a usar?	Edad																		
1. Antes de los 14 años	27-1	33-1	39-1		45-1	51-1	57-1												
2. Entre los 14 y 17	2	2	2	(pregunte de la siguiente droga)	2	2	2												
3. Entre los 18 y 24	3	3	3		3	3	3												
4. Entre los 25 y 34	4	4	4		4	4	4												
5. Más de los 35	5	5	5		5	5	5												
- No sabe ó no contesta	6	6	6		6	6	6												

11. Cuando dejó de usarlas, tuvo molestias especiales?

Molestias

1. Sí	5	5	5	5	5	5
2. No	6	6	6	6	6	6
- No sabe ó no contesta	7	7	7	7	7	7

(continue)

12. ¿Recibió usted ayuda de alguien para poder dejarlas? ¿de quién? ¿Médico, hospital, ayuda de tipo religioso, familiar o maestro, usted mismo?

Ayuda

1. Médico u hospital	26-1	32-1	38-1	44-1	50-1	56-1
2. Ayuda religiosa	2	2	2	2	2	2
3. Familiar o maestro	3	3	3	3	3	3
- Usted mismo	4	4	4	4	4	4
- No sabe ó no contesta	5	5	5	5	5	5

(continue)

13. ¿A qué edad la empezó a usar?

Edad

1. Antes de los 14 años	27-1	33-1	39-1	45-1	51-1	57-1
2. Entre los 14 y 17	2	2	2	2	2	2
3. Entre los 18 y 24	3	3	3	3	3	3
4. Entre los 25 y 34	4	4	4	4	4	4
5. Más de los 35	5	5	5	5	5	5
- No sabe ó no contesta	6	6	6	6	6	6

(pregunte de la siguiente droga)

3a. TARJETA

Alcohol

14a. Durante el año pasado, tomó usted alguna bebida como tequila, mezcal, aguardiente, pulque, vino, cerveza, ron, whiskey, cognac, etc.?

Sí 12-1 (pase a la 15)

No, no contesta 7 (pregunte 14b)

14b. ¿Alguna vez en el pasado tomó bebidas alcohólicas?

Sí 4 (pregunte 14c)

No, no contesta 5 (pase a la ficha de identificación)

14c. ¿Cuándo usted tomaba bebidas alcohólicas, tomaba usted, regularmente ocasionalmente, o de vez en cuando?

Regularmente 7 (pregunte 14d)

Ocasionalmente 8

De vez en cuando 9 (pase a la ficha de identificación)

No está seguro, no contesta 0

14d. ¿Dejó usted de beber por tener un problema alcohólico, o pensó que podía tenerlo si seguía bebiendo?

Sí 13-1 (pregunte 14e)

No, no contesta 2 (pase a la 20 pág. 15)

14e. ¿Cuando dejó usted de beber, recibió usted ayuda para dejarla, por ejemplo: de Alcohólicos Anónimos, Doctor o un Hospital o no recibió ayuda?

Sí recibió 4

No recibió 5 (pase a 20)

No está seguro o no contesta 6

15a. ¿Qué tan seguido toma usted cualquier clase de bebida alcohólica?

3 o más veces al día 14-1

2 veces al día 2

1 vez al día 3

casi todos los días 4 (pregunta 16)

3 ó 4 veces a la semana 5

1 ó 2 veces a la semana 6

2 ó 3 veces al mes 7

más o menos una vez al mes 8

menos de 1 vez al mes, no está seguro, no contesta 9 (pase a la ficha de identificación)

16a. ¿Qué tan seguido toma usted vino ó pulque?

- 3 o más veces al día15-1
2 veces al día 2
1 vez al día 3
casi todos los días 4
3 ó 4 veces a la semana 5 (pregunte 16b)
1 ó 2 veces a la semana 6
2 ó 3 veces al mes 7
1 vez al mes 8
Menos de una vez al mes 9
menos de una vez al año 0 (pase a la 17a)
no, bebe vino, no está seguro, no contesta x

16b. Por favor piense acerca de todas las veces que haya tomado vino o pulque recientemente. ¿Qué tan seguido toma usted de 5 a 6 vasos al mismo tiempo?

- * 1 casi todo el tiempo 16-1
* 2 más de la mitad del tiempo 2 (pase a la 17a)
* 3 menos de la mitad del tiempo 3
* 4 una que otra vez 4 (pase a la 16c)
* 5 nunca, no está seguro o no contesta 5

16c. ¿Qué tan seguido toma usted 3 ó 4 vasos cuando toma vino o pulque?

- * 1 casi todo el tiempo 17-1
* 2 más de la mitad del tiempo 2 (pase a 17a)
* 3 menos de la mitad del tiempo 3
* 4 una que otra vez 4 (pregunta 16d)
* 5 nunca, no está seguro, no contesta 5

16d. ¿Qué tan seguido toma de 1 a 2 vasos de vino o pulque?

- * 1 casi todo el tiempo 18-1
* 2 más de la mitad del tiempo 2
* 3 menos de la mitad del tiempo 3
* 4 una que otra vez 4
* 5 nunca, no está seguro, no contesta 5

17a. ¿Qué tan seguido toma usted cerveza?

- 3 ó más veces al día 19-1
2 veces al día 2
1 vez al día 3
casi todos los días 4
3 ó 4 veces a la semana 5 (pase a 17b)
1 ó 2 veces a la semana 6
2 ó 3 veces al mes 7
1 vez al mes 8
menos de 1 vez al mes 9
menos de 1 vez al año 0 (pase a 18a)
no bebe cerveza, no está seguro, no contesta x

17b. Pensando en todas las veces que ha tomado cerveza recientemente, ¿Qué tan seguido toma usted de 5 a 6 botellas?

- * 1 casi todo el tiempo 20-1
* 2 más de la mitad del tiempo 2 (pase a la 18a)
* 3 menos de la mitad del tiempo 6
* 4 una que otra vez 4 (pase a 17c)
* 5 nunca, no está seguro, no contesta 5

17c. ¿Qué tan seguido toma usted de 3 a 4 botellas?

- * 1 casi todo el tiempo 7
* 2 más de la mitad del tiempo 8 (pase a 18a)
* 3 menos de la mitad del tiempo 9
* 4 una que otra vez 0 (pase a 17d)
* 5 nunca, no está seguro, no contesta x

17d. ¿Qué tan seguido toma usted de 1 a 2 botellas?

- * 1 casi todo el tiempo 21-1
* 2 más de la mitad del tiempo 2
* 3 menos de la mitad del tiempo 3
* 4 una que otra vez 4
* 5 nunca, no está seguro, no contesta 5

18a. ¿Qué tan seguido toma usted bebidas como whiskey, vodka, cognac, etc. ó cocktails que contengan este tipo de bebidas?

3 ó más veces al día	22-1	
1 vez al día	3	
2 veces al día	2	
casi todos los días	4	(pase a 18b)
3 ó 4 veces a la semana	5	
1 ó 2 veces a la semana	6	
2 ó 3 veces al mes	7	
1 vez al mes	8	
menos de 1 vez al mes	9	
menos de 1 vez al año	0	(pase a 19a)
no toma esta clase de bebidas, no está seguro, o no contesta	x	

18b. ¿Qué tan seguido ha tomado de 5 a 6 bebidas de este tipo?

* 1 casi todo el tiempo	23-1	
* 2 más de la mitad del tiempo	2	(pase a 19a)
* 3 menos de la mitad del tiempo	3	
* 4 una que otra vez	4	(pase a 18c)
* 5 nunca, no está seguro, o no contesta	5	

18c. ¿Qué tan seguido toma usted de 3 a 4 bebidas de este tipo?

* 1 casi todo el tiempo	7	
* 2 más de la mitad del tiempo	8	(pase a 19a)
* 3 menos de la mitad del tiempo	9	
* 4 una que otra vez	0	(pase a 18d)
* 5 nunca, no está seguro, o no contesta	x	

18d. ¿Qué tan seguido toma usted de 1 a 2 bebidas de este tipo?

* 1 casi todo el tiempo	24-1	
* 2 más de la mitad del tiempo	2	
* 3 menos de la mitad del tiempo	3	
* 4 una que otra vez	4	
* 5 nunca, no está seguro, o no contesta	5	

19a. ¿Qué tan seguido toma usted bebidas como mezcal, tequila, aguardiente, etc.?

3 ó más veces al día	25-1	
2 veces al día	2	
1 vez al día	3	
casi todos los días	4	(pase a 19b)
3 ó 4 veces a la semana	5	
1 ó 2 veces a la semana	6	
2 ó 3 veces al mes	7	
1 vez al mes	8	
menos de 1 vez al mes	9	
menos de 1 vez al año	9	(pase a 20)
no bebe tequila, etc., no está seguro, no contesta	x	

19b. Pensando en todas las veces que ha tomado tequila, mezcal, guardiente, recientemente. ¿Qué tan seguido toma usted de 5 a 6 bebidas de este tipo en una sola ocasión?

* 1 casi todo el tiempo	26-1	
* 2 más de la mitad del tiempo	2	(pase a 20)
* 3 menos de la mitad del tiempo	3	
* 4 una que otra vez	4	(pase a 19c)
..... nunca, no está seguro, no contesta	5	

19c. ¿Qué tan seguido toma usted de 3 a 4 bebidas de este tipo (mezcal, tequila, aguardiente) en una sola ocasión?

* 1 casi todo el tiempo	7	
* 2 más de la mitad del tiempo	8	(pase a 20)
* 3 menos de la mitad del tiempo	9	
* 4 una que otra vez	0	(pase a 19d)
..... nunca, no está seguro, no contesta	x	

19d. ¿Qué tan seguido toma usted de 1 a 2 bebidas de este tipo (mezcal, tequila, aguardiente) en una sola ocasión?

* 1 casi todo el tiempo	27-1	
* 2 más de la mitad del tiempo	2	
* 3 menos de la mitad del tiempo	3	
* 4 una que otra vez	4	
..... nunca, no está seguro, no contesta	5	

20. (Pregunte a todos los que sí toman). ¿Qué tipo de bebida toma usted más frecuentemente: vino o pulque, cerveza, whiskey, vodka, etc., tequila, mezcal, aguardiente?

vino o pulque 28-1
 cerveza 2
 whiskey, vodka, etc. 3
 tequila, mezcal o aguardiente 4

21. ¿Cuántas veces ha tenido usted problemas con su familia por tomar bebidas alcohólicas? más de 3 veces, 1 ó 2 veces, nunca?

1. más de 3 veces 29-1
 2. 1 ó 2 veces 2
 3. nunca 3
 no está seguro, no contesta 4

22. ¿Cuántas veces ha tenido usted problemas con la policía por beber? más de 3 veces, 1 ó 2 veces, nunca?

1. más de 3 veces 5
 2. 1 ó 2 veces 6
 3. nunca 7
 no está seguro, no contesta 8

23. ¿Cuántas veces ha tenido problemas ó ha faltado al trabajo (esceula) por beber? más de 3 veces, 1 ó 2 veces nunca?

1. más de 3 veces 9
 2. 1 ó 2 veces 0
 3. nunca x
 no está seguro, no contesta y

24. ¿Aproximadamente, a qué edad empezó a tomar?

1. antes de los 14 años 30-1
 2. entre los 14 y 17 2
 3. entre los 18 y 25 3
 4. entre los 26 y 34 4
 5. más de los 36 5
 no sabe, no contesta 6

25. Al tomar bebidas alcohólicas, busca usted la bebida: ó por el estado que le produce, por el sabor de una marca especial, porque sus amigos, familiares, etc. (socialmente) lo hacen?

1. estado que producen 8
 2. por el sabor 9
 3. socialmente 0
 4. todos los anteriores x
 no está seguro, no contesta y

Ficha de Identificación
 (Pregunte a Todos)

Ahora vamos a hacerle algunas preguntas para poder clasificar nuestros datos.

26a. ¿Es usted soltero, casado, separado, divorciado, viudo, unión libre?

Soltero 31-1
 Casado 2
 Separado 3
 Divorciado 4
 Viudo 5
 Unión libre 6

26b. ¿Vive usted solo?

Sí 8 (pase a 28)
 No 9 (continua)

27. ¿Quiénes son las otras personas que viven con usted? (marque todas las categorías apropiadas)

Esposo 32-1
 Hijos 2
 Amigos 3
 Padres 4
 Hermanos 5
 Otros parientes 6

28. ¿Quién es la persona que aporta la mayor parte del dinero a su casa? (cabeza de casa)

Entrevistado 7
 Otra persona 8

INSTRUCCION: Si el entrevistado es la cabeza de la casa, preguntar 29 y 30 sobre él; si otra persona es la cabeza de la casa, preguntar 29 y 30 de esta otra persona.

29. Usted (El ó Ella) (quien aporte la mayor parte del dinero) trabaja actualmente tiempo completo, 1/2 tiempo, no tiene trabajo o esta retirado? (sólo marcar 1 opción).

Tiempo completo 33-1
 1/2 tiempo 2 (preguntar la 30a)
 Sin trabajo 3
 Retirado 4 (pase a 30b)

- 30a. ¿Cuál es la ocupación de (usted) (la persona que aporta el dinero) marque abajo en 30a. (pase a 31).

- 30b. ¿Cuál fue la ocupación de usted (la persona que aporta el dinero) marque abajo en 30 b.

	30a	(jefe) y 30b
1. Profesionista, alto ejecutivo gran comerciante	34-1	35-1
2. Pequeño propietario (de tienda, almacén o vive de rentas)	2	2
3. Empleado (tiendas, almacenes, burócratas, etc.)	3	3
4. Técnico obrero calificado	4	4
5. Obrero no calificado, artesano, trabajo especializado, carpintero, operador de máquinas, costurera, plomero, mesero, vendedor, etc. Servicios públicos (taxista, policía, etc.)	5	5
6. Militares	6	6
7. Servicios domésticos (chófer, mozo, jardinero, sirviente)	7	7
8. Campesino	8	8
9. Nunca trabajó	9	9

INSTRUCCIONES: Si el entrevistado es el que aporta el dinero pase a la pregunta 34. Si no es el que aporta el dinero, preg. 31.

31. ¿Trabaja usted tiempo completo ó parte del tiempo actualmente?

Tiempo completo 38-1
 1/2 tiempo 2 (pase a la 33)
 Eventual 3
 No trabaja 4 (pregunta 32)

32. ¿Es usted: (sólo marque 1 opción).

Ama de casa 37-1
 Retirado 2
 Busca trabajo 3 (pase a la 34)
 Sin trabajo, pero no busca trabajo 4
 Estudiante 6

33. ¿Cuál es su ocupación?

1. Profesionista, alto ejecutivo, gran comerciante 38-1
 2. Pequeño propietario (de tienda, almacén o vive de rentas) 2
 3. Empleado (tiendas, almacenes, burócrata, etc.) 3
 4. Técnico, obrero calificado 4
 5. Obrero no calificado, artesano, trabajo especializado, carpintero, operador de máquinas, costurera, plomero, mesero, vendedor, etc. Servicios públicos (taxista, policía, etc.) 5
 6. Militares 6
 7. Servicios (chófer, mozo, jardinero, sirviente) 7
 8. Campesino 8

34. INSTRUCCIONES: Pregunta p. 34 sólo a personas de 23 años o menos. Otras pase a la pregunta 35a.

¿Eres un estudiante de tiempo completo actualmente?

Sí 39-1
 No 2

PRECUNTAR A TODOS:

- 35a. ¿Cuál de estas opciones se acerca más a su situación?

	Entrevistado	Jefe
Nunca ha ido a la escuela y no sabe leer ni escribir	40-1	41-1
Nunca ha ido a la escuela pero sabe leer y escribir	2	2
Primaria incompleta	3	3
Primaria completa	4	4
Secundaria incompleta	5	5
Secundaria completa	6	6
Estudios comerciales (secretaria, auxiliar administrativo, etc.)	7	7
Carreras técnicas	8	8
Preparatoria	9	9
Carrera Universitaria	0	0
Especialización y postgrado	x	x

35b. Cuál de estas opciones se acerca más a la situación del jefe de familia (el que aporta la mayor cantidad de dinero).
(MARQUE ARRIBA en 41 Jefe)

* Si el entrevistado es el jefe de familia marque en 40 y 41 en AMBOS.

36. ¿ Cuántos años tiene usted ?

	Hombre	Mujer
14-17	42-2	43-2
18-24	3	3
25-34	4	4
35-49	5	5
50 ó más	6	6

37. ¿ Qué religión tiene ?

Católica	44-1
Protestante	2
Judía	3
Otra	4
No tiene	5

38. ¿ Qué lugar ocupa usted respecto a sus hermanos ?

Unico	45-1
Primero	2
En medio	3
Ultimo	4

39. Aproximadamente ¿ cuál es el ingreso mensual de su familia ?

\$	
1. Menos da \$ 1,250.00	48-1
2. De 1,250 a 2,499	2
3. De 2,500 a 4,99	3
4. De 3,000 a 9,999	4
5. Da 10,000 a más	5
..... Se niega	6
..... No está seguro	7

A

B

C

40. ¿ Cuántas personas dependen de este ingreso ?

1. de 1 a 3	47-1
2. de 4 a 6	2
3. de 7 a 10	3
4. más de 10	4

41. ¿ A qué grupo pertenece usted ?

Nació en una ciudad y ha vivido toda su vida en ella	48-1
emigró a la ciudad	2
Otros	3

42. ¿ Reside actualmente en su lugar de origen ?

Sí	5
No	6

43. Es usted:

Mexicano de nacimiento	8
Mexicano por nacionalización	9
Extranjero residente en México	0

INSTRUCCIONES: Sólo anote, *no pregunte*:

44. Nivel Socioeconómico de acuerdo al ingreso familiar (preg. 39).

A	49-1	bajo (de menos de \$ 1000.00 a \$ 2,499.00)
B	2	medio (de \$ 2,500.00 a \$ 4,999.00)
C	3	medio alto (de \$ 5,000.00 a \$ 9,999.00)
D	4	alto (\$ 10,000 ó más)

Colonias o zonas

Servicios Públicos	Sí	No	Equipo	Sí	No	Via de acceso	Sí	No
Agua			teléfono			autos		
Drenaje			telégrafo			camiones		
Luz			comercio			trenes		
Pavimento			(tiendas, mercado)			metro		
			escuelas					
			1/2 de espacimient					
			areas verdes					

45. Colonia o Zona urbanizada 50-1
(tiene todos los servicios)

Colonia o Zona semi-urbanizada 2
(carece de alguno de los servicios anteriores)

Colonia o Zona no urbanizada 3
(carece de todos o casi todos los servicios anteriores)

Colonia o Zona Residencial	Colonia o Zona Popular	Colonia o Zona de Paracaidista
5 <ul style="list-style-type: none"> — Localizada en mejores zonas urbanas. — Eficientes vías de acceso y equipamiento necesario, ahí mismo o próximo. — Col. bien planeada viviendas proyectadas y construidas por técnicos. — Ostentosas mansiones. — Buenos depts. o condominios. — Habitantes de nivel económico alto o medio alto. 	<ul style="list-style-type: none"> — Localizada en zonas menos buenas de la ciudad. — Generalmente el equipamiento y vías de acceso son deficientes en cantidad y/o calidad. — No hay buena planeación urbanística. — La vivienda no es adecuada a las necesidades de sus habitantes, en condiciones de habitabilidad e higiene. 	8 <ul style="list-style-type: none"> — Los habitantes se han apoderado del terreno. — Localizada en la periferia de la ciudad. — Al margen de la ley. — No urbanizada o sólo en parte. — Carencia o escasez de equipamiento o vías de acceso. — Vivienda de carácter semi-permanente. — Construida con material de desecho y sin dirección técnica. — Habitantes provenientes del campo de trabajo eventual y nivel económico muy bajo.

Antigua	Nueva
6 <ul style="list-style-type: none"> — Construcciones suntuosas en su época y ahora ruinosas — Con alta densidad de población (ej. vecindad) 	7 <ul style="list-style-type: none"> — nacida en fraccionamientos — construida paulatinamente por prácticos de la construcción bajo la dirección del propietario — habitantes del nivel económico bajo y medio bajo

VIVIENDA.

<i>Cuarto solo</i> material de desecho (piedra, cartón, madera, paríma) carencia de todos o algunos de los servicios (agua y/o drenaje y/o luz dentro de la vivienda)	51-1
<i>Casa sola propia o rentada o se está pagando</i> — construida de tabique, concreto cemento — sin acabado perfecto — más de dos cuartos — con servicios de agua, drenaje y luz dentro de la vivienda, aunque deficientes	2
<i>Casa sola propia o rentada o se está pagando</i> — construida con material de primera — con acabado perfecto — de 1 o más pisos — habitación completa (sala, recámaras, comedor, baños, patio, cocina, etc.) — con todos los servicios eficientes dentro de la vivienda	3
<i>Vecindades</i> — construidas con material de primera, pero en condiciones de deterioro — con servicios dentro de la vivienda y/o comunes como agua y W.C.	4
<i>Departamento</i> — con material de primera — con acabado sencillo — más de 3 cuartos — con todos los servicios	5
<i>Departamento o condominio de lujo</i>	6

OBSERVACIONES DEL ENTREVISTADOR:

.....

.....

.....

.....

.....

.....

.....

.....

Tiempo de duración de la entrevista

minutos

Uso de la oficina

52- 53- 54-

Hora en que terminó la entrevista:

Validado por:

Día, 1974.

APPENDIX II

TECNICA PARA LA DETERMINATION
DEL MUESTEREO (MEXICO)

En base a los datos que resultaron de la muestra piloto se determinó lo siguiente:

El objetivo fundamental es estimar la proporción de personas que han tomado drogas en cada uno de 3 niveles (estratos) económicos datos por: 1. Ingresos menores de \$2,500, 2. Ingresos entre \$2,500 y \$10,000 y 3. Ingresos mayores de \$10,000.

Si se toma p como estimador su varianza será $p(1-p)$

donde P es la proporción de drogadicción en cada estrato (se toma como base los valores de P dados por la prueba piloto). Entonces C.V. $(p) = \frac{1}{n} \frac{p(1-p)}{1-p^2}$

$\frac{P}{n} \frac{1}{p} (C.V.)$

Como para el estrato de alto nivel económico y para las drogas de mayor importancia para CEMEF, el valor de P más bajo es de 0.22, el uso de la fórmula anterior arroja una n de 544. Este tamaño produce C.V. menores del .30 (30%) para drogas con mayor valor de P en ese estrato alto.

Para los estratos medio y bajo los valores mínimos de p en las drogas importantes para CEMEF son del orden de 0.01. Entonces con base en esa $p = 0.01$ la fórmula anterior produce: $n = 1100$.

Luego los tamaños de muestras recomendados son:

<i>Nivel</i>	<i>n</i>
alto	544
medio	1100
bajo	1100

Debido a que las proporciones observadas por lo general son muy bajas del orden 0.02 a 0.008 (para algunas drogas no se detectó su uso en estratos medio y bajo) se considera que la aproximación a la distribución normal del estimador p de las proporciones no es del todo adecuada. Entonces se basa la determinación del tamaño de muestra en el coeficiente de variación del estimador (C.V.) (desviación estandar entre media) que nos da una idea del grado de variación que tendrán los valores estimados p alrededor del valor verdadero de la proporción P de gentes drogadictas en cada nivel.

En los casos de proporciones pequeñas, Deming en pa. 114 de su libro "Some Theory of Sampling" recomienda C.V. de 30% (.30 en tanto por uno) ya que si hay errores de esa magnitud o de 3 veces esa magnitud las consecuencias prácticas serán las mismas; esto es; si $p = 0.01$, el 30% será 0.033 o sea la desviación estandar de p es de 0.0033, un error de 3 veces la desviación estandar nos conducirá a estimar el valor real de 0.01 como 0.00 o 0.02. Sin embargo, desde un punto de vista práctico indica una "baja" proporción de drogadicción. Debido a esto se tomó 0.30 como valor máximo para el C.V. de los estimadores de las proporciones dentro de cada estrato.

QUESTIONNAIRE¹

(To be turned in at entrance)

1. Age: (in years)
2. Sex: male ☐
female ☐
3. Course of studies:
 - classical ☐
 - scientific ☐
 - technical institutes ☐
 - others ☐
 - what faculty do you attend?
 - in what year?
 - are you involved solely in scholastic activity?
 - are you a working student?
4. (a) Beyond those areas related to your faculty, are you interested in:
 - Sociology ☐
 - Psychology ☐
 - Other ☐
4. (b) What is your relationship to authority (family, school?) ☐
 - accept ☐
 - tolerate ☐
 - reject ☐

¹ From: Andreoli, V.; Giannelli, A.; Morselli, P. Rilievo epidemiologico del consumo di sostanze stupefacenti in un 'microambiente' mediante uso di questionario. *Droga e Società Italiana*. Giuffrè Editore, Milano, 1974.

5. From what information sources do you obtain knowledge about drugs?

Books Which?

Newspapers Which?

Meetings and conferences

Films

Radio

Television

Information from friends:

	yes	no	don't know
who have experimented with drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
who have not experimented with drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. At what moment, in what state of mind did you think about or wish to try drugs?

7. Have you had experience with drugs? YES NO

If not, were they offered to you? YES NO

Do you know friends who use them? YES NO

Did you ever want to use them? YES NO

If you have used them, how did your first experience come about?

It was offered by friends YES NO

You tried it in a group YES NO

You acquired it yourself YES NO

Which drug did you use in your first experience?

Marijuana ☐

Amphetamine ☐ oral ☐ injection ☐

LSD ☐

Opiates ☐

Cocaine ☐

8. Why did you use drugs?

Curiosity ☐

Better self-knowledge ☐

Lack of security ☐

Escape from reality ☐

To test the effects ☐

To search for artistic creativity ☐

To increase sexual capacity ☐

To be part of the group ☐

Are you still using drugs?

No ☐

Yes ☐ Sometimes ☐ Often ☐

Habitually ☐

What drugs are you presently using?

Marijuana ☐

Hashish ☐

Amphetamine ☐

LSD ☐

Opiates ☐

Cocaine ☐

9. What motivated you to reject the drug experience?

10. Why do you think people use drugs?

Family crisis ☐

Curiosity ☐

Within the framework of youthful rebellion in a world they consider absurd ☐

Desire to imitate the others ☐

An attempt to dispell distress and depression (pharmaceutical purposes) ☐

Group phenomenon ☐

Don't know dangers of drug use ☐

Means of exploring one's own psychological world ☐

Other ☐

11. What type of information would you like to have about drugs?

toxicological ☐

clinical effects ☐

psychological effects ☐

descriptive monographs on drug users ☐

legal information ☐

CONTINUED

1 OF 3

12. Do you think lack of sexual satisfaction (at the instinctive level) is an influence to use drugs?
-
13. Do you think that the lack of "success" in interpersonal relationships at the sexual level can be an influence to use drugs?
-
14. Do you consider your sexual impulses to be:
- normal ☐
- inadequate ☐
- excessive ☐
15. What do you think is the reaction of drugs on sexual activity?
- depressant ☐
- stimulating ☐
- no effect ☐
16. Sexual experiences already tried:
- masturbation at age of
- "petting" at age of
- coitus at age of
- homosexual experience at age of
17. Which sexual experience gives you most satisfaction?
- masturbation ☐
- "petting" ☐
- coitus ☐
18. Do you use alcoholic beverages?
- periodically ☐
- habitually ☐
- occasionally ☐
19. In what quantity and what type?
- wine litres
- liquor with less than 20% alcohol ml.
- liquor with more than 20% alcohol ml.

CHAPTER THREE

ATTITUDINAL STUDIES *

The degree to which any public programme can achieve its purposes is dependent on the attitudes both of those who construct and implement the programme and of those for whose benefit it was designed. This is as true for drug abuse programmes as for other public health measures. An understanding of these attitudinal factors is, then, a *sine qua non* for effectiveness.

The UNSDRI country study programme proposed that attitudes be examined at two levels: first, the attitudes held by individuals whose opinions, knowledge, experience and rôles place them in a position of importance *vis à vis* the formulation and implementation of drug-related policies and programmes; secondly, the public, or specific groups within the larger public, whose attitudes will determine acceptance or rejection of the programme objectives.

In this perspective, it is obvious that research into both of these sets of attitudes is a valuable tool in establishing:

1) the prevailing attitudes of the public at large, or particular groups within the population, who are likely to have a positive or negative impact on the viability of a programme;

* Throughout this chapter, it will be evident that the term 'attitudes' is used in the broadest sense, i.e., to encompass also opinions and perceptions about drug use and drug users.

2) the opinions and attitudes of those who influence policies and programmes in as much as these help to explain why some programmes work and other do not.

The studies which are described and reviewed in this chapter direct inquiry at both sets of attitudes. In some cases, the investigations focus on attitudes towards drugs and drug use, in other on drug users themselves. The insights gained by studies of this type have a number of applications. Information about attitudes towards drug use and drug users can provide a valuable guide in designing programmes of prevention, in identifying particular population groups at risk to harmful drug use, or in determining the degree to which a particular programme has succeeded or failed in modifying attitudes. In the field of treatment, insights may be gained into why drug users reject or accept the programmes offered to them. And, finally, such studies can occasionally provide glimpses into the extremely complex world of motivations, revealing something of the dynamic underlying both drug use and the reactions of societies to this form of conduct.

Puerto Rico

In the summer of 1975, an attitudinal study was conducted in Puerto Rico for the Department of Addiction Services¹. The focus of the survey research was opinions held by the public towards marijuana. The investigation was directed to a sample of the population 15 years of age and older. A total of 600 households were selected on the basis of statistical probability and one person in

¹ Stanford Klapper Associates, Inc., for Department of Addiction Services, *Estudio sobre las opiniones hacia la marihuana en Puerto Rico*, October 1975.

each household was selected randomly for interviewing. The major characteristics of the sample of 600 were:

Area

Metropolitan San Juan	32.8%
Other Urban centres	30.2
Rural areas	37.0

Sex

Male	49.8%
Female	50.2

Age

15-14 years	27.3%
25-34 »	20.7
35-49 »	21.7
50 or older	30.3

Occupation

Housewife	33.8%
Student	17.5
Employed	29.8
Pensioner/unemployed/retired	18.8

Education

Elementary or less	43.0%
All or some high school	37.3
Graduate or some university	19.7

Annual Family Income

Less than \$ 3,000 (US)	33.2%
\$ 3,000 to \$ 4,999	34.5
\$ 5,000 to \$ 7,499	15.0
\$ 7,500 or more	17.3

In summary, the survey attempted to discover attitudes as reflected in answers to a number of general questions, which might be stated as follows.

What is marijuana and what should be done with those who use it?

Who uses marijuana?

Of marijuana, tobacco and alcohol, which affects the community most?

Of marijuana, tobacco and alcohol, which affects the individual most?

Of marijuana, tobacco and alcohol, which affects the community least?

Of marijuana, tobacco and alcohol, which affects the individual least?

How should the use of marijuana be controlled?

Analysis of the responses to the first question (what is marijuana and what should be done with those who use it) show a clear division of opinion in the largest response categories.

TABLE 15: WHAT IS MARIJUANA AND WHAT SHOULD BE DONE WITH THOSE WHO USE IT?

Marijuana is a drug	Use should be considered a crime	Users should be imprisoned	%
X	X	X	24
X	X	0	14
X	0	X	13
X	0	0	39
0	X	X	—
0	X	0	—
0	0	X	1
0	0	0	8

Except in the age category over 50 years, responses were remarkably uniform regarding the question of who uses marijuana. Eighty-nine percent of the males and 92% of the females agreed that marijuana users are usually males. By age groupings, other responses were:

Who uses marijuana?

	AGES			
	15-24 %	24-34 %	35-49 %	50+ %
Adolescents	54	55	55	60
Young adults	40	40	37	32
Adults	2	4	5	4

In addition, almost three quarters of the respondents believed that marijuana use was most prevalent in the poorer and middle classes. A very large proportion (78%) thought that marijuana users also used related substances.

The survey also sought information regarding views about possible damages arising from the use of marijuana, alcohol or tobacco. The perceived dangers were identified as having more or less impact on the individual or on the community. The following is a summary of the most significant opinions expressed by the respondents.

A significant majority (69%) were of the opinion that marijuana use had the greatest effect on the individual, compared to the use of alcohol (22%) and cigarettes (7%). It is noteworthy, however, that in the age group 15 to 24, only 57% had this opinion and 37% felt that consumption of alcohol had a greater effect on the individual.

Some of the significant reasons cited for the perception of marijuana as the drug that has a greater effect on the individual than alcohol or cigarettes were: health danger

(28%); mental health hazards, reduction of capacity to think clearly (26%); it is habit-forming, leads to the use of stronger drugs (20%); causes brain damage and affects the nervous system (15%).

In response to another set of questions, 74% felt that among the three drugs, marijuana also had the greatest effect on the community. Only 22% felt alcohol had a greater effect, although 37% of the residents of Metropolitan San Juan and 33% of the age group 15 to 24 shared this belief.

Those who felt that marijuana affected the community more than the other substances gave as reasons: leads to crime committed in order to obtain money to buy it (46%); creates special conflict, destroys the community, corrupts the citizens (16%); people lose their reason, go crazy and are dangerous (15%).

In considering what should be done to control marijuana use, 31% of the sample favoured heavy punishment for traffickers and a smaller number favoured such preventive methods as education, orientation of youth and the community and more recreational facilities.

It is worth noting that this opinion survey coupled with another set of questions investigating the impact of a television message *. By using the single population sample and single interview, considerable economies were possible.

Mexico

The composite study reported here¹ is a study of opinions and attitudes in two populations in order to explore the existing phenomenon preliminary to conducting

* Cf. Chapter 4.

¹ Romero, A.L.; Jacobo, R.L., *Reporte Preliminar de la investigación social sobre la epidemiología del fenómeno de la farmacodependencia en el distrito federal*, Centro Mexicano de Estudios en Farmacodependencia y el Instituto Mexicano de Estudios Sociales A.C., 1974.

more profound epidemiological studies. The premise underlying the study was that before attempting to determine the prevalence and incidence of drug abuse in the Federal District (i.e., Mexico City), and lacking scientifically reliable data about the possible characteristics of the phenomenon, a study of prevailing attitudes among a sample population of the public and of opinions held by 'qualified informants' would assist in planning deeper research.

More specifically, the goals of the project were:

1. To verify qualitatively the existence of a social awareness of drug abuse;
2. To confirm the characteristics of drug abuse, the types of drug in use and the significant geographic areas where the phenomenon existed;
3. To obtain reference data on the forms and situations in which drug use occurs;
4. To delineate the social groups most at risk to drug use as well as the key social factors which favoured an increase in use;
5. To identify the possible existence of human and institutional resources as well as the socio-cultural potential for participation in programmes of prevention, rehabilitation or general support in programmes against drug abuse;
6. To measure the level of awareness and potential of the families in the various areas studied;
7. To determine the degree of participation of the authorities.

The Samples

For the larger sample drawn from among the public (but not representative of the population of the Federal

District), 142 married adults were selected and 137 unmarried young persons between the ages of 12 and 25.

Two criteria determined the selection of interviewees: the level of family income and the age of the urban area in which they resided. Family income levels were determined on the basis of demographic maps identifying socio-economic strata.

TABLE 16: INCOME CLASSIFICATIONS

Stratum	Monthly Income	
	Pesos	Dollars (U.S.)
Marginal	0 - 1,249	0 - 100
Working Class	1,250 - 3,499	100 - 290
Middle Class	3,500 - 9,999	290 - 835
Upper Class	10,000 +	835 +

The areas selected for the survey were also classified by determined criteria, as follows:

<i>Areas of Residence</i>	<i>Age of Area</i>
Old	Before 1910
Modern	1910 to 1950
New	after 1950

On these sets of criteria, 12 areas were selected for the survey, representing each of the four socio-economic

strata in each of the three types of zones. Streets in individual zones were selected randomly and individual houses chosen by external appearance which met the pre-established criteria.

The sample of qualified informants was comprised of 75 persons associated with various institutions located in the 12 zones referred to above. Forty of these persons were in positions of responsibility in the institutions, the remaining 35 in subordinate positions. The institutions included health centres, religious and educational institutions, police stations, courts, public offices and social centres.

Instruments

For the larger group, two questionnaires were designed, one for the married adult group, another for the unmarried youth. The questionnaires sought information about the personal characteristics of the respondents, their mobility and living conditions, family structure and inter-relationships, their perceptions of the drug abuse phenomenon and their knowledge of pharmaceutical products.

For the group of 75 qualified observers, an interview guide was designed to elicit information about the general characteristics of the respondents and the institutions, their general perceptions of drug abuse, their knowledge of the surrounding zone, their awareness of existing attitudes towards drug users, their own attitudes and those of the institution towards drugs and, finally, their level of interest and the solutions they offered for prevention and rehabilitation.

Both types of instruments were tested.

The questionnaires were pre-tested in zones identical to those to be used in the survey. The interview guide

was tested on persons meeting the criteria for the sample by teams of four interviewers, one of whom conducted the interview while the other three observed. Subsequent discussions among members of the team developed the themes that should be stressed and the most effective methods of conducting the interviews.

Data Collection

Although the general experience of the interviewers was satisfactory, some difficulties were encountered which are worth noting.

Among the qualified informants, interviews were refused at two health centres ("director never granted any type of interview") and a municipal office ("no one was authorized to answer these types of questions").

In the case of the population living in the selected zone, interviewing difficulties were largely confined to upper class families. Interviewers reported difficulty in talking with the respondents, except through servants, there was suspicion of strangers, a lack of time and little interest in cooperating. In some cases where interviews were granted, respondents carefully selected the questions to which they wished to respond and did not reply to others. These difficulties were not encountered in interviewing at the lower economic levels.

Some Characteristics of the Youth and Adults Sampled

In the adult sample, 53% of the respondents were female, 47% male. In the youth sample, 47% were female, 53% male. Some other characteristics of the samples are shown in Tables 17, 18 and 19.

TABLE 17: AGE DISTRIBUTION

Adult Sample	%
Under 20 years	1
20 - 24	7
25 - 29	18
30 - 34	10
35 - 39	13
40 - 44	9
45 or over	42

Youth Sample	%
12 - 14 years	19
15 - 17	43
18 - 21	26
22 - 25	12

TABLE 18: OCCUPATIONAL BREAKDOWN
(Adult Sample)

Occupation	Males %	Females %
Craftsman	12	3
Worker	9	—
Employer	16	8
Services	6	3
Tradesmen	10	3
Professional	21	7
Other	10	5
Doesn't work	15	72

TABLE 19: MONTHLY FAMILY INCOME OF RESPONDENTS

	Youths %	Adults %
Marginal	25	25
Working Class	26	28
Middle Class	25	23
Upper Class	25	23

Area of Residence

To determine the representativeness of the sample in relation to the areas in which they lived, the survey determined that 68% of the youths and 65% of the adults had lived 10 years or more in the zone. Another determinant was the way in which they related to the other residents in their neighbourhoods. In this respect, the survey revealed that 92% of the youth sample and 87% of the adults considered their relations normal, good or very good.

TABLE 20: EDUCATIONAL ACHIEVEMENT
(Adult Sample)

	Youths %	Adults %
No education	8	—
Incomplete primary	13	30
Complete primary	36	16
Secondary or equivalent	25	25
College and university	17	26

In the youth sample, 58% were currently in school.

Occupation

Of the youth sample, 71% were not employed, although it must be kept in mind that 58% were in school. The remaining 29% were employed in a variety of occupations. The occupations of the fathers of this group were categorized as follows:

	%
Craftsman	2
Worker	11
Employee	15
Services	9
Tradesman	15
Professional	23
Other	13
Doesn't work	8
No information	4

Family inter-relationships:

As noted earlier, one of the hoped-for products of the survey was the gaining of some insights into those groups or areas where the risk to drug use might be detected. It was hypothesized that one indicator of this might be inter-familial relationships. The data in Table 21 and Table 22 indicate, for example, a relatively low rate of failure to relate between parents and children.

An attempt was made to probe the quality of communication in the family by enquiring about how certain themes were discussed. In general, both groups felt that important themes were discussed amicably, although a

TABLE 21: HOW THE INTERVIEWEE RELATES TO OTHERS (YOUTHS)
(Percentages)

	Very well	Well, but could improve	Poorly	No information	Not applicable
Father	52	32	7	1	9
Mother	63	35	1	0	2
Brothers	34	45	10	1	11
Sisters	40	40	6	1	13
Relatives	31	50	18	1	1
Friends	57	41	2	0	0
Workmates	18	9	2	1	70
Schoolmates	42	31	1	1	26
Teachers	26	39	9	0	26
Neighbours	27	42	27	4	0

significant proportion of the youths (57%) admitted that sexual themes were not discussed with the father. In general, more friendly discussion of the themes was held with the mother than with the father.

Areas of family conflict were also investigated. Among the youths, 42% said their parents quarrelled and 39% said they had had strong disagreements with one of their parents, a statement agreed to by 34% of the parents interviewed.

The youth sample was asked about their perception of mothers and fathers. More than 70% said their mother was affectionate and understanding, while a somewhat smaller percentage viewed their fathers in the same way. A similar relationship was indicated between the spouses.

Among the youth, 92% reported that their family was a happy one, a view shared by 85% of the adults. Seventy-

TABLE 22: HOW THE INTERVIEWEE RELATES TO OTHERS (ADULTS)
(Percentages)

	Very well	Well, but could improve	Poorly	No * information
Father	26	12	7	55
Mother	38	15	7	39
Spouse's Relatives . .	39	32	19	11
Your own relatives . .	45	35	12	8
Spouse	57	24	4	14
Children	70	13	1	15
Friends	58	25	10	7
Workmates	32	21	4	43
Neighbours	46	31	16	7

* Includes cases without parents, children, etc.

four percent of the youths and 65% of the adults said that parents and children resolved problems together.

In Table 23 appear the responses of both groups to what they believe to be the predominant problems in the average Mexican family. Views do not differ significantly.

Social Perceptions of Drug Dependence

As noted earlier, the Mexican study was designed to provide some insights into how a sample population considered drug use, drug users and other aspects of the

TABLE 23: RELATIONSHIP WITHIN THE MEXICAN FAMILY IN THE OPINION OF THE INTERVIEWEES
(Percentages)

	YOUTHS					ADULTS			
	This is frequently the case	This is seldom the case	This is not the case	No information		This is frequently the case	This is seldom the case	This is not the case	No information
Problems between husband and wife	63	31	5	1		65	25	3	6
Parents do not know what their children think	68	29	3	1		71	15	7	7
Children do not understand their parents	55	36	6	4		60	25	6	8
Children do not confide in their parents	53	38	8	1		63	23	8	6

phenomenon. The authors of the study point out the difficulties encountered in this project, chiefly at the level of comprehension. For example, there was some confusion regarding what constitutes a drug. Many respondents did not include pharmaceutical products in this category, nor did most of them include alcohol. However, there was general agreement among both youth and adults that, in order of importance, drug addiction presented an escape or way out of problems, was a vice that was dangerous to health and that certain substances caused dependence.

Opinions regarding drug users and the effects of drug use ranged widely, as evidenced in Table 24. It is noteworthy, however, that three-quarters of both groups believed that drug users had deformed children and almost all of both groups believed that drug use caused mental imbalance. In relatively few opinions was there a significant difference between the two groups.

In response to questions about the characteristics of drug users, there was similar uniform opinion. The majority of both groups regarded drug users as sick, rebellious and dangerous persons, although a larger proportion of the youth sample (43%) tended to view users as being sociable persons, compared to only 30% in the adult sample (see Table 25).

The survey also attempted to determine how the respondents believed others would view drug use, particularly those in their own immediate environment. In Table 26 are presented the responses of the youth sample to this area of investigation. It is of interest that the youths believed that rejection of drug use would be lowest among their peer group outside the family, i.e., among friends, school mates or work companions.

This point was reinforced in another opinion of the youth sample regarding the attitudes of various persons if the respondent himself were to use drugs. While most

TABLE 24: OPINIONS ON SOME STATEMENTS REGARDING DRUG USE
(Percentages)

	YOUTHS			ADULTS		
	True	False	Don't know	True	False	Don't know
Drug users have more imagination and creative power	45	48	7	39	52	9
Drug users have deformed children	74	18	9	76	18	6
Drug users have more possibilities of communicating and making friends	26	71	4	27	69	4
Drugs are used by persons fearful of facing problems	81	18	1	83	12	4
Drugs are less dangerous than alcohol	14	79	7	10	81	8
The majority of drug users have homosexual problems	50	40	10	46	32	22
Drug users come to know themselves better	34	60	7	28	60	11
Drugs cause mental imbalance . .	93	5	2	94	2	4
Drugs increase sexual capacity . .	33	56	12	34	44	22

TABLE 25: OPINIONS ABOUT DRUG USERS
(Percentages)

	YOUTHS			ADULTS		
	Yes	No	No Information	Yes	No	No Information
<i>They are:</i>						
sociable	43	49	7	30	61	8
sick	66	29	4	77	20	3
very religious	19	71	10	21	65	14
rebels	78	21	1	84	13	3
dangerous	62	34	4	79	19	2
sincere with themselves	31	57	11	21	66	13

TABLE 26: WHEN SPEAKING ABOUT DRUGS WHAT WOULD BE THE ATTITUDE OF THE FOLLOWING PERSONS?
(Percentages)

	Would accept it totally	Would accept it more than reject	Would reject it more than accept	Would reject totally	No information
Father	1	1	6	69	23
Mother	1	0	3	83	13
Brothers/Sisters	2	2	13	66	17
Friends	11	18	21	42	8
Work or School mates	11	18	16	34	21
Doctor	7	6	7	38	43
Neighbours	2	8	11	45	34

felt that their drug use would not be accepted by members of the family or neighbours, 51% felt that it would be accepted to some degree by friends, and 39% by work or school companions.

Somewhat more ambivalence was demonstrated when both groups were asked what their attitude would be if a member of the family were a drug user. It can be noted in Table 27 that the adult group demonstrated considerably more tolerance of such a situation than the youth group.

TABLE 27: WHAT WOULD BE THE INTERVIEWEE'S ATTITUDE IF A MEMBER OF HIS FAMILY USED DRUGS?
(Percentages)

	YOUTHS (N=137)	ADULTS (N=142)
Would accept it totally	15	20
Would accept it with reserve	20	29
Would be indifferent	8	3
Would feel embarrassed	23	14
Would reject it totally	29	32
No information	6	2

Advancing beyond the area of opinions of others, the survey then asked about the situations in which the respondent himself would use drugs. The answers of both groups are tabulated in Table 28. On analysis it becomes

TABLE 28: CASES IN WHICH THE INTERVIEWEE WOULD ACCEPT THE USE OF DRUGS
(Percentages)

	YOUTHS			ADULTS		
	Yes	No	Don't know	Yes	No	Don't know
To have a new experience . . .	44	56	1	18	81	1
To have fun	23	76	1	8	91	1
To forget problems	18	81	1	8	91	1
When the person knows how to use them	35	63	2	22	76	2
On doctor's prescription	79	20	1	74	22	4

evident that the younger sample might be less resistant to experimentation than the adult sample.

In both samples a quite large proportion of the respondents had heard of most of the substances mentioned by the interviewers. Opinions about the damage caused by the use of these drugs demonstrated considerably less information on the part of both groups, as shown in Table 29.

The authors of this study also felt it important to discover the sources from which the respondents obtained information about drugs. They therefore asked both samples about persons they knew who had used drugs. The results are reported in Table 30. If these findings are related to the data reported in Table 31, it becomes evident that the youth group encountered many more persons — particularly friends — who had used drugs than had the adult group.

Respondents were also asked about their own drug use. In the youth sample, 22% said they had tried some drug and another 10% said they would like to do so. Fourteen percent of the total youth sample said they had experimented between the ages of 15 and 18 years. In the adult sample, 10% said they had experimented and another 7% said they would like to. In both groups the drugs predominantly used were marijuana and sleeping pills.

The significance of these findings is greatly limited, however, by the small size and unrepresentativeness of the sample, and so generalizations from them are not justified.

Both groups were also asked about their use of pharmaceutical products. Approximately one-fifth of the youth and two-fifths of the adults had used these substances, but in most cases on the advice of a physician.

Views of the respondents about the diffusion of drugs in Mexico were also solicited. While these perceptions might not reflect reality, the authors felt it useful to discover

TABLE 29: OPINIONS ON DAMAGE TO HEALTH CAUSED BY THE FOLLOWING SUBSTANCES
(Percentages)

	Always harmful		Harmful if taken in excess		Harmless		Do not know		No information		Not applicable	
	Adults	Youths	Adults	Youths	Adults	Youths	Adults	Youths	Adults	Youths	Adults	Youths
Sleeping pills	18	12	69	74	2	3	4	5	1	2	6	4
Tranquilizers	13	13	64	70	8	4	7	4	1	1	7	7
Stimulants	26	29	39	35	2	1	9	6	0	3	24	27
Acetone	32	29	17	32	1	3	20	17	0	0	30	19
Cement	70	63	21	30	0	1	3	2	0	1	6	3
Thinner	65	61	23	33	4	0	4	2	0	1	5	3
Glue	59	50	20	29	0	2	5	5	0	1	15	12
Marijuana	62	54	31	34	1	7	3	2	1	1	1	2
LSD	52	56	10	16	1	0	12	4	0	4	25	20
Mushrooms	49	45	15	21	2	2	16	9	2	4	17	19
Peyote	17	18	9	11	1	3	15	11	0	8	57	49
Morphine	59	53	19	17	1	0	9	4	0	5	12	21
Cocaine	58	56	19	24	1	2	8	5	0	1	13	12
Alcohol	23	22	72	71	3	2	1	1	1	2	0	2

TABLE 30: PERSONS KNOWN BY THE INTERVIEWEE TO BE
DRUG USERS
(Percentages)

	YOUTHS	
	Talk about it because they use it	Doesn't talk about it
Brothers/Sisters	6	94
Parents	1	99
Friends	44	56
Work mates	19	81
Neighbours	33	67
	ADULTS	
Children	1	99
Spouse	1	99
Relatives	6	94
Friends	14	86
Neighbours	18	82
Work mates	10	90

TABLE 31: NUMBER OF PERSONS KNOWN TO THE INTERVIEWEE
WHO ARE DRUG USERS
(Percentages)

	YOUTH (N=137)	ADULTS (N=142)
None	29	44
Only one	4	5
Less than 10	31	27
More than 10	36	22
No information	0	1

what stereotypes existed. Opinions about the classes most involved in drug use are reported in Table 32.

TABLE 32: OPINIONS ABOUT THE SOCIAL STRATA WHERE
THERE IS WIDE DRUG CONSUMPTION
(Percentages)

	YOUTHS (N=137)	ADULTS (N=142)
In well-off families	61	58
Middle class families	10	10
Poor families	22	17
No Information	7	15

The authors investigated opinions about which sectors of the population were believed to be most involved in drug use. Those findings are contained in Table 33. It is interesting that while in the previous table a majority of both groups felt the upper class was more involved in drug use than the other classes, nevertheless Table 33 reveals a very large percentage of both youths and adults who believed of drug use to be extensive among the unemployed. Students, artists and 'leftist groups' were also mentioned by a significant proportion.

On the assumption that the mass media have had some influence over the phenomenon of drug abuse, the research team asked the respondents what they felt that influence to be. Opinions were divided between the two groups. The adult sample felt that films (70%) and television (55%) were influential in increasing the use of drugs. In the youth sample, a considerably smaller portion (53%)

TABLE 33: OPINIONS ABOUT THE EXTENT OF DRUG USE, BY OCCUPATION
(Percentages)

	Extensive Use		Little Use		No Use		No Information	
	Youths	Adults	Youths	Adults	Youths	Adults	Youths	Adults
Students	72	78	18	17	1	0	2	5
Workers	12	11	57	65	25	18	7	6
Housewives	0	1	9	21	87	72	4	5
Artists	56	70	37	22	3	2	4	6
Peasants	7	3	28	24	59	66	7	7
Businessmen	15	20	47	42	32	27	7	11
Employees	7	5	59	58	27	30	7	6
Intellectuals	15	31	37	39	42	20	6	10
Unemployed	73	67	18	16	6	13	3	4
Religious Persons	3	3	29	23	62	62	6	13
Leftist Groups	23	26	40	25	23	31	15	18

felt that films exercised this influence, but an almost equal proportion of the young people were of the opinion that television either played no role whatsoever, or was influential in decreasing drug use. Both groups agreed, however, that magazines played a role in influencing the increased use of drugs.

The investigators also inquired about what role the respondents felt the media should play in relation to drug use. Responses from both groups were identical: about 70% felt the media should provide "more information about drug addiction".

Finally, respondents were asked for opinions regarding the level of increased drug use in Mexico in recent years. Those findings, reported in Table 34, show that more than three-quarters of both samples believe it has increased considerably.

TABLE 34: OPINIONS ON THE INCREASE IN DRUG USE
IN MEXICO IN RECENT YEARS

(Percentages)

	YOUTHS	ADULTS
Has increased very much	79	76
Has somewhat increased	10	6
It is the same	7	9
Has somewhat decreased	2	6
Has decreased very much	0	1
No information	2	1

Opinion Survey of Qualified Informants

The sample: As reported earlier, this latter sample was comprised of 75 persons — 40 supervisors, 35 subordinates — attached to religious institutions, health centres, educational institutions, police stations, courts, government offices and social centres. They worked in areas within or adjacent to the 12 zones selected for the youth and adult survey reported above. The objectives of this series of uniform interviews were to learn something of this group's perception of drug abuse and their attitudes towards it, their awareness of the nature of the phenomenon in the areas where they worked as well as existing public attitudes, what programmes had been implemented and what solutions to the problems were planned.

Average ages ranged from 32 years (police, court workers, etc.) to 51 years (religious institutions). Of the 75 persons interviewed, 21 were women, of whom 11 were in supervisory positions. Forty-five of the respondents were married. The educational level of the sample was generally high, with 48 of the 75 having completed university and another 9 studying for professional careers.

Perceptions of the problem: Seven areas were probed, covering opinions about youth problems, drugs and their effects, motivations to use drugs and what they believed adults and youth thought of drug dependence.

One-third of the sample felt that young people faced problems in their families, and a somewhat smaller number felt young people were confused and rebellious against society. Other existing problems mentioned were drugs (16 persons) and the socio-economic environment (12 persons).

When the respondents were asked: "What is drug addiction?", two-thirds of them furnished replies related more to the causes or effects of drug use. Only one-third correctly defined drug addiction.

Responses to a question about which drugs they were familiar with and what were their effects, revealed that while a relatively high proportion of the sample knew about the most commonly used drugs, a much smaller proportion was familiar with the effects of these same substances.

Replies were somewhat ambivalent in regard to which drugs were most dangerous. One-quarter of the sample replied "all" while another 21% responded that cement (volatile glue) was the most dangerous.

Five significant themes emerged when respondents were asked what they considered to be motives for drug use. These were: family problems; maladaptation by young people; imitation, curiosity and bad companions; being in a very high or very low socio-economic level; mass communication.

The respondents tended to feel that a difference existed between the way youths and adults regarded drug dependence. More than half believed that young people regarded drug dependence as a good thing, but only two persons believed that adults viewed it in this light. Ninety percent of the respondents believed that adults considered it a bad thing, but only 27% believed that young people also felt that way.

Knowledge about drug use in the areas where they work:

Three fields of information were sought:

- a) Zones in which drugs are used and the types of drugs involved;
- b) Opinions of the respondents about places of highest drug use in the zones in which their institution is involved, the types of drugs used and the reasons that accounted for the drug use;
- c) Distribution points for drugs in the zone in which the institution was located.

In response to the first area of inquiry, 70% of the sample were able to mention at least one of the city's zones where they had heard of drug use. In all, 40 different such zones were named by the 75 respondents. Marijuana was named as the drug most frequently in use in these zones. They also offered opinions on the socio-economic levels in which they believed there was the most drug use. Thirty-seven percent felt drug use was highest in the lower level; 28% in the upper level; 13% throughout all levels; and 11% did not know. Among those who felt the lower levels had the greatest amount of drug use, reasons given were that they lacked work, had no money for food, the family lacked integration. Those who believed drug use was highest in the upper economic level, attributed it to not knowing what to do with their money, lacking moral principles, etc.

When asked about places where they believed most drug use took place in their own working areas, the respondents were divided in their opinions. Almost a quarter mentioned schools, another 20% mentioned neighbourhoods and the remainder were divided among amusement centres and cafes, shops (drug stores, etc.), private parties, parks and similar public places.

The drugs believed to be most in use in the zones in which the respondents worked were marijuana (37%) and volatile glue and paint thinner (48%). Other substances accounted for only 16% of the replies.

The respondents also named a number of specific locations where they said drug distribution took place within the areas in which they worked.

Existing attitudes towards drug dependence: This part of the survey attempted to explore the opinions of the qualified informants about social attitudes towards the phenomenon. Five interest areas were delineated: the way society responds to drug dependent persons; the interest

of the institutions towards the problem; the interest of the health centres. Two general areas were investigated: the treatment accorded by society to drug dependent persons; the interest of the various institutions working the surveyed zones.

In regard to the former, 60% were of the view that society rejects drug-dependent persons and 19% said society was indifferent. The remainder felt that society tries to help them (16%) and that they are regarded as being a social stigma (5%).

In seeking opinions about the interests of the various institutions in the drug problem, the researchers analysed separately the views of the respondents connected with specific institutions and those connected with other institutions.

Thus, in analysing opinions about the role of the religious institutions, it was found that of 11 persons attached to these entities, four felt that no role existed, while seven felt it did exist. Among informants from other institutions, 53 of the 64 either felt there was no interest or did not know. Only 11 of this group believed there was an interest on the part of religious institutions.

In analysing the responses regarding the interest of health centres, to which 30 of the informants were attached, it was found that 24 of them believed there was an interest in the problem, although four other did not agree. Among the other informants, a majority felt there was an interest, although 14 said they did not know.

Personal and institutional attitudes towards drug dependence. The interviewers then solicited opinions about how the respondents believed a drug-dependent person should be treated. The results of this query were then correlated with a set of earlier responses, i.e., how the respondents believed *society* treated drug dependents. This

comparison showed very few or no differences between the views of the respondents on both occasions. About 57% felt drug-dependent persons should be rejected and another 21% considered them a social stigma.

As for the type of institutions that should treat them, 60% felt specialized psychiatric institutions were called for and 29% suggested medical centres.

The research also revealed that no criteria existed for treating drug dependents and the majority of the respondents said that their institutions either do not accept drug addicts at all, or refer them to other institutions.

Planning theoretical solutions: In reply to questions about what the respondent felt his own role should be within the institution in which he worked, three themes emerged:

a) general orientation, including counselling, discussion, understanding, etc.;

b) creating motivation towards, for example, responsibility, work, etc.;

c) educating parents.

When questioned about the types of institutions and programmes which should exist to avoid an increase in drug addiction, two-thirds of the respondents felt control should be confined to a single institution. Other views included programmes of preventive education for both youth and parents, destruction of illicit crops, research studies, etc.

In summary, the researchers concluded that there was little objective perception in this group of the problem of drug dependence, its causes and effects, and that proposed solutions were quite general in nature. They also concluded that among this group of respondents there was little interest in the drug problem at either the personal or institutional levels.

Italy

In Italy, under the auspices of the Centro Nazionale di Prevenzione e Difesa Sociale, two attitudinal studies were conducted which are described here for purposes of demonstrating two approaches taken under the UNSDRI country study programme.

One is a study of attitudes towards drugs and drug use of a representative sample of 1,000 persons in the Milan area.¹ The other is a pilot study of 160 young persons (80 who had used drugs; 80 who had not) in order to measure their proximity to drug use and to attempt to isolate factors that might lead to the non-medical use of drugs.²

Although the goals and methods of both studies are notably different, nevertheless in combination, within the Italian scene, they represent attempts to probe both the attitudes of the public at large in the Milan area as well as two significant sub-groups in the same region. For purposes of analysis, however, the studies will be considered separately here.

Public Opinion in Milan

The purpose of this study, as stated by the authors, was to obtain as complete and profound as possible a panorama of the attitudes of the population of the city and province of Milan towards drugs and drug users. The chief attitudinal areas investigated were:

Knowledge and information about the various drugs, the distribution of drugs and their effects;

¹ Quadrio, A.; Avanzini, B.B.; Dogana, F.; Sacchi, M., "Il problema della droga nella società contemporanea. Indagine sulla opinione pubblica milanese", *Droga e Società Italiana*, Giuffrè Editore, Milano, 1974.

² Dogana, F., "Proposte per la misurazione del 'gradiente di vicinanza' alla droga: risultati di una indagine pilota su un campione di soggetti 'drogati' e 'normali'", *Droga e Società Italiana*, Giuffrè Editore, Milano, 1974.

Sources of information about drugs;

Perceptions of drugs and drug users;

The formation and spread of attitudes of either tolerance or stigmatization towards the phenomenon;

Opinions about possible social causes of the phenomenon;

Opinions about possible means of intervening in drug-related situations.

The research instrument was a structured questionnaire, comprised chiefly of closed (multiple choice) questions based on an examination of the existing psycho-social literature on the subject and tested in a pilot phase on 50 subjects. The questionnaire was designed to provide information on the demographic characteristics of the sample as well as responses to 43 substantive questions directly related to drugs and drug use.

The sample for the survey was drawn from a universe of persons 16 years of age and older, living in the city and province of Milan. As noted earlier, 1,000 subjects were selected. The choice of interviewees was made on the basis of random stratification of subjects 21 years and older (from the electoral list) and on a quota basis from those between 16 and 21 years of age.

It was, however, decided to over-sample certain strata of the population — in particular, the age group presumed to be at greatest risk to drug use (ages 16 to 29) and the age group 40 to 54 years, representative of the parents of the younger age group. Since this resulted in some distortion of the representativeness of the sample, it was necessary, when compiling the data at a later stage, to apply a "weighting factor" in order to restore the representative character of the sample.

The final profile of the sample was as follows:

<i>Place of residence</i>	<i>%</i>
Milan	43.8
Provincial centres with less than 20,00	31.5
Provincial centres with more than 20,000	24.7

<i>Sex</i>	<i>%</i>	<i>Marital status</i>	<i>%</i>
Male	47.1	Single	25.2
Female	52.9	Married	67.0
		Widowed	7.7

<i>Age distribution</i>	<i>%</i>
16 - 20 years	8.0
21 - 24 »	7.8
25 - 29 »	8.2
30 - 34 »	9.5
35 - 39 »	10.1
40 - 44 »	9.7
45 - 49 »	8.5
50 - 54 »	8.1
55 - 64 »	18.5
65 and over	11.7

<i>Educational achievement</i>	<i>%</i>
Terminated before 12 years of age	38.0
Terminated between 12 and 15	20.7
Terminated after 15 years of age	12.2
Attended high school	21.4
Attended university	7.7

<i>Socio-economic class</i>	<i>%</i>
Upper	1.5
Upper-middle	11.5
Middle	51.7
Lower-middle	29.5
Lower	5.8

Survey Findings

1. *Level of knowledge and type of information about drugs:* In general, the younger, male subjects in the sample were more knowledgeable about drugs, as reflected in their ability to name the various substances and to discriminate among them as to relative dangers. A vast majority (83%) were of the opinion that drugs had only negative effects, although this proportion was somewhat smaller in the case of the better educated. Among almost all groups in the sample, there was general agreement that the psychic dangers outranked the physical dangers.

2. *Opinions about the spread of drug use:* Almost one-third of the sample felt that drugs were widely dispersed throughout the Italian population. Another 45% believed they were quite widely diffused. This somewhat alarmist perspective was also reflected in the following table, in which the respondents rated what they believed to be the most worrisome problems in Italy.

TABLE 35: PROBLEMS PRESENTLY OF GREATEST CONCERN IN ITALY
(Percentages)

	Total Sample	Young Respondents
Increase in robbery and crime . . .	39.3	12.4
Spread of drugs	24.4	70.2
Illegal abortions	12.3	3.8
Prostitution	9.1	3.6
Immorality in films and the press . .	8.6	6.6
Alcoholism	4.4	0.9
Homosexuality	1.2	1.8
Others, don't know	1.7	1.7

In addition, more than 88% believed that drugs have assumed a much greater dimension today than in the past. Various reasons were provided for this situation, as shown in Table 36.

TABLE 36: CAUSES OF INCREASED SPREAD OF DRUGS
(Percentages)

Social imbalance and decline in values	23.8
Related to progress, to the welfare society . . .	38.2
Mass media emphasize the problem	16.2
Strong economic interests behind it	9.1
Youth are deteriorating, are spoiled	7.1
The difficult situation of young people	3.4
Ineffective preventive efforts	3.7
Other	7.3

3. *Sources of information about drugs:* Opinions about where people obtained information about drugs varied among the various groups. The young age groups and university students, for example, most frequently felt that information was through inter-personal contacts or direct contacts with drug users; men believed the sources to be daily newspapers, books and scientific journals; women most frequently named radio, television and weekly publications.

When questioned about the nature of the influence of mass media on the drug phenomenon, almost two-thirds of the respondents were of the opinion that the mass media

created too much interest in it, increasing the attractiveness of drugs for persons predisposed to use them. One-third felt that the media contributed to throwing light on the danger of drugs and discouraged use by those who might otherwise be attracted.

4. *Image of the drug user*: The researchers were interested in discovering whether the public perceived the drug user ("drogato" in Italian) as one who used drugs continually or whether the term also extended to those who had experimented on one occasion only. More than 84% of the respondents chose the former designation.

Opinions about what motivated drug users were, however, more varied, as reported in Table 37. These were replies to an open question.

On analysis, it was found that the ideological reasons tended to be advanced by the younger respondents, while the older age groups tended to put forward the psychological factors, lack of ideals, lack of conscience, etc.

TABLE 37: OPINIONS ABOUT MOTIVATION TO USE DRUGS
(Percentages)

Curiosity, probing experience and emotions . . .	41.2
Conflicts and psychological maladjustment	24.3
Suffering from frustration, unhappiness	30.6
Ideological motives, rejection of society	13.4
Social reasons, fault of society	8.5
Influenced by companions, imitation	10.4
Others, don't know	8.8

The open question was followed in the questionnaire by a structured question. Responses to this also accented the notion of curiosity, the desire to seek new experiences, as well as the need of drug users to escape from a grinding reality.

The authors of this study concluded that only a small proportion of the public believes that drug users are motivated by ideological factors; the majority perceived much more realistic motives.

By employing a semantic differential technique, the researchers determined that drug users were thought of as weak, immature, sad, disorderly persons who dislike work. When asked which categories of persons they felt were more likely to use drugs, almost half replied men and women equally, while almost all of the remainder felt men were more predisposed. Only three percent believed women were so inclined. More than 88% felt the young were in this category; 50% said the rich were predisposed and almost all of the rest replied that rich and poor were at equal risk.

In another classification, the respondents listed those they felt would be most attracted to drug use. The groups most prominently mentioned were: actors (78.2%), students (72%), homosexuals (50.8%), champion athletes (40.7%), thieves (21.7%) and industrialists (17%).

In reply to other questions, the respondents generally characterized the drug user as sick (rather than guilty), weak, using drugs to make up for deficiencies, incapable of living harmoniously with society, lacking emotions and unable to relate to others. Almost all said they would be concerned if a drug user married into their family, and a large proportion would also worry if a drug user lived in their neighbourhood, became friends with persons they knew or wanted to become friends with them.

5. *Level of exposure to drugs and interest in them*: In order to measure the proximity to drugs of persons in

the sample, respondents were asked if they knew a drug user. Almost 80% replied in the negative; of the 11.4% who replied affirmatively, most were either young people or university students. When asked how difficult it would be to obtain drugs, 75% either felt it would be difficult or didn't know. A large proportion of the 25% who felt it would be quite easy to obtain drugs were, again, either youth or university students. Almost 97% of the respondents said, however, that they would definitely or probably refuse to try drugs if given the opportunity.

6. *Social aspects of the drug problem:* About two-third of the sample believed the use of drugs would increase. The major reasons given for this situation were the lack of a valid means of prevention, degeneracy in the world, social illness and an increase in curiosity. It is of interest that more than 17% felt that drug use was a phenomenon tied to the evolution of the society.

When asked whether society was responsible for the spread of drug use, more than half replied affirmatively, although 11.5% of the others said they didn't know. It is noteworthy that the younger age group and the university students were much more convinced that society was responsible for the phenomenon than in the older age groups. The major reasons given by the respondents were: a crisis of the family (74.2%), excessive technological development leading to a denial of the emotional needs of man, the lack of an authority meriting respect and crises in the schools and religion. It must be kept in mind, however, that these were responses to a multiple-choice question provided by the researchers.

7. *Prevention of Drug abuse:* Almost 70% of the sample felt that little or nothing had been done to check the spread of drug abuse. About 45% felt the authorities should strike more forcefully against traffickers, while about one-quarter said that more intensive re-education was

necessary. Only 6.8% said that the social and psychological causes of the problem should be dealt with. The young and better educated were more inclined to stress the use of education and information to attack the problem, while the older age groups and less educated supported the use of repression against traffickers and users.

Measuring Proximity to Drugs: a Pilot Study

The study summarized here is, in a sense, complementary to the project described above; that is, whereas the survey of attitudes in the Milan area projected a picture that was representative of the population at large, this project focussed on only one component of the area of inquiry: measuring attitudes to determine what factors impinge on the likelihood of drug use among groups of individuals.

Three hypotheses lay behind this study:

1. The probability that alongside other considerations, the degree of proximity to the world of drugs is accompanied by some depth and breadth of information and knowledge relative to this subject;
2. It is likewise probable, examining concrete behaviour, that the person most interested in drugs is also exposed to a greater number of occasions in which he is in direct contact with the phenomenon;
3. The person most attracted by drugs will likely respond emotionally to the subject and express his values in terms of a low level of censure or social condemnation and will demonstrate, instead, a posture characterized by tolerance and permissiveness.

Methodology

Research instrument: A multiple-choice questionnaire was designed for this project. An edited version of the questionnaire appears as Appendix I to this chapter. Of

the 27 questions, eight were designed to discover the amount and quality of the knowledge of the respondent regarding drug use, seven to determine the physical proximity (in original: "vicinanza spaziale") of the subject to drug use and 12 questions were directed to determining his psychological proximity to drugs and drug use.

Because the author of this study wished to determine where the various respondents in the sample were located on a scale of proximity to drugs, a system of scoring was devised which could provide not only global scores for both groups in the sample, but also establish the level of the groups in each of the three components of the questionnaire, i.e., physical proximity to drugs, psychological proximity to drugs and level of knowledge about drugs.

The sample was comprised of 160 subjects. All but two of these were between 16 and 21 years of age. The two groups were comprised of 80 subjects who had not used drugs and 80 who admitted to having used drugs. No differentiation was made in the latter group regarding the types of drugs used, the frequency of use or other related factors. Subjects for the most part resided in Milan, Venice and the province of Brescia. Of the 160 subjects, 33 were female, 15 in the 'normal' group and 18 in the drug-using group. The subjects were chosen informally, the drug users being recruited from contacts made in locations known to be frequented by drug users.

The majority of subjects in both samples were either high school or university students. Most were from the middle or upper-middle socio-economic levels.

Findings of the Study

Cognitive aspects: Among the drug-using group, higher scores were obtained in ability to identify a larger number of drugs. They likewise scored higher in identifying the

drugs obtained from certain substances and in being knowledgeable about jargon and terminology used in drug-using circles.

In attempting to determine the possible role played by contact with drugs or drug users (*physical proximity to drugs*), it was found that the subjects in the drug-using group:

- had more frequently come in contact with other drug users;
- had more frequently seen persons under the influence of drugs;
- personally knew more drug users;
- more frequently knew places where drugs were used;
- had more frequently been in physical contact with drugs;
- had had drugs offered to them.

Comparison between the two group in respect to psychological proximity to drugs use showed a similar pattern. The drug-using subjects' responses indicated that more of them:

- would consider or accept an offer to try a drug;
- had considerably more drug-using friends;
- more frequently experienced a desire to try drugs;
- had more liberal views regarding the circumstances for which the use of drugs should be de-criminalized;
- showed less concern if a drug user lived in their building, wished to enter their circle of friends or to marry into their family.

In summarizing these findings, the author points out that some salient data concerning the non-using group should not be overlooked. Namely, that 38% of them said they had seen at least one person under the influence of drugs; 31% had had the opportunity to see or physically hold some type of drugs; 30% had received an offer to try drugs.

Analysis

Although of necessity they suffer from certain limitations, the studies presented in this chapter have made possible important insights into the knowledge, opinions and attitudes of population groups in three different countries. On analysis, certain common findings become evident, some of which follow.

1. In each study in which respondents were asked about their perception of drug users, a stereotype image emerges. This was as true of the youths interviewed (although to a lesser extent) as of the older subjects interviewed. The most frequently mentioned connotation is one of mental imbalance. Even in the Puerto Rican study, in which respondents were not directly asked about their perception of attitudes, the notion of mental imbalance emerges in their responses to questions about the relative damage of marijuana to the community. Likewise, in the Mexican survey of qualified informants, the same perception is evident in the predominant suggestion that drug users should be treated in psychiatric institutions.

In a more detailed fashion, respondents in Mexico and Italy described drug users in such terminology as "sick", "frustrated", "unhappy", "psychologically mal-adjusted", "weak", "sad", "immature" and "unable to face problems". Throughout, the concepts of escape and unhappiness appear.

2. In every study in which discussion of drug users took place, over-concern was expressed about the presence of drug users in the society. In the Puerto Rican study, this emerged from those respondents who felt that marijuana caused more harm in the community than alcohol. One of the major reasons given by the sample was the danger of committing crimes in order to obtain money for purchasing the drug. In both Mexican surveys, the themes of fear, danger and rejection were evident. In the survey of youths and older persons, a significant proportion of both samples referred to drug users as "rebellious" and "dangerous" persons. In the Italian study conducted in Milan, even though respondents tended to view drug users as sick, rather than guilty, they nevertheless said they would be concerned if a drug user lived in their immediate neighbourhood or wished to marry someone in their immediate family.

The theme of social rejection of drug users was most emphatically put forward in the interviews of qualified informants in Mexico. In this series of responses, the subjects not only believed that society rejected drug users but, in answer to later questions, themselves felt that society *should* reject drug users. They also considered users to be a "social stigma".

3. A third recurring theme is the focus on youth. In part, this derives from the design of some of the studies themselves, which structured the sample and tabulated the data to determine the degree to which the variables under examination applied to younger populations. In Puerto Rico, for example, more than 90% of the respondents believed that marijuana was used almost exclusively by adolescents and young adults. In both Mexican studies, there is the assumption that drug use is heaviest in the younger age groups, as reflected, in one

study, by the fact that more than 70% believed there was extensive drug use among students and, in the other study, by the view that family problems, maladaptation by youth, imitation, curiosity and bad companions were the main motivation behind drug use. Likewise, in the Italian study, there was the view, held by 72% of the respondents that students were more likely to be attracted by drugs.

That is not to say that these assumptions were without justification. In many cases, the younger respondents agreed with their older counterparts that youth were at greater risk to drug use and, in both the Mexican and Italian studies, it was evident that young people had more information about drugs, knew more drug users and, generally, were less resistant to the temptation to experiment with drugs.

In making this brief analysis of these attitudinal studies, it is important to recognize the limitations to which endeavours of this kind are necessarily subject at this point in time. They arise, in part, from the complexity of that cluster of factors which come together to constitute what we call 'attitudes'. In part, they also derive from the relative crudity of the instruments presently available to the social sciences to measure attitudes, particularly as they might (or might not) result in particular forms of individual or social behaviour.

It might be asked why, in the face of these admitted limitations, UNSDRI included an attitudinal study component in the programme of country studies of drug abuse. The answer is that, lacking other scientific tools or reliable information, it was felt that well-designed studies of this type could, on the basis of *probability*, provide some useful insights into opinions or attitudes of either populations at large or specific groups within the population. Probability, is after all, the accepted language of estimation not only in the social sciences, but in the physical sciences.

The important thing, it was felt, was that the outer limits of such research be recognized and taken into account in interpreting the information yielded in the studies.

In examining critically the attitudinal studies conducted along the lines suggested in the Programme Outline and Guide*, it is recognized that some inherent shortcomings of the work arise from the exigencies of time, resources and, in some cases, the complexity of the circumstances that surround research projects of this kind. In such cases, criticism is directed not to those who designed and directed the research, but offered as a guideline for future attempts to find ways of avoiding one or another difficulty.

One such difficulty which presents itself in all of the studies presented here is the use of the 'closed question' — or multiple choice — in respect to attitudes. It is recognized that the use of pre-coded questionnaires is both an effective economic control in survey research as well as an important aid in avoiding serious error in the compilation of survey data. And, unquestionably, the technique can yield valid and reliable findings when applied to, for example, attempts to determine the knowledge that respondents have about a given subject or to obtain demographic or other background information about the respondents. However, greater caution should be applied in drawing too precise conclusions from responses to structured questions which bear directly on attitudes.

The question that must be asked in regard to this aspect of attitudinal surveys is: To what degree do the options offered to a respondent in a multiple-choice question reflect the range of attitudinal options before him in his normal daily life? At times, the 'shopping list' offered to him may indeed reflect the respondent's normal range of attitudinal responses. At other times it may not,

* Cf. Appendix A to this volume.

although he is faced with only those options listed in the questionnaire.

One possible solution to the dilemma is to use a greater number of 'open' questions in subject areas directly related to attitudes *during the pre-testing of the instrument*. This might provide the research team with more profound insight into the attitudinal range of the sample and yield some more precise direction in designing 'closed questions'. Another technique, employed in the Mexican study, is to precede the closed question with an open question, thereby providing an opportunity to compare responses evoked from the two questions.

A second difficulty arises from the use of prospective questions in attitudinal studies, i.e., questions which ask the respondent: "How would you feel if...?" or "What would you do if...?". The danger in this case lies not in interpreting the response as it relates to attitudes at the time of the interview, but in assuming that the subject, given a set of circumstances in a real situation, would, in fact, respond in the manner he predicts.

Implications for Policy

As pointed out in the opening of this chapter, the degree to which programmes of control, prevention, treatment and rehabilitation will succeed depends, to a large extent, on a predisposition of the various populations to accept these programmes. In developed societies, this is as true of the general public as of drug users themselves, for if there is widespread reluctance to tolerate certain programmes, they will almost certainly be doomed to fail. These considerations provide one rationale for attitudinal studies.

A second rationale for attitudinal studies has a more positive value. It arises from a need for data concerning the characteristics of the populations for whom programmes

are designed. In this role, attitudinal research data should not be used in isolation, but analysed and weighed alongside epidemiological data. At times, in fact, a certain amount of both data can be generated in a single study by, for example, designing questionnaires that elicit information about both areas of inquiry. Thus, one might develop, as a programme base, an analytical model that yields information on either the general population of an area or specific population groups within it, their behaviour with respect to drugs at the time of the survey, their attitudes towards drug use, drug users and drug-related programmes. This could have particular relevance in planning programmes of information, prevention and, where drug users themselves have been studied, for the design of programmes of treatment.

A third rationale is the utility of attitudinal studies as an evaluative tool. It is generally assumed that the purpose of programmes of education (with a view to prevention of drug abuse) is to change existing attitudes. The success or failure of such programmes can only be measured by studies over time which can help to verify whether, in fact, there is a significant change in attitudes in the target groups to whom such programmes are directed. (It cannot be assumed, however, that changes in attitude will necessarily be reflected in changes in behaviour, as failure to live up to good resolutions will so often attest. The behavioural outcome of programmes of education and prevention in regard to drug abuse can only be measured through epidemiological studies over time).

QUESTIONNAIRE

1.1 What are the names of the drugs which you know ?

- 1 6
 2 7
 3 8
 4 9
 5 10

1.2 It is known that some drugs produce tolerance; that is, they require a constant increase in the dosage in order to obtain the desired effect. Do you know which drugs induce tolerance ?

YES ☐

NO ☐

namely

1.3 Do you know which drugs are obtained from the following substances ?

- | | | |
|------------------|------------------------------|--------------|
| Cannabis Indiana | YES <input type="checkbox"/> | namely |
| | NO <input type="checkbox"/> | |
| Ergot | YES <input type="checkbox"/> | namely |
| | NO <input type="checkbox"/> | |
| Peyote Cactus | YES <input type="checkbox"/> | namely |
| | NO <input type="checkbox"/> | |

1.4 Do you know what the following terms signify in the jargon of drug users ?

- | | | |
|----------|------------------------------|--------------|
| Snow | YES <input type="checkbox"/> | namely |
| | NO <input type="checkbox"/> | |
| Weed | YES <input type="checkbox"/> | namely |
| | NO <input type="checkbox"/> | |
| Fix | YES <input type="checkbox"/> | namely |
| | NO <input type="checkbox"/> | |
| To sniff | YES <input type="checkbox"/> | namely |
| | NO <input type="checkbox"/> | |
| Flash | YES <input type="checkbox"/> | namely |
| | NO <input type="checkbox"/> | |

2.1 Do you happen to have spoken with anyone who has used drugs?

YES ☐

NO ☐

2.2 Do you happen to have seen anyone under the influence of drugs?

YES ☐

NO ☐

2.3 Do you know a person who is a known drug user?

YES ☐

NO ☐

2.4 Do you know any place in your city where people who use drugs gather?

YES ☐

NO ☐

2.5 Do you happen to have seen or held in your hand any kind of drug?

YES ☐

NO ☐

2.6 Hypothetically, if you decided to try drugs, would you know where to go or from whom to obtain them?

YES ☐

NO ☐

2.7 Has anyone ever offered you to try or to buy drugs?

YES ☐

NO ☐

3.1 If someone proposed that you try drugs, how do you think you would react?

— would refuse without even thinking about it ☐

— would refuse but would feel a certain desire to accept ☐

— would perhaps consider the proposal ☐

— almost certainly would accept ☐

3.2 Do you think that in your milieu, the number of persons who have tried drugs at least once is:

very large ☐

many ☐

few ☐

very few ☐

none or almost none ☐

3.3 Do you happen to have experienced the desire to try drugs?

— never, almost never ☐

— sometimes ☐

— often ☐

3.4 As you know, some maintain it would be just to liberalize the use of drugs, at least in certain cases. I will read to you a list of situations, and you tell me, for each one whether or not you would consider licit use of the drug.

— if someone wanted to try a new and different sensation ☐

— for an artist who wants to find new inspirations and excite imagination ☐

— to relieve the boredom of a life imprisonment ☐

— if one were suffering from depression or complexes ☐

— to express a real rejection of the social and political system ☐

3.5 In your opinion, drugs (excluding those used medically, like pharmaceuticals):

— have only negative effects ☐

— have both negative and positive effects ☐

— have only positive effects ☐

3.6 Let us suppose it is known for certain that a person takes drugs. In such a case, you would be concerned or indifferent if such a person:

	Concerned	Indifferent
— came to live in your neighbourhood	<input type="checkbox"/>	<input type="checkbox"/>

— frequented your school or place of work	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------

— wanted to enter or participate in your circle of friends	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

— came to live beside you in your apartment building	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

— wanted to marry into your family	<input type="checkbox"/>	<input type="checkbox"/>
------------------------------------	--------------------------	--------------------------

3.7 Which of the following terms best expresses your feelings when you think of a drug user?

— indifference	<input type="checkbox"/>	— concern	<input type="checkbox"/>
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— interest	<input type="checkbox"/>	— pity	<input type="checkbox"/>
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CHAPTER FOUR

ASSESSING THE ADMINISTRATION OF DRUG CONTROL PROGRAMMES

Part III of the Research Outline and Guide* recommended that participating country research teams undertake, as a first step towards measuring the effectiveness of the various programmes of control and intervention, the preparation of an inventory of these functions. No doubt benefit-cost or impact studies could ideally supply sophisticated insights into how and why various activities are working or failing; but such studies are costly and, as an essential pre-requisite, assume the existence of 'accounting' systems that lend themselves to such analysis. In very few countries does this desirable situation exist.

These limitations should not, however, deter researchers and other evaluators from taking the first steps in processes of this kind, i.e., the preparation of an inventory of control and intervention mechanisms. One direct benefit of these is the indications they provide to policy makers about the adequacy of existing programmes. Characteristically, for instance, policy makers tend to over-estimate the availability and effectiveness of medical treatment facilities (thus, perhaps, encouraging the adoption of legislative models in which the 'addict' is essentially given a choice between 'voluntary' therapy and punishment in prison). Another benefit is that stock-taking of this kind can

* See Appendix A to this volume.

identify lacunae in the range of drug-related activities of governments, thereby pointing to the need for particular measures.

But the ultimate utility of this approach can only be achieved within the general framework of, and in specific correlation with, data provided by epidemiological investigations of whatever kind, that will yield information which says something of the functioning of law enforcement efforts and treatment programmes. For these reasons, studies of this type were from the outset considered an integral and essential component of the UNSDRI programme.

The range of investigations recommended for inclusion in this research programme is broad and includes all aspects of those activities that impinge on drug use of all kinds. A rational conceptualization of these controls would arrange them in a linked manner, with different data being yielded at each link in the chain. Not all of these links have yet been analysed by participants in the UNSDRI programme, but the following summary descriptions are exemplary of steps taken in a number of the participating countries.

Legal Controls

While almost all countries have embodied in their legal codes the norms for controlling the distribution and use of psychoactive substances, a recitation of the norms alone would indicate very little about the effectiveness of the control system. Therefore, any analysis of drug laws must take account not only of the provisions of the law itself, but also of the functioning of the administrative instruments by which laws are implemented. This would include a history and description of the various statutory provisions, as well as the practices and procedures normally pursued in administering the law. Within this analytical framework, valuable data can be generated at a number of points.

One example of this approach merits description here. It began as a joint project of UNSDRI and the Department of the Attorney General of Mexico, and eventuated in a publication in 1974¹. This study was a comprehensive analysis of the legal control system of the Government of Mexico.

The introductory section of the Mexican study clarified a number of basic concepts and definitions in the federal drug law and explained the system of classification of the various controlled substances as well as the general character of the juridical system.

The study then describes the law presently in force, its constitutional aspects and history, as well as the international drug control treaties to which Mexico is a signatory.

The administrative aspects of the various laws in Mexico pertaining to drugs were also analyzed. This included a description of the public health legislation, including provisions for regulating the distribution of legally manufactured psychoactive substances, the relevant provisions of labour and social security legislation as well as the role of the Attorney General in the suppression of illicit cultivation, production and distribution.

A flowchart was also developed to demonstrate the procedures followed through the various stages of prosecution of drug cases, including the special provisions for drug addicts by which they are referred to treatment rather than to a strictly penal regime.

Special attention was focussed on an analysis and description of the juvenile court legislation as this related to young persons coming before this tribunal for illicit drug use or problems associated with drug use.

This Mexican research project has provided a model for similar analyses of legal codes relating to drugs. At

¹ Cárdenas de Ojeda, Olga. *Toxicomanía y Narcotráfico, Aspectos Legales*. Fondo de Cultura Económica. México, 1974.

this writing, legal researchers from five countries of that region are engaged in designing similar projects to assist in assessing the functioning of their laws and law enforcement efforts.

A somewhat similar analysis¹ was undertaken as part of the Italian research programme. Unlike the Mexican project, however, no empirical data were provided which could throw light on the results of administering the law in Italy. In any event, the legislation analysed in this study has since been abrogated and a new law enacted.

Medical Controls

In many countries, treatment programmes consume relatively large proportions of the funds allocated to drug control. This situation indicates that punitive controls for drug users are being replaced by therapeutic approaches. The degree to which treatment programmes are an effective control instrument is difficult to measure, since often there is little agreement on criteria for success and, more frequently, the actual outcome of treatment measures remains undiscovered.

A second difficulty often attaches to the assessment of therapeutic programmes when no integrated approach has been taken to their planning and operating of treatment programmes. In some jurisdictions, all programmes are state-operated. In others, however, some programmes are operated by private (often philanthropic) entities, others by government. This situation is further compounded when government interventions take place at differing jurisdictional levels (state, municipal, etc.).

Against this backdrop, it is evident that the systematic identification of existing therapeutic facilities is essential

¹ Delogu, Tullio. "L'esperienza giuridica in materia di stupefacenti", *Droga e Società Italiana*, Giuffrè Editore, Milano, 1974.

to any stock-taking or programme planning. Only when this step has been taken can one rationally contemplate any assessment or evaluation of the system and of individual programmes.

Methods for assessing medical control and intervention programmes will vary according to both what is legally permissible and what policies and programmes exist in practice. For example, narcotic maintenance programmes are permitted in some countries but prohibited in others; in some jurisdictions, legal provision is made for court referrals of drug users to treatment programmes, but in praxis inadequate or no treatment facilities are available.

Another limitation arises from the fact that what are loosely termed 'medical approaches' are, in fact, often much more than solely medical in nature. Medical intervention may be called for when a drug user initially enters a treatment programme, particularly during periods of withdrawal from opiates or, at a later stage, when a psychiatric evaluation may constitute a step in the total range of treatment modalities offered. Treatment is, therefore, most frequently a medical-psychological process, calling on the intervention skills of specialists from a number of disciplines. In this context, the preparation of an inventory of 'medical controls' will necessarily be complex and should, preferably, be systemic in nature.

Puerto Rico

Such a systemic, integrated approach was taken by the research team in Puerto Rico for purposes both of measuring of its performance and for setting programme goals for the short-term future. Because this approach represents the optimal use of control data, it is worth describing briefly here.

Responsibility for all government programmes of treatment and rehabilitation of drug users in Puerto Rico

falls to the Department of Addiction Services. Programmes in this field are administered by three divisions: 1) The Drug Addiction Treatment Division; 2) The Rehabilitation Services Division; 3) The Pilot Project for Multiple Services in the Correctional System. For exemplary purposes only, this brief description will be confined to the Drug Addiction Treatment Division, although an identical methodology was employed in analyzing each programme area in the department, resulting in the formulation of a comprehensive drug abuse prevention plan for Puerto Rico.

As a primary step, the Planning Division of the department prepared a reporting form which was completed for each activity area in the department. Information was sought in respect to four points: 1) the specific problems with which the programme was designed to deal; 2) the goals or longer-term objectives of the programme as they relate to 1); 3) the specific objectives for the programme year under review; 4) the operational activities carried out in that programme year.

In the Drug Addiction Treatment Unit, this information was compiled for each programme in the department's multi-modal operation; namely: the Admissions Unit, the Drug-Free Programme, the Chemotherapy Programme, and the Poly-Drug Programme. A Sample of this form of analysis is given below for the Drug-Free Programme.

Objectives 1973-1974

1. To treat 375 clients with extensive medical care.
2. To treat 3,000 clients in group therapy sessions.

Achievements 1973-1974

1. 348 clients treated.
2. 2,896 clients treated (duplicated).

Objectives 1973-1974

3. To conduct 10,275 interviews and individual orientations.
4. To attend 1,500 clients in recreation therapy sessions.
5. To offer occupational group therapy to 598 clients.
6. To offer vocational rehabilitation services to 230 clients.

Achievements 1973-1974

3. 10,246 sessions throughout the island.
4. 1,500 clients attended.
5. 598 clients attended.
6. 196 clients serviced in the following manner:
 Pre-Vocational = 55
 Community training = 48
 Remedial Courses = 47
 Other = 46

Total 196

7. To analyze 360,000 urine samples using a base of 1,300 treated clients to determine the rate of return to drug use.
8. To provide ample treatment services and activities to families of addicts.

7. 141,300 urine samples analyzed.
8. 51 families treated, including 173 individual visits. A total of 219 visits were made to individual houses, and 50 social events were organized.

*Objectives 1973-1974**Achievements 1973-1974*

- | | |
|--|--|
| 9. To carry out 75 orientation conferences in public agencies and communities. | 9. 75 conferences and 280 orientation sessions were conducted. |
| 10. To provide follow-up in order to evaluate the effectiveness of the programs. | 10. 120 cases were evaluated on follow-up. |
| 11. To treat addicts in the penal system. | 11. 204 addicts were treated in the penal system. |

During the past year, there were in operation:

1. 14 orientation centers;
2. 3 detoxification centers;
3. 4 community therapy residences;
4. 6 psycho-social day-time mobile units;
5. 1 psycho-social mobile unit.

By analyzing reported operations data in this fashion, programmers are thus enabled to give greater precision to the planning process. This assumes, of course, that the planner has available to him supplementary data from which he can project, including, for example, epidemiological trend data. One example of this form of planning is demonstrated in Table 38 which reports on the functioning of the Chemotherapy Programme for the year 1973-74 and projecting patient attendance for each of the following two years.

TABLE 38: AVERAGE NUMBER OF CLIENTS ATTENDING DAILY IN THE CHEMOTHERAPY MODALITY, IN RELATION TO THE STATIC CAPACITY BY CENTRE DURING 1973-74 (WITH PROJECTIONS FOR 1974-75, 1975-76)¹

	Static Capacity		Average Clients Attended Daily		Average Clients to Attend/Daily			
	1973-74		1973-74		1974-75		1975-76	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	1,309	100	794	57	931	67	1,069	77
Casita Verde	129	100	61	47	86	67	99	77
Alhambra	135	100	45	33	71	53	85	63
Casa Pelli	125	100	117	94	118	94	118	94
Adelina	125	100	118	94	118	94	118	94
Llorens Torres	125	100	108	86	108	86	108	86
Ferrocarril	125	100	124	99	124	99	124	99
Humacao	125	100	16	13	41	33	66	55
Aguadilla	125	100	19	15	44	35	69	62
Mayaguez	125	100	28	22	53	42	78	64
Caguas	125	100	42	34	68	54	80	53
Bayamón	125	100	118	94	118	94	118	94

¹ Commonwealth of Puerto Rico. Department of Addiction Services. *Drug Abuse Prevention Plan for Puerto Rico, 1974-75.*

Other Forms and Factors in Social Control

The assumptions that lie behind drug-related programmes are not always justified. Evaluative studies in recent years have demonstrated that for any number of reasons programmes remain unrevised or in force long after the conditions in which there were spawned have changed. It was for this reason that the UNSDRI Programme Outline and Guide suggested periodic re-examinations of various forms of intervention. It was not proposed that these necessarily had to be full-fledged evaluations, but rather a monitoring of these various programmes.

Italy

One relatively effective technique was employed by an Italian study team in order to determine, in a broad sense, the impact of drug information programmes conducted in the school system. This study¹ used a comparative technique, selecting parents and teachers from 11 schools in Milan and region in which a drug information programme had been conducted for the adults and parents and teachers from 11 schools in which there were no specific programmes. The schools selected were matched for such factors as population, location, socio-economic composition and type of school (experimental or not).

From each school, four persons were interviewed: two parents chosen randomly from among the members of the Parents' Council and two accredited teachers, one 35 years of age or younger, one 45 or older. In all, a total of 88 interviewees were selected.

¹ Madeddu, A., Arruga, A., Cicuta, P., Rivardo, M. "Possibilità e limiti dell'intervento preventivo in tema di tossicofilia e tossicomania. Valutazione di alcune iniziative specifiche con interviste focalizzate su gruppi campione atipici di insegnanti e di genitori". *Droga e Società Italiana*. Giuffrè Editore. Milano. 1974.

The questionnaire * was designed to elicit information which would assist in determining the level of information of the interviewees about drugs and their attitudes towards the phenomenon.

Content analysis of the responses was made by the interview team in a manner that permitted dividing the data into:

- a. direct responses, expressed intentionally by the interviewee;
- b. examples and commonplace references used by the responses to illustrate their thoughts;
- c. opinions about drugs and drug users expressed in the course of the interview.

On the whole, the analysis revealed almost no significant differences between those who had been exposed to the drug information programme and those who had not. Admitting the limitations of this particular study and that it was preliminary rather than conclusive, the authors nevertheless state:

"These results could exhaust or conclude our investigation. But from a more general point of view the material collected lends itself to a multitude of uses. From the ambivalence demonstrated when faced with drugs ('provides splendid sensations', etc., etc., and 'leads to death in horrible suffering'), magic substances which not only drive out pain but induce uncontrollable and uncontrolled pleasure which later is paid for by psycho-physical deterioration and death, to the stigmatization of the drug user as 'wretched', 'unhappy', 'depraved', 'amoral' — evident above all from the responses to items 11 and 12 — 'sick', 'deformed', all of which denote an 'alien', a different type of being

* Cf. Appendix 1 to this chapter.

exclusively identified by his 'immersion in drugs', to the incisiveness of some attitudes which were for us particularly revealing. We recall a teacher who, when asked by a child: 'what is a drug?' offered great understanding by proposing to him the help of specialists thus avoiding having to send him to the authorities'".

From a policy perspective, the authors conclude:

"The drug problem has no single solution. Education is one of the necessary aspects which can contribute to a solution. The drug problem lies within, and is diluted by, the much larger programme of health education. (It is a mistake to emphasize the drug problem isolated from other health concepts.) Health education should be taught in all schools. Teaching techniques should be sufficiently flexible to adapt to various levels and various needs. The family should be a complementary 'support' in order to round out health education... For the wider purpose of informing the informers, the teacher must keep in mind that the credibility of his teaching depends on the credibility earned by his own life style. Finally, it is possible that the psycho-chemical age is upon us and it is necessary to adapt to it. Possibly there is a message in these new experiences, but from the time that drugs become an object of collective consumption (evidence of growing discomfort in a society in schizophrenic evolution), the role of the educator and, even more, the collective role, will be to question themselves about death and madness (at times sought voluntarily as an escape from a reality perceived as intolerable) and, therefore, about the pressures of life and survival; i.e., to think about the minimum limits of authenticity which we can still have — we, among others."

While the study cited above demonstrated a need for carefully designed programmes of information about drugs

and drug use, another Italian study¹ described how a selected sample of the press had presented both the drug problem and the characteristics of the various persons involved in the phenomenon.

Six newspapers were selected — four published in Milan, one in Torino and another with national circulation — and the contents of drug-related articles were analyzed for the period of one year (1973).

First employing a technique for quantitative calculation of handling of drug articles in the press, the research team selected as the basic criterion all stories in which, in the headline or the article, the word 'drug' appeared or in which there was a specific illicit drug named. On the basis of this selection the following are some of the types of data collated:

The total number of articles published;

The space given to each article and to each headline;

The number of photographs published and the area they occupied;

The section of the newspaper in which the article appeared;

The location of the article on the page;

The orientation of the article, i.e., health, crime or moralistic;

The degree to which the article focussed on a particular drug both in the text and in the headline;

Reference to and the role of the protagonists in the story, i.e., users, those who assisted him to procure the

¹ Caraccia, C.; Costa, C.; Martinotti, G.; Blumir, G. "La stampa quotidiana e la droga". *Droga e Società Italiana*. Giuffrè Editore. Milano. 1974.

drug, those in opposition to his drug use or attempting to control it;

References to frequency of drug use, behaviour associated with it, motivation to use the substance;

The scale of activities of traffickers;

The general tone of the article, both in the headline and in the text (ranging from 'purely descriptive', through 'aggressive against particular institutions' to 'scandalous/alarmist');

Type and quantity of drug involved;

With regard to users, age groups involved, their economic status, where and from whom they acquired the drug, their occupations, the characteristics attributed to them in the story (hippy, political extremist, etc.).

Following a sophisticated analysis of these data, the authors of the study also analysed two specific cases, comparing the reporting of the case with the actual events. This analysis focussed on daily newspapers other than those involved in the larger survey.

From a policy perspective, one of the authors comments that based on his findings as well as an examination of other relevant literature there was a pressing need for a vigorous programme of information and education about drugs, and drug users in Italy. The rationale for this conclusion is summarized in the following statement:

"While on objective analysis of the facts the goal of repression prevails, nevertheless the combination of a repressive attitude and misinformation can give rise to diffused stereotypes which provide a rationale for opposition to unacceptable behaviour but which can have consequences of an opposite nature.

"From reading the daily press and examining the mass media in general as well as other documentary material, I believe that three fundamental kinds of stereotypes emerge.

The verification of the diffusion of these stereotypes and, even more, the occurrence of possible negative consequences,... should be the object of further probing.

"In my view, the three prevailing stereotyped reactions to the drug phenomenon are:

"A. A medical stereotype: 'drugs are destruction';

"B. A moral stereotype: 'drugs are escape';

"C. A social stereotype: 'drugs are deviance'.

After further characterization on these stereotypes, the author comments:

"There is no doubt that in a mass society such as the one in which we live, the communications media — and the press above all — typify the dominant culture and constitute a powerful instrument for intervention and control, even if not the only one. It is therefore of prime importance that the information which the press reports should contribute to a correct awareness of the facts, thereby contributing to the elimination or reduction of the dangerous consequences, both for the individual and for society, of behaviour which lies between licit and illicit zones and which tends to be growing even more, due to the profound changes in the social structure which flow from the major processes of transformation in modern society. If the official instruments of a society's culture lack accurate information, then there is no doubt that other information channels will find a place, controlled not by those whose goal is the reduction of individual and collective evils, but by those who have contrary interests, pursuing only their own interests, by benefiting from the weakness or illness of others."

Puerto Rico

Another study of the mass media — directed specifically to stated objectives in a particular medium — was conducted in Puerto Rico for the Department of Addiction Services.¹

It was a survey carried out to determine the degree of 'penetration' of a publicity campaign among the Puerto Rican population 15 years of age and older. The survey was, essentially, an assessment of the way in which the central message of the campaign was received, how it was perceived, upon which groups it had the greatest impact and how it was interpreted. The purpose of the message was to engender a set of attitudes that would search out alternatives to drug use.

The sample population employed was the same as that used in the survey of attitudes towards marijuana reported in the previous chapter, with a total sample of 600 persons. The method employed was a test on respondents in the sample to determine what they recalled of the message, employing an analysis by key words to measure its impact.

It was found that 73% of those interviewed recalled having seen or heard the theme, of which almost 70% were able to recall both the visual and audio elements. Respondents stressed the positive aspects of the message — helping, understanding, unity, sharing and loving.

The authors of the survey concluded that the campaign in its existing form was effective and should be continued.

Commentary

The studies briefly described above are presented as examples only and in no way are exhaustive of the various assessments and evaluations conducted by the country teams

¹ Stanford Klapper Associates, Inc., *Estudio sobre las actitudes y reacciones hacia la campaña publicitaria "Las cosas mejoran", fase II. 1975.*

participating in the UNSDRI programme. It appears to be true, however, that less progress has been made in this field of investigation than in such related fields as epidemiology and attitudinal studies. As noted earlier, one of the reasons for this is the difficulty that arises when we attempt to measure, in a reliable fashion, the outcomes of the various programmes in terms of the programme goals. But, at the very least, a start has been made in recognizing that goal identification is of prime importance.

The Puerto Rican approach described in this chapter stresses the achievement of short-term goals for purposes of programme planning. The merit of this method is that it is eminently practicable; it measures the measurable, and is an essential first step. Its shortcoming, however, is that it throws little light on the achievement of medium and longer-term goals of the various programmes. What, for example, is to be considered the ultimate goal of any particular treatment programme? The cessation of *all* drug use? The cessation of *illicit* drug use? The restoration of the individual to society as a productive member (with or without reference to his drug use)? What is the objective of a methadone maintenance programme? Obviously, it is not the cessation of all drug use. The answers to these questions cannot be taken for granted. Nor is the search for them a routine matter; rather, it can prove to a painful process which calls into question the underlying social philosophy of various drug-control policies.

Essentially the same problems are encountered in assessing other drug-related programmes. The Italian and Puerto Rican studies on the impact of information programmes, while useful in helping to learn something about specific programmes, do not comment on the more profound questions that must be asked. To what degree, for example, do they affect behaviour?

The Italian study of parents and teachers in 22 schools in Milan and area concluded that there was little difference

between the experimental and control groups with regard to increased knowledge about drugs or alteration of attitudes with respect to drug use. This is useful information, at least as it relates to the particular information programme to which the experimental group was exposed. But it is difficult to draw a more general conclusion from this study, since it dealt with only one particular information programme. One cannot conclude, for example, that information programmes are of no value; only that the particular programme examined in this study had little or no value. Although this study might have yielded more generalizable information had some of the subjects been exposed to at least one additional information programme, nevertheless the methodology employed is a helpful example and, with the modification suggested, would merit replication in other settings.

The television campaign impact study conducted in Puerto Rico, although less ambitious in its objectives, yields more conclusive information than the Italian study. In effect, it makes a statement about the impact of a particular campaign on a particular audience. As noted elsewhere, this type of survey also enjoys the merit of economy, since it was conducted simultaneously with a study of attitudes, thus employing the same sample, the same basic instrument design and, thus, the same set of interviews. Doubtless, there are limits to the length and complexity of survey interviews, but within those limits economies such as this are possible.

The study of legal norms and control mechanisms in Mexico exemplifies a serious effort to assemble and examine the totality of the national legislation that bears on all aspects of drug production, distribution and use. This effort is currently being replicated in a number of Latin American countries and, as pointed out in this chapter, has been done in Italy also. To obtain the ultimate utility from this type of study, however, it should be used as the

framework against which empirical data can be fitted, thus providing a constant check not only on the intent of the law and administrative regulations, but, more especially, on how the law functions, how well it encourages or deters and how it meets the intentions of the legislators.

The analysis of daily newspaper treatment of drug-related subjects conducted by the research team in Milan is the product of a serious and sophisticated effort to probe the field of information on drugs. While the daily press in most countries does not have a monopoly on the diffusion of information (or misinformation) about drugs, it remains an essential part of the total information output to which people are exposed in literate societies. If information programmes are to be designed as one preventive measure in the control of drugs, then the influence of the mass media cannot be ignored — either as a potential positive factor in the dissemination of accurate information or as a distorting force which necessitates offsetting programmes of information and education.

It would be useful, however, to also conduct research into the relative impact of the various media as agents in the transmission of drug information. With the guidelines which this type of information could provide, it would then be possible to establish priorities regarding which of the various media should be studied.

Finally, general comment is in order regarding the paucity of systematic studies of the functioning of drug programmes. As has been pointed out many times, drug use is not new, but programmes to cope with it are of relatively recent vintage. It follows, therefore that until programmes are established and operating there is little to assess. This is the situation that currently prevails in many countries, where drug-related problems have only recently become troublesome, or where drug legislation has been modified to move from punitive to treatment forms of control.

But as programmes multiply and become institutionalized they often assume an existence of their own, at times completely departing from the original goal for which they were designed. Given the relatively low availability of resources for drug programmes, administrators can ill afford the luxury of unproductive programmes or programmes which completely miss their target. It is in this optic that periodic assessments and evaluative studies find their utility. Ideally, of course, total systemic analyses would be welcome. But the cost of such studies might well exceed their utility, at least in the short run. The best we can hope for, then, is a set of instruments which can be administered at relatively low cost and with a minimum of unnecessary complexity capable of yielding information which can guide us in our efforts to be effective. In this connection, perhaps the fact that relatively few studies of this type have been conducted reflects overly ambitious expectations on the part of drug researchers. Perhaps more modest aims are called for so that little by little the community of researchers and administrators responsible for drug control programmes can set viable goals and construct effective measures to achieve them. This, essentially, was the purpose of the UNSDRI programme.

Proposals for Assessment

As pointed out earlier, the capacity to systematically assess drug intervention programmes is shaped, in large measure, by the availability of data on the actual operation of intervention systems. In very few countries today is there not at least the skeleton of an information-gathering system for data on non-medical drug use which can be applied to improving information flows.

For example, under the reporting requirements of the international treaties, signatory countries are required to report certain information annually about drug abuse to

the UN Commission on Narcotic Drugs. Although in the past these data have been incomplete, their sources unevaluated, their significance vague and generally of quite limited value, nevertheless the Commission has recently reached agreement on a revised form for annual reporting which will considerably streamline the analysis and general reliability of these data. In addition, while drug abuse reporting under the treaty provisions has hitherto referred only to such substances as the opiates, cannabis, coca and cocaine, in the near future there will be a requirement to report on the use of almost all the remaining psychotropic substances currently subject to abuse.

While the revised form of reporting will no doubt yield results beneficial to the United Nations and the international community, it can be of even greater benefit to individual countries as a tool to collect basic data on the distribution and consumption of psychoactive substances — both legal and illegal. The rationale for linking these reporting requirements to the needs of evaluators and researchers rests in the network-like character of the system of information collection. Data would be collected and reported from a variety of sources, including:

- Drug manufacturers, pharmacists and physicians;
- Importers and exporters;
- Law enforcement agencies, prosecutors and courts;
- Treatment and rehabilitation centres.

The statistical reporting of data from these various points in the distribution and control network constitutes a base from which more detailed, analytically sophisticated investigations can be launched. Unfortunately, up to the present in many countries the non-availability of these baseline data has made almost all broad research efforts

expensive and time-consuming. The evolution of a more detailed and relevant form of national data collection should significantly improve the situation that has prevailed in the past and evaluators and researchers should be encouraged to build on the new structure.

Techniques for assessing drug abuse programmes vary considerably, depending on what one wishes to measure. In quite recent years, as greater investment has been directed to developing prevention and treatment programmes, new techniques have evolved in various countries, many of which might lend themselves to replication elsewhere. For this reason, assessment and evaluation techniques could well be a subject area for inclusion in regional information exchange programmes. Through sharing information about experiences in applying these various techniques, it might be possible to reduce the costs of programme assessment and help to avoid wasted efforts in pursuing fruitless or erroneous lines of investigation.

This latter proposal assumes, of course, that such information exchange programmes do, in fact, exist and are operative. At the present time a number of international clearinghouses for information on drug abuse operate in developed countries. But for purposes of technique development in research and assessment, regional clearinghouse information exchange programmes seem to offer the best promise. One such programme, centred at CEMEF in Mexico City, has been functioning for more than two years in cooperation with drug research agencies in a number of countries of Latin America. The Mexical model might well be examined in the near future with a view to establishing similar operations in other regions of the world.

Regional programmes of cooperation in research and information have much to recommend them. These may or may not be formalized working relationships; the important thing is that by working together at the technical level, those responsible for designing and implementing research

and control programmes can build a significant body of expertise which they can apply to the solution of common problems. Since 1974 UNSDRI and CEMEF have jointly sponsored workshops for drug abuse researchers from countries in the Latin American region. Other regions — particularly those comprised of third world countries — would no doubt also benefit from similar working relationships.

Systematic planning can also greatly advance data development through the design of reporting systems on treatment and rehabilitation programmes which yield compatible data. The outcome of treatment programmes in any country or region can be reported in many ways, depending on what criteria are applied in assessing the relative success or failure of the programme. The important thing, however, is that the data gathered from different points in the programme network can be aggregated to provide a clear and valid picture of the functioning of the system. This, of course, is possible only if there is at least a minimum of uniformity in the way in which data are collected and reported. In jurisdictions in which treatment is channeled through a central intake unit, uniformity is relatively simple; in other structures, it is more difficult, although a uniform system of reporting, perhaps through the use of common reporting forms for cases, can be useful in collating compatible data.

In all of these various possible approaches, however, it must again be stressed that no perfect system exists which with absolute certitude can tell us all we would wish to know about the nature of the phenomenon or the final outcome of efforts to control or prevent it. This arises in part from the idiosyncratic nature of all human conduct, including the non-medical use of drugs. But more imaginative and systematic efforts are still possible which, in the long run, can at least help us to understand something of drug use.

Appendix 1

Questionnaire used in interviews on efficacy of preventive information

- Question 1. Did you attend the drug conference? If not, have you heard about it?
2. Have you ever spoken about the drug problem with someone connected with the school?
3. When a pupil (child) asks a teacher (parent) for information about drug what do you think should be the attitude of the teacher (parent)?
4. And if you encountered a pupil (child) who uses drugs?
5. Are you aware of what the present law provides for drug use?
6. Do you consider it fair or would you prefer another measure?
7. What kind of measure?
8. If a drug information course were initiated which required a weekly obligation to attend for one or two months, would you attend?
9. What information media do you think would be most useful within the framework of this course?
10. In your opinion, what is the correct way for the communications media to deal with the (drug) problem?
11. In your opinion, for what motives does a child use drugs?
12. But in the same situation, why does one child decide to use drugs, and another does not?
13. Which drugs do you know?
14. What about alcohol?
15. What about tranquilizers?

RESEARCH OUTLINE AND GUIDE
FOR A PROGRAMME OF
COUNTRY STUDIES ON DRUG USE AND CONTROLS

The programme set forth in this guide consists essentially of three phases designed to obtain information about the epidemiology of drug use and quantitative data relating to production and trafficking; public and official attitudes and opinions about drug use; the functioning and effectiveness of control programmes and other forms of social response. It must be stressed again that this research programme is not intended as a substitute for in-depth investigations of drug use. Rather, it is a broad programme designed to yield information which can become a basis on which decision-makers can rationally consider the most promising alternatives for preventing and coping with drug use in their individual countries. Epidemiology, for example, can indicate the size and characteristics of drug use. Surveys of attitudes, both public and official, can tell policy-makers something of the human perception of drug use, elucidating what approaches might be effective and which will have little or no impact. An examination of how the various social responses function, and some measurement of the degree to which they are meeting their goals is essential to the policy-maker in deciding just where his manpower and money might best be allocated to meet his policy objectives. In essence, then, it is a policy-oriented programme outline designed to assist both individual nations and international bodies to better understand the nature of the phenomenon of drug use.

Part A of the plan seeks to provide guidelines as to the various methods by which information can be gathered about the extent of drug use, the drugs in use, the social groups involved in its use, and the environment in which drug use takes place. This approach adheres to the classical epidemiological model.

Part B sets out the various approaches that can be utilized to ascertain the nature of attitudes towards drug use. This approach is necessarily broad, since in the regime of opinion and attitudes national and cultural variations will predominate. This part of the programme makes possible a selection from among a variety of methodologies.

Part C, as suggested in the present plan, is a prelude to evaluations of cost-effectiveness studies which, where appropriate, might be carried out in individual countries. The research and data collection proposed here is in the nature of an inventory of resources and programmes, which, as in any systemic assessment, is essential to policy-makers and administrators. Should this information be further analysed through the application of cost-effectiveness techniques, it will prove to be even more valuable.

The section entitled "Preliminary Items of Information" has been included in the research plan because it is an essential first step in determining, in advance of the research programme itself, the difficulties that are likely to be encountered in implementing the programme and the nature and extent of the resources that will have to be applied.

PART A

AN EPIDEMIOLOGICAL SURVEY

A.1. *Definitions*

A.1.1. The use of the term "epidemiology" is, admittedly, not strictly accurate since, in its literal sense, it is a field that is restricted to the application of medical principles. The term does have the advantage, however, of aptly describing the conceptual approach most suited to studying drug use, i.e. studies of the three components of the epidemiological model — the agent (drugs), the host (drug users) and the environment (set and setting of drug use).

A.1.2. The term "drugs" in this programme outline refers to the grouping of psychoactive substances which follows. Other equally valid groupings may also be employed.

Opiates (e.g. opium, morphine, heroin, methadone);
Cannabis (e.g. marijuana, hashish, bhang, ganja, charas, kif, etc.);

Cocaine; Stimulants (e.g. amphetamines, premetrazine, methylphenidate, etc.);

Sedatives and hypnotics (e.g. barbiturates, minor tranquilizers, bromides, alcohol, anticholinergics);

Strong hallucinogens (e.g. LSD-25, mescaline, peyote, psilocybin, other local products);

Volatile solvents and gases (e.g. substances containing toluene, acetone, benzene, ether, etc.).

Note that where it is available and relevant, data on alcohol and tobacco use should be included, although no special research into the use of these drugs is envisaged.

A.1.3. While data on the medical use of psychoactive drugs will be required, the emphasis is on non-medical use. This latter term denotes use which is not indicated on generally accepted medical grounds.

A.1.4. The term "multiple drug use" may have to be considered in some country studies. In the context of this paper, the term refers to the use of more than one psychoactive substance within a particular time frame. (For example, the use of barbiturates to sleep at night, followed by the use of stimulants to elevate mood the following morning).

A.2. *Existing Sources of Information*

A.2.1. Use: very little reliable data are available from existing official sources. In those countries which prohibit possession or use of certain drugs, police and court statistics can provide fragmentary information. These are not reliable indicators of the extent of drug use, however, because most drug use is not reported to police and, because private conduct is involved, little illicit use is detected by law enforcement authorities. Recently conducted surveys of drug use or case history files are the only reliable sources of information available.

A.2.2. Production: from the United Nations and some national governments, reliable and accurate data are available regarding the legal production of drugs. They are of limited value, however, unless information is also available regarding the amount of diversion of drugs from the licit to the illicit market. Likewise, these data reveal nothing of illegal production. In this regard, records of police seizures and crop destruction provide partial information, which will have to be supplemented by additional information from knowledgeable sources (police, physicians, etc.).

A.2.3. Distribution: as with production, much reasonably accurate and complete information exists regarding licit distribution, particularly records of importation and export of drugs for therapeutic use. Police data on trafficking are, obviously, unreliable guides to distribution mechanisms and operations, since they vary according to the adequacy of law enforcement in various areas. Again, expert opinion must be relied on for estimation.

A.2.4. Social correlates of drug use: In most countries very little information about the social characteristics of drug users is gathered systematically. General crime data are available, but interpretation of these alone is risky.

A.3. *Methods of Data Collection*

Actual research methods may vary from country to country, depending on the availability of demographic data (census and population survey data), finances and manpower resources. Cultural factors and literacy levels will also play a major rôle in that connection. The following are a number of complementary or alternative approaches that should be considered:

A.3.1. Recent literature including surveys of unpublished, current or projected research.

A.3.2. Identification and assessment of sources of systematically gathered data. These would include official government statistics bearing on drug use, police and court records, public health and coroners' records, as well as hospital admission records.

A.3.3. Informed opinion surveys by structured and uniform interviews with individuals whose information, while perhaps only partial, is nevertheless related to direct experiences with drug use and users. This group might include physicians and psychiatrists, lawyers, social workers,

police officials, sociologists, psychologists and educators. Group discussions can also be employed and the contents of the discussions analysed.

A.3.4. Structured surveys in scientifically selected population samples. This is generally the most sophisticated technique for obtaining an optimal amount of information, but requires the availability of funds and personnel whose training and experience has focussed on this type of survey research. Of prime importance in this approach are knowledge of the level of reliability in the responses and the representativeness of the population sample that will be surveyed. Both the questionnaires and the population sample must be pre-tested before the full survey is carried out in the field. (Cf. also combination with attitudinal surveys, p. 184 below).

A.3.5. In-depth interviews with selected individuals, accompanied, perhaps, by psychological testing and an examination of clinical case histories. Indications for this kind of project will probably come only from the findings of any of the other research approaches suggested above.

A.3.6. Participant observation studies: although requiring personnel with special training in the social sciences (sociology, psychology), such studies can yield valuable information on the life styles and values of drug-using groups. They require the systematic compilation of information obtained through observations made while living or moving with the group under study.

A.4. *Type of Information to be sought*

No specific directive can suggest all the kinds of information that should be gathered on epidemiology in a given country. Some forms of drug use will prevail in one country but not in another. In addition, different

populations may be surveyed in different nations. In general, however, the following types of information can be sought:

A.4.1. Background information: general information, including the following — use of specific drugs by age, sex, educational level, size of family, socio-economic status of either individual or family, occupation, size and condition of residential area, etc., and, if available, also, frequency of drug use, dosage consumed and time frames over which various drugs or combinations of drugs have been used.

A.4.2. Characteristics of drug users and non-users: in order to draw conclusions about the characteristics of drug-using individuals or groups, information must also be compiled regarding the characteristics of non-users. Only in this way can individual and social differences be detected. Among the data that should be gathered are the following — age of initiation into drug use, or cessation of drug use; circumstances in which drug use occurs (alone, at parties, at school, etc.); life situation during drug use, including employment, family relationships and school performance; attitudes of users (and non-users) to health, the law, employment, the educational system, sex, entertainment, religion and politics; their actual practices with regard to the above.

Special information might be sought about interaction of drug users in their sub-culture — patterns of use, way of life, value systems and relations with each other and those outside their sub-culture.

The sources from which users obtain information about drugs can also be investigated. This would include an examination of the rôle of the media, peers and other external influences. Within this framework, information could be sought about the dynamics of learning the

techniques of drug use — e.g. smoking, control of dosage, methods of injecting and other routes of drug administration.

The differential characteristics of users of various specific drugs can also be studied. This yields information, for example, on the way in which LSD users differ from amphetamine users. In this connection, special attention could also be paid to the "progression" from one drug to another, and, in particular, to patterns of multiple drug use.

The sources from which drugs are obtained can also be established. These might be traffickers, friends, fraudulent prescriptions, or theft. Average expenditures on drugs can also be established.

Motivations for beginning, continuing, desisting from or ceasing drug use can also be sought. However, the interpretation of self-reported answers regarding motivation must proceed with caution, since the reported motivation may not, in fact, be the real motivation. It would be useful, however, to determine to what degree the law is a deterrent to the non-medical use of drugs.

A.5. Data on the Production and Distribution of Drugs

An examination and analysis of government records will, in some countries, throw light on the production, importation, distribution and (by inference) the consumption of licit drugs. But an examination of these systems can also provide insight into the dynamics of diversion of legally produced drugs into the illicit black market. The volume of reported thefts of individual drugs from warehouses, pharmacies, physicians' bags or during transit, says something of the kind of drugs that are likely to be in illegal circulation. This aspect of the research will be related to Part C of the plan.

Information about the structure and operation of the drug black market is, for obvious reasons, more difficult to obtain. Convicted traffickers may be willing to provide information, although it should be kept in mind that the black market structure and operations may change with time. In essence, information about the different levels of drug trafficking must be substantiated from a variety of sources — police officers, customs officers, users and, when possible, traffickers.

The price of drugs will have a bearing on trends in use. Information about the prices of licitly distributed drugs will have little bearing on the sale price in the black market, where supply and demand take on different dimensions. Therefore, drug users are themselves probably the best source of information about black market drug prices.

A.6. Data on Referrals to Control Agencies

Some notion of trends and dimensions of drug use can be obtained from data gathered in connection with persons who are either referred to, or seek help from various treatment institutions and other forms of social intervention in drug-related difficulties. In this connection, court records (including juvenile and military courts) can be useful where the court has referred an individual for treatment. In some countries the referrals may be made directly by the police. In addition, the records of institutions where individuals may voluntarily admit themselves will also be useful. These would include public mental institutions and programmes, narcotic maintenance programmes, psychiatric referral services and private treatment clinics. Finally, some community-based programmes (half-way houses, drop-in centres, family counselling services) can also provide information on trends in drug use.

PART B

ATTITUDINAL STUDIES

Attitudes, both public and individual, will determine the manner in which individuals and groups will probably respond to forms of control or outside intervention in their affairs. This is true of law, government, education and a host of other institutionalized approaches that societies adopt for purposes of social stability. The goal of this component of the country studies research plan is, then, to attempt to ascertain the nature of various attitudinal responses to drug use and controls and programmes relating to them. These responses may allow policy-makers to estimate actual or potential levels of toleration of drug use as well as acceptance and rejection of particular approaches to prevention, law enforcement and treatment; this in turn is essential for all planning of control policies and the allocation of resources in that connection. It will complement the epidemiological information obtained through Part A of the country studies and is, of course, linked to cost-effectiveness analyses that might emerge from Part C.

B.1. *Methods of Data Collection*

Various methodological approaches are possible, either in combination or as alternatives. The choice of technique will depend on the financial and technical resources available in individual countries. In general terms, however, the following approaches should be considered:

B.1.1. Opinion polling techniques: relatively small samples of target groups can be employed to yield informa-

tion about attitudes towards various aspects of drug use. Countries employing questionnaires or interview surveys can, at very little incremental cost, include questions relating to attitudes in the epidemiological survey described in Part A (p.178 above).

B.1.2. Individual interviews: such interviews following uniform interview guides, can be conducted in population groups. Groups might include opinion leaders (e.g. journalists, religious leaders); the medical profession; criminal justice system operators (police, judiciary, correctional personnel, probation and parole officers); educators; prison population and former convicts; drug users, former users and persons in treatment.

B.2. *Information to be Obtained*

It must be borne in mind that attitudes are shaped, in part, by knowledge. Therefore, research in this field must also attempt to establish the level and kind of information about drugs and drug use that helped shape the various attitudes. Therefore, questions should be designed to discover:

B.2.1. Awareness and knowledge of drugs, their effects and drug users.

B.2.2. Knowledge of the legal system (prohibitions, penalties. etc.) as it relates to drug offences.

B.2.3. Attitudes towards different kinds of drug use (by type and amount of drug; by type of user, including age and sex); is it considered deviant, harmful to the individual user or to society, should it be controlled or prohibited, and if so by whom?

B.2.4. Attitudes towards the existing law and the particular agencies of the legal system (courts, police, etc.).

B.2.5. Attitudes and expectations regarding other forms of social intervention (e.g. compulsory treatment, voluntary treatment, narcotic maintenance programmes).

B.3. *Groups to be surveyed*

It is suggested that the following population groups could be surveyed and the data collated in the following categories:

B.3.1. Youth (14 to 18) in school, industrial training or apprenticeship, non-school, drop-outs.

B.3.2. Young adults (18 to 25) in university, apprenticeship, employment, unemployed, housewives, the military.

B.3.3. Adults (25 to 60).

B.3.4. Older persons.

PART C

AN INVENTORY OF CONTROLS
AND OTHER RESPONSES

The purpose of this phase of the research programme is to provide the policy-maker with an inventory of all of those mechanisms available for coping with the non-medical use of drugs. Clearly, the findings of this research relate to those yielded in Part A (epidemiology and production data) and Part B (attitudes towards various forms of response). Even in its crudest form, the information made available through such an inventory can provide a rough estimation to the policy-maker of the adequacy of the responses available.

An inventory alone cannot, without further and more sophisticated research, tell a great deal about the effectiveness of the various programmes and policies being pursued. Impact and cost-effectiveness studies, utilizing the information contained in the inventory, may be appropriate in some countries, and UNSDRI would be prepared to assist in designing such studies in countries where they were felt useful and appropriate. In any event, the inventory of controls and intervention mechanisms is an essential first step.

A proposed checklist of items to be covered by such an inventory follows. It is not necessarily comprehensive, nor will all of the items contained in the list be relevant to each country.

C.1. *Legal Controls*

C.1.1. A description and history of legal controls in force in the country (fiscal and administrative controls as

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well as penal controls) regarding the production of drugs, distribution, possession and administration. This should include a description of statutory provisions and practices regarding criminal sanctions (fines, compulsory treatment, sentences, criminal record, etc.), procedures, conditional discharge, probation or parole, the classification system and underlying criteria as well as international treaty commitments.

C.1.2. Statistical data should be collected and collated by type of offence (possession, trafficking, importation, etc.) and the specific drug involved. This information should further be differentiated by the number of arrests, convictions, acquittals and sentencing patterns.

C.1.3. Law enforcement structure and operations should be described as they relate to non-medical drug use (including alcoholism). This will involve information regarding the number and qualifications of law enforcement personnel, and quantitative records of achievements (seizures, crop destruction).

C.1.4. The judiciary, including prosecution, parole and probation systems should be surveyed along with a description of the processing followed in connection with sentencing, commitment for treatment, conditional release, probation and parole.

C.1.5. Correctional institutions to which drug users are referred should also be included in the inventory. These will include both centres for preventive detention and therapeutic facilities. Information should be compiled by type of drug offence, size of institution and by institutional programme (including educational, therapeutic and occupational facilities), administrative structure, type of supervision and the number of inmates.

C.1.6. Non-criminal legal controls should also be examined. These include the use of taxation, administrative devices (licenses, permits, etc.) and civil commitment.

C.2. *Medical Controls*

C.2.1. The nature of existing medical facilities for treatment of drug-related conditions should be described. In-patient programmes should be surveyed as well as programmes for ambulatory treatment, community-based projects (street clinics, etc.) and estimates can be made of the number of drug users being treated by physicians in private practice, as well as by para-medical personnel.

C.2.2. Methods of referral warrant inclusion in the inventory in order to provide a complete picture of the operation of the catchment network. This includes a survey of the legal provisions respecting voluntary and involuntary treatment, intermediate systems and civil commitment and the referral practices that can be followed by physicians, schools, employers and families.

C.2.3. Narcotic maintenance programmes should not be excluded. The programmes can be described, the number of individuals in such programmes estimated, the referral methods described and the criteria for admission to such programmes identified. Descriptions of maintenance programmes should include adjunctive or follow-up programmes of rehabilitation.

C.3. *Community-Based Programmes*

These programmes warrant special attention because they are closer to "the street" and in many countries may constitute the most effective contact of society with the drug user. The extent and nature of such facilities (including drop-in centres, half-way houses or therapeutic

communities) should be described, the programme activities identified as well as the nature of their relations with other helping agencies in the community, referral methods, the average number of individuals in the programmes, the duration of involvement in the programme and the nature and qualifications of the personnel who operate the facilities.

C.4. Other Forms and Factors in Social Control

C.4.1. Educational programmes related to drug use should be examined, the programmes described; where appropriate, methods of evaluation of results should be identified, as well as the specific audiences to which the various programmes are directed.

C.4.2. Crop substitution programmes, where these are operational, can be examined, although an evaluation of their effectiveness will require the collection of data of a nature beyond the scope of this inventory. Some general characteristics of the programme (acreages and populations involved, substitute economic activity, etc.) can be described, however.

C.4.3. In some countries special studies may be in progress or recently completed which describe the rôle of some social entities in the area of non-medical drug use. This would include the family, the mass media, religious groups, employers and labour unions, the military and recreational and service groups. These should be included in the inventory.

ITEMS OF PRELIMINARY INFORMATION

The questions which follow were already considered at the Frascati workshop. They constitute a first step in determining the scope of data already existing as well as in assessing the reliability of these data. It is suggested that answers to these questions should be obtained before designing a country study research programme. This will allow researchers to determine more adequately the form and volume of the research appropriate in individual countries as well as to make a rough estimation of the time resources that will be required to conduct the research.

1. What research relevant to drug use has recently been conducted, or is currently under way in your country?
2. Has a survey of the existing literature related to non-medical drug use been undertaken recently?
3. Are timely demographic data now available concerning your national population? Regional populations?
4. Do current statistics exist with respect to the production, importation, and use of drugs for medical purposes? For non-medical purposes? Are they available? Are they reliable? Do statistics exist regarding drug prices?
5. Are national crime statistics related to drug offences available? From what sources and in what forms are they available (e.g. arrests, convictions, sentencing patterns, recidivism rates, juvenile delinquency)? Are they now classified, or could they be classified by offence(s)? By drug(s) involved?

6. Are public health statistics available which yield information regarding non-medical drug use in your country (e.g. deaths, hospital admissions, prescribing records)?
7. Has attitudinal research related to drug use been undertaken in your country? Related to other forms of delinquent behaviour?
8. Are market survey and opinion polling techniques employed in your country? Are the samples surveyed adequate and representative for purposes of the country study programme?
9. Is it possible to conduct questionnaire-type surveys in your country?
10. Can research be conducted into informed opinion respecting drug use in your country? What groups have been interviewed?
11. Is it possible to assemble a team of field workers to conduct interviews?
12. Are facilities for coding and data processing available?

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