PRIMARY DRUG PREVENTION: DEVELOPMENTS IN GERMANY SINCE THE 1970S

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Primary drug prevention in Germany has been in a constant state of transition since the early 1970s. Five consecutive phases can be identified: (1) drug deterrence and repression; (2) drug education and drug information; (3) primary drug prevention through alternatives to risk-taking, and the strengthening of personal resources; (4) primary drug prevention through strengthening of personal and social resources, promotion of resistance and life skills; (5) primary drug prevention through strengthening of personal and social resources, promotion of resistance and life skills, the promotion of harm reduction and competence in risk-taking with young people who may already consume legal or illegal drugs. During the last decade, the concept of health promotion, with its integration of individual, contextual and structural prevention has served as a guide. Beginning in the mid-1990s, secondary and tertiary prevention efforts have attracted growing interest. The integrative concept of "risk-taking competence," which introduces harm reduction approaches into primary prevention strategies, is favored in contemporary discussion and practice.

DEVELOPMENT AND CHANGE THROUGH THREE DECADES

The efforts directed at primary prevention of drug addiction in Germany have been in a constant state of transition. Since the early 1970s there have been a continuous series of developments in primary prevention strategies; in some respects there have even been paradigmatic changes in these concepts, methods and ideas.

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At first professionals practiced drug-specific educational approaches, followed by life-style and context-oriented methods for the prevention of risk-taking behaviors. Beginning in the 1990s, the concept of health promotion, with its integration of individual, contextual and structural prevention methods served as a guide in these efforts. By the mid-1990s, secondary and tertiary prevention programs associated with the drug help system [Drogenhilfesystem] were met with growing interest. Most recently, harm reduction approaches have been coupled with the promotion of risk-taking competence.

A ubiquitous motto associated with prevention efforts in Germany has been "strengthen the children and youth" against contact with drugs and drug addiction. Recently this slogan has been complimented by a second goal: "Enable and safeguard youth" in case they are already engaged in risk-taking behaviors. Professionals working in primary drug prevention programs have welcomed the theoretical and practical imputs of relevant disciplines (e.g. therapy for alcoholism and drug addictions, HIV/AIDS-prevention, traffic safety education, developmental psychology and youth risk research, health promotion and public health). Since the end of the 1980s, the integration of primary drug prevention into health promotion strategies has been a critical concern. In Germany, professionals and planners were encouraged to adopt WHO's Ottawa Charter of Health Promotion, and especially its four strategies, including a philosophy of advocacy, enabling, mediating, and community participation.

Constant change and development have also led to inconsistencies in theories and models of good practice. Specific institutional, regional, and political differences shape these changes and the individual or generational backgrounds of the professional and political actors also affect theories and models of good practice. Furthermore, the dramatic changes that the1989/1990 German reunification fostered in the formerly socialist regions of the Federal Republic of Germany cannot be neglected, as they have had a major influence on the German welfare system.

At the present time a majority of professionals suggest a salutogenetic and empowerment-oriented concept of primary drug prevention as part of health promotion in all personal, family, community and social systems and sectors. Nevertheless, as part of the above-mentioned inconsistencies, personal and institutional gaps still exist between those who advocate traditional, repressive approaches and others who favor empowerment methods. Newcomers to primary drug prevention often follow a series of developmental stages as they modify their self-perceptions. Many of these persons proceed from an initial commitment to drug education that focuses on abstinence as the goal to a more general promotion of health and life-skills competence orientation in their interventions with youth.

Primary Drug Prevention

The conceptual and practical dynamics of these philosophical changes may be divided into five consecutive historical phases, beginning at the end of the 1960s and continuing up to the present time. In each case, the emerging phase takes up the focus of the previous one, but modifies and/or enlarges it by adding new components and/or eliminating previous elements. The process is best understood as a continuous feedback loop (see Figure 1).

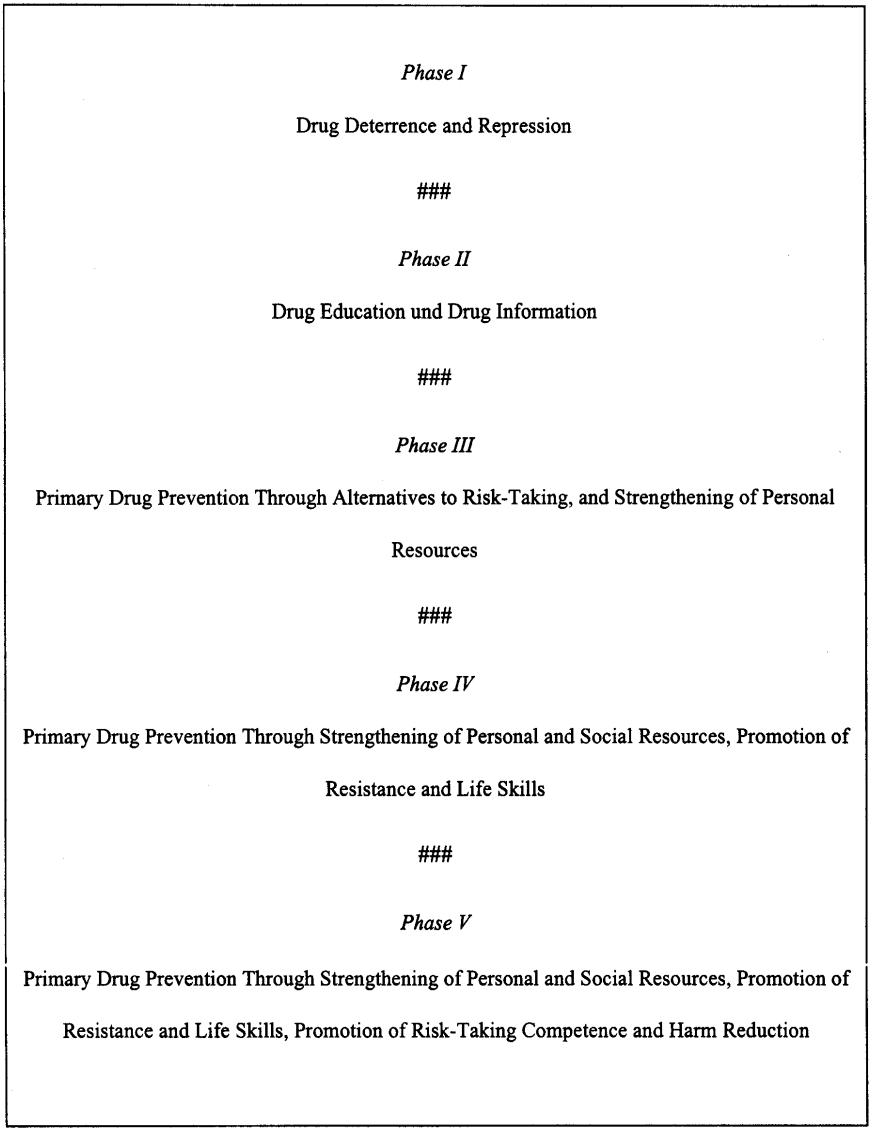
Phases I & II: Drug Deterrence and Drug Education

From the end of the 1960s to the mid 1970s when the first so-called drug wave [Drogenwelle] reached Germany, most approaches aimed at fighting drugs and any use of illegal drugs among youth by focusing on repression and deterrence. Drug-related information and drug education were designed to arouse fear, emphasizing the dangers and risks of all drug-taking. Experimenters, occasional users and regular users of illegal drugs were all blamed for their ill-chosen behaviors, risking penal prosecution by doing so. Drug use was described as being closely related to delinquent or "drop-out" life-styles. Experimentation and other forms of consumption were seen, with hardly any exceptions, as one-way tickets to addiction, social disengagement and mental and physical misery.

During this early phase, there was a severe stigmatization of illegal drugs and their consumers. Characterized by repressive strategies and mostly distorted information about drug effects [Drogenwirkungen], drug prevention efforts were directed at youth who already held negative attitudes about illegal drugs, that is to youth who were not in any real danger of embarking on an addiction career [Drogenkarriere]. By focusing these programs on illegal drugs, the more prevalent epidemiological hazards of popular legal drugs such as alcohol and nicotine were effectively ignored.

During the mid-1970s approaches to drug education changed, alterations which fostered the provision of more complex information about illegal drugs and their consumption. In addition, those promoting these new efforts embraced a relatively neutral stance and included more complex information in their messages about drugs, drug taking and its physical, mental and social consequences. The possibility that positive drug experiences could occur was no longer denied, as it had been previously. During this phase, a more liberal message was formulated: occasional consumption of illicit drugs for recreational or short-term compensatory purposes might be tolerable if it occurs in a controlled setting and is done in a socially acceptable manner. Consistent with this approach, practitioners of primary drug prevention and drug therapy resisted the traditional hidden agenda of "blaming the victims." In contrast, they emphasized the social and systemic determinants of social life-styles on youthful drug use, as well as the significant role played by the

FIGURE 1
RISK-TAKING COMPETENCE AS A FACTOR FOR BOTH PRIMARY AND SECONDARY/TERTIARY DRUG PREVENTION



culturally accepted drug, alcohol. The new focus was illustrated by campaign messages such as, "Perfectly normal addicts come out of perfectly normal families."

PHASE III: PRIMARY DRUG PREVENTION THROUGH ALTERNATIVES TO RISK-TAKING AND STRENGTHENING OF PERSONAL RESOURCES

After the 1970s, a conceptual reassessment occurred that led to a new wave of methods and projects in primary drug prevention. The traditional focus on deterrence or negative information was now regarded as biased and counter-factual. In rejecting these past approaches, it was noted that there had been many harmful "unintended consequences" of repressive prevention efforts. By blaming all consumers of illegal drugs as being responsible for their own misery (blaming the victim), these young people had been subjected to repression and criminal prosecution without any attempts being made to provide them with psychosocial support or help.

At this juncture the mainstream of primary drug prevention was readjusted to embrace non-repressive attitudes, information and education. It was also acknowledged that there was an obligation to provide unconditional help in cases of drug-related emergencies, heavy misuse and/or manifest addiction. No longer were illegal drugs and their associated life-styles the core of preventive information and education. Legal substances, and especially the misuse of alcohol and dependency on prescribed medications were now seen as appropriate topics for primary prevention.

One self-proclaimed objective of primary drug prevention during its first phase had been to decode basic biographical experiences, cultural attitudes, developmental challenges and individual stressors which were thought to have been responsible for drug experimentation, misuse and addiction. Proponents of this individual approach held that this information could lead to successful causal and/or compensatory interventions in drug use prevention. A typical slogan of educational strategies and campaigns during this phase was (and still is): "addiction always has a history." By strengthening personality and reducing stress-related problems, primary prevention specialists wanted to engender constructive coping mechanisms for dealing with developmental and other stressors.

This new orientation was a result of a "new wave" of empirical research, both epidemiological and qualitative, on risk-taking behaviors in adolescence. A major goal of this research had been to gain a better understanding of the individual rationales for drug-taking and drug misuse in the context of everyday developmental tasks or developmental crises. For the first time, this research acknowledged how and when sub-cultural life-styles may determine transitory and experimental drug use, and did so without imposing moral values on the data. New prevention approaches and their proponents took notice of the psychological concept of

developmental tasks, weighing not only negative but also potentially positive developmental functions of these risk exposure behaviors.

Beginning in the 1980s an experimental mindset prevailed with regard to methods and measures of drug education. While drug-specific information was not completely dismissed, it was modified according to the new functionalist understanding of the attraction of risk-taking. Practical efforts were concentrated on the promotion of functional, and "fascinating" alternatives to the kick and thrill associated with drug use and misuse. For example, adventure pedagogics (teaching how to constructively cope with risks in a non-drug adventure setting), and extreme sports [Extremsportarten] activities gained importance as counterparts to traditional cognitive approaches to prevention. While remaining rather popular among many professionals, in the 1990s adventure pedagogics faded in conceptual importance because of the growing lack of empirical evidence that they were actually effective deterrents.

PHASE IV: PRIMARY DRUG PREVENTION THROUGH A STRENGTHENING OF PERSONAL AND SOCIAL RESOURCES, PROMOTION OF RESISTANCE, AND THE DEVELOPMENT OF LIFE SKILLS

Beginning in the early 1990s, an increasing number of primary prevention specialists were attracted to comprehensive strategies that combined drug resistance training with the more general approach of life skills promotion. Here the development of a strong, stable and competent personality was regarded as an effective buffer against drug-related and other developmental risks. Based on a growing body of behavioral, psychological and epidemiological research and practice that had been developing in the United States during the previous decade, the promotion of the combination of resistance skills and life skills was accepted as the concept of choice. In both single and group trainings attempts were made to build skills for conflict resolution, the capacity to cope with social and developmental stressors and the promotion of self-efficacy. These efforts were used in combination with training regarding the development of specific drug resistance skills directed against alcohol, nicotine and illegal substances. Altogether, it was thought that not only young people, but their parents as well, could be enabled to cope constructively with developmental stressors and crises that had previously led to drug use.

Immunization programs were directed at elementary school children, and plans were made to provide supplementary/refresher sessions in later years. In nearly all of these situations, the methods and measures used were to be scientifically based and evaluated, a research based approach that was adapted from the American experience in the 1980s. However, for many professionals working directly with youth who were both drug and risk takers, the functionalist understanding of risk-taking as a developmental experience remained their guide.

Campaigns and concepts that were developed included slogans such as "Strengthen the children" or "Strong instead of addicted." In conjunction with the skills promotion approaches, a structural intervention component was introduced. Thus, primary drug prevention in Germany was quickly adapted to the WHO philosophy of health promotion. A commitment was made to intervene in the "life-world" [Lebenswelt] of children, their parents, teachers and the entire community in order to build a lasting program of health promotion.

PHASE V: PRIMARY DRUG PREVENTION THROUGH STRENGTHENING OF PERSONAL AND SOCIAL RESOURCES, PROMOTION OF RESISTANCE AND LIFE SKILLS, AND THE PROMOTION OF RISK-TAKING COMPETENCE AND HARM REDUCTION

Health promotion was a strong emphasis of modernization, but it soon proved to be unsatisfactory in dealing with the new problems that primary drug prevention faced in the mid and late 1990s. At that time, the use and misuse of so-called party drugs, ecstasy, MDMA, speed and others, rose dramatically among German youth, especially in rave subcultures. Also, the rates of harmful poly-drug consumption had increased. Following three decades of professional and institutional segregation, the systems of primary drug prevention and drug treatment [Drogenhilfesystem] finally became permeable, as prevention experts became amenable to the inclusion of tertiary prevention as adjuncts to their programs.

In its current phase, abstinence no longer serves as the core goal of German primary drug prevention efforts. Rather, safe(r) drug-specific use and increasing general risk-taking competence have become equivalent objectives when reaching out to all drug-experienced adolescents and youth, and especially with regard to hard-to-reach subgroups. In a further step, and one that has not yet been fully realized, the concept of building risk-taking competence (which includes the option of abstinence) will be expanded to cover all adolescents and all psychotropic substances, and especially alcohol.

The notion of risk-taking competence embodies several interrelated components. The first of these is the provision of comprehensive, non-biased, realistic and explicit information about legal and illegal drugs, their effects and side-effects, and the potential hazards of non-recreational use, misuse and addiction. The second concern is the development of informed action with regard to all drugs, drug-taking and drug addiction. A third component is the development and critical evaluation of norms for use in order to minimize personal risks and prevent or reduce harmful consequences for family, school, community and society. Fourth there must be a formalization of ritualized patterns and contexts, sets and settings of a non-harmful (safe) use of psychotropic substances. Fifth is the promotion of consistent abstinence [Punktnuechternheit] in selected settings and/or developmental stages (childhood,

early adolescence, pregnancy, schools, work-places, hospitals, etc.). Finally there must be the assurance of freedom of decision making – with regard to the mental, social and legal stage of development in adolescence and youth – the goal is to foster self-determined risk-taking in a continuum reaching from abstinence, through reflected and controlled substance use, to (temporary) risky misuse patterns. Each stage is safeguarded by harm reduction and counselling regarding risk accompaniment ["Risikobegleitung"].

The drug treatment system revealed successful examples for primary prevention with regard to long-term positive experiences in peer education, harm reduction and the practice of counselling consumers regarding safety concerns, but not for demanding abstinence. Primary prevention experts quickly adopted suggestions such as the idea that there should be safety rules established regarding use and misuse, and that unbiased support and help should be made available in case of emergency. All of those innovations however, were to be imbedded in non-repressive, pragmatic counselling and with the provision of developmental support. It soon became clear that the provision of accurate information and harm reduction strategies can only work when drug education and prevention practitioners modify their "hidden" agendas, allowing for an accepting approach ["akzeptierender Ansatz"] towards young people's risk-taking, drug experimentation and drug use.

It must be repeated that the promotion of risk-taking competence always allows for the promotion of occasional or general abstinence. Building resistance skills among early adolescents and the promotion of life skills through the childhood and youth years remain the backbone of today's primary drug prevention efforts in Germany. In the current praxis, however, they have been enlarged and are now accompanied by a more accepting approach with a new focus on drug-specific counselling, safety rules and harm reduction practices.

Parallel to these conceptual changes, preventive programs and institutions in Germany during the 1990s concentrated their efforts on sub-groups and sub-cultures which were either at high risk for addiction or which had not been adequately reached before. Gender-specific drug prevention, prevention aimed at migrant youth, and work with male youth, especially in social problem areas, are three examples of this new approach. Furthermore, in all areas and institutions we find an increasing trend towards interdepartmental networking, project evaluation and quality management.

CURRENT STATE OPTIONS AND PROBLEMS

As we have noted earlier, up until the mid 1990s, nearly all primary drug prevention in Germany was based on the professional and political idea, that abstinence should be enforced with regard to all illegal drugs, as well as with the

non-medical use of prescribed medications. This orientation was modified only with regard to the primary cultural drug [primaere Kulturdroge], alcohol. With alcohol, however, even the German government in its National Alcohol Action Plan of the 1990s spoke out for acceptance and tolerance, operationalizing their objective as the moderate and self-controlled use of this drug, a position that was found acceptable for this drug only.

Over time the ruling "dogma of abstinence" became more and more questionable. Youth risk research and decades of professional experience suggested that a more realistic, pragmatic position was called for. In the early 1990s, youth researchers and public health scientists formulated two new fundamental questions:

- Given that coming to terms with risk-taking behavior is "normal" and/or normative in the development of adolescents, how can such behavior be limited to non-harmful experimentation or short-lived misuse?
- How can we assist young people to avoid or minimize harmful long-term effects on personal integrity and coping resources when engaging in risk-taking behavior?

Coming to terms with (not only drug-related) risks and risk-taking is now widely regarded as a genuine developmental task of adolescence and youth. In Germany and Western Europe, it is both normal and normative that young people are initiated into alcohol-tolerant cultures. Experimentation with alcohol, and in smaller subcultures also with cannabis and/or party drugs, is a normative, transitional experience in the process of growing up. As such, prevention cannot assume the narrow objectives of enforced abstinence, proclaim a hypocritical "war on drugs," or a double-standard position of "just say no." Longitudinal studies carried out in Germany since the early 1970s reveal that in every generation the overwhelming majority of adolescents and youth do come to terms with legal and illegal drugs in a stable, non-harmful, and risk-competent manner.

One model for policy and practice is the British Department of Health's non-dogmatic campaign for alcohol prevention and control: "Sensible Drinking," which started in 1981. Aimed primarily at the adult population, practical rules for alcohol consumption are recommended, stressing both limits and positive potentials. The British rules for controlled, sensible drinking are operationalized in terms of maximal units per week with recommendations for prescribed drinking intervals and participation in activities taking place in non-alcohol settings. These standards are based on epidemiological evidence regarding the benefits and risks of alcohol use with regard to cardiovascular health and psycho-social well-being. The application

of this concept and practice to youth, whether in Great Britain or elsewhere, has not yet been undertaken, although it seems long overdue.

Primary drug prevention proponents must never lose sight of the socio-ecological lessons of all drug education and modern health promotion. Specifically, negative social milieus and socialization severely limit the possibilities of achieving preventive success. Children and youth from groups and sub-cultures with long-term stressors and social burdens [hoch belastete Lebenslaeufen und Lebenslagen] will always be more susceptible to early drug misuse and drug addiction with both legal and illegal substances. These high-risk youth need comprehensive personal and social support, as well as structural interventions in and improvements of their life-situations [Lebenslage], in order to reinforce their resistance to drugs. With these high-risk youth, however, cognitive education approaches and behavioral training of resistance and life skills alone, without any socio-ecological interventions, will not have long-term preventative effects. Problem consumers and their settings require the application of specific strategies, and these must not be mingled with those aimed at the majority of youth and their less harmful forms of transitional drug use.

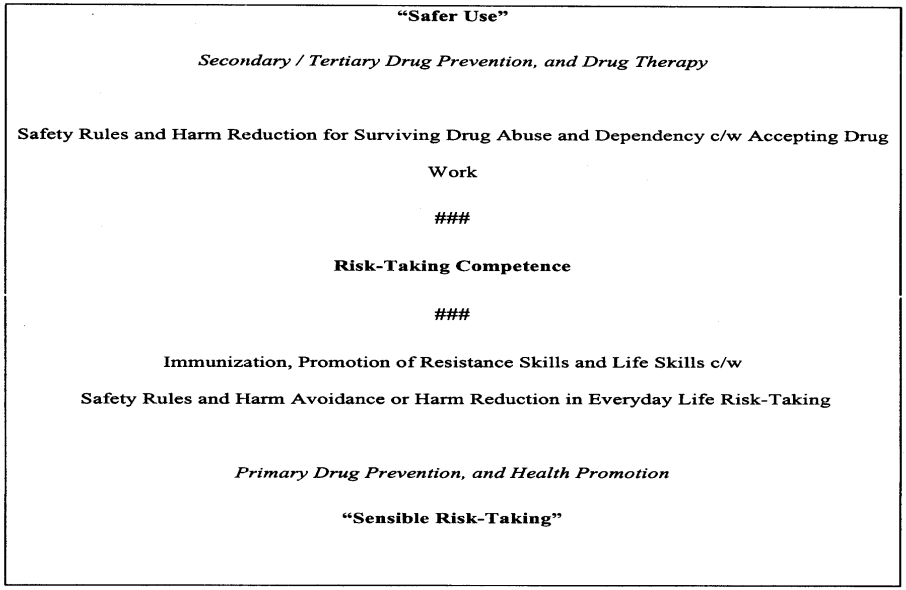
A second problem continues to affect both theory and practice. For decades, inadequate and even inaccurate information about the effects of controlled alcohol and illegal substance use has been the norm. This distortion has resulted from the fact that the mainstream of research and policy has narrowed its scope to models of disease, studies of crisis, delinquency and/or psychopathology. Its focus has been on addiction, and a litany of other negative effects associated with drug use and misuse. Not surprisingly, its analyses drew equally narrow conclusions with regard to prevention, based on consumption patterns and drug effects that were only relevant for those with addiction careers [Suchtkarrieren]. Unbiased research related to more successful "risk-taking careers" was neglected. At this point, such research is long overdue, and its importance for structuring new, more effective primary prevention techniques cannot be underestimated.

With the recent acceptance of harm reduction and risk-taking competence as legitimate goals for drug prevention efforts, the efficiency of earlier narrow and conservative approaches have been questioned. Nevertheless, the new orientation and its complex mix of competence promotion and harm reduction raises its own set of questions:

- Given that we do not have sufficient experience and/or data on the measures [Masse] that adolescents and youth employ for self-controlled, non-harmful risk-taking, how can these be operationalized and properly communicated to youth, parents, professionals and policy makers?

- To what extent can a youth's self-determined strategies be tolerated as functional for coping with developmental tasks and as non-harmful for long-term stability and health? When, for whom, and in what settings do they have destructive effects?
- Can we determine measures and rituals that may serve as safety rules for recreational use as well as the transitory misuse of alcohol and other psychotropic substances?
- What age-related differences should there be with regard to these safety rules? What are the gender-related differences in risk-taking competence? What subcultural differences have to be considered?
- What are the limits of risk-taking competence with regard to consumption of several drugs at the same time [Mischkonsum], or polydrug use [Polytoxikomanie]?

FIGURE 2
RISK-TAKING COMPETENCE AS A FACTOR ESSENTIAL FOR BOTH PRIMARY AND SECONDARY/TERTIARY DRUG PREVENTION



- What are the developmental preconditions and legal requirements for testing and evaluating safety rules and harm reduction in the context of practical drug use in a teaching setting? Is this possible or desirable?

In addition to these questions pointing to possible problems and conflicts in the future, it can be stated that in Germany's current phase of primary drug prevention, the two previously separate drug-related welfare sub-systems are approaching one another. The concept of risk-taking competence offers a great deal as the unifying theme for primary "sensible risk-taking," secondary and tertiary drug prevention "safer use"; see Figure 2. Following three decades of continual conflict and the construction of irrational barriers, there now seems to be a reasonable chance of achieving complimentary, coordinated and effective drug prevention work.