there was too much permissive therapy of the young psychopath. Dr. Wilfred Warren said that he always avoided using the term psychopath for adolescents, and did not believe in permissive therapy. One could not treat a mare running loose in a field; first it had to be caught and controlled. The same applied to adolescents, who often required training and education as well as treatment, and in many cases these were more important than treatment.

Suicide in Adolescents

Professor E. Stengel (University of Sheffield) stated that suicidal attempts in adolescence had increased, and that this might be related to the increase in delinquency. The factors common to most cases were inability to cope and aggression. Aggressive tendencies could find an outlet in antisocial behaviour or be directed against self in the form of suicide. The increase in alcohol- and drug-taking by teenagers might lead to a further increase in teenage suicide.

A teenager in the audience asked what there was left to believe in after the individual had been educated. It did not take long to learn that religion was nothing more than a means of integrating society, and there was then nothing left to trust except one's own feelings. Nothing was real any more except what one felt oneself. This was not enough—so one repented the people who had done this, and detached oneself from the values of society.

The discussion concluded with criticism of the cynical, commercial exploitation of teenagers—of which drug addiction was one feature. This was commercial exploitation of the teenager by the drug peddlers.

In concluding, Mr. Quintin Hogg said that the meeting had shown that both natural laws and supernatural qualities could help to reduce teenage difficulties. He felt that the supernatural qualities associated with religion were not acceptable by the majority, that everyone could be made to accept natural laws. Nobody believed that lies, hate, sexual irresponsibility, drug taking, and crime were right, but the teaching profession, the law, parents, and others in authority had not had the courage of their convictions about these things.

Health Education and Venereal Disease

[FROM A SPECIAL CORRESPONDENT]

At a meeting of the Royal Society of Health held in London on 17 February Dr. R. S. Morton (Sheffield United Hospitals) and Mr. Ambrose King (Whitechapel Clinic, London) spoke on health education in the prevention of venereal disease.

Referring to the high and rising incidence of venereal disease throughout the world, Dr. Morton pointed out that the incidence of gonorrhoea had more than doubled in America quite recently—while in Britain 100,000 persons, or 1 in 500 of the adult population, sought advice every year from venereal disease clinics. About half of those attending had some form of venereal disease, one-quarter had some other condition, and one-quarter sought reassurance because of a casual exposure to infection. The rising incidence of venereal infection was greater in young people, particularly teen-aged girls, immigrants, and male homosexuals. Girls aged 15 to 19 formed 6.4% of the female population, yet in this age group constituted 40% of the cases of female gonorrhoea, with an infection rate of 1 in 660. The lower incidence in males of the same age was not due to greater chastity but to the higher degree of promiscuity in the women concerned. Immigrants, who had an infection rate of twenty times the overall national figure for males, were largely infected after arrival in this country. In some London clinics about 12% of all male patients were homosexual. There was an alarming increase in venereal infection among students, some of whom were sexually promiscuous. About 0.5% of all students in this country sought advice from venereal disease clinics.

Dr. Morton considered that much of the increase in venereal disease could be attributed to lack of education on the subject, diminished parental control, increased mobility of the population, the modern affluent society, widespread availability of contraceptives, and the moral laxity of some television productions. In some of the latter casual and extramartial sexual intercourse were considered to be quite normal rather than abnormal. Health education to combat venereal disease was in the hands of various authorities, but Dr. Morton doubted if it was being treated seriously enough.

Role of Education in Prevention

Mr. Ambrose King discussed the educational methods that might be adopted to control venereal disease. Fornication and adultery had come to be accepted as normal activities in our society, but illogically there was nothing but contempt for those unfortunate enough to suffer from one of the effects of promiscuity—namely, venereal disease. This attitude was also found among the medical and nursing professions. Patients with venereal disease feared contempt and moral reprobation, and this led to concealment and neglect. In his view, therefore, we must educate not only the public but also doctors and nurses to approach the subject humanely and sensibly. In particular, young people should be properly instructed in sex matters. In one investigation of 1,000 males belonging to the lower socio-economic group and suffering from gonorrhoea, 54% acquired the infection in their teens, and the average age at which sexual experimentation began in this group was 13.

Sex instruction by parents and teachers, which should start early in life, should be frank and without embarrassment, and should be followed by systematic instruction given to individuals or small groups in the schools, preferably before the age of puberty. An educational campaign directed towards homosexuality was also needed, as many of them seemed unaware of the risks they ran of contracting venereal disease. The medical profession had the responsibility of ensuring that the right kind of information was available to those who gave instruction, who should be selected for their ability and personality and not necessarily for their technical or specialized knowledge. Those with highly specialized knowledge of the subject frequently failed to put the essential information over, although their help was invaluable to lay educators. Venereal disease was largely spread by sexual promiscuity. Health and sex education should therefore be directed to preventing this. Efforts should be made to inculcate a healthy moral attitude; to give the facts of venereal disease, its consequences, and method of prevention; and to encourage the infectious and infected to report for diagnosis, treatment, and follow-up. However, habitually and persistently promiscuous people usually had sustained damage to their personalities in childhood, and were difficult if not impossible to re-educate. Social and psychiatric research into this group and their problems was essential.

Mr. King considered that fundamentally the question was one of moral sense and the development of the will and character. Moral sense distinguished between right and wrong and people should be given sufficient information to encourage them to adopt correct moral standards. Those with religious convictions had a greater sense of idealism and morality and were more likely to observe moral standards in sexual relationships. Sex education restricted; anatomical and physiological facts was quite useless in preventing venereal disease; sound reasons should be given for sexual restraint. Knowledge itself did not confer virtue. Much of the modern literature and advice on sex to the young but that the young was debasing. The young should be taught that sexual intercourse was not just another form of amusement, and that premarital restraint and marital fidelity were the ideals they should attain. Unfortunately modern methods of contraception were leading to the negation of these ideals and to increasing promiscuity, with venereal disease in its train.

Methods of Instruction

With regard to the methods of instruction, Mr. King considered that group discussions
Forged Prescriptions

[FROM A SPECIAL CORRESPONDENT]

The Pharmaceutical Society of Great Britain and the British Academy of Forensic Sciences held a joint meeting on "Forged Prescriptions" in London on 17 February.

Opening the meeting the Chairman, Mr. J. C. Bloomfield (President, the Pharmaceutical Society of Great Britain), pointed out that the problem of forged prescriptions was linked with the growth of drug dependence and that all available information should be reduced to the quantity of drugs obtained in this way. Dr. T. E. A. Carr (Ministry of Health) said that in 1965 monthly returns from executive councils showed that 889 altered or forged prescriptions were detected. Nevertheless, these figures had to be set against the 45 million prescriptions for 230 million items prescribed in 1965 under the Health Service. The increasing incidence was more disturbing than the actual number of forgeries. Perhaps surprisingly forged prescriptions for dangerous drugs were a poor third in popularity, being exceeded by the amphetamine group, especially for Dinitropropyl (amyllobarbitaline and amphetamine), and the barbiturates, and followed by the tranquilizers and other items.

Turning to the forgers themselves, Dr. Carr thought that they were mainly amphetamine- or barbiturate-dependent, although the purpose restrictions for morphine and cocaine might alter this. The taking of the latter two drugs for any length of time would lead to addiction in even the most robust person, but some instability of character was required for dependence on the amphetamines or barbiturates to occur. The doctor should weigh the benefits and risks of these drugs very carefully before prescribing, particularly in patients of unstable character, where in fact they were often used with great benefit. The early detection of dependence meant that doctors had to keep good records, so that increasing attendance for repeat prescriptions was quickly noticed. All doctors had been circulated by the executive councils in 1964 and given advice—to use words for quantities of addictive drugs and to guard against patients their partners, posing as temporary residents, and claiming that prescriptions had been lost; and to take care of E.C.10 prescription pads, which were easily stolen from the surgery.

Pharmacist's Position

The pharmacist's position was considered by Mr. A. D. Oxford (Inspector under the Pharmacy Acts, the Pharmaceutical Society of Great Britain). He stated that the middle-sized busy pharmacy, particularly in districts declining socially, was the most likely to allow forged or altered prescriptions to be dispensed. Alertness in such pharmacies was reduced because genuine scripts were often written badly, incompletely, or ambiguously, and part-time and changing staff did not know the patients or the doctors. In 1964–6 226 male and 253 female forgers had been detected by the Inner London Executive Council. The peak age group was in the 20s in men and between 30 and 50 in women. The forger revealed himself by being in a tearing hurry with a very urgent prescription. A useful ruse if forgery was suspected was to keep the customer waiting—which upset his self-confidence—and then to offer a small part, with the rest to be called for later. In scrutinizing the actual script the paper, writing, and signature should be considered and a colleague's opinion also sought before deciding to raise an alarm, which might be a false one. The Inner London Executive Council had established an alarm system so that a report of stolen prescriptions would be circulated to all pharmacies within 24 hours.

Detective Inspector J. Lynch (Drug Squad, New Scotland Yard) reviewed the legal definitions of forgery. It was a surprise to the police how many forged prescriptions were initially passed by the pharmacists, though many were detected. More care was needed over the issue of prescriptions. Quantities were easily altered when figures only were used; additions were easily made where space was left; genuine prescriptions were easily taken from piles left for collection—much to the mystification of the patient for whom the prescription was really intended. E.C.10 forms were often left lying around the surgery and even used as scribbling pads. When private prescriptions were used it should be possible for doctors to provide local chemists, at least, with a sample of their notepaper and also of their signatures. Pharmacists could easily arrange a liaison with the local police station so that a quick phone call could be made. The prescription should always be stamped at once so that the customer could not take it to another unsuspecting pharmacist. A few simple precautions along the lines suggested would help considerably, Inspector Lynch thought, and reduce the quantity of drugs available to peddlers and addicts.

Mr. R. M. Mitchell (Director, Home Office Forensic Science Laboratory, South Wales Area) described himself as a document examiner, to whom documents were not genuine until proved so—the reverse of the pharmacist's position, where suspicion has to be aroused. Mr. Mitchell had not come across any forged E.C.10 forms, but acquiring genuine ones did not seem to be very difficult. Forging doctors' signatures needed considerable skill, and a high standard of letter design and fluency was seldom reached—though with the illegibility of many signatures an improvised signature might be better. Tracing lines, impression lines, and guide dots were easy to recognize. To fill in extra items on a genuine signed form required space which might have to be created by erasing other items with ink eradicators or erasers. These attempts could usually be seen, as they damaged the paper, while the ink written on top spread. The same type of pen and ink as the original had to be used, and black ball-point pens were the easiest to match. Differences could be detected in the ink, after extraction, by infra-red light or chromatography. Mr. Mitchell was convinced, however, that the use of E.C.10 forms which were "security printed" would largely ease the problem. Such forms would reveal attempts to alter them and, though more expensive than the present forms, should be considered at least for prescribing drugs of addiction.