Chapter 1
A Foundation for Knowledge and Understanding

Introduction

Almost every human services professional and volunteer will encounter individuals for whom the use of alcohol or other drugs is a serious problem in itself or a complicating factor in other problems. Even if you are not employed in human services, fundamental knowledge about the field is valuable for interacting effectively with people whose lives are affected by the use of alcohol or other drugs. A foundation of knowledge and understanding about these substances and the roles they play in our culture is valuable to all of us, whether or not we deal with these problems as our primary responsibility.

Gaps in Communication

What each of us "knows" about alcohol and other drugs is necessarily limited. It is based on a combination of factual information, personal experience, and opinions formed in both our private and professional lives.[1]

This manual seeks to bridge at least two kinds of "communication gaps" in our collective understanding. The first relates to the way people from different disciplines and different experiences describe the field. The second gap occurs between research findings and their application to clinical practice, prevention strategies, and social policy.

Two kinds of communication gaps are (a) being "expert" in different fields that have different background, terminology, or knowledge; talking to someone "outside the area" is difficult, because what you say has to be translated out of the field's "shorthand"; and (b) the gap between abstract knowledge and concrete experience.

The First Communication Gap

The first type of communication gap is illustrated by the physiologist who may be well informed about the biological effects of certain drugs, but who knows very little about their effects on the psychological health of a family. Similarly, a cultural anthropologist may know a lot about groups that use alcohol and other drugs in religious ceremonies and social rituals, but have little understanding of genetic influences on the way we behave when we drink alcohol or use other drugs. A sociologist may be an expert regarding the effects of peer groups on the behavior of individual members who are labeled as deviant, but be quite naive about how to help someone in active trouble, who is experiencing the negative pressures of a drug-using life. In other words, the special knowledge that these professionals possess is but a small part of a much larger picture.

Perhaps the problem is best illustrated with the story of the blindfolded people who were each asked to describe the same elephant (see Figure 1.a). As you may recall, they came up with very different descriptions—each true (insofar as they could tell) for the part of the elephant which they happened to explore.

This is not to suggest, however, that the only disagreements in this field are across professional

disciplines! Two different biologists, psychologists, or school counselors, for example, may look at the same situation from very different points of view. And indeed, as with the blindfolded explorers of the elephant, they each may have valuable insights to share. A significant challenge in this field today is to gather many separate pieces of information and to construct the "big picture."

The Second Communication Gap

The second "communication gap" relates to how the results of research make their way into social policy and the practices of prevention and treatment. Researchers usually work on specific areas of interest, developing and testing theories in their search for more knowledge about those areas. Typically, their findings are published in scientific journals, which many people in the field do not read. And their reports are often presented in language only other scientists in their discipline can easily understand.

Counselors are trained to help people solve their problems. They usually are *not* trained to evaluate research data which might improve their insights and skills. Prevention specialists and social policymakers try to improve social systems to prevent problems from occurring or to reduce the incidence of new problems. Yet they, too, may neglect to seek out important findings in the professional literature which could be helpful in designing effective interventions.

There exists a large collection of research on all aspects of drug use in most disciplinary areas. However, until fairly recently, most of it has been done outside the mainstream of each discipline's traditional focus. Historically, colleges and universities did not teach about these topics to those they were training, funding sources did not encourage studies in this field, and human services professionals avoided involvement with the area. Problems with alcohol and other drugs were most often considered political or moral issues, and many scientists thought them inappropriate topics for objective study until comparatively recently.[2]

The contributions of many different disciplines are necessary for understanding and dealing with problems involving alcohol and other drugs. In Chapters 3, 4, and 5, we will look at these disciplines, their roles in the field, and how each has contributed to our collective knowledge. These chapters will provide an opportunity to explore current knowledge ranging from cellular biochemistry to international relations, noting among other things their impact on matters as diverse as drug metabolism and drug trafficking.

Differences in Perspective

It is likely that each reader will take a different route and experience different reactions while learning this material. The route you take will depend on your previous experiences, your own values, your needs, and your orientation to the task.

The use of tobacco, alcohol, and some other drugs is commonplace in our culture. All of us are exposed to them in one way or another during our lifetimes. We often hold strong opinions about particular drugs and/or particular patterns of use. These views are sometimes inconsistent with information gleaned from research and clinical practice. Part of the learning process includes an understanding of how our *own* experiences and biases shape the way we think about this topic, and how that understanding may be less than complete.

For example, if you have little experience with alcohol or other drugs, you may have accepted

stereotypes in our culture about alcohol and other drugs, such as the drug-crazed dope fiend or the skid-row bum, but be unaware that this has happened. You may not realize how difficult it is for others to change patterns of use which may be destructive, or at least counter productive. On the other hand, if you have overcome a personal problem with alcohol or other drugs, you are likely to hold a much different view of the same situation.

Personal experience provides valuable perspectives on which to build a comprehensive understanding of alcohol and other drug problems. However, experience alone is not enough if you want to develop a full understanding of the complexities involved. Those of you who are in training to be counselors need to understand how your personal experience contributes to your preparation and in what way it limits you. If you have had problems with alcohol or other drugs, you may have a special understanding and credibility with people who are currently experiencing such problems. Yet each person's experience has areas of uniqueness, and it is risky to generalize from your own circumstances without comparing them with what is known by others.[3]

In fact, if a therapist believes that the way she addressed her own problems is the *correct* way, she may have difficulty absorbing new knowledge and accepting alternative strategies that may better fit another's situation or personality. Similarly, a counselor who views the way he was taught to practice therapy as the *only* way that works may be limited in his ability to learn new techniques and add new knowledge to what he has already learned.

Intervention

Throughout much of the text, you will read about **interventions** with persons having problems with alcohol and other drugs. An understanding of these methods will be the main topic of Chapter 7, although an introduction seems appropriate early in the text.

When people use the term **prevention**, they usually mean intervention before the problem occurs, such as when young children are taught social and coping skills to reduce the likelihood that they will use substances to help them get along better with their peers. Prevention strategies can also focus on the community's environment; for example, alcohol and other drugs can be made more difficult to get. Community programs may work to reduce peer pressure to use, or to create other ways for teen-agers to have fun and to feel good. (See Chapter 7 for more examples of prevention strategies.)

Treatment may be variable in length or intensity. Short-term treatment approaches often focus on providing persons who show early signs of a disorder with prompt assistance. Crisis intervention, case-finding, referral, initial treatment, and brief therapy efforts are all examples of short-term interventions.

More intensive treatment or rehabilitation efforts attempt to reduce the severity and disability associated with a strongly entrenched or **chronic** disorder. Rehabilitative care may be on an inpatient or residential basis or involve partial hospitalization or outpatient care. Some interventions can be very intensive (multiple hours per day) and some much less so (one hour per week).

About "Drugs"

Just what is a **drug**, anyway? For the purposes of this manual, we will be referring to those substances which, although unnecessary for survival under most circumstances, acquire such a perceived, powerful positive value that some people will avidly pursue their use even when there

is significant harm to their health, their occupation, and the status of their interpersonal relationships.

Although drugs frequently have other effects on our bodies which may also be important, our focus will be on their mood—or consciousness —altering potential. A common example might be the way in which alcohol or marijuana is used to change psychological or social perceptions in order to escape from unacceptable realities or to foster a feeling of well being. Drugs which affect emotions, behavior, and thought are sometimes called **psychoactive** because people seek them out to change thoughts and feelings. It is not uncommon for people to take increasing quantities with increasing frequency, sometimes leading them to experience drug craving or become ill if they stop using.[4]

In this manual, we will focus on drugs of current concern and importance, particularly those which, interacting with other factors, combine to affect and disrupt behavior and have consequences of special concern to human services professionals. The drugs most familiar to all of us are alcohol, caffeine (in coffee, tea, and soft drinks), and nicotine (in tobacco products). In our culture, alcohol is, by an overwhelming degree, more frequently involved in drug problems than all other drugs combined! Tobacco also has a wide range of negative health consequences.[5]

Users of drugs often use more than one drug, either in combination or at different times. Thus people concerned with issues related to alcohol and other drug use should know the properties of many drugs and how to learn about those that are unfamiliar. Classifying problematic drug use by the particular drug is often further complicated because different people have different names for the same substance. While the technical name is usually constant, street names keep changing, as do the concentrations and mixtures of ingredients found in drugs illegally marketed. In Chapter 5, you will become acquainted with some characteristics of specific drugs including their generic names, pharmacological properties, brand names, and specific effects.

Problems with alcohol and other drugs are found across our society, in all cultures, and in all economic groups.[6] The way these problems are manifested is shaped by numerous factors including age, gender, ethnicity, geographic region, and time in history. They vary in levels of severity, types of drugs, and types of consequences. They include the problems of both the user and others associated with the user who are impacted by their use. Chapters 2, 3, and 6 look at the way we measure some of these differences.

Throughout the text, we will include short fictional "profiles"—or vignettes—of people who are experiencing problems with alcohol and other drugs. We hope that these vignettes will illustrate the key points we are making in the text and serve as a reminder that the people and problems we encounter in this field are always unique and often complex. Consider the following three stories:

> Patrick, a foundry worker, is one of a pair of fraternal twins. His father was a foundry worker with the reputation of being "a man who could hold his liquor." Peter, Patrick's twin, reacted to his father's drinking (which was not as well controlled in their home as outside among fellow workers) by becoming an abstainer. Patrick, however, enjoys having drinks before dinner at the local bar with fellow workers. A small group of them attend the races on weekends, then skip work on Monday if they make money on the horses, in part to recover from being "under the weather." On two occasions in the past six months, Patrick's foreman has spoken sharply to him about his absenteeism.

Elizabeth and her family have lived in the California wine country ever since their ancestors migrated to North America several generations ago. For as long as anyone can remember, both in the Old World and the New, most family members have been involved in the production of wine. Plentiful and inexpensive, it is always available, both at mealtimes and in-between. For most of her adult life, Elizabeth has enjoyed drinking between one and three bottles daily, the amount depending on whether there was some kind of celebration. Aside from a tendency toward stoutness, she has been in general good health and good spirits. Last week, however, she suddenly began to vomit bright red blood and then passed out. Although she's out of danger now, her doctor has told the family that her "condition" is "serious."

Gregory does not do drugs regularly, but he smokes a little pot on occasion. Friday night, however, he discovered crack cocaine and, at his friends' insistence, ended up using it for the whole weekend. Sunday night he developed an agitated appearance and briefly left the group. He returned with a shotgun that he discharged into the chest of his closest friend, killing him instantly. Returning home, he found that he was unable to sleep, so he took a handful of his wife's sleeping pills. The next day, he woke up depressed and confused but did not remember what had happened. When told of his friend's death, Gregory was panic- and grief-stricken. As he waits in his detention cell for a psychiatric evaluation, he maintains that he must have been temporarily insane.

Do these people all have the same problem? If we change their ages—to teen-ager or senior citizen, for instance—how would considerations change? How would differences in race or sexual orientation effect the problem or intervention by a helping professional? Would the situation look the same for marijuana as for amphetamines or cocaine or alcohol? What about prescription drugs in problem circumstances? Do you know someone who fits one of these pictures? What other identifying characteristics can you add? In later chapters, we will consider some answers to these questions. Next, we consider some historical issues to the use of alcohol and other drugs.

Historical Issues

Drugs are not a unique feature of our times. The use of alcohol as a beverage has been an important feature of human culture since the dawn of civilization. The most fundamental literature of ancient peoples, such as the Jewish and Christian Bibles and the Rig-Veda of the Hindus, mentions alcoholic beverages in conjunction with both ceremonial and casual social use.

Opium and hemp products (including marijuana and hashish) have been used for centuries as both medicinal and "recreational" drugs. When cocaine was introduced to Europe in the 1860s, it was considered a pharmacological miracle and was included in all kinds of elixirs, including (until 1903) Coca Cola.[7] A popular patent medicine for infants in the late nineteenth century, "Mrs. Winslow's Soothing Syrup," was reported to contain from one-half to one grain (32-64 milligrams) of morphine per bottle. Heroin was the trade name given to diacetyl morphine because it was initially hailed as a "heroic" cure for morphine dependence.

At one time all drugs were either legal or unregulated. But as attitudes about particular drugs

changed and as problems arose with each drug, controls on use were enacted. Although the types and severity of controls and penalties for use vary widely across substances and cultures, all of the drugs just named are now covered by some kind of regulation, as are a wide variety of synthetic drugs which have been introduced more recently. We define **regulation** to mean some mechanism to limit access to a specific drug, or constraints on how or by whom a particular drug may be used.

Public opinion about which drugs should be more available and which are considered more dangerous (and therefore should have more stringent regulation) is strongly influenced by *whom* the public perceives as using particular drugs. In general, people feel less need for regulation of the drugs which *they* use or which are used by other people whom they admire and accept. Thus "my drugs are okay—those used by people different from me are less okay—and those used by people I fear, or people I think are inferior to me are bad and/or dangerous." [8]

Numerous examples of this phenomenon exist in our country's history, and our social policies about drugs have been heavily shaped by prejudice and discrimination. For instance, opium use was associated with Chinese immigrants, imported to provide cheap labor to build the railroads in the West. Cocaine use was associated with African-Americans in the South; in fact, myths about the effects of cocaine were so mixed with racial fears and biases that many police forces acquired higher caliber guns for fear that drug-crazed African-Americans couldn't be stopped with standard issue weapons. The growth of fears surrounding the use of opium products by Chinese, and cocaine by blacks was influential in the passage by the Congress of the Harrison Act of 1914 which imposed a special tax on all producers, importers, manufacturers, dealers in, and distributors of opiates and coca products, and outlawed use except by prescription.[9] However, use of opiates and coca was widespread in all segments of the population at this time.

Biases about drinking patterns of Americans of Irish and German descent, as well as patriotism fueled by World War I, helped to get the Volstead Act (the immediate precursor of Prohibition) passed by Congress in 1917, leading to the Eighteenth Amendment to the Constitution. After ratification by thirty-six states, the amendment established prohibition of the manufacture, sale, or transport of intoxicating liquors in or from the United States and its territories in 1919.[10]

The regulation of alcohol and other drugs requires a vast, complex infrastructure which involves, in part, the medical and social service communities, the pharmaceutical and insurance industries, multiple layers of government agencies, legal systems, and enforcement efforts, ranging from local liquor commissions to federal customs bureaus. In fact, some people believe that all of these controls are still insufficient and that they should be strengthened. Others believe that the existing controls may cause almost as many problems as the drugs they are meant to counteract! Chapter 8 will discuss some specific examples of these issues.

For all we have learned about alcohol and other drug problems, the clearest fact is that there are *no* easy solutions. Social policies tend to ebb and flow in relation to costs and swings in public sentiment. Epidemic cycles in problem use seem to be closely associated with major social crises, such as recessions, wars, and other stresses.

Ask several people what they think about local or national problems regarding alcohol or other drugs, and you will likely discover that they all hold strong opinions or feel deeply about these issues. The topic of alcohol and other drug problems in our culture is almost certain to trigger an emotional response. Perhaps the most famous collective example of such a response in recent history was the previously mentioned introduction in 1919, and then the repeal in 1933, of

prohibition on alcoholic beverages. We are still living with some of the spin-offs of that social experiment.

Beginning with the Prohibition era, many people in society divided into two camps: those who abstained (the "drys") and those who drank (the "wets"). Feelings ran so high that everyone else ran for cover! Some are still running, and some social commentators have suggested that we are currently approaching another era like that of sixty years ago, where abstinence is increasingly valued as the norm.

Federal Efforts To Deal with Alcohol and Other Drugs

Because federal statutes always take precedence over state statutes in the United States, it is important to understand the involvement of the federal government in this field. (In the next section, we will examine the specific approach that the State of Michigan has taken to providing services related to alcohol and other drugs.)

In the colonial period, before the advent of the United States as a political reality, there was little concern about either alcohol or other drugs. Indeed, alcohol was held in high esteem and was referred to by a prominent clergyman of the era, Cotton Mather, as the "good creature of God." The tavern was a key institution in every town, the center of social and political life, and every variety of drink was available. (You might recall that the "colonies," as they were called, had largely British origins. The situation in colonial times was much the same as exists in Great Britain, even today.) Yet drunkenness, as it was usually referred to, was widespread, and both Cotton Mather and Increase Mather, his father before him, inveighed against it from the pulpit. Opiates were widely used to self-medicate almost every problem, including, of course, the problem of drinking too much! They were available on demand and without prescription at the local apothecary shop.

A change in all of this began with the work of Benjamin Rush (1745-1813). Rush was active as both a physician and patriot. He was a signer of the Declaration of Independence and later was surgeon general of the Continental Army during the Revolutionary War. In 1785 Rush authored his classic treatise, *An Inquiry into the Effects of Ardent Spirits upon the Human Body and Mind, with an Account of the Means of Preventing and of the Remedies for Curing Them.* This remarkable document is usually considered the first modern exposition of problems arising from the use of alcohol. The title is a key to the contents; Rush's concern was principally with "ardent" or distilled spirits; that is, whiskey, rum, and gin. In common with many of his contemporaries, he felt that the moderate use of beverages with low alcohol content, such as wine and beer, was generally conducive to good health. It is thus somewhat ironic that, at a subsequent period in history, the prohibitionist movement cited Rush as the founder of their efforts.

The young federal government, to whose founding Rush had so nobly contributed, was not long in facing problems arising from alcohol, though from its production rather than its consumption. Farmers in western Pennsylvania had been accustomed to shipping distilled spirits over the Allegheny Mountains because of their relatively low bulk as compared with grain. When the new federal government levied taxes on this traffic, the farmers refused to pay. President Washington took the matter seriously and, when compromise measures failed, in 1794 sent a large army (10,000 troops) marching into the area to suppress what was by now called the "Whiskey Rebellion." The army was led by General Henry ("Light Horse Harry") Lee, the father of General Robert E. Lee, and consisted of federalized state militias, the first time that this tactic had

been employed. Resistance collapsed upon the President's show of force, and federal sovereignty was established.

During the 1800s the **Temperance Movement**, which led directly to national **prohibition** in 1919, was founded and gathered momentum. The country also began to become concerned about other drugs. At the opening of the century, the powerful drug morphine was isolated from crude opium, and at mid-century the hypodermic syringe was developed in England and France and came into general use. Morphine by syringe became a common medical intervention during the Civil War. Many veterans continued to use opiates afterward, a phenomenon referred to at the time as "the soldier's disease."

But it was not only the military who were using opium. In a report on "The Opium Habit in Michigan," for example, submitted in 1878, Dr. O. Marshall presented the results of a survey he had conducted in the State.[11] He estimated that there were 7,763 "opium eaters" in Michigan at that time. He concluded that "the consumption of opium in this country is enormous and out of all proportion to its necessity in disease."

By the turn of the century there was great popular concern regarding the consequences of the use of alcohol and other drugs. This prompted a number of important responses from the federal government, but now in the form of legislation rather than armed troops. First came the Pure Food and Drug Act of 1906, in part directed against such patent medications as Mrs. Winslow's Soothing Syrup, which contained opiates. This was followed in 1914 by the Harrison Narcotics Act, which in effect outlawed opiates for any but prescription use by physicians (heroin, or diacetyl morphine, was considered a special problem and was not even permitted on prescription). On January 16, 1919, two months after the cessation of hostilities in World War I, the Eighteenth Amendment to the Constitution, establishing the national prohibition of the manufacture and sale of alcoholic beverages, became law.

The prohibition on alcoholic beverages, which had been based on religious, moral, and patriotic grounds, was repealed by an additional constitutional amendment on December 5, 1933, largely because people had come to feel that its enforcement had created more problems than it had resolved. The food and drug legislation and the anti-narcotic legislation have remained in effect and have been strengthened by additional legislation, perhaps most notably the Marihuana Tax Act of 1937. Thus the federal approach has been, and continues to be, largely a regulatory approach oriented toward other drugs, as attested to by several "wars on drugs" waged by more recent federal administrations.

Alcoholics Anonymous, an important lay organization, was established in 1935. In this same year, the Lexington, Kentucky and Fort Worth, Texas Public Health Service Hospitals were opened. These events occurred within two years of the repeal of national prohibition. The hospitals sought to provide treatment for those arrested for drug involvement, mostly with narcotics. Many of the physicians and others prominent in drug treatment received their early training at Lexington and Fort Worth. For alcohol, several types of health clinics, hospital programs, and community approaches began to emerge, including those sponsored by the Salvation Army.

Scientists at Yale University had become interested in the effects of alcohol, and their work led to the establishment of the Yale School of Alcohol Studies in 1942, later transferred to Rutgers University. Associated closely with these activities was E. M. Jellinek (1890-1963), a founder of the scientific study of alcohol use. Jellinek became the single most influential worker in the field,

and in 1960 he published his classic monograph, *The Disease Concept of Alcoholism*. At about the same period, the National Council on Alcoholism, the largest public interest group in the field, was founded. (It is significant that the group has recently added “and Drug Dependence” to its title.)

The development of methadone, which can be administered orally and lasts longer than heroin, but which blocks the craving for heroin, led to additional treatment approaches. More recently, perhaps as a consequence of a continued increase in the use of alcohol and an upsurge in the use of other drugs in the late 1960s and early 1970s, the federal government has become increasingly involved in research, prevention, and treatment. Most of the funding of our field that is available for research, treatment, and prevention in the United States flows from federal agencies, and a speaking knowledge of their current status and activities should be part of the general knowledge of those working in the field. The funding and regulatory environment is very complex, changes periodically, and has a powerful effect on local resources.

Both the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) grew out of the National Institute on Mental Health (NIMH). Until recently, these three institutes—NIMH, NIDA, and NIAAA—comprised the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). To broaden their focus on the field, two additional agencies were added to ADAMHA: the Office of Substance Abuse Prevention (OSAP) and the Office of Treatment Improvement (OTI). There is also a federal agency which serves as a resource for information in the field called the National Clearinghouse on Alcohol and Drug Information (NCADI).

Most recently, the congress reorganized this complex of agencies. Because most of the research carried out by NIDA, NIAAA, and NIMH has been basic research, these institutes were transferred to the organization that carries out basic research in other areas of health care, the National Institutes of Health (NIH). The residual organizations, OSAP and OTI, were viewed as conducting research that was more applied than basic. Accordingly, ADAMHA was redesignated as the Substance Abuse and Mental Health Services Administration (SAMHSA). There are three major components in SAMHSA: OSAP, now renamed the Center for Substance Abuse Prevention (CSAP); OTI, now renamed the Center for Substance Abuse Treatment (CSAT); and a new organization created partly from former components of NIMH, the Center for Mental Health Services (CMHS).

Special Issues in Michigan

Services for those touched by alcohol problems became a state responsibility in Michigan with the creation of the State Board of Alcoholism in 1951. Prior to the late 1960s, when other drugs moved out of the inner cities and became a more visible problem for middle- and upper-class young people, state-supported services for other drugs were not available in Michigan.

In 1951, Public Act 219 specified four attributes which were the basis for the State Board of Alcoholism Program:

- Alcoholism is an illness that should be approached from many angles.
- A variety of already existing resources can be brought to focus on alcoholism.
- Service needs for alcoholism can best be met on a local level.
- Limited state funds can be provided to help local resources assume this obligation.

Those limited funds amounted to approximately $100,000 a year for the first few years. With these funds, the state program paid their own staff and financed their program.

State efforts focused on *helping* rather than *punishing* alcoholics. To do this, they needed to educate personnel of existing helping agencies. So they offered scholarships to schools of alcohol studies for helping professionals who wanted to learn about alcoholism—to prepare them to deal more adequately with this population.

The facilities established during the term of the State Board of Alcoholism were products of state and local cooperation. Some were voluntary nonprofit corporations, some were located in county health departments, some in mental health agencies, and a few were in community hospitals and prisons. If a community had an interested group which was able to start a resource and provide matching funds to those requested from the State, either in cash or in kind, they received a grant and all the help that the staff could offer in educational materials and technical assistance. Local programs were expected to become self-supporting as soon as they could, so the limited State funds could be put into other new programs.

In 1965, Michigan formulated a new constitution, under which all State agencies were folded into twenty departments. The Alcoholism Program became a small unit in the Division of Adult Health in a very large Michigan Department of Public Health (MDPH). While the program continued to function with the same strategies, it lost both personnel and resources to long-established programs in the health department and became less effective in promoting its mission.

The rapidly growing problems with use of illegal drugs in the late 1960s, particularly among young people, caused the governor to name a separate Office of Drug Abuse (ODA) in 1970. The ODA placed emphasis on linking independent drug treatment centers to community mental health centers.

In 1971, the Legislature passed Public Act 197, creating a new combined Office of Drug Abuse and Alcoholism (ODAA) in the Executive Office to which the MDPH Alcoholism Program reported. The ODAA designed the system which, in 1973, under Public Act 56, replaced it as the Office of Substance Abuse Services (OSAS), a semi-independent agency in the Department of Public Health, with a first-year budget of $22 million. That structure, with some recent changes in its status in the state public health department, still provides state financing, resources, and licensing for substance abuse services in Michigan with a budget that has grown to nearly $84 million.

The OSAS structure was built on the foundations laid by the old State Board of Alcoholism, adding characteristics needed for sustaining what had become a very large and complex organization. In addition to the central office, OSAS added a system of regional coordinating agencies, designated by the OSAS administrator, but subject to the approval of the affected county boards of commissioners. These coordinating agencies are located in community mental health, public health, or other nonprofit human services organizations, depending on what best fits the already established local network of services.

Since its creation, OSAS has undergone a number of changes. Until recently, it had grown increasingly independent. However, as part of the restructuring of state government introduced by the Engler administration, it has been returned to the Department of Public Health and renamed the Center for Substance Abuse Services (CSAS). (A more detailed account of

Michigan's substance abuse services, how they grew, and where they are today is included in the Appendix to this manual.)

It is useful to consider the implications of the historical (and often continuing) separation of alcohol from other drugs in terms of the structure of federal, state, and local government and the general omission of prescription drugs from the group of drugs which alarm our society. Michigan has worked hard to combine our thinking about *all* drugs, but history and the current federal structure sometimes make this difficult. Not very long ago, those who focused on alcohol use knew much less about other drugs, developed different types of treatment approaches, and created differing theories and bodies of research. This manual is only one of many current efforts to bring "alcohol" and "other drugs" intervention activities closer together.

The Evolution of Lay Movements

Interventions targeted at those afflicted with alcohol and other drug problems have also varied over time, depending on the drug and the state of the art. Societal attitudes about various drugs are closely intertwined with when and how each drug became regulated. They have also been affected by a wide range of other factors, including changing views about public health and the role of government, and the skilled manipulation of public opinion by those who stand to gain from particular laws and practices (either by amassing more personal or political power, or wealth).

Much of this manual is concerned with treatment that is provided either by health care professionals or by those working under their supervision. Yet in this field there is a very strong tradition of nonprofessional assistance. We have chosen not to devote a specific chapter to this, but we will touch upon it here.

The earliest lay efforts in this country to intervene with those in trouble through excessive use of substances came from the Washingtonian movement, founded in Baltimore in 1840 by six "regular drinkers" who, inspired by a temperance lecture, decided collectively to quit drinking and form a total **abstinence** society.[12] To make their weekly meetings interesting, each member related his own experience with alcohol. This worked so well that they soon began holding public meetings where others were invited to share their experiences with the group.

The movement rapidly spread up and down the East Coast and even inspired similar women's groups called Martha Washington Societies which, among other things, engaged in the rehabilitation of women with alcohol problems. However, by 1847, the movement had pretty well died out, primarily because of its relationship to the temperance cause, which aimed for abstinence by everyone, not just "drunkards."

The major principles of Washingtonian groups, borrowed nearly a century later by Alcoholics Anonymous, included:

- Alcoholics helping each other.
- The needs and interests of alcoholics kept central.
- Weekly meetings.
- Sharing experiences.
- Constant availability of the group's fellowship or of its members.
- Reliance on the power of God.
- Total abstinence from alcohol.

However, they differed markedly from Alcoholics Anonymous in admitting nonalcoholics as members and in taking a moralistic rather than a psychological or therapeutic approach.

In 1935, in Akron, Ohio, Bill Wilson and Dr. Bob Smith founded Alcoholics Anonymous (often referred to as "AA"), and the concept of self-help for problem drinkers was reborn. Though the historical connections between the two movements are not clear, AA apparently learned much from the mistakes of the earlier movement. Only alcoholics could become members, and alcoholism was considered a *chronic disease* rather than a *moral fault*.

Another group important to the evolution of Alcoholics Anonymous was the Oxford Group, a Protestant evangelical organization aimed at the spiritual rebirth of all humanity, founded in the early 1900s by Dr. Frank Buchman, a Lutheran clergyman. Bill Wilson, who had been a member of this organization, indicated that AA got its ideas of self-examination, acknowledgment of character defects, restitution for harm done, and working with others directly from the Oxford Group. Alcoholic Anonymous and its spin-off organizations, Alanon and Alateen, have had a vital influence on the growth and the underlying philosophy of treatment and still provide important social supports to persons recovering from heavy drinking and to their families. Alanon was well ahead of the professional world in recognizing and addressing the needs of the other members of families with one or more problem drinkers. Families where one or both parents use alcohol or other drugs excessively may develop special problems related to the socialization of their children, and therapeutic interventions which include the whole family can be very helpful.

Therapeutic communities have become one of the principal treatment methods in the United States. Synanon, for individuals having problems with narcotics and other illicit drugs, was founded in 1958 by Chuck Dederich, a participant in Alcoholics Anonymous.[13] Initially, attendance at AA meetings was a feature of Synanon's program, but later Dederich modified the program to fit the somewhat different needs of narcotic users. These changes included shifting from a nonresidential program to a residential program and focusing on a secular ideology instead of a God-centered theology.

Other Community-Based Developments

In the 1960s, a convergence of new drugs that reduced the symptoms of major mental illness, along with new knowledge about the negative effects of institutionalization and about the importance of family and community supports, began to dramatically affect mental health counseling and other forms of treatment.

New crisis intervention strategies were developed, often by young people concerned about their friends. Women's advocacy groups and consumer action groups sounded the alarm about the harmful effects of prescription drugs, such as tranquilizers, sedative-hypnotics, and amphetamines, and lobbied for stronger restrictions on their use. Better research led to more knowledge about the effects of marijuana and other types of drugs.

Most recently, groups like Mothers Against Drunk Drivers (MADD) have lobbied for stronger sanctions against those who kill and maim others while high on alcohol and other drugs. Along with Students Against Driving Drunk (SADD) and various health movements, they are significantly changing public attitudes about both alcohol and tobacco use. With the growth of the Adult Children of Alcoholism (ACOA) movement in the early 1980s, knowledge about family dependencies is increasingly being applied to help those who have been significantly

impacted by their relationships with those experiencing alcohol and other drug problems.