

# Chapter 10

## Afterword: An Alert About the Future

### Introduction

The history that we have detailed in previous chapters has described evolving clinical wisdom in the last century or so. Some of that wisdom has held up over time, but much of it we now understand was wrong, or in some cases incomplete.

In this chapter, we will alert you to some of the dynamics, technology, and concerns which will influence, and sometimes dictate change in our field. We can predict with certainty that change will occur.

Significant changes have evolved culturally in our conceptions of what are approved and what are disapproved patterns of use, as well as about which substances should be controlled. As basic science finds new answers to the biological, psychological, and sociological questions which arise in this field, important changes are already being made, and others are sure to follow. No doubt, some of these findings will themselves be erroneous or incomplete, as has happened in the past, and lead us down “yellow brick roads” paved with fool’s gold. Certainly, the gaps in communication which still exist between researchers and practitioners require that both the scientist and the clinician work harder to close them. Some bridging mechanisms are currently being developed; health services research is an area which has been able to reflect changes accurately in practice far more sensitively than has previously been possible. Both at the federal and state levels, planners keep reorganizing the systems in order to develop and sustain a variety of other bridging mechanisms. These include encouraging basic research, translating basic research to practical implications, and validating models of intervention and assessment which lead to program modifications.

Newer drugs, such as “crack,” may radically change our notions of addiction and dependency and lead us to think differently about these phenomena. Since the media’s role in disseminating knowledge as well as myths about new developments is so crucial in today’s world, how we improve the accuracy and relevance of their output will partially determine the pace and direction of change.

What now seems like truth is likely to be altered by financial policy decisions, historical and cultural shifts, and new technologies. In this chapter we sample four specific areas that we think will exert prominent influences on our field’s future.

### Information Management

#### *The Quest for Knowledge*

From an historical perspective, information about alcohol and other drugs is a relatively recent phenomenon in the United States. At the close of the Great Experiment of Prohibition in 1933, little was known about alcohol, and less about other drugs. In 1940, the Laboratory of Applied

Physiology at Yale founded the Quarterly Journal of Studies on Alcohol. The information explosion in our field had begun. This quarterly periodical is now published monthly and we have literally dozens of other journals presenting hundreds of articles on alcohol and other drugs from every point of view every month!

The number of treatment programs has grown, the scientific community has increased its interest in this area, and government at all levels has recognized the need to come to terms with the use of alcohol and other drugs by developing effective policies, and all have a need for information. While in a certain sense there can never be too much information on these subjects, the sheer bulk of what now exists presents problems for everyone in the field, and particularly for those who have only recently entered it. How does anyone come to terms with this enormous body of information? Further, how can you make use of the information in your daily work?

Certain guidelines can be set that may be helpful. As a first principle, it may be useful to make a distinction between *information* and *knowledge*. When information is subjected to critical evaluation, some of it will be rejected as incorrect, and another portion will be accepted as correct. That latter portion may be considered knowledge. A wise colleague used to say: "Information is like lumber; it should not be used until it is well seasoned." Of fundamental importance, then, is the exercise of critical evaluation. You should evaluate every piece of information before you accept it.

Once you accept it as knowledge, however, this evaluated information should not be grasped too tightly. Rather it should itself be subjected to periodic, and even frequent evaluation. What is true today may not be true tomorrow. People and circumstances change in quite extraordinary ways. For example, think of the changes which occurred in the early 1990s in the Soviet Union. What we accept as knowledge must change as well.

Holding on to certain pieces of knowledge for dear life has been a particular problem in the alcohol and other drug field. A term that may be applied to knowledge that is held on to too tightly, and is not subjected to frequent reevaluation, is *ideology*. There are many ideologies in the alcohol and drug field. Much valuable time and effort have been spent in defending them against all challengers. It would be preferable if an open, probing, and questioning attitude were maintained toward all knowledge.

It is not difficult to understand why individuals, especially in this field, might tend to hang onto presumed knowledge with a certain desperation. Dealing with people having alcohol and other drug problems is often a difficult, frustrating task, with whatever gratification that may result being well down the road. Under such circumstances, it is comforting to believe that we are in possession of absolute and unshakable knowledge that must eventually prevail. Comforting, but misleading. "The truth" has been defined by a philosopher as "that thing of indefinite approximation." In this field, at least, absolute certainty is in short supply. We do the best that we can, based on the best current knowledge that we have, and we constantly upgrade what we know.

Another principle that has been found useful is to gather the information from many sources rather than from a single source. Personal experience, for example, is an important (and readily available) source of information, but we all know how misleading it can be. Different people have different experiences, and none is automatically more valid than the rest. Clinical experience is of value, but it also is limited by a variety of factors. For example, those who deal exclusively with inpatients lack the leavening experience of contact with less severe cases, and

vice versa. While one does well to consult the opinions of experts, one also does well to take them with a grain of salt. Experts may be less likely to make a mistake than others, but they are not perfect.

The scientific literature in the field is a rich source of information. One of its great advantages is that it has been subject to careful evaluation prior to its appearance in print. It is also cumulative, in that current scientific work tends to build on past scientific work. Journals and books also allow us to gather information from sources that we do not contact on a personal basis. Many see the lack of utilization of scientific findings in clinical practice as a major problem for this field, as well as for therapeutics generally.

While we can subscribe to this concern, at the same time we must recognize that the scientific literature does not always present an adequate picture of problems as complex as those associated with alcohol and other drugs. One reason for this is that scientists tend to be trained in a single discipline, such as medicine, psychology, sociology, or anthropology, for example. While a single discipline can offer useful insights into complex problems, such problems must be approached from the standpoint of many disciplines simultaneously to be realistically viewed as a whole. The story of the blind men and the elephant, introduced in Chapter 1 of this manual, is appropriate to recall here.

Nor is this the only problem we encounter when dealing with the scientific literature. Some of it, for example, is simply wrong. Other portions may be correct as far as they go, but are too restricted to generalize to the kinds of clinical situations we encounter on a day-to-day basis. To make matters worse, each discipline has its own jargon, which often leads to serious difficulties in communication between investigators from different fields. And very few of them explain their findings in a language either familiar or exciting to clinicians.

None of these sources of information should be neglected. But none should be relied upon to the exclusion of the others. Sift and winnow the information from different sources, and arrive slowly and cautiously at your truth for the moment, holding on to it lightly. You may miss the certainty of absolute knowledge, but that certainty, at least in this field, is an illusion.

### *A Helping Hand from Technology*

Even if you routinely exercise your critical judgment, draw your information from multiple sources, and reevaluate it frequently, there is still a great deal of it. Throughout history, technology has facilitated the gathering of information. Think of the printing press, or more recently the television set. Technology can also help you to master information. Clearly, the technological innovation that is most helpful in this regard is the computer.

We urge you to become “computer literate.” The computer is an invaluable aid to exploring the research literature, mentioned above as a significant source of knowledge. With a properly connected computer, you do not have to go to the library. An “on-line” literature search service will let you search through the information in books and journals (the **database**) quickly. In many cities, if you should find an item that is of interest to you, you can arrange to have a copy sent directly to you.

Other kinds of databases can be constructed. Let us say that you are interested in how many men and how many women have been treated in your program in the last year. If you have created a database that contains these characteristics, you can rapidly have the answer. You may be

particularly interested in data on women who have been in the program. You can then ask the database to tell you how many of these women were African-Americans and how many were not. If you want to focus on African-American women, the database can tell you how many of them were under thirty years of age, how many were older, and so forth.

The questions you can answer will depend on the completeness of the **demographic information** (personal characteristics such as gender, date of birth, race, etc.) which you have collected from each of your clients. A very practical reason for doing this would be to check the characteristics of the individuals who have entered your program against the known characteristics of the general population in your area. This would tell you whether you are drawing larger or smaller numbers than would be expected from particular population groups. Or, for instance, if you discovered that your clients were mostly Hispanic, you might want to be sure that you have a Spanish-speaking employee available, and that the therapist treating them is familiar with the special customs of their ethnic group.

One area of particular importance is often neglected in treatment: outcome. It is important to know whether the people who have been treated in a program are in general doing better after treatment than they were doing before treatment. The computer can help here too by assisting in information-gathering and record-keeping.

Every treatment program needs to be evaluated. Although an improvement in status after treatment does not necessarily mean that the improvement was caused by the treatment (for example, it may be due to a change produced by the passage of time itself, and unrelated to the treatment), accumulated instances of improvement after treatment provide a good indicator of how the program is doing overall. Certainly, if there are regular indications of no improvement after treatment, you would want to go back to the drawing board and redesign your program.

Our present knowledge indicates that there is no one treatment that is effective for *all* people with alcohol or other drug problems. Rather, it is likely that most treatments are effective for some individuals and not for others. Gathering and analyzing information about outcome can help a program determine for whom treatment is helpful and for whom it is not helpful. To do this, we need to know in considerable detail what the status of a given individual was *prior* to treatment in order to evaluate whether or not treatment has made a difference. This is why, in earlier chapters, we have consistently stressed the necessity for assessment. The time is not too distant when the funding of programs, in both the public and private sectors, will require some level of evidence that your program is effective, and for whom it is effective.

There are other aspects of technology that will also help you to grasp the information that you will need to master. Programmed learning packages for computers provide another way to stay ahead of the information and technology explosions, to enhance your own effectiveness in your chosen work. In addition, increasing numbers of videotapes and audiotapes on all aspects of alcohol and other drug problems are becoming available.

In a field dedicated to humanistic values, like the alcohol and drug problem field, some people have difficulty with the introduction of any sort of machine technology. They may feel that, in some way, it interferes with their interactions with other people, colleagues as well as clients. Indeed, this can happen. But with technology as with information, much depends on how it is used. If technology is critically evaluated and used intelligently, it can become a strongly positive factor in all human services in the future.

### *Scientific Advances*

Spurred on by the technological progress initiated during World War II, researchers from every discipline in the natural and social sciences began an era of scientific investigation such as the world had never before experienced. In fact, the mass of scientific knowledge has grown more in the last generation than in all of previously recorded history, and much of this information relates to health issues. While this achievement is admirable, some argue that the impact of research on our quality of life is not all that it could be, or should be.

One reason for this may lie in the realm of communication, and a paradox seems to have developed here. That is, the more we appear to understand, the less able we are to share that understanding with others. Education, in its truest sense, has declined, and the highly developed sciences have become isolated. Is this merely due to the extraordinary breadth and depth of knowledge we must contend with today across all of the sciences? Or is it the result of attitudes somehow instilled in a majority of lay people that erect mystical barriers to such understanding? In either case, the problem is not insurmountable. Its roots are deep, so a lasting solution will require deliberate and far-reaching efforts. However, if we are striving not so much for knowledge as wisdom, the ability to apply our knowledge in meaningful ways, we must dedicate much more of our energy and resources to communication about science.

While societal commitments reside in forces greater than ourselves, a large part of the solution to this communication problem actually may lie within our own attitudes and behavior. To correct the problem, we must discard the notion that education is something which takes place in school during a certain part of our lives. We must adopt the view that we are both life-long learners and life-long educators. If we do these things effectively, our natural curiosity and interest will guide us to learn more about the many different things that could help us in our work and daily lives. Researchers will be encouraged to bridge the “jargon gap” and to explain what they have found and why it may be important to all of us. As we become more discerning learners, we become better educators.

## **Health Care Policies and the Delivery of Treatment Services**

The delivery of treatment services to persons with alcohol and other drug problems is appropriately considered a part of the overall delivery of health services. If there is a difference, it is that treatment for these problems, together with the treatment of mental disorders, tends to be even less available than other health care services. There are both fewer treatment providers in relation to the extent of the problem, and less financial support for treatment from funding sources. While many reasons have been advanced for this imbalance, it is in large measure the product of two general factors. First, there is a continuing belief that individuals with alcohol, drug, and mental health problems are to a greater extent the creators of their own difficulties, and hence less deserving of help. Second, from a historical perspective, the public funding of these services is more recent and hence, more readily sacrificed when money is short—the health care equivalent of “last hired, first fired.”

It is tempting to think that changes in the way that alcohol and other drug problems are viewed, in the direction of considering them to be “real diseases,” might alter this situation. But this strategy is now at least fifty years old and may well have achieved all that it can. At present, it seems more likely that changes in policy toward the delivery of treatment services for alcohol and other drug problems will vary with changes in health care policy generally. While there have been occasional periods of focus upon the key issues of health care policy, fundamental views on

health care policy in the United States have been highly resistant to change over time. The national elections of 1992 may have signaled a change in this regard; it is too early to be certain as this goes to press.

The problems in health care are not obscure or hidden, but are well understood and well recognized. Although the quality of health care in the United States is commonly of a high order, access to that care is increasingly restricted. According to data from the Current Population Survey of March 1991, there are approximately 34.6 million Americans without health insurance. The absolute number of uninsured has been increasing steadily. Fifty-four percent of the uninsured are married couples, 72 percent have incomes that place them above the poverty level, and 59 percent work either full- or part-time.<sup>1</sup> Hence, this is not a problem primarily for poor people, for welfare recipients, or for people living on their own. Nor, of course, is it a problem only for the uninsured. Many individuals who have health insurance have only minimal or limited coverage. This is a problem that cannot be solved by publicly funded entitlement programs, such as Medicare and Medicaid: the 34.6 million Americans without health insurance are not eligible for these programs. (And alcohol and other drug treatment is always the first item on the chopping block even in the entitlement programs, so even those who are entitled may not be able to obtain these services.)

Basic to these troubling facts is the deeply held belief that, in the American context, health care is a commodity. Like other commodities, it is appropriately bought and sold. According to current thinking, there is, and should be, a free market for health care services, as for other goods and services. The implication of this belief, which is less often stated, is that if one lacks the requisite financial or insurance resources, one is effectively and even appropriately excluded from health care services. In other countries, health care is considered a fundamental right that is the responsibility of the government to guarantee. For example, the total number of persons without health care in the United States is greater than the entire population of Canada, all of whose citizens are fully covered by health insurance as a principal item of government policy. Among modern industrialized countries, only the United States and the Union of South Africa do not provide universal health insurance to all of their citizens.

There are problems in obtaining services even for those who can afford them. For example, there is no relationship between the prevalence of alcohol problems and the presence of treatment programs.<sup>2,3</sup> In many areas where there are severe problems, treatment is scarce; in other areas with fewer problems, there are many treatment programs. Why? As is generally the case with health care, treatment services for alcohol and other drug problems are not planned. Rather, their development is left to individual initiative. We are accustomed to speaking of the sum total of treatment programs as the treatment "system." A system, however, is a set or assemblage of things connected, associated, or interdependent, so as to form a complex unity; a whole composed of parts in orderly arrangement according to some scheme or plan (Oxford English Dictionary). By this definition, there is no treatment system, either for alcohol and other drug problems or for health care generally.

A true system could be created<sup>4</sup> (see also the discussion of treatment systems in Chapter 7 of this manual), however, it would require not only a large expenditure of funds, but strong central direction, and a high level of control. Over the long run, the initial investment required to create a health care system would largely be compensated for by lowering the administrative costs of delivering services through a reduction in the number of insurance carriers and other economies of scale, as well as by the more effective and efficient treatment that would result. But at present, money is in short supply, and there is a tendency not to consider the future. Such measures as the

consolidation of insurance carriers are seen as unwanted intrusions, and the strong central direction or control required to create a true system is viewed with suspicion and even alarm. An integrated health care system could be approached incrementally, one step at a time, but even the first steps are not being taken. Our national belief in free enterprise as an essential principle in all areas of activity including health care continues to be strong, despite increasing evidence that it has not worked in the health care sector.

Thus, as nearly as we can foresee the future, concern will continue to rise about the unavailability of treatment services, and their availability will continue to decrease, but the necessary steps to remedy the situation will not be taken soon. To move forward would require a fundamental change in attitude toward health care, viewing it as a right rather than a privilege. Such a change will be long in coming, if it ever does come. Although we are inclined to expect progress in every area with the passage of time, in health care generally, and in services to alcohol and drug problems in particular, progress is not evident. Rather, we seem to have gone backward. Our overall approach at present is well characterized by the statement of the Reverend Justin Edwards, a temperance advocate, in 1882: “Keep the temperate people temperate; the drunkards will soon die, and the land be free.”<sup>5</sup>

Persons entering the field of treatment for alcohol and drug problems should understand that, to some degree, the responsibility for this deeply unfortunate state of affairs also rests with us. Our practices have contributed to a widespread skepticism about the services we offer. We have tended to view alcohol and other drug problems as single problems with single solutions, and as a result have been content to rely upon uniform treatment for everyone, rather than attempting to individualize treatment. Until prevented from doing so by others, we have insisted upon costly treatments for everyone, without requiring hard evidence that this was always necessary. In general, we have not examined treatment outcomes with a view to improving services, but have been content to assume their effectiveness and not to depart from our customary practice. We have not made a systematic effort to incorporate research findings into our work. We have been slow to establish adequate systems of certification for treatment and prevention program staff, and in other ways have resisted accountability for our actions. We have not established the sort of curriculum in institutions that train our future practitioners of human services that would enable them to deal effectively with these problems. Nor does this exhaust the catalog of our shortcomings. In sum, although we should recognize that many elements of the health care delivery problem lie outside our field, we should also not neglect to put our own house in order.

## **Changing Social Norms**

### ***Future Patterns of Use and Efforts To Reduce That Use and Its Consequences***

We noted in earlier chapters that a mixture of factors—biochemical, psychological, political, and economic—have affected the history of:

- What drugs have been used in what ways by whom.
- What behaviors and consequences of use have been accepted by society or have been of public concern.
- How particular individuals, communities, and societies have tried to influence or change (regulate) patterns of use and the consequences of that use.

Many of the events and forces that have shaped these patterns and regulations in the past are

likely to continue to influence individuals, groups, and whole societies in the future. And new ones may emerge.

How well we are able to anticipate, understand, monitor, and influence these forces will help to determine alcohol and other drug use patterns and consequences in the future. As discussed in Chapter 3, important elements to consider in planning prevention programs, that also provide the context for treatment in any community, are social norms: expectations, definitions, and formal or informal rules about what behaviors and consequences are socially acceptable or not acceptable.

We noted earlier that social norms and values help to determine what groups, drugs, and behaviors are defined as “deviant”—outside what is accepted and valued within a group or community. Norms and values also help to define what kinds of prevention and treatment programs are seen as needed and are funded, and what social rituals, rights, and responsibilities are valued or seen as undesirable to the common good. Prevailing norms and values affect the likelihood that an individual will use a drug because they influence whether or how it is available, and whether and how its use is accepted and promoted or actively discouraged. A drug will be used more often if it is easy to get, inexpensive, used by influential people, associated with social rewards (such as having fun, being popular, sexy, glamorous, attractive), or used often in social rituals (for example, at sports events or to celebrate major life events). If a person experiences negative consequences from using a drug, it will be more difficult to recognize these consequences and change his or her use if (1) such use is widespread and accepted (even seen as normal and desired), and (2) any alternatives which exist carry a stigma or exclude the person from participating in desired situations.

Social opinions vary and change about the kinds of use that are acceptable, and by whom. They change over time, and they may differ from family to family and in different cultural groups. Clearly defined expectations can help to promote more desired or accepted behaviors and to reduce or eliminate those defined as unacceptable, especially when they are associated with valued rewards or lead to negative consequences.

In the future, as in the past, new technologies and other medical, biological, and chemical advances are likely to produce or identify new substances that have psychoactive effects. Both legal and illegal drug manufacturers and distributors are likely to continue to seek new products and markets for those products. They will also find more effective, efficient, and cheaper means to produce and sell them. Thus, there will continue to be forces that promote new use unless making money becomes a less-valued measure of success in our culture than public concern about the consequences of promoting such products and marketing strategies.

Other forces likely to yield new drugs and new uses for old drugs include scientific curiosity, personal desires to achieve and be recognized, and the wish to reduce disease, suffering, and death. As in the past, searching for pleasure and a better life, trying to avoid pain or to get high, or aspiring to an ideal society will also lead people to seek and consume new drugs. The way in which our society, communities, and families define health and good citizenship, and how we evaluate and react to different lifestyles will also continue to help determine how alcohol and other drugs are perceived and used and what alternatives are possible and available to the world of the future.

We noted in Chapter 1 some of the tensions in the history of the United States which related to the use of alcohol and other drugs. Pursuit of pleasure, play, and the “good life” battled with values of work, productivity, and individual and social restraint and control. An emphasis on

social change and experimentation conflicted with an orientation emphasizing the values and virtues of the past and efforts to maintain the status quo. These tensions occurred within specific periods of time and also stretched over different time periods, as society alternated between “permissiveness” and more restrictive attitudes and policies.

When major shifts in policy and opinions have occurred, the knowledge and experience gained at an earlier time have usually either been discounted or not adequately transmitted to the next generation. During periods of transition, variations in use patterns result in social conflict about the value and consequences of such use, and previous social norms become weaker, leading to multiple and ambiguous messages and practices.

When use is either completely prohibited or fully allowed, people have difficulty learning by trial and error how to fit their use of alcohol and other drugs into the range of behaviors acceptable to society. Individuals and groups gain little experience in making choices, recognizing how much is too much, and establishing their own values about use. “Public mood” about alcohol and other drugs, the behaviors that are emphasized and valued, and the amount of conflict between different segments of society at any given time are probably related to other societal changes. These can include changes in the economy, wars and other shifts in national and international relationships, local, regional, and national disasters, and even climate and weather changes. Times of stress and dissension tend to be more strongly associated with changes in values about patterns of use than times of optimism, prosperity, and relative stability. We do not really understand how these elements interact to influence social norms and patterns of use and vice versa. In the future we shall, through research and experience, begin to understand more about these processes, their consequences, and how they might be influenced.

In the early 1990s, many shifts in the social acceptability of use for some drugs are occurring. A strong focus on abstinence from use of illegal drugs is increasingly being accompanied by sanctions on legal drugs, primarily tobacco and alcohol. Laws are changing to limit locations for use, restrict access, and increase prices. Governments and private organizations are mounting advertising campaigns to reduce use and to counteract ads of producers and sellers which encourage use.

In a society which values individual freedom, there is always tension between those protecting individual rights and those promoting group rights and responsibilities. We will probably continue to disagree about what behaviors should be the concern of the larger society and which should be left up to individuals. Moreover, the very technologies and research designs that are required to monitor the effects of some policy changes may intrude on individual and group rights (for instance, drug testing, or identifying and tracking specific risk factors). Such techniques also may be more expensive than we feel we can afford. In many cases, we do not yet have the skills, knowledge, or techniques to do the research needed, or the research itself may influence the outcomes of the phenomena being investigated.

All of this makes our field an interesting, as well as challenging one. As a person who is concerned about problems associated with the use of alcohol and other drugs, you will need to develop ways to learn about new research and to follow the policy debates as they develop and change. Complex forces help to shape use and to determine patterns of use. If you are to become and remain effective in this field, you must continue learning about these forces and the programs which arise to influence them. We hope that this manual has provided a background to help you to do this.

### *Changing Cultural Norms/Local Subcultural Issues*

In addition to the ongoing changes in our knowledge and in public perceptions and cultural assumptions about which drugs and what kinds of use and consequences are more or less acceptable, communities, neighborhoods, and families also differ markedly in many ways—in their attitudes about use, their patterns of use, how they try to influence use and reduce problems, their ethnic and age mixtures, political structures, services available, and so forth. General knowledge and skills have to be adapted to “fit” particular communities and situations, the histories of past efforts, what a community or group will accept, the resources available, and many other factors that need to be taken into account.

It is easy to feel overwhelmed by all of these complexities, but there are also many exciting challenges and opportunities, and much you already know that can be applied to alcohol and other drug issues. With regard to your own community or family, you have much to contribute to the development of new knowledge and effective programs.

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