

Chapter 8

Critical Issues

Introduction

In previous chapters, we have focused on various characteristics of alcohol and other drug use in our society and described the skills and knowledge required to deal with the problems associated with that use. We have tried to indicate the numerous complexities involved in that pursuit. Now it is time to examine the real world in which these efforts take place.

That “real world” consists of human beings whose experiences and biases affect policies, legislation, and programs. All of these are influenced in turn by politics (in its broadest meaning of competing and controlling vested interests), access to resources (particularly funds), and the state of available technology and know-how. In addition, the effects of these forces are sometimes modified by attempts at advocacy for those experiencing the problems.

Some important variables which operate in these endeavors are:

- *Setting* (for example, worksite, schools, health care network, community).
- *Structure of the services* (in Michigan, CSAS, which dispenses the resources, is in the State Department of Public Health, which controls its budget and operations, but regional coordinating agencies are located in mental health agencies, free-standing public corporations, and local public health agencies).
- *Compensation and financing* (for example, federal and state funds, third-party payers, grants and contracts, and the rules and standards by which they reimburse services and workers).
- *Public perceptions of the problems and of the agencies dealing with them* (often directed and strengthened by media treatment of the issues and activities).
- *Strength of discrimination associated with the problem area* (for instance, differential perceptions about particular drugs and particular populations that use them).
- *Availability of resources to those who need them* (for example, including access to services, ability to pay, ratio of services to the number of people who need them).

In this chapter, we will try to look at some of these specific issues in more detail to give you a sense of both their reality and their complexity, and to reinforce what we have said earlier. There are simply no easy answers.

Control Policy and Availability

How Funding Influences the Delivery of Services

Virtually all decisions about the delivery of services for alcohol and other drug problems today are made with financial considerations in mind. Level of care, duration of treatment, and even the specific profile of eligible services may be controlled by the preeminent cost factor. This is by no means unique in the health care field, where decisions about elective surgery, cancer treatment, and psychiatric care, for example, are all influenced by the cost and resources available. While delivery of care in the public sector has always operated under these constraints due to limited resources, the much larger and more influential private sector has been forced into a posture of cost containment by escalating medical expenses.

The evolution of health care delivery systems in the United States over the past decade has culminated in a pattern that is often referred to as **managed care**. This is not to be confused with the earlier and still current model of **case management** which serves to coordinate all of the professional services required by a single client through one health/human services professional. While the latter may conserve resources (and therefore dollars) through greater efficiency, case management was actually introduced for the purpose of increasing the efficacy of services. Managed care was conceived specifically to reduce costs and improve efficiency, yet it may also provide benefits when it results in delivery of the most appropriate services.

As it is currently employed, managed care places the prime responsibility for determining the type, degree, duration, and even the personnel involved with delivery of care in the hands of a third-party (insurance, HMO) professional rather than a direct service provider. To be sure, this individual utilizes a detailed set of criteria to enable assignment of the most appropriate and cost-effective determination. These criteria have been developed by experts in the field, drawing upon their own clinical experience as well as the research literature. But they are often applied by staff with very limited experience with the populations and problems being addressed. To date, we have very little data regarding the impact of this system on the outcome of treatment for alcohol and other drug problems. However, the imposition of managed care (and the implied demand that more be accomplished with less) has energized and stimulated a resurgence of creativity among professionals working with alcohol and other drug problems. At the very least, it has prompted intensive review and validation of treatment strategies which potentially could improve the process of client-treatment matching and the actual services provided.

Controls On Alcohol and Other Drugs

It has been argued for a very long time that one of the main determinants of the prevalence of substance abuse is the widespread availability and easy access to abusable substances. Unfortunately, controversy surrounds this notion. Its most fervent adherents claim that controls on availability alone will eliminate the problem. This is simply not defensible. But such strategies, in conjunction with others, can effectively reduce the incidence of negative health and social consequences associated with alcohol and drug use in specific cultural settings.

This may be understood in its deepest sense in terms of illicit drugs that are sold on the streets, like crack cocaine and heroin. The market for these drugs is controlled (to some extent) through a variety of law enforcement and community-based efforts. Police try to limit availability of and

physical access to these drugs by getting dealers off the street—using the threat of incarceration. This strict and narrow conceptualization does not seem to work, apparently because it only addresses the *supply* side of the equation. We now know that much more attention needs to be paid to the *demand* side.

In other words, we must think about *perceived* and social availability. What are the community norms? To what degree do we tolerate, allow, approve, and even encourage the trafficking and use of drugs? Do family members, friends, and neighbors make it possible for drugs to be bought and sold in their homes and on their streets? And is the answer “Just say no!” meaningful when selling drugs may be the only *perceived* means for an impoverished community to achieve the American dream?

The same issues pertain to the purchase and consumption of alcohol. With this drug, these issues are larger in scope, while at the same time more subtle and tenaciously bound to our cultural practices. Many people—including many professionals in the field—do not accept the basic idea that underlies the “single-distribution hypothesis,” which states that “alcoholics” are simply drinkers at the high end of the (single) curve that relates the number of drinkers to how much they drink (*not* a distinct and separate population of alcohol consumers). The single-distribution hypothesis would predict that controlling availability (physical, perceived, and social access to alcohol) will reduce the amount of consumption for all drinkers across-the-board and thereby limit the disastrous health and social consequences associated with heavy alcohol use.

State and local governments impose formal controls on the sale of alcoholic beverages in order to limit consumption. These include restrictions on when, how, to whom, and how long a purveyor may sell beer, wine, or liquor. For example, no server or package store clerk in Michigan may sell or otherwise provide alcoholic beverages to anyone under the age of 21. In addition, the cost of alcoholic beverages is increased by taxes. This has an indirect inhibiting effect on sales, especially for people with limited means.

The Legal Drinking Age

Certainly one recurring issue that is directly connected to the problem of youthful alcohol involvement is the question of how old young people should be before they have the right to purchase and freely consume alcohol. Our laws are quite clear about this point, and currently set this age at 21 in every state in the Union. But the age we have used as a standard has not always been 21. Even within the last decade there has been considerable variability in opinions across the states concerning what the legal drinking age should be, including whether the concept is even useful. The push to raise the drinking age to 21 was partly due to the fact that drinking teens cause a disproportionate number of accidents, and that the leading cause of teen deaths is drunk driving.

It is important to remember that, in this society, alcohol use is clearly one of the rites of passage, and is a sign that many people, both adults and teen-agers, use as visible proof that we have achieved adult status. What are the issues about beginning to legally use alcohol that have led us as a nation to set this standard of adulthood? In recent years, our society has become more condemnatory of excessive drug and alcohol use for all of its members. Yet at the same time, as a nation, we are still users of legal drugs like alcohol and tobacco products. (As you may remember from Chapter 2, the majority of adult Americans are drinkers, and at least a large minority use tobacco products extensively.)

Still, there is a conflict of generations that exists here, and one group is sometimes required to bear a greater than normal burden of legal sanctions; that group is young people. In the passion to safeguard future generations from the harm of excess, communities sometimes exact fairly harsh punishment for early (and therefore illegal) use of alcohol, despite the fact that learning how to drink is clearly one of the tasks that most teen-agers will undertake as they grow up in a society in which a majority are alcohol consumers. Our laws, and the enforcement of them, take no account of the fact that legal consumption of alcohol is not going to be learned in one day, at the time of one's 21st birthday, but rather is likely to take place over adolescence. There probably are some settings (clearly supervised) where learning to use this legal drug could be tolerated. At the same time, it continues to be important for us, as a society, to send a clear, unambiguous message that excessive and situationally inappropriate alcohol and other drug use is unacceptable at any age. As a culture we do not understand this, but it is probably important for prevention and treatment personnel to appreciate the contradictions and inconsistencies in law and practice that still exist, and to some extent unequally punish the young as a special group.

Dangers of Labeling Youthful Behaviors

Drug and alcohol use is also complicated in another way that is sometimes forgotten in our efforts to help the future adults of our society to move on into lives that are free of alcohol and drug problems. Within the past decade, in an effort to identify problems early, the practice has increased of diagnosing the disorders of adulthood in patients who are not yet adults. While this effort at early identification is commendable, it brings with it a danger that we will be labeling something not yet fully developed and helping to make it more, not less of an issue. Problem use of alcohol and other drugs is, to some extent, a part of growing up in our society, but that part often drops out as we move into adulthood. The early identification and labeling of a disorder may actually work to keep it in place, rather than help it to subside.

This is not to say that we should ignore or deny alcohol or other drug problems in our young people. If anything, awareness and attention to them at this time may be preventive and more effective than treatment applied later, after the problem has become more established. The point, however, is that awareness and positive response may be more useful, and less damaging, than diagnosis and labeling.

Alcohol and Highway Safety

“We have received a communication containing the history of twenty-five fatal accidents occurring to automobile wagons. Fifteen persons occupying these wagons were killed outright, five more died two days later, and three died a few weeks after the accident, making twenty-three persons killed. Fourteen persons were injured, some seriously. A careful inquiry showed that in nineteen of these accidents the drivers had used spirits within an hour or more of the disaster. The other six drivers were all moderate drinkers, but it was not ascertained whether they had used spirits preceding the accident. The author of this communication shows very clearly that the management of automobile wagons is far more dangerous for men who drink than the driving of locomotives on steel rails. Inebriates and moderate drinkers are the most incapable of all persons to drive motor wagons. The general palsy and diminished power of control of both the reason and senses are certain to invite disaster in every attempt to guide such wagons. The precaution of railroad companies to have only total abstainers guide their engines will soon extend to the owners and drivers of these new motor wagons. The following incident illustrates this new danger: A recent race between the owners of large wagons, in which a number of gentlemen took part, was suddenly terminated by one of the owners and drivers, who persisted in using spirits. His friends deserted him, and in returning to his home, his wagon ran off a bridge and was wrecked. With the increased popularity of these wagons, accidents of this kind will rapidly multiply, and we invite our readers to make notes of disasters of this kind.”

-from the Quarterly Journal of Inebriety, Vol. 26, 1904!

Sure enough, just as the gentleman in 1904 predicted, research on the relationship between *driving, drinking, and traffic accidents* has established that the first two variables in combination have a high correlation with the third variable. There is even good evidence that a large proportion of traffic accidents caused by drivers who drink can be attributed to those who drink excessively. When one moves beyond these generalities, however, questions rather than answers are the order of the day. We encourage you to assume an inquiring posture as you examine this very complicated topic. You can by no means believe all you may read or hear about it.

For instance, what are the crucial characteristics of a “safe” driver? If they do not leap to mind, it may be because we do not ask the question very often, and, in fact, we have collected very little data. To the question—“what are high-risk drivers?”—we can say that they are individuals who cause lots of accidents and injuries on the highway, but we do not know much about them either, except, as was noted in the 1904 article, they have often been drinking quite a lot.

We might also ask how the use of alcohol affects “safe” or “risky” driving, and whether these effects are the same for all drinking drivers and for the same amounts of alcohol consumed by them. In fact, the assumption is frequently made that the presence of alcohol in the system is the only problem, and that unsafe driving is simply a result of the facts that alcohol impairs our motor skills, our vision, and our judgment. In this arena, as in the others we have explored in this manual, it is not that simple.

When we look a little closer, we find that alcohol-involved drivers are most often found among two subpopulations, teen-agers and chronic heavy drinkers. The teen-agers often get into trouble because they have had very little experience with either drinking or driving, tend to do both unsafely, and have very little margin for error. Little mistakes can result in severe consequences.

There is one characteristic which they are most likely to share with older chronic drinkers who have alcohol-involved accidents (and, in spite of what you may have heard or read, a large percentage of older chronic drinkers *do not have traffic accidents*). Both teen-agers and older chronic drinkers involved in traffic accidents are often using their vehicles primarily to express anger, frustration, or despair—rather than as a way to get from one place to another.

One reason we do not have more clear answers to the questions posed above is the difficulty of collecting and combining clear and reliable data. Traffic violations and other offenses classified as reckless driving, violent or disorderly conduct, expired license, or as a more serious crime may not be recorded as alcohol-involved, and so will not be considered when studying drinking driver phenomena. But even if we assume that the records collected are both reliable and thorough, it is still very difficult to assemble and use complete and meaningful data about alcohol offense repeaters.

Only recently have law enforcers and court systems at the city, county, and state levels systematically begun to collect and share information with each other. And when such information is available, it is seldom used to help determine the common characteristics of offenders and the best ways to intervene effectively to either change their driving behavior or to keep them off the road. Efforts to get them off the road have increased significantly in the last decade, but the most popular response, once they are apprehended, is to send them to driver education sessions especially constructed for drunk drivers—or to jail if they will not attend the classes—and to restrict their driving privileges for a period of time.

Another assumption which is regularly made is that if they go to jail—or attend the classes—that will teach them to be more responsible and commit fewer offenses, though available evidence

suggests that repeat offenses are still quite common.

Those who repeatedly commit such offenses are also more likely to be involved in the most serious, often fatal, accidents. Repeat offenders may be sent to programs offering therapy for their drinking problems rather than to jail. To the extent that such therapy helps them to live more effectively without using alcohol and other drugs, the safety of their driving behavior will also improve.

We must not assume, however, that the drunk driver is all we must change to reduce drunk driver problems. Modification of these systems is crucial and must be done thoughtfully, based on real data about the interacting, ongoing characteristics of the present systems which can help us understand why they are not working better and what is needed for this.

Some repeaters may go undetected throughout their driving careers if they are not convicted twice in the same jurisdiction. This happens less frequently in Michigan than in some states because the master file of Michigan drivers puts all cases entered into it into a common database. The existence of advanced computer technology also makes it feasible for us to identify the characteristics of the particular drinking drivers who are responsible for accidents and injuries on the highway, develop adequate screening measures and effective ways to intervene, and regularly monitor questionable driving records both for the type of interventions and for later evaluation of the effectiveness of those interventions.

We can also begin to define the conditions under which driving problems and drinking problems interact to result in traffic accidents. This knowledge would permit earlier intercession in the driving careers of those at highest risk for involvement in traffic injuries and fatalities. Without such crucial information about the target group and the circumstances underlying their high-risk potential, a countermeasures program must use broad-brush techniques, directed at a large, grossly defined population of drivers in the hope of somehow reaching and helping the crucial subgroup who might benefit from the interventions.

Violence

Many issues arise when one considers violence, its interrelationships with alcohol and other drugs, and implications for prevention programming, policy development, and treatment. For example, consider how the criminal justice systems (and public opinion) react when violence occurs and alcohol or other drug use are involved. Opinions differ about whether alcohol and other drug use should be taken into account in diminished capacity or some other defense, or whether people who commit violent crimes should be held accountable for their behaviors even if they are intoxicated or high. Many argue that there is no incentive for an individual to examine and change patterns of alcohol and other drug use that have destructive consequences for others if the person who commits the violence is treated more leniently when intoxicated or high. Public sentiment and practice appear to be moving toward stronger accountability, although there is still great variability in practice and interpretation.

A number of research studies have also found significant variation in the perceived relationship between alcohol and other drug problems and violence, as a function of gender and race-related discrimination. Such differences in perception have led, in turn, to variation in the way in which laws and policies end up getting enforced. For instance, when police are called to intervene in a domestic violence/battering incident, if the man is drinking, he is more likely to be told to “sleep it off and cool down” than he is to be arrested (probably a result of attributing the violence to the

alcohol). If the woman is drinking or using drugs, however, the male perpetrator is also less likely to be arrested than if she is sober.

Police reports suggest that the officers share the larger society's double standards about inebriated behavior in women. If the woman is "no good" or shameful in some way (by being "drunk" for instance), she is perceived to be at least partly responsible for the attack on her, since she has already violated key societal prohibitions for women. Similar patterns have been found in how the law is interpreted and enforced with regard to race. These "double standards" must be addressed if women and men, blacks and whites, are to receive equivalent, equitable attention within the criminal justice and other social systems. The current patterns hold white men less accountable for their violence, and contribute to more punitive approaches with men of color and all women.

The apparently high incidence of violence in the childhoods of many who later develop problems with alcohol and other drugs has implications for prevention programming—both for children who have or are experiencing violence and for adult survivors of violence. Such prevention programming could focus on the person who was the target of the violence, the person who was the perpetrator, and the situation in which violence occurs.

Within treatment programs for alcohol and other drugs, the presence of violence, either in the behavior of an individual or within a family system, is usually not a target of treatment. The individuals may need to surface and face the violence that was perpetrated on them, or they may be more likely to relapse. Yet these memories are often not identified in alcohol and other drug programs, nor is much special programming available. Assessment and intervention with perpetrators of violence are even less likely. Attention to these issues, both with those who have been victimized and those who are actual or potential perpetrators, may be important in a treatment plan if either the victim or the perpetrator is to address successfully his or her problems with alcohol and other drugs.

In addition, treatment programs cannot assume that patterns of violence will cease when problems with alcohol and other drugs are addressed; both sets of problems need attention. Many who drink are also violent when they don't drink. Others drink to create excuses for their violence and are able to find other excuses when they stop drinking or using drugs. In fact, early abstinence and its associated irritability is likely to be a time for increased risk of violence. Attending to this likelihood should be a goal of treatment programs, both with the recovering person and with key family members. Otherwise, programs may indirectly condone the violence by not addressing it.

Other Ethical and Legal Issues

Confidentiality

Confidentiality is the protection of the information and trust which is shared between clients and treatment/prevention providers. Every client has a right to confidentiality, and there are both federal and state rules which protect this right. All licensed programs, regardless of their funding sources, must comply with these rules. Designed to protect the rights and privacy of clients, they prohibit disclosure of any information about clients to anyone who does not have a need and legal right to know.

These rules also protect the service provider with legal support for dealing with client questions.

In addition, they help the provider make informed decisions about the kinds of information that can be shared with other people, either in written form (involving use, maintenance, storage, and security of client records) or by oral disclosure. For instance, conversations about clients with friends or staff members outside one's program without explicit client permission is both illegal and unethical.

Release of client information outside the service provider's program requires the client's written consent except under very special circumstances such as the following:

- When it is necessary for medical staff to meet a medical emergency.
- When it is authorized by a court order accompanied by a subpoena.
- For scientific research, financial audits, or program evaluation, although for these purposes, the information released may not reveal the identity of the client.

Employee Assistance Programs in the Workplace

Destructive use of alcohol and other drugs by workers results in loss of productivity associated with illness, accidents, and personal problems which cost industry, government, and the military billions of dollars each year. Since work constitutes a central and crucial role of most adults in our culture, early intervention in the context of the workplace with those experiencing problems with their use of alcohol and other drugs can often be quite effective. This usually involves "constructive confrontation" between the supervisor and the employee, designed to motivate the employee to do something about his or her problem behavior.

Employee assistance programs (EAPs), functioning either within corporations or as referral sources for them, provide confidential consultation, case management, and/or treatment for such employees, without involving a threat to their continued employment as long as they cooperate in the intervention. Since their introduction in the late 1960s, such programs have resulted in considerable savings to both employers and employees in terms of reductions in job-related accidents, leaves of absence, and sickness and accident insurance costs. While quality of job performance is harder to measure, it is not unreasonable to assume that sobriety on the job enhances both one's skills and one's judgment, two very important components of job performance.

Drug Testing: Implications for Detection

The term "drug testing" generally refers to a quantitative assessment of the amount of a drug present in the body. The most commonly used drug test is with urine. The reasons probably have more to do with convenience and acceptability than quality of the data. It is important to realize that urine is an excretory product that accumulates over a variable period of time. So the actual urine drug concentration may bear little relationship to either blood level or functional impairment. What it *does* say is simply that a drug may have been used at some time in the recent past. Urine drug testing is widely used in the workplace as well as in drug treatment settings. While we discussed some of the more technical issues in Chapter 5, it is well for us to think about its purposes, procedures, and ethics.

Urine screening for drugs is included in preemployment exams conducted by a majority of Fortune 500 companies. Many of the same organizations, and government agencies as well, perform regular random testing of their employees. The intent is to reduce the probability that a

new employee will have a drug problem or that other employees are using drugs. Perhaps the most unfortunate accompanying caveat is that blood *alcohol* levels are not accurately reflected in the urine, and alcohol is the drug most frequently abused! Most businesses, especially those in high-risk or security industries, conduct urine drug tests for evidence of cause—following an incident in which drugs may have been a factor.

For those who may use the procedure, it is essential to consider the legal and ethical ramifications of urine drug screening. Privacy, confidentiality, and application of the findings are all important. Privacy has become an issue of controversy because those providing urine specimens must be observed—to avoid the possibility of substitution or manipulation of the sample to defeat the test. Confidentiality is of utmost concern, since the information could literally destroy a person's life and livelihood. Procedures are in place in all responsible drug testing programs to guarantee that samples are correctly identified from start to finish through a formal chain of custody. The findings are a private matter, though they may be cause for reprimand, referral to treatment, or dismissal in the work setting.

Pregnancy

The issue of the pregnant, chemically dependent woman is a hotly debated issue in the 1990s. Some feel that a woman should be prosecuted for delivery of drugs to the infant if, for instance, cocaine is found in the infant's urine or cord blood at delivery. It is believed by some that the mother should be imprisoned and the infant placed in another home. Others feel that illicit drug use by pregnant women is not a criminal justice issue but a public health or medical issue. Such women need good prenatal care and treatment for their addiction. The "casual" user of drugs may be able to stop using while pregnant, but the addict cannot stop without help. The chemically dependent female has major handicaps to seeking and receiving treatment such as lack of money, child care, and transportation, and other factors like personal denial and denial by her partner, family, and friends.

One approach to helping women is exemplified by Families First, an intensive, short-term social work intervention. The aim of Families First is to empower the family and provide access to the necessary services. Residential treatment programs for women and their children are decreasing the rate of treatment dropout among women. In addition to treatment for their addiction, they receive education and training about parenting, job skills, and money management.

Drug Use in Sports

For a number of years, a variety of drugs have been employed by athletes to enhance their performance. Those used most commonly are anabolic steroids and stimulants, and it is certainly true that drugs in both classes have some effect on physical performance. Anabolic steroids do increase muscular bulk and capacity, while psychomotor stimulants seem to affect drive and intensity. The point that is always missed by the users is that both types of drugs have extremely negative physical and emotional consequences that should preclude their use.

Historically, drugs in both of these classes were introduced in the 1930s and used extensively by German soldiers during World War II. After the war, athletes in international competition began using them as training aids. Russian Olympians, especially the weight lifters, were put on specially designed steroid regimens, while American football players used amphetamines in game situations. It did not take long for these practices to spread among all types of athletes and filter down to the ranks of high school players who aspired to the big time. The pressure to perform

and to strive for some ideal of appearance is extraordinarily intense among young men and women today, and this fuels the perceived need for these drugs.

The fact that steroids, as well as amphetamines, have harmful psychoactive properties has never been fully appreciated. In fact, we now know that steroids can produce intoxication and dependency very similar to that of the stimulants. Health professionals must recognize that, in addition to the potentially tragic physical consequences of steroid abuse, there is the strong possibility of addiction.

Legalization of Illicit Drugs

The long-standing debate on **legalization** of illicit drugs rages on. It is an issue that, unfortunately, generates more heat than light. Those for and against legalization deal in extreme remarks more often than reasoned argument—a natural consequence of the issue's complexity, ethical intrusion, and scarcity of empirical support. Indeed, the complexity of the problem cannot be understated! Even the term legalization seems to have multiple definitions. Some people take it quite literally; that is, total elimination of all legal sanctions for personal use and sales. Others would have a form of **decriminalization** that simply reduces penalties for personal possession and use. The discussion is sometimes limited to marijuana and in other cases includes all drugs, including cocaine and heroin.

Undoubtedly all parties to this debate are sincere in their wish to resolve our nation's drug problem. But there are genuine differences of opinion on the right solution. The primary motivating factor in all of the proposals for legalization or decriminalization is the desire to eliminate or at least reduce the *legal* consequences of drug abuse, most importantly, the violent crime. Advocates of legalization believe that the legal availability of drugs would do away with the reason for the violence, the business of dealing, by removing the monetary incentive. Adversaries believe that, to the contrary, any reduction in drug dealing-related crime would be replaced by other social and health problems due to an increased number of drug users and escalating quantity of drugs used. Advocates state that we should attack the potential health consequences with a prevention-education campaign, but adversaries counter that legalization makes a statement of silent approval, and people would only be confused by the multiple, mixed messages. Besides, prevention-education can (and should) be done just as things are, they say.

Although we do not have controlled experiments to guide our decisions here, we can look to past and present experiences with alcohol, tobacco, and other drugs for some help. For example, when alcohol sales were banned during Prohibition, the business went underground and generated a good deal of violence. However, national measurements of alcohol-related health problems showed a reduction during the same period. Of course, the available data did not capture all the costs on both sides of the equation (crime versus health), and the interpretations remain emotionally charged. Today, with alcoholic beverages legal and widely available, we have virtually no crime attached to the sales, but the health and social consequences of alcohol use are immense—amounting to an estimated \$70 billion each year. Tobacco sales have never been similarly outlawed and controls on its availability as cigarettes have always been extremely permissive. We have no reported violent crime associated with tobacco sales or use, but we do know that cigarette smoking accounts for more than 450,000 deaths each year due to lung cancer, emphysema, and other respiratory disease. While heroin has never been legal in the U. S., it was legal in Great Britain for physicians to prescribe. The purpose was to control availability for people who had become dependent through medical treatment. Unfortunately, the plan fell short

in several respects. With the rise in recreational drug use in the late Sixties and early Seventies, the number of identified users increased rapidly with free access to the drug.

The bottom line on legalization, of whatever type, is whether or not it can produce the desired outcome. Is legalization feasible? Most of the debate has been conducted in a socio-political venue, with little testimony from the health perspective. Feasibility can only be projected with a full consideration of all potential consequences. For example, will we see drug-intoxication-related violence increase while drug sales-related crime diminishes? And who will control the ever-increasing needs of users who become progressively more drug tolerant (and dependent)? The answers to these and many other questions can only be obtained empirically, but what community is willing to risk an experiment that could fail with such disastrous consequences?

HIV Prevention in I.V. Drug Users

While Acquired Immuno-Deficiency Syndrome (AIDS) was first described in homosexual men in 1981, it is likely that it was present in intravenous (I.V.) drug users years prior to that time. The belief that most AIDS cases are the consequence of certain negative behaviors has had a major impact on the subsequent framework for AIDS prevention. Needle-exchange programs, wherein the I.V. drug user turns in contaminated needles in exchange for clean needles, were not favorably received because they were seen as condoning drug use. The teaching of needle-disinfecting techniques using bleach was met with less, but nevertheless some resistance. However, current evidence is inconclusive regarding the usefulness of this procedure.

The Ethics of Organ Transplants and Rationing

Medical advances of the last decade have raised ethical issues that present challenges and dilemmas for the alcohol and drug field. For example, should a person with advanced liver failure secondary to alcohol use receive a life-saving liver transplant? Many people would say “no” if there were a limited number of available livers or if taxpayers must bear the cost of the transplant. Others believe that, if available, the liver transplant should be given to the individual if he or she has been abstinent for a significant length of time (one to two years), making relapse less likely. A few years ago, a Michigan Medicaid recipient was denied a liver transplant because he had not been abstinent from alcohol use long enough.

As medical costs continue to spiral, issues around health care rationing for those with or without private health insurance continue to mount. Who needs that organ transplant the most? HIV infection may confound the already complex problems. An example discussed in Chapter 5 was that of an HIV-infected I. V. drug user who had many complications from I.V. drug use to the point that she needed a life-saving heart transplant. Since she “caused” her medical problems and is already HIV infected, an organ transplant would be considered wasteful by some. Transplant patients require close medical follow-up and costly medications to prevent rejection of the new organ. Should so much money and time, let alone a scarce organ, be given to someone with a greatly shortened life expectancy? Answers to such questions do not come easily.

Summary

As a professional, you must strive to remain current and know the critical issues of the day. In many cases, you may find yourself regarded as the expert. The issues discussed in this chapter are important as this book is being written. Tomorrow other issues may take their place. To work in this field is to become involved in a constant struggle to know what the relevant issues are at all times and to develop your own position with respect to these issues.