

Chapter 7

Intervention

Introduction

Prevention and treatment represent a *continuum* of interventions that cover the spectrum of alcohol and other drug problems. Prevention occurs earlier, in fact, often before problems manifest themselves, and it is group focused. Treatment takes place later, when the problem is established, and is directed toward individuals.

Yet, prevention and treatment are closely related. Prevention activities are expected to reduce the need for personalized intervention, and treatment activities are viewed as preventing further deterioration. All who deal with the process of intervention for substance use must have a basic understanding of both prevention and treatment because:

- (1) At present, there are no universally effective methods of prevention. Until they are developed, there will always be people with problems who need to be treated.
- (2) At present, there are no universally effective methods of treatment. Until they are developed, prevention will be the only avenue toward creation of a society that is relatively free of problems with alcohol and other drugs.
- (3) *Universally* effective methods of prevention and treatment are probably beyond accomplishment. Thus, both prevention and treatment will always be needed.

The three points made immediately above illustrate the natural relationship between treatment and prevention, which is a reason for discussing them together. But there is another important reason for doing this. Treatment and prevention have for the most part been separately dealt with in the field of alcohol and other drugs (as well as in other fields, such as medicine). Different individuals have concerned themselves with each, and few have concerned themselves with both. In general, treatment and prevention have gone their separate ways, and, in certain respects, there has been hostility between them (for example, as to which is more important). We think that both are very important, and that anyone entering the field should have a sound, basic knowledge of both. For these reasons we have chosen to present them together in the same chapter.

Goals and Ingredients in Types and Levels of Intervention

For both prevention and treatment, you must determine the goals or desired outcomes of the activities or programs. What behavior(s), condition(s), or outcome(s) does the program strive to prevent or to treat?

The goals or desired outcomes can vary widely. Interventions should be based on knowledge of the factors or conditions that shape the behaviors or consequences that the program or activity designer wishes to avoid, reduce, or repair. Ideally, programs should be based on **empirical evidence**; that is, research evidence and documented experience that demonstrate that the interventions lead to desired changes and effects, and that support the theory or model being used. The more you know about causes or **risk factors**, the better you can design a program to deal with these factors. Risk factors are elements which have a high probability of causing the problem, but have not yet been proven to do so.

Goals can differ in the level of prevention or treatment on which they focus. They can also differ as to their “target.” For instance, some treatments may focus on the individual person, or even some component of the person’s body, like a particular gene or body chemical. Others might focus on a larger social system, such as a family unit or neighborhood. Still others might focus on national policies (laws, regulations) or even international agreements. We will give examples of programs at different levels throughout this chapter.

What levels and target systems are chosen can depend on the knowledge we have about the problems of concern and the factors that help create them. Some of these include: the resources available; the priority given to alcohol and other drug problems relative to other problems of concern; the types of programming acceptable to a particular person, community, or country, determined by their past experiences; compatibility with their customs and culture; and how much valued routines and rights are severely disrupted.

Creating and implementing an intervention, even if it is using a new medication or a new treatment program, always involves some degree of change. Unfortunately, there is always some resistance to change, even if it is seen as positive, because systems of all sizes inherently strive to maintain stability. Program designers are most effective when they try to anticipate the ways that the changes will affect those targeted and the overall community. Unless the people who may be affected by the change *accept* the need for changes, new programs may face opposition. Since people in different situations often disagree about how they view the need, the strategies, and the types of programming, one of the best ways to design an effective program is to involve key segments of a community in its development. If opposition develops, a new program, no matter how well planned, will experience difficulty or even failure.

Levels of Prevention: The Public Health Model

One common framework for thinking about treatment and prevention overall is called the **public health approach**. This model considers treatment as a component of prevention and describes three levels of preventive intervention. In the following sections, we will define the different levels of prevention in the public health model. Then we will discuss some key elements of current work and theory with regard to alcohol and other drugs.

In the public health framework, long-term treatment and rehabilitation are referred to as **tertiary (third-level) prevention**. Third-level prevention activities usually target persons or situations in which the problems of concern have already developed. The object of this kind of prevention is to reduce the long-term effects of the problems. This is usually accomplished by either shortening the time that the person is incapacitated, or by helping the person to return to the highest possible level of functioning. This level may be much less than it was originally, but still better than it would likely be without the intervention. In the next section, we will look at tertiary intervention as it manifests itself in the field of alcohol and other drug problems.

Secondary, or second-level prevention, strives to identify a problem or pathology at its earliest stages. This is done in order to intervene quickly to prevent its further development. This second-level prevention may take advantage of a crisis in order to reduce longer-term consequences, or change the environment supporting the problem, reducing the likelihood that it will spread to other individuals or communities. This may include training health care providers and those in troubled environments to recognize the early manifestations of the problem or pathology so that therapeutic interventions can occur promptly, and a milder or shorter course of

the trouble may be possible. Crisis intervention and brief forms of therapy are examples of secondary prevention. The expectation here is that recovery or cure are more likely because of the intervention.

The main goals of **first-level, or primary prevention**, are usually to promote health and resilience so that we can reduce or eliminate the problem behaviors or conditions altogether—*before* they start. The targets can be systems of various sizes—from a biological cell, to a person, to the entire ecosystem of the earth. Most programs that we label “prevention” deal with this kind of intervention.

The development of alcohol and other drug problems is caused or influenced by many factors which interact in ways that we only partially understand. Research suggests that risk factors for problems with alcohol and other drug use are patterned quite differently in particular communities, neighborhoods, and individuals. Of course, we hope that we will eventually understand better the crucial factors in the development of such problems. To the extent that we are successful, primary prevention strategies will be easier to design and more likely to succeed.

Treatment in Perspective: Improvement Without Formal Treatment

Most people with alcohol and other drug problems do not come to the attention of formally designated care givers. Yet their problems can be resolved by informal interactions with other people, and as a consequence of life events. This phenomenon is referred to as “spontaneous remission,” an unfortunate term, because it is often neither spontaneous, nor a remission in the sense of a medical “cure.”

Remissions are common in all human problems, including medical ones such as cancer, so it is not really surprising that they should occur for alcohol and other drug problems as well. Estimates of the frequency of remissions for those with alcohol problems range from 0-80 percent; the most commonly cited figure is around 30 percent. The rate appears to be variable for different groups. Improvement without treatment is strongly associated, for instance, with increasing age, having an intact family, home, and professional life, and also with being female.

Recognizing that improvement can occur without formal treatment, plus the fact that time and experience are critical variables, has important implications for treatment. It should permit a more measured and deliberate approach, rather than a reflexive, crisis-driven one. Of course, this does not eliminate the need for treatment. In a given instance, we can never be certain that improvement will occur without intervention. In fact, it is probable that appropriate intervention will accelerate and enhance improvement.

Kinds of Treatment Available

Throughout this manual we have stressed that problems with alcohol and other drugs are quite complex. Different people have different kinds of problems. Because they are different people, they react differently to the problems they have. As a result, the treatment provider faces not merely one, but a whole series of therapeutic challenges.

To meet these challenges, it would be ideal to have a whole range of treatment options. No single treatment has been found to be effective for all persons with alcohol and drug problems. Rather, different individuals require different sorts of treatment in order to deal with their problems. This

is one of the reasons why, over the years, many different treatment approaches have been developed by those working in this field.

It is true that certain kinds of treatment have become more popular than others, and tend to be used more frequently. These include:

- 21-28 day residential treatment programs.
- Alcoholics Anonymous.
- Antabuse treatment for alcohol problems.
- Methadone and therapeutic community (longer-term residential) treatments for problems with opiates.
- Therapeutic community treatment for other (mostly illegal) drugs.

All of these programs have demonstrated effective positive outcomes with some people. All are available, at least to some extent, in Michigan. At the same time, these programs are not effective for everyone. Regrettably, we do not have the numbers of treatment programs or the range of program types that we are likely to need to address the diverse ways that alcohol and other drug problems manifest themselves in different people. In order to have a spectrum of programs broad enough to meet our needs, we will have to develop new methods of treatment.

To give you a deeper understanding of the many different kinds of treatments that are or could be available for alcohol and other drug problems, we will outline some key ways to describe any treatment program. Describing treatment programs is similar to describing individuals, in that certain specific descriptive categories, or *descriptors*, are generally used. In describing an individual, we might make use of such descriptors as age, height, weight, gender, marital status, racial or ethnic background, and so on. In describing a treatment program, we can also use specific descriptors, but they will be different from the descriptors used for individuals. For example, we may wish to use descriptors such as modality, philosophy, strategy, goals, setting, and so forth.

Table 7.1 provides a list of descriptors of treatment, as well as the relevant subcategories for some of these descriptors. In the text that follows, we will discuss the first eight descriptors in this list at a moderate level of detail. The remaining four descriptors—cost, availability, utilization, and organizational characteristics—are quite straightforward and will not be further discussed.¹

Table 7.1 Descriptors of Treatment

- I) Modality
 - a) Name
 - b) Type
 - 1) Biophysical
 - 2) Pharmacological
 - 3) Psychological
 - 4) Sociocultural
 - 5) Mixed
 - c) Strategy
 - d) Goals
 - 1) To modify alcohol or other drug taking directly
 - 2) To modify antecedents of alcohol or other drug taking
 - 3) To modify consequences of alcohol or other drug taking

- II) Philosophy
 - a) Moral models
 - b) Spiritual and existential models
 - c) Biological models
 - d) Psychological models
 - e) Sociocultural models
 - f) Integrative models

- III) Stage specificity
 - a) Acute treatment stage
 - 1) Emergency treatment
 - 2) Detoxification/withdrawal
 - 3) Screening
 - b) Active treatment stage
 - 1) Assessment
 - 2) Intervention
 - 3) Stabilization
 - c) Maintenance stage
 - 1) Continuing care
 - 2) Relapse prevention
 - 3) Supportive living arrangements

Table 7.1 Descriptors of Treatment (cont.)

IV) Setting

- a) Specialized treatment settings
 - 1) Inpatient
 - 2) Residential
 - 3) Intermediate
 - 4) Outpatient
- b) Other treatment settings

V) Target

- a) Specific drugs
 - 1) Alcohol
 - 2) Opiates
 - 3) Other depressants
 - 4) Cocaine
 - 5) Other stimulants
 - 6) Cannabis
 - 7) Hallucinogens
 - 8) Other substances
 - 9) Combinations of substances
- b) Interactive unit
 - 1) Composition
 - individuals
 - couples
 - families
 - groups
 - networks
 - communities
 - populations
 - 2) Characteristics
 - structural (demographic)
 - age
 - race
 - gender
 - ethnicity
 - other
 - functional
 - drinking drivers
 - dual diagnosis psychiatric patients
 - homeless persons
 - college students
 - children of alcoholics
 - others

Table 7.1 Descriptors of Treatment (cont.)

- VI) Provider
 - a) Training
 - b) Special characteristics
- VII) Time frame
 - a) Usual time per session
 - b) Usual time per course of therapy
- VIII) Efficacy
 - a) Anecdotal evidence
 - b) Evidence from outcome studies
 - c) Evidence from randomized controlled trials
- IX) Cost
 - a) Cost per session
 - 1) Negligible cost
 - 2) Lower cost
 - 3) Moderate cost
 - 4) Higher cost
 - b) Cost per course of therapy
 - 1) Negligible cost
 - 2) Lower cost
 - 3) Moderate cost
 - 4) Higher cost
- X) Availability
 - a) Not available
 - b) Available but limited
 - c) Moderately available
 - d) Widely available
- XI) Utilization
 - a) Up to 20 persons
 - b) Up to 50 persons
 - c) Up to 100 persons
 - d) Up to 1,000 persons
 - e) Up to 5,000 persons
 - f) More than 5,000 persons

Table 7.1 Descriptors of Treatment (cont.)

- XII) Organizational characteristics
 - a) Administrative auspices
 - 1) Freestanding
 - 2) Part of another organization
 - health or public health
 - mental health
 - social services
 - other
 - b) Financing
 - 1) Primarily public
 - 2) Primarily private
 - 3) Mixed

Modality

The first descriptor is **modality**—the kind of treatment that is to be provided. There are three subcategories within modality: type, strategy, and goals.

Types of Treatment. There are four basic types of treatments.

Biophysical treatments employ various physical agents to induce a change in the biology of the individual that may enable him or her to deal with alcohol or other drug problems. Examples include electric stimulation of various kinds, hyperbaric oxygen (the delivery of oxygen under high pressure), and radiation. Biophysical treatments are rarely used in the United States, although acupuncture (which is used) might be considered to be in this category. Other countries make extensive use of biophysical treatments.

Pharmacological treatments use medications of various kinds to assist an individual to overcome alcohol or other drug problems. Two of the major therapeutic approaches, the use of disulfiram (Antabuse[®]) in the treatment of alcohol problems, and the use of methadone (Dolophine[®]) in the treatment of opiate problems, are examples.

Psychological treatments, on the other hand, influence people not through the use of medications, but through talking and other forms of interaction that convey various feelings and thoughts, or that focus on specific types of behavior that are part of the alcohol and other drug-taking event.

Sociocultural treatments exercise their influence by exposing the individual to particular social settings. The drug-free therapeutic community, which is one of the major treatments used in dealing with drug problems, is a good example of this kind, and self-help groups such as Alcoholics Anonymous and Narcotics Anonymous are others. Historically, both the drug-free therapeutic community and Narcotics Anonymous developed as offshoots of Alcoholics Anonymous.²

Finally, some treatments are best understood as a mixture of these various types. Group therapy is a possible example. Many of the techniques used in group therapy are psychological in nature, but the group setting in which the treatment is conducted is also an important element. There is a temptation to categorize most treatments as “mixed,” and there is some validity to this practice; however, for most treatments, one or another type predominates.

Strategies of Treatment. The **strategy** used by a given modality (kind of treatment) is the specific

manner in which it attempts to achieve its effect. For example, the basic strategy in the use of disulfiram (Antabuse[®]) is to block the metabolism of alcohol at a point at which a highly toxic substance, acetaldehyde, accumulates in the blood and causes a powerful physical reaction that is so unpleasant that people are unlikely to drink while they are taking the medication. Another element of this strategy is that, because of its prolonged duration of action, the decision to take disulfiram only has to be made once a day; in the absence of the medication, the decision not to drink will have to be made many times a day. The basic strategy in the use of methadone (Dolophine[®]), which is a synthetic narcotic, is to provide legally a sufficiently high level of opiates so that the individual will not wish to use illegal drugs such as heroin. This in turn decreases drug-related criminal behavior. Again, because of the prolonged duration of action of methadone as opposed to heroin, it decreases the number of daily decision points. Because methadone is effective orally and heroin is not, the use of methadone decreases the possibilities of infections, including hepatitis and AIDS. An excellent example of a strategy for a nondrug treatment is the twelve-step approach pioneered by Alcoholics Anonymous. Each treatment modality has its own strategy; strategies are so variable, however, that they are difficult to categorize.

Treatment Goals. Different types of treatment have different **goals**. One treatment modality may seek to modify alcohol or drug taking directly. The use of Antabuse[®] and methadone is associated with this goal. Relapse prevention techniques are another way to reach this same goal. Other treatment modalities attempt to modify *antecedents* of alcohol or drug taking; that is, they try to deal with the factors that predispose people to use alcohol and other drugs. If, for example, an individual's use of alcohol and other drugs arose from depression, a treatment directed against that depression, such as cognitive psychotherapy or an antidepressant medication, would have this goal. Or, if his or her use was an attempt to blunt the psychological pain arising from the recall of a severely stressful event or events, dealing effectively with this painful recall might reduce the use of alcohol or other drugs. Still other modalities seek to modify the consequences of alcohol and other drug use. An example would be the use of narcotic antagonists, which block the effects of opiates, eliminating their positive reinforcing properties—the pleasurable reaction one gets from their use—and hence diminishing their use.³

Philosophy

Another important descriptor of a treatment is its **philosophy**: the basic view of the problem being treated. The categories of treatment philosophies are often referred to as models; in the context of Chapter 6, these are best understood as *conceptual* models, rather than *etiologic* models. And although they define the basic assumptions about the root causes of the disorder, these assumptions are virtually all made as philosophical affirmations, rather than being based on empirical models.^{4,5,6} [See also the discussion in Chapter 6 of this manual.]

Moral models of treatment, in general, hold that the excessive use of alcohol or other drugs is *bad* (in the sense of morally repugnant, rather than in the sense of “bad for you”) and that the individual needs to exert his or her will to avoid this kind of behavior. Moral models are said to be very much out of fashion, but in fact may be far more prevalent than they appear to be. In a sense, any treatment activity is based on the view that sickness or dysfunction is *bad* and health or functionality is *good*.

Spiritual and existential models hold that alcohol and other drug problems may occur in individuals who are unable to see or to think beyond their own individual and immediate

experience and to relate to larger or broader considerations—to some aspect of the divine or holy, in the case of spiritual models, or to some abstract principle in the case of existential models. In other words, these people lack a sense of ultimate meaning or purpose in their lives; the treatments that are offered attempt to foster the development of meaning or purpose, or indeed to provide it. Alcoholics Anonymous is an example of a treatment approach that includes a major consideration of spirituality, although it also contains other elements and is best considered an example of an integrative model, described below.

Biological models affirm that alcohol and other drug problems are due to one or another kind of malfunction in the body that needs to be dealt with. Among the more popular biological models currently are those that see genetics as the principal cause of these problems.^{7,8} The so-called “**disease concept**” of alcoholism is often thought of as a biological model; it does indeed have some biological components, but is probably best viewed as an integrative model (described below).

Psychological models relate alcohol and drug problems to the thoughts, feelings, and behavior of the individual. For example, a person may use alcohol and drugs because he or she is unhappy, or because of a past set of learning experiences.

Sociocultural models relate the use of alcohol and other drugs to social circumstance and tradition; for example, an individual’s use may be attributed to poverty or to socioeconomic status, or to the values about alcohol and other drug use present in the culture.

Finally, **integrative models** use *more than one* of these explanatory frameworks at the same time. The disease concept may be considered integrative, for example, because it maintains that alcohol and drug problems are fundamentally biological in nature—such as the “allergy” concept of Alcoholics Anonymous—but also that a spiritual reawakening of the individual is required to resolve them.

We will make two general points about the descriptors of modality and philosophy. The first is that, although these two descriptors are closely related, they are not the same. It is true that psychological modalities tend to be based on psychological models, and that pharmacological modalities tend to be based on biological models. But this is not always the case. Antabuse[®] is a good example. Its use is based on its ability to interfere with the biology of alcohol metabolism (certainly a biological effect), but its basic intent is psychological. By pairing the drinking of alcohol to a severe physical reaction, it is hoped that a strong negative association of a psychological nature will be developed and will prevent future alcohol use. Thus, in characterizing treatments it is desirable to describe both the type of modality and the basic philosophy; they *may* or *may not* be the same.

A second point is that we are not implying anything here about the validity of various modalities or philosophies, or concluding that one is superior to the other. Unfortunately, many people, both inside and outside the field, engage in this sort of relative evaluation of different models, saying that only treatments based on a particular conceptual model will do. Rather than making demeaning comparisons, one should instead rejoice that there are a number of alternative models and modalities. As has been stressed earlier it is likely that different individuals will respond to different treatments, and, in this sense, the more the merrier. What is probably needed for the future is the greatest possible diversity of treatments, rather than a narrowing of the treatment effort to one or a very small number of approaches.

Some Other “Ingredients” in the Treatment Process

We pause briefly in our discussion of descriptors here to focus on more general issues pertaining to treatment and change during the intervention process. For example, one must be able to build rapport with the patient, and lay a foundation for building trust. If this does not happen, then the issue of trust must be addressed—either before or at the same time as the alcohol or other drug problems. Suggestion, as a process of providing information by someone perceived as authoritative, is a backdrop to most intervention work. Similarly, the provision of an empathic and caring attitude is part of the necessary climate. So also is the attendance to the background needs of the client (such as physical health and ability to have three square meals a day and a roof over one’s head), not only while treatment is going on, but afterward. We frequently take for granted these vital ingredients of giving help, which are frequently provided by either nonprofessional staff or by others outside the immediate treatment agency—and yet, *they are a backdrop to successful treatments—to everything else that takes place*. At the same time, it is important to remember that these other interventions are not of themselves rightfully regarded as treatment.

The word counseling has frequently been used as a label for the provision of treatment services, but it is also a term that has much ambiguity connected with it. We have investment counselors, camp counselors, school counselors, counselors-at-law, guidance counselors, pastoral counselors, and many others who also use this title. Here we make a distinction between counseling and therapy,⁹ as a way of sharpening the differences between these activities, and differentiating between those activities which have an explicit change-oriented focus (therapy) and those which help people cope with their problems and the world in which they live (counseling).

What distinguishes counseling as an activity most clearly from other things that clinicians do is its emphasis on *growth*. The basic counseling assumption is that life from beginning to end involves change, and that the counselor can facilitate development in desirable directions. Someone may seek counseling because they are wondering how to begin addressing their alcohol or drug problem, trying to find a career, or wanting to address the family wounds created by excessive drinking. Each of us faces the challenge of addressing these issues, and the counselor’s role is to help individuals cope with the complexity of their world. The counselor, in contrast to the therapist, does not advise, suggest, or plan for the client. The client is the one who maintains decision-making responsibility.

The counselor is likely to utilize many more kinds of factual information and specialized community services than therapists typically do. To do a good counseling job, the client must be connected to dependable sources of information and special programs that will address his or her needs. The individual must be helped to cope with the challenges of adaptation. Thus, it is the counselor’s job to obtain information about housing and family situation, and then to offer guidance about opportunities that may offer the potential for growth and enhancement. These activities are likely to be an important part of any comprehensive treatment plan. At the same time, it is important to emphasize that such activities are generally not the treatment.

We use the term treatment to refer to specific activities focused upon the alleviation and remediation of problematic alcohol and other drug behavior. One of the critical distinctions to be made is that treatment requires specific and detailed knowledge of the problems, along with a commitment to plan and implement an appropriate intervention regimen by the therapist. In addition, in contrast to counseling work, one of the more difficult aspects of engagement with some alcohol and drug problems is that the treatment does not always initially bring a sense of

personal relief. Everyone who has worked with individuals who have had problems of chronic alcohol or other drug involvement understands that the work will sometimes require access to painful memories and grief before change can take place.¹⁰ Other aspects of the work sometimes require delving into conflict, and even apparently making things worse.¹¹ Thus, it cannot automatically be assumed that hope and empathy are sufficient. A very substantial amount of knowledge and training is required to understand how to treat these difficulties if lasting change is to take place.

Stage Specificity of Treatment

The remaining descriptors of treatments are considerably more straightforward. **Stage specificity** refers to the fact that most treatments are keyed to the stage of treatment. There are three general stages: acute, active, and maintenance.

There may in some cases be a need for an **acute treatment stage** that requires a variety of emergency treatment measures (such as setting a broken limb that has resulted from a fall while intoxicated), detoxification, or withdrawal. To this can be added a screening function: a systematic determination as to whether further treatment for alcohol or drug problems is indicated once the acute phase is over.

If treatment is felt to be indicated, the **active treatment phase** is initiated. As already noted in Chapter 6, this is best begun with a comprehensive assessment, designed to determine which of the available interventions might be the most appropriate for a particular set of problems in a given individual. The next stage is the provision of the appropriate intervention; much of what is usually thought of as “treatment” will happen in this portion of the active treatment phase. Our overall point, however, is that treatment has *several* stages and is most appropriately considered to be a process which involves them all.

The **stabilization** portion of the active treatment phase is a good example. If intervention is thought of as a process that rapidly enhances the ability of an individual to cope with alcohol or other drug problems, stabilization is what is done to *keep* the individual at this level of competency. In some important ways, methadone in the treatment of opiate problems may be thought of as a stabilization device. But stabilization is a phase of the active treatment stage that has been insufficiently developed to date and certainly requires additional attention in the future.

Much the same can be said of the **maintenance** stage. This stage has in the past been referred to as “aftercare.” But this designation is unduly negative, and seems to imply that these activities are far less important than the major treatment interventions. Nothing could be further from the truth! A strong case can be made that a positive outcome is more closely related to what is done in this stage than what is done in the intervention phase of the acute treatment stage. Treatment cannot stop at the end of the acute treatment stage. It is very important to provide some sort of continuing care after formal treatment is ended.

Relapse prevention is considered a particularly important part of the maintenance stage. Many treatment interventions do not focus on particularly stressful situations that an individual may encounter following the intervention and that could cause the individual to return to the excessive use of alcohol or other drugs. Research^{12,13} suggests that these situations differ for different individuals. Relapse prevention consists of the identification of these high-risk situations and the development of alternative strategies to cope with them. Finally, supportive living arrangements may be extremely important in helping to maintain whatever gains the individual has made. A

return to the environment that was the context in which the problem developed in the first place may not be helpful—for any length of time.

Setting

Treatments occur in a number of different **settings**. Specialized treatment for alcohol and other drug problems tends to be provided on an inpatient basis (such as a 24-hour hospital setting); a residential basis (i.e., a 24-hour, nonhospital setting), on an intermediate basis (day care or partial hospitalization), or on an outpatient basis. These are settings in which treatments occur, and not treatments in themselves. There is a tendency to speak of “residential treatment” or of “outpatient treatment” as though these represented discrete and unified forms of treatment. Rather, they are merely the spatial and temporal arrangements in which treatment occurs. Ideally, any treatment modality would be potentially available to individuals in any setting. The choice of a setting is (or at least should be) determined by the social circumstances of the person being treated and what is available, while the choice of a modality is often determined by other factors.

Most general human services agencies may serve as the setting for treatment of alcohol and other drug problems, especially for brief interventions. These kinds of agencies, whether they provide health care, social services, educational services, criminal justice, or correctional services, all deal with a high proportion of persons with alcohol and other drug problems. It has been recommended that persons seeking assistance from such service agencies be screened systematically for alcohol and other drug problems, and that brief interventions be provided to those who are positive on the screen.¹⁴ If this were to be done, these kinds of agencies would become extremely important treatment sites.

Target

A given treatment may aim at a particular **target**. Some treatments are aimed at particular drugs, as Antabuse[®] is aimed at alcohol, and methadone is aimed at opiates. Treatments may also be directed at different collections of individuals. Some are directed only at the individual who has the problem, while others are directed at the relationship between that individual and his or her spouse, at the individual’s family, at a group of people with similar problems (for example, people who are recently widowed), at the individual’s entire social network, or at even larger targets such as communities and whole populations. Treatments may also be targeted at different structural or functional characteristics of individuals; for example, some treatments target women with alcohol problems (for example, Women for Sobriety), while others target drinking drivers, college students, or the children of persons with alcohol and other drug problems (such as Adult Children of Alcoholics groups). On the other hand, some generic treatments (psychotherapy might be an example) do not have a specific target but may be applicable in a variety of circumstances.

Provider

In specifying a treatment, one also needs to look at the characteristics of the **provider** of the treatment. Various kinds of training may be necessary on the basis of either law or custom in order to deliver treatments. At the present time, for example, drug treatments must be provided by a physician, or at least must be given under medical direction. Although counseling is usually thought of as a very general treatment, there is a strong movement at present to certify all counselors, and in the future such certification may be required in order to provide counseling. In addition, it has long been felt that certain special characteristics of individuals are required for effective treatment. Successful psychotherapists, for example, have been thought to require empathic skills (the ability to understand what is happening with their clients), nonpossessive

warmth, and genuineness in the therapeutic situation.^{15,16,17} Evidence has also surfaced of complex interactions between what has been called the “cognitive level” (ways and complexity of thinking) of a treatment provider and those he or she deals with.^{18,19} No doubt there are many other characteristics of a treatment provider that interact importantly with the persons with whom they deal and influence the outcome of treatment in a critical manner.

Time-Frame

The **time-frame** of treatment is another important descriptor. Some treatments are lengthy, others are brief. Because alcohol and other drug problems can be quite severe, it has long been thought that prolonged and intensive treatments were necessary to deal with them effectively. But evidence has begun to surface that, at least for some persons with problems, very brief interventions may be significantly effective. A series of studies has shown that, in some cases, treatment interventions as brief as a single session of twenty minutes can produce important results.²⁰ Much remains to be learned about these kinds of interventions and their overall place in treatment. This is not to say, however, that there is no place for lengthier interventions. It seems certain that some individuals will continue to require long-term treatment.

The remaining relevant descriptors have to do with the efficacy, cost, availability, level of utilization, and organizational characteristics of different treatments. The latter four are entirely straightforward, but it may be worthwhile to pause briefly over the issue of efficacy—whether the treatment provided produces the desired results (is effective).

Efficacy

Regrettably, it cannot be *assumed* that the treatment provided to a given individual has been effective. Rather, effectiveness must be *demonstrated*. This is true not only from a research standpoint, but from a clinical standpoint as well—in the sense that one needs to know whether an intervention has worked for an individual in order to plan for the future. The demonstration of efficacy may at some future time also be required to assure the funding of treatment. With funds in increasingly short supply, purchasers of treatment services are more and more likely to require evidence of efficacy as a precondition of purchase.

Such evidence can only be developed with a reasonable level of certainty through a systematic evaluation of the individual following treatment that compares his or her status at that time to his or her status prior to treatment. Evaluations of this kind at the present time are rarely carried out in treatment settings, though they are often a feature of research studies. Anecdotal evidence (impressionistic reports by individuals or their treatment providers) of success has some small value in terms of the demonstration of treatment efficacy, but requires much more substantiation if it is to be considered credible.

The “gold standard” of proof of effectiveness has long been thought to be the **randomized controlled trial**. In simple terms, in a randomized controlled trial, all of the individuals exhibiting a particular kind of problem are randomly assigned to two different conditions: a treatment condition and a no-treatment condition. Random assignment is an attempt to assure that the groups in the two conditions of the study do not systematically differ from each other in terms of severity of problem, length of problem, age, sex, race, and all other factors, including those that may be unknown. If the two groups are alike at the start, then differences in outcome cannot be attributed to differences between the groups other than the treatment itself.

Outcome of all participants is then examined. If those who receive no treatment do as well as those who receive it, the treatment is judged ineffective. If those who receive treatment do much better than those who do not, the treatment is judged effective.

While there is much to be said for controlled trials of this kind, they are not without their own problems.²¹ The bottom line is that positive results in a randomized controlled trial study conducted by researchers do not necessarily mean that the same treatment will give positive results in your hands—if applied to your program population by your treatment staff. But they do tend to indicate the treatment has the *potential* to be effective. If positive results in a controlled trial are coupled with a systematic evaluation of the outcome of the people your program has treated, and most are doing well, a much better case can be made for the efficacy of your program. You could, of course, conduct a controlled trial within your own program, but this is a very difficult undertaking, and in a number of clinical settings simply may not be possible, since a controlled trial denies treatment to some of its participants.²² In such cases, different treatment strategies can be compared, but there is no control or placebo condition.

It may be worth noting that many controlled trials have been conducted and many outcome evaluations have been done in the alcohol and other drug treatment area.²³ The results of all this work can be summarized quite simply: (1) no particular kind of treatment is effective for all such persons, and (2) some programs are effective for some people.

Two major conclusions follow from this. One, as indicated at the beginning of this section, is that if no one program is broadly effective, we need many different types of treatment programs in order to produce generally good results for people seeking treatment. The other is that we need to learn which programs are likely to be best for which individuals—a process generally referred to as matching.²⁴ These are among the tasks of the future.

Toward Treatment Systems

Thus far, we have been discussing individual treatment programs. This is a sensible procedure because, at the present time, treatment is largely delivered by individual programs, each of which commonly provides only a single kind of treatment. An idea that has been increasingly advocated is that, in the future, treatment should perhaps be provided by treatment *systems*, each of which would be capable of delivering a large number of different kinds of treatment, rather than just one. This idea is a natural consequence of the growing conviction that no one treatment will prove to be effective for all persons with alcohol or other drug problems, but rather that many different approaches will be required (see earlier). A treatment system is an attempt to provide multiple treatment interventions in an effective and efficient manner.

Another advantage of an approach to treatment through systems rather than through individual treatment programs has to do with a number of essential functions that tend not to be provided by individual treatment programs. To provide effective and efficient treatment in the future it is felt²⁵ that these functions must be available. It will save much in terms of duplication of effort and of resources if these functions are attached to systems of treatment rather than to individual treatment programs. The functions that have been seen as essential with regard to treatment are the following:

- **Assessment:** Objectively evaluating the nature and extent of the problem and the strengths and weaknesses of the individual who has the problem. Assessment helps one to select the most appropriate treatment, and hence

should be done prior to treatment.

- **Matching:** Selecting from among the treatment options available the one(s) most likely to be effective in a given case.
- **Outcome evaluation:** Determining whether the treatment selected actually did benefit the individual. (If a detailed pretreatment assessment has been carried out, outcome determination is equivalent to reassessment.)
- **Feedback:** Using knowledge of outcome for a given individual to assist in selecting the most appropriate treatment for others who may have similar characteristics. Feedback allows the treatment system to learn from its own experience and to improve itself over time.
- **Case Management:** Guiding individuals through the complex treatment process and acting as their advocates with the many public and private individuals and agencies that they will encounter.

The development of treatment systems is clearly a task for the future. At present, no treatment system exists in the United States or elsewhere that provides multiple alternative treatments while fulfilling all of the functions listed above. However, there have been systems that have come close to doing this.²⁶ In addition, some of the elements of a system, particularly pretreatment assessment, are being developed in some areas. For example, assessment prior to treatment is mandated by law in Minnesota; the Province of Ontario, Canada already has some 35 assessment and referral centers in operation; and the Center for Substance Abuse Services (CSAS), the relevant State agency in Michigan, is now requiring the development of such centers in all areas of the State. Because the development of treatment systems has not yet occurred, we will leave our discussion of it now. But it seems quite likely that such systems will be under active development while readers of this manual are active in the field.²⁷

The Community Component of Treatment

As mentioned before, a majority of people with alcohol and other drug problems are unlikely to enter specialized, formal treatment for those problems. An estimate is that fewer than 10 percent, and perhaps fewer than 5 percent of those with alcohol problems will ever seek treatment *for those problems*.²⁸ With regard to other drug problems, there is less information, but the proportion of people seeking treatment is probably smaller, perhaps less than 1 percent. This is particularly true for those using illegal drugs. Thus, it is very unlikely that the alcohol and drug treatment system will encounter all of those who have these problems.

Many such people will, however, seek help for the consequences of these problems from health care providers and other human services providers. They will come to the attention of social agencies, schools, workplace assistance programs, courts, mental health agencies, and others. If some form of effective help is to be made available, the community must be responsive and prepared to provide it through:

- **Identification:** People *who do have* problems need to be detected. While

problems are often apparent, they are not always obvious, so systematic screening is desirable. Ethical issues can be minimized if this is done in a progressive way for all people. Most people will agree to be screened, just as they accept metal detectors at airports, although people with problems may be most resistant to screening.

- **Brief intervention:** People *who are identified* with mild or moderate problems can be given a brief, “therapeutic” intervention within the context of the human services program. There is ample evidence that such interventions are beneficial for many clients, and they are highly cost effective.
- **Referral:** Those *who have substantial* or severe problems can be referred to specialized treatment agencies. When brief intervention has proven ineffective, those clients should also be referred for specialized treatment.

From a public health standpoint, this kind of community strategy is more likely to reduce the magnitude of alcohol and other drug problems than specialized treatment. A truly comprehensive system of care would consist of a closely linked community and a specialized service sector. Many treatment programs conduct what is often called **outreach** or **case-finding**. Such activities can also be called marketing, which refers to selling a product; in this case, probably treatment, crisis intervention, or educational services. Activities in this category can be financially motivated by the need to keep treatment slots full so that employees are kept busy full time by “paying customers” (which can mean payment through insurance, grant slots, or public allocations). If the primary goal is to lure “paying customers” who would otherwise go to other service delivery settings, marketing activities would probably be considered a component of a treatment or tertiary prevention program (preventing longer-term disabilities).

Outreach activities, however, can also have the goals of identifying a wider range of persons who need assistance than are currently being reached and/or working to get them services that will be useful for them before their problems become more serious (see “Identification” above). Creating new ways for such identification, and trying to engage people earlier in the process of developing difficulties is one key goal of secondary prevention. Identifying more people whose problems have not yet become severe is one way of preventing more severe and chronic treatment from being necessary.

Another goal is to strengthen the ability of a community, neighborhood, or a human services system to act quickly and effectively in a crisis situation. Usually, the type of crisis that is meant is one experienced by an individual that often signifies the onset or deepening of an area of problems. This could include an overdose, or a major health problem either directly or indirectly related to their use of alcohol and other drugs. It could also be an arrest for impaired driving, violence, or disruptive behaviors, or a relationship crisis, problems in a marriage or with a child, for instance.

A time of crisis is often a period in which individuals are more likely to be open to change; thus, effective work with someone during a crisis period can reduce the likelihood that longer-term and more chronic patterns will develop. Earlier in the development of the alcohol and other drug fields, very basic information and procedures were not available within the community to deal with very basic crises (such as overdoses) and many died. Now emergency personnel are routinely trained to manage basic medical crises. As noted in the section on community programs, we still have a long way to go in most communities before we are able to recognize the multiple ways that alcohol and other drugs are involved in crises that are managed within other

systems (such as family or mental health services), and to develop appropriate interventions.

Other types of crises that should be noted are those experienced at a community or institutional level. These can indicate that problems are developing, or that procedures in the system are not sustaining a healthy environment for its occupants or responding well to their problems.

Examples of these types of crises might be:

- A student protest at a high school over how regulation of behavior at school dances is being handled, including a protest that students who have consumed alcohol purchased outside the school are being excluded from social functions.
- A fatal car crash involving a prominent citizen with a high blood-alcohol level. A newspaper reports that this official had been stopped for erratic driving the week before, but not cited because the officer recognized him.
- An increased influx of cheap drugs into a community, with a rise in overdoses and serious allergic reactions seen in the local emergency room.

In each case, there is evidence of trouble with procedures for reducing and intervening early with crises. In the first case, the school's efforts to keep alcohol out of school functions and to reduce dangerous behaviors are being challenged by students arguing infringement of their rights. Here we have a discrepancy in two sets of community values, and a conflict between norms developing among the students and those their parents and school authorities wish to encourage. Secondary prevention efforts would work to develop more consensus and procedures that the majority believe are fair. Some students may be reacting to the way the rule is being enforced, rather than to the substance of the rule. Others may resent not being involved in establishing the rule, and may agree with the need to reduce violence often initiated by those who have been drinking.

In the second example, efforts to prevent alcohol and other drug-related car accidents by identifying and arresting inebriated drivers failed because the mechanism was not equally enforced. In the third case, efforts to control supply (availability) failed, and the community would need to decide why this had happened. For instance, a new drug which was not yet included in the availability schedule may have appeared, a new means of manufacture may have lowered the cost, new routes of supply have been developed, or the law may not be well enforced in a poor community. Each of these reasons would suggest a different approach to the developing problem.

It often requires careful assessment of *what* is going on, and *why*, to develop an effective response to a problem in an individual, or within a community. Sometimes the first set of assumptions prove incomplete or inaccurate, and must be reviewed as additional information and experience are available. None of these are easy tasks, but they are all very important if communities are to have strong and comprehensive programs.

Primary Prevention

Effectiveness of primary prevention efforts is difficult to evaluate. If the programming is optimally successful, the problems of concern will never develop. "Proving" that they would have developed if the prevention activities were not present is virtually impossible, unless one can make comparisons with other settings, situations, and communities that are similar in which the intervention(s) are not present.

As with other levels of prevention, a major task in primary prevention is to determine what behavior or outcome is the target or goal of the activity. Does one wish to prevent *all* use? Simply prevent crime that occurs because people need money for drugs? Long-term health consequences related to regular use of alcohol? Use of some drugs by children under 21?

Once goals are established, one must design activities, programs, and policies that will move a person, group, neighborhood, or community toward the desired goal. It is important to evaluate, as well as one can, the effects of the program and to review regularly whether one's original assessment and program design were appropriately targeted.

Prevention Efforts with Adolescents: A Brief History

In the late 60s and early 70s, efforts to prevent any use of drugs (especially in youth) relied heavily on “scare tactics”—focusing on the negative effects of use such as car crashes, overdose deaths, and withdrawal symptoms. The presenters of these messages were usually persons with formal authority, often in “uniform”—police (with badge and gun), physicians (in white coats), or persons in recovery who told their “horror stories.”

After some assessment, a number of problems were identified with these approaches. The first problem was with the messengers. For adolescents who were rebelling from symbols of authority, reactions against people in uniform often led to the *very behaviors* that were of concern. The recovering messengers, in addition to telling horror stories were often perceived to be heroic (and charismatic), and some who heard them identified more with the journey to the current situation than the message to avoid taking a similar journey. There is also some evidence that “scare” tactics alone can lead to anxiety, which then may lead to self-medication patterns. It is true that “scare” tactics are effective with some people, but the proportion is small.

These anti-drug messages also sometimes included inaccurate information shaped by the value systems of the persons doing the presentations. Another concern was that the presentations often excluded information about alcohol, tobacco, and other legal drugs. Thus, the presentations omitted the drugs that are most used in society, that affect the most people negatively over time, and that are most readily available to youth.

The next efforts moved toward having more neutral presenters and strictly factual information—the assumption being that people will make healthy decisions if presented with accurate, unbiased information about what types of behaviors are likely to be most healthy. Studies of health-related decision-making and behavior in other fields documents that this is rarely the case. Knowledge is necessary, but it is not enough. In fact, a few studies of the “facts” approach, suggested that such education led to an *increase* in some forms of drug taking, since the information conveyed suggested less danger than the students had initially believed. The presentations increased their curiosity, decreased their reservations, and led to minor increases in use of some drugs.

The next wave of prevention programming used approaches being developed in the “**confluent**” **education movements**. By confluent, educators meant educational approaches that gave attention to multiple parts of a person: how they thought and felt about things, their physical health and well-being, the knowledge and skills they had and their approach to learning, and so on. These included work to (1) *clarify values*, with the assumption that decisions are made in the context of values, and if the child has not developed strong family values, does not

recognize or is not able to talk about these values, the values will not support healthy decision-making, and (2) *develop interpersonal skills and self-esteem* to strengthen support systems and communication patterns, and to make one less vulnerable to peer pressure.

The earliest programs assumed that strengthening of these aspects of education would spread to many areas of decision-making and health, including various drugs and contexts. More recent evidence suggests that this generalization doesn't readily happen, and that education must be more specific to the situation and a particular drug if it is to influence behavior effectively. In short, we are still trying to develop effective strategies for preventing alcohol and drug use by adolescents.

Current Approaches To Prevention—Goals, Strategies, and Assumptions

Prevention of First Use

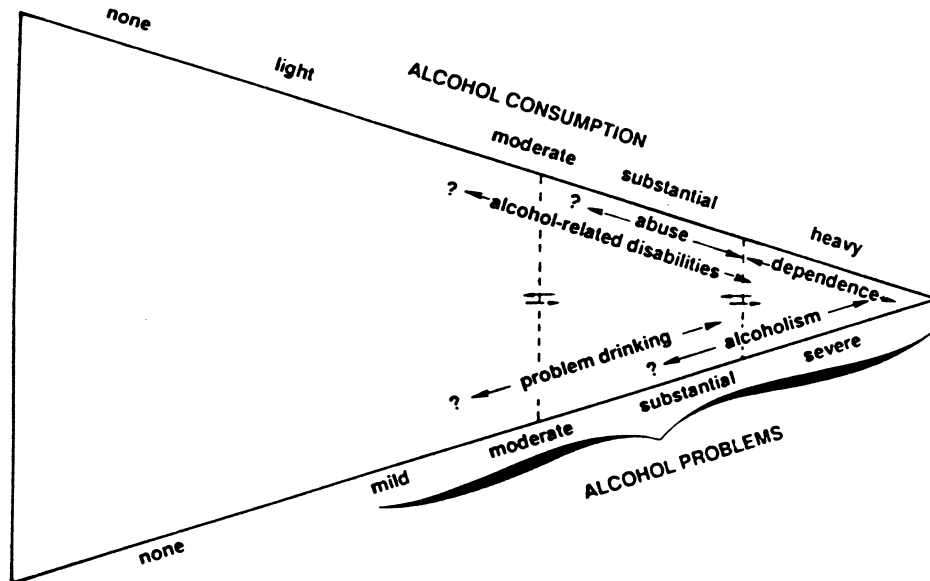
Models that include elements of the confluent approach still exist, but are now more often called “social competency” approaches. In fact, some describe them as “inoculation” approaches, using an analogy to vaccination approaches to disease. The programs are thought to develop behavioral “antibodies” that will allow the individual to resist temptations to use before one is exposed to them. Those programs which exhibit positive outcomes include the provision of specific information about specific drugs and situations, and provide training to practice refusing drugs in various circumstances and to develop ways of handling high-risk pressures and temptations. The context for these approaches is sometimes within K-12 schools (either in a comprehensive curriculum or in special modules or classes), through parents, community programs, or within other institutions, such as churches.

Other types of prevention also seek to prevent first use of alcohol and other drugs, under the assumption that abstinence is the best form of prevention, and that *any* use of that substance is a problem. Such programs may focus on media messages about the dangers of any use of particular drugs, on the assumption that individuals will not engage in behavior they know is dangerous. Others try to change the social acceptability of any use, on the assumption that consumers will be less likely to buy a product of which others they care about disapprove. Examples of this are the extensive media campaigns designed by The Partnership for a Drug Free America (a consortium of advertising executives) to prevent any use of illicit drugs in the early 1990s.

Overall Reduction in Use

Overall patterns of alcohol use and the numbers and types of negative consequences related to alcohol suggest that reducing overall consumption within a population also reduces the overall level of problems (see Figure 7.a). This is illustrated by the research examples noted earlier.

Figure 7.a A Terminological Map



A number of strategies that follow have the effect of reducing overall consumption. We will illustrate this point with the following three examples.

Delaying First Use

Some programs are concerned with delaying first use as long as possible, and are based on research that shows that those who begin use at earlier ages are *far more likely* to suffer negative consequences of various kinds, both in the early stages of use and later in life. One likely explanation for this effect is that use by those who begin earlier may interfere with successful negotiation of the tasks necessary at later stages of development. As adults, these people would have many more difficulties and fewer ways of addressing them successfully. If people do not use alcohol or other drugs until they have learned adult coping skills and developed an adult identity, they are more likely to have a stronger sense of life goals, a wider range of ways to cope with stress and life transitions, better health, adult support systems, and many other potentially useful attributes before they begin to engage in potentially disruptive behaviors. Thus, they should be better able to regulate their use and problems would be less likely to develop. Should they experience problems, treatment would focus on returning them to better functioning (rehabilitate), rather than having to help them learn (habilitate) to be a “healthy,” coping adult.

An example of a program designed to reduce or prevent early use are laws against the sale of alcohol and tobacco to minors. Asking students and parents to sign contracts agreeing not to use alcohol and other drugs until a certain age also has this goal.

Other programs focus not on delaying first use, but on reducing the potential of negative consequences from early experimental use. Congress voted to raise the age at which it is legal to drink in part because of concerns about automobile fatalities among drinking drivers under the

age of 21. Young adults were learning to drink and learning to drive simultaneously—a dangerous combination. Students Against Driving Drunk (SADD) is focused in part on reducing automobile crashes, and does not focus specifically on preventing drinking (although it certainly does not *encourage* drinking).

Availability Reduction and Increase in Costs

Two of the above examples are also examples of another potential set of goals— to reduce the ready availability of alcohol and other drugs, and to increase the expense of using them. The assumption is that people use alcohol and other drugs because they are easy and available. If using were more difficult, the casual user will be less likely to experiment; if it were more costly (through extra taxes for alcohol and tobacco) or less available (because illicit drug routes are disrupted through arrests and seizure of shipments), then potential users will need to acquire additional sources of money or spend more of their resources on alcohol or other drugs. People who are not extremely motivated to use will be less willing to do so.

If there are additional “costs”—such as arrest, social disapproval, jail terms, and fines—those who are not motivated to break rules (or not very dependent on alcohol and other drugs) will be less likely to engage in the behaviors that might incur these costs. These are the types of rationales that underlie a range of interventions, including what hours liquor stores are open, regulating who can prescribe which types of medication under what circumstances, the development of particular laws, required sentences, and law enforcement strategies, as well as much of the work on reducing drug crops and importing activities that supply this country with many illicit drugs.

Cultural Regulation/Norm-Focused Approaches

Through work done primarily by those who study culture and social organization, as noted in Chapter 3, we have come to understand that cultural expectations and norms influence what drugs are used in a society or subculture, how they are used, and what behaviors linked to that use are deemed acceptable or unacceptable in that society, subculture, or social grouping. Creating consistent and clear standards about acceptable behaviors and unacceptable consequences helps individuals and groups develop well-regulated patterns of behavior, and makes it more difficult to deviate from these standards. In situations that present conflicting messages about what behaviors are acceptable, the individual is more vulnerable to other forces that affect how alcohol and other drugs are used.

Another important cultural mechanism for conveying procedures in which use is acceptable is through rituals of various kinds. For instance, a fraternity that has 52 “games” played at various social functions which require the use of alcohol, will promote higher levels and very different patterns of use than one which values wine at meals but frowns on more than several drinks at parties and has penalties if a brother engages in too boisterous, destructive, or lewd behaviors while intoxicated. We noted SADD earlier as an example of efforts to reduce consequences, but its activities also create major forces toward different views of what behaviors are responsible and valued among youth.

Thus, prevention strategies based on a cultural orientation would work to change peer group and larger system social norms and practices and to strengthen rituals that either do not involve use at all, or that limit use to particular times, places, and circumstances. These could involve media

campaigns, work groups to develop and build consensus for particular kinds of behaviors and sanctions for violations of them, or contests to create new alcohol/other drug-free (or well-regulated) symbols and social games.

High-Risk Identification

Another set of strategies target particular high-risk groups. These could include;

- Those with particular personal histories (such as experiencing the death of a parent or being a survivor of violence).
- Being a member of a group which experiences discrimination or is less valued (for example, by virtue of ethnicity, gender, sexual orientation, or disability).
- Experiencing high levels of stress which might lead one to self-medicate (or look for chemical ways to manage the stress).
- Social isolation or experiencing low levels of self-esteem.
- Other types of problems often associated with use of alcohol and other drugs (such as violence, some types of psychiatric disorders, or eating disorders).
- Having particular biological or genetic susceptibility (immediate family history).

Obviously, the types of interventions which would make sense would all require ways to identify those with particular types of risk factors, and to address key elements of the particular risk-factor of concern.

To give an example, one might identify lack of self-esteem as a problem for women in a particular community. If insufficient assertiveness was seen as a cause for this low self-esteem, one could use assertiveness training to counteract it. If high rates of domestic violence were identified as a cause, one might change police practices so more batterers are arrested, and might work to change public attitudes that blame women for violence directed against them. For African-American children in some communities, Afro-centric curricular elements would be an appropriate prevention activity if a lack of pride in one's African heritage in this country were identified as a risk factor. Low self-esteem could also be related to a lack of perceived options for meaningful work and discrimination. Job training, job development, and mentorship programs would be program types that would be appropriate for this assessment, as would more recreational options and reducing negative encounters with police and school.

As we discussed in the previous chapter, other subpopulations may also experience particular risk-factors at particular times. For instance, those over 60 may have particular issues with misuse of prescription drugs and interactions among drugs taken for physical problems (especially if they are mixed with those taken for recreation or relaxation). Education about drug interactions, warnings about sharing medications with friends, readily available consultation with a clinical pharmacist, and mechanisms to help seniors keep track of their meds and which ones they have taken might all be useful in particular situations.

Discrimination and Poverty

Those who are poor and must deal with day-to-day survival issues are at greater risk for developing problems with alcohol and other drugs, since the drugs can *temporarily* allow the user to blot out the realities of their lives. Even though a lack of money may limit access to more expensive drugs, grinding poverty or worry about not being able to find a job have many negative

consequences—including problematic use of alcohol or other drugs. A primary prevention approach would focus on the economic situation or the factors that caused it—lack of jobs, child care, job skill training, transportation problems that interfere with getting to work, etc. They could also focus on alternative ways to feel better for awhile, which, although not addressing the primary causes, might help to reduce some of the negative consequences.

The experience of discrimination can lead to high levels of resilience and very hardy survivors—if people are taught to recognize and manage being discriminated against and if they have strong social support systems. Many types of discrimination are quite subtle, however, and can undermine self-esteem and self-concept in ways that are quite destructive. If one's life opportunities are also restricted by the consequences of discrimination—inadequate schools, teachers who expect less, more difficulty in getting jobs, lowered performance expectations because of biases in assessment procedures, for example—discrimination can lead to depression, despair, and feelings of low self-worth. Prevention approaches would need to take these possibilities into effect, work to remove or reduce societal discrimination, and help those who experience the effects of discrimination to be as resilient as they can. For all of the above, of course, programming should also be sensitive to incorporating respect and knowledge about one's ethnicity.

Creating or Strengthening Alternative Means of Coping

These approaches could also fall into the “high-risk identification” category noted above, but are employed often without clear signs of risk, and are so common in many discussions of prevention that they deserve their own heading. They arise from the knowledge that many people first use (or continue to use) alcohol and other drugs as a means of coping—either with pain, emotional distress, or social situations—that they do not believe they can handle without a chemical support. Given these assumptions, primary prevention programming could target many levels.

One level would focus on the situation with which the person (or group) was trying to cope. Reducing factors which cause stress would mean there would be less need to cope, or that other, more positive means of coping would be adequate for the situation. One would need to understand the nature of the stressful situation in order to design the intervention. For instance, some teens and many women (and more men than has been recognized in the past) have experienced past and present violence; many believe they cannot escape this violence. Very heavy care-taking responsibilities (for an elderly or impaired relative, for instance), too much work to do in too little time, chronic physical pain, or an undiagnosed major depression or anxiety disorder can all lead persons to “self-medicate”—either to help themselves keep going under difficult conditions, or because they feel hopeless about other solutions. Unfortunately, efforts to “self-medicate” often cause other problems, especially if the person becomes dependent on the drug. The other problems can be obscured and the person's ability to find other solutions or means of coping may be reduced by their use.

In these examples, the reader can see that working to reduce the *need* for coping could happen in many ways. In the work example, intervening in the workplace to redesign the job or develop different kinds of supervision could resolve the situation. If the whole workplace atmosphere is the problem, the target may be the “climate” of the organization.

Another approach within this area targets individuals and their immediate support systems, with the assumption that developing a wider range of coping skills and abilities would make it less likely for someone to rely on alcohol or other drugs for relief.

Increasing Social Support

One more aspect has been implied in several of the examples above. People with strong social support systems, those who have people they can talk to and rely on for assistance, tend to be more resilient in the face of many problems. This is partly because they have more help and resources on which to draw, and probably also because they are less isolated and feel better about themselves as people. There are many approaches that can be designed, depending on the culture and circumstances within an environment; social support systems can be strengthened and even newly constructed. New social contacts and skill training are also possible ways to increase different kinds of support and decrease isolation. Many believe that the most important aspect of self-help groups is their ability to provide social support for their members.

Creating Alternative Ways To Socialize and “Get High”

This is likely to be of particular concern if the risk-factor assessment turns up evidence of boredom or an absence of social or enjoyable things to do for a group or a setting that does not include the use of alcohol and other drugs. What the *alternative* activities might be would depend on what was already available, the interests of the group for whom the activities would be designed, and a variety of other elements relevant to the environment.

Summary of Intervention Issues and Approaches

In summary, just as every community should have a range of treatment options (see earlier), every community should probably have a mixture of prevention programs that are selected based on considerable assessment of the groups and settings of concern. Table 7.2 presents a range of prevention strategies and their rationales.

Table 7.2 Examples of Prevention Models

<u>Causes of alcohol/other drug problems Strategy</u>	<u>Suggested Intervention</u>
1) Societal norms promote use and do not disapprove of relevant negative consequences	-Change norms -Adopt formal rules (behavior not allowed) -Change cues of approval (e.g., advertisements, party games)
2) Peer/reference group norms promote use and do not disapprove of relevant negative consequences	-Change norms -Formal rules when possible -Examine norms, influence opinion leaders, processes
3) High availability Alcohol/other drugs are easy to get	-Reduce availability Higher prices, fewer sources, restrict who has access
4) Lack of desirable alternatives	-Develop desired alternative activities -Social events without alcohol -Promote healthy lifestyle
5) Individual risk factors	
a) High stress	-Identify sources of stress and reduce/eliminate -Stress management training
b) Low self-esteem	-Develop ways to increase self-esteem relevant to particular groups
c) Isolation from others	-Create ways to engage with others

Table 7.2 Examples of Prevention Models (cont.)

d) Discrimination	-Reduce internalization -Reduce discrimination
e) Inadequate skills in decision-making or action-taking, leading in high vulnerability to peer pressure	-Skills training (e.g., resistance, lower-risk behaviors) -Values clarification, so act in accordance with values
f) Inadequate knowledge or understanding about dangers of use	-Educational interventions -Media, publicity -Classes, seminars -Health promotion, wellness interventions
6) Inadequate identification of those at high risk or with problems	-Training of those in position to identify; new referral routes
7) Lack of culturally or gender-sensitive programs	-Develop more options
8) Lack of knowledge of sources of assistance for problems	-Better advertising of treatment alternatives and how to access

This summary was developed for a large, midwestern university, based on a review of studies that identified particular “causes” of problematic alcohol and other drug-related behaviors on university campuses. It provided a framework for the development of systematic, consistent, and comprehensive policies, programs, and practices that will reduce overall consumption and consequences.

As in this example, any community should employ a variety of strategies that ensure that:

- Reasonable efforts are made to prevent the conditions that allow problems to develop and people from being negatively affected by those conditions. Efforts should be made to identify and intervene with conditions at multiple levels, for instance, in the community, neighborhood, family, peer group, school, and with individuals directly.
- Mechanisms are in place to identify and intervene with developing problems early, before they become more serious and more chronic/long term.
- Help is available to deal with problems that develop in spite of other efforts.

The mixture of interventions available in any particular situation, community, or country should fit the circumstances of that setting and context. These would include identifying the specific problems and populations of concern, and the factors that allow or promote the development of these problems in that community. Other considerations are the degree of resources available and the types of programming likely to be accepted in that context, taking into account what barriers must be addressed, and what steps must be taken to implement the program.

A Note on the Human Context of Intervention

Our discussion so far has focused on many characteristics that are thought to be relevant in bringing about change to reduce alcohol and other drug problems. We have discussed important ingredients for successful prevention programming and for developing successful treatments. But the informed reader may well ask the question: where is the *human being* in this dispassionate account? We are given a great many details about what is important in creating change, but we also know from experience that other ingredients that are harder to describe and understand—sometimes identified as elements of spirituality—seem to be lost in these descriptions.

The late Carl Rogers, an eminent psychotherapist who developed Client-Centered Therapy, wrote some years ago that one of the most difficult problems for all of us, living as we do in this increasingly technical world, is to grapple with the reality that the base of scientific knowledge sometimes contains more information about us than we are personally able to comprehend.²⁹ So when we visit the physician, and the complex notes from the lab tests indicate that we have a small, but already metastasized cancer, we may have no sense that a sword has already begun to hang over our heads—and that it appeared without our ever knowing it. We are, for that short period of time, innocent of what may thereafter be.

This creates a dilemma for the health care professional, in our example, the physician. How is the professional to let us know, in a gentle and caring way, that the scientific information he or she has access to, has already revealed that something humanly awful is already taking place for us? And how are we to wrestle with that reality? After all, once we know it, our lives will be changed forever. It is in this context that the human bond serves as a bridge. Contact with another—who cares, who understands some of what we may be going through, and who will stand by and stay with us—allows us to face even death, without necessarily feeling alone. People also feel less alone, more hopeful, and more resilient in the face of problems when they feel connected to a larger whole in other ways—by appreciating and feeling part of a glorious sunset, for instance. Without such contact we have the possibility of living in an unending nightmare, or what is in some ways worse—a life that is empty and meaningless.

An awareness of the centrality of this experience—that two human beings can share and ease the pain that belongs to one of them—is a long acknowledged part of the healing process. Healers of old used to do “a laying on of hands” and this is one way that we still have, in many religious traditions, for giving or transmitting a blessing to another. Such contact is not just a blessing, but also a sharing. Similarly, most healers understand that their work could not take place without a support structure of knowledge and understanding that is learned in apprenticeship with others. That is as much a *social process* as it is one involving the mechanics of transmitting knowledge in the service of help giving.

Feeling connected and a part of a larger whole strengthens a sense of self and of one’s worth and meaning in most people. Thus, approaches that strengthen positive connectedness are likely to have many preventive effects. This tradition is also a backdrop for physical medicine and is even more a central part of the healing process involved in psychotherapy and other forms of psychological intervention with severe behavior problems. The ability for empathic connectedness is known to be vital in dealing with all forms of severe psychic pain. Similarly, the healer’s capacity to convey some sense that he or she can be a guide, and that the voyage through trouble and suffering has been traveled by others before, is itself a way of sharing a

message of hopefulness that is a central ingredient in bringing about change.³⁰

The experienced clinician who has treated alcohol and other drug problems will readily recognize that the characteristics we have described here are central tenets of the fellowship of Alcoholics Anonymous. In fact, the “Big Book” (the nickname for the major book describing AA and its principles) account of the recovery process provides an articulate description of some of the most vital ingredients involved in relinquishing an old pattern of destructive and maladaptive behavior.^{31,32} These ingredients include the recognition of our need to be vitally concerned with issues and ideas that transcend our own individuality, openness to the possibility that hope exists for the future, and the willingness to accept one’s problems and one’s worth. We note these characteristics as generic human aspects of healing and healthy experiences that are as important to the prevention and treatment of alcohol and other drug problems as they are to the treatment of other forms of severe human suffering.

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