Papers and Originals

Place of Treatment Professions in Society's Response to Chemical Abuse*

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Introduction

In the past few years there has been a reawakening of interest in the preventive approach to dependency diseases (Bacon, 1969); many have asked how sufficient the treatment approach (Chafetz, 1970) is for conditions of such epidemic proportions. It has become fashionable to advocate education of the young as being the real answer, but such views sometimes seem to lack depth. The suggestion, for instance, that alcoholism could be prevented if children were "taught healthy drinking attitudes" ignores the fact that society is already such a successful teacher that most children will not become alcoholics. Moreover, the very minority who are at risk may be precisely those who are resistant to education. Their resistance seems to be rooted in their experience of parental relationships, personality handicaps, culturally determined mechanisms for coping with society, social disadvantages, and other matters of profound complexity, all of which are probably quite impervious to any known powers or skills of the educator.

Furthermore, educational methods have often paid only scant attention to what is known of the psychology of attitude change. In addition, there has been confusion about whether education is to be achieved by the mere cognitive business of offering information or by something more subtle. As for evaluation, research in this area is singularly beset with problems. Paper-and-pencil measurement of attitude change after a classroom lecture must bear a totally uncertain relationship to drinking behaviour 20 years later; long-term prospective studies of large populations are expensive operations, and no study of this sort without controls is of much value. To ask that proper research should be done on educational efforts may indeed be in vain, but so far as the value of any educational investment is concerned only a strictly agnostic position is justified today. Education is of even less certain worth than treatment.

Has Prevention All the Answers?

Do all these factors mean, therefore, that hope of prevention is inevitably ill-founded? On the contrary, historical evidence suggests that considerable changes have at times occurred in a particular society's drug or alcohol problems. This fact seems to indicate that forces must exist which can profoundly affect the number of people in a society who fall victim to problems of chemical abuse. The questions are whether education can be shown to be one of these forces and whether we can indeed hope to identify, control, and exploit such forces rather than merely witness passively the inexplicable and uncontrollable change of an order of magnitude which must make both the clinic doctor and the hopeful educator envious.

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Alcoholism

An example of this argument is the incidence of public drunkenness. In the last 100 years the incidence of public drunkenness offences in England and Wales (Wilson, 1940; Home Office, 1968b) has fallen (Table I). Rates are calculated

TABLE I.—*Drunkenness Offences in England and Wales 1868-1968*

Year	Male/Female Arrest Ratio	Total Offences per 10,000 of Population
1868	3.0	38
1878	3.2	70
1888	3.5	53
1898	3.4	57
1908	3.9	55
1918	4.0	9
1928	5.2	15
1938	6.1	13
1948	6.2	8
1958	12.4	14
1968	15.3	16

on the basis of population aged over 15; a correction factor might perhaps be usefully introduced to take account of the increasing proportion of the population in the older age groups. Fluctuations in the incidence have occurred, but generally during the twentieth century it has at no time approached the figures which were reported during the latter half of the nineteenth century. These fluctuations can perhaps largely be accounted for by two world wars and the between-war economic depression. Nevertheless, despite these fluctuations, today's Englishman is not so often arrested for drunkenness in the streets as was his nineteenth century forebear. Criminal statistics of any kind are notoriously difficult to interpret. Some variation in notification procedure has occurred, and one must always be on the lookout for artifacts produced by change in the law or in police practice. In this particular instance, however, there is probably no artifact which can explain away the central conclusion. The figures also suggest that public drunkenness among women has decreased proportionally more dramatically than drunkenness among men; the male/female arrest ratio was 3.0 in 1868 and had risen steadily to 15.3 in 1968.

Until comparatively recently the argument was often heard that public drunkenness had little to do with alcoholism. Recent work in London (Gath *et al.*, 1968) would, however, suggest that three-quarters of a sample of 151 men interviewed at two courts showed signs of having serious drinking problems; about two-thirds of these had symptoms of physiological dependence on alcohol. The 1960 figures for arrest for drunkenness seem therefore to be more a reflection of alcoholism than of casual roistering. The quantitative relationship between the drunkenness arrest rates and alcoholism in previous decades can, however, only be a matter for speculation. These figures should therefore be regarded as an interesting index in their own right, rather than as a pointer to any trend in alcoholism.

The apparent decline in arrests for public drunkenness over the last century, and of women in particular, has occurred without any large-scale or concerted health education campaign. Similarly it cannot be attributed to the efficiency

of treatment services in the twentieth century. This decline therefore appears to be evidence of the changing course of social history rather than due to our efforts in the clinics or at education.

Heroin Addiction

The figures for the growth of heroin addiction from 1958 to 1968 in the United Kingdom also seem to show similar evidence (Table II). In 1958 there were 62 heroin addicts in the

TABLE II.—*Growth of Heroin Addiction in the United Kingdom 1958–1968 (Home Office Figures)*

Year	Total Known Heroin Addicts	Total Known Heroin Addicts Aged under 20
1958	62	
1959	68	
1960	94	1
1961	132	2
1962	175	3
1963	237	17
1964	342	40
1965	521	145
1966	899	329
1967	1,299	395
1968	2,240	764

country; 80% of the total number of narcotic addicts were of therapeutic origin. The figure for 1968 is not realistically comparable, however, with previous years and tends to exaggerate the rate of rise. It represents the list of names known to the Home Office before notification came into force plus the total number of notifications. Ten years later there were 2,240 known addicts and a total of 2,782 narcotic addicts, of whom only 11% were of therapeutic origin. The number of reported cases of heroin addiction in subjects under 20 had risen dramatically. Furthermore, convictions for drug offences in which cannabis was involved also rose alarmingly over the last 10 years (Table III).

TABLE III.—*Convictions for Cannabis Offences (Home Office Figures)*

Year	1958	1960	1962	1964	1966	1968
Cannabis convictions ..	99	235	588	544	1,199	3,071

Social Research

Are there any insights available at all into the forces which are related to these changes in social pathology? So far as drunkenness is concerned, now that the worst consequences of the industrial revolution have been overcome and the whole nature of English city life has changed, the English working man is more likely to be found in the evening sitting at home in his council house watching his television set than going off to the gin palace to escape the squalor of his home and the hopelessness of his condition. Unfortunately, the message is not as simple as that. The drug figures show that such simple remedies—as righting obvious social wrongs—are not the whole answer. In trying to understand the background social forces which determine a fall in drunkenness or a rise in drug addiction, guesses have to be made. For this reason there is an urgent need for research and particularly for transcultural inquiries which may throw light on these matters.

So far as the dependency diseases are concerned, the health educator or public health specialist is not necessarily fighting a hopeless battle against those inevitable and invincible trends in society which are the real underlying determinants of prevalence of chemical abuse. It is of course hardly within the realms of possibility for any profession abruptly to “reshape society”; it is most unlikely that the health educator could have prevented the Industrial Revolution or the public health specialist curbed the consequences of unfettered capitalism in

a society whose whole dynamo was the entrepreneurial spirit. On the other hand, it may be possible to identify many small but important individual aspects of society's organization which bear on the likelihood of chemical abuse and which are proper and possible targets for immediate action. The clinician who treats the alcoholic has for long known that treatment aims must be realistic; the same is true when it comes to treating society.

A Government report (Report of Select Committee. 1834) provides a classic example of this non-Utopian approach to prevention of a dependency disease. This select committee was set up under the chairmanship of James Silk Buckingham, and its brief was to inquire into the “extent, causes, and consequences of the prevailing rise of intoxication among the labouring classes of the United Kingdom.” The committee's recommendations were based on a perspicacious analysis of the many ways in which the environment seemed almost to force drinking on the working man of that time. Among the committee's proposals were the following:

(1) Limitation of the number of liquor outlets, annual licensing, and “the keepers of such houses to be subject to progressively increasing fines for disorderly conduct, and forfeiture of licence and closing up of the houses for repeated offences . . . the closing of all such houses at an earlier hour in the evening than at present . . . the making of all Retail Spirit Shops as open to public view as other shops where wholesome provisions are sold.”

(2) “The discontinuance of all issues of ardent spirits (except as medicine under the direction of the medical officers) to the Navy and Army.”

(3) “The prohibition of the practice of paying the wages of workers at public houses . . .” and “payment of such wages to every individual his exact amount . . . so as to render it unnecessary for men to frequent the public houses, and spend a portion of their earnings to obtain change.”

(4) “The payment of wages at or before the breakfast hour in the mornings of the principal market day in each town to enable the wives to lay out their earnings in necessary provisions at an early period of the market, instead of risking its dissipation at night in the public house.”

(5) “The establishment of public walks, and gardens, or open spaces for athletic and healthy exercise in the open air, in the immediate vicinity of every town, of an extent and character adopted to its population: and of district and parish libraries, museums and reading rooms, accessible at the lowest rate of charge; so as to admit of one or the other being visited in any weather, and at any time; with rigid exclusion of all Intoxicating Drinks.”

(6) “The reduction of the duty on tea, coffee and sugar, and all the healthy and unintoxicating articles of drink in ordinary use; so as to place within the reach of all classes the least injurious beverages on much cheaper terms than the most destructive.”

(7) “The removal of all taxes on knowledge and the extending of every facility to the widest spread of useful information to the humblest classes of the community.”

Those brief extracts can give only a very incomplete impression of the reach and imagination of a really very remarkable document.

Social Revolution

The Industrial Revolution and the slum drunkenness of a hundred years ago may seem a far cry from drug use in the rich suburbs of the 1970s. The lessons of the past may, however, be now surprisingly apposite, since most probably today we are heading for an economically determined social revolution as profound in its impact as any which our ancestors experienced. Computers and burgeoning technology are, according to Herman Kahn (1969), likely to mean that in post-industrial societies the *per capita* income will in 10 years' time have risen to approaching \$5,000. The ordinary

man (and ordinary adolescent) will be richer and have more time on his hands than ever before—the half-time job may become for many the norm. As a by-product of economic changes Kahn expects ethical changes, and he suggests that the achievement ethic will be much devalued. Because of more money, more leisure, and an emphasis on self-experience and self-realization, drugs will undoubtedly be one of the major health problems of the societies of the latter-day revolution. Perhaps the committee which prepared the 1834 report should be reconvened, and the small, sensible, and possible things which could be done to ensure that adolescence in the cities of the 1970s and 1980s does not inevitably become an invitation to destructive drug taking examined.

Thus, prevention in terms of “educating our youth” is of totally uncertain worth, whereas “reshaping society” on the grand scale is a worth-while dream and enterprise for any individual—but as next year's programme for the preventive health expert it is *folie de grandeur*. Prevention in terms of the 1834 report makes sense; social workers or doctors, as intelligence agents, could advise society on where practicable preventive efforts might be focused. Finally, though rational prevention has perhaps much to offer, the casualties will still occur; society will not—within the next 10 years—be able to dispense with the treatment professions.

Research Investment and Treatment Research

The doctor who is trying to run a treatment service on an inadequate budget is not a rare figure. How many clinics have, for instance, enough social worker support, let alone adequate psychiatric staffing? It is not surprising, therefore, that such a doctor may criticize some aspects of society's research spending. Nevertheless, though most doctors readily acknowledge the importance of adequate research investment and know that some of the most important research has no prospect of immediate pay-off, their plea is that society should have some sort of rational and planned strategy with respect to the balance between treatment and research investment and to priorities in research investment. Such planning is seldom evident today.

Another aspect of this problem is that when research findings which might bear on social action are available action by no means always follows. The La Guardia report (New York Mayor's Committee, 1944) suggested that the dangers of cannabis had been exaggerated; the result, however, was not a more rational law. The Wootton report (Home Office, 1968a), which was based on the very careful deliberations of an expert and non-partisan committee and its specially commissioned review of all available research evidence, modestly made the suggestion that penalties for possessing small quantities of cannabis should be lowered. This recommendation again was not accepted. Pittman and Gordon (1958) showed that the imprisonment of the chronic inebriate was an absurdity, yet the practice has still not been stopped. Research in Britain (Edwards *et al.*, 1966, 1968) indicates that the social origin of much chronic public drunkenness is the young Irishman or young Scot, who, immigrating to London as an unskilled labourer, has his social controls removed, money in his pocket, no healthy or attractive leisure alternative to the pub, and no invitation to spend his money on much other than beer. The doctor who witnesses all this from his clinic or his community may sometimes feel that what is needed is not always more research investment but a greater willingness on society's part to capitalize on the already available findings—society sometimes seems to regard the research worker as merely decorative.

Society's reaction to the treatment professional who censures society's lack of skill as a consumer of research would no doubt be to suggest that the doctor should return to his own

sphere and offer some statement about the place of treatment research. In fact, of all aspects of research on the dependency diseases, it is treatment research which is the least well developed and which most frequently falls down on methodology. For this reason, grant-giving bodies seem by now to be wary of supporting research on therapy, with the result that this particular area of dependency investigations is under-invested.

Dependency Diseases

Treatment of the dependency diseases has its “paraphernalia” and its “essence,” and clearly there is a sort of core of treatment being practised, whatever the superadded physical methods or particular regimens or programmes. The alcoholic may be offered disulfiram (Antabuse), given aversion therapy, prescribed tranquillizers or antidepressants, given a week or three months in hospital or simply treated as an outpatient, introduced to Alcoholics Anonymous, or left to recover on his own. On the other hand, the drug addict can be given methadone, treated within a therapeutic community, sent to prison, or put on parole. Whatever the paraphernalia the common core of treatment is to advise the patient to abstain totally from drink or narcotics; invite him to review the present pattern of his social existence; explain to him the advantages of abstinence and the disadvantages of continued chemical abuse; and to suggest various strategies which will help him to get through life without his favoured chemical, hoping that he will have a good opinion of us and take our advice.

Paraphernalia of Treatment

Some research which has already been done on the paraphernalia carries conviction. But the general trend of the evidence seems to indicate that claims for the value of any specific treatment seldom withstand the rigorous scrutiny of a controlled trial. Emrick (1969), reviewing previous work, concluded that disulfiram and aversion therapy are probably of only marginal value in the treatment of alcoholism, while claims for the efficacy of newer aids such as lysergide (L.S.D.) and metronidazole are equally insecure. Hypnosis has, in some countries, been widely used as an adjunct to treatment of alcoholism, but convincing evidence of its benefits is not forthcoming. The value of admission—as opposed to outpatient care—of alcoholics has been questioned. As regards treatment of drug dependence, controlled trials which evaluate specific treatments appear to be lacking, though the influence of a methadone programme on the otherwise expected social maladjustment of the heroin addict should probably be accepted as *prima facie* evidence (Gearing, 1969). The careful retrospective reconstruction of the impact of various handlings on the outcome of heroin addiction is also noteworthy (Vailant, 1966). In general, however, we have no very strong reason for supposing that specific methods have much impact on the natural history of the diseases. The paraphernalia is not unimportant, but no specific treatment has yet been discovered of such power that we can at this stage afford to neglect what has been referred to above as the “essence.”

Essence of Treatment

The essence of treatment as practised today is remarkably similar to that practised by Thomas Trotter (1804). His treatise is valuable for anyone treating either alcoholism or drug addiction 166 years later and is a powerful reminder of the fact that there is “nothing new under the sun.” Here are some instances of his teaching:

(1) *Treatment has to be determined for each patient individually.* “In treating these various descriptions of persons and characters, it will readily appear to a discerning physician that very different methods will be required.”

(2) *The addiction and not just the complications have to be treated.* "Stomach complaints, with low spirits, premature gout, epilepsy, jaundice, or any other of the catalogue, it is useless to prescribe for it until the evil genius of the habit has been subdued."

(3) *Rapport has to be established.* "When the physician has once gained the full confidence of his patient he will find little difficulty in beginning his plan of cure."

(4) *The relationship is the essential tool.* "This disease, I mean the habit of drunkenness, is like some other mental derangements; there is ascendancy to be gained over the person committed to our care, which, when accomplished, brings him entirely under our control."

(5) *Within the setting of that relationship confrontation can be used.* "Particular opportunities are therefore to be taken to hold up a mirror as it were, that he may see the deformity of his conduct, and represent the incurable maladies which flow from perseverance in a course of intemperance."

(6) *Confrontation must be joined with offer of hope.* "At the conclusion of every visit, something consolatory must be left for amusement, and as food for his recollections."

(7) *The wife's behaviour bears on the chances of recovery.* "The good sense and management of an amiable wife, we know, will often accomplish wonders."

The essence of the treatment may not have changed over almost two centuries, but what is entirely new since Trotter's day is an investigatory scientific discipline which allows the efficacy of psychiatric treatment to be measured. The urgent task today is to apply scientific assessment methods to this essence, which has for so long been employed in the treatment of the chemically dependent person. To some it may seem unnecessary or even impossible to bring harshly objective methods to bear on the study of anything so sensitive and complex as the doctor-patient relationship and the communications which the doctor makes or implies by nuance to his patient. Everything points, however, to the fact that the treatment professions can go wrong and continue to go wrong unless long-hallowed therapeutic approaches are submitted to the cold scrutiny of neutral science. An important recent lesion is provided by Smith *et al.*, (1969), who in a "study of studies" explored the relationship between the claimed efficacy of antidepressant drugs, as reported in 490 drug trials, and the adequacy of experimental design in each of these trials. There was a significant relationship between poor research technique and optimistic claim.

Communication

Treatment always implies attention to social setting and to social problems as well as to words which aim to bring about some change in attitude; thus social and psychological approaches interreact. Within these terms every doctor and social worker believes that what is said to the patient is important. But all who take part in treatment know that sometimes words can work wonders while at other times they fall on seemingly irrevocably deaf ears. Is success or failure just the luck of the draw, of the presence or absence of some mystical quality tautologically named "motivation"? Or could research give such sharpened understanding of the processes involved in attitude change and so make success more probable? Can the essence be identified and refined? Only recently has experimental social psychology offered a framework of theory which provides an apt language for discussing those phenomena which the clinician has for so long been observing: ambivalence and denial are, for instance, translatable into the language of dissonance theory. Research into psychotherapy in general is, of course, also much further advanced than a decade ago. From various directions this confluence of ideas and techniques should now make it more feasible than ever before to set up clinical experiments which take as their starting-point the physician's practice and experience.

If society is adequately to meet the problem of dependency

diseases in the coming decades and if the treatment professions are going to be given a proper place within the total plan, we cannot persist in methods which are not shown to be of value merely because of tradition, inertia, the therapist's emotional set and resistances, or the politician's expedience. The treatment professions (and society) must increasingly see scientifically competent research as providing the only criteria on which the value of any approach (paraphernalia or essence) is to be judged. If the treatment professions could increasingly accept the philosophy which insists that research is not the optional extra but part of all treatment endeavour, society would be provided with the best assurance that treatment is still a proper part of the total response.

Organization of Treatment Services

Even though there are no magic treatments, and provided careful evaluative research is carried out on the present treatment methods over the next 10 years—with the possibility of rejecting some of what is at present practised—the fact still remains that tomorrow's clinic brings its patients and that "we have to do something." Perhaps ultimately research will show that doing something is better than doing nothing, and for this reason we will decide meanwhile to go on with the job of offering to the patients who consult us the best treatment at present known. But in fact the patients who do consult us probably form the minority of people who need our help. Treatment ought to be concerned not only with treatment methods but with the organization of treatment services. It is no good having the most admirable clinic if 9 out of 10 people in the surrounding streets who need its help simply walk past its doors.

Finance

The organization of services for treating the alcoholic or drug addict must depend partly on the bigger question of what proportion of the total national product is going to be given for medical services. Maxwell (1969) analysed British hospital services and, with information collected by Abel-Smith (1967), he clearly showed that the United Kingdom, when its gross national product is compared with that of other countries, is not spending as much money on its medical services as it should (Table IV). These figures are obviously by now in some instances out of date; the figure for Britain is

TABLE IV.—*Gross National Product per Head and Percentage spent on Health (Abel-Smith, 1967)*

Country	Per Capita Income (U.S. \$)	Percentage of Gross National Product Spent on Health
United States	2,306	5.8
Canada	1,475	6.0
Sweden	1,420	5.4
Australia	1,236	5.2
United Kingdom	1,172	4.2
Israel	1,042	6.3
Netherlands	885	4.8
Chile	541	5.6

TABLE V.—*United Kingdom: Mental Health Problems and Psychiatric Manpower*

Index	Basis of Calculations	Rates per 1,000 Population
Formal psychiatric illness	Annual consultation rate	102.1
Psychiatric-associated conditions	Annual consultation rate	48.6
Alcoholism	Jellinek, prevalence	8.3
Heroin dependence	Home Office, prevalence	0.045
Consultant psychiatrists	—	0.023

perhaps by now nearer 4.6. Where spending on health services is insufficient, spending on the less popular health problems is likely to be completely neglected.

Those particularly interested in alcoholism or drug addic-

tion are likely to criticize society for neglecting dependency treatment services and to campaign for more money to be spent. But, though there are many alcoholics, there are many more people suffering from other forms of disturbed psychological functioning and few psychiatrists to go round (Table V). This table must be regarded as giving an impressionistic rather than a properly accurate picture, for the indices, base populations, and years differ; psychiatric morbidity is based on the data of Shepherd *et al.* (1966); alcoholism is given as a prevalence rate for England and Wales (W.H.O., 1951), and heroin dependence as the prevalence rate for 1968. Data on psychiatric manpower are based on a 1969 estimate for England and Wales. Quite clearly, however, the picture is accurate enough to refute the erroneous idea that all society needs is more specialists to take on the sick in the classical one-to-one relationship.

Manpower

The world's resources in terms of psychiatrists are summarized in Table VI (W.H.O., 1963). Perhaps Manhattan has enough psychiatric manpower to treat a few of its alcoholics, but many other parts of the world must have only sufficient psychiatrists to point to the total self-defeat of any approach to the dependency diseases which sees the answer in terms of the specialist sitting in the hospital clinic. The specialist will have to take on the role of *agent provocateur*, mobilizer of community resources, exploiter of what already exists, and managerial and business expert who makes sure that resources are used with the maximum efficiency.

TABLE VI.—World Availability of Psychiatrists

Psychiatrists per 100,000 Population	No. of Countries	Aggregate Population (millions)
0	8	20
Up to 0.49	35	890
0.5 – 1.99	13	194
2.0 – 4.0	21	582
Over 4.0	8	265

Treatment Programmes

Morris (1969) pointed out the shaky criteria which society at present uses to determine the priority of its spending—lavish outlay on spare-part surgery with pitiful neglect of the vastly important chronic illnesses. All too probably in many countries the stigma which still attaches to the dependency illnesses will determine spending rather than any rational appraisal of community needs. There is, however, never going to be enough money to go round, and it must therefore be spent effectively. A report by the North American Association of Alcoholism Programs (1966) stressed that not only treatments but treatment programmes must be evaluated. Before a community sets up a service someone has to state what he hopes that service will achieve and the objective measurements that are going to be used to determine whether hopes are fulfilled. Otherwise, by nature man will introduce a treatment service in which not only money but ego is invested; some years later he will persuade himself that a fine job has been done, and will pick *post hoc* criteria which give us all the greatest reassurance.

The point that has to be made here is simple but important. The day has gone when the treatment professional's only responsibility was to produce an effective treatment; in future, society's attitude toward him is likely to be marked by an increasing insistence that the product is not only manufactured but also distributed.

Treatment Professions—What Future?

To ask for rationality in any aspect of health planning is to ask much. When the problems involve not only health departments but law enforcement and many other agencies of government, the demand is particularly ambitious. There is, however, no likelihood of society being able to meet the dependency endemics and epidemics of the next years by a policy or investment which is haphazard. Preventive measures, treatment, research, all require integrated planning and establishment of priorities. Research is as relevant to the actions of the legislator as to the procedures of the clinic. Within this planned and total response the treatment professional must find his future place. If society is to have confidence in him, he will perhaps have to be more self-critical than in the past. He will have to accept that he operates within economic and political realities. Any society which is, however, so timorous and incompetent as to seek to inveigle his connivance in running inadequate clinical services which offer unsubstantiated therapies to an uncertain minority of potential patients, while down the road more patients are created, is likely to win only his strictures. He may, as he sits ruminating in his clinic, even at some time find himself asking this question—What is society?

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