ALCOHOL POLICY CONSIDERATIONS FOR INDIAN PEOPLE

JAMES W. THOMPSON, M.D., M.P.H.

In a thoughtful and well-documented paper, Dr. Philip May calls our attention to the need for a proactive and aggressive public policy stance in Indian communities toward alcohol abuse and dependence. He outlines three important approaches: controlling the supply of alcohol, shaping the drinking practices of Indian people, and reducing the physical, social, and environmental risks of drinking. In addition to presenting these approaches, May debunks several myths about alcohol use among Indian people. These include the myths that a greater proportion of Indians than non-Indians drink, and that alcoholism is different in Indians than in other people. He points out that simply educating Indian people about alcohol is not sufficient to rid Indian communities of alcohol-related problems. Also, May correctly stresses the importance of a total community approach to alcohol-related problems, as well as the need for data collection and evaluation.

May's discussion is scholarly and as free of ideology as is perhaps possible. The result is a paper that is rich with information and carries the field a step closer to effectively dealing with alcohol-related problems in Indian communities. There are, however, several areas of concern. The first of these is the conceptualization of "prevention" and the "public health approach" (after Beauchamp, 1980). As presented, these do not fit well with some aspects of alcohol use and misuse. Second, the way in which the Indian population is presented may lead to some unintended negative consequences if misinterpreted by readers. Third, May's definitions of alcohol-related problems are somewhat confusing. And fourth, although the last portion of the article gives an important review of steps a community might take in formulating an alcohol policy, it falls short of helping communities spell out exactly what they need to do in designing and implementing such a policy.

Prevention and the Public Health Approach

Although the invocation of "prevention" (usually meaning primary prevention) has a seductive ring to health policy-makers and persons

working in community health settings, primary prevention has, in fact, had little success in most areas of medicine. Infectious disease is perhaps the only area in which primary prevention has been an unqualified success. With regard to the mental disorders (including substance abuse), although one often hears strong ideological support for prevention programs, there has been little demonstration of success. At present, there is not a single DSM-III-R mental disorder (American Psychiatric Association, 1987) that can be prevented from occurring. It is true that substance abuse and dependence can be prevented by totally abstaining from such substances, but accomplishing abstinence in entire populations is a goal that has thus far proven elusive.

In general, the lack of success in preventing mental disorders is so complete that any shifting of existing resources towards primary prevention programs is highly questionable. But in the case of substance abuse, three facts make such shifting a reasonable consideration. These facts are the widespread nature of the problem, the serious consequences which can result, and, most important, the relatively poor record of treatment efficacy. However, if resources are to be shifted towards prevention, several groups of caveats must be entered into the discussion.

A Realistic Outlook

The first point is that the primary prevention of alcohol-related problems is an enormous task. Communities clearly need to break out of the fatalism that is so often the case regarding alcohol, but a swing to the opposite extreme (i.e., believing that prevention would be easy, if only it were tried) is not useful either. A second caveat is a lesson that was clearly demonstrated in the Alkali Lake experience (Alkali Lake, undated), and is alluded to by May and by Beauchamp (1980). That is, before actual programs are instituted, a great deal of work must go into building the political power-base necessary for broad social change. (In fact, May's suggested approach might be more accurately called "community organization and consensus building," rather than "prevention.") Finally, Indian communities must be prepared for setbacks and must have strategies for dealing with such setbacks. And communities must not only learn from one another, but also from culturally sensitive consultants who specialize in community organization, prevention, and clinical care.

A Focused Approach

Also related to primary prevention, any programs formulated must contain a clearly identifiable intervention that is to be focused upon a specific problem or risk factor (e.g., concomitant depression, low socio-

economic status, unemployment, family disruption) and which targets a specific target group (e.g., sixth grade children who are not alcohol users). Vague, unfocused programs are essentially worthless.

Another important point about focused programs is that even though much of the "public health approach" relates to populations, most prevention programs require attention to the individual at some point (for example, to give an immunization). The challenge is to know when to apply strategies that are population oriented and when to move toward interventions with individuals.

Also, as May points out, it is essential to set up data-oriented surveillance mechanisms and formal evaluations. These let a community know the results of their efforts and allow the generalization of successes to other communities. But surveillance and evaluation are impossible with a poorly conceived program. For example, a drop-in center that serves nonalcoholic beverages to all youth in a community cannot be evaluated as a prevention effort. Even if alcohol problems among youths in the community decrease, there is no defined intervention focused on a specific risk factor or on a specific target group. Therefore, there is no way to know whether the program was linked to changes in the prevalence of problems in the community.

Dealing With All Levels of Prevention

It is important to recognize that policy changes must be instituted at all levels of prevention: primary (the prevention of onset of disease), secondary (early intervention and active treatment), and tertiary (prevention of relapse, including rehabilitation) (Manson, Tatum, & Dinges, 1982). There have been rare instances when one change in public health policy accomplished a primary prevention goal. An example is removing the handle of the Broad Street pump during a cholera epidemic in London (MacMahon & Pugh, 1970). But in this example, everyone was getting the same disease from the same point source. Removing access to alcohol is in some ways similar to removing that pump handle, but then the analogy breaks down. Alcohol problems are not the same in every person afflicted. For example, May describes differences in behaviors in persons with the same blood alcohol level as due to social and cultural factors. These factors are somewhat different in each person. He also ignores individual variation due to genetics and upbringing, and differences in the status of the individual brain (e.g., due to head trauma or chronic substance use). In addition, all alcohol problems do not originate from the same source. Some individuals may start to drink because their parents taught them that this was an acceptable coping mechanism;

others because they have a major depressive disorder and are "self medicating"; still others because they are addicted to the substance and cannot stop without help; and so on.

The bottom line is that alcohol problems cannot be approached in the same way in every case. Therefore, multiple approaches must be taken, including primary prevention, clinical treatment, and rehabilitation. This is implicitly recognized by May, as he includes emergency medical services and training in cardiopulmonary resuscitation in his discussion, which are certainly not primary prevention. But he does not stress the need to create policy and programs at all of these levels.

Secondary Prevention

Policy changes are badly needed in the delivery of "mental health" and "alcoholism" services to Indians. Increased funding is necessary, as is an increase in well-trained professional staff to provide Indians with state-of-the-art care (Indian Health Service, 1989). In addition, coordination between the mental health, alcohol, and general health programs is essential (Thompson, Walker, & Silk-Walker, in press). Because of poor funding, inadequate staffing, and poor coordination, many Indian people are effectively denied state-of-the-art psychiatric care. This is not only important in the delivery of services to primary substance abusers, but also in services to the dually diagnosed, who represent a large population (Ross, Glaser, & Germanson, 1988).

It also should be recognized that the treatment of certain psychiatric disorders (e.g., anxiety and mood disorders) may be among the best programs for the primary prevention of substance abuse. That is, anxious or depressed persons who "self medicate" with drugs or alcohol might never turn to substances if he or she receives appropriate care early in their illness.

Preventing What?

A final concern about prevention is one to which May indirectly alludes. It is important for a community to understand what it is trying to prevent (in planning either primary, secondary, or tertiary policy or prevention programs). Is the goal to prevent (1) all alcohol use; (2) only some kinds of alcohol use; (3) alcohol abuse; (4) alcohol dependence; (5) negative behaviors while under the influence; (6) negative sequelae of chronic use; and/or (7) relapse? Strategies, policies, and interventions may be very different, depending on which of these is the goal.

Diversity and Similarity Among Indian People

May makes it clear that the belief that all Indian people are alike is a myth. But he then presents data that may contribute to this very myth. These data either group all Indian people together or place them into broad geographic subgroups. I fully understand that the need to have enough cases to calculate reasonable rates places pressure on the investigator to use more diverse groups than he or she would like. But such data tend to perpetuate the pan-Indian myth. When an investigator finds it necessary to do this, many more caveats are necessary. May also makes nonquantitative statements that tend to overgeneralize about Indians. One example is the statement (which I question per se) that "most Western Indians live in reservation areas."

A related problem is that May (by design) leaves out large groups of Indian people — e.g., those in the Eastern United States; rural Indians not on or near reservations, such as Oklahoma Indians; and urban Indians. The focus of May's work is understandably on western reservations. But there is a danger that other groups will be seen by the reader as essentially similar to the groups May addresses, or they may be ignored altogether. Again, more caveats are necessary.

Conceptualizing Alcohol Problems

May's terminology is somewhat out of date and is confusing. He appears to use the terms "alcohol abuse" and "alcoholism" as equivalent, respectively, to "sporadic" and "chronic" use, and these as equivalent respectively to "nondependent use" and "use with dependency." This is problematic, since, for example, monthly binges represent a chronic pattern, although there is no dependence. The psychiatric nosology is somewhat in flux on this point, but the use of the terms "alcohol abuse" and "alcohol dependence" more accurately reflect present day DSM-III-R terminology (American Psychiatric Association, 1987). The use of language is important here. May's use of the term "abuse" as opposed to "alcoholism" appears to let those who "only abuse" off the hook as not having a disorder that requires treatment. As another example, it is not clear why homicide, suicide, and car accidents are considered only "alcohol abusive" rather than as occurring in acute intoxication, abuse, and dependence. Chronicity does not protect an individual from such experiences.

The use of DSM-III-R terminology as a standard may not appeal to those who disagree with its philosophy or criteria. But the use of standard terminology that is relatively well operationalized would help assure that all policy-makers and program planners are communicating about the same problems. This would be no small accomplishment.

Another comment on definitions is that "addictive personality" is not a recognized entity. May's use of the term seems to imply that some individuals, because of their personality structure, cannot be rehabilitated. This may be the case, but a community that is planning policy change would be unwise to write off a large group of afflicted persons before even starting.

A final issue concerning alcohol definitions is the distinction between a *policy* of prohibition versus abstinence by a given individual. As May states, when a population or a community as a whole is contemplating a policy shift, total prohibition will not be the answer for all. It is important for each community to deal with alcohol problems in its own way, including the possibility of allowing some drinking behaviors. Of course, it is also important that a community with a high prevalence of alcohol abuse and dependence not see what is normative, i.e., common, as "normal." When thinking of *individuals* with alcohol abuse or dependence, however, it would be unfortunate if some read May's statements about community policy formulation as endorsing controlled drinking by individuals with alcohol problems, a treatment strategy that has been roundly discredited (Pendery, Maltzman, & West, 1982; Wallace, 1990).

Spelling Out the Tasks

The final part of the May article provides communities with important guidelines to follow in formulating an alcohol policy. Still, if a community is to put some of May's suggestions into practice, it will need much more specific guidelines and perhaps will need technical assistance. A community leader who reads the article may well feel overwhelmed with the extensive list of possibilities presented. One must always avoid a paternalistic stance, but the truth of the matter is that most Indian leaders are not trained in policy analysis, alcohol studies, or planning and evaluation. In addition, communities are often so embedded in the problem that they cannot see obvious possibilities for policy formulation or new program initiatives. An outside consultant can help with such process issues and with content. Even after a community has formulated and operationalized an alcohol policy and has created programs, there is a need to maintain those programs, to set up surveillance mechanisms (Thompson, Larson & Moscicki, unpublished manuscript) and formal evaluations, and to adjust policy as is appropriate. Consultants on evaluation (who, of course, must be culturally sensitive) can provide technical expertise, but also can help to dispel the still all-too-common attitude that "we're too busy to evaluate our work, and besides we already *know* we're doing good."

Conclusion

Perhaps the most important contribution made by May is his implicit and explicit call to put aside ideology and to collaborate in finding answers. It is very easy to lapse into an ideological stance related to alcohol problems and treatment, prevention and clinical care, or approaches to community organization. But the problem before us is too serious and difficult to allow ideologic discussions to rule the day. Fighting one another at the expense of dealing with the basic problem at hand has never served Indian people well. Perhaps all can express their beliefs as hypotheses, rather than as gospel, and adopt as a basic stance that we must collaborate to try *something,* even if everyone is not in total agreement. If this can be done, we will we well on our way to successfully dealing with alcohol problems in Indian communities.

Department of Psychiatry
University of Maryland
645 West Redwood Street
Baltimore, Maryland 21201

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