



## ROMANCE, REALISM AND THE FUTURE OF ALCOHOL INTERVENTION SYSTEMS

[COMMENTARIES ON HUMPHREYS & TUCKER]

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### Recent History

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The astute commentaries of our colleagues share two themes. The first is that scientific knowledge is never the only force affecting alcohol intervention systems and may, on

occasion, be a trivial one. [Öjesjö \(2002\)](#) notes that responsive systems need responsible funding, [Perl & Hilton \(2002\)](#) argue that fiscal forces usually move systems more than do research findings, [Blomqvist \(2002\)](#) and [Babor \(2002\)](#) point out that broader social policy factors may affect societies' alcohol problems more than do treatment systems, and [Moskalewicz \(2002\)](#) describes the political and ideological constraints on what intervention systems can accomplish.

These concerns are undeniably realistic, and we have made similar points ourselves elsewhere ([Humphreys & Rappaport 1993](#); [Tucker 1999](#)). However, as we indicated at the outset of our editorial, we deliberately presented an idealized vision based on what the scientific labor of our field would support. One might say it was rather romantic of us to act as if scientific results should have a place in social policy formation comparable to that of politics, ideology, and money. However, articulating such a vision unencumbered by political concerns has inherent value because it gives all stakeholding groups a clearly stated, scientifically supported agenda which they may embrace, reject or modify in intervention development, policy formulation and funding decisions. We have no doubt that our colleagues would agree that articulating in an unvarnished fashion what the scientific community knows is better than articulating only those scientific findings that would not run counter to powerful cultural, political and economic forces.

The absence of significant disagreement with the substantive points of the editorial concerning intervention development and applied research directions is the second theme apparent in our colleagues' comments. It is a considerable achievement for addiction research to have matured to a point that it supports a coherent perspective about alcohol problems and yields a set of consensus recommendations for interventions systems in our often divided field. To the extent that principles and conclusions are widely shared, they offer a practical map for infusing some scientific content and influence into decisions about alcohol

intervention systems.

That broad-level agreement noted, our colleagues make clear that certain specific points in our editorial merit refinement, clarification, and further debate. For example, all of the commentators make useful caveats about our proposal for more extensivity in intervention, including greater promotion of self-help group involvement. [Blomqvist \(2002\)](#) and [Moskalewicz \(2002\)](#) warned sagely of the potentially damaging effects of professional systems on self-help organizations and other voluntary sector initiatives. Unfortunately, many helping professionals think of non-professionals engaged in similar activities not as potential collaborators, but as second-rate helpers in need of consultation and control. This threatens the authenticity of voluntary initiatives ([Blomqvist 2002](#)) and risks turning them into subsidiaries of professional systems ([Moskalewicz 2002](#)). If our proposal is to succeed, the education and socialization of addiction treatment professionals will have to incorporate more lessons from the growing literature on respectful, productive collaboration between professional and voluntary sector organizations (see, e.g. [Powell 1987](#)).

In his witty commentary, [Babor \(2002\)](#) raises another concern about extensive services, namely their lack of glamor and marketability relative to the intensive interventions which are currently showcased on 'Cooks' Tours'. This observation applies to extensive interventions across a variety of public health problems (e.g. work-site wellness programs, safe highway design, chronic disease support groups). Such interventions lack the visibility and drama of intensive interventions addressing more salient morbidity and mortality, even though the latter affect only a small segment of the population. As a result, intensive interventions may command more political and economic support and attract greater professional interest. The US health-care system illustrates repeatedly this well-known conundrum, with its over-allocation of resources to high technology clinical medicine for the gravely ill and its under-allocation of resources for preventive care. Thus, the challenge of generating more interest in extensive interventions is not unique to the alcohol field, and we would be wise to learn from the broader field of public health about how to address it better. We have some optimism about this possibility, because even though we concede Babor's chicken, we also know there is an egg: professional and public interest can be a product of where a society invests intervention resources, as well as a cause of it. If societies invested more money in extensive interventions, the Cooks' Tour might well include some new stops.

Taking another tack, [Blomqvist \(2002\)](#) points out that there is no more extensive intervention than a personally fulfilling life context; for example, a positive employment situation (cf. [Öjesjö 2002](#)) and satisfying interpersonal relationships. Again, we are in agreement. Our proposal that intervention systems link patients to enduring, sobriety-supporting social contexts is obviously more workable to the extent that broader social policy makes such life contexts available.

The only comment with which we would differ significantly is [Moskalewicz's \(2002\)](#) suggestion that extensive interventions may simply be a return to the revolving-door concept and that they may raise costs over time by creating or adding to chronic patient populations. Regarding the former point, the 'revolving-door' concept emanates from an intensive intervention approach (e.g. public psychiatric hospitals), in which patients receive intensive services for short periods and are then discharged with little or no support in place, only to return at a later point for more short-term intensive treatment. In extensive interventions, these

extremes are softened, with treatment being less intense at its crest, more intense at its trough and more persistent over time. On the second point, although only a few studies are available, empirical work indicates that alcohol-related extensive interventions actually reduce health-care costs, in part because they break the revolving-door cycle associated with intensive service systems (Hilton et al. 2001; Humphreys & Moos 2001).

Moving beyond the comments about extensive interventions to more general issues addressed in our editorial, we concur with Babor's (2002) analysis of the complexity of understanding how drinking problems and their resolution are influenced by the environment, which we 'tend to ignore, but only at our peril' (p. ••). Addiction research (particularly in the US, see Humphreys & Rappaport 1993) often ignores, minimizes, or oversimplifies environmental influences on alcohol problems. As Babor observes, environments are not static influences on drinking practices and problems, but rather entail a complex, dynamic set of micro- and macro- variables that range, for example, from personal social networks to treatment availability to alcohol advertising to international treaties concerning alcoholic beverage markets. Research aimed at understanding local environmental influences on drinking is growing, but we know little about macro-level environmental influences, much less how they may interact with microlevel variables. The field of economics has wrestled with parallel distinctions between micro- and macro-economic influences and therefore may offer addiction researchers some useful guiding theory and research on these issues (see, e.g. Bickel & Vuchinich 2000).

We close with an enthusiastic endorsement of Perl & Hilton's proposals to make science matter more in shaping systems. They seem to share our romantic optimism of how science can be more than 'scribblings in the margin' (Babor 2002), and implementing their perfectly realistic suggestions for developing reciprocal learning relationship between scientists, clinicians and policy-makers is an essential step for creating more responsive and effective alcohol intervention systems.

Some academics would argue that Perl & Hilton's (2002) proposal would take researchers outside the appropriate borders of their enterprise, and that science should keep an arm's length from applied concerns such as technology transfer, policy-making and budget decisions. Our position, especially in light of the thoughtful comments of our colleagues, is that we can ill afford to sit on the sidelines in research areas that involve significant public health concerns such as alcohol-related problems. To be effective, we must try to remain mindful about where policy formulation and political processes gain ascendancy over scientific processes (which, of course, may contain a measure of political activity as well). It is in service of keeping these margins clear that our editorial is offered. We end by acknowledging the need for behavioral scientists to extend our borders into these other realms, but we urge them to do so with a vision of the landscape as articulated by the applied science firmly in mind.

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## Section Description

*We publish below a series of invited commentaries on the editorial by Humphreys & Tucker, together with a reply by the authors.*

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