The Case for a Problem Prevention Approach to Alcohol, Drug, and Mental Problems

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IN CONSIDERING THE RELATIVE MERITS of health promotion and disease prevention, we are heirs to a considerable history in the fields of health and social problems in general and in the area of alcohol, drug, and mental problems in particular. The accomplishments of public health agencies in the prevention of infectious diseases during the past century are well known, and the familiar brand names that memorialize W. K. Kellogg and C. W. Post are reminders of the substantial commitment of 19th century Americans to health promotion. Moreover, we would be hard pressed to match the temperance movement's commitment to problem prevention through Prohibition, as well as to mental and physical health promotion—as exemplified in Frances Willard's "do everything" policy for the Women's Christian Temperance Union (*1*).

In fact, disease prevention and health promotion strategies are well rooted in the past in each of the three fields of alcohol, drug, and mental problems. Along with such preventive strategies as soliciting temperance pledges and shutting down saloons, the temperance movement lent its weight to many efforts in the promotion of alternatives—providing public drinking fountains, opening temperance coffee shops, introducing soft drinks, and promoting public parks and young men's clubs as alternatives to the saloon (*2*). Similarly, drug use prevention efforts in recent years have included —along with the efforts of the Drug Enforcement Administration (DEA) and other agencies to interdict supplies—a variety of efforts by the National Institute on Drug Abuse (NIDA) to promote alternative ethoses, lifestyles, and activities to those involving drug use. For mental problems, the promotion of mental hygiene and later of mental health was a prominent theme of the movement started by Clifford Beers, and already 20 years ago it was argued that the promotion of mental health was not identical to the prevention of mental illness (*3*).

Disease Prevention Versus Health Promotion

The current distinction between health promotion and disease prevention derives primarily from discussions of physical health and tends to arise in arguments in behalf of health promotion. A common line of argument notes that the era of infectious diseases as primary causes of mortality is over; we are in a new era when chronic diseases associated with general lifestyle characteristics are the greatest contributors to early mortality; and therefore we must turn from the specific disease prevention strategies—such as mass immunization—to more general strategies of health promotion.

Part of the appeal of the distinction in the general

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health area is its lumping together of a number of dichotomous factors. Promotion sounds optimistic and positive, while prevention sounds a little small minded and negative. Most of us would rather work to accentuate the positive than to build fences around the negative. The rhetoric of health promotion often taps into the mainstream of American secular puritanism—positive thinking and good behavior now will lead to a long and healthy old age. Associated with this materialistic perfectionism is a new health moralism: in an era of societal responsibility for health and welfare supports, it is every citizen's duty to promote his or her own health.

Another dimension of contrast invoked by the health promotion-disease prevention dichotomization is the theme of self-help versus professional help in health maintenance. A prominent part of recent waves of populist and consumerist thought is that one's health is too important to be left to physicians; one must take responsibility for one's own health. This theme has stemmed partly from a revulsion against technological sophistication, professional specialization, and the claims of laboratory science—if there are to be professionals, they should be among and of the people and willing, for instance, to attend a delivery in the home. Manufactured pharmaceuticals also are suspect—unlike homespun herb teas. Thus, disease prevention tends to be seen in terms of the "technological fix," while health promotion emphasizes people helping themselves and perhaps each other.

In a related fashion, switching from disease prevention to health promotion implies switching from the microbiological level to the behavioral level as the seat for health maintenance efforts. Despite the positive rhetoric, health promotion usually turns out to mean stopping things from happening. But instead of stopping the spread of a virus or bacterium, health promotion implies changing human behavior—cutting down on butter and eggs, stopping smoking, getting enough sleep, avoiding second helpings and desserts, and jogging.

Finally, health promotion arguments draw on the revival of holistic approaches to health as opposed to the allopathic tradition of specific prophylactics and remedies for specific conditions. The current profusion of holistic systems of medicine rivals the lush diversity of 19th century America. The holistic critique of allopathic medicine accuses it of often "curing the disease but killing the patient." Applied to health promotion, the argument emphasizes the indivisibility of life versus death—the successful attack on one disease only leaves us free to die of another.

In my view, combining these different dimensions in the contrast of health promotion and disease prevention confuses together dimensions that can and do often operate independently—professionalization versus self-help, sophisticated technology versus simple tools, a holistic versus a targeted approach, and incentive and encouragement versus deterrence and dissuasion.

For alcohol, drug, and mental problems, the health promotion rhetoric has some special attractions, but also some drawbacks. In its concentration on health-related

behaviors, health promotion provides an explicit rationale for a focus on alcohol, tobacco, and drugs as major health concerns and thus helps to bolster the legitimacy of including agencies for alcohol, drug, and mental problems in the health establishment. On the other hand, not all of the general rhetoric of health promotion really applies to alcohol, drug, and mental problems. For physical illness, the inevitability of death is a powerful argument for health promotion: to prevent death from one cause leaves us at the risk of many others, one of which will eventually claim us. But this is not the case for alcohol, drug, and mental problems—to prevent a specific mental distress or a particular drinking-related problem does not imply that some other problem as bad or worse must occur in the end.

The rhetoric of health promotion fits well into some already existing strands in thought and programing in the areas of alcohol, drugs, and mental problems. Thus, the health promotion-disease prevention dichotomy maps fairly well onto the demand reduction-supply interdiction dichotomy—a distinction that has a long history in the drug field and that is reflected in the split of functions at the Federal level between the DEA and NIDA. Of course, the equation of health promotion with demand reduction and disease prevention with supply interdiction requires that drug use per se be defined as the problem, in fact as a disease. But for opiates, at least until the early 1970s, policymakers could comfortably assume that usage meant addiction.

Reduction of demand for drugs is indeed commonly pursued in a style that is more in keeping with health promotion than with disease prevention. Although warning the public of the evils and dangers of drug use is a time-hallowed form of drug education, NIDA was formed when a revulsion was occurring against what were seen as the counterproductive scare tactics of the traditional talks to high school students by narcotics squad officers—and when the literature intimated that paying attention to the "disease" might even glamorize and encourage its spread. NIDA's preventive efforts have therefore been weighted toward health promotion in the form of promoting alternative lifestyles, activities, and "highs" to drug use and of affective education and values clarification.

In the alcohol field, the divisions have not been so neat. For young children and teenagers, the pattern has been like that for illicit drugs—for them, after all, alcohol use is illicit, so the "disease" to be prevented is alcohol use. In this frame of reference, the progression of strategies has been similar to (in fact, antedated) the progression for drugs—in reaction to what were seen as the negative and scare tactics of the old "scientific study of temperance"—first an emphasis on facts about alcohol and alcoholism, succeeded by emphases on promotion of alternatives, affective education, and values clarification.

For adults, until recently, preventive efforts have been shaped by the classic disease concept of alcoholism and by the political unacceptability of any strategy identifiable with temperance. Thus, the use of alcohol was irrelevant—the issue was the spiritual disease of loss of control over one's drinking behavior. Since the disease's etiology was unknown, and indeed was assumed to be inherited or formed in early life, preventive efforts tended to be secondary rather than primary. In fact, the older Alcoholics Anonymous concept of the need to "hit bottom" tended to push attention away even from secondary prevention.

A substantial exception to this pattern has been the prevention of drunk driving, which over the past decade has included a variety of preventive strategies or "countermeasures" (*4*). These strategies—public service announcements, educational programs, and enforcement and deterrence programs—relate more to disease prevention than to health promotion, if drunk driving can be regarded as a disease. The various attempts to encourage mass transit might be viewed as health promotion efforts, although these efforts generally have not been aimed specifically at reducing drunk driving casualties.

Mental Health-Mental Illness

The rhetorical distinction between health promotion and disease prevention fits easily with the longstanding split in the mental health-mental illness field (*5a*), epitomized by the dual name for the field. The emphases on positive parenting and the promotion of happiness by the mental hygiene movement of the 1930s, the mental health movement of the 1950s, and such groups as Parent Effectiveness Training and Transactional Analysis in the 1970s reflect the enduring tradition of health promotion activity. On the other hand, those with a clinical orientation and a focus on mental illness remain generally skeptical of the conceptualization and pursuit of positive mental health (*6*) and prefer to pursue instead a more narrowly conceived "primary prevention of psychopathology" (*7*), focusing on efforts to find the causes of specific mental illnesses and then to remove or prevent them.

A continuing problem with the strategy of promoting mental health is the vastness and vagueness of its goals. As Kessler and Albee note, "nearly everything, it appears, has implications for primary prevention, for reducing emotional disturbance, for strengthening and fostering mental health" (*5b*). Of course, since the goals frequently are ill-defined, it is difficult to evaluate

promotion efforts. Even if proximate goals of a project can be identified and measured, their relation to eventual goals remains a matter of faith. Thus, although a program may succeed in its short-term aim of teaching coping skills to school children, there is little empirical evidence of what this means for mental health promotion in the long run.

More seriously, the ill-defined and broad-ranging goals of mental health promotion are easily bent to the purpose of a variety of political perspectives. On the one hand, the promotion of mental health can serve as a rubric for proposals for a radical restructuring of society; for example, Marx's argument against the alienation of workers from their labor relates partly to promoting mental health. On the other hand, mental health promotion efforts can simply sweeten bitter pills that the powerless are forced to swallow—poor housing, unemployment, and so on. Such efforts have multiple advantages for the powerful—they depoliticize the situation, soothe the powerless, and salve the consciences of the powerful. Actually, the mental health movement has not moved unambiguously in either of these directions. But sociologists have noted repeatedly the tendency of the movement to function as a secular religion that promotes middle-class values and lifestyles (*8, 9*). Just as people tend to define a heavy drinker as someone who drinks twice as much as they do, mental health professionals tend to regard the lifestyle of their own class as the most mentally healthy.

On the other hand, the strategy of the prevention of mental illness has been associated with a relatively narrow and dogmatic perspective on the nature of the illness. Despite the ferment over models of mental illness in recent decades, psychiatrists still tend to retreat to a model that assumes that mental illnesses are located in the individual rather than in interactions or the social environment, are rooted in biology or early development, and are limited to the disorders seen in mental hospitals. In the purest form of this perspective, preventive efforts are limited to genetic counseling and to the elimination of toxins and early developmental factors related to brain damage. For the bulk of mental illness, prevention is viewed as a task for the future, after research has illuminated what is to be done.

Prevention Efforts for Children

The two perspectives, the promotion of mental health and the prevention of mental illness, are thus at a partial impasse over the direction of prevention programs. As a result, energy has been focused on prevention programs that are acceptable to both perspectives. To an overwhelming extent, this has meant a focus on children as the target of prevention.

The concrete emphasis on children in the mental health movement dates back to the child guidance clinics of the 1920s and such efforts as the "Pierre the Pelican" pamphlets in the 1930s, and it continues today. This emphasis reflects an optimism that the fulminating mental problems of adulthood can be obviated by ensuring a positive childhood experience. From a mental illness or psychopathology perspective, the emphasis on infants and children partly reflects an extension by analogy of major successes in mental illness prevention —identification of and action on physiological factors impeding fetal and infant development and the improvement of institutionalized children's mental functioning by the provision of a stimulating environment. The emphasis also reflects the continuing strength in psychiatric thought of Freudian and other traditions that focus on childhood events as determinative of adult mental illness—the assumption broadly referred to as the "psychogenic hypothesis" (*5*).

The emphasis on infants and children in preventive programing also reflects the high value we place on our children. Undoubtedly, a program for children can gain greater immediate political support than a program for adults, as signaled by the preference for "poster children" rather than adults in fundraising campaigns for various disabilities. The tendency to tap into the pathos surrounding abnormal children and their suffering parents in designing mental health efforts is evidenced by the current Federal efforts concerning the sudden infant death syndrome (*10*). After all, a variety of life crises are more common and potentially as disruptive as loss of an infant through SIDS—death or imprisonment of a spouse, divorce, job loss, for example. Focusing limited staff resources and program effort on SIDS, like the analogous NIAAA emphasis on the fetal alcohol syndrome, may be a reflection of our cultural priority on children.

Children have other attractions as targets for prevention efforts. Frequently, they are used as our moral surrogates; as acolytes to their own future, they are held to behavior standards not expected of adults. When they are of school age, they form a captive audience. And they have little legal or social power to resist what adults do to or for them.

The extent to which infants and children dominate discussions of prevention in the framework of mental health and mental illness is epitomized by the chapter titled "A Strategy for Prevention" in the report of the President's Commission on Mental Health (*11*). This chapter and its annotations include eight recommendations. One of these is procedural, calling for the establishment of a Center for Prevention in the National

Institute of Mental Health. All seven of the substantive recommendations are concerned with infant and child care.

The primary rationale for the focus on children, whatever its sources, is the assumption that the mental illness or mental health of adults is determined largely by what happens during childhood. Thus, improving the experience of childhood is seen as resulting not only in happier children in the short run but in mentally healthier adults in the long run. In my view, this key assumption is not defensible empirically. There are indeed limiting senses in which the assumption is undoubtedly true; for example, brain damage in an infant imposes limits on functioning as an adult, and teenage suicide forecloses a well-adjusted adulthood. Moreover, there are broad senses in which it is partly true—life history research in psychopathology has shown some continuity between childhood and adult behavioral problems. But even if we had effective strategies for preventing childhood behavioral problems, they probably would not efficiently prevent adult mental problems. In the context of the general population, mental problems at one time of life are only moderately predictive of mental problems at another time, and the strength of the relationship generally decays over time. To carry the argument to the extreme, provision of developmental day care programs is certainly not a direct and probably not an effective strategy for preventing the mental problems of widowhood.

Lest I be misunderstood, let me note that I do favor provision of services to children and efforts to prevent mental problems among them. What I am questioning is the facile assumption that doing good things for children is necessarily primary prevention of mental problems and constitutes a sufficient strategy for the prevention of such problems among adults. Doing good things for children is a good idea regardless of its effect on mental health, but it is no substitute for thought and action on a general program for the prevention of mental problems.

Focus on Specific Problems

As I have implied, the overemphasis on children in the mental health-mental illness field, and for that matter in the drug and alcohol areas, is symptomatic of a general constriction of current thought about prevention in the three areas. The distinction between health promotion and disease prevention maps fairly well onto current tendencies in the three fields, but I believe that we must transcend this distinction to plan effectively for prevention. The conceptualization appropriate for the governmental role in these fields, in my view, is oriented more to prevention than to promotion, but it avoids the constricting channels of psychiatric nosology in defining what is to be prevented. I believe that our primary aim should be the prevention or, more accurately, the minimization of alcohol, drug, and mental *problems*.

With respect to mental health-mental illness, this view proposes a focus on specific mental problems rather than on a global concept of positive mental health. Positive mental health as it is usually defined is a utopian aim rather than a positive guide to action. Much of what falls within its definition is more appropriately a task for voluntary and private programs—for instance promoting particular values and lifestyles, as in the current "self-actualization" movements. For governmental programs, a more appropriate task is the elimination of agreed-on problems.

The view also proposes a focus on mental problems at their face value rather than on assumed underlying psychopathologies. Indeed, defining prevention efforts around the categories of psychiatric nosology may in several ways be a hindrance to those efforts.

—Psychiatric nosology shares in the Sydenhamian tradition of Platonic realism, which tends to discount presenting complaints as mere epiphenomenal symptoms of presumed underlying entities.

—As parts of the practical tool of differential diagnosis for clinicians facing clinical cases, nosological categories are organized around such clinical agendas as therapeutic indications and clinical history (*12*), which are not necessarily relevant to prevention programs for the population at large.

—Reflecting its basis in the clinician-client relationship, psychiatric nosology is resistant to definitions of the nature of mental problems as interactional, situational, or sociocultural, and thus it tends to point prevention efforts toward only the individual psyche, passing over social or structural strategies. (Again, the work of the President's Commission on Mental Health is instructive. In that work, community support networks and public images of mental illness are given substantial and welcome attention; there is a task panel for each topic. Yet neither task panel emphasizes prevention as a focus for its topic. And neither the Task Panel on Prevention nor the Commission itself includes the strengthening of community support networks or the influencing of public images of mental illness within the scope of prevention efforts.)

The proposal to focus on the prevention of mental problems is by no means novel. Hollister (*13*) has concretely expressed such a proposal, calling for the pursuit of:

> some simple, direct, modest goals such as preventing:
> (a) *specific behaviors* that are self-defeating or harmful to

others, such as poor or unhealthy habits, overeating, procrastinating, evasiveness, blaming others, and 'setting the stage' to fail
(b) *role failures*, as a student, a parent, or an employee
(c) *relationship breakdowns* between husband and wife, parent and child, boss and employee, including detection and control of interpersonal 'games' that are destructive
(d) *feeling over-reactions* such as panics, new situation anxiety, flights, and temper tantrums
(e) *psychological disabilities* such as the social deterioration of a confined ill person, decompensation, 'going to pieces,' or falling into melancholia instead of experiencing normal grieving.

As Hollister continues: "With such a conceptualization, many of the commonsense services already given in the community by mental health and other helping agencies can be identified and publicly acknowledged as prevention efforts."

The argument for a focus on the prevention of concrete problems is even stronger for alcohol and drug-related problems than for mental problems. To confine preventive efforts to the psychiatric diagnostic categories of drug addiction or dependence and alcoholism or the alcohol dependence syndrome is to exclude a wide variety of alcohol and drug problems that do not necessarily have a mental component—for example, cirrhosis, accidental overdoses, alcohol and drug-related casualties, and public drunkenness.

The argument for what is sometimes called a "disaggregative" approach to the prevention of alcohol problems has been developed in detail (*14–17*). As I have noted elsewhere (*16*), the alcohol-related prolems of major concern comprise a relatively small number of main categories:

—acute health problems, such as overdose or delirium tremens;
—chronic health problems, such as cirrhosis or head or neck cancer;
—casualties, such as accidents on the road, in the home or elsewhere, and suicide;
—violent crime and family abuse;
—problems of demeanor, such as public drunkenness and use of alcohol by teenagers;
—default of major social roles—work or school and family roles;
—problems of feeling-state—demoralization and depression and experienced loss of control.

This list obviously can be applied to other drugs, although the relative prevalence of different classes of problems varies by type of drug and for some drugs certain problems usually do not occur. For illicit drugs, use at all is a major problem of demeanor in terms of current social definitions.

Roughly the same list can also serve as a catalog of major mind-related problems, although it may sometimes take us into territory far from psychopathology. For instance, although psychopathology is probably a relatively minor factor in traffic accidents, the mental factor of fatigue is undoubtedly a major contributor to late-night auto crashes; in fact, its role may be more important than that of alcohol. In this perspective, the task of preventive efforts in the mental problems field becomes not only the prevention of mental illness but also the elimination of the mental component in major social and health problems.

The preceding list of major problem areas is more a description of popular concerns than a conceptual classification. In considering its interplay with the array of possible preventive strategies, one should keep in mind the following salient conceptual similarities and differences between the problem areas:

—As is our cultural wont, the problems tend to be expressed at individual rather than collective levels; for example, in terms of problems on the job rather than problems of productivity. Gregg and associates (*18*) document this tendency specifically in six alcohol, drug, and mental health research literatures. Problems at different levels of aggregation do not necessarily map into each other—loss of production may be a problem for the company or the economy but not for the worker; unemployment may be a problem for the worker but not for the economy.
—Problems can be events or conditions. An accident, a quarrel, a bout of drinking are events; cirrhosis, depression, or a drug habit are conditions. Events and conditions may be connected intrinsically—a marriage that is in a problematic condition may end in the event of divorce; an accident may leave a person permanently disabled. But often events and conditions are connected by our interpretation, particularly the common clinical interpretation that an event or series of events symptomatize and should be viewed as a condition. From a prevention perspective, events often can be prevented, for instance, by environmental manipulation, without changing the condition of the participants.
—Alcohol, drug, and mental factors have many forms of relationship to problems. In particular, they may have acute or chronic effects. Acute effects are primarily associated with problematic events and chronic effects with problematic conditions. Alcohol, drug, and mental factors can be intrinsic to the problem—an alcohol factor is part of the definition of public drunkenness, a mental factor part of the definition of a "nervous breakdown." They can be a precondition of the problem, necessary but usually not sufficient for its occurrence; thus, drug use or fatigue can be causal factors in a driving fatality. Or, they can be coincidentally associated with the problem, in which case removing the alcohol, drug, or mental factor will not reduce the problem. Pre-

vention programing must be attuned to the various relationships of alcohol, drug, and mental factors to social and health problems.

—Different alcohol, drug, and mental problems have various "seatings," and these differences have implications for prevention. Some problems are those of irreversible biological action, and prevention requires forestalling this process. Thus, preventing the biological sequelae of substance ingestion—cirrhosis, drug overdose, mental problems from eating lead-based paints—usually requires prevention or alteration of the pattern of ingestion. This goal, of course, can be pursued by a number of means—consumer education, forcible confinement, regulation of producers, tax incentives, among others.

Other problems are those of accidental casualty—injury, death, or property damage from impact, fire, immersion, or other physical mishaps. Intrinsic to such problems is not only the behavior of the individual but also the characteristics of the physical environment. Thus, more prevention strategies are available for accidental casualty than for biological action problems. Like the biological action problems, casualty problems can be reduced by preventing or changing an alcohol, drug, or mental factor that is a precondition of the problem. Thus, we can persuade, deter, or stop people from drinking before driving in order to prevent drunk driving casualties. But we can also prevent casualties by changing the physical environment or by insulating people from harm in it. For instance, we can require fireproof mattresses to prevent fire fatalities from drinking and smoking, and we can require airbags or passive restraints to insulate the drinking driver and others from injuries in automobile crashes.

Many alcohol, drug, and mental problems are problems of social interaction. The "seat" of the problem is not only an awkward or problematic behavior, but also others' reaction to it. To what extent drunkenness is viewed as a problem depends not only on the individual's behavior, but also on the feelings and actions of others concerning it. Similarly, studies by Cumming and Cumming (*19*) and others have documented the differences by locale, professional training, and so on in the extent to which eccentric behaviors are defined as actionable mental problems. It is now widely recognized that the definition of marijuana as a social problem is a matter of the social reaction to the behavior as well as the behavior itself. Of course, such problems of social interaction can be prevented by eliminating or changing the behavior. But such problems, like casualties, also can be prevented by the provision of insulation or boundaries between the behavior and those who might otherwise react. These boundaries may be physical, temporal, or cultural (*20*). Thus, public drunkenness as a social problem can be prevented by moving the drinking indoors, and legal problems with alcohol and drug use in college dormitories are often limited by informal agreements governing police entry. Teenagers' problems with their parents are often avoided by their using alcohol, tobacco, or drugs only when their parents are absent. A third option for problems of social interaction is to decrease the social reaction to problematic behavior. One example is the call of the National Commission on Marihuana and Drug Abuse (*21*) to deemphasize and desensitize societal reactions to marijuana smoking. Another example is the appeal for toleration of the lifestyle of "urban nomads" on skid row (*22*).

Other alcohol, drug, and mental health difficulties are existential problems of what is self-perceived as an undesirable chronic behavior or condition—the loss of control over drinking behavior that is the pathognomic symptom of the Alcoholics Anonymous concept of alcoholism, the seemingly uncontrollable thoughts and behaviors for which people seek out therapists or clergy. One approach to prevention is to prevent or change precursors of such existential conditions, although the linkages between precursors and the conditions have often proved elusive. In this era of gay liberation and the American Psychiatric Association vote to remove homosexuality from the diagnostic manual, it should be clear that an alternative is to stop regarding the behavior or condition as a problem. The change in professional and social attitudes toward masturbation in recent years may have been one of the most effective ways to decrease mental health problems among teenagers.

Comments

The style of analysis I have sketched out, to identify specific alcohol, drug, and mental problems and to consider the strategies and agents that can be brought to bear on them, entails a wider definition of preventive activities than is conventional. For instance, in the recommendations of the President's Commission on Mental Health not only the issues discussed under Prevention but also aspects of the topical areas of Community Supports and Improving Public Understanding are highly relevant to prevention programing. Other strategies not considered by the Commission or its Task Panels are also viewed as relevant prevention strategies.

If we engage in a systematic process of broadening the scope and analyzing the potentialities for prevention programing, the end result might be seen as a matrix of program possibilities, with a number of dimensions of variation: (*a*) the specific problem areas, (*b*) ap-

plicable strategies of prevention for each problem area, (*c*) relevant social institutions and situations through which the strategies may be applied, and (*d*) specific target populations and contexts for the prevention efforts.

Such a matrix is, of course, a menu rather than a meal. The hard choices between competing priorities still have to be made. And in making these choices, it must be borne in mind that a strategy that diminishes one problem may inadvertently increase others. For example, deglamorizing alcohol and desensitizing people to drinking may diminish the social disruption and violence associated with drinking, but it also may result in more heavy drinking and thus more mortality from cirrhosis.

Other than considering such interconnections, priorities presumably will reflect the scope of problems affected and the effectiveness and feasibility of the strategies. Inevitably, priorities also will be influenced by political agendas. In the areas of alcohol, drug, and mental problems, we are dealing with human behaviors that often are attached not only to economic but also to intellectual and moral interests. Thus, change often comes hard, and even a commitment to change is often contentious. Alcohol, drug, and mental problems are relatively small silhouettes on the political horizon, and even small special-interest groups may effectively block prevention efforts. A drawback of the disaggregative approach that I propose is the very size of the menu it offers; it gives policy brokers ample scope to pick and choose in terms of political realities rather than of practical effect.

Nevertheless, in my view the approach is an improvement on a disease prevention strategy in that it avoids the constraints of a nosology designed for purposes other than prevention. It also is preferable to an exclusively health promotion approach, which tends to focus on specific strategies of persuasion and education about behavior that is commonly difficult to change. Like any skilled plumber or surgeon or general, we can best perform as prevention strategists by analyzing in detail the nature of the problems to be solved and by designing specific programs to counter them.

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