Who gets to define failure in regard to drug use and its treatment?

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John Kleinig’s paper is thought-provoking, but I suspect will be a kind of Rorschach test for those commenting, since reading it starts rabbits off in so many directions. In the context of psychoactive substance use, the question is not only, as Kleinig (2012) discusses, what is meant by failure, but also who gets to decide this.

There are potentially two conditions which might be defined as failures in the course of treatment for psychoactive substance use. The condition Kleinig’s paper focuses on is one of these: what happens after treatment. The other is implicit in coming to treatment in the first place. The classic paper by Brickman et al. (1982) starts from this distinction between the two conditions, examining the ideological choices in assigning responsibility for action on each of the “failures” (though they get AA’s position wrong).

Someone uses a drug; as Marvin Garson (1971) once put it in a piece reprinted in these pages, the person has “a modest appetite for white powder”. Is this habit something which needs treatment (or some other kind of response)? Need for treatment, as a concept, denotes a kind of failure – that the person’s health or behaviour falls short of some standard or ideal. It may be the user him- or herself who imposes this standard – the user may decide that the drug use has become a habit he or she wants to change in some way. This is the classic model of the inception of the therapeutic situation with which cognitive behavioural therapists, for instance, will be comfortable.

However, it is a model with assumptions about the therapeutic situation which often do not apply (although therapists tend to stick to this definition of the situation, however ill-fitting, because it glosses over many ethical questions
about their role). The model does not apply because the need for treatment – the definition of the behaviour in negative terms and the wish or demand for change -- often is defined by others.

It may be defined by those near and dear to the drug user. They may, in fact, spend years trying to persuade the user to change his or her behavior, and in case of failure may then summon therapeutic or other help to back up their view of the behavior (Wiseman, 1991).

Or it may be defined politically, in the wider society. If the white powder is a legal commodity like sugar, for instance, a heavy user may eventually suffer sugar-related health problems, but there is presently no societal or legal standard for requiring treatment or another intervention for the use. But if the white powder is a prohibited substance, the user may be arrested, and locked up for punishment and maybe to keep him or her away from the substance. Or, in what is defined as a more humane alternative, the user may be pushed into treatment, under threat of a jail term otherwise. The need for treatment or some other intervention is here defined politically at a societal level, and the threshold of what level of use is acceptable may be set at zero.

A fourth major set of actors in defining need for treatment is professions which claim professional jurisdiction over the behavior and the treatment. Treating substance use is actually a bit of a no-man’s-land between professions, but psychiatry is the most prestigious profession claiming jurisdiction, and psychiatric definitions hold sway in terms of the major diagnostic systems such as WHO’s International Classification of Diseases and, of course, the Diagnostic and Statistical Manual of the American Psychiatric Association. Diagnoses in such systems become an objectified standard assumed to define need for treatment – not only concerning those actually in treatment, but also concerning drug users out there in the wild, in the general population. Particularly in the context of US health care financing, there is a strong incentive for psychiatrists to set the threshold of diagnosis inclusively. Hence drug use disorders are now defined in terms of a disjunctive list of behaviours or experiences; in DSM-5, the list of such criteria is to be expanded to eleven, and a user reporting any two of them is to be defined as having the disorder. I have argued elsewhere that such criteria have lost any clear connection to what experienced clinicians would consider a suitable case for treatment (Room, 2011), but the criteria are commonly assumed to indicate such a need (e.g., Epstein, 2002).
What happens in treatment then also becomes a second chance for failure -- the chance on which Kleinig focuses. But again the question arises, who gets to define success or failure? It could be the drug user. There is substantial variation in what substance users coming to specialised treatment are seeking as an outcome (Heather et al., 2010; McKeeganey et al., 2004). Or it can be those around the drug user who have been adversely affected. Both of these sets of actors might define failure in terms of the substance use, or they might define it more broadly, in terms of “recovery” or some other definition of the good life. From a political and societal perspective, failure may be defined in terms of abstinence, or in terms of reduced frequency of substance use – or more expeditiously in terms of reductions in rates of drug-related criminal behaviour, which was the main criterion of success for methadone maintenance in its early years in the U.S. There is variation among clinicians, too, in criteria for failure. Some would define failure in terms of any recurrence of substance use. Others might acknowledge cutting down as “partial remission”, in the terminology of DSM-IV. But, according to DSM-IV criteria, someone who has been dependent can only qualify for “full remission” if they are no longer positive on any of the dependence criteria. And the term “remission” in itself implies that the disorder, once present, cannot be expunged; the primary failure of having qualified for the diagnosis is still always there in some sense in the patient.

I agree with Kleinig that “failure is bounded and undergirded by numerous assumptions, often hidden, and those assumptions need to be made transparent”. But I think there is also a need to ask the question, with respect both to substance use and to treatment and other societal responses to substance use, who gets to define what is failure and success? Given the high prevalence of coercion among those entering substance use treatment (Urbanoski, 2010), it is clear that there is substantial disagreement between the patient and other actors on defining need for treatment, and there is likely to be divergence too in defining treatment failure. Paying attention to these differences in definitions of success and failure according to who is doing the defining seems to me not only an agenda for research and philosophical inquiry but also an ethical imperative in clinical work.

REFERENCES


