DRUG & ALCOHOL FINDINGS Matrix cell

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Drug Treatment Matrix cell A2: Interventions; Generic and cross-cutting issues

This cell is currently being updated. Apologies for any as yet uncorrected mistakes.

S The 'miracle' recovery of the Vietnam veterans (1977). In the 1970s fewer than 1 in 8 of the US soldiers who became dependent on heroin in Vietnam relapsed in the three years after their return. The great majority usually remitted without any treatment. For discussion click here and scroll down to highlighted heading.

S Pioneering insight into common factors in therapy (1991). First published in 1961 and culminating in a third edition in 1991, Jerome D. Frank's book *Persuasion and Healing* was a pioneering insight into the important features shared by effective therapies in mental health including the addictions, features now widely acknowledged as more influential than the specific theories and methods of different approaches.

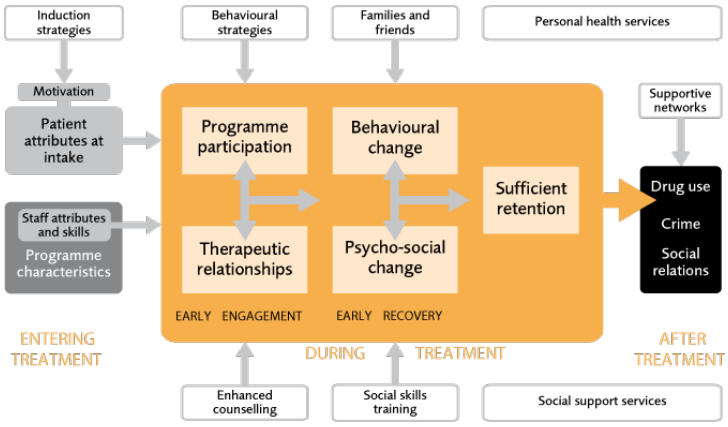
S 'Pre-recovery' foundations of recovery orientation (2000). Original article here. Justification for the 'seminal' tag is that by many years this study predated the recovery era in British policy, yet laid some of the foundations for its shift in emphasis from the psychological or biochemical grip of addiction, to lifestyle change which forges a positive, non-addict identity as a bolster against relapse.

K Remission is the norm but some take much longer than others (2011). US national population survey found that after ten years two-thirds of people dependent on cannabis were no longer dependent and three-quarters for cocaine. Reanalysis (2013) of same surveys points out that most remit without treatment and calculates that no matter how long ago someone became dependent, their chances of remission remain the same, challenging assumptions that progressive neural, lifestyle or psychological changes increasingly lock-in addiction. Related reviews below. For related discussion click here and scroll down to highlighted heading.

K English treatment services vindicated (1999). NTORS recruited its sample of patients in drug treatment in England in 1995, but remains the most important treatment study in Britain. Conducted when the modalities it studied (inpatient, residential and methadone) were under threat, it found they reaped benefits which greatly outweighed costs. Sampling about 11 years later, DTORS (2009) reached similar conclusions, but nearly three-quarters of the patients could not be followed up. For discussion click here and scroll down to highlighted heading.

K Abstinence rare outcome in Scotland (2006). Recruiting its sample in 2001, the DORIS drug treatment study was the Scottish equivalent to the English NTORS and DTORS. The apparent mismatch between the abstinence ambitions of the patients and the lack of abstinence outcomes was the main theme, but actually the findings were not so clear cut. See also reports on employment (2008) and crime (2007) outcomes, and an omnibus report (2008) on the project's findings. For discussion click here and scroll down to highlighted heading.

K Influential treatment process model emerges from US studies (2002). The US national drug treatment study DATOS was one of the US equivalents to the Scottish DORIS and the English NTORS and DTORS studies. Instead of heroin, cocaine was the main drug patients were dependent on. For the UK the study's significance was the highly influential model of how treatment works – and therefore how it can be improved – which emerged from this and other studies by the same US research institute ▶diagram.



DATOS model of how treatment works; click to see full size

K Validation for English treatment exit outcome measure ([UK] National Treatment Agency for Substance Misuse, 2010). Support for the argument made by England's National Treatment Agency for Substance Misuse that relapse is less likely if patients leave treatment after having successfully completed the programme rather than dropping out – but staying ([UK] National Treatment Agency for Substance Misuse, 2012) in treatment for at least a few years is in some respects even better.

K Non-residential rehabilitation usually matches residential ... but not always (2007). Confirmed that unless there are pressing contraindications, intensive day options deliver outcomes equivalent to residential care. Often of course, there *are* pressing contraindications. See also this informal Effectiveness Bank review.

K Motivating aftercare (2007). US inpatient treatment centre systematically applied simple prompts and motivators to substantially improve aftercare attendance and sustain recovery. See also later report from same study.

R What is addiction treatment for? (2016). Effectiveness Bank hot topic asks the big question, on the way roving through 'recovery' as an answer (the focus of another hot topic 2016), and noting that "though those who later become addicts often start with few personal, social and economic resources, the little they do have will be eroded by criminalisation and social stigma, and by services which explicitly or inadvertently encourage the adoption of an addict identity". For discussion click here and scroll down to highlighted heading.

R Remission is the norm (2010). In the general population and in treatment samples, on average studies have found half (or more in recent studies) of all problem substance users were later in remission. After treatment, six out ten remitted by becoming abstinent, but among general population samples, six out of ten continued to use. Similar territory covered in another review (2010). Related key study above. For related discussion click here and scroll down to highlighted heading.

R Engaging the treatment-resistant (2010). Shock-tactic confrontation and tough-love disengagement found less likely to persuade

dependent users in the family to enter treatment than a 'community reinforcement' approach aimed at engaging them in fulfilling activities incompatible with continued substance use.

R Tailor induction to treatment (2005). When considering or starting treatment some patients need motivation bolstered and options explored, for others this is not just unnecessary, but counterproductive.

R Chronic care for chronic conditions (2009). Based on a count of studies which found improvement on at least one substance use outcome, generally the offer of long-term continuing care/aftercare leads to better outcomes, implying that dependence is best treated as a chronic condition. A later review (2014) (free source at time of writing) added 13 studies to the 20 previously identified and aggregated all substance use outcomes reported in the trials. Still the offer of continuing care helped retain treatment effects but more modestly than found by the earlier review. Guidelines based on review below.

G Recovery defined (2008). A national UK drug policy charity brought together 16 experts to (if they could) agree an understanding of 'recovery' from problem substance use. Remarkably, they did agree, characterising it as "voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society". For discussions click here and here and scroll down to highlighted headings.

G Guide for UK clinicians on treating problem drug use ([UK] Department of Health, 2017). There is no more important document for UK clinicians involved in treating problem drug use than the so-called 'Orange guidelines'. This major update offered detailed guidance on the range of problems, settings and patients clinicians encounter, establishing the foundation for deciding what in Britain constitutes acceptable and unacceptable medical practice.

G Treatment principles ([US] National Institute on Drug Abuse, 2012). Presents 13 research-based principles of addiction treatment, seven of which have been tested against the North American evidence. Principles relating to individualising treatment were consistently supported.

G US guidance on matching patients to intensity and type of care (American Society of Addiction Medicine, 2013). From the professional body for US addiction clinicians, world's most widely used criteria for deciding what kind of treatment to start with or move on to for different kinds of patients.

G Strategies to promote continuing care (2009). Expert US consensus on practical strategies to promote continuing care based on review above.

G Crucial case management role (Association of Alcohol and Other Drugs Agencies Northern Territory, 2015). Australian state 'peak' body for non-governmental drug and alcohol services offers guidance on the important and widely implemented (but barely researched) role of the case manager in integrating and coordinating service delivery.

MORE This search retrieves all relevant analyses.
For subtopics go to the subject search page or hot topics on promoting recovery through employment, on mutual aid and user-involvement, the need for residential care, on individualising treatment, on what treatment is for, and on recovery as a treatment objective.

Close Matrix Bite

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

What is this cell about? Whether medical or psychosocial, chosen positively or under pressure, patients have to decide to get help and find their way to treatment or get sent there. Decisions must be made about treatment objectives and the form, intensity and duration of care, relationships forged, and attention paid to psychological problems and social circumstances which affect the chances of a sustained end to dependent substance use. Specific medical and psychosocial interventions are respectively covered in cells A3 and A4. This cell is about factors common to both – for example, the very fact that someone or some institution sanctioned by society has identified the patient/client as in need and deserving of help, believes they will benefit, and is accepted as an authority in the problem and its solutions, components of the so-called 'placebo effect', but which are actually active ingredients in the treatment of behavioural problems.

This cell is about these generic functions and 'common factors', now widely recognised as at least as important as the particular therapy. Also here we touch on the nature of addiction and the nature of the caseload seen in treatment services, helping place those services in the context of the spectrum of dependent drug use in society and the 'natural' processes of recovery which treatment seeks to harness and accelerate. Other cells home in on common factors to do specifically with how the practitioner relates to the patient/client and the nature of the treatment service.

Where should I start? Perhaps at the end, with where treatment should be trying to get to. Inevitably, that 'should' word plunges us in to the worlds of values and politics (in the form of whose values prevail) not susceptible to resolution via randomised controlled trial. Among the aims of this commentary is to expose how those worlds generate research in the expectation that it will help further their agendas, and also influence the research itself – which like every other intentional human action, is a *motivated* endeavour; science is never *just* about science.

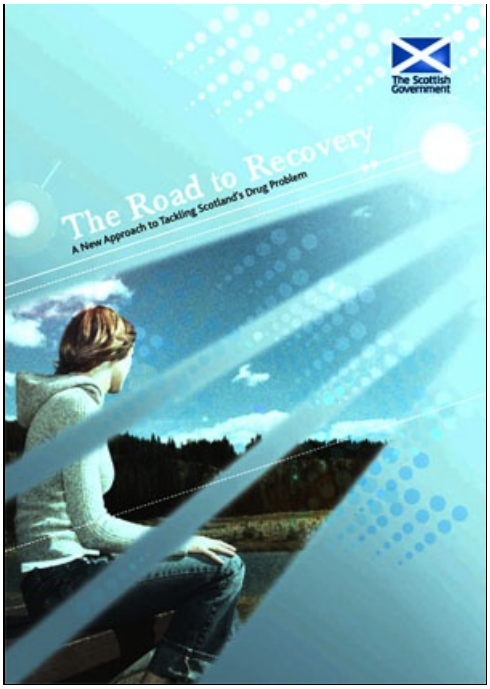
We have constructed two starting places in the form of Effectiveness Bank hot topics. One (listed above) asks "What is addiction treatment for?", while the second (listed above) homes in on a currently favoured answer – 'recovery'. Here we give you a taste what you will find in those documents.

The governments of the UK agree that above all what they want out of treatment is 'recovery'. What they mean by that is not spelt out, but the broad themes are clear: some of the most marginal, damaged and unconventional of people are to become variously abstinent from illegal drugs and/or free of dependence and (as Scotland's strategy put it) "active and contributing member[s] of society", echoing governmental ambitions in England dating back to the mid-2000s for more drug users to leave treatment, come off benefits, and get back to work, becoming an economic asset rather than a drain.

In this they echo in modern terms a longstanding feature of addiction treatment – that it is about restoring citizens to a normal and productive life, not just overcoming dependence – evident when in 1933 US President Roosevelt proclaimed, "In this institution the victims of the opium habit will be restored to usefulness", and in 1926 when in England the Rolleston committee legitimated the continuing supply of opiates to patients who

could lead a “fairly normal and useful life” with the drugs, but not without them.

Do experts and the people on the ground see it the same way? Not all; for some harm reduction is the primary aim and recovery as normally defined nice if you can get it, but not to be subjugated to keeping people alive. The definition of recovery has itself been so contested – and so crucial – that special commissions have been set up to try to reach a consensus. In 2008 the non-governmental UK Drug Policy Commission brought 16 experts together to thrash it out. They couldn’t agree what *being* recovered was, but did agree that *getting* recovered is “characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.” Their brief report expanded on each element of the definition, explaining that that by “control” they meant “comfortable and sustained freedom from compulsion to use” – the traditional treatment goal of sustainably ending addictive patterns of substance use. But that was, they said, not enough; recovery is not just about ending pathology, but about gaining “positive benefits … a satisfying and meaningful life”.



Inspirational vision of recovery depicted on 2008 Scottish drug strategy cover

Note what was *not* in their definition. Abstinence was missing – perhaps justifiably given its loose relationship with quality of life and other dimensions of recovery – and so too was leaving treatment, a rejection of what for government dating back to 2005 was the starting point of their emphasis on social reintegration which morphed in to recovery – the need to move patients through and out of the treatment system to free up slots in what was clearly going to be a less resource-rich era. Another government ambition was to get ex-patients back to work, and that the commission’s 16 accepted, but in a softer formulation which allowed for other routes to a meaningful and productive life. This then is the agenda for the UK’s recovery era – or at least, the most worked-out version we have. Unfold 👁 supplementary text for more on a major US influence on the UK’s vision of recovery and what in England some drug and alcohol users think this vision means in practice.

Having gone to the end in the form of a currently dominant vision of where treatment should get to, in the last section of this commentary readers can reverse to the beginning – how addiction is generated, which in turn has implications for how and whether it is treated, and whether there is an ‘it’ in the first place.

Highlighted study Burned into the memory of the UK drugs field in the mid-90s is the National Treatment Outcome Research Study, better known by its acronym NTORS (pronounced ‘entors’). It was succeeded – but not superseded – in England by DTORS and in Scotland by DORIS, and remains the most important treatment study ever conducted in the UK. It also exemplifies two lessons for this ‘bite’: that research may be motivated by the desire to support or challenge certain values; and that how the resulting research is conducted and presented may be tilted by (perhaps a different set of) values and motivations. There is no motive-less research, and the motives intrude into the ‘facts’ – how they are generated and presented.

The study was spawned by a task force set up in 1994 by Dr Brian Mawhinney, a UK health minister who saw his mission as infusing biblical values into public life. Mawhinney’s views were in the frame when the task force’s chair Reverend John Polkinghorne said his review was partly driven by concern that “treatment might often be insufficiently oriented towards the attainment of abstinence. More specifically … there were those who questioned the acceptability and legitimacy of methadone maintenance programmes, which seemed to some simply to replace an illegal drug with a similar drug legally prescribed” – sentiments strikingly similar to those expressed by the current UK government.


Dr Brian Mawhinney: Conservative health minister in the early 1990s who set up an inquiry into addiction treatment

Suspicious of ‘expert’ opinion, Mawhinney had condemned the “‘drug industry’ who resist any threat to their present autonomy.” Ironically, his review commissioned its key research project from the heart of that industry, the National Addiction Centre, whose allied health services provided the treatments he questioned. The dubious, headline-grabbing ‘£3 in social benefits for £1 spent in treatment’ extrapolation from that study is critiqued in cell E2. For the moment we record that while acknowledging room for improvement, NTORS vindicated all the treatment modalities it studied (inpatient, residential and methadone), described by the researchers as a “powerful national asset”. Yet with no control group of non-treated problem drug users, the improvements it documented could not (but effectively were) wholly be attributed to the treatment episodes on which the study focused. That was the major and largely unavoidable limitation of the study, but there were others (highlighted in an extract from an Effectiveness Bank presentation) which resulted from choices made by the

researchers. Some of those choices make sense as protective tactics; highly political, the genesis of the study lie in an attack on the drug treatment sector, but the study itself can be understood as that sector fighting back.

In 2015 the lead researcher on the project summed up its significance as promoting the slogan 'Treatment works', helping persuade government to 'invest' in treatment services to gain the crime reductions and cost-savings NTORS seemed to establish. Though in scientific terms built on sand, its influence remains. Without its dubious manipulations of the economic findings, the sidelining of the fundamental limitation of no control group, and its camouflaging of the performance of inpatient detoxification units, instead of expanding, treatment might have withered. On balance, a good thing, or unacceptable agenda-promotion when science should have prevailed?

Issues to consider and discuss

▸ **A new life – or just the ending of drug dependence?** With (above) the prevailing 'recovery' objective defined, let's work backwards to what that means for treatment. Some argue that addressing non-substance use elements of recovery like wellbeing and reintegration are not the business of *addiction* treatment, but of other welfare, employment and health services. The UK group which defined recovery did not let treatment off so lightly. Their definition was, they said, about "the goals of treatment and rehabilitation … that could be applied to all individuals tackling problems with substance misuse, and all services helping them."

Take that seriously, and it means treatment services will need to equip their patients with integrated access to vocational experts, family re-unification inputs, artistic and creative opportunities, and whatever else is needed for their patients to transition towards a meaningful and productive life. Pause and shift ground from illegal drugs to tobacco or alcohol. Would we say someone who has sustainably stopped smoking or drinking, but hasn't found a job, is still on benefits, maybe even offending, and who remains at a loss for meaning in life, has failed to recover from their addiction?

But perhaps there are good reasons why these broader issues intrude for socially unacceptable addictions like heroin and cocaine, in a way they don't for drinking and smoking. By the time you have narrowed down to the minority who try these drugs, the very few who become regular users, the fewer still who become clinically dependent, and finally the subset who want to stop but feel they can't without treatment, then you have sifted down to a highly atypical and usually multiply disadvantaged and/or troubled population who find it very difficult to sustainably overcome their dependence. These are the serially-relapsing caseload of drug addiction treatment services, whose drug use is entangled with social, economic and psychological features which unless addressed repeatedly precipitate them back into dependent substance use.

They might need the holistic support implied by prevailing visions of 'recovery', but not because that need is integral to dependence, or to recovery from dependence. When a wider cross-section of young men is liberally sprinkled with heroin in an environment devoid of other diversions and normal ties, the more deviant and drug-experienced among them may use regularly, but on return to their normal environments, all but a few will remit and stay that way without ever having received any substantive support. These were the totally unexpected observations (report listed above) of Lee Robins and colleagues, commissioned by the US government to investigate the looming avalanche of ex-military heroin addicts created by the Vietnam war. That avalanche never materialised, and the returnees barely troubled US treatment services. However, the few who did resort to treatment exhibited the classic pattern of multiple problems and post-treatment relapse.

The soldiers who became addicted in Vietnam and who re-used on return tended to have pre-service risk factors: "People who use heroin are highly disposed to have serious social problems even before they touch heroin." Reflecting on the implications for treatment, Robins argued that "drug users who appear for treatment have special problems that will *not* be solved by just getting them off drugs". From the 1970s then comes this strong argument for what today we might call a recovery orientation in services treating dependence on drugs like (in terms of their social as well as pharmacological properties) heroin.

Now you may be in a better position to ask yourself: Should we accept repeated and widespread post-treatment relapse as a sign of the intractability of addiction, or is it a sign of the inadequacy and mistargeting of treatment – the failure to address the "serious social problems" Robins referred to? If treatment takes on the recovery challenge, how many fewer patients will we be able to afford to treat, and will that be counterbalanced by greater success in closing the revolving door of treatment re-entry due to relapse? Is it simply beyond the reach of any feasible treatment service, even with partner services, to create environmental changes of the magnitude which led to rapid, widespread and lasting remission from dependence among Vietnam returnees? Must we set our sights well below 'recovery', and ameliorate while we seek usually only slightly to accelerate the normal processes of remission (1 2 3) – or could that prove a self-fulfilling lack of ambition?

▸ **What do the patients want?** Deference to the patient's wishes and choices is required content in any health publication which claims to embody patient-centred practice. That makes those wishes contested territory – a 'hot topic'. Advocates for certain treatment goals can greatly bolster their case by appealing for validation to the ultimate authority – the patient. In turn, that can make research on patient perspectives contested territory.

Our prime example comes from Scotland, where researchers from the DORIS national treatment evaluation study (listed above) differed over the implications of their findings. It started with the "surprising" finding that 57% of Scottish drug treatment clients selected abstinence as their sole goal for changing their drug use, said to be the first time any large-scale British research project had asked this fundamental question.

For the lead author the answers were a sign that we have failed to match patients' aspirations to become abstinent and instead prioritised harm reduction. Without the multiple reservations in the scientific paper which reported these findings, he told the readers of a drugs field magazine that "The drug users in the Scottish research have spoken with admirable clarity." The appeal to the authority of what they said followed: "what would our drug treatment services look like if the voice of the drug user was given much greater prominence? … You know you are in an odd place when your addicts are telling you they want fewer drugs and their doctors are telling them they need additional drugs" – the 'drugs' in question being methadone.

Armed with more in-depth findings from England, later a former DORIS colleague argued (listed above) that it was not at all clear what patients meant when they ticked "abstinence/drug free" in response to the question, "What changes in your drug use do you hope to achieve by coming to this agency?" Free from all drugs, or just the one(s) causing them problems? Free now, or in the future? An aspiration rather than a realistic goal? It might also be asked whether the finding really was "surprising"; 44% of the patients were starting drug-free and/or explicitly abstinence-based treatments and the same proportion were in prison. Rather than a surprising mismatch, the paper can as easily be read as showing patients' objectives match those of the treatment they are entering and the constraints of the setting.

The clear/unclear aspirations of the patients were contrasted with another seemingly clear but actually muddy finding that in the DORIS study, after 33 months just 3% of Scottish methadone patients emerged from treatment drug-free. This small proportion was headlined as proving methadone fails Scottish patients (1 2 ▸ panel) and used by politicians to justify what the media described as a "Cold turkey plan for Scots addicts." Their case was sharpened by the further contrast with what was reported (1 2) to be a corresponding figure of 25% in England, a comparison the media had been led to make by the researchers.

Methadone fails 97% of drug addicts

A KEY government drugs policy has been exposed as a shocking failure after it emerged that giving methadone to heroin addicts has a 97% failure rate. In a damning indictment of the Scottish Executive's 'softly softly' approach to managing the heroin problem, research found that three years after receiving methadone only 3% of addicts remained totally drug-free.

The Scotsman, 29 October 2006

It looked almost as bad as it could be: patients overwhelmingly seeking but being denied abstinence while in England proportionately eight times as many left methadone free of drugs. DORIS's lead researcher reportedly called for "an end to the 20-year-old policy of harm reduction, which sees services hand out methadone and needles to addicts in the hope of stabilising their lives and preventing infection". Scotland's governing Labour politicians responded, promising a tougher policy.

All this was sloppy at best, deliberately misleading at worst. DORIS's '3%' figure for drug-free exits from methadone was based on patients who had entered methadone programmes only *after* leaving their first treatment during the study period. The 'corresponding' 25% figure for England instead (and more conventionally) related to methadone as the *initial* treatment, invalidating the comparison.

Among other discrepancies were that the definition of abstinence in Scotland, but not in England, excluded patients on methadone. In scientific print DORIS researchers had adjusted for this, raising their estimate for abstinent (ex)methadone patients in Scotland to 11%, a fact ignored by news reports, in some cases apparently informed by DORIS's lead researcher.

For the DORIS team, adjusting for methadone evened the playing field, but in fact the field remained tilted – because the Scottish study was about methadone as a follow-on treatment, because its participants had a year longer to overcome their problems, and because the English data ignored cannabis use, which in Scotland would have disqualified the patient from being considered abstinent. Given that this is the most pervasive of the illegal drugs, it would have made an appreciable difference, bringing the Scottish and English figures closer. Had the playing field actually been even, all these adjustments would probably have brought the Scottish figure up to near 20%, within a few % of the English one. Scottish apples were being compared with English pears, and then with the supposedly clear aspirations of Scottish patients, which in reality were not clear at all.

> *All this was sloppy at best, deliberately misleading at worst*

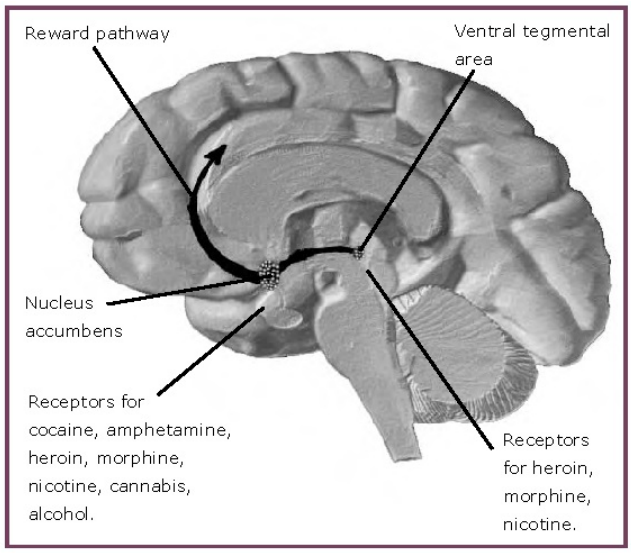
Was this a case of science being bent to agendas? And even if it was, did it highlight a valid point about insufficient attention to patient wishes and abstinence-based recovery in Scottish services? Misleading interpretations of the DORIS findings should not obscure the fact that stopping use of some drugs (especially use so problematic that it has driven them to seek help) is often a primary treatment goal, and that for substitute prescribing patients, it often extends to being free of legal substitutes too. For people who want to but have had trouble containing their substance use – the caseload of treatment services – keeping way from drugs and alcohol altogether often seems the most feasible route to recovery. Via detoxification, they may want to get there quickly, rejecting or terminating prescribed substitutes.

Should that be encouraged, or is it the clinician's role to point out the risks and perhaps counsel a more

gradual process? Interviews with patients in England highlighted this dilemma: “some individuals, especially those without extensive treatment histories, ‘willingly’ subject themselves to very rapid drug detoxification. This phenomenon appears to have emerged in recent years alongside the recovery agenda and seems to increase the propensity for cross addiction and relapse.” When abstinent treatment exit is seen as indicative of success, staff who caution against attempting this must be ready to be castigated for perpetuating addiction and spraying icy water over their patients’ ambitions, but unless they do, on balance more relapsed, infected, imprisoned and fatally overdosed former patients are likely to be the result (1 2). On the other hand, some individuals will succeed at making abstinence stick, and clinical caution may counterproductively delay or divert them from their preferred route to recovery. Where do you stand on this issue? If you work in a relevant service, has it been discussed?

▸ **Does it matter what addiction is?** After in the *Where should I start?* section gone to the end in the form what treatment should be aiming to achieve, we now reverse to the beginning – to addiction itself and how it is understood. From the reams written on this issue we have been highly selective; this book offers a fuller picture.

Expanded on in this hot topic, we focus on the prominent ‘chronic, relapsing disease of the brain’ model of addiction, which it has been argued, “would have never taken hold had it not converged with recovery discourse and become effective at organizing meanings in the popular realm”. In other words, it fit with the recovery agenda, and to the public and their information sources ‘made sense’ of otherwise contradictory phenomena – like how someone could keep doing something they know is bad for them and want to stop doing.



The brain reward pathway seen as common to addictions

If addiction treatment is about normalising deviation from social and cultural norms, the brain disease model renders this deviation physical – it can even be ‘seen’ in neuro-imaging scans of the brain. This at first unlikely alliance between the brain-disease model and re-normalisation formulated as ‘recovery’ lies at the core of the “addiction science” understandings offered their public by the US National Institute on Drug Abuse. For this institution, treatment so often fails, not because it has a false understanding of its target, or because it offers insufficient support, but because “Brain changes that occur over time with drug use challenge an addicted person’s self-control and interfere with their ability to resist intense urges to take drugs. This is why drug addiction is also a relapsing disease.”

A ‘critical neuroscience’ author has argued (free source at time of writing) that the supposed natural state of brain functioning from which regular drug use generates a deviation is a chimera: there is no “first nature entirely free of human values and interests”. But the implicit acceptance that there is, and that mental illness and addiction are aberrations, has real effects. A focus on the brain and on chemicals – or even surgery and electrical implants – thought to correct faulty brains lends itself to a failure to make the most of other contributors to effective treatment, including environmental conditions, self-management by patients, the treatment setting, and relationships with staff.

‘Critical neuroscience’ examinations (1 2) of the brain-disease model go further, suggesting that the dominant conceptualisation of addiction actually shapes the nature of the condition, partly by inspiring and legitimating certain responses and de-legitimising or excluding others. These social responses affect the people (self-)diagnosed as having the condition, and therefore how the condition itself is presented, potentially including how it looks in brain scans.

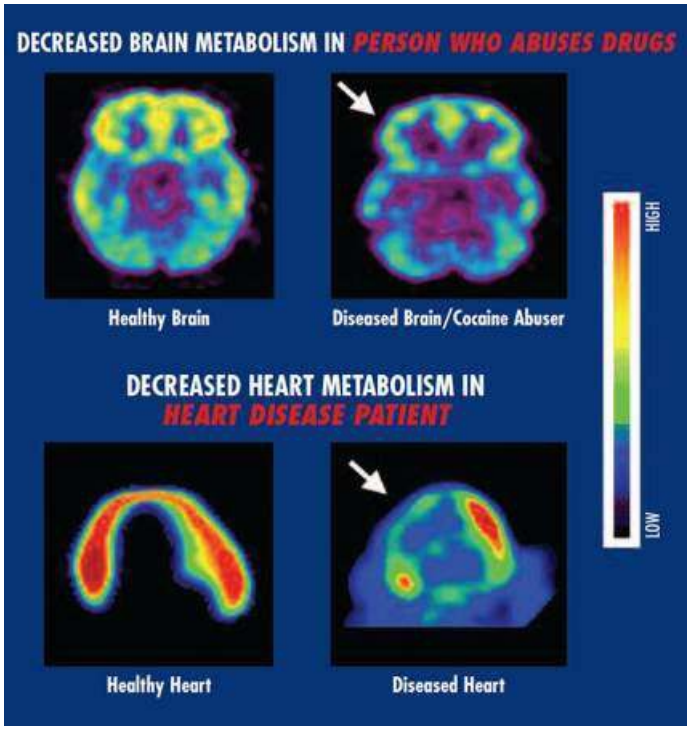
But even in the USA, this influence is not strong or pervasive enough to disrupt an underlying pattern in remission from dependence which belies the expectation that drugtaking progressively alters neural functioning in ways which lock the user into addiction. Outside of treatment services, ‘cold turkey’ attempts to end frequent substance use are very common and very commonly succeed. If addiction is a brain disease, given strong enough reasons/incentives, it is one its sufferers usually choose not to have.

Based on population-wide surveys, these studies primarily reflect the usual pattern of remission without treatment. Treatment caseloads are very different, and it is here that relapse is so common that the ‘chronic relapsing brain disease’ model partly fits the facts – not because the brain is stuck, but because so much else is stuck (1 2 3) in the patients’ lives which generates uncontrolled and continued substance use.

Treatment services are in turn not passive recipients of set-in-stone addictions, but shape the understanding of their patients and therefore how those patients present their addiction. One study has shown that authoritative depictions of addiction as primarily a chronic disease can undermine the degree to which drinkers feel they and other substance users can control their use. If this can happen in a short-term study,

how much more profound might the changes be in treatment: “[I]t would be likely that the more frequent and influential exposure that occurs in treatment settings would have a much more pronounced influence on addiction beliefs,” commented the researchers.

One aim of brain-disease model advocates was to challenge conceptions of addiction as a failure of the will or of morals, destigmatising addicts into the category of victims (of disease) rather than perpetrators (of a moral failing). By and large it has not worked, and along the way has justified punitive measures and enforcement-based policies to stop potential addicts risking this disease by starting to use. The study referred to above which found that depictions of this model undermine confidence that drinkers can control their use also found no compensatory diminution in the stigma and shame attached to addiction.



‘Diseased Brain’ brain scan from the US National Institute on Drug Abuse web site. Caption: “Addiction is a lot like other diseases, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, and are preventable and treatable, but if left untreated, can last a lifetime.”

But the intentions were good, and so too might be some of the effects. As with mentally ill patients, purported sufferers of this disease may seize on the brain-disease model and its representation in brain images as a kind of vindication, proving that something is wrong with them, rather than that they are morally wrong as a person. Addiction treatment advocates also seize on the model as a “useful way for particular agencies to convince Congress to raise the budgets [and] it has been very successful … a Faustian bargain – the price that one pays is that you don’t see all the other factors that interact [in addiction]” – a quote from the eminent US addiction psychiatrist Jerome Jaffe.

Is this support for treatment and vindication for patients bought at the price of solidifying their self-image as an addict and undermining their confidence that they can change, or is it a confidence-generator – at last they can see that something is there which can be fixed?

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