



Commentary

The problem of over-medicalisation: How AOD disease models perpetuate inequity for young people with multiple disadvantage



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ABSTRACT

Young people who experience multiple disadvantage have been identified as some of the most marginalised and under-serviced people in the alcohol and other drug (AOD) system. In this paper, we draw on a range of research evidence to argue that one of the challenges in responding appropriately to the needs of these young people are models of care which seek to ameliorate 'illness' rather than promote wellness. While disease approaches have some important benefits, overly-medicalised AOD treatment responses also have negative impacts. We argue that disease models rest on understandings of substance use as an individual enterprise and thereby pay insufficient attention to the material disadvantage that shape young people's substance use, creating feelings of shame, failure and a reluctance to return to care if they continue to use. Additionally we draw on literature that shows how disease models construe young people's substance use as compulsive, perpetuating deficit views of them as irrational and failing to account for the specific meanings that young people themselves give to their substance use. By focusing on clinical solutions rather than material and relational ones, medicalised treatment responses perpetuate inequity: they benefit young people whose resources and normative values align with the treatments offered by disease models, but are much less helpful to those who are under-resourced. We suggest that alternative approaches can be found in First Nations models of care and youth programs that attend to social, cultural, and material wellbeing, making *living well* the focus of treatment rather than illness amelioration.

Introduction

It is thought that young people with multiple disadvantage are some of the most poorly serviced clients in alcohol and other drug (AOD) treatment settings (Bruun & Hynan, 2006) and there is surprisingly little research internationally about how AOD services support and respond to this group (Fomiatti, Farrugia, Fraser, & Hocking, 2021). As the existing scholarly literature describes, young people who experience multiple disadvantage have complex needs in relation to mental health, disability, poverty, criminal justice, geographic disadvantage, and cultural exclusion, among others (Sandu, 2021). Substance use is often implicated in this disadvantage, both as cause and consequence (Hart, 2018; MacLean, Bruun, & Mallett, 2013), although there are few studies that focus specifically on *how* disadvantage operates for young people in AOD treatment (Fomiatti et al., 2021). Young people with multiple disadvan-

tage are often poorly serviced in other institutional settings, including education and housing services (Skattebol, 2017), and so AOD treatment can become yet another fragmented experience in their efforts to improve their opportunities and living conditions. This is especially true in Australia, the setting from which this paper derives, where people aged under 30 years comprise over 40% of those entering AOD treatment settings (AIHW, 2018) and where it is widely accepted that there are too few treatment places to support young people and adults who need AOD care (Bryant et al., 2021, 2022; Lubman et al., 2014).

In this commentary, we argue that one of the problems in responding effectively to young people with multiple disadvantage is the emphasis given to medicalised approaches to substance use treatment which can draw attention away from more holistic approaches that can better address their material needs and the specific social relations that characterise their lives. We describe how many AOD service providers actively

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try to work around disease models, but that biomedical priorities are privileged in policy and funding responses. We suggest that overly medicalised AOD care can work to perpetuate disadvantaged young people's inequity in treatment access and outcomes. In what follows, we outline the implications of over-medicalisation, including the stigmatisation that the disease model brings and the related impacts on engagement with the AOD system and allied sectors. We cite evidence that is largely based on adult populations, highlighting the need for much more research on young people's experiences in the AOD system. We conclude by describing several existing models of care that take fuller account of social, cultural, and material wellbeing as the foundation for treatment, including First Nations models of AOD intervention, and existing models in the youth AOD sector.

AOD treatment in Australia

AOD treatment in Australia is offered through specialist health services that include medication assisted treatment, rehabilitation services, detoxification services, self-help groups and a range of therapeutic counselling services (Australian Government Department of Health, 2019). These services use therapeutic clinical interventions comprising various forms of psychological therapies (cognitive behavioural therapy, individual counselling, and other therapies aimed at building cognitive and practical coping skills) and pharmacological technologies (opioid substitution treatments or medicated withdrawal), and many seek to offer additional social support and coordination for clients (Australian Institute of Health and Welfare, 2021). For example, some services are co-located with other health, welfare and justice support services, seeking to offer a cohesive response for those who need it; and some programs exist to increase continuity across treatment modalities, for example through case management and other coordinated care approaches (Australian Government Department of Health, 2019). Young people can access adult services if they are 18 years or older, and there are also specialist, tailored AOD services for young people (starting from age 12 years) including youth-specific residential withdrawal and rehabilitation centres, outreach and support services, and assisted accommodation (Department of Health and Human Services, 2020; Meumann, Allan, & Snowdon, 2018). Youth services, in particular, make concerted efforts to provide wrap around responses and coordinate care for their clients (Bruun & Hynan, 2006).

With its primary focus on clinical therapeutic intervention, the Australian approach to AOD care reflects a dominant view about substance use and how it is thought to be best addressed: as a problem or dysfunction of the individual that can be diagnosed and fixed through clinical interventions (Fomiatti, Moore, & Fraser, 2019; Pienaar et al., 2017). 'Addiction' is understood as a primary disease (Barnett, Hall, Fry, Dilkes-Frayne, & Carter, 2018; Thombs, 2013) that, as with other diseases, follows an intervenable trajectory that can be diagnosed and treated in isolation from other problems (MacLean et al., 2021; Moore & Fraser, 2013). Research has identified how this approach results from policy and administrative practices that privilege biomedical knowledge, and create conditions where service providers must continually balance their desire for person-centred approaches that meet the range of needs of clients (Marchand, Beaumont, & Westfall, 2018) with the epistemological, financial and practical demands of a service system underpinned by the logics of the disease model (Hart, 2018; Moore & Fraser, 2013). Indeed, many service providers recognise the limits of disease models and want alternative approaches (Fraser & Ekendahl, 2018; Hart, 2018).

In Australia, AOD services are largely administered and funded through an 'episode-of-care' system (van de Ven, Ritter, Berends, Chalmers, & Lancaster, 2020). A treatment episode is thought of as any completed course of care, which can vary markedly between a few counselling sessions and several months of residential care (Chalmers, Ritter, & Berends, 2016). The system can permit a broad understanding of treatment outcomes, and service providers can arrange long-term support

for clients, however this requires that they open multiple care episodes (van de Ven et al., 2020), in effect 'gaming' the system so to provide a less-fragmented form of care (Moore & Fraser, 2013). This system is symptomatic of increasingly managerialist approaches, which at the core reflect biomedical logics that problem substance use is acute and amenable to intervention (Keane, 2021), and which can work against the intentions of service providers to support clients in broader health, welfare and justice needs (Fraser & Ekendahl, 2018; Hart, 2018).

Of course, biomedical approaches to AOD treatment have a range of positive impacts. Outcome studies show that specialist AOD treatments work for many people to reduce substance use and improve mental and physical health outcomes (Lubman et al., 2014; Manning et al., 2017; Teesson et al., 2006). Disease approaches can also be useful in accommodating treatment of co-occurring issues, such as when mental illness and substance use are experienced together (Roberts & Maybery, 2014). In addition, the dominance of disease frameworks has helped to shift focus away from *moral models* (Barnett et al., 2018) of addiction by re-framing substance users as 'sick' rather than morally inferior (Foster & Spencer, 2011). This conceptual shift towards addiction as illness has helped to reduce the stigma associated with moral inferiority and increased treatment seeking by defining problematic substance use as a legitimate disease requiring medical intervention (O'Brien & Dackis, 2005; Volkow & Koob, 2015). It has also permitted the development of diversion programs that send adolescents and adults into the health care system, rather than the criminal justice system (Gray, Green, Bryant, Rance, & MacLean, 2017; Seear & Fraser, 2014).

However, as research with adults shows, there remains substantial inequity in the treatment system, both in access and outcomes (Laudet, Stanick, & Sands, 2009; Pratt, Pernat, & Kerandi, 2019; Saloner & Cook, 2013; Spooner, 2009; Stahler, Mennis, & DuCette, 2016; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2016). For young people, the barriers to access include lack of knowledge of services, geographic isolation, language barriers, poverty, social exclusion and others (DoH, 2017; Douglass, Block, Horyniak, Hellard, & Lim, 2021; Hallam et al., 2018; Myers, 2013). This inequality is further amplified as multiple engagements with treatment are often required (Manning et al., 2017). Like adults, young people need to repeatedly negotiate complex treatment systems. As we argue next, inequity in access and the need for multiple engagements is due, in part, to the system's reliance on disease models. We suggest that these models draw attention away from young people's material needs, the specific social relations that characterise their lives, and creates a new kind of stigma for them to navigate.

Biomedical approaches draw attention away from unequal material conditions

One of the shortcomings of disease models has been their focus on fixing the physiological and psychological 'problems' of the individual, to the neglect of social and material conditions (Duff, 2017; Gowan, Whetstone, & Andic, 2012; Moore & Fraser, 2006). This focus on individual solutions persists, despite the extensive body of research showing the contribution of material environments and social relations to trajectories of problematic substance use: homelessness, engagement with the criminal justice system, and poverty work to create inequity in treatment access (Sutherland & Shepherd, 2001; Galea & Vlahov, 2002; Galea, Nandi, & Vlahov, 2004). For example, for young people with multiple disadvantage, long-term treatment outcomes are considerably affected by the conditions of their lives upon exiting treatment (MacDonald & Marsh, 2002; MacLean, Hengsen, & Stephens, 2017). While intensive residential treatments place them in highly structured settings, when they return to lives where friends and family members use substances, and where meaningful education or employment opportunities are few, decisions *not* to use alcohol and other drugs can be very hard to maintain (MacDonald & Marsh, 2002; MacLean et al., 2017). Similarly, inequities in treatment access are well-documented in adult populations, whereby people with fewer material and social resources have a

much harder time finding and securing treatment places (Begun, Early, & Hodge, 2016; Manuel et al., 2017; Treloar & Holt, 2008). In contrast, people who have families to support them, and a home to stay while on waiting lists, have more choice and can manage their treatment access more easily (Bryant et al., 2021).

Thus, problematic relationships to AOD are not only located in individuals, as imagined in biomedical logics, but rather for some young people emerge from the material environments of disadvantage in which they live. Indeed, Keane (2021) and Fraser (2017) have criticised addiction science narratives that promise ‘breakthroughs’ and set up AOD treatments as ‘uncomplicated solutions to the problems of living’ (Keane, 2021: 2) when it is widely understood that such treatments are poor at accounting for some of the key drivers of problematic substance use, such as inequality and criminalisation. In this way, medicalised approaches treat individuals’ bodies and minds without also attempting to address the social and material under-resourcing in their lives. By focusing on physiological and psychological solutions in system design and accountability metrics, rather than material and relational ones, such treatment approaches *perpetuate inequity*: they benefit people whose material resources and normative values align with the treatments offered by disease models, but are much less helpful to those whose resources and values do not align, such as young people with multiple disadvantage.

Biomedical approaches draw attention away from the unique meanings given to substance use

Relatedly, the meanings young people give to their substance use matter significantly in terms of how they relate to and take up treatment. There is a small but consistent body of research that identifies that the unique identities and values held by young people are often ontologically at odds with biomedical appeals to substance use as disordered and compulsive (Boys, Marsden, & Strang, 2001; MacLean et al., 2013; Järvinen & Ravn, 2014; Bryant, 2018). Young people often report that their substance use is purposeful (Järvinen & Ravn, 2014), aimed at managing their social obligations and achieving certain experiences: to relax, have fun or stay awake; to manage work or study (Boys et al., 2001); to relieve negative emotions (Boys & Marsden, 2003; Kvamme, Pedersen, Alagem-Iversen, & Thylstrup, 2021; MacLean et al., 2013); to feel socially connected with friends (MacLean, 2016); and to achieve a sense of excitement, wellbeing, calm or autonomy (Maycock & Howat, 2005). This research suggests that, for young people, substance use may have a specific role in managing life, or making it better; an understanding that is incompatible with disease model logics that position it as compulsive behaviour. This may be especially true for the substantial proportion of young people who enter AOD care on orders from the criminal justice system (Hallam et al., 2018), who have not sought treatment and may not see a need to change their patterns of use. If young people do not see their substance use as disordered and it serves a valued purpose, there will likely be a disconnect with AOD treatment services that make fixing disordered behaviour the basis for their intervention. As Keane (2021) identifies, disease models make care conditional on ‘moralised norms of health and abstinence’ (pg 4). For young people who use substances, and who want to be seen as in control of their treatment experiences and goals (Bryant, 2018; MacLean et al., 2013), these norms are often at odds with the values they give to their own substance use.

Biomedical approaches create a new kind of stigma

There is substantial existing scholarship about how biomedical approaches to substance use create and perpetuate stigma for people who use AOD services (Fraser, Moore, & Keane, 2014; Treloar & Holt, 2009; Pienaar et al., 2017; Gowan et al., 2012; Sear & Fraser, 2014). Stigma impacts the way that people who use drugs understand themselves, how other people understand them, and how they interact with the AOD

treatment system. While disease models have reframed people who use substances as ‘sick’ rather than ‘immoral’ and ameliorated some forms of stigma, this reframing brings a new set of meanings of substance use as ‘a disorder of compulsion’ (Pienaar et al., 2017; Gowan et al., 2012). In this reframing, those with substance use issues are seen as people who lack moral and physical agency to control their consumption (Karasaki, Fraser, Moore, & Dietze, 2013; Pienaar et al., 2017). This framing brings particularly negative connotations in Western settings, given the cultural importance ascribed to self-management and self-control (Beck-Gernsheim, 1996; Gowan et al., 2012). It also contrasts with marginalised young people’s view of themselves, given the research showing that they tend to place value on their autonomy and on maintaining rational, self-managing and ‘grown up’ identities (Barker, 2013; Bryant, 2018). Indeed, for young people with multiple disadvantage, the imperative to be seen as ‘in control’ is high because they are already viewed as risky, ill-informed, and lacking capacity to properly resource themselves (Foster & Spencer, 2011).

Biomedical approaches can reduce engagement with AOD system

Deficit meanings ascribed to people who use substances through disease models have real and negative consequences for how people engage with the AOD system, something that is carefully documented in the research literature (Fraser, Moore, Farrugia, Edwards, & Madden, 2020; Treloar & Holt, 2009; Biancarelli et al., 2019). Attributions of individual deficit underpin the stigma that is commonly experienced by clients in AOD settings (Broady, Brener, Cama, Hopwood, & Treloar, 2020) Fraser et al. (2020). describe how stigmatising experiences happen through repeated incidents of “feeling ignored and shamed” (p. 1801) during efforts to access treatment, subtle signs of disapproval from staff, and through omission of welcome and encouragement. Clients develop strategies to avoid these negative experiences, including delaying seeking treatment, under-reporting their drug consumption and seeking care elsewhere (Fraser et al., 2020; Biancarelli et al., 2019). In addition, and with perhaps more deep-seated consequences, deficit representations become part of how people who use substances understand themselves and their place in the world: as *undeserving* of treatment and care (Bryant, Brener, Pepolim, & Harrod, 2019; Treloar & Holt, 2009). This can be seen in the reluctance that some clients report when returning to treatment if they ‘relapse’ (Bryant et al., 2022; MacLean, Bruun, & Mallett, 2013). When treatment trajectories are conceptualised as individually-authored, and people are primarily seen to be responsible for their treatment outcomes, they can experience shame and a sense of failure when they use substances again. This reluctance decreases treatment access (Fraser et al., 2020; Biancarelli et al., 2019) and further entrenches their marginalisation.

Models that focus on living well

Biomedical approaches have clear value in that they help many people achieve goals related to substance use and other areas of their lives, at least in the short term (Manning et al., 2017). However, as we have described above, experiences of substance use are influenced by social conditions, the values given to substance use in people’s lives, and the deficit meanings attached to it. A treatment system that accounts for the unique conditions that frame the lives of young people with multiple disadvantages has enormous potential for improving treatment outcomes for these young people and reducing inequity.

Social science research already gives insight into what these material and social needs are for marginalised young people. Meeting basic *material and care needs* is essential - safe accommodation, regular meals, connection to appropriate skilled mental health and other support services (Hallam et al., 2018). Stable circumstances, together with feeling relatively safe and healthy, are needed before being able to fully engage with physiological or psychological interventions: these are integral resources for living well. Yet high-quality care must also support

young people to flourish, through service practices that build social, emotional and cultural capacities and support young people to secure decent living conditions and other resources taken for granted by more resourced young people. For example, *safe relationships* are known to be essential for young people to manage their daily lives. These entail relationships with family and loved ones that nurture and sustain (Barker, 2012; Barker & Thomson, 2015; Green, Mitchell, & Bruun, 2013); relationships with staff that are trusting and reliable and that can help to foster connection with other mentoring adults (Bryant, 2018; Neale & Brown, 2016; Neale & Stevenson, 2015); and relationships with peer groups that are emotionally supportive and in which reduced levels of substance use is accommodated (Green et al., 2013; MacLean et al., 2013). Equally important are '*cultural*' capitals or opportunities to build a positive sense of self and future: for example, service contexts where there is access to identities of worthiness, and that foster resilience and resourcefulness (Bryant & Ellard, 2015; MacLean et al., 2013); services that prioritise educational and training opportunities and encourage meaningful social participation (Demant, 2014); and service contexts with opportunities to build on and learn impactful life skills, including the literacies needed to navigate service systems, and educational and work environments (Laudet & White, 2010).

Models of care that focus on building the capacities of young people, as described above, have goals that extend far beyond reducing substance use and instead focus on *living well*. They seek to foster the material environments and social resources needed by young people to respond to the challenges of their daily conditions, and in doing so, address the underlying reasons for substance use among young people with multiple disadvantage. Moreover, a focus on *living well* can accommodate the range of motivations that young people bring to an AOD treatment service. This might include reducing their substance use through the skills accrued through clinical treatments, but can also include broader motivations to improve the conditions of their lives, secure safe housing, reduce their involvement with the criminal justice system, establish supportive and safe personal relationships, and build future opportunities. Services with an orientation towards wellness, rather than the amelioration of illness, make possible a range of meaningful health and social improvements, and hence can attend to the needs of the individuals and groups that seek care, whatever their social and material conditions.

Some models of AOD care already take these holistic, wellness-based, capacity-building approaches. For example, First Nations models of care understand substance use as symptomatic of colonisation, loss of connection to culture and land, and an imbalance in social, emotional and cultural well-being (Bryant et al., 2021; Chenhall & Senior, 2013; Graham et al., 2021). These programs place emphasis not only on time spent in treatment, but also on the cultural knowledge and identities built during the process, with the view that these capacities promote well-being in the longer term (Munro, Allan, Shakeshaft, & Breen, 2017). They build on the strengths of First Nations cultures and communities and provide flexible approaches to treatment. *Recovery-oriented systems of care* also contend that substance use does not happen in isolation and acknowledges the assets in people's lives that effect changes in substance use, including access to community support groups, peers and family support (Best & Coleman, 2020; Best & Lubman, 2012). Some youth-specific AOD treatment services have similar goals whereby, along with therapeutic approaches, young people are supported with material resources (e.g. accommodation) and reconnected to employment, training, education, family and community (Hallam et al., 2018) as a way to live well and manage substance use over the longer term. In these wellness-oriented approaches, *safe relationships* with AOD service staff are foundational: these workers are often the most trusted adults in young people's lives (Bryant, 2018). Through these relationships young people learn the emotional and life skills needed to navigate complex circumstances (Bruun & Hynan, 2006) and to maintain their treatment goals (Manuel et al., 2017; Schroder, Sellman, Frampton, & Deering, 2009). However, descriptions and analyses about how these models work, how young clients and staff engage with them, and which programmatic ele-

ments are the most impactful, are few in the research literature – something that is important if we wish to move away from overly-medicalised approaches towards more holistic ones.

Treatment models that focus on *living well* must navigate the policy and administrative demands of the previously described 'episodic-care' system, and this creates particular problems for youth AOD providers. For example, a system that privileges biomedical treatment goals (Moore & Fraser, 2013) means that what counts as a successful treatment outcome for young people is determined by the system, rather than by them or their families. This works against the normative values of autonomy and self-management that are known to be important (Barker, 2013; MacLean et al., 2013). Similarly, the provision of long-term, continuous care of the kind that young people themselves say is necessary if they are to build trust and feel safe with service providers (Bryant, 2018) is difficult in an environment that requires youth service providers to manipulate the system in order to create an unfragmented care experience. There is little research about how youth AOD service providers understand young people's substance use and work around policy and funding imperatives Hart (2018), documented that, despite beliefs that adverse life circumstances were the main problem in young clients' lives, the boundaries and resourcing structure of the clinical environment meant that clinicians' work largely focussed on managing substance use rather than other problems. Importantly, Hart (2018) suggests that researchers have a responsibility to develop tools that help clinicians better understand and identify the complex interactions between substance use and life circumstances. Emerging research has begun addressing this in relation to adults (Neale et al., 2016) and young people (Roarty, Wildy, Siggers, Conigrave, & Wilson, 2012).

Conclusion

We have outlined some of the problems with an overly-medicalised approach to substance use treatment for young people with multiple disadvantage. We show how it can detract attention from the material environments and social relations that structure their lives, including the meanings they give to substance use - themes that are already identified in the existing research literature. We also highlight how deficit meanings attached to substance use might operate for young people, including how they can reduce engagement with the AOD treatment system, although there is limited research on this and more is needed. We have argued that a system that is overly attentive to clinical interventions benefits young people whose material resources and normative values already align with the moralised notions of disease models, but is much less responsive to young people with multiple disadvantage – even though they are the ones who most need intervention and support. While some holistic models of intervention exist, these services must operate in policy and funding environments where their relevance and benefit is inadequately supported. Thus, overly-medicalised approaches not only underplay the various needs of different client groups, but can work to further disadvantage those who are in most need.

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Ethics approval

The authors declare that the work reported herein did not require ethics approval because it did not involve animal or human participation.

Declarations of Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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