Title:

Harm to others does matter in substance use disorders, and so does discordance between the diagnostic systems

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As Degenhardt and colleagues (1) indicate, the psychiatric tradition had decided by the 1960s that addiction was the main game with respect to psychoactive substances, but renamed it "dependence", in part seeking the greater prestige of the physiological phenomena of tolerance and withdrawal, from which the term was adapted (2). But however it was named, the primary location of the disorder was defined as in the mind of the user, and anything used as an indicator was conceptually subordinated to the mental urges and ambivalences of the user. This is reflected in the key phrases cited by Degenhardt and colleagues from the questionnaire items to measure aspects of dependence. Thus, for instance, "problems with family, friends or others" are subordinated to "continued use despite it causing" the problems, so the item is classified as measuring one of the criteria for dependence, "substance use becomes an increasing priority in life".

The Platonism in interpreting the items makes one of the paper's conclusions from its analysis quite problematic. The paper interprets the item, "family been hurt by your substance use", as its measurement of harm to others, and finds that few answered yes to it, so that it did not add substantially to overall rates. But this ignores that harm to others is quite widely referred to or implied in other questionnaire items in the surveys; not only the item already mentioned but also items classified under "harmful use", such as "interfered frequently with your work or other responsibilities at school, on a job, or at home" and that the use "resulted in problems with the police". Reclassifying all relevant items as indications of harm to others from the substance use would considerably increase the weight of this aspect in the ICD-11 diagnosis. The aspect contributes to the clinical utility of the diagnosis, since harm to others is an important determinant of which substance users become "cases" to be treated and managed, as reflected in the commonplace that those who come to treatment in alcohol and drug treatment services are more often than not being pushed in the door by others, whether formally or informally (3). All in all, Degenhardt and colleagues' conclusion questioning the diagnostic validity of self-reported "harm to others" does not seem justified.

At a more general level, the data and findings in their paper (1) alert us to implications of the radical split between diagnostic systems which ICD-11 and DSM-5 embody. ICD-11 has continued the distinction between dependence, on the one hand, and harmful use, on the other. DSM-5 has abandoned any distinction; all symptoms are now equal indications of "use disorder"; dependence has officially gone, but often indirectly is inferred by severity as measured by the number of items. The paper's results demonstrate that the two systems also arrive at different conclusions about whether an individual case has a disorder: in Table 6, of the cases where any disorder is found, it is found by only one of the systems for 36% of the alcohol cases, and for 46% of the cannabis cases. In the new era, the two diagnostic systems disagree not only on concepts but also on what constitutes "a case". It is not clear what this means for treatment. In many countries, especially for alcohol, most cases never receive treatment, and those treated may not qualify to be a psychiatrically defined case (4). Thus, the diagnostic definitions and surveys seem to exist in a somewhat different world from the social realities, including in treatment systems.

From a population-based public health perspective, we need to reconsider what makes the most sense as indicators of substance use-induced hazard or harm. Dependence turns out to be a rather culture-specific concept (5,6), with different regions of the world showing quite different relationships between amount of drinking and reported alcohol dependence rates (7). There are two alternative bases for population-level indicators. One option is levels and patterns of consumption (8). The other is a cumulative indicator of substance-use related harm, whether to the user or to others – as in ICD-11's harmful use, or in traditions of population studies of alcohol and other drug

problems (e.g., 9). In trying to figure out what is most useful at a population level (though not necessarily in a clinical situation), maybe it is time to look beyond interpretations and diagnoses which privilege what is in the user's mind, instead taking items about substance-induced harm at their face value and focusing on reducing them.

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