WHAT DO HAMBURGERS AND DRUG CARE HAVE IN COMMON: SOME UNORTHODOX REMARKS ON THE MCDONALDIZATION AND RATIONALITY OF DRUG CARE

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This paper traces the question of whether there is a growing process of rationalization underlying drug policy and drug treatment, in the sense of the "McDonaldization" thesis established by Ritzer (2000). Taking Germany as an example, there is some evidence that endeavors to achieve enhanced efficiency may actually lead to a lack of rationality. Here we explore the historical background of this McDonaldization process as it relates to drug policy and treatment in Germany. Is it possible to escape from the "irrationality of rationality," that is, the intense efforts directed at efficiency in drug treatment?

PROLOGUE

While a hamburger and its raw materials are well-known, tangible entities, drug policy and approaches to drug treatment seem to be largely amorphous, much less objective concepts. The conceptual basis for drug policy and treatment is determined by countless established institutions, associations, departments within particular ministries, and the like that cope with its different facets. Proponents of current drug prohibitionist policy envision a world completely free of individuals who consume mind altering substances. Yet, they seek to institutionalize their notions of a better world by using the language of "treatment" and "care." This vision and the language of treatment and care are at odds with each other. The idea of a drug-free society is, so to speak, the raw material of the drug care system – or to put it differently in the sense of Husserl's phenomenology: The reality of drug care has

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no tangible objectivity; the system is only intention, something conscious, something becoming evident (Schischkoff, 1991, p. 555). Thus, drug care is not something naturally given, but rather a social construction that takes shape only in reference to a certain drug treatment system, with its own unique rules.

If we leave aside qualitative differences, a hamburger will keep its phenotypic manifestation; if that is lost, it ceases to be a hamburger or would not be identified as one. On the other hand, the drug care system changes its appearance every time its intentions and objectives change, as was the case in the mid 1980s when AIDS first became an issue. Since then the shift from abstinence to harm reduction has led to a dramatic change in and diversification of drug treatment approaches (syringe exchange, injection rooms, methadone substitution, etc.).

INTRODUCTION

The (stylized) hamburger appears as the outstanding (pop-art) icon of a rapidly spreading fast food culture. This culture can be seen as a symbol of a completely rationalized society, one that is strictly oriented toward calculability and the rapid pace of life; this societal structure now appears to be spreading as part of a global process. One of, if not the most, prominent representative of this development is the fast food chain McDonald's. This company, representing modern fast food culture, has been featured in a thesis developed by the astute American sociologist, George Ritzer, which he has subsequently elaborated on in many publications. Ritzer's thesis is aptly titled the "McDonaldization" of society (Ritzer, 2000). In his terms, McDonald's serves as the ideal-typical (Weber, 1980) example for ever more sectors of everyday life in an increasingly rationalized society where efficiency, calculability, predictability, and control have become decisive criteria of the quality of life. When you visit McDonald's, you know what you will get. When entering these restaurants under the sign of two golden arches, we know that we won't be disappointed, and this predictability is now possible all over the globe, seemingly whenever we are confronted with hunger. The McDonaldization thesis springs from Ritzer's observation that the principles guiding McDonald's "affect not only the restaurant business but also education, work, health care, travel, leisure, dieting, politics, the family and virtually every other aspect of society" (Ritzer, 2000, p. 2). This paper asks the reader to think about how far the drug care system has already progressed in terms of Ritzer's McDonaldization process.

THE MCDONALDIZATION THESIS

As it was first presented, Ritzer's McDonaldization thesis was strongly influenced by Weber's ideas and research on bureaucracy and on the rationalization process of society:

> Weber feared most that bureaucracies would grow more and more rational and that rational principles would come to dominate an increasing number of sectors of society. He anticipated a society of people locked into a series of rational structures, who could only move from one rational system to another – from rationalized educational institutions to rationalized workplaces, from rationalized recreational settings to rationalized homes. Society would eventually become nothing more than a seamless web of rationalized structures; there would be no escape. (p. 25)

The McDonaldization process mirrors Weber's rationalization process in so far as it covers four core dimensions which could be subsumed under the term rational – at least in an economic sense of "adjustment of means to the purposes" (Boudon & Bourricaud, 1992, p. 410). Each of these is discussed below:

Efficiency

Ritzer states, "Efficiency means choosing the optimum means to a given end" (Ritzer, 2000, p. 40). Our fast-moving age brooks no delay. Consequently the (leisure) industry endeavors by every means to efficiently allow us to achieve satisfaction at any time and anywhere. Examples abound: To satisfy one's hunger, to make most of leisure time wherever we are, to give in to sexual urges whenever they occur, to conveniently take care of business at drive-through windows, etc. First and foremost, efficiency means saving people from the necessity of always having to watch out for the easiest way to accomplish things in the various sectors of society. This follows Weber's "formal rationality":

> . . . Formal rationality means that the search by people for the optimum means to a given end is shaped by rules, regulations and larger social structures. . . . After the development of formal rationality, they could use institutionalized rules that help them decide – or even dictate to them – what to do. An important aspect of formal rationality, then, is that it allows individuals little choice of means to ends. In a formally rational system, virtually everyone can (or must) make the same, optimal choice. (Ritzer, p. 23)

The norm of efficiency is the core principle within a McDonaldized society.

CALCULABILITY

A second characteristic of the McDonaldization process is calculability. According to the principle of efficiency established above, the number of products produced in the least possible time is a crucial criterion of the assessment of the processes. "Quantity tends to become a surrogate for quality" (Ritzer, 2000, p. 62). The emphasis on numerical standards is intertwined with the other dimensions of McDonaldization: The greatest output within a given time period is considered to be the most efficient and thus, desirable. Once a process is quantified, we can more easily predict the number of customers and orders as well as anticipate the workload. In accomplishing this, calculability is linked to control, because a criterion of assessment is given; what to expect from those engaged in the various processes. However, our experience shows that calculability yields "irrationality since, among other things, the emphasis on quantity tends to affect quality adversely" (Ritzer, p. 63).

PREDICTABILITY

"In a rationalized society, people prefer to know what to expect in most settings and at most times. . . . To achieve predictability, a rationalized society emphasizes discipline, order, systematization, formalization, routine, consistency, and methodical operation" (Ritzer, 2000, p. 83). It is obvious that predictability is closely linked to the dimension of calculability: In a restaurant situation, we expect portions of constant size and quality, we want to know in advance what it will cost and what to expect from services and products in diverse sectors of everyday life. We have come to expect a smoothly functioning and predictable bureaucracy with regard to the management of everyday life, for example, when purchasing insurance or paying taxes. In order to ensure predictability of products and services in the diverse sectors of everyday life, it is imperative that we standardize processes, services and administrative regimens. Predictability is a priority matter in McDonaldization and it is pursued in more or less all sectors of society in terms of "quality management."

CONTROL

Finally, control is necessary to ensure efficiency, calculability and predictability. Initially, control is directed toward humans, as they represent a core element of uncertainty in the rationalization process. This control is increasingly realized by replacing human with non-human technology. "Technology includes not only machines and tools but also materials, skills, knowledge, rules, regulations, procedures, and techniques. Thus, technologies include not only the obvious, such as robots and computers, but also the less obvious, such as the assembly line, bureaucratic rules, and manuals prescribing accepted procedures and techniques"

(Ritzer, 2000, p. 104). In the outline of the dimensions of McDonaldization, certain negative effects of an increasing, life-dominating rationalization were already implicitly indicated. Following Weber, Ritzer deals with the negative side of McDonaldization under the heading 'The Irrationality of Rationality': "Rational systems, contrary to their promise, often end up being quite inefficient. . . . What is purported to be an efficient method of doing things . . . often turns out to be quite inefficient" (Ritzer, p. 124). One serious negative aspect of McDonaldization, especially relevant to this discussion, is the gradual disappearance of diversity. With fast food chains, the regional kitchen is being sacrificed in order to provide predictability. In Asia, for example, fast food products will be served the same way they are in America or Europe. Except for a few signs that feature local languages, even the physical setting of the fast food restaurants fails to provide any indication of the particular country one is in. McDonaldization removes the actors involved from their particular cultural and region-specific context. Identical eating habits are now being globally cultivated, along with humor, clothing, lifestyles, value orientations, music, and sports preferences. These developments are driven by the worldwide presence and popularity of increasingly successful soap operas, Hollywood films, television productions ("ideal-typical": MTV), and the like.

The McDonaldization of Drug Policy and Treatment

Below we respond to the question of whether, the McDonaldization of society has affected the drug treatment system and if so to what extent. This will be done by analyzing a few examples taken from current drug treatment practice. This is not intended to be a comprehensive overview, and readers can probably think of many more examples from everyday practice. We anticipate too that counter-examples can be found that strongly contradict the thesis. In fact, the author will later discuss how the drug treatment system has attempted to oppose McDonaldization tendencies. The following analysis serves simply as a warning of potential problems that may impact the drug treatment system in an increasingly McDonaldized world.

Until the late 1980s, drug treatment discourse in Germany was dominated by a 'linear' image/idea of addiction. In other words, addiction was conceptualized as a career model, a steadily progressing condition that over time leads to increasing involvement in a drug related lifestyle. Furthermore, addiction was held to be irreversible, as reflected in the colloquial adage "once addicted, always addicted." Based on this concept of drug use, treatment was aimed at preventing initial use (primary prevention), aborting the addiction process as early as possible once it has begun (secondary prevention), or facilitating abstinence status among long-term users (tertiary prevention). This linear concept of addiction and drug treatment was

formulated early on and became the classic approach to the problem. It was focused on abstinence and designed to remove drug users from the diverse career stages of their addiction (disease), in order to abort the process. Ultimately drug treatment was based on an action model that has been discussed by experts as the "abstinence paradigm."

The classic drug treatment system satisfies the four core dimensions of McDonaldization. Drug treatment facilities have been strictly oriented towards the addiction-model and the abstinence-paradigm, and these were – as regards both content and conception – closely linked in order to foster optimal efficiency. Seen from this perspective, the calculability of the treatment processes and especially the predictability of therapeutic interventions should have been improved. This was relatively easy because the system limited its goals to drug abstinence (though this was seldom achieved). The ideal-typical model of drug care was visualized as an interlocking system or therapy chain based on a division of labor (counseling centers, therapy facilities, and aftercare facilities). It was thought that this could ensure the efficient achievement of abstinence. Drug treatment providers thought of this system as a paragon of efficiency because the people it was designed to treat did not have any choices to make. The long-term objective and the stages involved in getting there were clearly defined and institutionalized. In a general sense, this classic interlocking system of drug treatment appears to be a prototype of the McDonaldization thesis.

In practice, however, research and experience revealed that drug use does not follow such a logical sequence. This system failed to produce an acceptable level of success, despite its efficiency and predictability. From about the mid 1980s on, partially driven by the rapidly emerging challenges posed by HIV, it became possible to discuss the system "outside the box," that is outside the framework of these earlier dogmatic ideas of addiction and drug consumption. Several drug researchers helped to bring about this change of thinking regarding the earlier uni-directional development of drug use.[1] Recent research findings – especially those concerned with the controlled use of psychoactive substances and self-recovery – make clear[2] that drug addiction, seen as a phase of compulsive use, represents only one *possible* stage in a longer lasting, and also reversible development. Moreover, addiction is not a kind of final, inevitable stage in a drug career. There are other "career patterns" that never lead to any kind of compulsive, addictive drug use. Progressive groups in the drug treatment debate notwithstanding, the following facts were discovered in the 1980s: drug use patterns develop heterogeneously, drug use does not inevitably lead to addiction, and use does not necessarily have to be stopped entirely in therapy. These theoretical shifts led to an increase in the diversity of drug treatment options that have been made available since the mid 1980s. These changes would not have

occurred without the enormous socio-medical challenges posed by HIV/AIDS. For example, since that time it has become acceptable to consider methadone substitution as a legitimate treatment form in Germany. In fact, this form of treatment has now become well established – methadone is an accepted form of maintenance substitution, and the medical prescription of heroin has even been given serious consideration.[3] Furthermore, the older counseling centers, whose primary aim was to motivate drug consumers to participate in a therapeutic recovery process have been supplemented by numerous and diverse low-threshold facilities. The latter facilities, often termed "contact cafés," offer a variety of supports for everyday life in order to prevent a progressive impoverishment of the marginalized drug consumer who is, in most cases, experiencing serious health problems. These centers offer sleeping facilities, medical care, and food, and they also include needle-exchange programs (the first of these were established during the early 1990s) and the recently emerging safe-injection rooms (the first of these opened in 1994 in Frankfurt am Main; cf. Kemmesies, 1999). The latter two programs are now legally protected, so long as they do not violate the German drug law, the BtMG (Betaeubungsmittelgesetz). The diverse programs that have endured during the last decade need to be interpreted as examples of de-McDonaldization. That is, there are now more rather than fewer facilities and there are more individualized treatment options rather than less - the opposite of what one would expect in a McDonaldized system. However, we should not attach too much significance to this because the symptoms of McDonaldization are still dominant. The latter are based on the legally limited scope for action in the drug field – the reason why rationality in drug policy and drug care is hard to realize in practice. Below we will provide some examples of the four dimensions of McDonaldization with regard to their application to drug treatment. Following that, the writer will attend to the question of the current state of affairs regarding rationality in drug policy and drug treatment.

Efficiency

Despite the expanding range of treatment options, the highly medicalized drug care system still seems too concerned with efficiency – though one is tempted to assume that the medical care sector should be immune to rationalization efforts because treatment should not be a matter of economics. Treatment should be based on individual needs, rather than their health insurance status. To illustrate this, we turn to an example taken from methadone treatment. The attempts to assure efficiency are not only revealed by the fact that the medical doctors' rights to a free choice of therapies is de facto restricted by administratively imposed treatment guidelines [the so called AUB-Guidelines[4] and the legal framework (BtMVV)].[5] Also, the limited amount that health care providers can charge the client or the

health insurance providers commits them to efficient organization of methadone treatment to maximize profits or, at least, to recover their costs. We note too that the requirement that psycho-social therapy complement substitution treatment can not be seen as action based on limited financial resources. The relentless pressure brought on by rising costs inevitably forces the drug care system to irrationally adjust its activity to accommodate available financial resources. A rational plan of treatment that takes into consideration individual needs is thwarted by limited financial resources. There is only limited time for thorough social anamnesis, and this hampers the planning of further interventions. This often leads to a situation where the appropriate therapeutic facilities are not selected, thereby jeopardizing the potential for treatment success. This serves as an illustrative example of the "irrationality of rationality": Where the attempt to increase efficiency ultimately produces its opposite. In the end, such actions are not cost saving, but actually lead to cost enhancement.

Another factor fostering efficiency in health-care, including drug treatment, is the growing pressure of competition. When substitution treatment emerged in the early 1990s, many of those working in long-term therapeutic facilities feared that their client base would erode as a result. While this fear never materialized, the situation led to increased concern with efficiency. In order to deal with the perceived threat, a fierce competition developed among drug care providers in larger cities. One need only glimpse the annual reports of diverse facilities and institutions: Columns of figures are presented to document upward trends and forcibly used to favorably position competing facilities in the fight for the allocation of public funds. The figures concern counseling contacts, therapy, placement of drug addicts with therapy facilities, telephone contacts, meals served, condoms distributed, syringes exchanged, and the like. They fail to tell us anything about the quality of these contacts, however, and because these intensified efforts have been efficiency driven, we may assume that quality is often sacrificed to quantity concerns. The dimension of calculability within the McDonaldization of drug treatment complements this process, as described above.

When considering efficiency, a debate on quality management has flared up within the last few years in the wake of increasing financial difficulties associated with the acquisition of public funds. These problems have led to calls for increasing the efficiency of drug care by implementing appropriate quality management measures. Often it appears as if the assessment of quality follows a "rational" perspective based largely on financial considerations according to a pure economic means-end relationship. But the need to guarantee and to assess quality of the interventions in this field is a sensitive balancing act. For example, what criteria are to be used to analyze the means-end relationship, balancing the costs against

the returns? Is it just drug-using status? Or is it the state of mental and physical health and the ability of the user to resume employment? Or is it about such difficult to assess – not to mention quantify – criteria such as the quality of life?

Calculability

Earlier we argued that approaches to drug treatment have become increasingly receptive to the dimension of calculability. This is an outcome of the need for efficiency according to the already mentioned pressure towards cost savings. Moreover, we emphasized that in the course of the McDonaldization process, quantity concerns come to dominate. Though social work does not produce any standardized products, it appears as if proper qualitative assessments of the drug care praxis have been replaced by quantitative measurements. In doing so, we remove ourselves from the qualified, individual oriented drug care praxis.

Predictability

Recently there have been attempts to increase the predictability of social work and therapeutic intervention by means of their standardization. These endeavors now penetrate the entire drug treatment system. The rationale underlying these efforts is the maximization of the success of interventions by fixing suitable treatment standards.[6] At this point, efforts have been made to increase the quality of drug user treatment placement by improving anamnestic diagnostic proceedings. In doing so, extensive evaluation studies have become especially significant. However, given the complexity of these issues, they cannot be reduced to simple causal chains or stimulus-response chains following black-box models. Consequently predictability remains a vague "quantity."

Control

The use of illicit drugs has served as a target of enormous legal and socio-medical control efforts. Given the context of the discussion of the McDonaldization of drug care, raising the issue of legal control may seem strange, although there are links between the legal and socio-medical control sectors that are extremely relevant. These links refer to the measures implemented in the German Narcotic Drugs Act (NDA – Betaeubungsmittelgesetz, BtMG) under the slogan "therapy instead of punishment."[7] In certain respects, the high number of "condition-clients" (Auflagenklienten- forced treatment clients[8]) in long-term therapy facilities are a reflection of the society's enormous control efforts in this field. With the legal demands for therapy, both the treatment objective (abstinence) and the means to achieve it (long term in-patient therapy) are predefined; there are almost no individual choices – the only alternative is serving a sentence of imprisonment. In

this way institutionalized laws and bureaucratic structures completely restrict "the last bits of freedom of movement being 'individualistic' in any sense" ("Reste einer in irgendeinem Sinn 'individualistischen Bewegungsfreiheit" – Weber, 1980, p. 836).[9] Here the state paternalistically rules out by law any decision to use certain psychoactive substances. If individuals violate this law, they are required to achieve abstinence by a variety of fixed means – although the adoption of substitution treatment has introduced some degrees of freedom within the drug care system, as discussed above in reference to "De-McDonaldization."

Currently, the organization of substitution treatment largely corresponds with the dimension of control within the McDonaldization process. The simultaneous consumption of other substances may be prevented through suitable controls (urinalysis). In addition, there is a commitment to psycho-social therapeutic care, and an enormous amount of control over the individual's everyday life, due to strongly regimented treatment modalities. The latter strictures attach importance to the place of the treatment facility and to maintaining a prescribed schedule. Participants are forced to reconcile the demands of everyday life (for example, being employed, bringing up children, and being in training) and substitution treatment. Those who refuse to comply with these treatment conditions and modalities are threatened with exclusion from treatment.

Substitution treatment is not the only object of a strict control regimen. However, in different areas of the drug care system we can make out control scenarios that are potentially linked to one another and in such a way foster the "irrationality of rationality" of the McDonaldization process. For example, persons in substitution programs are prohibited from using safe injection rooms. The justification for this ban is the argument that simultaneous consumption of methadone and other psychoactive substances (especially heroin) is a high risk, and unacceptable, activity. Given the results of substitution research, however, supplemental drug use during the first phase of substitution treatment is a phenomenon that can only be seen as typical. Thus, the ban appears to be positively harmful because a safe injection room offers ideal conditions to counter potential consumption risks. The hygienic setting helps prevent infection and the professional staff who are present can immediately intervene in cases of overdose.

In summary, drug care has been undergoing certain developments which mirror the McDonaldization thesis. Ritzer (2000, p. 19) states, "Although McDonaldization is ubiquitous, there is more to the contemporary world than McDonaldization. It is a very important social process, but it is far from the only process transforming contemporary society. Furthermore, McDonaldization is not an all-or-nothing process. There are degrees of McDonaldization." Despite such caveats, the recent McDonaldization trends identified above give cause for critical reflection.

McDonaldization of Drug Care

The tendency toward McDonaldization is becoming obvious within the context of the debate on quality management. The efforts to ensure quality in drug care practices are welcome demands. However, the irrationality of rationality appears wherever quality management focuses on increasing efficiency, and this is then measured by quantifiable, calculable outputs of the drug care system. This response is absurd in view of the particular nature, obstinacy ('Eigensinn'), and individuality of – even – drug use related biographies. The process and volatility of drug using developments on the collective and individual levels counter any standardization efforts intended to increase efficiency.

But what are the criteria of quality management in the drug care system under McDonaldization? What or who is the point of reference within the quality management debate: the immediate social setting, the individual, the state or the society?

A Lack of Rationality and Knowledge

So what is the objection to rationality in drug care? Of course, there can be no objections to efficiency, quality management, and calculability – so long as their realization does not produce irrational side effects. But the latter seem to be unique consequences of our drug-political approach from which the drug care system derives. There is considerable evidence that our prohibition-based drug policy has failed to achieve abstinence.[10] Worse, there is abundant evidence that the policy may actually be counterproductive, insofar as it produces serious – though likely unintended – negative consequences.[11] We seem to be far away from achieving the ideal of being able to translate into action an instrumental rationality in the Weberean sense (see also Weber, 1980, p. 13). First (and completely in accord with McDonaldization), this rationality calls for an optimal means-end relation. But a substantial pre-condition – which seems to play only a marginal role in McDonaldization processes – is, according to Weber, that the purposes are rationally weighed against each other[12], as well as against the side-effects.[13] In contrast to this way of thinking, our drug policy widely follows a rationale based on a socially defined conviction of what is "good,"[14] and ignores potential side effects of the law itself. It seems as if McDonaldization within the drug care sector is following a model of value rationality rather than one of instrumental rationality. A value rationality – that is, one based on a value system – often leads to an emotional reaction instead of a practical response, and such irrationalities are inevitably taking place.

In the present situation, a realization of a rational drug policy in the sense of an instrumental rationality seems impossible: There is a quality management discourse taking place which follows the outlined core dimensions of McDonaldization. The

precarious thing is that this discourse and the associated processes of McDonaldization are happening as if there were: (a) a social consensus about the drug policy objectives; and (b) a comprehensive, certain, reliable knowledge about the phenomenon's context. But both of these are absent – though it would be a precondition, a *conditio sine qua non* to realize a drug political praxis on the foundations of an instrumental rationality. According to the discussions on drug policy alternatives[15] that have taken place everywhere since the emergence of HIV, there is no longer a consensus about these issues(if there ever was one).[16] The so-called abstinence paradigm[17] which drives our drug policy and drug treatment system has been losing its unifying power. Consequently, there is now a serious debate taking place that questions whether an abstinence-oriented drug policy and drug care system can adequately deal with the phenomenon's cultural, social, and psychological complexity. We noted earlier that inadequacies of the abstinence paradigm are becoming more and more apparent.[18] Our change in perspective has been frustrated by the results of a variety of extensive studies of controlled, socially integrated use of illicit drugs and the so called self-recovery or maturing-out processes (see notes 2 and 4). These studies deconstruct the myths underlying the old policy. We have supported a causal automatism towards addiction, a kind of "pharmacological inescapability" has been associated with the (illicit) substances as reflected in the so-called stepping-stone theory or the idiomatic expression "once addicted – always addicted."[19] However, although we are increasingly developing an "empirically based" awareness of the phenomenon's complexity, continued support for a monodirectional drug policy will reduce and limit our knowledge of drug use.

This complicates matters. Rational drug policies and approaches to drug treatment require more extensive, profound knowledge about the phenomenon of drug use, as well as about expected action and intervention outcomes. At the present time, however, we are far from achieving this ideal. Admittedly, we do have quite extensive ideas about the context of explanation found in the theoretical construction of the so called "causal triad" model comprised of "drug, set and setting."[20] Although this model remains quite general and only produces pictures with poor resolution.[21] Thus, our superficial knowledge about the interplay of the different factors allows for only vague anticipation of the possible outcomes of drug policy interventions. We now find ourselves in a paradoxical situation. In the name of quality management we have tried to conceptualize a rational drug care system, and this attempt has been widely based on spurious certainties, convictions and myths shaped by the dominant dogmatic (scientific) ideology. In the manner of McDonaldization, we endeavor to achieve treatment processes which are attended by quality management, though we have no precise ideas about the relevant factors that drive drug use patterns. We do know that simple causal assumptions are deceptive and inaccurate,

however. A more realistic perspective would assume a multi-layered spectrum of drug use operating between the extreme poles of total abstinence and physical and/or psychological dependence.

This confusion makes the conceptualization of a rational drug policy impossible at the present time. Such a policy would require a far-reaching scientific praxis independent from the dominant drug images and one that focuses on the side-effects – not only of drug use itself but also of governmental reactions to drug consumption. In this context it is essential that we not only take into account the social-medical components, but also the punitive legal outcomes of drug control. Until this is accomplished, there can be no rational drug policy discourse. There would be no harm if the McDonaldization issue was put in the limelight, because then it would happen as a scientifically sound process with respect for the individuality of drug use related biographies and a clientele with varying psychological and social orientations. In that event, the McDonaldization of drug care would probably protect us from the lack of rationality in this extreme value- and emotion-laden field. Thus, the core question for the future is "whether reason, based on scientific evidence, day by day reality, and a willingness to think clearly and imaginatively about a complex issue can play even a slightly larger role than it has on a topic dominated by unthinking reaction based on moralistic rhetoric" (Hartnoll, 2000, p. 251).

Epilogue: Back to Haute Cuisine

It remains doubtful if such an optimistic view of the prospects for the future is justified. Due to the existing uncertainties about the legal requirements and the suitability of different scientific theories, an optimal goal-means relationship is simply not realizable unless we follow the particular views that dominate drug policy and drug treatment. When it is the avowed purpose of drug policy to do good things, these questions arise: "Who defines what is good in this field? Moreover, which interests are to be considered in the definition?" Surely, not only the interests of the beneficiaries of this or that interpretation of the drug phenomenon,[22] but also those of the affected users should be considered.[23] Following Horkheimer's (1947) critical theory, "reason" could be instrumentalized in order to serve individual interests. If we do not critically reflect on certain aspects of the drug phenomenon (e.g. drug deaths) and only consider these aspects in a positivistic manner as manifested in the substance/user and not in the way society handles the phenomenon through legal and socio-medical control, we run the risk that policy is instrumentalized and serves certain interest groups (treatment agencies, politicians, police, the pharmaceutical industry, and health insurance providers). In other words, drug policy represents a field in which "reason" can easily be sacrificed to institutional interests. And we must not forget that the phenomenon is in a permanent

state of flux. That which appears rational today might easily to be seen as an inappropriate intervention tomorrow. Therefore the phenomenon requires close monitoring and continual critical reflection. Within this context it is not helpful to take drug prohibition as an unquestioned norm, as seems to be the case when looking at international conventions and (American, United Nations) drug policy. When looking at global policy, it appears that the ban on drugs is taken as a natural and immutable law.[24]

The question remains as to what will take us closer to a kind of haute cuisine in this field. Perhaps we should more seriously consider such vague criteria as "quality of life" in shaping our drug policy efforts, in order to protect us from irrational treatment approaches. The question remains as to *who* will define these criteria for drug policy in general and drug care in particular. And *how* is quality of life to be operationalized? It seems very likely that it has to be defined much more carefully than it has been under the abstinence model. It is also possible that drug consumption itself may be an expression of a certain kind of quality of life – and this applies to a cup of coffee or a glass of good red wine as well as it does to these other substances. We probably have to revise our images of drug consumption: If we pay attention to the many cultural studies, we are made aware of the fact that drug consumption takes place as a multifunctional, rational behavior; there seem to be a multitude of practical reasons for taking drugs[25]. A myopic perspective that pictures drug use solely as irrational behavior understates and distorts the phenomenon's complexity and diversity. This appears to be the reason why the observable tendencies of McDonaldization in this social field of action has thus far produced such irrational outcomes. In other words, this is likely the crucial obstacle to identifying optimal, rational – taking account of the side-effects of drug political interventions – means-end relations for the social handling of drug use.

NOTES

1 Just to name some classic studies: Snow, 1973; Powell, 1973; Waldorf and Biernacki, 1981; Zinberg, 1984.

2 e.g.: Waldorf et al., 1991; Mugford & Cohen, 1989; Parker et al., 1998; Kemmesies, 2000

3 In 2001 a scientific study of a heroin substitution trial began in seven cities with about 1500 opiate addicts. In 2002 a scientific study of a heroin substitution trial has begun.

4 AUB: Anerkannte Untersuchungs- und Behandlungsmethoden – Established Medical Examination and Treatment Methods.

5 BtMVV: Betaeubungsmittelverschreibungsverordnung – Ordinance for the prescription of narcotics

[6] The enormous efforts towards standardization of methadone treatment undertaken in the last years is a good example to illustrate this development (e.g.: Buehringer et al., 1995).

[7] "The (.../NDA) is part of the so-called supplementary laws (Nebengesetze) of the Penal Code and regulates the handling of narcotic drugs. (…) The therapy directives indicated in §§ 35 to 38 NDA comprise regulations regarding the referral of a drug addicted offender into therapy. (...) This regulation gives the law enforcement authorities the opportunity to defer the execution of a prison sentence for a maximum of two years for those offenses committed due to drug addiction. The same is valid for a corresponding remaining sentence concerning offenders convicted to longer terms of imprisonment. The deferment implies that the convicted person will be released from prison or does not even have to go to prison provided he or she participates in a treatment program instead" (Kurze, 1994, p. 283).

[8] Auflagenklienten – Clients being referred into therapy on the basis of the NDA's therapy directives.

[9] Translated by the author.

[10] A large proportion of the population have had earlier experiences with illicit drugs and sizable numbers are currently consuming them. In addition we can assume that the statistics taken from representative surveys fail to reveal dark figures of drug use: "Lifetime prevalence of illicit drug use (at least once in lifetime) was reported by 14.2% of 18-59 year old western Germans and 4.8% of 18-59 year old eastern Germans. (...) During the past 12 months a total of 5.9% of 18-59 year olds in western Germany (estimated population total: 2.0 million) as well as a total of 2.7% of 18-59 year olds in eastern Germany (estimated population total: 220,000) had taken illicit drugs" (Kraus & Bauernfeind, 1998, p. 9).

[11] These include large amounts of criminality (e.g.: acquisitive crime, corruption), overdose risks, and physical harms that result from the black market and the absence of controls over the products being sold.

[12] Abstinence is dominant in our internationally embodied drug policy: Abstinence is the objective of the drug political and drug care related interventions. But are there not other, alternative objectives imaginable? Would not a controlled use of substances while being aware of the potential risks be a worthwhile objective? This would be much more pragmatic as it would be much more in line with the significant spread of even the illicit drugs in our society and probably much more in accord with the cultural foundations of the use of psychoactive substances (e.g. Brecher, 1972, p. 195; Weil & Rosen, 1993) than the drug prohibition is.

[13] To give an example: The term "drug death" has only recently been discussed and interpreted as a possible side-effect of drug prohibition. It was formerly discussed as a consequence of the substances' pharmacological potency: The focus was put mainly on the "drug" and not on the (macro-social) "setting."

[14] Abstinence is good and drug use is bad because use is – according to a particular point of view – criminal, deviant, maladaptive, pathological behavior.

[15] The alternatives range from harm reduction approaches being – more or less – in line with our prohibitive drug policy, to claims for legalization.

[16] This holds true for both an *inter*national and *intra*national perspective: We can observe enormous political differences between (even when committed to the UN-Conventions on "psychotropic substances") and within nations (e.g., due to the federal structure of Germany, we observe significant drug policy differences between states).

[17] Following the abstinence paradigm (related to the vision of a drug-free society) all drug political efforts are directed towards the abstinence of illicit drugs.

[18] HIV is to be seen as a catalyst in the context of this development because the problems associated with HIV do not tolerate any stoical persistence in old drug treatment regimens and political convictions.

[19] It appears as if our knowledge is distorted and interspersed with spurious truths; that is the reason why we commonly speak of so called drug myths, which are particularly being cultivated in the scientific field (a comprehensive and exemplary overview of this phenomenon with regard to cannabis is provided by: Zimmer & Morgan, 1997).

[20] According to this theoretical minimal consensus (which is nowadays seriously called into question by no discipline), a comprehensive understanding of drug use is only possible when simultaneously taking into account the person, the drug and the respective (physical and micro-/macro-social) setting.

[21] We have only imprecise ideas about the relationships between circumstances and risk-factors (e.g.: genetic predisposition, predisposition related to the psychological development, social factors, the spectrum of pharmacological effects et cetera) and how these are transformed into problematic drug using behavior.

[22] Ranging from politicians, the pharmaceutical industry and treatment facilities to scientists who work in this field.

[23] It surely would be helpful to become receptive to the needs of the customers of drug care by means of appropriate research (and why not in the sense of market research): Studies using appropriate qualitative methods that focus on the perspective of the persons affected and their patterns of interpretation and constructions of reality lead a shadowy existence (as an example consider the

research on substitution treatment: Hunt and Rosenbaum, 1998: 188ff). In this respect, the individual interests and needs respecting quality management is seriously hindered.

[24] Unfortunately even the sciences are not committed to this: For instance, an examination of the wide field of decriminalization and depenalization has mainly (and in accordance with the research on the genesis of norms) been theoretical. Empirical studies are rare, though herewith a worthwhile research field with view of a drug political reflection is touched on: How are ideas of drugs control developing and changing over time? What are the underlying motivations and interests, what are the supporting arguments and reasons? Answers to these questions surely would be useful to better analyze and assess existing and alternative drug political and drug care strategies and resources.

[25] Blaetter (1995), for example, in her study on the functions of drug consumption and their culture-specific patterns of usage, identifies different areas of everyday and working life in which the consumption of drugs has certain – and entirely rational – functions. She differentiates religious, medical, hedonistic, social, compensational, economic and political functions. Or to put it in the words of Sandwijk, et al. (1995: 91): "The use of drugs is active, intentional in relation to the functions it is required to fulfill." See also: Weil and Rosen (1993, especially, p. 14).

References

Blaetter, A
1990 *Kulturelle Auspraegungen und die Funktionen des Drogengebrauchs.* Hamburg: Wayasbah.

Boudon, R., & Bourricaud, F.
1992 *Soziologische Stichworte. Ein Handbuch.* Opladen: Westdeutscher Verlag.

Brecher, E.M.
1972 *Licit and illicit drugs.* Boston and Toronto, Little, Brown and Company.

Buehringer, G., Gastpar, M. Heinz, W. Kovar, K.-A., Ladewig, D., Naber, D. Taeschner, K.-L., Uchtenhagen, A., & Wanke, K.
1995 *Methadon-standards. Vorschlaege zur Qualitaetssicherung bei der Methadon-Substitution im Rahmen der Behandlung von Drogenabhaengigen.* Stuttgart: Enke.

Hartnoll, R.
2000 International trends in drug policy. In R. Coomber (Ed.), *The control of drugs and drug users. Reason or reaction?* (pp. 233-252). Amsterdam: Harwood Academic Publishers.

Horkheimer, M.
1947 *Eclipse of reason*. Oxford University Press, New York.
Hunt, G., & Rosenbaum, M.
1998 "Hustling" within the clinic: Consumer perspectives on methadone maintenance treatment. In J.A. Inciardi & L.D. Harrison (Eds.), *Heroin in the age of crack-cocaine* (pp. 188-214). Thousand Oaks, London, and New Delhi: Sage.
Kemmesies, U.E.
1999 *The open drug scene and the safe injection room offers in Frankfurt am Main 1995. Final report*. http://home.muenster.net/~indro/injection_room.htm
Kemmesies, U.E.
2000 Umgang mit illegalen Drogen im 'buergerlichen' Milieu: Zum Steuerungseinfluss formeller und informeller Sozialkontrolle – Erste Ergebnisse einer Pilotstudie (Use of illicit drugs in the 'civil' milieu: on the influence of formal and informal social control – preliminary findings of a pilot study) *Sucht, 46,* 101-110.
Kraus, L., & Bauernfeind, R.
1998 Population Survey on the Consumption of Psychoactive Substances in the German Adult Population 1997. *Sucht*, *Special issue 1*.
Kurze, M.
1994 *Strafrechtspraxis und Drogentherapie* Wiesbaden, Kriminologische Zentralstelle.
Mugford, S., and Cohen, P.
1989 *Drug use, social relations and commodity consumption. A study of recreational cocaine users in Sydney, Canberra and Melbourne.* Sydney: University of Sydney, Department of Sociology.
Parker, H., Aldridge, J., & Measham, F.
1998 *Illegal leisure. The normalization of adolescent recreational drug use.* London and New York: Routledge.
Powell, D.H.
1973 A pilot study of occasional heroin users. *Archives of General Psychiatry, 28,* 586-594.
Ritzer, G.
2000 *The McDonaldization of society.* New Century ed. Thousand Oaks, London, and New Delhi: Pine Forge Press
Sandwijk, J.P., Cohen, P.D.A., Musterd, S., & Langemeijer, M.P.S.
1995 *Licit and illicit drug use in Amsterdam II. Amsterdam.* Instituut voor Sociale Geografie - Universiteit van Amsterdam.

Schischkoff, G.
1991 *Philosophisches Woerterbuch.* Stuttgart: Kroener.
Snow, M.
1973 Maturing out of narcotic addictions in New York City. *The International Journal of the Addictions, 6,* 921-938.
Weber, M.
1980 *Wirtschaft und Gesellschaft.* Tuebingen: Mohr.
Waldorf, D., and Biernacki, P.
1981 The natural recovery from opiate addiction: Some preliminary findings. *Journal of Drug Issues, 11,* 253-308.
Waldorf, D., Reinarman, C., & Murphy, S.
1991 *Cocaine changes.* Philadelphia, Temple University Press.
Weil, A., & Rosen, W.
1993 *From chocolate to morphine.* Boston: Houghton Mifflin, Boston.
Zimmer, L., & Morgan, J.P.
1997 *Marijuana myths marijuana facts.* New York: Lindesmith Center.
Zinberg, N.E.
1984 *Drug, set and setting. The basis for controlled intoxicant use*. New Haven and London: Yale University Press.