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Addiction Treatment Professionals are not the Gatekeepers of Recovery

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Abstract

Addiction treatment is beneficial to many individuals who have substance use disorders. However, only a minority of individuals who recover from addiction receive it. Despite this, addiction treatment is sometimes granted the status of the "gatekeeper of recovery". The myth that treatment is necessary for recovery has no empirical support. It also undermines the confidence of individuals in their ability to change on their own and is unduly dismissive of the efforts of nonprofessional helpers.

Keywords

Addiction treatment; professionalism; mutual-help groups; natural recovery; pastoral counselling

Question: How many treatment professionals does it take to screw in a lightbulb?

Answer: Just one. We grab the light bulb and then the world revolves around us.

Addiction treatment is a worthy enterprise in which trained helping professionals provide counselling, medications, skills training, vocational guidance and other services to patients in need. I have provided addiction treatment, overseen its administration at the local and national levels, directed government funding to it, and advocated for it. I have done these things because I believe addicted people deserve quality health care and because scientific evidence shows that many do in fact recover with the aid of treatment. That said, professionally-provided addiction treatment is the subject of something I refer to as "the gatekeeper myth". The gatekeeper myth holds that the path to recovery can only be walked with the aid of highly-educated specialists in addiction treatment. This myth undermines individual efforts to change without treatment (i.e., "natural recovery" see Kilngemann & Sobell, 2011; Shorkey, 2004) and denigrates the contributions of recovery supports other than professional addiction treatment, including mutual help groups, pastoral counselling and swift, certain and fair community supervision programs operated by the criminal justice system. Further, even though the gatekeeper myth in one sense flatters addiction treatment professionals, it can also create unrealistic expectations that are eventually destructive to treatment's credibility.

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Let me begin by describing how the gatekeeper myth expresses itself in public policy, professional attitudes and conduct and in the lives of people manifesting substance use disorders. At a policy level, the gatekeeper myth is instantiated in studies of "unmet need for treatment". For example, many national governments have agencies (e.g., The U.S. Substance Abuse and Mental Health Services Administration, 2014) that regularly tot up the number of people in the population who meet diagnostic criteria for substance use disorder and the proportion of those people who receive treatment. If the proportion is 10%, the "treatment gap" is declared to be 90%. The implicit plea for funding sufficient to meet this 90% level of "unmet treatment need" is predicated on the gatekeeper myth's assumption that everyone with a substance use disorder must receive treatment from helping professionals as there no other way to recover. As I will discuss presently, this assumption is demonstrably untrue.

One also sees the gatekeeper myth reflected in the conduct and attitudes of some helping professionals. For example, despite the fact that far more addicted individuals seek help from non-professional mutual help organizations than from addiction treatment professionals, the amount of theorizing, analysis, commentary and research devoted to professionally-provided addiction treatment dwarfs that devoted to mutual help organizations (Humphreys, 2007). This remarkable allocation of attention stems from the gatekeeper myth, which more generally leads some helping professionals to undervalue approaches to recovery that they do not themselves implement and oversee (Humphreys, 2004; Sarason, 1981). After all, why should addiction professionals focus their thinking on anything else, respect anything else, or refer a patient anywhere else, if we ourselves are the fount of all recoveries?

The gatekeeper myth also plays out in individual lives. Almost 30 years ago, I assessed a crack cocaine and heroin dependent woman who had used drugs on a daily basis for many years, stopping 54 days before our interview. When I asked her why she had stopped using drugs, she informed me that for the first time in her life she had decided to tackle her substance use problem. She had secured a place on the waiting list for treatment 54 days ago, and had abstained since "to get ready for treatment". The fact that she had attained the longest period of abstinence of her adult life without treatment had no impact on her belief that something special was going to happen when she finally was admitted, and that whatever it was would deserve credit for her recovery. I secretly wondered at the time if staying on the waiting list forever might have been a benison for her.

The reality of how people with substance use disorders change

Contrary to the tenets of the gatekeeper myth, every single addicted person did not die from their disorder until medicine began developing addiction treatment specialists a few centuries ago (White, 1998), and neither is that their fate today. As has been shown by survey research conducted over the past half-century, *most people who recover from a substance use disorder never access any professional treatment at all* (Klingemann et al., 2001; Klingemann & Sobell, 2001). Substance use disorders are not tumors that are removed by doctors in the hospital, but chronic behavioral health problems that are continually shaped by individual motivation, skills, choices and environments (Humphreys & Tucker,

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2002; Kelly & White, 2010). Importantly, the influence of the interplay of individual and environmental factors on substance use is just as pronounced among individuals who have been treated as those who have not (Moos, 1994).

Many extra-treatment factors influence the course of substance use disorders: the availability of substances in the environment, the presence of alternative rewards in the environment, the degree of support and stressors present in families, the quality of workplaces and schools, and the positive and negative consequences of use (Moos, 1994). Individual decisions – again whether someone receives treatment or not – also shape the course of substance use disorders. Almost every practical strategy I might recommend as a trained healthcare professional (e.g., avoiding haunts where one scores drugs, finding alternative ways to relax and have fun, socializing with people who don't drink, making a plan to change and setting reasonable limits on one's behavior) are thought of and implemented independently by countless untreated, untrained people manifesting substance use disorders. Some people of course are utterly disabled by their addiction, but most function to at least some degree in the domains of work, education and family. When they choose to address their substance use disorder, they bring their existing coping skills and intelligence to bear rather than having their chances of recovery be utterly dependent on whether they consult a helping professional like me.

Just as important, even when people do seek help for a substance use disorder, only in a minority of the world's cases are they going to medical professionals. Most notably, many countries have thriving mutual help organizations such as Narcotics Anonymous, Women for Sobriety, Abstainer's Clubs, Vie Libre and Danshukai, to name only a few (Humphreys, 2004). In the developing world and even to some extent in the developed world, pastoral counsellors from various religious traditions are also a common source of care (World Health Organization, 1993). Such "amateurs" are sometimes criticized for not being "real treatment" but prospective outcome studies indicate that mutual help organizations are a major route to recovery (Humphreys, 2004; Strang et al., 2012). And if you believe that a rabbi, priest, reverend or imam cannot provide counselling like a well-trained addiction treatment professional, recall that that the largest meta-analysis of the question every done estimated the impact of professional training on psychotherapy outcomes at .00 (Smith, Glass, & Miller, 1980).

Last but not least – as ideologically dissonant as it may be for the health professional tribe to accept – a new generation of "swift, certain and fair" criminal justice interventions is showing remarkable ability to curtail substance use without treatment (DuPont & Humphreys, 2011). Programs such as HOPE probation and 24/7 Sobriety employ drug/alcohol testing and contingency management principles to mandate that criminal offenders (e.g., repeat drink drivers, those guilty of assault) refrain from substance use or else face swift, certain but modest consequences (e.g., one night in jail). Although treatment is offered to all participants, most do not take advantage of it. Nonetheless, rigorous research shows that such programs dramatically reduce substance use and its consequences (Hawken & Kleiman, 2009; Kilmer et al., 2013). Despite the strength of the evidence on these programs (unlike in virtually all treatment evaluation studies, outcomes are assessed continuously based on biological tests taken as often as twice a day) some treatment professionals flatly

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refuse to believe the findings. When the government of The United Kingdom recently passed a law allowing such programs, it explicitly exempted anyone with diagnosed alcohol dependence on the assumption that they were incapable of abstaining from drinking without professional addiction treatment. Gatekeeper hypothesis devotees similarly argue that anyone who abstains from substance use due to being in a swift, certain and fair community supervision program must not have had a "real" substance use disorder. Why then did many of these same people have previous, unsuccessful addiction treatment?

From the point of view of the gatekeeper myth, programs such as HOPE probation and 24-7 Sobriety cannot work. But as mentioned, substance use behavior is profoundly shaped by environmental forces. Moving from an environment in which substance use is usually rewarded to one in which abstinence is consistently and promptly rewarded whereas substance use is consistently and promptly punished affects people's behavior. Only a believer in the addiction treatment as gatekeeper myth would find this surprising.

Why we must let go of the gatekeeper myth

When we convey to the public that the only way people can recover from substance use disorders is to seek out treatment professionals, we are not only spreading a falsehood, but doing harm, much as if we told the public that the only way to lose weight was to ask a doctor to perform liposuction or gastric-band surgery. This message undermines the self-confidence and autonomy of people with substance use disorders and may also lead them to spend money on treatment services they don't need (Good for us obviously, but not for them). A more accurate message would be that there are many steps other than treatment-seeking that people can undertake to change their own substance use behavior, and, that most people who do change are able to do so without professional treatment.

Second, it is wrong to even implicitly minimize organized efforts to promote recovery that do not emanate from addiction treatment professionals, for example by dismissing the evidence supporting their effectiveness outright or by seeing them only as junior partners who provide adjunctive services after the real work has been done by us professionals. Many addicted people derive significant benefit from mutual help organizations, pastoral counselling and swift, certain and fair probation programs for substance-involved offenders. From a public health viewpoint, rather than putting our fellow travelers down, we should be celebrating their creation of additional paths to recovery.

Finally, though the idea that treatment is the royal route to change is at one level self-aggrandizing, in the long run it sets us professionals up for failure. If the fate of all addicted people is truly in our hands, then a surge in substance use disorders that occurs when, for example, the mill closes and all jobs are lost, or the streets are flooded with a new addicting substance, is our responsibility. Having spent so much time denying the influence of any force other than ourselves when things go well, we will not be able with a straight face to blame those some forces when things go badly and we are blamed.

To return to my opening, addiction treatment is a valuable, indeed often lifesaving, form of help for many individuals seeking recovery and should be made as accessible and as high-quality as possible. Yet it will never be the only route to change and to suggest otherwise is

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inaccurate and probably harmful. Even people with serious substance use disorders possess individual resources and can initiate change attempts on their own. Environmental factors will also constantly influence recovery, whether people receive treatment or not. And many targeted efforts to change addicted behavior that are beyond the reach of the medical establishment – mutual help organizations, pastoral counselling, and swift, certain and fair supervision progams – are perfectly fine sources of support for people seeking recovery from addiction.

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Biography

Keith Humphreys, Ph.D., US, is a Career Research Scientist in the U.S. Veterans Health Administration and a Professor of Psychiatry and Director of Mental Health Policy at Stanford University. His research, clinical and public policy work focuses on substance misuse and its concomitants. He has been extensively involved in the formation of public policy in the U.S. and the U.K., and was a volunteer in the international humanitarian effort to rebuild the mental health system of Iraq.

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