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Implications of treatment providers' varying conceptions of the disease model of addiction – A response

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People providing treatment for alcohol and other drug (AOD) issues are a diverse group. They come from very different walks of life, with varying educational backgrounds, and bring vastly different experiences to the task of helping people overcome problems with drugs. Unsurprisingly, they also have divergent views about the nature of AOD problems (whether viewing it as a disease, a moral or social problem). As a result, people accessing AOD services may face multiple, even contradictory, explanations of their AOD issues [1].

In their responses to our systematic review of treatment providers' views about the disease model of addiction [1], Savic and Lubman [2] and Storbjörk [3] make compelling cases against attempting to 'standardise' treatments to address contradictory explanations that treatment seekers may face. Savic and Lubman's argument against implementing an 'overarching, universal addiction model' is threefold. Firstly, attempts to translate a standardised treatment model into practice would be challenging. Secondly, a 'one-size fits all' approach would not account for people's complex needs in treatment. Thirdly, implementing an overarching model would paternalistically rely on 'expert' knowledge at the expense of consumer participation and client-centred care. Advocating for the maintenance of multiple treatment models in practice, Storbjörk argues that "different conceptions in the treatment landscape [...] facilitate better matches between service user beliefs and the models and goals available" [3].

However, these arguments against attempts to standardise addiction treatment, run the risk of overlooking the consequences of a system where treatment providers have such varying views about the underlying nature of AOD problems. Savic and Lubman [2] understate the extent to which treatment providers' varying conceptualisations of addiction shape and direct treatment practices. Savic and Lubman argue that clients' needs and beliefs should be the starting point in understanding their concerns and that treatment providers play the role of presenting clients with a range of possible ways of understanding and addressing their problems. While we don't disagree, the findings of our review suggest that treatment providers play a more active, assertive role in directing care in line with their belief systems about addiction and treatment [1].

For example, there is evidence that treatment providers who support the disease model of alcoholism are more likely to insist on abstinence as the only treatment goal [4], less likely to consider controlled drinking [5], more likely to refer to Alcoholics Anonymous [6], and more likely to impose their own treatment goals rather than incorporate the goals of the client [5]. A critical area of future research is the extent to which support for the disease model of addiction influences practice and how discrepant client and treatment provider views of addiction are negotiated in care settings where power and authority is vested in the treatment provider.

Storbjörk [3] discusses the contested medicalization of addiction in the “non-medical stronghold” of the Nordic countries. As she states, in Sweden, key stakeholders within AOD treatment and policy resist abandoning the social tradition in favour of biomedical understandings of addiction problems (e.g. [7]). Storbjörk’s commentary prompts us to consider tensions between biomedical and social frameworks of addiction in the global context. For instance, when examining AOD treatment in Victoria, Australia, we see a highly heterogeneous treatment provision landscape made up of services that differ in treatment philosophies (e.g. pharmacotherapy clinics based on harm reduction approaches; therapeutic communities based on abstinence models). Within such settings there has been tension (e.g. [8]) between a biomedicalised framing of addiction as a ‘chronic, relapsing brain disease’ [9,10], and social models such as the *Social Identity Model of Recovery* [11] that see the solutions to AOD problems residing within individuals’ social networks.

Schmidt [12] also draws attention to conflicts between different models of addiction. She notes that we found that treatment providers appear to endorse disease and other models simultaneously and strategically deploy different models for their presumed therapeutic benefits. Schmidt suggests that moralised formulations of the disease concept were present in Benjamin Rush’s original formulation of alcoholism as a ‘disease of the will’ [13,14] and, because they “have never fully dropped away”, continue to pose problems for clients (e.g. stigma deterring people from accessing treatment). Schmidt sees this as problematic because addiction treatment stakes its claims to legitimacy on evidence-based medical science rather than ideological systems of belief.

In addressing Storbjörk’s [3] and Schmidt’s [12] concerns, we see no reason why different treatments based on social and biomedical models cannot co-exist, particularly given that medical and social factors are so intertwined for people experiencing AOD problems. Treatment clients may benefit from both social interventions (e.g. built on a Social Identity of Model of Recovery approach) and biomedical interventions (e.g. pharmacotherapies). However, matching people to individualised treatments remains a challenge. Addressing this challenge, centralised intake and assessment processes (such as we see in Victoria, Australia) provide one practical way to assess clients’ needs and direct them to appropriate care.

As we elaborated on in our review [1] (p. 21), the ‘hybrid approach’ [15] in which treatment providers endorse varying models of addiction simultaneously, may be useful. In one ‘treatment situation’ the use of a medical model might de-moralise clients, whereas in another, a moral model may encourage clients to take responsibility for their recovery [16,17]. Critically, the decision when to deploy different models and how to frame clients’ AOD use lies within the expertise of treatment providers and their interactions with clients. In view of this, training programmes are vital for treatment providers on the clinical impacts of disease models of addiction.

To conclude, all three commentaries point to a wider debate on how diverse views of addiction cohere and function in treatment services. While it may not be preferable to standardise treatment along the lines of a single approach (e.g. a disease model approach), in order to improve treatment we need to give greater attention to addressing the diversity of treatment providers' views and their impacts on clients seeking treatment and support to address AOD issues.

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