Treatment Doesn't Work

Like Alcoholics Anonymous, treatment professionals claim success in the face of contradicting evidence. AA groupers boast “Rarely have we seen a person fail who has thoroughly followed our path.” The truth is people rarely succeed when following the path of those in AA. As stated previously, 95% of the existing treatment centers in the United States adhere to the 12 Step philosophies. Not surprising, the success rate of treatment is no different from the success rate of AA: 3%.

While treatment professionals boast “treatment works,” the question is what is exactly working? As Stanton Peele so eloquently put it “…the blanket assurance that "treatment works" does precious little for most people who drink too much.” (All Wet, Stanton Peele) Of course treatments alternative counterpart and co-conspirator, Alcoholics Anonymous, leads with the same misleading and outright dishonest assurance that its program “Works if you Work it.” Groupers, the GSO, and AAWS conveniently claim success without any foundation. In reality the statement is a complete contradiction to empirical evidence. Both AA and treatment are outright failures when held to any standard but their own. But, apparently it’s a matter of semantics. It comes down to who is using the word “works.”

The general public would believe that these programs “working” would be a testament to helping people with substance abuse issues get sober. In other words the people who join the groups can get well. But, after arriving in treatment or AA with the hopes of finding a way out of the misery individuals have created, those in need are told that they can never get well, there is no cure. So, what exactly is working? What kind of program are our loved ones attending?

The knowledge that “Treatment Doesn’t Work” is not an idea exclusive to those outside of the existing treatment paradigm. Those within it, and promoting it, are also well aware of treatments ineptitude and damage. Enoch Gordis, Director of the NIAAA stated the following: “In the case of alcoholism, our whole treatment system, with its innumerable therapies, armies of therapists, large and expensive programs, endless conferences, innovation and public relations activities is founded on hunch not evidence, and not science…To determine whether treatment accomplishes anything, we have to know how similar patients who have not received the treatment fare. Perhaps untreated patients do just as well. This would mean that the treatment does not influence outcomes at all. Perhaps treated patients do worse: that is perhaps treatment is really harmful in unexpected ways so that patients who are not treated get better more often. Perhaps even if the treatment is helpful, a little bit of it is just as useful as a lot of it.”

Again, this statement was made by Enoch Gordis. For years he has promoted the benefits of treatment as the spokesman for one of the largest institutions for drug and alcohol treatment and program research. It was Enoch Gordis who implemented the $27 million dollar campaign attempting to prove “Treatment Works”. Enoch heads the organization founded by one of the foremost contributors to the institution of the medical model and the disease concept, R. Brinkley Smithers. One must understand that in many respects

Enoch is a politician lobbying for public support and federal funding for the programs his organization advocates. This statement would be like the president saying we're going to try communism based on the hunch that it could benefit the citizens.

We could safely assume that Enoch made this statement based on the knowledge that treatment is a detriment to those who enter it. Politics does not allow for statements that could easily collapse platforms. It would be ignorant of us to assume he has no real knowledge of the effect of treatment after years of being directly involved with treatment programs and funding for them.

Baldwin Research has long been aware of the failure of conventional treatment methods. When the Saint Jude Retreat House was founded the intention was to provide a much needed working program. After the program was established, and it worked, the next step was to make efforts to change the existing treatment paradigm. As we began proactively moving forward, it has been important to show the difference in success of conventional methodologies and the didactic social-educational method of the Saint Jude Retreat House. While we have accomplished this, there have been some difficulties that need pointing out.

It is difficult to compare an alternative program to AA in regards to success. The problem is AA is a "lifelong process" and 95% of treatment providers recommend AA and NA as aftercare for program graduates. While the patient has successfully completed one program they can never complete AA. Alcoholics Anonymous, like every organized religion, has no completion; it is a way of life. As treatment absorbed AA philosophy, treatment became a separate sect of its own, but remains intertwined and enmeshed in 12-Step ideology. While still dedicated to the original principals in practice, variations of the original program pulled the possibility of success further down the spiral. Treatment and AA joined with a seemingly genuine purpose, but soon warped and twisted through an unfettered amalgamation of misinformation and confusion, soon, giving birth to common failure and anecdotal success. Alcoholics Anonymous, and thereby conventional treatment centers, are dogmatic and ritualistic programs, developed by a deified leader who misrepresented himself from the start to provide the same failure in sobriety for millions that he had as an individual. Comparable to a religious institution, there is no program completion. The Saint Jude Retreat House offers a program that is 6-weeks. The program ends and life begins. For AA and treatment, substance abuse ends and recovery begins, never to end.

The treatment industry pumps out empty promises and walks away hand-in-pocket, fist full of familial contribution, confident they did the best they could. The program graduate steps out of the door riddled with fear about "what's out there." Professionals drive a wedge between the real world and the world of recovery that provides for back breaking stress for any substance abuser believing dogmatic treatment jargon.

While many question the efficacy of conventional treatment programs most do not understand how treatment began. Like the disease concept of alcoholism, the path to national acceptance was paved by politics and personal agenda.

In the late 1800's drug addiction and alcohol abuse were not publicly viewed as national problems. In fact, in the past, drinking in quantities that today would be considered outrageous, were a social norm, early pioneers drank alcohol as a substitute for water. Most had come from countries where pollution made the consumption of water dangerous. But, even with the amounts of alcohol consumed, alcoholism was extremely rare. At the same time, in the early late 1800's and early 1900's doctors freely prescribed opiates like morphine. They were considered a staple of medical practice. A more familiar brand name today, Bayer, manufactured heroin as an anti-diarrheal. "During this period, writes historian David T. Courtwright, "The public thought of addiction as neither a crime nor a fit object for mandatory treatment." (Sarah Glaser, "Treating Addiction," CQ Researcher, January 6, 1995)"

But, the practice of prescribing opiates soon turned into a problem of its own. Many middle class women were becoming addicted to the drugs. Some doctors set up asylums to treat the addicted and many could buy "opium habit cures" to assist in relieving the problem. But by the early 1900's, injectable morphine and cocaine were developed which led to a public concern for a growing population of people using the drugs for pleasure. Shortly thereafter the American public went from an opinion of addiction as, "being a pathetic condition to a stigmatized one," writes Courtwright.

In 1914 the Harrison Act was passed in an effort to control the drug problem. After prohibition laws were passed in the 1920's, the government stepped up its efforts to eliminate drug abuse by closing the first maintenance treatment facilities for addicts. But, due to an influx of drug addicted prisoners, federal officials, in conjunction with the U.S. Public Health Service, successfully proposed and implemented two institutions that used a medical approach to house addicts in Kentucky and Texas.

The late 1940's brought with it an epidemic of heroin abuse and due to articles published advocating the benefits of methadone in treating addiction; the medical model was more widely used and accepted. Two major contributors to the acceptance of the medical model were Vincent Dole, an endocrinologist, and Marie Nyswander, a psychiatrist. They purposed that heroin abuse led to a permanent metabolic imbalance that necessitated the use of corrective medications.

In the 50's Alcoholics Anonymous was available for problem drinkers, but no such meetings were available for addicts. A former addict named Charles Dederich began meetings for addicts called Narcotics Anonymous. Eventually his efforts produced the first Therapeutic Living Community called Synanon. Since its inception, its methodology has been replicated by other facilities, but, has been done, in the face of Synanon's failure to produce results.

In the late 1960's an amendment to the Community of Mental Health Centers Act, mandated substance abusers to treatment centers implemented by the Kennedy Administration. At this time a reputable and wealthy philanthropist, R. Brinkley Smithers, stepped on to the field. He was the financier for much of the "research" promoting the disease concept and treatment programs. His ties to Richard Nixon

allowed for the creation of the NIAAA and the continued existence of a struggling NCA(DD).

The Nixon-era brought with it a stepped up “War on Crime.” Nixon’s administration financed a national growth in methadone programs. The expansion of methadone treatment centers was implemented in the hopes that addicts would substitute methadone for heroin, therefore, reducing crime. In 1971, Nixon created the Special Action Office for Drug Abuse Prevention which began increased federal funding for substance abusers awaiting treatment. It was at this point that control over federal funding and client payment for treatment centers began to shift to state organizations. The shift from Federal control to state control began a rapid influx of private institutions. The treatment industry blossomed into a multi-billion dollar juggernaut. The modalities implemented were not researched or proven effective but, treatment providers were not obligated to provide success. Therefore, in the face of lacking empirical evidence and success, the dollars continued to roll in by the millions.

There is substantial evidence that the decline of Alcoholics Anonymous’ effectiveness over a forty-year period was inversely proportional to the growth of the drug and alcohol rehabilitation industry. Our initial interest, then, was with Alcoholics Anonymous, and not the rehabilitation industry. However, as we studied Alcoholics Anonymous’ declining success rate, it was clear that the decline in the success rate emanated from the burgeoning rehabilitation industry. The rehabilitation industry promoted a secular solution based on the assertion that alcoholism and drug addiction (and perhaps other compulsive and obsessive conditions) are forms of mental illness. As such, the treatment for these conditions, in many states, was legislated to be the responsibility of the mental health community.

Moreover, these legislated methods of treatment were implemented without any clinical evidence supporting the notion that alcoholics and drug addicts could benefit from group therapy, counseling, and other psychological techniques. As time went by and few recovered, the mental health community concluded that alcoholics and drug addicts could never completely recover and relapse became an unexpected characteristic of the “disease.” Rather than improving the treatment methods or trying alternative methods to medical and psychological methods, the treatment community changed its understanding of the malady to fit the poor results achieved by the treatment offered.

Of course the lack of treatment success not only effects the individuals well being but has been found to be a tremendous waste of money. In the early 1990’s, Dr. Diana Chapman Walsh of the Harvard School of Public Health reported that after two years it was 10% less expensive to refer people to Alcoholics Anonymous directly without any treatment. The significance of this study is that it did head to head comparison between AA and professional treatment and concluded, as we have, that the benefits of professional treatment programs are questionable.

While scientific studies are lacking, treatment professionals, through personal experience do have an estimate for conventional program success. Surprisingly, the treatment

community actually uses the low success rate to motivate patients. Credentialed alcoholism counselors typically tell their patients that only 1 in 12 (many counselors use the ratio of 1 in 30) will "make it." The theory is that if only one in twelve (or thirty) patients are going to get well, each one wants to be the one who gets well. Whether the patients try or not seems to have little impact on the outcome of their treatment, and it is of more than passing interest that independent studies confirm that, indeed, the success rate for these programs range from 3% to 8% at 5 years post treatment. Treatment professionals tell their patients and the public that 1 out of 10 to 1 out of 30 "will make it". 1 out of 10 is 10% and 1 out of 30 is around 3% (some numbers are higher or lower, but on average these are the excepted numbers). The obvious contrast is that those who enter treatment have 20-27% less of a chance to recover then those who never entered treatment. Treatment programs actually lessen the chances of success for their patients.

Deborah Dawson of the NIAAA, an epidemiologist, analyzed 4,585 interviews from those who at one time had been alcohol dependent. Dawson's study conclusively showed that untreated alcoholics are approximately 2 times more likely to get sober and stay sober then alcoholics subjected to treatment. Henry R. Miller of the University of New Mexico in Albuquerque has concluded much of the same. "In 1995 Henry R. Miller and his colleagues rated forty-three kinds of treatment by combining the results of 211 controlled trials that had compared the effectiveness of a treatment [method] with either no treatment or with other alcoholism therapies. The treatment with by far the best score was 'brief intervention'-followed by social-skills training and motivational enhancements… The Miller report described the standard treatment in the United States as 'a milieu advocating a spiritual twelve-step (AA) philosophy, typically augmented with group psychotherapy, educational lectures and films, and …general alcoholism counseling, often of a confrontational nature."

This means that statistically, the success that treatment claims for there own is actually from a group that would have recovered without treatment. In other words treatment at best has no effect. Billions of dollars later and treatment has at best no effect? Even more striking, treatment takes credit for the "success" of those people who would have gotten well without treatment. In addition, treatment professionals have claimed brief interventions as a part of treatment methodology when they are mutually exclusive.

In Alcohol Alert a publication of the National Institute on alcohol Abuse and Alcoholism, No. 43, April 1999, Dr. Gordis reports the following: Some studies conducted among alcohol-dependent patients have found that brief intervention is as effective as more expensive treatment approaches used in specialized alcohol treatment settings (8,9,41,42.) Edwards and colleagues (8) compared the effectiveness of one session giving brief advice to stop drinking with standard alcohol treatment among 100 alcohol-dependent men… One year later both groups reported a 40% decrease in alcohol related problems. After 2 years patients with less severe problems were more likely to report improvement if they received brief intervention than if they received intensive treatment. However, patients with more severe problems were more likely to report improvement if they received intensive treatment (43)." A brief intervention is just that, brief. It can consist of as little as a family member saying "I think you should stop drinking" or a

person asking themselves if they have a problem. Treatment is not a brief intervention it is exactly the opposite.

"The American Medical Association estimates that 25-40 percent of patients occupying general hospital beds are there for treatment of ailments that result from alcoholism. In the United States, the economic costs of alcohol abuse exceed $115 billion a year. Physicians in general practice; hospitals and specialty medicine have considerable potential to reduce the large burden of illness associated with alcohol abuse. For example, several randomized, controlled trials conducted in recent years demonstrate that brief interventions by physicians can significantly reduce the proportion of patients drinking at hazardous levels." (Thomas R. Hobbs, Ph.D., M.D, "Managing alcoholism as a disease 1998. What is not surprising is that those treatment methods most commonly used by current treatment centers in the United States are those that scored the lowest for effectiveness in Millers study. In final analysis the Dawson Study and Millers findings show that depriving alcoholics of the treatment modality most commonly used would actually be beneficial for the alcoholic and addict.

Baldwin Research Institute Inc. recently surveyed 38 treatment programs spread across 36 states. We discovered that the average cost per day was $370.94. The average cost of program completion was $18,844.39 and the average length of stay was 81 days. Of the 38 programs, 90% were 12 Step based, 89% have patients attend AA meeting while in the program and 95% taught the disease concept. Only one program had verifiable statistics.

"Barry McCaffrey, drug czar, and the government's Substance Abuse and Mental Health Services Administration, announced as proof that treatment works a study in which 1,800 people were surveyed after treatment (in other words, this was a "pre-post" comparison): One in five were still clean and sober." (Stanton Peele) That's 20%. Once again, reduced use is the basis to prove their point — a 45 percent drop in cocaine use, a 28 percent drop in marijuana use, and a 14 percent drop in heroin and alcohol use. Even ignoring the idea that reduction of use is not the supposed goal of treatment and reporting it as such only misleads the public, 20% hardly seems like success.

This is not uncommon by any means. Most, if not all studies that support conventional treatment methods, are skewed and misrepresentative. Almost all who report a success rate more then 30% survey their patients while currently in treatment or shortly after leaving. Many use a decline in negative consequences as a determination for success as well as program completion and discontinued use of primary substance. Very few consider sobriety, the supposed goal of a treatment program, a measurement of its success. The absurdity of this situation is striking.

A report by Linda C. Sobell, PhD, John A Cunningham, PhD, and Mark B. Sobell, PhD called Recovery from Alcohol Problems With and Without Treatment: Prevalence in Two Population Surveys also confirms the previous statement. This is a published report presented in the American Journal of Public Health, July 1996, Vol. 86, No. 7. This report demonstrates that more alcoholics recover without treatment than do those who

receive treatment, at a rate of more than 3:1. To say that "Treatment Doesn't Work" according to this study, and many others would grossly understating he impact of treatment.

On any given day there are 700,000 people in the United States receiving treatment. One in 5 men and 1 in 10 women who visit their primary care providers meet the criteria for at-risk drinking, problem drinking, or alcohol dependence (Manwell et al. 1998). In the year 2000, the census bureau released a population overview that estimated there were 134,979,000 men in the United States. Using the Manwell et al study that would mean there are 26,995,800 men who show signs of alcohol abuse and 14,108,000 women who also show signs of alcohol abuse, giving a combined total of 41,103,800 million residents of the United States who can be classified as alcoholics. This is 6.7% of the population.

Using the report by Linda C. Sobell, PhD, John A Cunningham, PhD, and Mark B. Sobell, PhD called Recovery from Alcohol Problems with and without Treatment: Prevalence in Two Population Surveys, with the above numbers, if everyone who was diagnosed with alcohol dependence sought treatment, 27,128,508 would not get sober in treatment. Using Kolenda's estimates, if everyone who was diagnosed with alcohol dependence sought help in AA, after five years, 41,001,041 will have failed in AA.

An area where OASAS (New York States Certifying agency for treatment programs known as Office of Alcoholism and Substance Abuse Services) and Baldwin Research have been unable to agree is the efficacy of treatment programs. We have provided OASAS with information on dozens of studies over the years that indicate that the efficacy of OASAS style treatment results in less than 30% of those treated remaining sober and drug free for six months and less than 14% remain sober and drug free for five years or more. We provided OASAS the results of a New York State adolescent study we conducted in 1993 where 100% of the 30 subjects from three different school districts relapsed within 14 months post treatment. All thirty adolescents were treated at OASAS type treatment programs.

Recently we reviewed a report by the Office of Alcoholism and Substance Abuse Services or OASAS (New York States treatment program certifier and provider) entitled OASAS Evaluation Systems: Preliminary Analysis of Behaviors of Clients Remaining in Treatment at Least Six Months. This report asserted some rather remarkable conclusions that to be sure, supported OASAS treatment programs, but failed to be persuasive as unbiased, scientific study.

Section IV of this report states: "Although an experimental design was not employed and a control group was not utilized, the data presented in this report convincingly demonstrate the effectiveness of the four drug/alcohol use." Without a study, it is reasonable to expect that while in treatment, particularly residential treatment, measurements such as arrests, incarceration, detoxification services, hospitalizations, ER episodes and drug and alcohol use would decline. However, to suggest the decline is the result of a specific type of treatment, such as psychological or medical treatments, would not be true. Non-professional social programs comprised approximately 30% of the

providers in the CALDATA Study. These social programs presented better overall results than residential programs, outpatient programs, and methadone programs, although outpatient and methadone programs were less expensive in the short term.

Further, in section IV of this report it states: "The analysis demonstrates that clients retained in treatment at least six months produced significance saving to New York State taxpayers." These "savings" may be far more elusive then the report indicates. The author points out "that the cost of treatment was not factored into the savings figures." The author suggests that because the benefits are so great, accounting for the cost of treatment would not appreciably change the results. Although interesting, such a conclusion is not accurate. Conservatively, the average cost (average of all four programs types) of six months of treatment can be estimated at $3,600 per individual. Thus, the cost of treatment for the entire client sample would be approximately $67 million or a loss to the taxpayers of $16.8 million. If one extrapolates the purported savings from the 58% sample to all the clients expected to stay in treatment at least six months the total savings would not be $87 million but a loss of more than $30 million.

It is disturbing that the report measures the efficacy of the programs using pre-existing conditions in its favor. For example, the report indicated that Alcoholism Outpatient Clinic programs were 52% effective in "Maintaining Full-Time or Improving Employments-Related Status." If people were employed at the time of entry into the program, there is not evidence that suggests that they would not have been employed six-months later without attending the program. What's more, it is likely that 45% or more of the 52% were already employed and would have remained that way without treatment. Thus, the "real" impact of the treatment may have been 4% or 5%. However, even 4%, 5%, or 7% cannot be attributed to the types of treatment promulgated by OASAS. Arguably, those same individuals putting the same amount of effort into Alcoholics Anonymous, which costs nothing, could have achieved the same results.

But probably the most disturbing information is the report of "% Discontinued Use of Primary Substance." This category implies that one measure of efficacy of treatment is the reduction in use of the clients' primary substance while in treatment. While it would be good if clients refrained from using their drug of choice during the time they are in treatment, the goal of treatment programs is usually thought to provide methods and skills for clients to refrain from using their drug of choice when they are not in treatment.

Recently, Baldwin Research Institute, Inc., requested program outcome studies or success rates of OASAS certified programs. Not surprising this is the response we received from Alan Kott, Director for Evaluation on December 29, 2003:

"Your information request was forwarded to me by our Communications Office. OASAS traditionally did not conduct post-treatment outcome studies. We do have one such study currently underway in the Northeast Region, but results are not yet available. However, we continually monitor program performance utilizing retention rates, completion rates, employment-related involvement and abstinence measures. This information is collected

at client discharge. So, whether we can provide you with the information being requested will depend on how you are defining 'success.'"

Our organization defines success as sobriety, which, most would assume, is the goal of all treatment programs. Apparently this idea is lost to OASAS. OASAS is a government funded organization who, apparently, has never had to prove the efficacy of their programs. Yet, this same organization, opposes treatment alternatives based on the assertion that their programs are more affective. Obviously, their assertion is an outright lie because they have no studies to back their claims what-so-ever nor have they ever been required to produce any.

We, however, are not the only organization that has been reporting poor results by OASAS type treatment programs. Over the past decade insurance companies have overtly backed away from drug and alcohol treatment citing poor results as the reason. Of course, the idea that treatment is ineffective is not only a concern for insurance companies. Doctors are aware as well. "Surprisingly, Dr. Peele's view that alcoholism is a personal conduct problem, rather than a disease, seems to be more prevalent among medical practitioners than among the public. A recent Gallop poll found that almost 90 percent of Americans believe that alcoholism is a disease. In contrast, physicians' views of alcoholism were reviewed at an August 1997 conference held by the International Doctors of Alcoholics Anonymous (IDAA). A survey of physicians reported at that conference found that 80 percent of responding doctors perceived alcoholism as simply bad behavior." (Thomas R. Hobbs, Ph.D., M.D, "Managing alcoholism as a disease 1998.

But, treatment professionals once again pass the blame. "The problems are a lack of training on substance abuse and doctors' lack of faith that traditional treatment methods work," says Joseph Califano, president of the National Center on Addiction and Substance Abuse at Columbia University, which conducted the study. USA Today Information Network May 10, 2000. The disease concept is a convenient excuse for treatment providers. Not only does it provide a reason for failure, it excuses counselors from responsibility.

The question is why are we told treatment does work? Why are studies sited that "prove" that they do? It all comes down to interpretation of the facts. Such proclamations of treatment success are common among biased researchers with personal agendas. In fact, these non-scientific proclamations are so common and so ludicrous that the scientific community is now publishing articles ridiculing these reports. I direct your attention to An Invitation to Debate: How to have a high success rate in treatment: advice for evaluators of alcoholism programs by William R. Miller (Department of Psychology, University of New Mexico) and Martha Sanchez-Craig (Addiction Research Foundation, Toronto, Ontario, Canada. This article appeared in Addiction (1996) 91(6), 779-785. The abstract reads as follows: "Two seasoned alcohol treatment researchers offer tongue-in-cheek advice to novice program evaluators faced with increasing pressure to show high success rates. Based on published examples, they advise: (1) choose only good prognosis cases to evaluate; (2) keep follow-up periods as short as possible; (3) avoid control and comparison groups; (4) choose measures carefully; (5) focus only on alcohol outcomes;

(6) use liberal definitions of success; (7) rely on self-reporting and (8) always declare victory regardless of finding." While Miller and Sanchez-Craig's humor is not lost to us, the tragic truth they expose is not humorous. Alcoholics and drug addicts are dying everyday because of studies that are published proclaiming treatment works when, in fact, everyone in the treatment industry with any ability to be objective knows that it doesn't.

Certainly Baldwin Research Institute, Inc. reporting the truth to the public about drug and alcohol treatment not working is an economic threat to treatment programs. Furthermore publicly reporting that treatment doesn't work is an economic threat to the treatment industry whose entire existence is dependent on the drug and alcohol treatment community. And it is a direct economic threat to Alcoholics Anonymous who derives the bulk of its revenue and members from the treatment community.

It is not the mission of Baldwin Research Institute to end substance abuse. Substance use and abuse has existed for thousands of years. Substance abuse is socially functional. It has a purpose and a place. But, it is the mission of Baldwin Research Institute to provide a working solution for people who want it. Unlike conventional treatment, we do not wish to strip the public of a choice, a choice to drink or use drugs. It is everyone's right to choose what they want in their lives. We only wish to report the truth.