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## **Treatment Institutions**

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This article reviews the history of institutions established to “redeem,” “reform,” “rehabilitate” or “treat” individuals who experience problems in their relationship with alcohol and/or other drugs. Historically, the combined use of alcohol and other drugs has been very common, and institutions established to treat obsessive drinkers rapidly found themselves dealing with habitués of opium, morphine, heroin, cocaine, and in later years, a variety of more exotic substances.

### **Therapeutic Temperance**

Pleas from physicians and social reformers for the creation of specialized institutions for the care and control of habitual drunkards came on the heels of a tripling of annual per capita alcohol consumption in the decades following American independence. It was in this context of widespread heavy drinking and related problems that medical leaders like Dr. Benjamin Rush and Dr. Samuel Woodward conceptualized chronic drunkenness as a disease and called for its treatment.

The first such institutions were established by temperance organizations shortly before and after the Civil War. Although the temperance movement would become increasingly associated with the goal of alcohol prohibition, groups like the Women’s Christian Temperance Union, founded in 1874, typically supported efforts to sober and rehabilitate obsessive drinkers. Most temperance leaders believed that while prohibition would prevent the creation of drunkards and make treatment measures unnecessary at some point, in the meantime, treatment was an important element in the battle against Demon Rum.

The temperance movement’s most important contribution to the history of treatment was a fellowship-based approach, drawn from Protestant religious practices (most notably early Methodism). Put simply,

“therapeutic temperance” as practiced by the Washingtonians, fraternal temperance societies and reform clubs, relied on collective measures to exhort drunkards to pledge their abstinence and keep their pledges. Sobriety was to be achieved within a network of likeminded others who provided support and maintained surveillance. Usually, this process was undertaken without the use of any segregation in a formal treatment facility. The affected individuals, typically men, attended temperance meetings and other “elevating” activities held in local temperance halls and tried to limit their social partners to others pledged to abstinence. Visiting committees looked in on recovering people and their families. However, some temperance groups established formal residences for recovering people. Often, these were called “homes” to convey their simultaneously supportive and controlling character.

The first “inebriate homes” based on these principles were established in Boston (1857), San Francisco (1859), and Chicago (1863), with many others following their lead. These homes shared several important characteristics: Their residents were present on a legally voluntary basis rather than treated by force of law; they were private organizations (although some received public funds); they employed recovering people as staff; they were relatively small, housing fewer than fifty residents at a time; and they were located in cities so that family, friends, and the members of temperance fellowships would be available to each resident. Finally, they relied on a very short term of residence, usually just long enough for residents to get through withdrawal symptoms and be restored to reasonable health. The real work of achieving sobriety was to be accomplished in fellowship outside of the institution.

It is impossible to know how effectively such institutions and their related fellowships restored alcoholics to sobriety. For every testimonial to their success there is a condemnation of their methods. The homes’ critics focused mainly on the voluntary nature of the treatment and its short duration. They developed an alternate view of treatment derived from institutions for the treatment of people with mental illness. In time, the asylum model prevailed, but inebriate homes never disappeared entirely. Though transformed in significant ways, the philosophy of therapeutic temperance remains influential, as we discuss further on in this entry.

## **Nineteenth-Century Inebriate Asylums**

In some part, the conflict between the supporters and critics of inebriate homes was about understandings of human nature. While many

supporters of inebriate homes were physicians, and while most used the language of disease to characterize habitual drunkenness, they emphatically denied that inebriety could be reduced to an involuntary state created by changes in the brain or nervous system. Their logic was religious: Human beings had immortal souls that represented the spirit of God; thus, habitual drunkards had a residual self-control that could never be entirely extinguished. While treating the physiological symptoms of inebriety, the homes' methods spoke to matters of human purpose and community in ways that were often frankly spiritual.

Their critics tended to be younger, trained more rigorously in scientific medicine, and enormously influenced by the neurological research emerging from Europe. They took a decidedly material approach to inebriety: It was a disease of the brain and nervous system, often incurable, and always requiring lengthy treatment in settings distinctly segregated from insalubrious influences, including those of friends and family. Asylum enthusiasts had little regard for the methods of therapeutic temperance, and to achieve treatment of the sort they admired, they turned to the model of the insane asylum.

Important reasons quite apart from therapeutic ideology inclined these men to admire the asylum. In the late 19<sup>th</sup> century, public insane asylums – or mental hospitals as they would begin to be called early in the 20<sup>th</sup> century – represented the single largest annual expenditure of American states. They were grand, castellated affairs and their superintendents were men of great professional and political power. The Association of Medical Superintendents of American Institutions for the Insane (AMSAMI), the forerunner of the American Psychiatric Association, was the model for any professional group seeking power and influence. The promoters of inebriate asylums were attempting to create a new medical specialty and the AMSAMI's success was not lost on them. A specialty needed an institutional base. The American Association for the Cure of Inebriates (AACI) was formed in 1870 to do for medical specialists in inebriety what AMSAMI had done for “alienists,” physicians now known as psychiatrists.

In addition to the prestige and power associated with the control of public institutions, the inebriety doctors sought financial stability. The cyclical depressions that followed the Civil War caused many inebriate homes to fold, especially those that depended on payments from patients. Early in its career, the AACI took up the cause of creating public inebriate asylums on substantially the same political and financial footing as asylums for the insane.

The asylum model offered another advantage that was both therapeutic and political: The force of legal commitment could be brought to bear most easily on the patients of public institutions designed to provide some measure of secure custody. Legal commitment would permit the lengthy detention of patients, thus allowing the AACI to portray the inebriate asylum as a potential solution to the endemic homelessness of the late 19<sup>th</sup> and early 20<sup>th</sup> centuries. Just as the insane asylum had to some extent allowed local poorhouses to transfer the care of the insane to state institutions, inebriate asylum promoters envisioned a similar transfer of tramps and habitual drunkards who turned up in local police courts over and over again. Indeed, as the inebriate asylum idea was elaborated over time, it became two institutions in one: A treatment facility for “recent and hopeful cases,” as the asylum rhetoric often put it, and a custodial facility for the castoffs of poorhouses and jails.

The strategy failed. Very few public inebriate asylums were ever opened, and even the best run and most long-lived example, in Foxborough, Massachusetts, closed with the advent of Prohibition after only twenty-seven years (1893-1920). Ironically, the seed of the public inebriate asylum movement’s failure was contained in its therapeutic approach. While the methods of therapeutic temperance were derided as sentimental and unscientific in an era increasingly enamored of hard-headedness, therapeutic temperance at least had methods appropriate to its philosophy. The asylum approach, on the other hand, had no therapeutic methods consistent with its claims about the nature of inebriety. Simple custody, healthy diet, exercise, the routine of institutional work – these were not medical interventions. Moreover, such methods were the stock in trade of a variety of institutions that managed inebriates at far less cost. In the end, the inebriate asylum was perceived in most jurisdictions as a costly and redundant enterprise. In Toronto, Ontario, the only North American jurisdiction in which public support for an inebriate asylum was put to a vote (in 1889), it failed in every ward, usually by a wide margin.

Other responses to the treatment of inebriety in the nineteenth century included private, for profit addiction cure institutes, bottled home cures offered by the same patent medicine industry that was distributing alcohol-, morphine- and cocaine-laced patent medicines, and religiously-oriented urban rescue missions and rural inebriate colonies. The most culturally visible and controversial of the nineteenth-century treatments promised brief, low-cost treatment usually involving some medicinal specific that was promised to destroy all craving for one’s pet poison. Most of these cures

bore the names of their founding entrepreneurs: Keeley, Neal, Gatlin, Key, and Oppenheimer, among the most prominent.

### **The Influence of the Mental Hygiene Movement**

In 1875 the AMSAII grudgingly approved the creation of public inebriate asylums. The superintendents were reluctant to create political competitors, but this was outweighed by their intense desire to rid their institutions of patients whom they bluntly characterized as “nuisances.” Indeed, by the 1870s many well-established private mental hospitals had banned the admission of inebriates. Others hoped for the day when their finances would permit them to do the same. But as the years went by and few inebriate asylums materialized, state hospitals remained the principal sites of public treatment. In large states with several hospitals, it was common for one to be designated mainly for inebriates. From the superintendents’ point of view, this concentrated the evil in one location.

In the decade before World War I, however, what we now call “deinstitutionalization” began to take hold in several states under the influence of what is customarily called the mental hygiene movement. Mental hospitals were scandalously crowded and their therapeutic intent had been, in most places, reduced to professional pieties. Involuntary commitment resulted in many infamous abuses of civil liberties. At the same time, office practice had become a more common method among psychiatrists and neurologists, who devoted themselves increasingly to the treatment of mental distress that fell short of psychosis. In this context, the treatment of what was by now frequently called “alcoholism” was recast, particularly if the patient was employed or had a family to support. In Massachusetts, the Foxborough State Hospital was reorganized in 1908 to emphasize brief, voluntary inpatient treatment combined with systematic aftercare in local outpatient clinics. Here, the older methods of therapeutic temperance were reworked in the service of building a coherent system for the treatment of inebriates that linked hospitals and community care. Although the “deinstitutionalization” of inebriates would not occur until the 1960s and 1970s, the methods employed by Foxborough during its last decade were a striking anticipation of treatment as it developed after World War II as the result of community psychiatry and the rapid growth of Alcoholics Anonymous.

### **Early and Mid-Twentieth Century Treatment**

The number of inebriate homes, inebriate asylums and private addiction cure institutes diminished dramatically during the first two decades of the twentieth century as America sought to resolve problems related to alcohol and other drug use mainly by prohibiting or aggressively controlling the manufacture and distribution of these drugs.

Four different types of institutions filled the continuing need for treatment: 1) outpatient clinics that utilized recovered alcoholics as lay psychotherapists, 2) private sanatoria and hospitals, such as the Towns Hospital in New York City that provided discrete detoxification for the affluent, 3) public hospitals that treated narcotic addiction (Riverside Hospital in New York City), and 4) outpatient narcotic maintenance clinics, most of which operated only briefly between 1919 and 1924. The brunt of care for the impoverished inebriate fell upon the large public hospitals, the “drunk tanks” of city jails, county work farms – many of which functioned as inebriate colonies -- and state psychiatric hospitals.

Beyond private hospitals and sanatoria, there was very little specialized institutional treatment for alcohol and drug addiction during the 1920s and early 1930s. Only California funded a specialized facility (the State Narcotic Hospital at Spadra, 1929-1941) for the treatment of narcotic addiction, and few state-funded alcoholism treatment units existed. This began to change in 1935, with the opening of the first of two U.S. Public Health Hospitals for the treatment of narcotic addiction and the founding of Alcoholics Anonymous (A.A.).

Through much of the 1930s and 1940s, the only addiction treatment facilities were these federal hospitals in Lexington, Kentucky and Fort Worth, Texas. During this period a growing number of hospitals did begin to collaborate with A.A. The first were Rockland State Hospital, a psychiatric facility in Orangeburg, New York, and Blythewood Sanitarium in Greenwich, Connecticut. To detoxify and stabilize the large number of “late-stage” alcoholics entering the A.A. fellowship, members pioneered a model of brief detoxification and treatment at St. Thomas Hospital in Akron, Ohio, St. Vincent’s Hospital in Cleveland, Ohio, and at Knickerbocker Hospital in New York City. So-called “A.A. wards” spread across the United States in tandem with A.A.’s growth. A.A. “retreats,” “farms” and “rest homes” were also started by A.A. members to meet the post-hospitalization needs of alcoholics. Many of these small institutions, such as Alina Lodge (Kenvil, NJ), High Watch Farm (Kent, CT) , and Beech Hill Farm (Dublin, NH), later evolved into formal alcoholism treatment programs. In 1939, having worked with alcoholics along the lines of therapeutic temperance since the 1880s, the Salvation Army opened its first

alcoholism treatment facility. The Army subsequently became one of the largest providers of alcoholism treatment services in the United States.

During the 1940s, several new models of alcoholism treatment gained prominence. First, an inpatient psychiatric model of addiction treatment was promoted by private psychiatric hospitals like the Menninger Clinic in Topeka, Kansas. This approach provided medical detoxification and treatment of the primary psychiatric illnesses of which alcoholism was thought to be a symptom.

The second approach was an outpatient clinic model pioneered at the Georgian Clinic and Rehabilitation Center for Alcoholics (Atlanta, GA), the Yale Plan Clinics (New Haven and Hartford, CT), the Institute of the Pennsylvania Hospital (Philadelphia, PA), and Johns Hopkins Hospital (Baltimore, MD). These clinics viewed alcoholism psychodynamically as an escape from life's travails and, like the Menninger Clinic, sought to resolve underlying problems.

The third approach was a residential model of alcoholism treatment developed within three Minnesota institutions: Pioneer House, Willmar State Hospital and Hazelden. The major components of the "Minnesota model" were the conceptualization of alcoholism as a progressive, primary disease (not as merely symptomatic of other disorder); the use of a multidisciplinary treatment team that incorporated recovered alcoholics as primary counselors (a practice that recalled the era of therapeutic temperance); the infusion of A.A. philosophy and A.A. "step work;" the focus on abstinence from all mood altering drugs; and reliance on continued support from A.A. following treatment. This approach became closely aligned with a "halfway house" movement in the 1950s that provided a structured transition from institutional treatment to a sustained recovery lifestyle in the community.

While there were other residential models of alcoholism treatment during this period (Bridge House in New York City, Portal House in Chicago, Brighton Hospital for Alcoholism in Brighton, Michigan), the Minnesota model evolved into the dominant approach in the second half of the twentieth century. A rise in juvenile narcotic addiction led to the re-opening of New York City's Riverside Hospital as a juvenile treatment facility and the creation of addiction wards in such hospitals as the Detroit Receiving Hospital, Chicago's Bridewell Hospital, and Bellevue, Kings County, Manhattan General, and Metropolitan hospitals in New York City. Local religious organizations also sponsored new counseling agencies aimed at juvenile addiction. Some of the more notable were St. Mark's Clinic in Chicago, the Addict's Rehabilitation Center in Manhattan, and Exodus

House in East Harlem. During this period, many states organized alcoholism treatment units within their state psychiatric hospitals, and a few states organized hospitals that specialized in alcoholism treatment (Blue Hills Hospital in Connecticut and Avon Park in Florida).

### **Treatment Comes of Age**

. The National Council on Alcoholism and a joint committee of the American Medical Association and the American Bar Association were at the forefront of advocacy for the expansion of treatment for alcoholism and “drug abuse” during the 1950s and 1960s. To be successful, this movement needed models of addiction treatment that could be widely replicated. Added to the outpatient clinic, detoxification, and residential treatment and halfway house models were three new approaches to narcotic addiction and “polydrug abuse.”

Ex-addict-directed therapeutic communities (TCs), representing a long-term, residential model for the treatment of drug addiction, began with the opening of Synanon in 1958. TCs viewed drug addiction as a problem of immaturity and poor socialization that required a reconstruction of personality and character. By 1975, there were more than 500 TCs in the U.S. modeled after Synanon. In 1964, Drs. Vincent Dole and Marie Nyswander conceptualized heroin addiction as a metabolic disease and introduced the daily oral administration of methadone as a means of stabilizing the addict’s disordered metabolism so that social rehabilitation could begin. By 1973, more than 80,000 heroin addicts were maintained on methadone in licensed treatment programs in the United States. Growing concerns about youthful alcohol and polydrug use during this same period generated an outpatient clinic model that provided individual, group and family counseling for young people experiencing problems with drugs other than narcotics. Outpatient drug-free treatment quickly became the most frequently utilized treatment modality in the United States.

Federal support for community-based treatment of alcoholism and other drug addiction increased through the 1960s and culminated in the passage of landmark legislation in the early 1970s. The Comprehensive Alcoholism Prevention and Treatment Act (Hughes Act) of 1970 and the Drug Abuse Treatment Act of 1972 created a federal, state, and local partnership to treat alcoholism, drug addiction and drug abuse. The major elements of this partnership were two federal institutes (The National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse), designated treatment planning authorities within each U.S.



state and territory, and community-based treatment agencies. Together, these partners planned, built, staffed, operated, and evaluated treatment programs across the United States. The remote federal narcotic hospitals and alcoholism wards in state psychiatric hospitals gave way to community-based treatment agencies.

The emerging field of addiction treatment was marked by expansion (from less than 200 programs in the 1960s to more than 500 in 1973, 2,400 by 1977, and 6,800 by 1987), increased regulation (development of accreditation and program licensure standards), and professionalization (preparatory training and worker certification/licensure). The field also reorganized itself from what had essentially been two separate fields (one treating alcohol problems, the other treating “drug” problems) to a single field that addressed all alcohol- and other drug-related problems within an integrated framework. This very contentious integration process was nearly complete at the state and local levels by the mid-1980s, leaving in its wake new language such as “chemical dependency” and “substance abuse.”

The 1980s witnessed significant growth in for-profit and hospital-based addiction treatment programs and an expansion of programs for special populations of clients: adolescents, women, ethnic and cultural minorities, and those with co-occurring psychiatric illness. The service missions of many treatment institutions also expanded to include early intervention with alcohol and other drug-impaired employees, students, and drivers.

The growth of residential treatment programs was reversed in the 1990s when ethical concerns about the field’s business and clinical practices led to an aggressive scheme of managed behavioral health care that significantly reduced inpatient treatment admissions and lengths of stays. This led to the closure of many for-profit and hospital-based treatment programs and in all programs, a greater emphasis on outpatient, brief therapies..

### **The Current Status of Addiction Treatment Institutions**

Some 15,239 institutions participated in the latest (1999-2000) national survey of alcoholism/addiction treatment facilities in the United States, 45 percent of which were concentrated in eight states. This national network of facilities is made up of private non-profit agencies (60 percent), private for-profit organizations (26 percent), and state/local government-operated facilities (11 percent). In sixty-five percent of these facilities, treating addiction was the primary organizational mission. Ninety-six percent of the facilities treat both alcohol and other drug-related problems.

Types of care provided by these agencies include outpatient rehabilitation services (82 percent of facilities), residential rehabilitation services (25 percent), partial hospitalization (19 percent), outpatient counseling (13 percent) and residential detoxification (5 percent).

Seventy percent of all clients admitted to American treatment institutions are men. The racial/ethnic composition of these clients is 60 percent non-Hispanic white, 25 percent non-Hispanic black, 10 percent Hispanic, and five percent other. The primary drug choices of clients being admitted to these facilities are alcohol only (26 percent), alcohol with a secondary drug (20 percent), opiates (16 percent), cocaine (14 percent), marijuana (14 percent) and other stimulants (5 percent). More than 1,200 facilities (8 percent of all facilities) dispense methadone or LAAM (levo-alpha-acetylmethadol) for the treatment of narcotic addiction. Two-thirds of the facilities provided both treatment and prevention services.

Addiction treatment programs in the United States are today funded by a combination of federal, state, and local grants and contracts; public (Medicare and Medicaid) and private health insurance; and by client self-payment. Costs of treatment vary widely by modality and by type of provider organization (public versus private). Most programs meet the accreditation standards of the Joint Commission for the Accreditation of Healthcare Organizations or the Council on Accreditation of Rehabilitation Facilities and/or state program licensure standards. The programs are staffed by interdisciplinary teams of physicians, nurses, social workers, counselors, counselor assistants, and outreach workers.

Individuals with alcohol and other drug problems get to these programs by self-referral or referrals from physicians, community service agencies, the courts, employee assistance programs, schools, alumni and members of recovery support groups like A.A. and Narcotics Anonymous. Most treatment consists of a combination of one or more of the following: outreach/engagement services, detoxification; individual, group, and family counseling; pharmacotherapy (e.g., methadone, LAAM, antabuse, naltrexone); relapse prevention training; linkage to community mutual aid groups; and a structured program of follow-up counseling. Nearly all addiction treatment programs in the United States provide treatment that is based on the goal of complete abstinence and the majority provided treatment based on A.A.'s Twelve Steps.

The United States spends more than \$3.1 billion federal dollars per year on addiction treatment and treatment-related research, and more than one and one half million people each year are admitted to the nation's treatment institutions. Today's field of addiction treatment has achieved

partial ownership of the nation's alcohol and other drug problems. The field has attained a high level of professional organization. It is supported by multiple federal and state, addiction-focused agencies. Its interests are promoted by public advocacy organizations (National Council on Alcoholism and Drug Dependence) and numerous trade organizations (American Society of Addiction Medicine, National Association of Addiction Treatment Providers, the National Association of Addiction Treatment Professionals). And the field's development is being supported by major philanthropic foundations (the Smithers Foundation, the Robert Wood Johnson Foundation).

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