

The “Minnesota (12-Step,
Abstinence-based) Model” in the
Treatment of Disadvantaged
Populations:
Historical Perspectives

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Presentations Goals

- Present a brief history of “Minnesota Model”
- Identify the distinctive elements of the “Minnesota Model”
- Identify the historical roots of view that AA and the Minnesota Model are only effective for culturally empowered White men.
- Outline the scientific & historical data that challenges this notion of restricted effectiveness

History of Minnesota Model

Context

- Pat C. gets sober: AA Comes to MN (1940)
- NCEA's 5 Kinetic Ideas & 5 point strategy (1944)

Synergy of 3 Programs

- Pioneer House (1948)
- Hazelden (1949)
- Willmar State Hospital (1950)

Elements of MN Model

1. Alcoholism is an involuntary, primary, chronic, progressive biopsychosocial (& spiritual) disease
2. Recovery is contingent upon, but is more than, abstinence from all non-medical alcohol and other drug use. Early conceptualization of "chemical dependency"
3. Recovery best achieved through the Twelve Steps of AA and immersion in a community of shared experience, strength & hope.

Elements of MN Model

5. Focus on direct treatment of the disease.
 - Abandonment of psychoanalytic and moral views of addiction
6. Addiction best treated in a milieu of dignity and respect
7. Altered view of motivation
 - Motivation or lack of it at intake is not a predictor of outcome
 - Motivation is as much the responsibility of the milieu as the patient

Early Treatment Innovations

Use of Multidisciplinary Team

- Introduced "Counselor on Alcoholism" role into addiction treatment (1954) (adaptation of earlier lay therapist role)
- Introduced Pastoral Counselor as key role
- Use of patient, AA and alumni volunteers

Philosophy of Respect / Choice

- Unlocked the "inebriate wards"

Early Treatment Innovations

Patient education via introduction of lectures (possibly adapted from Ray McCarthy's work at Yale).

--28 lectures over 60 days at Willmar

AA participation during treatment

AA viewed as essential framework for long-term recovery

Early Model Diffusion & Adaptation

Linkage of MN Model to emerging halfway house movement

Movement of MN model to community hospitals

- Lutheran General Hospital via Bradley, Rossi & Keller (1959-1963)

- Parkside Management Services (1980)

Growing emphasis on family-focused care

Model Diffusion & Adaptation

Adaptation for women, adolescents & other
"special populations"

Adaptation for other problems, e.g., gambling,
eating disorders.

Model commercialization, profiteering and the
emergence of a financial and ideological
backlash against treatment

- Aggressive Managed Behavioral Health Care
--Collapse of Parkside in 1993
- Anti-12 Step & Anti-treatment Movement

A Key Criticism of AA & MN Model

Contention: AA and AA-derived treatment models are inappropriate for women, adolescents, people of color and other historically disenfranchised groups.

Source: AA and the MN Model were historically derived almost exclusively out of the experience of White, working class and upper-middle class men.

Overlapping Criticism of AA and MN Model

This idea of limited utility remained prevalent and unchallenged until the idea was tested with scientific studies and by historical evidence of minority involvement in AA/NA/CA and wide adaptation of MN Model in public treatment and in minority communities.

Scientific Challenges Regarding AA Restrictiveness

- Majority of African-Americans and Hispanics in community surveys view AA positively (Caetano, 1993)
- Women and people of color affiliate with AA at rates that equal or exceed White men (Humphreys, 1994; Kessler, et al, 1997; Winzelberg & Humphreys, 1999)
- No ethnic differences in AA attendance in Project MATCH (Tonigan, Connors & Miller, 1998)

Scientific Challenges Regarding AA Restrictiveness

- Growth in Women's meetings and % of total female representation in AA (from 22% in 1968 to 35% in 2004) (AA, 2004)
- Dramatic growth of AA and NA in urban communities of color and in Native American communities (Coyhis & White, 2006)
- Where participation in AA for African Americans and Hispanics decreases over time (Tonigan, et al, 1998), this may in part reflect a transfer of recovery maintenance to indigenous institutions, e.g. churches (White & Kurtz, 2006).

Scientific Challenge to Restrictiveness of Minnesota Model

Widespread adaptation of MN Model to adolescents, women, people of color, sexual minorities, and people with co-occurring conditions (DDA, DTR) (White, 1998; Winters, et al, 2000; Borden, 2007; Iliff, Siatkowski, Waite-O'Brien & White, in press)

Application of MN Model to Historically Disenfranchised

- MN model adaptations now a dominant model within publicly-funded addiction treatment
- Representative Programs: Haymarket House (Chicago), Dawn Farm (Ann Arbor, MI), Gateway Community Services (Jacksonville, FL)
- Comparable outcomes across gender and ethnicity (Harrison & Asche, 2001)

Nature of MN Model Adaptations

- Expanded view of etiology, e.g. historical trauma (Brave Heart, 2003; Durant, 2005)
- Cultural adaptation of Twelve Steps, e.g., Red Road to Wellbriety, 2002; Coyhis & White, 2006)
- Use of empowerment-focused alternatives to Twelve Steps (Kirkpatrick, 1986; Kasl, 1992; Williams, 1992)
--Patterns of co-attendance (White & Kurtz, 2006)
- Integrating indigenous therapeutic practices into MN Model (Jilek, 1974; Abbott, 1998)

Nature of MN Model Adaptations

- Multidisciplinary team expanded, e.g., outreach workers, recovery coaches, primary care physicians
- Emphasis on multiple levels of professional care
- Emphasis on post-treatment recovery environment, e.g., recovery homes & community development efforts (e.g., “community resurrection” in Tampa)

Why MN Model Programs Have Grown in Minority Communities

- Public funding of adapted model
- AA/NA as continuing care resources both free and increasingly accessible
- With indigenous leaders & links to indigenous institutions, model is viewed as a source from within the community
- Congruent with historical role of religion and spirituality within communities of color
- Outreach of MN Model programs to communities of color