



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (1999). Addiction treatment: Gone yesterday, gone tomorrow? *Behavioral Health Management*, 19(5), 40-44. Posted at www.williamwhitepapers.com

The Collapse of 19th Century Addiction Treatment: Could It Happen Again?

William L. White

Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

For years I have been asking audiences of professional and lay people when treatment for addiction to alcohol and other drugs began in the United States. Their responses usually place such origins in the mid-20th century and note such milestones as the founding of Alcoholics Anonymous (1935), the opening of two federal Narcotics “farms” in Lexington, Kentucky (1935) and Fort Worth, Texas (1938), the alcoholic halfway house movement (the 1950s), the founding of Synanon (1958), the introduction of methadone maintenance (1964), and the founding of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse (the early 1970s). Very few are able to report that addiction treatment in America began nearly a century before these admittedly important events. This article will briefly outline: 1) the rise and fall of 19th century addiction treatment in America, 2) identify those factors that led to the virtual demise of this network of treatment institutions, and 3) speculate on whether a similar collapse of treatment could occur again.

The Rise and Fall of 19th Century Addiction Treatment

A dramatic rise in alcohol consumption in the late 18th and early 19th centuries and the subsequent rise of addiction to opium, morphine, cocaine, bromides, chloroform, ether, chloral, and nicotine set the stage for what Harry Levine has christened the American “discovery of addiction.” Recognition of this problem led to calls for, and the eventual (mid-19th century) creation of, specialty institutions whose sole purpose was to care for the addicted. This new field of addiction treatment had several branches. There were inebriate homes, like the Boston and Chicago Washingtonian Homes, that viewed recovery from alcoholism as a process of moral reformation. There were private physicians, such as Drs. J.B. Mattison and H.H. Kane, who treated alcoholics and addicts within their specialized addiction medicine practices. There were the medically-oriented inebriate asylums such as the New York State Inebriate Asylum. There were dozens of private, franchised

institutes and sanitariums such as the Keeley, Gatlin, and Neal Institutes and the Battle Creek Sanitarium. There were many proprietary, bottled home cures that sold under such trade names as Antidote and Opacura. And there were the urban rescue missions and rural religious colonies that viewed recovery from alcoholism as a byproduct of religious conversion. An unusual assortment of temperance missionaries, physician activists, business entrepreneurs, and religious evangelists had, in spite of their differing views about the nature of addiction and its treatment, birthed a new arena of professional endeavor during the second half of the 19th century.

The growing smorgasbord of services for addicts embraced hundreds of individual practitioners, institutions, and businesses. Some of the major institutional providers of treatment came together in 1870 to found the American Association for the Cure of Inebriety. In 1876, they established a central vehicle of communication—*The Journal of Inebriety*—to share the growing knowledge about treatment methods and the management of treatment institutions. Their advertisements filled the newspapers and journals of the day, boldly proclaiming that drunkenness was a disease that could be cured. They lobbied state legislatures to provide financial support for treatment and to pass involuntary addict commitment laws. The cultural viability of some of these institutions is indicated by the hundreds of thousands of patients who were treated in ever-expanding franchises that spread across the country and made their founders wealthy. The future of addiction treatment as a professionally directed endeavor looked exceedingly bright in 1895, yet the field had virtually disappeared 25 years later. Only a few 19th century addiction treatment programs survived into the modern era, and none from that period exists today.

The Dynamics of Decline

Many factors led to the collapse of America's first network of addiction treatment providers. There were unanticipated economic depressions that

undermined financial support for these enterprises, and there was a cultural shift away from the view that alcohol- and other drug-related problems were treatable diseases. As the 19th century came to a close, the country moved toward a bold redefinition of, and solution to, her growing drug problems: let those currently addicted to alcohol and other drugs die off, and prevent the creation of new addicts through the vehicles of moral suasion and the legal prohibition of the non-medical use of psychoactive drugs. The shift from medical to moral/criminal models of viewing addiction and addicts undermined the foundation of the future of addiction treatment as America entered the 20th century.

A weakened field found itself unable to respond to these environmental threats. Several factors contributed to the field's professional and political impotence. The field's public reputation had been wounded by highly publicized breaches of ethical conduct. Newspaper exposés charged incompetence and fraud in the field's clinical and business practices. Allegations abounded of inadequate care, patient abuses, sleazy marketing practices, and the financial exploitation of patients and families. Muckraking investigations of the bottled addiction "cures" exposed products secretly loaded with alcohol, opium, morphine, and cocaine.

Because 19th century treatment institutions catered mostly to an affluent population, they had done little to ease the burden indigent alcoholics were placing on jails and community hospitals. Many institutions became viewed not as agencies that served their communities but as places where the rich went to dry out and escape the consequences of their drinking behavior. As a result, there were few community leaders who came to the defense of inebriate institutions during their time of most critical need.

There were also problems of scientific credibility that grew out of the field's modality bias (sustained residential sequestration), its poorly developed clinical technology, and its aversion to the use of scientific methods to study addiction and evaluate treatment

methods. Conflict within and between treatment institutions and between the addictions field and allied professions (particularly the emerging field of psychiatry) created a fragmented field that never was able to speak with one voice. And the failure to address problems of leadership succession had over the years left the field without competent and energetic leadership to respond to emerging threats to the future of the field. Unable to respond to such environmental and internal vulnerabilities, 19th century treatment institutions faded from existence in the opening decades of the 20th century, its leaders gone or too demoralized to even record the field's demise.

Back to the Future?

What relevance, if any, does this musty story have to the modern field of addiction treatment? Everywhere I travel within the world of addiction treatment today, I hear depictions of a field in crisis. That crisis is most often described in the same two categories that posed a threat to 19th century addiction treatment. The first category, that of external financial threat, is said to be posed by an aggressive scheme of managed care that is, as it moves from the private through the public sector, altering both the availability and character of addiction treatment in America. Remarkably, this threat has unfolded within the healthiest economy in American history.

The second category, the demedicalization and re-criminalization of addiction, is said to be evident from the widespread transfer of alcoholics and addicts from hospitals and other treatment agencies to the criminal justice system during the 1980s and 1990s. The public rationale for addiction treatment today is rapidly shifting from a focus on personal and family recovery to a focus on social control: reducing the addict's threat to public safety (via crime, violence, and disease) and managing the addict's cost to society. The growth ring in addiction treatment is not at its core (which many believe is in a state of decline) but at the periphery—the extension of addiction treatment into the workplace, the

schools, the criminal justice system, and the arenas of public health (HIV/AIDS) and child protection. Some of the external threats that mortally wounded the first generation of addiction treatment providers are clearly evident in today's environment.

And what of those internal vulnerabilities? Like our 19th century counterparts, we have been, and continue to be, prone to modality bias (first to a high dose inpatient/residential bias and now to a continually declining low dose outpatient bias). We have been, and continue to be, vulnerable to breaches in ethical conduct in the field's business and clinical practices—breaches that contributed directly to the emergence of the very system of managed care that now threatens the field. We have poorly developed ethical sensitivities, few organizational codes of professional practice, no universally accepted model of ethical-decision-making, and poorly defined and under-utilized ethics disciplinary procedures. We continue to have organizations prone to incestuous closure and the resulting problems of stagnation and implosion, or organizations with such weak leadership, poorly developed infrastructures, and porous organizational cultures that they are vulnerable for colonization by more powerful organizations within their operating environments. We continue to have weak relationships with allied fields in spite of all our rhetoric to the contrary. And we have done very little to stem the high turnover among front line treatment personnel or to prepare the field for the vacuum that will occur when a large portion of today's long-tenured leaders exit the field in mass.

These depictions of the field do nothing to detract from the fact that the field of addiction treatment today brings many strengths not present a century ago: most importantly, a federal, state, and local infrastructure responsible for the planning, construction, operation, monitoring, and evaluation of addiction treatment programs. While this larger and much more sophisticated field may not suffer the fate of its 19th century counterpart, there are quite clearly some of the same contextual and

internal factors that undermined the field's resiliency a century ago that are being replicated within the current period.

If the field of addiction treatment should face extinction again, it will likely not be from one but a combination of contextual and internal threats. The worst potential scenario would be a sudden and sustained downturn in the economy and a concurrent increase in social disorder. Such a combination would have public and private policy leaders making tough choices regarding the allocation of resources and doing so within a climate of fear that could shift the focus from one of treating addicts to one of sequestering and punishing addicts. The most likely scenario would be the destruction of addiction treatment as a categorically segregated enterprise, the widespread integration (merger) of addiction treatment into more powerful health and human service entities, and the illusion of continued service availability while large numbers of alcoholics and addicts are moved from the public health arena to the criminal justice arena. This scenario could happen only in the face of a weakened field of addiction treatment—vulnerable in the marketplace of ideas about who should have cultural ownership of this problem, vulnerable in terms of the field's scientific and public credibility, vulnerable from the loss of the grass roots movement that birthed and sustained it, and vulnerable from the lack of statespeople to lead a response to such threats.

To prevent such a scenario, we must rebirth the grass roots movement that laid the cultural foundation for the rise of 20th century addiction medicine and the modern system of addiction treatment. We must both aggressively monitor the ecosystem within which we operate and take a more activist role within that ecosystem. We must get ourselves clinically and ethically re-centered. We must take a highly splintered field and find a way to speak with one voice. And we must rebirth a new generation of leaders who can carry our mission of serving the still suffering addict into the 21st century. If we fail to meet these challenges, we may be doomed to repeat an episode in history little known to today's providers of addiction treatment. And that lack of knowledge is perhaps itself a source of great vulnerability. As the great comedic scholar Lilly Tomlin once suggested, "Maybe if we listened, history wouldn't keep repeating itself."