# Addiction Treatment Designed to Fail

*How the Established Treatment System Exploits Us & Our Families*

**UNDERSTANDING WHY RELAPSE IS SO COMMON**

William Messinger

## Chapter One

*(With What We Want for Our Recovery and Best Practices for Our Treatment to Follow Soon*)

## PART 1 — ADDICTION TREATMENT DESIGNED TO FAIL US

*With so many treatment centers across the country falsely claiming to have high success rates, it is imperative that families receive proper education and accurate information so when their loved ones need help, they receive the best care available. That is why I am taking the lessons I've learned from the loss of my brother, and many others, to delve into how families are duped into paying thousands for multiple, ineffective treatments. Let's end exploitation and abuse in interventions and in-patient treatment.*

Additional Chapters to follow:

- *What Works for Our Recovery - New, Evidenced Based Practices*
- *A Case Study Applying the New Model to a Question from Mom,*
- *Resources for Seeking Help*

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# PROLOGUE

In my conversations with my brother, Rob shortly before his dialysis ended, he apologized for failing treatment. All of a sudden, a light bulb went off and I responded, "*You spent six months in treatment, you didn't fail treatment, treatment failed you.*" That is the moment this book came into being to warn other families and their loved ones needing help that the predominate treatment system is designed to fail: Effective treatments are withheld from patients and families are exploited for economic advantage. And we were exhibit A.

This book explains how the current system thrives in an unregulated environment with families desperate for help being duped into paying over and over again for treatment. Having learned about the outstanding recovery rates for doctors and airline pilots in 1998, I spent twenty-five years working with families, their trustees and advisors on implementing their program concepts with their loved ones. Bottom Line: I know of no rational explanation for failing to offer similar services to the general population. This is the only area in medicine where doctors are offered a different treatment than the rest of us. If it was cancer treatment, there would be a riot.

One missing voice is ours – the person in recovery on the receiving end as the addict, alcoholic, person with the problem – whatever you want to call us – of an abusive system. As I say in the article – we are the bodies being brokered by the patient finders for treatment centers – and we have a right to be heard, despite being addicted. The voice of the person with the problem is too often ignored, when it comes to advice books for families. From my perspective as a person in recovery, it's time for us to speak up and ask for what we need to support our recovery. And to ask for compassion and reconciliation as we try and overcome the harm inflicted upon us and our families under the dominant intervention-in-patient model with its low success rates.

Some people say, "why examine the past and dig up old wounds?" I say to repair the damage done, we need to acknowledge the past, understand what happened to all of us under the old system, and then we can begin to reconcile and move forward as families.

**About Bill**

I grew up in Milwaukee in a second-generation business family, attending Yale and the University of Minnesota Law School. As I matured, I realized many relatives suffered from alcoholism and so my goal after graduation was to avoid this fate. Unfortunately, several tragedies and setbacks led me to turn to alcohol as a solution, entering in-patient treatment in 1995.

When in treatment I began wondering why so many of my relatives never were able to quit – why it is so difficult for people with money to recover. And not only for my immediate family but extended families (in-laws, exes) and other affluent families. I decided to make it my life's work to figure out how to improve recovery outcomes so that if a relative or child needed help, I could find the resources to assist them. Self-preservation!!

In 1998 I learned about the outstanding success rates for pilots and doctors and decided to apply their program concepts to other groups. This led to conflict with the existing treatment system – Interventionists, In-patient, AA/Al-Anon – because this system promotes the exact opposite of the pilot/doctor model. The conflict continues on today with the focus now on implementing evidence-based practices that are research driven to improve outcomes. It is the research that is finally forcing change, along with grieving parents beginning to speak up and demanding answers.

This book is aimed at explaining to parents how they were duped into paying over and over again for treatment that has low success rates. And to explain how it feels to be on the receiving end as the addict, alcoholic, person with the problem – whatever you want to call us – of an abusive system. As I say in the article – we are the bodies being brokered by the patient finders for treatment centers – and we have a right to be heard, despite being addicted. And then in Part Two – explaining how we want to be treated, not only with kindness but evidence-based practices. When we need treatment follow the research, please. Find professional help.

## PART 1 — ADDICTION TREATMENT DESIGNED TO FAIL US

*With so many treatment centers across the country falsely claiming to have high success rates, it is imperative that families receive proper education and accurate information so when their loved ones need help, they receive the best care available. That is why I am taking the lessons I've learned from the loss of my brother, and many others, to delve into how families are duped into paying thousands for multiple, ineffective treatments. Let's end exploitation and abuse in interventions and in-patient treatment.*

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## TREATMENT REFORM MOVEMENT LEADS TO "LIGHT BULB" MOMENT

**Compassionate, Patient Centered Approach**

With the treatment reform movement gaining momentum, many of us who were subjected to the traditional model are reevaluating our experience as we become familiar with the emerging compassionate, patient centered approach driven by evidence-based practices. This new model of support for loved ones living with SUD is best exemplified by President Biden's call to his son:

> *It's Dad, I'm calling to tell you I love you. I love you more than the whole world, pal. You gotta get some help. I don't know what to do. I know you don't either. But I'm here, no matter what you need.*

Families are now recognized as influential partners in their loved ones' efforts at recovery, with even Hazelden abandoning tough love for the interactive CRAFT model.[i] Unconditional love and families working together are replacing the authoritarian, do what I tell you or hit the road approach. An approach that continues to result in many preventable deaths and untold suffering for so many of our substance dependent family members and friends.

Simultaneously, driven by low recovery rates and multiple failed in-patient treatments, parents suffering the ultimate loss are shaking off their shame and grief by demanding and leading the charge for change. This new, family focused, supportive approach to recovery is reflected in these two principles espoused by parents in their Recovery Coaching for Families non-profit:

- *We believe every person, including those using substances, has intrinsic value and should be treated with kindness, compassion, and unconditional positive regard.*
- *We believe that families are one of the most critical components to recovery and when educated and supported can create the conditions most beneficial for an individual to recover.*[ii]

Amen! Tears flowed when I read these words. With one family member excepted, I never heard these words. Nor did my recovery friends.

The predominant model never made sense to parents - *My child needs help and you are telling me not to talk to her or at least find out what she wants to do about the problem?* Nor did it ever make sense to us addicts - *Wait – we have a pressing health problem – we can't stop using – and you won't help us?*

That's why so many families experience finding effective treatment a full-time job. Looking for help, I inadvertently attended an Al-Anon meeting and heard this joke:

*How many Al-Anon members does it take to screw in a light bulb?*

*None, they just watch it screw itself.*

The horrible irony is that most people with substance use disorder, including myself, are trauma victims. Rejection and abandonment only re-trigger our trauma. Fight or flight is our immediate response to coercion. When we needed kindness and understanding, we received an iron fist from interventionists, treatment centers, and relatives who were told not to talk to us. And above all, this system drove an almost unrepairable wedge between families and their LO's– one reason for high relapse rates and why too many families remain broken.

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## THE KING HAS NO CLOTHES

So many people died under the traditional model, that relatives, those of us in recovery and counselors new to the field finally recognized the king has no clothes - we were scammed – exploited and used for economic gain by interventionists and treatment center administrators. And then referred out to an AA community which often was unable to effectively address underlying drivers of use such as trauma, PTSD, and abuse, with relapse soon to follow.

These statements are undoubtably going to be hotly contested by those reaping the economic and emotional benefits from the predominant system. But remember recent headlines and the documentary on kickbacks by treatment centers for patient referrals - "body brokers" and "patient enticement".

- Well, we are the bodies being brokered and enticed - sold for money or other inducements.
- *We have the right to complain!!*

I first encountered the multiple treatment phenomena in the early 90's when I met a friend's brother who was living in the Twin Cities after several stints at local centers. He would remain clean for a while and then relapse. It turns out his family had paid for multiple in-patient treatments, including extended stays. All to no avail, as sadly, he eventually overdosed. Then, after doing my 28 days in 1995, I was surprised to discover that most of my peer group relapsed. What gives? Well, I was naïve! Many people enter treatment, stay clean for a while, and then pick up again, with their families paying tens of thousands for each stay.

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## NAME IT – WHAT HAPPENED TO US WHEN WE ASKED FOR HELP

**It's Time to Talk About What Happened to Us**

It's time to name it – and to call out the other rampant abuses that are clear violations of long-standing clinical practices and professional ethics, exacerbated by our status as vulnerable adults. And it's time to figure out how when our families sought help, they were so easily deceived and misled into spending so much money, often repeatedly, on a system that too often leads to relapse and lost lives. Some of the wealthiest, most powerful families in our country are being conned over and over again.

While being brokered on its own is bad enough, let's start with the two most outrageous and destructive practices: the withholding of effective treatment known to reduce relapse and overinflating treatment success rates to induce sales.

**Withholding Effective Treatment from Us (the Doctor/Pilot Model)**

For over 25 years treatment centers have known about the high recovery rates for doctors and pilots, yet they refuse to provide their programs to other patients. Here is the evidence - back in **1998**, I saw this headline in the Hazelden Bulletin: *Airline Pilots Soar to Success in Recovery.* It turns out pilots have a 92% continuous abstinent rate at two years. For doctors the data is similarly impressive with 78% abstinence at seven years:

> *The research showed that 78 percent of 904 doctors in the studied programs completed an average of 7.2 years of monitoring without relapse.* ***Those are just over-the-top numbers for a chronic, progressive disease that kills people.***[iii]

Here is what a medical professional at Hazelden wrote in **2011**:

> *Research has shown that physicians' health programs achieve extraordinary outcomes in substance use disorders (SUDs). One recent study demonstrated nearly 80 percent abstinence at five years. The success of physicians' health programs (PHP) in driving superior outcomes in addiction treatment raises critical questions about how treatment can be improved for all with SUDs.*
>
> *Physicians who must pay for PHP-driven treatment are getting a better return when long-term results are considered. So, if treatment centers would adopt and demonstrate the superior value of PHP-style treatment and case management, they would win the case for it from payers.* ***Why pay for multiple detoxes and no follow-up, indeed?***[iv]

A **2014** report of the John P. McGovern Symposium reviewing efforts at applying the doctor/pilot model to other groups with participants from leading treatment centers across the country, titled *The New Paradigm for Recovery: Making Recovery – and Not Relapse – the Expected Outcome of Addiction Treatment,* describes in detail the protocols leading to these

programs high success rates.[v] I was at this conference and witnessed treatment centers receiving this information.

Aside from the published evidence, in 1998, when I learned about these highly successful programs for doctors and pilots, I began urging treatment centers to use the same protocols for other population groups to no avail. I decided to become an alcohol and drug counselor and help families apply these effective strategies to their loved ones' recovery efforts, writing numerous articles to support them in that endeavor.

**So no, they can't claim ignorance**. I know many families who would have gladly paid for this program, including ours. But the point here is that the pilot/doctor program reduces relapse and that hurts the bottom line of interventionists and treatment centers. Relapsing patients represent a substantial portion of their business. Get it? They make money when we relapse.

But to entice families into paying for in-patient treatments, there must be a convincing sales pitch and that is the BIG LIE on treatment outcomes.

**The Big Lie on Success Rates for Inpatient Treatment**

To help sell in-patient treatment, recovery rates are grossly inflated, with many promoting 80% and higher success rates. The reality is closer to 20% or less continuous abstinence one year after leaving treatment.

Success rates are unregulated by the government, leaving no oversight on how these rates are calculated or reported. Also, when treatment centers do attempt to track outcomes, they're calculated based on self-reporting of former patients contacted by phone in contrast to the doctors and pilots who are drug tested. This means interventionists and treatment centers can claim high success rates without fear that the FTC or FDA might crack down on fraudulent claims. In a 2005 article, Who and What can You Believe, White and Godley, wrote:

> *Reporting addiction treatment outcomes has a long, problem –filled history.*
> *Claims of 50 to 70+ percent success rates for particular programs are common in our queries of treatment program representatives, and the Internet is filled with treatment*

*claims of 70 to 100 percent success rates – rates that far exceed those reported at scientific conferences and in the scientific literature.*[vi]

This large gap between what is told to prospective payers and the actual vetted outcome studies continues into today with no oversight. Families desperate for help are vulnerable to what are sold as quick solutions.

Of course, we in the community and our families experience the real rates. But in the lead up to treatment, families are in such a state of distress that they are willing to believe almost anything in the hopes of alleviating the immediate crisis. If parents knew the real rates were closer to 20%, they would rarely pay for treatment.

It gets worse when you consider that there are more effective outpatient models so going in-patient is a lost opportunity for real recovery. Harvard's Recovery Research Institute weighs in:

*…the substantial majority of people who resolve a substance use problem do not receive, nor require, residential treatment - which can be both costly and may unnecessarily remove people from their homes and work situations. Many respond well to less expensive outpatient level care….*[vii]

And that is from Harvard. There's your hard evidence: not everyone needs to go in-patient. Particularly people who have gone there one or two times already. Us users know the drill. (By the way, we are not in denial. We just don't want to stop using - we want you to think we don't know we have a problem. Get it? We BS you.)

With a system in place generating relapses and marketing schemes overstating success rates, the next area to explore is how parents are convinced to continue paying for interventions and multiple treatments. One answer has to do with the traditional Johnson Confrontational Model, as explained in theory and practice in the next section.

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## THE JOHNSON CONFRONTATIONAL MODEL: A SET UP FOR RELAPSE

Familiar to many from the show *Intervention*, this model was developed in the 1960's and is known as the surprise, confrontational or motivational model. It usually lasts two hours or so and is a complete ambush to the target. With little preparation and minimal education for the family, the addict is confronted and pushed into treatment.[viii]

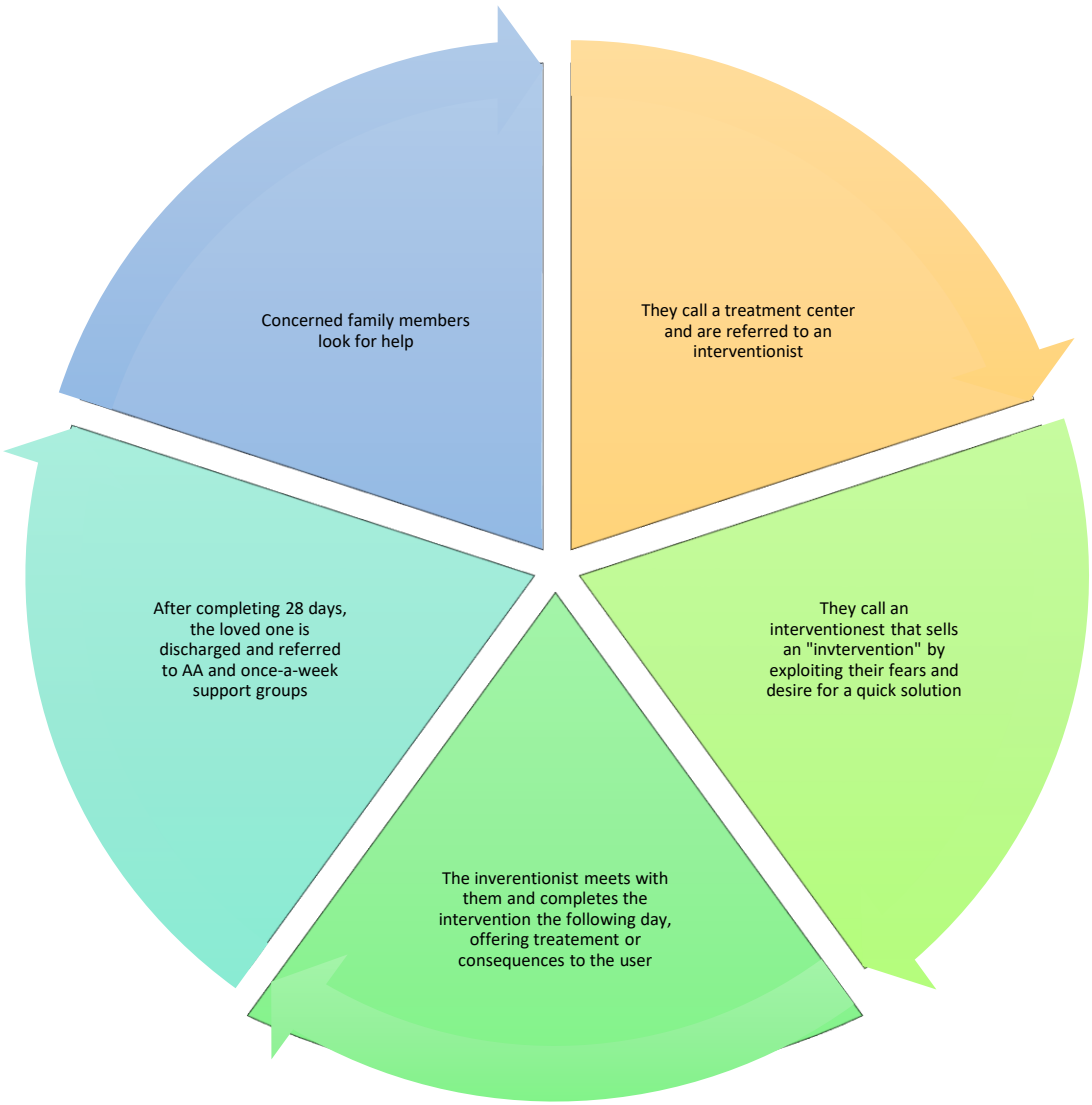
<u>The Johnson model is characterized by:</u>

- Focus on Identified Patient
- Focus on individual
- Goal: Individual Treatment
- Potentially Disrespectful
- Confrontational
- No Education
- Directed at Intervention
- Impact from Shock/Group Power
- Message: **YOU** need help
- Fear of Failure

With sufficient economic, emotional, or legal pressure, the target will often agree to go to treatment, but at the cost of alienation and further separation from the family and little commitment to recovery. Many resisted if they had the resources to fend off economic threats.

**The Johnson Model in Practice**

Any mention or indication that we might have a problem controlling our drinking or drug use often led to the following scenario:




We were told that because we were addicted, our opinions and experiences did not matter, and we had to comply if we wanted continued support. If we relapsed, it was our fault and the negative consequences escalated.

**Fear of Asking for Help**

While different versions of this scenario played out for many of us, an additional detrimental effect was our reluctance to ask for help because we knew what would happen if we were to acknowledge our struggles to control our use. Any mention of a problem would very likely lead to our family members instituting the Johnson model process. To reiterate, the mere

knowledge this might happen to us, postpones our asking for help and keeps us isolated – one reason so few people seek treatment.

**The "Resistance - Denial – Enabling" Construct: Anti-Therapeutic – Anti-Family**

Asking questions or requesting more information in the context of an intervention or at a treatment center is deemed pathology and a supposed marker of desire to use. We are told to shut up and follow orders because we are addicted and do not know what is good for us. This results in untold numbers being coerced into treatment or ejected when in treatment for questioning the process, with us lawyers leading the list as the most inherently inquisitive demographic. Here is the simple construct:

Asking questions = resistance

Resistance = denial

Helping a person in denial = enabling

Enabling = supporting continued substance use

One end result: Family members are told not to talk to their loved ones about any treatment issues, our ideas about what might work for recovery or underlying issues that might be driving our use.

In short, *we were cut off from our support system at the very time we needed family the most.* See Paris Hilton's documentary, *This is Paris* for a moving description of the rampant, gross abuse this system perpetuates for minors, let alone for adults. An estimated 100,000 teenagers are currently locked up, with most in programs based on similar philosophies, often subject to "confrontational therapy". (See NYT Article Trauma, Not Therapy for Troubled Teenagers)[ix]

**Families Told Not to Ask Questions About Treatment**

One corollary to this construct is families are instructed to not ask questions about the intervention or services because that would undermine treatment for their LO. They are told to go to Al-Anon, with its Three C's: I didn't *cause* it, I can't *control* it, and I can't *cure* it.

This misleading simplistic slogan is contradicted by studies identifying factors leading to addictive behavior in family systems as well as factors that lead to recovery, beginning with family support as number one. It brings to mind the name brand beer family where the kids were allowed to drink beer when old enough to reach the tap on the keg. Or numerous instances of physical and sexual abuse by parents. Or medicating primary school students with ADD medications. Maybe you did cause it!

**The Only Way that Works *(My Way or the Highway)***

The final nail in the coffin was being told this traditional model was the sole way to recover, nothing else would work, and intervention, treatment and AA/Al-Anon are the only options. For many years this was the standard message, promoted and defended by treatment centers and AA promoters. The results:

- Many of us were ashamed and full of self -blame for our inability to attain stability.
- Our parents, siblings, and friends angry at us for being so weak - so lacking in character – deserving what happens to us.

We suffered immensely, isolated, often in relapse hell, with too many giving up hope and giving into our disease because we "failed" treatment or could not relate to AA. If sufficiently motivated many of us reached stable recovery despite this model. But of course, many more failed. What approach do we want? One example is the Invitational Model, which is similar to the CRAFT approach now promoted by Hazelden. It is discussed at the end of this paper. Many other community-based approaches are as effective as in-patient treatment, particularly when medication is prescribed to reduce cravings.

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## HOW COULD FAMILY MEMBERS BE SO EASILY DUPED?

**Exploring the Helper Relationship**

Most well-off families pay for intervention and treatment, with many spending hundreds of thousands for multiple stays at high end centers. The question is how could they be duped into doing so even when their loved one's repeatedly relapsed? One answer has to do with expectations surrounding the helping profession. Let's take a step back and figure out how families were so easily and systematically exploited for so many years. To do so, we need to look at the basic elements of the helping professions:


While this seems like a straight-forward transaction, the psychological underpinnings and assumptions are much more complicated and can be used by the unscrupulous to take advantage of people seeking help.

By way of background, in the 70's I was in a therapy group that by chance included a law school classmate. I saw him at recent reunion, and he mentioned that one of the group leaders, Marilyn Peterson, wrote a book on abuse in the therapeutic relationship. (Yes, the other co-leader likely inspired her work. Thanks for asking.) Her book explains in detail how the therapeutic relationship is exploited to take advantage of families seeking help: the missing link.

**The Elevated Status of the Helping Professional – Power and Information Imbalance**

Our expectations and hopes as well as our projections as to how the expert can help us are a covert source of power – we become dependent on the expert to solve our problem. As Ms. Peterson, noted in her book on boundary violations in the professional client relationship:

> *The space between the professional's authority and the client's vulnerability creates a fundamental inequality in terms of who has the advantage in the relationship and the factors that diminish the client's ability to be self-determining.*[x]

Ms. Peterson identifies factors that influence and create vulnerabilities in the patient- therapist relationship. Keep these elements in mind when seeking help and evaluating your therapist. Also, it may be valuable to review your past relationships with interventionists and treatment centers for insight as to where the relationships may have gone astray. In any event the purpose here is to review these factors to see how they are used to manipulate and deceive in the traditional intervention-treatment model.

**Factors in the Helper – Client Relationship**

Parsing the therapeutic relationship

| | |
|---|---|
| Anointment | Helper has elevated status as a professional – The Expert! |
| Professional Privilege | Helper controls time with the client and the nature of the relationship |
| Power Differential | The helper has the information the client needs, and thinks will solve the problem |
| Client Dependency | The client feels vulnerable due to inability to solve the problem |
| Information | The helper has information the client needs to solve the problem |
| Shame | Both the active user and family members carry a high degree of shame – one over the inability to stop using and the family over the addiction. This powerful emotion surfaces in other ways: anger, rigidity, self-blame, destructive interactions |
| Secrecy | Secrecy and shame go hand in hand in the addicted family system, thus allowing the situation to progress and escalate |

| | |
|---|---|
| Families | Viewed as either toxic or enabling, thereby fair game to be taken advantage of |
| Trauma | Childhood abuse, neglect and bad parenting can result in not questioning authority or responding to defend oneself. This silence can be misinterpreted as agreement |
| Client anxiety | The client is worried their loved one will die. That fear, plus years of arguing over what to do leads to off the charts stress |
| Trust | Trust in professionals' rests on the assumption they will act in the best interests of the client and loved one and not in furtherance of their personal goals |

While these factors underlie the helper relationship, most are never discussed despite their impact on the helper relationship and the importance of clients understanding their vulnerabilities when seeking assistance.

**Finding Help and Evaluating the Helper**

It's important to do your research and ask thorough questions of someone you're depending on and inviting into your family dynamic. Good questions to ask include:

- What is your prior experience?
- What is your training?
- How long have you worked in this field?
- Will they use the DSM V assessment and ASAM placement criteria?
- How will we assess progress?
- What kind of follow up will you provide?
- Ask about alternatives to in-patient treatment

The therapeutic relationship factors are a good check list for families evaluating the quality of help. Examples:

- Check for professional licenses and degrees from accredited, known academic institutions.
- What is the quality of information and is it in writing so you have to time to review it and can share it with concerned friends.
- Is the helper decreasing or increasing anxiety?
- Are you operating within your time frame, or some artificial deadline imposed by your helper?
- Specific expertise with family systems and therapy.
- Are the helper's motives authentic or strictly monetary based?
- Do you feel listened to and respected?
- Are you part of the "team"? Or a bystander?

As mentioned, this list is also helpful for a retrospective look at past interactions with helpers when in crisis, for an understanding as to **how** families were exploited and misused by people we counted on to advise us.

**The Scam in a Nutshell**

The basic elements have much in common with other fraud schemes:

- Puff expertise and credential
- Increase client anxiety to induce a quick decision – sign up for an intervention
- Convince family Johnson model is the only path to recovery
- Isolate the patient from family
- Blame LO for problems and any relapses.
- Control the time and nature of the relationship
- Always ask for excessive money up front.
- Withhold effective treatment

As previously stated, treatment success rates are not regulated by the government and most interventionists are not required to be licensed or subject to professional oversight. Therefore, it is an anything goes, buyer beware field. Once again, this list is a good reminder as to the

tactics used to scam you. If you experience any of these elements happening to you it is a "red flag" warning to explore other options. And of course, make sure any representations about services or interactions with family are in writing.

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## THE SCAM IN DETAIL

**Mismatch Between Intentions and Expectations**

Most families assume the same standards apply as in other health care and professional settings. They are not aware they are stepping into an unregulated space where most anything goes. And with good intent, saving a loved one's life, they are easy marks to be taken advantage of by these "helpers". Let's look at the elements in more detail.

**We wrongly believe the people helping us are qualified professionals and therefore give their advice far too much weight.**

*Helpers are often not licensed, credentialed professionals (Anointment)*

Unbeknownst to most families, many helpers do not hold degrees from recognized academic institutions or counseling licenses. Because the family wants action NOW, they fail to perform minimal due diligence (send me your resume) and sign on with the person with the most impressive sales pitch or friend of a friend. And when the helpers do violate ethical standards, there is no place to complain – no governmental body regulates the non-licensed when they violate professional standards.

Affluent family systems are complex and require highly skilled, specifically trained experts for assistance. As vulnerable adults needing help, we have legitimate complaints with a system that directed our families to people who failed to follow professional standards. And we also have legitimate complaints with family members who hired these people and joined in to impose their will on us.

**Client Anxiety/Shame Leads to Poor Decision Making in a Crisis**

*Probably the highest degree of anxiety a family will face in their lifetime*

Family members are often in crisis, worried that their loved one will die and at the same time are angry and fed up with his/her behavior. The goal of any legitimate counselor is to reduce stress and fear. However, too many interventionists sell their services by fueling anxiety and exacerbating negative feelings toward the problem family member. *(The last family that turned me down saw their son die.)*

**(Mis) Information- Lying and "Puffing" About Treatment Success Rates**

As previously discussed, to help sell in-patient treatment, recovery rates are grossly inflated, with many promoting 80% plus rates, whereas the reality is closer to 20% or less at one year.

**(Mis) Information on Outcomes Results in Blaming the Substance User, Further Alienating Family**

*With family thinking 80% stay clean after their 28 days, almost all blame their LO for relapsing.* Treatment centers and interventionists add fuel to the fire by saying things like "*He didn't get the miracle of recovery, follow his treatment plan or get step one."* Families become emotionally exhausted and ready to accept any advice. Rather than take a step back and try to figure out what's not working when we relapse, it's on to the next "intervention" and more in-patient.

Harvard's Recovery Research Institute published a study indicating it can take up to four to five good faith efforts at stopping before a person achieves stable recovery. But no wants to hear evidence-based information when its crisis time.

**(Mis) Information About Outcomes Results in Users losing hope (Trauma**

*Being told most people recover causes relapsers to despair.*

Yes, many of us do enter first time treatment with great hope and excitement about a new life. Then, even with the best of intentions relapse happens and we tell ourselves we are in the small minority that can't stay quit. It must mean there's something wrong with us, we will never recover, and we might as well keep right on drinking and drugging. Remember, users

already have a huge amount of self-blame and low self-worth. We far too readily accept that we are too flawed to recover, reject efforts offering help and further alienate our support system.

**(Mis) Information about Services Provided**

*Get it in writing*

Another common misrepresentation concerns services provided at a prospective treatment center. A colleague's brother once proposed writing a book on the gap between what services his parents were told he'd receive and the reality of his twelve treatments. Because many surprise interventions are done quickly, parents as the buyer of services rarely think to obtain statements as to programs or services in writing. This same problem exists for sober homes and half-way houses.

**Fail to Follow Professional Standards on Assessment and Placement**

*Families are told the Johnson model and in-patient are the only models for success*.

Most families do not know that both practice and licensing standards require assessments and evaluations before their LO is shipped off to treatment. Again, the Recovery Research Institute states:

> *A survey of nearly 300 treatment centers found many admission practices are both deceptive and fail to follow ASAM practice standards, leading to unnecessary (and costly) in-patient admissions.*[xi]

These practice standards include long standing resources such as:

*Diagnostic and Statistical Manual V assessment of Alcohol Use Disorder*

- An eleven-factor test to diagnose mild, moderate, or severe dependency. Only the more severe cases need in-patient treatment. (DSM-V)

*Society of Addiction Medicine Six Factor Placement Test* (ASAM)

- A strength-based multidimensional assessment taking into account a patient's needs, obstacles and liabilities, as well as their strengths, assets, resources, and support structure.

*This includes, by the way, asking for and listening to our preferences*.

Since the goal of the Johnson style intervention is to force the target to in-patient treatment, it's fair to assume these assessments were not performed. (See Part II for a detailed discussion of the DSM-V diagnostic criteria and ASAM standards.)

**(Increase Client Dependency) Isolate the Patient from Family -Non-Communication with Family**

*No asking, no telling.*

As explained above, under the Johnson model, families are told not to ask questions about treatment. Nor are they to listen to the concerns of their LO. Once in treatment, there is very little communication with family, with HIPPA being used as the ostensible reason.

*Patient did not sign a release*, is a common excuse. The very people we need to help us know nothing about our progress, our diagnosis, including trauma, and therefore have no idea how to support our recovery.

A few treatment centers will only admit patients if they sign a release to communicate with family members. However, many centers play off our resentment and fear of family generated by the intervention and passively support our reluctance to sign releases, rather than seeing our refusal as a therapeutic issue. This despite the fact that the degree of family support is an important consideration in post-treatment planning.

**(Professional Privilege) Control the Time and Nature of the Relationship**

*Are you on their schedule or your schedule?*

Families are dependent on the helper to schedule time with them and as well as the information they receive about substance use disorders. The Johnson intervention model is often a quick process with an interventionist flying in the night before and leaving the next day with or without the person of concern in tow. This can be very disruptive to families who are looking for more support and opportunities to process feelings from what is an often a highly emotional confrontation.

**Secrecy/Shame Isolates Family**

*Increases dependency on the helper.*

Creates a "closed loop" system with the family afraid to talk to friends, relatives, or advisors for fear their secrets and disfunctions will be known to others. The code of silence around behavioral disorders is one reason for low success rates, both in terms of not seeking help soon enough and then not checking on the quality of advice when doing so. The reality is it takes a village to support recovery, with many people pitching in to provide positive feedback and accountability.[xii]

**Inherent Financial Nature of the Helping Relationship - The Why**

Aside from failure to comprehend the power imbalance and opportunities for exploitation., the even more significant vulnerability is that the professional client relationship is also a business venture. This commercial motivation can too often override what is supposed to be a partnership of trust characterized by professional self-restraint.

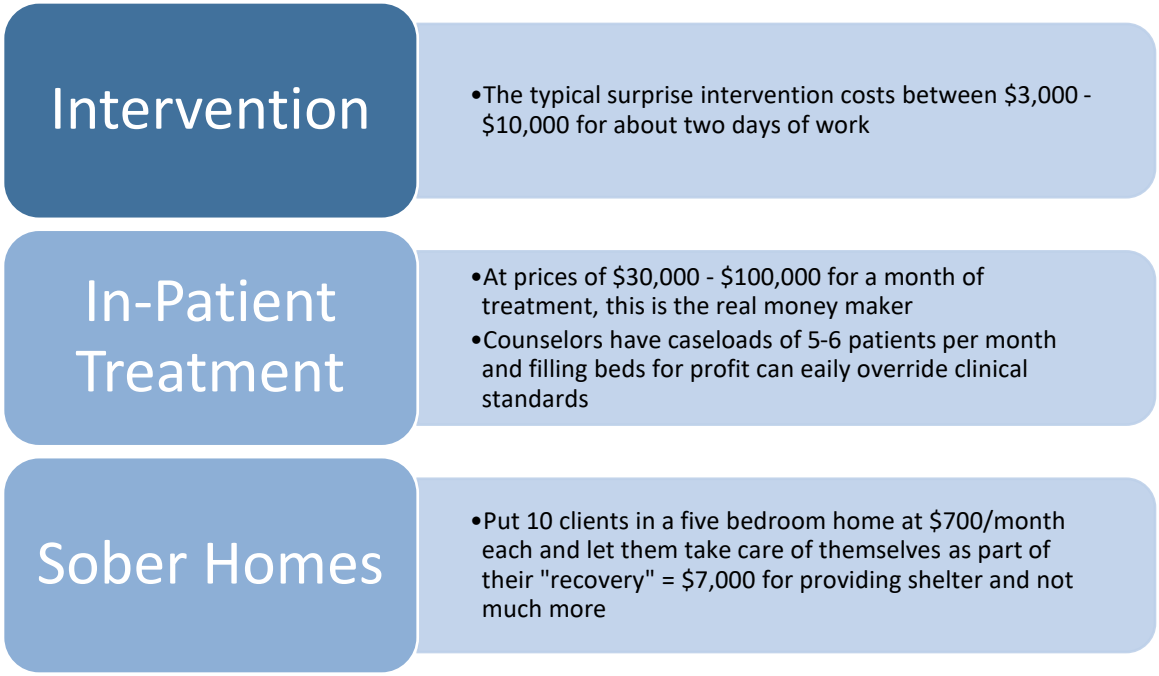
Normally, the hourly fee model lessens the opportunities for excessive charges because the client pays before the session or insurance covers the cost. The real danger lies in the one - time large transaction charge – this is where economic incentive can often override any ostensible pretense of professionalism. These incentives are found in intervention, in-patient treatment, and sober homes. It's the WHY for our exploitation.

#

## FOLLOW THE MONEY

**Find Out Who is Benefiting from a Failed System**

Under the current traditional treatment model, the money makers are intervention, in-patient treatment, and sober homes:




These large, upfront cash payments incentivize the current system with the focus on selling a service, not recovery from an illness.

BOTTOM LINE: The traditional model generates a lot of money – so much so that it perpetuates a system that takes advantage of the vulnerable for the financial benefit of the few under the guise of "saving lives". (Note that AA is also a problem: One "brand name" relapser told me he had three sponsors, all borrowed money and never paid him back.)

#

## CLOSING THOUGHTS

**The Ultimate Betrayal: We believed the people helping us have our best interests at heart**

The burning question for me since completing treatment in 1995, is why are so many families buying into a system that clearly does not work for them?

- It may that there is such an emphasis on secrecy that they do not seek other opinions and therefore continue to rely on their first contacts when they call for help, even after repeated failures.
- Shame carries its own weird dynamic, limiting open communication even when family and friends know about struggles with substance use.

- TV shows like intervention also play a role in shaping opinion as to what help looks like.
- And of course, families are looking for quick fixes and don't want to hear that it may take five or six tries or they may be part of the problem.

But above all, it is a system designed to fail!! Desperate for help, we are taken advantage of by people we trusted to save our loved one's health and lives.

We can't bring back family and friends. That is our hard reality. But we can advocate and support efforts at treatment reform and inform ourselves on new evidence-based approaches to recovery.

And those of us seeking help can ask for what we want:

- *Supportive, Interactive, Evidence Based Help, and Reconciliation with our Families.*

No more dismissing our views on the grounds we are addicted and don't know what is good for us. That not only harms our recovery, but it's also abusive. And no more "tough love"! Stop Killing Us! That should be a crime.[xiii]

**What's a contemporary model**?

Local or in-home detox followed by wrap around comprehensive services based on assessments and evaluations, plus accountability and incentives if needed.

- Turn to your health care provider for qualified counselors, look at the ASAM website[xiv] and contact a professional in your area or find a Community Recovery Organization.
- Use Medication Assisted Treatment (very important for oxy/heroin users)
- Do not call a treatment center, intervention service or your friend in AA or Al-Anon.
- When you go on-line, stick with academic institutions such as the Recovery Research Institute at Harvard or professional journals.
- Talk to your friends and family about what you are facing and different options – do not keep it a secret – too easy to be manipulated. And it takes a village to support recovery.

**Bottom Line: Don't Get Fooled Again.**

**(And Read Part II for how to help us and what works to improve outcomes.)**

[i] . (CRAFT model https://drugfree.org/article/craft-community-reinforcement-family-training/).
[ii] (From the Guiding Principles of Thrive Family Recovery Resources)
[iii] -Dr. David Carr, Director, Mississippi Physicians Health Program
[iv] Redefining Addiction Treatment By: Omar S. Manejwala, MD, MBA, FAPA, CPEBehavioral Healthcare, April 2011
[v] Institute for Behavior and Health, March 2014
[vi] Who and What can You Believe? COUNSELOR Magazine. June 2005, Volume 6, By William L. White, MA and Mark D. Godley, PhD
[vii] Buyer Beware June 2021 Recovery Research Institute
[viii] *Intervention Models*, Reference to Bayarea-intervention.com, 2006
[ix] NYT 10/22/23, Maria Szalavitz
[x] P. 43, At Personal Risk, Boundary Violations in Professional-Client Relationships, M. Peterson, Norton, and Co. 1992
[xi] See 6 above
[xii] Star Tribune 8.6.11 Article by: Lynn Benson
[xiii] Killing in the Name of Tough Love is Legal, Huff Post, 11/17/21 Maia Szalavitz
[xiv] asam.org/publications-resources/patient-resources/fad