

(Washington State Council on Alcoholism)

POSITION STATEMENT

July 28, 1972

The recent administrative attempt to force alcoholism back into the territorial jurisdiction of the mental health professions, in the name of administrative efficiency, has precipitated a crisis in the alcoholism field throughout the state of Washington.

It is a matter of record that the vast majority of the hundreds of thousands of alcoholics who have recovered have done so outside of, and in spite of, the mental health movement rather than within its therapeutic boundaries. Against the background of persistent failure to cope adequately with alcoholism on the part of psychiatry and the other mental health professions, Alcoholics Anonymous and other non-psychiatric approaches have inspired both a valid alcoholism rationale and an empirical platform for comprehensive reform. As the gulf has widened over the years it has become more and more evident that the failure-success contrast between the two approaches is only a surface manifestation of an irreconcilable difference in views of human nature and of the basic nature of alcoholism and of the recovery process. Admittedly this is a complex technical matter, but we feel strongly that public officials must look into the substantive issues deeply enough to align public policy with the alcoholism reform movement rather than with administrative expediency, which in this instance is antagonistic to the reform.

In brief, the mental health view of alcoholism insists on the primacy of psychological and social variables in the causation and progression of the illness. Many millions of dollars and several decades of intensive effort to substantiate the mental health approach to alcoholism have failed to produce either supportive research evidence or significant recoveries. Objective comprehensive reviews of the psychological research literature in alcoholism have been published from time to time. Each author in turn has been forced to the same conclusion, that no acceptable evidence has been reported that would warrant the assumption of psychological causation of alcoholism or that persons with any psychological characteristic are more or less likely to become alcoholics than persons with any other psychological characteristic.

WSCA "Position Statement"**Dr. James Milam****July 28, 1972**

In sharp contrast, the rationale of the alcoholism reform recognizes that both scientific evidence and clinical knowledge point the other way - that the obvious and profound psychological symptoms of the alcoholic are secondary to his unique physical reaction to alcohol as a drug. Rather than denying the importance of psychological variables - addictive drinking, regressive immaturity, mental confusion, personality inadequacy, emotional disturbance, etc. - the viewpoint of the reform actually stresses the seriousness of these symptoms by recognizing that they are rooted in the progressive toxic and organic effects of alcohol. The reform has been inspired by the simple empirical fact that both neurophysiological and psychological symptoms ameliorate toward normal with continuous total abstinence and treatment compatible with the redefinition of the illness. Hundreds of thousands of sober, recovered alcoholics attest to the validity of this treatment approach, and there is a substantial body of research evidence confirming the validity of the corresponding scientific rationale.

With such an obviously viable alternative at hand, and with so many millions of lives at stake, it is important to understand why the mental health professionals have clung so tenaciously to their unsupported position through so many years of punishing failure to cope adequately with the problem of alcoholism. One reason of course is the fact that the whole mental health movement has been deeply committed to the environmental, as opposed to the constitutional, view of human nature. (Many leading university psychology departments have been split down the middle by this controversy in recent years.) A related reason is the fact that mental health professionals have a deep self serving interest in the belief that alcoholism is primarily a functional psychological disorder. For them to surrender and give up this belief would be to invalidate their credentials and their claim to expert knowledge in the field of alcoholism.

Sharing in the basic error, society has always vested social workers, psychiatrists and psychologists with the authority of expert knowledge in alcoholism in spite of the fact that not one in a thousand has ever had even a basic course in alcoholism, much less anything like adequate education and training. When professionals in the field say that they do not understand what all the criticism and furor is about we should believe them, for the relevant research evidence and illuminating clinical experience have been denied them. The primary defense of this obvious academic

negligence has been essentially the same argument that has been used to accredit the professionals without relevant education or training, the argument that special courses and training are not necessary because alcoholism is merely a symptom of psychological and social problems already thoroughly covered in many other courses and training programs. Thus the wealth of contrary scientific and clinical evidence does in fact lie beyond the purview of this psychogenic commitment. After several generations of such circumscribed educational orientation and training mental health professionals speak the simple truth when they say that they know of no scientific evidence on the opposite side. They look but cannot see. The minority of scientific spokesman for the alternate view, evidence in hand, have either been ignored or summarily dismissed as failing the basic test of "validity", i.e., professional consensus.

The frustration of chronic treatment failure has been lessened somewhat by the professional practice of blaming it on the patient, and new treatment techniques are sought endlessly in the hope of penetrating the patients "defenses". Many practitioners have found it more expedient to simply give up the criterion of sobriety and recovery, claiming that it is unreasonable to expect alcoholics to achieve continuous lasting sobriety. Worse than mere failure, the assault on the patient's neuropsychological and secondary psychological symptoms, without understanding, has resulted in the destruction of many alcoholics in the name of treatment. In their desperation, many psychiatrists treat the psychological symptoms of this physical illness by adding other toxic drugs, and some have even resorted to electroconvulsive shock or frontal lobotomies.

In all fairness, many mental health practitioners have recognized the inadequacy of their treatment approach and have abstained from participating in the debacle. Very few, however, have ever seriously considered giving up their basic premise in favor of the threatening alternative.

With the onset of the reform and the imminence of many millions of tax dollars for alcoholism we should not expect the mental health professionals to willingly discredit and disqualify themselves by capitulating at this juncture.

It has been argued that mental health organizations could learn more effective approaches if given jurisdiction over alcoholism programs. It is a matter of record that they have steadfastly refused to do so in the past, and professional reform has not occurred in many instances in which mental health professionals have been charged with alcoholism responsibility. They have seldom been willing or able to diagnose alcoholism, as alcoholism, except in the obvious late stages, and they have tended to substitute palliatives and psychotherapy for the expectation of lasting sobriety and full recovery.

Alcoholics Anonymous was founded in 1935, the same year that Shadel Hospital was founded in Seattle. Both programs were surprisingly effective and for the first time in history alcoholics began to recover from what had come to be accepted as an unalterably hopeless disease. It was soon obvious to many that a major breakthrough had occurred. We might have expected that both approaches would have been adopted or at least tried experimentally in state hospitals and other mental health facilities. Instead both were held in contempt and rejected from their inception for the simple reason that neither had attacked the alleged "deep underlying psychological causes" of the illness.

As more and more alcoholics were restored to normal lives in the community, AA groups spread throughout the state, and the Seattle Police Farm for alcoholic rehabilitation demonstrated that society could actually program recoveries in an agency setting. The mental health professions were intransigent in their rejection of these early precursors of reform. No amount of evidence, argument, or coercion could persuade them to bend to the obvious responsibility for community leadership thrust upon them by the simple fact that it was possible to treat alcoholism effectively. Finally in 1959, because of their dereliction, jurisdiction was transferred out of the Department of Institutions into the State Health Department. Thus liberated from the stultifying effects of the mental health belief about alcoholism, the long suppressed energies of reform were released and the next decade witnessed a proliferation of alcoholism information and referral centers and treatment programs throughout the State. As could be expected with such an explosive development, some mistakes were made, and some state and local programs are still contaminated by the lateral intrusion of the mental health influence, but by the end of the sixties it was clearly evident that the state of Washington had made

a major administrative breakthrough by releasing and legitimizing the grass roots forces of reform. Inspired by the early Seattle Police program, King County's Cedar Hills Alcoholism Treatment Center for indigent alcoholics was opened in 1967. It was soon recognized both nationally and internationally as a model treatment center and several National awards already have been bestowed on the County for this exceptional program.

It is important to realize that the state of Washington anticipated the National reform by a decade, and is now in the forefront among the fifty states. It was not by chance that Washington was the first state to pass the Uniform Alcoholism and Intoxication Treatment Act. Here as elsewhere, the reform has been fueled and guided by the growing number of recovered alcoholics in all sectors and echelons of society in concert with an equally diverse consortium of enlightened and concerned citizens. With a few notable exceptions, the mental health professionals have yet to discover the awkward fact that the reform has taken root beyond the territory not only of their administrative jurisdiction but also of their ideological purview.

The Washington State Council on Alcoholism is a body representative of the reform and we must insist that these basic facts be recognized. As we strive to move from thousands of recovered alcoholics to millions, it is unconscionable that mental health professionals who have constituted such a major obstacle to reform should be encouraged by official government sanction to continue to pose as leaders in the field of alcoholism. We are not at all impressed by the merely semantic concessions or the soothing administrative reassurances that we have heard. The field is polarized by a substantive technical issue and any solution must be compatible with the broad structure of the reform.

By act of Congress, the National Institute for Alcohol Abuse and Alcoholism is now the sole source of Federal matching funds for community alcoholism treatment programs, and several recent changes in Federal policy are of special significance to the change over to the new scientific rationale in alcoholism. The new Federal Grants program no longer requires that a psychiatrist be in charge of community programs, and it is no longer a requirement that community programs be administered under mental health jurisdiction. Any non-profit organization may sponsor and administer such programs. It is also recommended that qualified recovered alcoholics

be employed in program administration whenever possible.

Although County Alcoholism Councils must be strengthened to meet the new responsibility, they offer the strongest prospect for providing enlightened local program administration. In contrast, the Mental Health Boards are not only lacking in relevant experience, they were established with a philosophy and purpose alien to the alcoholism reform. To our knowledge none of the County Mental Health Boards has shown any ability or inclination to recognize and overcome their historical incompatibility with the alcoholism reform approach. Some have instead resorted to power plays to try to force County Alcoholism Councils to surrender to their arbitrary authority. Public disclaimers notwithstanding, factional advice emanating from Olympia has alleged that it is the will of State and Federal governments that all alcoholism programs must be subordinated to local mental health authority in order to receive State and Federal Funds and cooperation. County Alcoholism Councils have been subjected to onerous local mental health pressures purporting that County and City governments will be alienated from State and Federal funding sources if they do not support the local mental health take over.

For reasons discussed earlier, this crisis in alcoholism is more real than apparent at all levels of government. A continuing storm of protest from around the Nation reaching Senator Harold Hughes, the prime mover and architect of the national reform, has supported him in introducing Senate Bill #3644, to totally remove the National Institute of Alcohol Abuse and Alcoholism from National Institute of Mental Health jurisdiction. Whether the proposed legislation passes or not, Federal Administration sources have issued advisory statements, for example in the Uniform Alcoholism and Intoxication Treatment Act, indicating that Alcoholism should not be subordinated to mental health but should have separate, autonomous status at State levels of government.

Many specific recommendations come to mind at this point, but we will limit ourselves to those that are most currently relevant to the purpose of this position paper.

- I. We recommend that alcoholism at the State level be moved out of the jurisdictional area associated with mental health into an organization, such as the Service Delivery Division or Health Services Division, with a health perspective broad enough to

accommodate the fully comprehensive alcoholism reform program. The new organizational setting should provide for as much alcoholism program autonomy as feasible within the limits of sound administrative policy. Concurrently, local officials throughout the State should be informed of the change and advised to look to their County Councils on Alcoholism for leadership in the planning, implementation, and administration of comprehensive local alcoholism programs. Primary contracts, third party agreements, and affiliations with various community agencies (including Mental Health for its special services) could, of course, be negotiated directly by the County Alcoholism Councils.

- II. We recommend that the Washington State Council on Alcoholism be officially appointed to serve as an advisory board to the State Alcoholism Section and to the administrative organization responsible for its supervision. The Council would be called upon to deliberate and advise on administrative and program issues of policy, personnel, Federal and local relationships, public and professional relations, and general program evaluation and improvement. We are prepared to immediately enter into coordination to the end that this recommendation may be implemented.