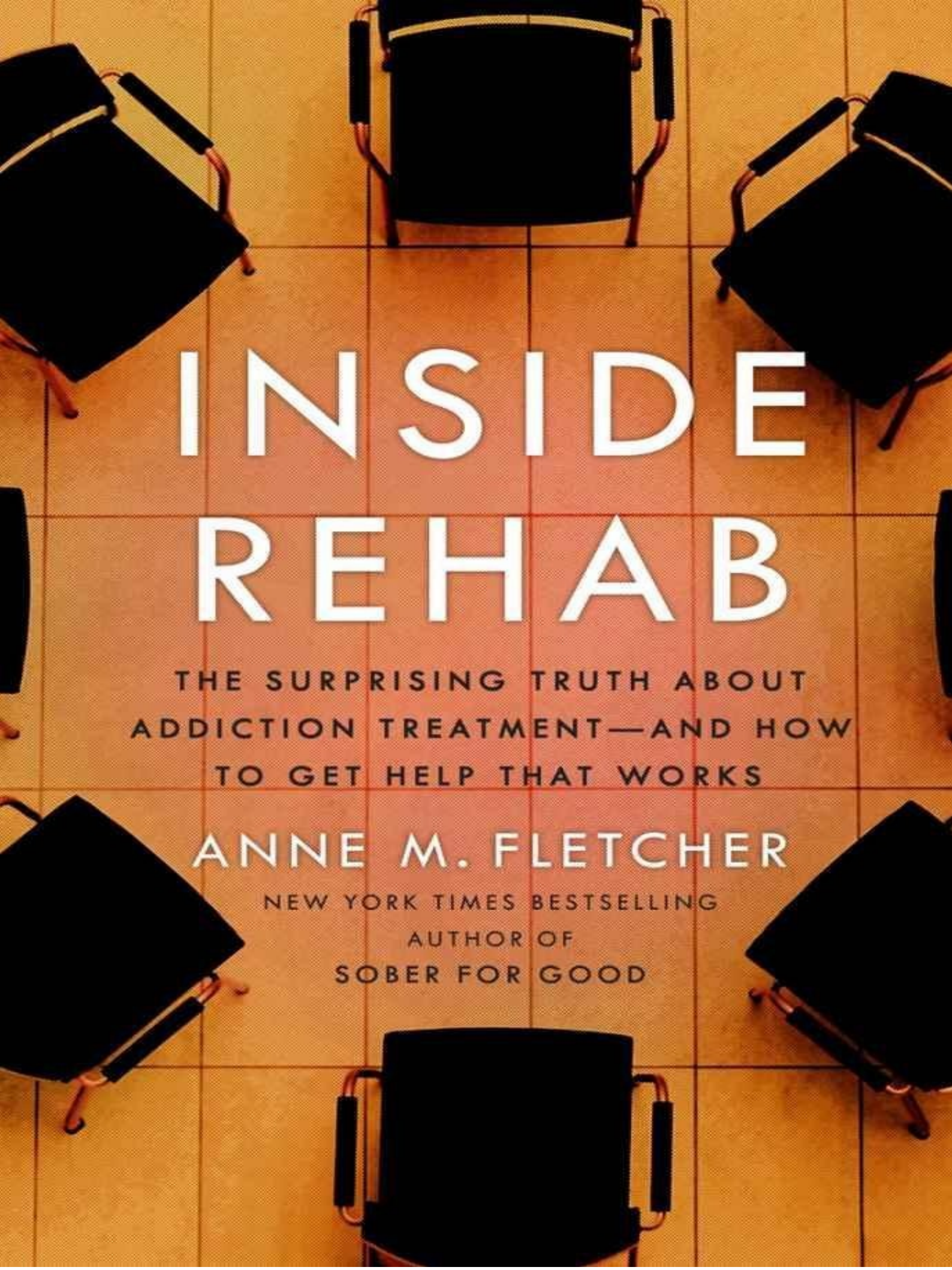
INSIDE
REHAB
THE SURPRISING TRUTH ABOUT ADDICTION TREATMENT—AND HOW TO GET HELP THAT WORKS
ANNE M. FLETCHER
NEW YORK TIMES BESTSELLING
AUTHOR OF
SOBER FOR GOOD

Sober for Good: New Solutions for Drinking Problems—Advice from Those Who Have Succeeded Th
for Life: 10 Keys to Success from People Who Have Lost Weight and Kept It Off Thin for Life
Daybook: A Journal of Personal Progress Eating Thin for Life: Food Secrets & Recipes from Peopl
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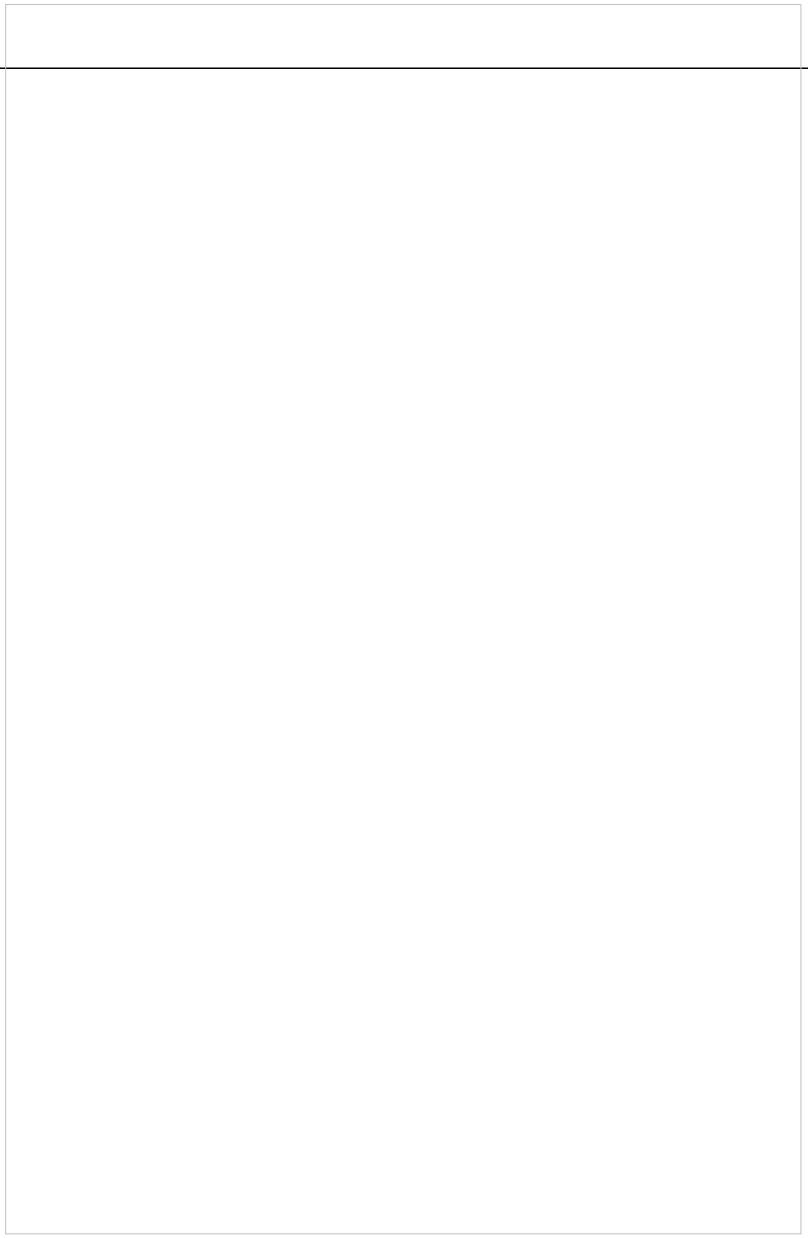

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For all of the people who so selflessly contribute to my books

And in memory of Dr. Alan Marlatt, who encouraged and inspired me to write about addiction and recovery

Just because it is written in stone it does not mean it cannot change.

—On a stone outside a rehab dormitory

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NOTE TO READERS

The ideas, procedures, and suggestions contained in *Inside Rehab* are not intended to be a substitu for consulting with a physician, mental health professional, and/or credentialed substance use disord treatment professional in dealing with any kind of drug or alcohol problem or any underlyi psychiatric conditions, such as depression or anxiety. Neither the publisher nor the author is engage in rendering professional advice or services to the individual. Anyone who has been overusing alcoh or drugs consistently should consult a physician and/or consider going to a professional detoxificati unit or a hospital emergency department before giving up drugs or alcohol completely. Neither th author nor the publisher shall be liable or responsible for any harm, loss, or damage allegedly arisi from any information or suggestion in this book or omitted from this book.

The names and, in some cases, identifying details of people who shared their stories about the drug and alcohol problems have been changed. Some remarks that are in quotations were edit slightly for clarity. Most of the information in this book was gathered over the course of the yea 2009–12, and some information, such as any particular facility's rehab policies and procedures, ma have changed since that time. While an effort was made to provide a comprehensive picture of th nature of and possibilities for substance use disorder treatment, this book does not cover every aspe of treatment or every type of program.

Readers should bear in mind that some programs operate multiple sites and that statements abo a particular facility may not apply to other facilities in the same program. The rehab stories collect for this book involve many more than those from programs the author visited. Information abo programs other than those the author visited is largely taken from interviews with clients wh attended those programs and/or staff members who are currently or were previously employed at su programs. The experiences of any one person may or may not be representative of the experiences others who attended the same facility. Praise or criticism of one aspect of a program should not b construed as a representative view of the entire program.

Because of the possibility of post-publication developments in behavioral, mental health, medical sciences, readers are encouraged to confirm the information in this book with other reliab sources. Neither the publisher nor the author vouches for the value, merit, or accuracy of any of th outside resources (books, articles, Web sites, etc.) mentioned in *Inside Rehab,* nor are they responsib for the use of any information or advice found in any of these outside resources. For the resourc discussed in this book, the author has made every effort to provide accurate telephone numbers an Internet addresses at the time of publication, but neither the publisher nor the author assumes an responsibility for errors or for changes that occur after publication.

WHAT'S WRONG WITH ADDICTION TREATMENT? WHAT WILL HELP?

AN INTRODUCTION TO *INSIDE REHAB*

Inside Rehab is filled with disturbing accounts of seriously addicted people getting very limited ca at exhaustive costs and with uncertain results—but in my experience, they are accurate account Indeed, my research on addiction treatment programs suggests that this discouraging picture may eve underestimate the conceptual and procedural problems in this very distressed but essential treatme system. But how did it get this bad?

There has never been a question that alcohol and other drug addictions are immense problems f society. The question instead was always, Just what kind of a problem is addiction—and who shou manage it? Because the stereotypical "drunk" or "junkie" was often seen as violent, a liar, a thief, an in general disruptive of family and social life—problems that were viewed as moral or lifesty failings—addiction was addressed by laws, social sanctions, and moral teachings. But whe unparalleled numbers of America's veterans returned from service with drug and alcohol problem after the Vietnam War, it became politically untenable simply to punish these young addicts. In th early 1970s a national addiction treatment system was called for. Few physicians or nurses knew muc about addiction medicine—there was very little to know. Almost no scientific research on the origin of alcohol or other drug addiction was available upon which to develop treatment. Instead, th treatments were derived from the earnest efforts and experiential wisdom of those who had overcon their *own* addictions and were willing to help others. The Minnesota model of residential care that ha grown out of do-it-yourself treatments offered at "Hazelden" (the name of the farm property on whic Hazelden's main campus now stands) several decades earlier proliferated at rehabs across the countr and "therapeutic communities" employing ex-addict counselors grew in number.

Perhaps most significant, the addiction treatment system was purposely designed as a segregate system—separated financially (through funding largely with government block grant dollars, n medical insurance), culturally, and often physically from the rest of general health care. (The Veteran Administration was an important exception because its general health care, addiction treatment, an mental health care have long been integrated.) That segregated system grew into today's network o over thirteen thousand addiction "programs"—still largely isolated from the rest of medicine an health care; still largely financed by separate protected dollars; and still largely distinct in terms the types of interventions applied and the professional providers involved. Like other segregate systems, it is loaded with stigma. Few addicted individuals (about 10 percent) are willing to ent care. Drop-out rates are high. And among treatment completers, one-year relapse rates are 40 to 6 percent. The public deserves more and our society desperately needs reliably effective care.

Addiction has not been the only segregated illness, however. Many "conditions," includin depression, polio, and tuberculosis, were not recognized as medical illnesses and have only recent been taught in most medical schools and treated by physicians. They were seen as "lifestyle problem and care was typically provided by concerned, committed individuals or institutions not we connected to mainstream health care. Tuberculosis provides an instructive case. While TB had lon been considered a serious threat to the health and safety of most societies, science had not develope to the point where it could explain the causes or the course of the illness. Those with "consumption

were offered the treatments of fresh air, nutritious food, and relaxation in sanitaria under the view th
this "lifestyle problem" would benefit from those healthy conditions. By 1935 there were more tha
fifteen thousand sanitaria in the United States. In fact, this type of care—though based upo
inaccurate conceptions of the disease—often produced recovery, particularly among those who we
otherwise healthy and in whom illness was detected early. Thus it was seventeen years before TB wa
recognized and treated by many traditional physicians and health-care facilities as a bacterial diseas
and labeled as such in medical textbooks. The parallels with contemporary addiction treatment a
hard to ignore.

Thanks to four decades of NIH-sponsored research there is a new foundation for the treatment
addiction. This science now suggests that addiction is best considered a chronic illness. As in oth
chronic illnesses, a still incompletely understood combination of genetic and environmental ris
factors combined with risky personal behaviors—particularly repeated drug use itself—produce th
chronic illness of addiction. Most scientists agree that the genetic, brain, and behavioral chang
associated with addiction do not appear to be completely reversible—like other chronic illnesse
most cases of severe addiction can be managed, but not cured, with continuing care. But as revealed
Anne Fletcher's research in *Inside Rehab*, continuing care according to a chronic care model is ve
hard to find—and there are still few insurance plans that support such evidence-based treatment.

This divide between what we know about the genesis and development of addiction, and how w
insure, treat, and evaluate it cannot last. As was the case in tuberculosis treatment, addiction scienc
has advanced, and both the public and policy makers are becoming more informed and awar
Ultimately, the insurance and treatment systems will meet the new scientific understanding and th
new public demand. Addiction treatments in the near future will build upon the emerging science an
will borrow from advances in disease management practices, team treatment methods, tailore
treatment planning, and continuous patient monitoring that are now common in the management
other chronic illnesses. Group counseling, individual counseling (hopefully, more of it than we se
now), and recovery support groups will likely remain key elements of future addiction treatme
because they are economical and effective methods for changing and maintaining a recovery lifestyl
But these good old-fashioned elements of addiction treatment are likely to merge with greater use
currently approved and to-be-developed medications, remote telemonitoring of blood drug and alcoh
levels, continuous patient contact outside of clinic settings, and marital and family therapy, as well a
team-based disease management to foster treatment adherence and forestall relapse. And thanks t
health-care reform legislation, the great majority of addiction treatment—as well as prevention an
early intervention for less severe substance use disorders—is expected to be reimbursed by healt
care insurance. As in the case of treatments for polio, depression, and tuberculosis, addictio
treatment will become integrated into conventional medical and nursing education and in
mainstream health care.

In closing I admit that it was personally difficult for me to read about the problems within th
distressed field that Anne Fletcher has documented so carefully in *Inside Rehab*. I have made m
income and professional identity from work in the addiction treatment field. More important, I ow
the lives of several of my family members to very fine addiction treatment. My deepest regrets to th
day are that even as an expert in this field, I was not able to get my brother or son into the kind
treatment that could have saved their lives. But as you will see as you read *Inside Rehab*, addictio
treatment must change and it *can* change. My hope is that the important information provided in th
book promotes public demand for the kind of effective addiction treatment that now is well with
reach.

A. Thomas McLellan, PhD, CEO and Cofounde

REHAB NATION

THE QUESTIONS AND THE ISSUES

Lindsay and Britney have been there, along with Robin Williams, Robert Downey Jr., Charlie Shee Eminem, a former Miss USA, Mel Gibson, Congressman Patrick Kennedy . . . and the list goes o Rehab seems to be the place where celebrities and politicians go when they mess up, not only to "g clean" from whatever addiction ails them but, sometimes, in an attempt to change their publ personas from ne'er-do-wells to helpless victims.

Media and public interest in addiction, drugs, and rehab is fervent, fueled by accounts of famou people yo-yoing in and out of celebrity programs, along with sensational stories of untimely deat caused by prescription drug abuse, a number of which, sadly, took place during the writing of th book. That, and the popularity of reality shows on addiction interventions and "celebrity rehab" a indicate that a lot of people want to know what really goes on inside addiction treatment programs- sometimes in a voyeuristic way, but more often for compelling personal reasons.

It seems to be accepted as fact that when someone is struggling with addiction, we should simp send him or her away to a place to "get fixed" by a team of experts. But does the view of addictio treatment we get from TV shows and movies provide an accurate picture of what happens when mo people go in for help? Is the rehab to which wealthy and famous people flock much like the reha available to the general public? And are most people with serious addictions likely to "get fixed" fro a month-long stint in rehab? As *Inside Rehab* will demonstrate, the answer to all three questions is resounding No.

• • •

Why *Inside Rehab*?

My desire to write a book on rehab was kindled by a shocking front-page story titled "Th Treatment Myth" that ran in the *Minneapolis Star Tribune* shortly after I'd moved to Minnesota fro the East Coast in 1993. As someone who had personally struggled with a drinking problem, I wa immediately drawn to the subheadings of the four-page feature: "Chemical dependency program exaggerate their success rates"; "Treatment has little scientific support"; "For many clients it's revolving door"; "Even an elite treatment program has many failures." As I found in researching th book, the current treatment system continues to suffer from many of the issues that were documente in this article.

I recall thinking at the time that at some point I'd like to write a book about all of this, and I d go on to write a book that challenged many myths about overcoming addiction: *Sober for Good: Ne Solutions for Drinking Problems—Advice from Those Who Have Succeeded* (Houghton Mifflin, 2001 It is about the many different ways people achieve long-term sobriety and personal guidance f recovery rather than rehab for addiction.

After the publication of *Sober for Good*, my interest in drug and alcohol rehab grew as I got know A. Thomas McLellan, PhD, cofounder of the Treatment Research Institute (TRI), a grou dedicated to conducting studies to evaluate what works in addiction treatment, and why. I

periodically call him to find out about developments in the field. Much of what he shared w appalling. "If you've seen one rehab, you've basically seen all of them. Yes, there are exceptions, bu of the many thousands of treatment programs out there, most use exactly the same kind of treatme you would have received in 1950, not modern scientific approaches. Counselor training impoverished, and staff and director turnover in these programs is higher than in fast-foo restaurants." Of the rehab consumer, Dr. McLellan said, "When it comes to picking a rehab, mo people ask more questions before buying a vacuum." In 2009, McLellan became deputy director of th Office of National Drug Control Policy, or what's commonly known as the "deputy drug czar" for th Obama administration, but has since returned to be president and CEO of TRI.

Early in this book's writing, I spoke with the late renowned Alan Marlatt, PhD, former director o the Addictive Behaviors Research Center at the University of Washington in Seattle. Our conversatio made me realize that it's not unusual for addiction experts themselves to be in the dark about wh happens inside the walls of treatment centers. Amid the media frenzy over one of Lindsay Lohan early trips to rehab, *People* magazine interviewed Marlatt, who later told me, "This reporter calle and one of the first questions he asked me was, 'How can we find out what goes on inside the places?'" The truth is that even Dr. Marlatt didn't know.

When people I cared about were struggling with addictions, I'd also faced frustrations in seekin treatment that was effective, affordable, and timely. Most people simply know little or nothing abou the extensive range of rehab and recovery options, the uneven quality across treatment programs, an the big-picture problems within the addiction treatment infrastructure in the United States.

Through visits to programs, stories of people who went to rehab, and interviews with experts *Inside Rehab* explores the strengths, weaknesses, and current state of the addiction treatment industr in the United States. More specifically, the goals of the book are:

- To give consumers a realistic picture of what goes on when a person goes to residential o outpatient rehab
- To uncover myths and facts about addiction treatment in the United States
- To address problems and issues faced by people in rehab and by the treatment industry itself
- To provide a guide to different types of treatment and ways to recover
- To inform consumers about science-based practices that *should* form the basis of addictio treatment and to spotlight programs and professionals using those practices
- To provide guidance for finding quality treatment

GETTING THE INSIDE STORY

To get a firsthand picture of what really goes on inside rehab, I visited fifteen addiction programs- from so-called celebrity rehabs to the outpatient options available to most people—in different par of the country. "Rehab" usually refers to residential programs in which the traditional stay is about month (unlike outpatient treatment, where people typically go multiple times a week to group session lasting several hours during the day or evening). For the purposes of the book, I use the word "rehab to describe all types of addiction programs. After all, the goal, regardless of where you go, rehabilitation from drug and/or alcohol problems. (For more on the different types of rehabs, se chapter 2.)

At most of these programs, I was able to get a close-up view of what treatment is like b attending group counseling sessions, sitting in on individual client* appointments with counselor and/or participating in activities such as relaxation exercises. In so doing, I promised to protect th privacy of clients. My visits focused on primary or "phase one" care, which refers to the first stage

treatment, typically about a month at a residential rehab and variable but often longer at an outpatie program. (Extended and continuing care refer to subsequent phases of treatment, and are discussed chapter 9.) My goal from the visits was to get an overall, day in, day out picture of what went on each setting—to see for myself what different types of programs are like, to find out if things I heard were true, and to answer my many questions.

I also spent countless hours reading questionnaires completed by and interviewing more than or hundred current or past program administrators, staff members, and other clinicians from variou programs and practices across the country, many at the places I visited. I read scientific studies o what works best for recovery and frequently queried leading experts in the field, particularly tho who study addiction treatment to determine what's effective and what's not.

I realized, however, that the best way to get an accurate picture of what goes on inside rehab wa to interview people who had recently gone through treatment themselves or were currently goi through it, again making it clear that any information they gave me would be rendered anonymou Hence, my decision to collect more than one hundred stories* from clients and/or their fami members, many of whom I met at the programs I visited, and include a subset of individuals wh recovered from drug and alcohol problems without going to rehab. Some people came my way b word of mouth or through recruitment notices I sent to addiction professionals or posted on e-ma lists. I had the opportunity to follow quite a few individuals over time, sometimes for several yea and also periodically as they struggled through relapses and went to multiple programs. Knowing th it's hard to admit a setback, I give them credit here both for staying in touch with me and working s hard on their sobriety.

Some of their rehab stories are disturbing while others are inspiring. All provide an honest an critical look at addiction treatment in the United States. Their accounts illustrate serious issues faci individuals in rehab *and* the treatment industry today, yet they also highlight some of the innovativ approaches used by selected programs across the country. Perhaps most important, *Inside Rehab* giv a voice to people who have been there, whether their treatment experiences were good or bad. Tho who had a positive outcome eagerly showed that they wanted to reach out and share the great new often in the hope that others would benefit from their experiences. Those who had a negative time of often felt beaten down and as though they had nowhere to turn; as a form of catharsis, and to spa others from a similar misfortune, they welcomed the chance to divulge what had happened to them.

WHO OPENED THEIR DOORS

In selecting rehabs I went coast to coast, making an effort to visit a wide range of programs, son famous for the celebrities who've walked through their doors and others better known for workin with individuals on public assistance. It turns out that my home state of Minnesota is renowned for i multiplicity of addiction facilities—from traditional twelve-step-based residential and outpatie programs representative of those across the country to unique programs that serve certain subgrou of people. So I rounded out my visits by also visiting a number of places close to home.

I wondered if at high-end rehabs I'd find posh, indulgent vacation-like settings where clien were having massages and getting their nails done. I also was curious about whether I'd observe wh had been described to me as harsh, in-your-face approaches designed to break down addicts an alcoholics. In reality, I came across neither one. Contrary to the notion that high-end rehabs are mo like resorts than places that heal, even at the most expensive ones I witnessed no kid-glove handlin no fancy "spa" cuisine (and I ate plenty of patient fare), and saw no luxurious bedrooms—in fac some of them were quite basic, even dormitory-like. Two high-end places only provided cha massages, and at one that's been called a celebrity rehab, I saw young men getting haircuts whi

sitting in a straight-backed chair—which reminded me of when I used to trim my kids' hair in my ow kitchen.

And although I sometimes questioned the approaches used in treatment, I saw almost none of th old-school, confrontational strategies common in the past. However, I was told about some mo recent, rather demeaning experiences people had had at certain programs I didn't visit.

What astounded me most in my travels was the number of places that opened their doors to m and how open they were, some having prepared elaborate schedules for my stay. Following my visit many helped me contact clients for anonymous interviews for the book. For a complete list programs I visited, please see The *Inside Rehab* Tour.

WHAT'S AN ALCOHOLIC OR AN ADDICT?

In rehab parlance, if I were in a traditional residential program, I'd no doubt introduce myself this way many times each day: "I Anne, and I'm an alcoholic" (or "an addict"). So would my fellow group members at the opening of every group session. One day, one of the residential rehabs, I heard women in the same unit, all of whom knew one another, introduce themselves this way ma times. Someone forgot to do this at one point, and a fellow client who was leading the group said, in a rather confrontational wa "What *are* you?" as if everyone needed to be reminded, and that the label somehow defined the person.

Personally, I don't care for the words "alcoholic" and "addict" because, in my opinion, both labels come with a lot of stigmatizi baggage. (For more on this, see "What's in a Name?" in chapter 7.) I'd rather ask, "What does it mean to be a person who's addict to alcohol and/or drugs?" (In this book, alcohol and illicitly used drugs are sometimes collectively referred to as "chemicals" "substances"; and alcohol is a drug, too.) The word "addiction" comes from a Roman law having to do with "surrender to a maste When she first contacted me, Shari P. shared what it was like to lose control to her "master" as follows: "I come from a good fami and even managed to attend a university, although I wasn't able to graduate because the drugs became too important. My life h been a never-ending cycle of chaos in which heroin is the central cause. The sheer amount of time spent finding, getting, and usi the drug is exhausting. You feel like the biggest loser on earth but you just do it over and over and over again. I am desperate f change."

The definitions that professionals typically use to diagnose someone with alcohol and drug use disorders are determined by guidebook called the *Diagnostic and Statistical Manual of Mental Disorders (DSM*). The DSM edition that was in use for many yea and was just about to be retired as *Inside Rehab* was being written used the term "dependence" to describe what most people think as addiction. ("Abuse" is another category, often used to describe less serious drug and alcohol problems.) However, it is expect that the new edition—the DSM-5, due for release in May of 2013—will do away with the terms "dependence" and "abuse" a instead use the term "substance use disorder" and employ subcategories such as "alcohol use disorder," "cocaine use disorder," an so on. The list of eleven possible defining characteristics of a substance use disorder includes failure to meet work, social, or fam obligations because of substance use; continued use despite persistent negative consequences; tolerance (needing more chemical get the desired effect); regularly taking a substance in larger amounts or over a longer time than intended; devoting a lot of time getting, using, or recovering from the effects of a substance; withdrawal (physical or mental symptoms if the drug is abrup stopped); craving; and a number of others. People with two to three of the characteristics would be considered to have a m substance use disorder, while those with four to five of them would be in the moderate category. Neither of these categories would considered to be addiction. A person who meets six of the criteria, however, would be considered to have a severe substance u disorder or what most people would term an addiction.*

It's important to note, however, that tolerance to and withdrawal from some medications—such as certain painkille antidepressants, and antianxiety medications—can occur even when these medications are taken at appropriately prescribed dos without a user having a substance use disorder. Many individuals use these drugs without any evidence of abuse or aberra behavior.

Alcohol and drugs produce their pleasurable, euphoric effects by directly or indirectly targeting what's known as the brain reward system, flooding it with a neurotransmitter or chemical messenger called dopamine and motivating use again and again. W repeated use, dopamine's impact on the reward system in the brain can become abnormally lowered, so that even heavier and mo frequent use results in less pleasure or "high." Other brain systems such as the stress response system become overactive and result unpleasant feelings such as anxiety and "the blahs." As addiction worsens, afflicted people are driven to repeated use more in ord to relieve these unpleasant feelings than to seek pleasure. In other words, they use to feel "normal" or "not sick" more than to g high. Addictive use eventually leads to profound changes in the brain and its memory systems such that reminders of drug or alcoh use—for instance, seeing a needle or a martini glass—can trigger cravings, even after many years of abstinence. In short, chron heavy drug and alcohol use can alter the brain's structure and function, resulting in changes that last long after someone stops usin and may explain why relapses can occur after prolonged periods of abstinence.

Certainly, some people are more prone to addiction than others, depending on their genetic background. Genetic factors a believed to account for between 40 and 60 percent of a person's vulnerability to addiction. Use of drugs and alcohol at an early a also increases the odds of addiction, as does having a history of childhood trauma, including physical or sexual abuse and serio neglect. Plus, living, working, or going to school in places where alcohol and drug use is common increases the likelihood addiction. The bottom line is that there's a biological as well as an environmental component to becoming addicted to drugs a alcohol, and the role that each plays varies from person to person.

THE QUESTIONS

The stories of clients and interviews with treatment professionals, as well as visits to treatme facilities, helped me find the answers to questions like these:

- What determines whether someone should go to rehab in the first place?
- How do most people choose a rehab? Is there much variation from one rehab to the next?
- How much money do people spend on rehab? What percentage is typically covered by heal insurance—and what if you don't have health insurance?
- Does more expensive treatment mean better treatment?
- Who are the professionals who work with patients in rehab, and how are they trained?
- What do people actually do in rehab? How do they fill their time, and what do they do weekends?
- If someone is struggling with another psychological problem, such as depression, can he or sh expect to get help with that at rehab? Should one problem be tackled before the other is treated?
- Are family members usually included in treatment? What does that entail?
- How much of a say do clients have in what goes on in their rehab experience?
- What happens if someone has a slip with drugs or alcohol while in rehab?
- What happens after you get out of rehab? What occurs next for both the client and his or h family members?
- How do you know if a program is effective?

A QUESTION OF HONESTY

Have you ever heard this joke?

Q: How do you know when an addict is lying?

A: When his lips are moving.

Quite frankly, I find it offensive. It stems from the widespread notion, often promulgated in addiction treatment itself, that virtua all people with alcohol or drug problems are dishonest. Even a nationally known expert in the field included "they're all liars" in h definition of an addict when talking with me. Emily E. said that at a halfway house she attended, "They told us we're addicts and w lie and can't be trusted. It made you feel like crap." And at one outpatient group I visited, where the counselor seemed to have good overall rapport with her clients, she said to them with a smirk, "The one thing we know about alcoholics and addicts is th you're always one hundred percent honest." It's hard to imagine that this is therapeutic, but is her implication accurate?

I had to think this through, realizing that some people might question the veracity of the stories I heard, particularly those fro people who shared negative treatment experiences. There's no question that in most cases I was only getting one side of the stor For a variety of reasons, it would have been very difficult to try to confirm the client's version by going to the treatment programs f their views of what had happened. Not only would this have violated the confidentiality of the clients who shared person information with me, but there's no way of knowing if the rehabs would have given me a balanced view either. Indeed, psycholog Tom Horvath, PhD, director of Practical Recovery, a California program I visited, said, "Self-deception is a process any of us ca develop. It can occur in providers just as easily as in clients."

What does the research reveal about whether you can trust the reports of people with addictions? In response to this questio respected addiction experts Mark Sobell, PhD, and Linda Sobell, PhD, psychologists at Nova Southeastern University in Florid

summed up their findings from extensive research on this topic: “The bottom line is that if people believe what they are telling y will be confidential—particularly that it will not incur adverse consequences—and they are asked in a clinical or research conte then what they say tends to be reliable and valid. (This all holds if the person has no substances in their system at the time of t inquiry.) But people are not stupid—if telling the truth about using drugs or drinking to a significant other, probation offic schoolteacher, or work supervisor is going to bring trouble, why not lie and avoid the negative consequences? In short, if peop have no reason to lie to you, the evidence suggests they will be truthful.”

Certainly, the people I interviewed had no reason to be threatened by participating in my book anonymously. Still, when tackli a subject like this, there’s bound to be some distortion from the client’s perspective, at least part of the time, even if it’s just the resu of faded memories. To get another perspective on some of the stories, I did ask certain individuals to sign a release form that allow me to talk with their counselors, therapists, and/or family members. In some other cases, I talked with other people who’d been to t same treatment program around the same time period.

However, so many of the same issues were raised—both by clients and professionals—so often and with so much similarity, th it’s difficult not to believe them. And many of the negative impressions shared with me were representative of problems consistent reported by experts who have studied the field.

MYTHS UNCOVERED IN *INSIDE REHAB*

As I interviewed person after person who’d been through treatment, talked with staff member queried experts, and read studies on addiction treatment, the following myths became apparent. The will be explored in greater depth throughout the book:

MYTH: To recover from addictions, most people need to go to rehab.

FACTS: While the knee-jerk reaction when someone has a drug or alcohol problem is “Get thee to rehab the truth is that most people recover (1) completely on their own, (2) by attending self-he groups, and/or (3) by seeing a counselor or therapist individually. (Chapter 5 takes a look at wh belongs in rehab and who doesn’t.)

MYTH: Most people who go to addiction treatment programs go to overnight residential rehabs.

FACT: Of the more than two and a half million people who go to a treatment program each year, the va majority do not “go away to rehab.” After numerous studies showed no difference in how peop fared after going to residential versus outpatient programs, insurers and other funding sourc drastically cut back on paying for residential rehab. Today, various forms of outpatient he comprise more addiction treatment experiences in the United States than residential stays.

MYTH: Thirty days is long enough to “fix” most people with addictions.

FACTS: The idea that someone goes away to a thirty-day rehab and comes home a new person is naïv Rather, there’s a growing view that people with serious substance use disorders commonly requi care for months or even years, just as they would for other chronic medical conditions, such diabetes. Unfortunately, the length of treatment often depends less on a person’s needs and mo on financial coverage limits imposed by health insurers, and/or the patient’s ability to pay. Th short-term-fix mentality partially explains why so many people go back to their old habits. Th majority who complete treatment start using alcohol or drugs again within a year, and at least ha do so within thirty days after leaving rehab.

MYTH: Group counseling is the best way to treat addictions.

FACT: While group counseling is the staple approach in the vast majority of programs, there’s litt evidence that the type of group counseling used at most of them is the best way to treat addiction On the other hand, individual counseling, which has been found to be helpful, is used infrequent at most programs and may not even exist at others. Zack S., who first went to an outpatie

program where there was no individual counseling, told me, “I’m fairly introverted and didn participate much at all in groups.” When I interviewed him, he was still struggling with alcoh and attending a unique program that primarily provides individual counseling. (Chapter 6 has discussion of group versus individual counseling.)

MYTH: Highly trained professionals provide most of the treatment in addiction programs.

FACTS: Addiction counselors provide most of the treatment at rehabs, and states have widely varyin requirements in both educational level and training for a person to become a drug and alcoh counselor. Some states don’t require any degree for becoming a credentialed addiction counselo and many require just a high school diploma, general equivalency diploma (GED), or associate degree, according to a groundbreaking 2012 National Center on Addiction and Substance Abuse Columbia (CASA Columbia) report on the state of addiction treatment titled “Addictio Medicine: Closing the Gap Between Science and Practice.” Although there’s been a movement t professionalize treatment, much counseling still is provided by minimally trained addictio survivors-turned-counselors whose own rehabilitation forms much of the basis for their expertis And sometimes, when standards are raised for new counselors, old-timers are “grandfathered in with their existing credentials (or are given a certain amount of time to obtain the new ones), an they may or may not be well qualified. Most of the people I interviewed for *Inside Rehab* we oblivious about the credentials of the people who provided their care. When I asked Ann B. abo the counselors at the outpatient program she attended, she responded, “You just assume you’r seeing a doctor or that they know what they’re talking about.” In the state in which she w treated, a licensed addiction counselor was not required to have a college degree. These facts a particularly disturbing given the complexity of substance use disorders and the fact that more tha half of people in the general population with addictions suffer from at least one other ment disorder such as depression, anxiety, or bipolar disorder, which also must be treated to optimiz their chances of recovery. One woman I interviewed went to a famous celebrity rehab, where sh never received any professional psychological counseling for her troubled past. While I w writing the book, she died from a cocaine overdose when dealing with a possible reunion wi someone who’d sexually abused her throughout her childhood. (For a discussion about the reha work force, see “Who’s Minding the Store?”.)

MYTH: The twelve steps of Alcoholics Anonymous (AA) or a similar program, such as Narcoti Anonymous (NA), are essential for recovery.

FACTS: When I wrote *Sober for Good*, more than 90 percent of rehabs in the United States were based o the twelve steps. While the ratio appears to have dropped somewhat, most programs still ba their approach on the twelve steps, include a twelve-step component, require twelve-step meetin attendance, and/or hold twelve-step meetings on-site. As was well documented in *Sober for Goo* however, the twelve-step approach isn’t for everyone, and many people overcome addictions usin other methods. Yet it’s hard to find a program that doesn’t include the twelve steps, and mos people I interviewed were offered no alternatives. When I asked Elizabeth F., who went to renowned high-end residential rehab, about this, she said, “The only thing they’ll talk about is th twelve steps. When I brought up Women for Sobriety [an alternative group to AA], I was met wit a blank stare. When I asked about when we’d be getting into other modes, the counselor said, ‘W are a twelve-step program.’ There was no other literature, discussion, *etc.* They were fair adamant that ‘this is what we have to offer, and if you want what we have, this is how you get it. (See chapter 6 for more about twelve-step programming and information about alternative rout to recovery.)

MYTH: Most addiction programs offer state-of-the-art approaches shown in scientific studies to b effective.

FACTS: Although many say they use them, rehabs commonly fall short on implementing practices th studies show lead to the best outcomes for clients. The 2012 CASA Columbia report mentione earlier concluded that "the vast majority of people in need of addiction treatment do not receiv anything that approximates evidence-based care" and that "only a small fraction of individua receive interventions or treatment consistent with scientific knowledge about what works." T bring practice in line with the evidence and with the standard of care for other medical condition it said, "Nothing short of a significant overhaul in current approaches is required." The repo went so far as to raise the question of "whether the insufficient care that patients with addictio usually do receive constitutes a form of medical malpractice," given the prevalence of substan problems, the extensive evidence available on how to identify and address them, and continue failure to do so. When it comes to providing services that address the whole person and thereb improve the chance of success, a 2010 report from the University of Georgia's National Treatme Center Study suggests that fewer than a third of 345 representative private rehabs offered any kin of vocational services, housing or shelter assistance, legal assistance, educational services, financial counseling. (The full five-hundred-plus-page CASA Columbia report can be found http://www.casacolumbia.org *templates*NewsRoom.aspx?articleid=678&zoneid=51. For more o the gap between what goes on and what should go on in addiction treatment, see here in th chapter and chapter 4.)

MYTH: If you relapse and go back to rehab, they'll try something new.

FACTS: Rather than being offered a new approach, clients who return to using alcohol or drugs a commonly blamed for "not getting with the program" or not trying hard enough, and often have "start all over again," even though they've experienced very similar programming many tim before. Sometimes, they just were not ready to tackle their addiction and could benefit from mo of the same; other times, they need a completely different approach upon returning. Emily E. we to multiple twelve-step-based programs in an effort to get off prescription painkillers (initial prescribed for severe migraines) and heroin. She finally met a counselor-intern who said, "Yo don't need more treatment, you need to go on methadone." When I interviewed her, Emily had year of sobriety with the help of a methadone program and its non-twelve-step outpatient progra She concluded, "So many addicts just go to rehab again and again, and the same basic kind treatment never changes. It's ridiculous." (Chapter 8 addresses the topic of relapse.)

MYTH: Addiction treatment programs have high success rates.

FACTS: "Treatment works" has long been a mantra of the rehab industry, but reliable statistics supportin it are hard to come by. There's a great deal of inconsistency in the quality of care provided acros programs and in how success is measured, if it's measured at all. In a *Los Angeles Times* articl University of Texas researcher Scott Walters, PhD, coauthor of a landmark study on treatme success rates, said, "Anybody can make any claim they want and get away with it. . . . It essentially an unregulated industry." Yale University School of Medicine's Kathleen Carroll, PhD one of the foremost experts on addiction treatment in the United States, asks, "In what other ar of medicine can you go to a place for treatment and not have them be able to give you any idea their outcome rates or point to the scientific basis for the treatments you might receive? I think consumers started pushing for information on outcomes, a lot of these places would dramatical change how they deliver and measure treatment." (For more on success rates, see chapter 9.)

MYTH: You shouldn't use drugs to treat a drug addict.

FACTS: Research clearly shows that certain prescription medications help people addicted to drugs an alcohol get sober and stay sober. Yet many rehabs are unfamiliar with them or refuse to use ther because of the old-fashioned notion that drugs should not be used to treat an addict—or that the should be used *very* sparingly. In the course of writing *Inside Rehab*, I got to know addictio psychiatrist Mark Willenbring, MD, who had just stepped down from his position as director o the Division of Treatment and Recovery Research at the National Institute on Alcohol Abuse an Alcoholism. In practice as an addiction psychiatrist in Minnesota, he told me, "I've bee particularly disturbed by several patients of mine who recently went to a treatment program f opioid addiction, and none of them received maintenance Suboxone. All of them relapsed. This unconscionable." Sometimes rehabs will use drugs like Suboxone just to "detox" a patient durin treatment, but research suggests that most people addicted to opioids* or heroin need to b discharged on "maintenance" doses of such medications or they are very likely to relapse. Shari told me that one of the rehabs she went to actually gave patients Suboxone and took it awa depending on whether their behavior was "good or bad." (See chapter 9 for a discussion medications for people with drug and alcohol problems.)

MYTH: More money gets you better treatment.

FACT: Not necessarily. Sometimes, programs that treat clients who rely mostly on public funds hav counselors with more qualifications and use more state-of-the-science approaches than expensiv rehabs. Margaret F., who went twice to both an expensive high-end rehab and a communit outpatient program said, "I thought the outpatient program was at least as good as the residenti one."

MYTH: Treatment approaches used for adults work for teens, too.

FACTS: According to the nonprofit research institute Drug Strategies, "Treatment experts agree th adolescent programs can't just be adult programs modified for kids"—which is often wh happens. And sometimes, kids are put in programs with adults, a practice definitely again professional recommendations. Also, despite minimal research support, the majority of tee programs incorporate AA's twelve steps. What works best for adolescents, according to a plethor of studies, is family-based treatment, something rehabs seldom offer, instead favoring teen grou counseling, twelve-step approaches, and family education groups, none of which have been foun to be as effective as interventions involving the entire family. (Chapter 7 is devoted to adolesce rehab.)

THE FACTS OF THE MATTER

How many drug and alcohol rehabs are out there and how many people use them? The grand total for 2010 was 13,339 according the National Survey of Substance Abuse Treatment Services (N-SSATS), a figure based on a yearly inventory of all known special facilities that treat drug and alcohol problems maintained by the federal government's Substance Abuse and Mental Health Servic Administration (SAMHSA). (An unknown number of other rehabs exist, probably fewer than a thousand, but they either didn respond to the survey or were ineligible for participation.) Of the types of care offered at these programs, 81 percent were outpatie accounting for nine out of ten of all clients in treatment. About a quarter of the programs offered residential (nonhospital) treatme which accounted for about one out of ten clients in rehab. Hospital inpatient treatment was offered by 6 percent of facilities and on accounted for 1 percent of clients in treatment. (See chapter 2 for the differences in these types of programs.)

Another way that SAMHSA tracks how many people go to addiction treatment programs and where they go for help is throu the National Survey on Drug Use and Health (NSDUH), which queries a large nationally representative group of noninstitutionaliz U.S. civilians (about 67,500 people), age twelve and older, about drug and alcohol use, problems, and treatment in the past year.

the 22.1 million individuals (almost 9 percent of the population age twelve or older) who were estimated to have a substance u disorder in the past year, according to the 2010 NSDUH, 2.6 million received help at a specialty facility. Another 2.3 million peop went to a self-help group, such as AA, but this is not considered formal treatment. That same year, just over 7 percent of teens (abo 1.8 million) age twelve to seventeen were reported to have a substance use disorder but only 138,000 of them went to an addicti treatment program.

The message is that with more than thirteen thousand residential and outpatient rehabs out there and more than twenty-two milli adults and teens estimated to have a drug or alcohol problem, only a small minority receive professional help each year. Of tho who do, far more go to outpatient programs than to residential programs.

DRUG OF CHOICE

What kinds of substance problems brought the *Inside Rehab* participants to treatment program "Drug of choice"—meaning the drug (or drugs) that a person prefers—ran the gamut. For many it w "just alcohol" that took its toll. In fact, alcohol can be a dangerous drug—heavy drinking is the thi leading preventable cause of death in the United States. Marijuana was the primary drug problem f others. Some administrators told me things like, "Alcohol is a given" and "alcohol and marijuana a always mainstays," suggesting that most clients had a problem with *at least* those two.

For many people, a combination of drugs wreaks havoc. Steve R. began abusing drugs ar alcohol at the age of fourteen and told me, "I've used almost every drug, ending with an addiction meth. I couldn't get through a day without being high or drunk or both. I was thirty-nine when I w finally busted with a meth lab." When I interviewed him, he had had a successful experience at Christian rehab, followed by a drug court program.

At high-end programs, the preferred drugs of abuse were alcohol, opioids such as Vicodi OxyContin, and Percocet, and benzodiazepines, commonly known as "benzos" and included bran name drugs such as Valium, Klonopin, and Xanax. At one of the programs that serves a low-incom population, the most commonly abused drugs were less likely to be pills and benzos and more like to be crack cocaine, alcohol, and PCP (phencyclidine, which has hallucinogenic effects). Program that treat teens told me they were seeing abuse of painkillers (often taken from parents), heroi Adderall (a stimulant drug commonly used to treat attention-deficit/hyperactivity disorder), ar inhalants—all in addition to alcohol and marijuana. Rural programs were seeing a resurgence methamphetamine problems.

At the national level, according to the 2010 National Survey on Drug Use and Health, of tho who received help from a facility, about 37 percent said they did so for alcohol use only; 34 perce for illicit drug use only; and 24 percent for both alcohol and illicit drug use. (The numbers don't ad up to 100 percent because some people didn't specify whether their treatment was for a drug or a alcohol problem.)

ONE PROGRAM, CONTRASTING EXPERIENCES

As I visited rehabs, I told administrators, "I will no doubt find people who say that your progra saved their lives. But others may tell me that your program was wrong or even destructive for them Indeed, that's what I found. Chantal R. says of one of the most prominent residential treatme programs in the country, "It was one of the best experiences I have ever had. I can't think of one thin that didn't help me. They lectured AA and the importance of it—the tools are so simple to use. would recommend every person I meet to go there in a heartbeat. It changed my life."

Another woman who went to the same place told me, "While there were some valuable lesso there, I was very unimpressed with most of the counseling and the facilitating of group discussion

What I really got was that the most important thing was AA, reading the Big Book [*Alcoholi*
Anonymous, the so-called bible of AA], doing the twelve steps, living your life every day a day at
time, and all the other '-isms' that were thrown around. From day one, it didn't resonate with me, ar
the day I left I knew that it was not how I was going to live in recovery and be happy about it. I w
humbled by the people that I met and the places their addiction had taken them, but there was a l
that I just hated. I can't believe they have the reputation that they do."

One explanation for such contrasting experiences at the same program is that, sometimes, peop
are simply at different life stages when they enter treatment: one may be more ready to get sober; or
person may have a different or more severe addiction than others. People may go into a facility wi
dissimilar expectations or levels of experience—perhaps one person has had years of psychotherap
while others have not. Also, one's reaction to a certain program may compare unfavorably to previou
treatment. The variable reactions may also stem from differences in personality, religiosity, c
education. Sometimes, it's a matter of the counselor the client is assigned or the unit he or she
placed in that colors their experience. And although most of the people I spoke to had been
treatment within a few years of one another, programs can change within a very short period of tim
depending on owners, directors, and funding sources. One woman whose son had been to seve
different rehabs told me, "The director changes, and the whole place changes."

I found that some of the rehabs I visited became more progressive in the course of the three
four years that I was in contact with them. For instance, a mental health professional called one of th
programs "a dinosaur" because she felt it used antiquated approaches. One year later, however, after
change in leadership, she was making referrals to the place.

WHEN TREATMENT ISN'T RIGHT

In some cases, people were hurt by what they'd experienced in treatment. I heard sad tales of repeate
visits to rehab with the implication that the client had somehow failed, when it seemed apparent th
something about the treatment had very likely failed the individual. Other stories came from peop
who didn't belong in rehab at all, but were coerced to go. The following is just a sampling of what
heard:

• Will R.'s alcohol abuse was secondary to serious psychological issues left unaddressed by h
first rehab, where no individual counseling was provided over the course of residential treatmen
When I interviewed him, Will had found a second rehab with highly individualized care th
recognized the complexities in his case and realized that his psychological needs should be th
primary focus of his treatment rather than substance use itself. This is counter to the philosophy
many treatment programs.

• Carrie G. went to two famous residential rehabs, one of which, she said, "had no medical staff
all for $40,000 a month." (She qualified that by stating that a psychiatrist came in once a week an
that "we'd be called out for five minutes for random assessment, no conversation.") When she was
their "detox," she felt her medical needs were not managed appropriately, and she wound up in
hospital emergency room. (For this amount of money, it would be logical to expect that a rehab woul
provide adequate medical supervision of someone in detox, but she got the impression that they we
not "equipped for a hard-core physical addiction.") As far as counseling was concerned, she said,
never saw a psychologist or social worker. All the therapists were recovered addicts." The only on
on-one counseling she received for her money was a once-a-week session with a woman she believ
was a drug and alcohol counselor. The rest of the time, it was group counseling.

• Sam D. overcame his addiction to painkillers through individual counseling despite the fact th