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**On Science and Service:
An Interview with Tom McLellan, Ph.D.
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Science has served as a powerful tool to elevate the quality of modern addiction treatment, and there is no name more associated with that effort than Dr. Tom McLellan. Dr. McLellan served as Professor of Psychology in Psychiatry at the University of Pennsylvania, developed the Addiction Severity Index, authored more than 400 articles and chapters on addiction treatment, founded the Treatment Research Institute (TRI), and held the position of Editor in Chief of the *Journal of Substance Abuse Treatment*. He currently leads demand reduction efforts at the White House Office of National Drug Control Policy (ONDCP). His persistent and eloquent voice challenging the field to fundamentally rethink how addiction treatment is designed and evaluated has earned him innumerable awards from professional societies in the United States and Europe. In this wide-ranging interview, Dr. McLellan explores his career and what he has learned from his studies about addiction treatment and the role of the addiction counselor in treatment outcomes. He also shares his thoughts about the future of addiction treatment and how he has sought to influence that future through his work at ONDCP.

Bill White: Tom, you've spent your career wrestling with questions of great relevance to frontline addiction professionals. What circumstances led to your pursuing research on addiction treatment?

Dr. McLellan: Well, like almost everybody I have ever met who has been a career addiction researcher, I didn't start out with this intent. I, like most people, had a different idea in mind. I studied psychology, but not clinical psychology. I was a rat runner and an animal learning guy with a background in physiological psychology, and that's what I intended to do. When I got out of graduate school, there weren't any jobs, but circumstances permitted me to buy a small farm in central Pennsylvania. I looked around for a job, and the closest one was the Coatesville Veteran's Administration Medical Center. I went down there equipped with a degree in animal learning and nothing else, and surprisingly, they had no jobs for anybody with an animal learning degree. They did have a job as a Research Technician at that time (1975) in an emerging area of interest for the Veteran's Administration: treating addiction in returning Vietnam-era veterans. I became enamored of the whole field the first time I walked into a therapeutic community. There were guys my age. They looked like me. They had the same background I had. I knew nothing about addiction, and nothing in my academic training prepared me for anything of it, but I immediately found it really interesting.

Bill White: One of your early interests there was the relationship between patients' drug choices and particular types of psychiatric disorders. How did that interest develop?

Dr. McLellan: Well, once again, there was no planning involved. I was a junior faculty member at the Coatesville Veteran's Administration Medical Center. At that time, they had about 3,000 residential beds that were constantly filled with people who had psychiatric illness, really quite severe psychiatric illness. This was the era of the first patients' rights movement, and it fell to me to evaluate a random sample of patients and ask them confidentially about their satisfaction with all manner of things, like their treatment, the food, the doctors, and all of that. Well, in the course of this, I was able to insert some additional questions about whether there had been any drug use in their history. And indeed there was. More importantly, many of them were actively involved in using alcohol and other drugs right on the campus. I was amazed by that—showing my naïveté—so that was the first report. But the second report was a little more interesting.

Because I had interviewed these individuals without any kind of background, I later went and looked up their diagnoses. It turned out that their diagnoses were quite related to the kinds of drugs that they had been using. People who were diagnosed as depressed were often using a variety of depressant or tranquilizing drugs. People who were diagnosed with schizophrenia had histories of using amphetamine—there was very little cocaine use at that time. The people with alcohol and opiate use backgrounds had a variety of diagnoses. I wrote an early paper on this possible relationship.

This led me to ask such questions of current patients, many of whom had been coming to the Veteran's Administration for a number of years. By tracing back their early psychiatric test results, I found over a six year period, in a sample of people who had returned to treatment every year for six years, that there was a progressive development of psychiatric problems that mirrored the actions of the drugs they were using. Particularly interesting were the changes in psychiatric diagnoses among people who used amphetamine/methamphetamine over a six year period. They moved from being treated primarily in the drug unit to being treated in the psychiatric unit, and finally into locked wards. It looked as though, after some period of time, the symptoms that were purely drug-related and temporary ultimately ended up being permanent or semi-permanent. The same thing happened with people who used combinations of alcohol and depressants. Depression—significant, serious depression—was sustained. Also interesting, we saw no major changes in the psychiatric problems of people who used opiates or alcohol.

As a point of potential interest to young researchers, I wrote these findings and tried to present them to the American Psychological Association, and they turned it down flat. A friend of mine said he thought it had some medical interest, and it was later a lead article in the *New England Journal of Medicine*. So, for young people who are starting out, don't get too worried if you get a rejection. The other point of interest is that much of what I've learned and done was not achieved through planned studies and experiments, but by being in a clinical situation and keeping my eyes open and listening to the clinicians and especially to the patients.

Bill White: That reinforces for our readers the importance of observation and reflecting on those observations.

Dr. McLellan: Yes. Today, I'm in a policy office and haven't had patient contact for several years. I miss that very much. Very selfishly, if you don't have direct patient contact, it's very difficult to come up with sensible, relevant clinical ideas.

Bill White: Many of our readers at *Counselor* know you through your work developing the Addiction Severity Index. When you look back over the years since its original development, what are the most important things you have learned about the process of clinical assessment?

Dr. McLellan: There's a real theme emerging here. The Addiction Severity Index was completely unplanned. It was born entirely of clinical necessity. I was working in a residential therapeutic community, and every patient who came into treatment was clinically staffed. Staffing meant that you had—boy, these are the old days—a psychiatrist, a psychologist, a nurse, a counselor, a social worker, an employment counselor, and someone from administration. Every person who came in sat at the end of a table after they stabilized and were interviewed by all of these people from the various service areas. I was asked to develop something that would be easier and faster than this rather grueling 90-minute process. So I tried to distill the questions that had been asked by those various service representatives into questions that could be asked by somebody with far less training. I had two goals in mind: 1) getting an initial assessment of the severity of the various kinds of presenting problems, and 2) developing a sort of screen through which this initial assessment might lead to more detailed professional assessment.

So being very proud of myself, I showed it to the clinical staff. They didn't like it one bit, primarily because it was filled with numbers, and the numbers couldn't really translate into something that they were used to—a nicely written, professional admission note and a treatment plan. So I said, "You don't want a researcher without a lot of clinical experience doing a treatment plan, so suppose I just summarize the information in each area into a single severity as a single number?" And that's what I did. I had already named it the Addiction Severity Index because I fully expected that all of the problems—the employment, the legal, the medical, psychiatric, etc.—would be the direct result of the severity of the drug use. Well, I was amazed to find that that was not the case.

People with the most severe drug problems often did not necessarily have the most severe employment or psychiatric problems. People with really severe psychiatric problems, for example, often did not have severe drug problems. I had named it an "Index" because I thought we could add up all the numbers into one single number, but that was clearly not possible given what we were finding. But more importantly, it suggested to me from the very beginning that "addiction related problems" can be related in very different ways. Some problems cause substance use; some problems result from substance use, and some simply emerge along with substance use as the result of genetic, personality, or environmental conditions. This was one of the most important things I ever learned about addiction. Like many of the people I meet in my current job, I too thought that if you just reduce the drug use, all the other "drug related" problems would

disappear. This was, and still is, a very naïve view. Worse, it has been a very big force in the way the original—and some of the existing—treatment programs were conceptualized, designed, funded, and evaluated.

Bill White: You have challenged the field to make addiction treatment more attractive and engaging. How might addiction professionals working in local treatment programs contribute to that goal?

Dr. McLellan: I do think treatment has to be more engaging, but I also have to first say that it's quite easy for a guy who's sitting at a desk here in Washington to start making pronouncements about what clinicians working every day with very difficult patients ought to do. I do know that none of what I am about to say is easy to do.

I've spent my whole career looking at all of the kinds of things that have been tried—at least in this country—to reduce substance use problems, and treatment is by far the best. So my whole goal from early on has been to find ways of getting more people into treatment and keeping people who are already in treatment, in treatment longer. With that proviso, let me begin by saying that the nature of most existing addiction treatment has not been particularly attractive to most of the individuals who could benefit most from it. That is not my opinion; that is just simple fact. We have between 23 and 25 million people with diagnosed substance use problems in the country, and on any given day, there's maybe 2 to 2.5 million of them in treatment. So only one-tenth of those with a diagnosed illness are receiving care. More importantly, that 10 percent is by no means representative of the rest of the 25 million people. They're the most severe. They're the most chronic and difficult. Most of them have been forced into treatment. Further, they're in treatment that is typically segregated from the rest of healthcare. So I don't see this as the best way to attract more people into treatment or to keep patients in treatment longer. We have to find ways to make treatment more attractive and effective for this larger population.

Bill White: Tom, do you see a day when addiction counselors will be working in a wide variety of settings outside of specialized addiction treatment?

Dr. McLellan: Yes, I do. In this policy environment that I'm in now, one of the emerging themes is integrating addiction treatment into mainstream healthcare. I know a lot of readers are going to get very worried about that. They know the bad old days when addiction was treated under the mental health umbrella and was viewed as merely a symptom of an underlying depression or personality disorder and never given the emphasis it properly required. I hope that doesn't come back, but here's the other truth: addiction treatment as a field is currently reaching only a tiny fraction of the people it should reach.

Addiction is causing and is complicating a lot of medical disorders. Mainstream healthcare has never really paid the attention it should have to addiction related problems in the mainstream healthcare system. Meanwhile, as addiction treatment has become more segregated, budgets have been reduced virtually every year since I've been working in this field. I know of no kind of treatment, education, or public enterprise that is best when it is segregated. So we're trying very hard to bring addiction treatment—

particularly screening and early intervention with mild to moderate substance use disorders—into lots more healthcare settings, particularly primary care and family medicine centers. Importantly, I am talking less about “addiction,” than about the less severe and less chronic forms of substance use - unhealthy use, problematic use, etc. We’re trying to develop more and more varied kinds of treatments: treatments that will involve medications, treatments that will involve families, treatments that will involve whole communities. We are hoping that different types of treatments for mild to moderate substance use problems, delivered within the same context as the rest of medical care, are more attractive and engaging to those who will not even consider treatment now.

And if you’re wondering if I’m ever going to get around to answering your question, in every one of these environments, there is a need for workforce. Certainly physicians are not going to do this alone. Nurses, counselors, psychologists, and social workers are going to be needed. Behavioral health disorders so complicate other health disorders that all of these conditions need to be treated in an integrated fashion. So we need more counselors and other behavioral health specialists ready to rise to this challenge. Tomorrow’s counselor is going to need to know a lot more about medicine, a lot more about genetics, and a lot more about case management. It will be a quite different role in the coming years.

Bill White: One of the questions that you’ve researched that will be of great interest to the readers of *Counselor* is whether the counselor is an active ingredient in addiction treatment outcomes. Could you summarize what your research revealed on this question?

Dr. McLellan: The research that I did on counseling was among the more interesting chapters in my professional life. Once again, it started in an unplanned way. I was, by this time, working with George Woody and Chuck O’Brien at the Philadelphia VA Medical Center in a large methadone treatment program. Two counselors, each with a very large caseload, both quit at the same time. Their patients had to be reassigned and because time was of the essence, they were simply distributed among four other counselors. This gave us an unplanned but very real opportunity to see if the counselor made a difference in patient outcomes. Remember that all of these patients had been stabilized on methadone. All had been in treatment for at least six months. They all had had a counselor, and now, we’re going to lose their old counselor and get, through what was basically random assignment, one of four new counselors. Well, it turned out that the counselors that they got really made a significant difference. Patients did reliably worse when they got changed to one particular counselor. Others assigned to a different counselor did reliably better. Turns out—surprise, surprise—not every counselor is a good counselor; and some counselors are really extraordinary.

This early finding led to a much more systematic effort. During the rapid expansion of methadone treatment in response to the AIDS epidemic, there was a call for “minimum methadone,” basically methadone alone, without any kind of counseling. This was and remains a well-intentioned effort to get this very potent medication to people who are using street opiates. So we asked, “Is a counselor really necessary?” We did a randomized controlled trial where patients got very minimal counseling—only an admission assessment—and then were brought up to a pretty conventional dose of

methadone. A second group got the same methadone at the same dose, but they got regular, standardized counseling using the kind of model that the Johns Hopkins folks have used developed by Maxine Stitzer. The third group got the same methadone, the same counseling as the second group, but they also got access to lots of social services: employment, psychiatric, medical care. The findings on any measure that you wanted to look at were just like a dose response. Patients who got methadone alone did show improvement, but it was modest; it was minor. Many of them had to be essentially rescued and then received more counseling. The patients who got exactly the same methadone dose plus counseling did much better, and the patients who got the combination of methadone, counseling plus additional social services did the best. In terms of cost-effectiveness, it was methadone plus good solid counseling that was best.

So that affirmed for me in both clinical ways and in cost-effective ways that counseling was essential. But the other thing that's as important to say again is not everybody can be, or ought to be, a counselor. There are protocols to do counseling that can be combined with case management and information management. I'm afraid that not enough counselors are learning counseling as a profession. They're simply being thrown into it and asked to "do group." That's not counseling.

Bill White: You've spent much of your career assessing the relative effectiveness of addiction treatment. What major conclusions have you drawn from the treatment effectiveness research?

Dr. McLellan: My idea was to look at the relative effectiveness of addiction treatment versus some other illnesses that I thought the public and certainly, I, felt were really effectively treated. I thought about conditions like hypertension, diabetes, and asthma. I picked those because they were inarguably real medical conditions, and candidly, I really expected to see excellent results. So when my colleagues and I—Herb Kleber, Chuck O'Brien, David Lewis—did a literature review and looked at articles from the prior 10 years, we were frankly all amazed by it. There were so many similarities. The twin studies showed that the genetic heritability of opiate, alcohol, cocaine, and now marijuana dependence, was very similar to the heritability seen in twin studies of hypertension, diabetes, or asthma. Management problems were almost identical. The biggest ones were lack of adherence. About 50 to 70 percent of patients who are in treatment for diabetes, asthma, or hypertension don't take their medications as prescribed, don't follow through with recommended life changes suggested by their physicians. Correspondingly, the relapse rates are about the same: roughly 50 percent per year. Even the predictors of relapse were very similar: low socioeconomic conditions, i.e., poverty; poor family supports; genetic heritability; and psychiatric symptoms were all major predictors of relapse, not just in addiction, but in hypertension, diabetes, and asthma. Subsequently, I've seen studies that have shown the same thing in response to dental management.

There are two conclusions I've drawn from all this. One, from a clinical perspective, I think addiction has much to be proud of – but also a long way to go. With far less support, far less organization, but far more use of individuals actively managing their disease (people in recovery), we've managed to have roughly the same levels of success and unfortunately, failure as other major illnesses. I think the next steps for our

field are to incorporate some of the lessons learned from the management of other chronic illnesses. The second conclusion is that guys like me have been evaluating addiction treatment in the wrong way for a very long time.

Because addiction has been segregated, because its origins haven't been understood, because addiction causes so many social problems, it's been easy to think of addiction as a moral problem or a sin, and those who are addicted as simply criminals who need to be punished, taught a lesson, all that. God forbid you would have attractive, long-term treatments for that kind of a person. No, you want acute care, short and punitive. Better if they don't like it. Better if they learn to get discipline and take their medicine.

Well, that is not the way you treat other chronic illnesses. It's not the way you treat illnesses that don't have a cure, and I don't think we have a cure for addiction. We've had explicitly as our therapeutic goals to get people out of addiction treatment as soon as possible—to get them graduated. The rest of medicine realizes that if you don't have a cure, the best thing you can possibly do is keep people *in* treatment. I'm not talking about residential care for the rest of their lives, but keeping them engaged in outpatient treatment for at least a year, perhaps two years, where relapses are anticipated, caught early, and intervened upon directly and therapeutically. That's one of the most important lessons I have learned.

The third and final thing I've learned is not only have we been evaluating it the wrong way, the government has been purchasing it the wrong way. The government is not purchasing the kind of sustained, outpatient, continuing, multifaceted care that the evidence shows has the best results. The government spends a lot of money on short-term detoxifications not followed by any other kind of care. That is money wasted.

Bill White: You recently collaborated with Deni Carise and Herb Kleber to address the question of whether the current infrastructure of addiction treatment could support the public's demand for quality treatment. What were your conclusions that you drew from that study?

Dr. McLellan: I'm sorry to say that I have a very negative view about the current status of the United States addiction treatment infrastructure—particularly the infrastructure in the public treatment sector. I want to hasten to say I don't hold the treatment professionals responsible for this state. I hold the government and the public responsible for this state.

We have brief interventions to intervene early in the development of substance-related problems that are very clinically effective and cost-effective. We've got medications for opiate, alcohol, nicotine, some indications for cocaine, not much yet for methamphetamine treatment, but we've got good medications. We have many evidence-based therapies that require sophisticated therapists, but that can have enduring benefits. These are not simply my opinions but facts based on two decades of very good research.

Well, the average treatment program in this country simply cannot implement most of those treatment ingredients. Most do not have a doctor so medications are out. Most do not have integrated information systems, and there are government regulations that prohibit exchange of information between addiction treatment and the rest of healthcare, so case management and information management is very difficult. Most

treatment programs don't have a workforce that's been adequately trained and clinically supervised. Worse, because of contemporary funding constraints, I'm sorry to say I don't think significant upgrading of training or clinical services is going to happen in these programs, again, in some significant part, because addiction treatment is segregated from the rest of healthcare financially, administratively, and in terms of regulations and information.

I do think it's going to be a difficult transition, make no mistake, but I think ultimately the future of this field is to become part of the rest of healthcare. By the way, I'm not saying we should become integrated simply because it's time for the rest of healthcare to do the addiction field a favor or even because it's the right thing to do—although it is the right thing. No, I think integration of mental and substance use care into the rest of healthcare is one of the biggest favors we will ever do for mainstream healthcare in this country. Truly integrated healthcare will produce far better and far cheaper healthcare generally, and particularly for the many millions of people who currently have a range of untreated substance use disorders.

Bill White: One of the issues that has dominated many discussions in this past decade is the whole issue of the gap between clinical research and clinical practice as one dimension of this larger quality of treatment issue. What are your current views on the issues related to that gap between research and practice?

Dr. McLellan: Well, I think there's no doubt about it. Elizabeth McGlynn from RAND published a study a few years back showing that in terms of integrating evidence-based practices—that is, clinical practices that research has shown to be effective—the treatment of alcoholism ranked among the lowest of all the medical treatments studied (she was not able to study drug abuse treatment). Of course, there is a research to practice gap in every healthcare disorder, but the gap is bigger and wider in the substance use field. Once again, I have to say I think it's partly a function of segregation.

While much of the addiction treatment system is segregated from the rest of healthcare, most addiction researchers are very integrated into mainstream academic healthcare settings. So the medications, therapies, and other interventions are generally developed in more academic, full-service environments, often with better trained staffs and research infrastructures to back them up. That kind of infrastructure just isn't available in the mainstream field, and thus many of the treatments that are studied and shown to be effective simply won't fit in the “real world.” So who do we blame for this—the researchers for working under very good conditions; or perhaps we should blame community treatment providers for working in much more difficult situations? Neither of these makes sense. We need to put infrastructure dollars into the kinds of treatment interventions that have the best results. Isn't that what they do in the treatment of other illnesses?

Bill White: I was really struck by one of your recommendations to enhance the quality of addiction treatment resources. You recommended that addiction treatment be formally declared a distressed industry to bring additional resources to support workforce development. What do you think are some of the most important next steps for workforce development in the field?

Dr. McLellan: This is not an opinion; this is a fact. We don't have near the number of trained professional counselors, social workers, and psychologists working in the addiction field that we need right now. Second, a significant proportion of those people who are working are at or near the retirement age. Third, we don't see new people standing in line to enter this field. That's not all; the problem is going to be even worse because, as I've said repeatedly throughout this interview, the future is integration into the rest of healthcare. So not only will we need to retain the professional skills and professional knowledge about substance use disorders that we've acquired over the last several decades and impart that to new people, we need to also upgrade our training. Counselors need to know much more about the genetics of addiction so they can explain to the families and the patients some of the origins of these illnesses. Case management skills are going to be necessary. Fundamental knowledge about medications as well as knowledge about, and ability to describe different kinds of treatments are all going to be important skills.

The labor department, who we're now working with, is responsible for the training and development of workforces. In the past in this country, the declaration of an area of commerce that has particular importance for our society and has suffered workforce problems (e.g. electronics, alternative energy, farming, etc.) has been associated with an infusion of new money, new training programs, new credentialing, and skill development programs all from the Department of Labor. Those kinds of interventions have been responsible for some of the dramatic developments in the electronics and farming industries in this country. I think they ought to be brought to bear in the behavioral health field, particularly addictions.

Bill White: I've acknowledged the article that you, David Lewis, Charles O'Brien, and Herb Kleber published in the *Journal of the American Medical Association* in 2000 on addiction as a chronic disease as a historical milestone in modern thinking about addiction treatment. What progress have we as a country and a professional field made since 2000 on our understanding of addiction as a chronic disorder requiring sustained recovery management?

Dr. McLellan: I don't think we're anywhere close to where we should be in terms of accepting addiction as a chronic illness, and—more important than anything else—acting on those expectations. In my current role, I am surprised virtually every day to meet people in highest levels of government agencies that work in the drug arena that have never imagined that addiction has public health implications. They think of it entirely as a criminal justice issue.

They say, "Well, if it's an illness, it is one brought on by the individual" or "If it is an illness, it's not a *real* illness." They don't understand that most illnesses in this country, particularly chronic illnesses, *are* brought on by the behaviors of those who ultimately contract the illness. Adult-onset diabetes, hypertension, asthma, tooth decay, lots of them are brought on by behaviors combined with genetics, and they produce really significant public health conditions that are unambiguously treated in healthcare settings.

Perhaps worse, I hear lots of people who are working in the addictions field say the words "addiction's a chronic illness," but they keep doing the same acute care kinds

of treatments and addiction researchers keep evaluating the effects of addiction treatment with 12-month post-treatment outcomes. Insurance coverage for addiction treatment has finally begun to realize - as a result of parity legislation and now through the Healthcare Reform Act - that addiction ought to be managed the same way, in the same kind of an environment, with the same kind of clinical information exchange as other chronic illnesses.

Bill White: If we really did treat addiction as a chronic disorder, how would the current role of the addiction counselor change?

Dr. McLellan: Despite all the problems we have in our field and all the things we need to develop, we have one of the best fundamental models for the treatment of a chronic illness that you're ever going to see. The addiction field has learned to integrate criminal justice interventions where necessary with therapeutic interventions, and that is a very important part of maintaining public health and public safety. Second, we have some of the most cost-effective and lasting recovery-oriented interventions that I know about in medicine. We found ways to get people who are recovering from addiction to work with others who are just entering or just thinking about entering recovery. I can't think of a more cost-effective model for maintenance of treatment effects, and we are now seeing treatments for other chronic illnesses incorporating peer-led continuing support. So all that is something we should be rightly quite proud of.

Recovery-oriented systems of care are starting to emerge in many places as they are now in Philadelphia and the state of Connecticut. As far as I'm concerned, they offer a very nice model for how you should treat other chronic illnesses in a cost-effective manner. With that said, I think people with behavioral health experience—counselors, social workers, family counselors, psychologists—who learn about addiction and learn about the methods to manage it through combinations of medications, family involvement, peer involvement, monitoring, and social supports are going to be invaluable, not just to the treatment of addiction, but to the treatment of chronic illness generally.

Bill White: It is interesting to me that at this late stage of the field's development, we are just getting around to defining recovery. You led the effort by the Betty Ford Institute to assemble a consensus panel to create a working definition of recovery. What would you say you've learned from that process?

Dr. McLellan: I think one of the more satisfying things I have been part of in my career was the effort by the Betty Ford Institute with a lot of other professionals—including yourself, Bill—to take on the task of defining recovery, not for the person who's in recovery, but for the great majority of the world who don't know anything about it and often have misgivings and misunderstandings about the concept. It was challenging to develop a succinct way of presenting what is a very complicated concept. I took three lessons from this experience.

First, there is no single way to get into recovery. That was a lesson I learned from you Bill. The most popular and storied way of getting into recovery is through

involvement in a 12-Step program. It remains one of the staples of our field, but it's not the only way.

Second, abstinence is necessary but not sufficient. People who simply don't drink but continue behaviors and attitudes that are associated with an addiction lifestyle are not going to be abstinent for long as far as I'm concerned.

Third, probably more important than anything else, is that recovery is not only achievable, it's downright expectable. There are, according to the Faces and Voices of Recovery, at least 20 million people today who consider themselves to be in active, stable recovery, and the public at large has no idea about that. Too many think that addiction is a lost cause. They think that there's no real hope, and unfortunately, it's because they don't know that they are quite literally surrounded by people who are in recovery but don't talk about it every day. This is one of the things that we want to make clear to the public: that recovery is not only possible, it's expectable, and it should be the goal of every treatment episode. Having a solid, well supported recovery community is a tremendous resource for any community and any family and any individual.

Bill White: Were you surprised at the international interest that the Betty Ford Institute recovery definition consensus generated?

Dr. McLellan: Actually, no. Once you have a definition that people can agree on and can measure in sensible terms, the hardest work is done. I was quite certain that this process of defining recovery would be well worth the effort, and it has been. Countries all over the world are interested in adopting the definition or some variation of it. More important than adopting the definition—although I think that was the necessary first step—they're developing strategies to bring recovery into much broader reality. That's what's been really gratifying about this work. It gives hope to people who really don't think there is any hope. When they hear that 20 million people were in the same situation as they were in, that there are a lot of different ways to get into recovery, and that there are a lot of very willing people who can help them do it, that instills hope at the individual, family, and community levels, and hope is the one thing this field desperately needs.

Bill White: The current call to transform addiction treatment into recovery-oriented systems of care seems clearly an outgrowth of much of your work. Do you see this current focus on long-term recovery as a sustainable movement as we go forward?

Dr. McLellan: I do. I think recovery is first understood from a clinical perspective but what will sustain it in the public perspective are the financial, public health, and public safety benefits. Sustainable recovery is what makes treatment and initial care worth it. Because of this, it follows that we need systems that will sustain the recovery process. Good treatment without the additional personal and social investment in sustaining continuing recovery is like having a damn good junior high school education—very important but not near enough to make it in the world. Just like education, we need to make it clear to individuals, families, and the public at large that short term, quick fixes or simply physiological stabilization is necessary but not nearly sufficient to manage substance addictions.

But I think you are right to emphasize not just recovery but also the recovery *system of care*. We have always had charismatic individuals who could bring individuals into recovery—wonderful, but not adequate. We need systems that can be created and implemented and managed at the community level that will make recovery an expectable outcome of becoming sober and beginning a new lifestyle. I think it's going to be one of the most cost-effective kinds of infrastructure development that we will do in this country.

As we begin healthcare reform, addiction treatment will be quite dramatically effected. Addiction treatment will be part of the rest of medicine. A very realistic question is what will happen to the federal Block grant? My own view is the federal Block grant ought to remain, and that it ought to be more directed toward building and sustaining recovery-oriented systems of care. As individuals get interventions and initial primary care through the mainstream healthcare system of the future—and that care is reimbursed through Medicaid—they will hopefully get a kind of care that they've never had before, *but they won't be cured*. What they'll need is places they can go following that initial care where they can get recovery support services: peer support services, parenting skills, drug free housing, help with job transition or job placement, family support services. That's what I'm hoping the Block grant will be used for.

Bill White: Many people working in the addictions field draw upon experiential knowledge related to their own personal or family addiction recovery experiences. You have been quite public about how addiction recovery affected your family. How has this experiential knowledge influenced your work in the field?

Dr. McLellan: Anybody that has a particular kind of a disease in their family is more acutely aware of the research in that field and new interventions or proposed interventions or medications, and that's been the case with me. I have worked in this field for 35 years, studied all parts of it. Not only that, through my whole professional life, I have been surrounded by some of the best professionals in the field. But with all that going for me—knowledge, contacts, and benefits that most Americans do not have access to—I found myself almost completely lost when members of my family first got into trouble. Because I am painfully aware of just how devastating addiction can be when it strikes your family, I have been working with lots of my colleagues for the past several years to translate what we are learning from science into practical knowledge and skills and supports that can be used by parents, families, and communities. The good news is that lots of researchers in this field have turned to this type of translational activity, and there are an increasing number of parent groups and community organizations that are coming forward to demand better and more practical interventions and skill development.

Bill White: On August 10, 2009, you were sworn in as the Deputy Director of the White House Office of National Drug Control Policy. What enticed you to leave the Treatment Research Institute and assume this role?

Dr. McLellan: I had had a fairly public loss in my family as a direct result of addiction, and that, combined with a very persuasive telephone call from Vice President Biden, led me to believe that maybe I should leave what I really loved doing and the people that I

loved working with to see if I could help this administration make a contribution to the field at a policy level. I have to say it's been a forced fit to put me in a policy environment—and this will come as no surprise to those who have worked with me in the past. I am an impatient guy, I favor a “ready – fire – aim” approach and government is much more of a “ready – aim – aim – aim...” environment. If you think research or clinical work requires patience, oh baby, try national budget-making, priority setting, and consensus building in the context of pitched ideological battles, suspicious federal agencies, and intensely invested private interest groups! I do know that our Director, Gil Kerlikowske, has really improved the morale and function of ONDCP, and we have unprecedented support and involvement from the Vice President's office. Day to day, it's like walking through jello, but I think we have a shot at really helping people in the long run. I miss terribly the puzzles and excitement of investigation and discovery with my friends at my old job.

Bill White: Could you talk about how you have tried to influence the future of addiction treatment through this role?

Dr. McLellan: First, it's clear that addiction at a policy level now is predominantly considered a criminal justice issue and thus managed by Departments of State and Justice, and by various law enforcement branches within those agencies. While they're all doing a very good job, I was surprised to find that many of my colleagues in these agencies are unaware of the new developments in prevention, intervention, treatment, and recovery. So, what I have tried to do is enhance their knowledge and help them with some new tools to add to what they are already doing. Thanks to the leadership of Gil Kerlikowske I think we have already formed some really good functional partnerships between what is called the “demand reduction” side of addiction policy and what is called the “supply reduction” part of addiction policy.

Second, I have tried to move addiction integration forward. Despite the pervasiveness of addiction problems, they seem to be hidden under rocks, under rugs, and behind doors. And yet, substance use problems affect every part of mainstream society from education to business to healthcare, criminal justice, and welfare. Part of my role here has been to help those in policy positions see that they will never get a handle on healthcare reform, prison reform, sentence reform, welfare reform, or educational reform if they don't address substance use issues. My sinister plot for insinuating this issue into mainstream policy is to show them that attention to substance use issues within their own areas will help them develop far better policies and programs—that attention to substance use issues will help them reach their own goals in a much better way. We can add value to the rest of mainstream society. Substance use and addiction as an issue needs to be part of mainstream society, not shoved off to the side.

Bill White: You recently announced that you will be leaving ONDCP at the end of September. What factors led to this decision?

Dr. McLellan: It really boils down to two things and neither of them have anything to do with either my current position or with the staff or leadership of ONDCP. I am

honestly very proud to have served with these people and I can say they are as committed and diligent a group as I have ever worked with.

The first factor in my decision is that I think much of what I can do has been done with the passing of the Parity and the Healthcare Reform Acts. Thanks to the work of many, many people working in and with government we have an unprecedented future for the substance use prevention, early intervention and treatment fields. That legislation will bring our issue directly into the mainstream of healthcare and while it will not be smooth or easy, addicted people will have opportunities they never have had. While the legislation, regulation and money to bring this came from the hard work of many in the federal government, the actual translation of how these opportunities will emerge, will *not* come from federal government – it will come from the innovation and dedication from public and private groups in our industry. I want to be part of the innovation and creativity that I think will generate from within and outside our field over the next decade. New solutions will be developed by people already in – but also people that are now outside our field. Those ideas and opportunities will be tried at the community level and those that show benefit will become incorporated while old ways and new ones that don't work will be discarded. I think that is the way it should be and I would like to play some part in those efforts at the grass roots.

The second factor is simply that government processes do not suit my personality. I do not like the partisanship and institutional defensiveness that I see in so many places in government. Both these factors combine to turn issues where there is an empirical answer into a political or populous decision. The answer to “What does 2 + 2 equal?” does not take a committee or a vote; and regardless of public support or outcry – it is simply the correct answer. Researchers spend their lives looking for correct answers and I like industries and environments that foster that process.

Bill White: There is considerable interest in what activities you will pursue after leaving ONDCP. What are your immediate post-ONDCP plans?

Dr. McLellan: I really do not know what I will do when I leave. I want to take some time and think about things. I will not make any decisions for at least 2 – 3 months while I do some relaxing, reflecting and soul searching. I do not want to retire – but I do want to regroup and reorient. Government has disappointed me but it has not decreased my optimism. There has never been a better time to be in this field and I look forward to finding a useful opportunity to contribute for another ten years or so.

Bill White: Are there any final messages you would want to convey to frontline addiction professionals across the United States?

Dr. McLellan: My final message to counselors and other addiction professionals would be that your work is critically important. Our field has turned a corner, and we are beginning to become integrated into mainstream society. And it's your work that is making that possible.

About the Authors: Dr. Tom McLellan is Deputy Director of the White House Office of National Drug Control Policy. William White is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.