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Clinical Leadership in Addiction Treatment: An Interview with Dr. Joan Zweben

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

Introduction

One of the most influential clinical leaders within the addiction treatment field over the past four decades has been Dr. Joan Zweben. She has distinguished herself through her clinical activities, her training presentations and her unrelenting advocacy work. She has pushed, often against prevailing trends, to elevate the quality of addiction treatment through her speeches and her prolific writing. Many clinical leaders within the addictions field get pulled out of clinical specialization into the arenas of teaching, research or administration. Dr. Zweben has been involved in all of these latter areas but has steadfastly maintained a focus on elevating and refining the clinical treatment of addiction. I had the honor in January of 2014 to interview Dr. Zweben about her life's work. Please join us in this conversation.

Early Career

Bill White: You completed your doctoral work in Clinical Psychology at the University of Michigan in 1971 following your undergraduate work at Brandeis. How would you characterize the addictions-related training that clinical psychologists received during this period?

Dr. Zweben: In retrospect, I'm shocked that they didn't talk about alcoholism at all. It simply wasn't on their radar. I was in an orthodox psychoanalytic training program and in that setting they focused only on populations "suitable for analysis." They viewed alcoholics as not suitable for analysis. There were drugs around by that time, but nothing was addressed related to the treatment of drug addiction in my course work or supervision. Addiction was regarded as a deviant social behavior with severe alcohol and other drug problems viewed as not fitting well within the analytic model. There was a not so subtle stigma attached to addiction in the attitudes of the faculty.

***Bill White*:** Would you say that was pretty typical of training programs for helping professionals during this time period?

***Dr. Zweben*:** Absolutely. The early responses came from the fringes of these training programs—from students, like Don Desjarlais and newly trained docs like Sid Schnoll who would go on to make significant contributions within the emerging addiction treatment field. But you saw no focused integration of addiction treatment within the larger training curricula of the sixties. Even when training programs began to add a single course, there was no full integration of this subject within the total training experience.

Bill White: Given that lack of focus, what circumstances or interests led to your early specialization in addiction treatment?

Dr. Zweben: My earliest involvement was through Steve Schwartz, a fellow graduate student who started a Drug Clinic at University of Michigan in response to emerging drug problems. We entertained ourselves on the weekends going to rock festivals and talking people down from bad LSD trips. As psychology grad students, we were caught up in the romance of psychosis, and thought hallucinogens were a way to learn about psychosis. We also took LSD within our friendship group. Many of that group moved to northern California and we remain friends today. Steve moved to New York and held leadership roles there.

I met and married David Deitch in 1973. He exerted a major influence on my work. David was eager to offer baseline clinical skills in drug treatment settings, at that time, methadone maintenance programs and therapeutic communities. He was concerned about attack therapy, which he considered a distortion of appropriate approaches to confronting destructive behavior. We formed a consulting group with three colleagues and did training programs locally and sometimes elsewhere. At that time, I was teaching psychology to first rate graduate students at UC Berkeley and teaching school dropouts within the treatment settings. Both groups were wonderful. The drug treatment staff members were frustrated with their own limitations and were very eager to learn.

I started publishing one or two papers a year around 1985, partly because the teaching materials I needed did not exist. Writing became something of a compulsion. It helped me clarify my ideas and develop them more fully. I had no idea at the time what an important role such writing would play in my career.

In the 13 years David and I were married, I met many of the leaders in the treatment field and visited many different treatment programs. I was at UC Berkeley on soft money for four years, and after that, I had established myself in private practice and was doing consultation and teaching in substance abuse, often with David. We shared a suspicion of rigid ideology and a great distaste for stigma-based attitudes and practices.

Early Therapeutic Communities

***Bill White*:** Now when you first came to California in 1971, you had some volunteer experience with a TC in Berkeley. Could you describe that initial experience?

***Dr. Zweben*:** Yes. It was called, “Bridge Over Troubled Waters.” A couple of my friends and I were new to Berkeley and didn’t have a lot of roots. We were looking for interesting things to do so we started volunteering there. This did not go on for very long and I don’t have a lot of memories of that experience, although I do remember that the director died of a cocaine overdose. The program later re-named itself and is now providing very good treatment.

***Bill White*:** I am assuming when you began volunteering that this was an early concept TC perhaps most known in this era for heavy confrontation, signs and shaved heads.

***Dr. Zweben*:** Yes, and those were the things that David Deitch was so adamant about changing. When I met David, he pulled me into the therapeutic community at a whole

other level. I visited a lot of programs and supported David in his efforts to infuse the TCs of that era with really good clinical skills and to get rid of the attack therapy and other bad practices. This marked what might be thought of as the early professionalization of the TC. I learned a great deal from George De Leon, Ph.D., who conducted very important research on the TC and wrote a terrific manual (*The Therapeutic Community: Theory, Model and Method*, 2000) on the essential elements of the TC and how to operationalize them. He provides detailed material on how to implement them effectively.

This was actually a quite interesting time. David and I and others did training within Walden House (now merged with the Haight Ashbury Clinics to become HealthRight360). I was put on the board of Walden House and eventually became president of the board. It was during this time that professionals became increasingly involved in TCs and that there was a lot of tension between the professionals and the predominately ex-addict staff. I used to joke that it was not a blessing to have a Ph.D. in those settings. Those with such credentials were immediately suspect. Most professionals didn't get the idea that it was not your brilliance as a clinician that mattered but your skills in shaping the community as a powerful change agent that was important in the TC setting. And so, the relationships were uneasy for a very long time. I loved TCs and found a vitality within the TCs that you don't find in the most other systems of care.

The vitality of the therapeutic community made a big impression on me. I was always interested in communities, and this one was creative and vibrant. Graduation and other rituals were extremely powerful. I had the same reaction when I decided to find out what AA was about and attended open meetings in my community. The sense of fellowship was palpable and I knew that those forces were more influential than any therapist could exert alone.

***Bill White*:** Do you feel any of that vitality was lost in the history of the TC movement as TCs became more professionalized and commercialized?

***Dr. Zweben*:** I think a lot of what made the TCs special has gone away and it is very difficult to reflect on this. Parts of the TC model that were just very hard to sustain due to pressures from funding sources and changes in characteristics of those entering TCs. For example, as we began to get more people with co-occurring disorders, the practices were modified and some of the intensity needed to be scaled back. That intensity was such a powerful force for people who needed something exciting to belong to and to substitute for the street culture, but it didn't serve the needs of people who were more fragile and needed things not to be as such a high pitch all the time. So, I do think some very important things have gotten lost as it's become professionalized. The people we see in TCs need a total habilitative effort. Rehab is when you reclaim stuff that you had once and you just need to get it back. Habilitation is for people who never had such assets and levels of functioning in the first place. That's what the TC provided and I think it will be a shame to lose that kind of resource if we turn TCs into rehab-focused, short-term residential programs.

***Bill White*:** Do you feel that we do a disservice when we put people who need that kind of habilitation into short rehab models and then punish them when they don't do well following such treatment?

***Dr. Zweben*:** Yes, that is a disservice. I think short-term treatment works for many people if there's adequate follow-up and safe post-treatment living environments. But with the most severe and complex of such problems do not respond well to such brief interventions. I think the fantasy that you can cure these problems with the right short-term stay is absurd. I am very concerned with the threats brought by the shifting funding streams. Many TCs have become very sophisticated, particularly about co-occurring disorders, and implement evidence-based practices, but the TC still

does not fit well into the medical model, and may become extinct. If that happens, we will have to reinvent them. There is nothing so powerful for the population that needs them.

Two Fields: "Alcoholism" and "Drug Abuse"

Bill White: You entered the field at a time there were really two fields—an "alcoholism field" and a "drug abuse field." What role did you play in the subsequent integration of these two arenas?

Dr. Zweben: I have always loved clinical work, and it was clear that most clients used both substances. Drug treatment counselors knew little about alcohol, and alcoholism counselors considered drug users lower on the hierarchy. I began calling attention to the need to address both in my consultation and teaching activities. Most of the programs today address both alcohol and other drugs, but there are still vestiges of that past separation.

Funding sources were strictly bifurcated for a long time, and this also contributed to the inability to address co-occurring addictive and mental health disorders. I began challenging this when I got the opportunity. Eventually, this put me in a position to influence policy, not because of any specific title I held, but because I began to be considered an expert who attended many meetings and worked on committees. For example, I worked on CSAT's COD Treatment Improvement Protocol in the early 1990's (first version was TIP#9; now TIP #42), and met many of the people whose work I had been reading for years. I think that document really facilitated efforts to integrate substance abuse and mental health treatment.

Bill White: You were one of the first people to send an alarm bell about early policies towards alcohol in the TC movement. Could you share the story of how early TC policies on alcohol changed?

Dr. Zweben: I don't know the full story on this, but David Smith did a talk at the TC conference in San Francisco around 1986, and it got a lot of attention, particularly since he and I followed up with a paper. I know that many TC folks were uncomfortable with the permissiveness around alcohol, especially since one did not have to look hard to find senior staff who were practicing alcoholics. In one large program, a beloved clinical director with a very high blood alcohol level killed himself in a car accident. That kind of event shakes complacency. I think David's and my role was to articulate the discomfort many were feeling, offer a rationale, and give some momentum to change policies.

Early Career Influences

Bill White: Who were some of the people that exerted the most influence on you during the early years of your career?

Dr. Zweben: I have been incredibly fortunate to work with brilliant, skilled and dedicated people throughout my career. I cannot possibly give credit to all of them. Being on a variety of committees working on specific issues put me in communication with a wide range of experts. I considered this to be my continuing education. I owe a deep debt of gratitude to many.

I am indebted to David Deitch, Ph.D. for his vast knowledge base, continuous insights, and openness to new ways of thinking even when it meant discarding his own favorite ideas. He could relate well to street addicts with long criminal justice histories as well as highly accomplished professionals and political dignitaries, and everyone in between. Over the years, we have worked together on training activities. He did initial and subsequent training for Project Pride, EBCRP's residential treatment program for mothers and their children.

David Smith M.D. introduced me to the disease model and taught me about many other aspects of alcoholism. He was willing to join me in a variety of activities to fight stigma. "David Smith does not like methadone" was a common refrain in the early 1980's, but David hated stigma as much as I did and persuaded ASAM to form

a committee on methadone. This contributed greatly to bringing legitimacy to this treatment modality, first among physicians and then others. He also tackled the problem of alcohol use in the therapeutic community by giving a talk at the TC international conference when it was in San Francisco in the 1980's. At that time, drinking privileges were a reward for progress in program, and many former heroin users relapsed with alcohol as the precipitant. We subsequently wrote it up as a paper. He also involved me in *The Journal of Psychoactive Drugs* and I subsequently organized and edited issues on special topics.

When I decided I needed more direct experience with treatment, I launched The 14th Street Clinic in 1979 and East Bay Community Recovery Project in 1989 (both in Oakland). Susan Wengrofsky helped launch and ran daily operations at 14th Street, and worked tirelessly to implement our shared vision. She created a respectful and welcoming environment, which heroin users could not take for granted at that time. Marta Rose and I wrote the grant that launched EBCRP. Marta continues to run the daily operation. I am extraordinarily lucky to have such long and productive working relationships with colleagues who are so capable and dedicated, and who share my values about treatment.

Peter Banys, MD is an addiction psychiatrist who was the Director of Substance Abuse Programs at the San Francisco VA Medical Center, where I held a 10% appointment since 1974. We ran a Faculty/Fellows Seminar for about 25 years. Right up until he left the VA, I heard Peter say things I had never heard from anyone before. He is superb teacher and never shy about "advising" me. Although I did not have a good science background, Peter could explain medical aspects in language that was crystal clear, and contributed greatly to my understanding. I feel strongly that non-physicians working in the field should learn as much of the medical basics as possible.

H. Westley Clark, MD, JD, MPH did the Addiction Medicine Fellowship at the San Francisco VA and we led a group together during that time. He has remained a close friend and colleague over the years. He developed the Substance Abuse and PTSD program at the VA, and we co-authored what was one of the first papers on traumatic experiences and substance abuse in 1994. I already had close connections with CSAT when he became its Director, and he has continued to provide insight into the problems in the field.

Tom McLellan, Ph.D. helped me learn to love research. There is often an inverse relationship between the rigor with which you can study something and its relevance in the real world. Tom's research is grounded in reality and addresses questions that are important to clinicians. His speaking style is accessible to a wide range of audiences. No matter how many times I have heard him talk about a topic, I always hear something new.

Judy Martin, MD is a family practice physician who was Medical Director at 14th Street Clinic for many years. This was another wonderful collaboration that evolved over the years. She is skilled at traditional medicine and interested in alternative medicine. She is a great teacher, who I often turn to for explanations when I don't understand medical issues.

Rick Rawson, Ph.D. provided an inspiring example of the clinician/researcher who systematically examines important clinical questions and uses findings to improve treatment in community settings. He is an outstanding teacher of clinicians and others and is a wise consultant on policy. He has been unfailingly generous when I asked for information and teaching materials. He is pragmatic, witty, passionate about implementing evidence-based practices in a realistic way and is deeply committed to the field.

Arnold Washton, Ph.D. is the co-author two of my books. I was initially impressed by how he cut through ideological rhetoric, and I have continued to enjoy his incisive analyses of many different issues. He is not afraid to challenge tradition and offers practical, effective alternatives.

I am indebted to CSAT & NIDA. These two federal agencies contributed extensively to my knowledge base, skills and networking opportunities. EBCRP obtained

grant funding from the Center for Substance Abuse Treatment for over 20 years, and this allowed us to do innovative programs with enough resources to do them right. To me, they are an example of government at its best: facilitating good work in the community. They promoted a collaborative relationship that made it easy to acknowledge problems and find appropriate help. I was a participant in NIDA's Clinical Trials Network for about 10 years and found it to be an extraordinary learning opportunity. Although EBCRP was not able to participate in many trials, we did make good use of the resources to implement evidence-based treatment and I learned an immense amount about research.

Finally, I am indebted to Mary Jeanne Kreek, MD, Joyce Lowinson, MD, and Liz Khuri, MD who are often referred to as the "Three Sisters" of methadone treatment. They were pioneers in its early development. They welcomed me and coached me, and I learned an enormous amount from them.

Work with the VA

Bill White: The VA played an early and continuing role in your career. What are some of the most significant experiences and lessons you have drawn from this sustained involvement?

Dr. Zweben: I went to the VA in 1974 to do clinical supervision, and soon afterwards, was asked if I wanted to be placed on what was then the Alcohol Inpatient Unit. This was a phenomenal learning experience for me, as it was the first time I had regular clinical interactions with alcoholics. The San Francisco VA Medical Center is affiliated with University of California, San Francisco, and this put me into academia with all its wonderful resources. As an Executive Director, it was too complicated to do clinical work in my own programs, and I had phased out of private practice when I began to travel more for work projects. I still do clinical work at the VA, and continue to learn from the vets. My seminar continues, and keeps me in touch with developments in substance abuse and related areas. My colleagues are wonderful and we have our own little think tank there. I particularly enjoy working with some of the bright young professionals who come for our specialized addiction fellowships. Some have become leaders in the field.

I am troubled about how veterans have fared on their return home, and am glad that EBCRP recently received funding to provide assistance in securing permanent housing. We hope to build other services around this.

The 14th Street Clinical and Medication-assisted Treatment

Bill White: You founded the 14th Street Clinic and Medical Group in 1979 and served as its Executive Director until 2007. Describe this clinic and its work.

Dr. Zweben: I had been doing consulting and training and was feeling a bit sheepish about never having run an organization. A colleague approached David Deitch and I about opening a clinic for heroin users and I agreed to take this on. I was fortunate that Susan Wengrofsky was available to help launch it, and she continued to run the daily operation until 2007. This was an eye opening experience. We started with opiate detox using methadone, and moved on to include maintenance and other medical services. I was astonished at the level of stigma. One of our patients had been stabbed multiple times while protecting her child from her boyfriend, and was treated abominably by emergency room staff once they discovered she was a methadone patient. I quickly understood the need to educate other professionals about this modality and was fortunate to have colleagues to help. We did training in medical settings. I started publishing articles. One of my first was published in a medical journal, and within a few days, I received a letter from one of our methadone patients. She worked in a physician's office, and spoke of how methadone had given her life back. About her boss: "If he knew I was on methadone, all the trust would leave his eyes….As for me, I'm still on methadone and

truly, I am scared to get off. Since I've gotten off heroin, I have a job I love that I've stuck with, bought a home, etc. Life is good and life is *stable.*" Yet she apologized for remaining on methadone. Those kinds of experiences made a deep impression on me.

In the early 1980's, the HIV virus was identified and the epidemic became apparent. Our Medical Director, Susan Lambert MD, created the first screening protocol for HIV to be used in drug treatment clinics. We realized we had the second highest risk population (at that time) and spoke to California county administrators about screening and referral. We became hostess to a variety of researchers from the Centers for Disease Control, UCSF, and elsewhere. Researchers love methadone patients because they can find them more easily than others, and we welcomed them. Besides screening, counselors were trained to provide HIV education and work with clients on very difficult issues. In those early days, there were no effective medications, so the prospects were terrifying.

I realized that many patients concealed their methadone treatment from their primary care physicians, for fear of a negative reaction, so we opened 14th Street Medical Group to provide some primary care services, to they would have a place to go where they could be honest with their physicians. The funding mechanisms changed after a few years, so we could not provide medical care, but it was a good experience.

We did, however, use the Medical Group as the vehicle to start providing treatment for cocaine dependence in the mid 1980's. The cocaine epidemic was spreading, and we were getting lots of referrals from Children's Protective Services to work with cocaine-using moms in danger of losing their kids. Individual social workers had a small pot of money to purchase specialized services, and no one else was doing much in this area. Around this time, I found Rick Rawson and Arnold Washton, and learned a great deal from them about how to work with cocaine users. Soon, the amount of our monthly billing attracted the attention of the county Social Services agency, and they put us on a contract. We immediately grew a large waiting list. This was frustrating at the time, but it positioned us to launch East Bay Community Recovery Project and apply for our first federal grant under the Waitlist Reduction Program. We received $835K, and EBCRP was off and running.

Methadone Maintenance and other Pharmacotherapies

Bill White: How do you view the current status and future of methadone maintenance and related pharmacotherapies?

Dr. Zweben: Opioid maintenance pharmacotherapy is very fortunate to have Mark Parrino as its leader for several decades. He was active in the northeast coalition that became a national organization, now called the American Association for the Treatment of Opioid Dependence. Mark is a true statesman, with great skill at bringing people together to collaborate on important tasks. He is fearless and forthright in identifying the issues and getting key people to address them. Under his leadership, a lot of the stigma issues have been addressed and methadone and related pharmacotherapies have been made available in many states where they were previously absent. He works continuously to promote collaboration between the many federal and state agencies that are involved in regulating or providing treatment. The AATOD conference every 18 months is very well done and brings together a wide range of researchers, policy makers and clinicians working in the field. AATOD provides many educational resources and help in addressing stigma issues. Over the more than three decades that I have been involved, methadone has become better understood and accepted, though the work is far from complete. Newer medications such as buprenorphine seem to be less stigmatized.

Bill White: You have written a great deal about the public and professional misconceptions about methadone. Which of these misconceptions do you feel are still pervasive today?

Dr. Zweben: I continue to be surprised that many of the same old misconceptions are around today. A student recently brought a message from a psychologist I know: "Tell Joan I still don't believe in methadone." I quoted Tom Payte: "Methadone is a medication, not a religion." I am particularly frustrated when physicians refer to it as an "addicting drug." Addiction is currently defined in terms of the person in relation to the substance. It is no longer defined in terms of the properties of the substance. Medications are not "addicting." They are dependence producing or not, and we use other medications that produce physical dependence: antihypertensives, thyroid replacement, antidepressants. If this seems nit picky, words embody concepts, and concepts can facilitate or discourage clear thinking. Non-physicians make this error too, but physicians should know better.

There is also a pervasive misconception about the relationship between detoxification and long term abstinence. There is no correlation. Buprenorphine is easier to discontinue, but studies are revealing that many of these patients will require maintenance medication to preserve their gains, just like methadone patients. This is not a matter of motivation, which is essential but not sufficient for a successful taper. No one makes me a second class citizen because I remain on thyroid medication, and patients on opioid meds should be treated the same.

Because of the stigma, many successful methadone patients conceal their use of the medication, sometimes even from their family. If you want to see the successes, you have to visit the clinics between 5:30 AM (when many open) and 8:00 AM. After that, the patients who are doing well have gone to work. Most visitors come during normal working hours (9:00 AM until the clinic closes, usually by 3:00 PM) when many of the less functional patients are visible. This perpetuates the stigma.

Bill White: You were one of the first people writing about the potential integration of methadone maintenance and Twelve Step oriented treatment and the value of MMT patients participating in 12-step groups. How do you view the status and potential of such integration today?

Dr. Zweben: I see it much as you described in your paper with Lisa Mojer Torres: hopefully possible someday but great difficulty in getting there. People hang onto their biases with great tenacity.

***Bill White*:** Did you get any kind of push-back when you began to propose the integration of medication and 12-step oriented treatment and suggests that TCs needed to be working with patients on methadone?

***Dr. Zweben*:** Well, I didn't experience any push-back internally because I was the Director of the clinic and I could say, "We're going to ask our patients to give us a list of twelve-step meetings they've been to that they liked and where they weren't hassled about methadone" and we are going to link our patients to those meetings. I wasn't fighting with anybody about whether it was okay or not. Our staff was totally on board with this. They loved trying out new things. Now, in terms of methadone in the therapeutic community, that was really a long saga because I was on the board of Walden House at that time and they grudgingly started to admit methadone patients who wanted to taper off. I said, "No. People make decisions to taper off for very bad reasons and eighty percent crash and burn. Please explain to me why staying on methadone is more terrible than me staying on thyroid medication." If you look at the brain chemistry, if you look at the science of it, it's not very different. These discussions went on for a long time and, you know, TC people I was dealing with were not all polite professionals. I took a lot of heat for that but I kept pushing. A young guy, Brian

Greenberg Ph.D., came to Walden House fresh out of graduate school, super-smart, and able to write grants that brought in millions of dollars. He promoted the idea of doing a research project on integrating methadone patients in TC. What turned attitudes around somewhat was Yih-Ing Hser and Doug Anglin's thirty-three year follow-up up study on addict careers. This was a sample that was started, I think, in the '50s from the civil commitment program so almost none of them were on methadone because it simply wasn't available to them. The high death rates and continued addiction rates helped improve Walden House attitudes toward the integration of methadone and TC methods to improve such long-term outcomes.

***Bill White*:** In the UK, there is a push for increased recovery orientation in addiction treatment, but in the UK this call for increased recovery orientation is being interpreted as pressure to get people to terminate methadone maintenance in the name of getting them "drug-free."

***Dr. Zweben*:** That's terrible. A methadone patient is abstinent if he or she is not using illegal drugs or unprescribed medication, not drinking, and using prescribed medication as instructed. Whether you're on medication or not is tangential to whether you're doing a solid recovery process.

***Bill White*:** That's beautifully stated. Do you think this language issue is critical for us as we move forward--defining abstinence and drug-free in the context of medication-assisted treatment?

***Dr. Zweben*:** Yes. I become feisty when I hear the term, "drug-free." I actually worked to convince NIDA to get rid of that term in its requests for applications. What does it mean? Prozac-free? it's meaningless and it's stigmatizing. It suggests that the recovery of someone who does not need medication is somehow more noble than someone who does. We have to get beyond this "drug-free"/methadone polarization, and the idea that people who are on medications can't recover.

Bill White: There have been growing calls to increase the recovery orientation of MMT and MAT. What do you see as the promises and potential pitfalls in this trend?

Dr. Zweben: I think a well-run clinic has always promoted a healthy recovery in all the commonly understood ways. Just to clarify once more, for a patient on methadone, buprenorphine, or psychotropic medication, they are abstinent if they are not drinking, or using illicit drugs, and using legal ones as prescribed. This is not widely understood, even within the recovery community. Integration into the community is very important, yet there are many barriers. I cannot in good conscience urge a patient to disclose and face the vitriol that is all too possible.

Bill White: Walden House was one of the first TCs to experiment with the integration of methadone and other medications. Do you see that kind of integration in the future for both psychosocial treatments and medication-assisted treatment?

Dr. Zweben: Yes, it has happened in a lot of places, but availability seems to be quite regional. Our own Project Pride opened in 1994 and accepted patients on methadone or psychotropic medications without barriers. It is necessary to continuously deal with staff and client misconceptions and antipathies toward methadone.

East Bay Community Recovery Project

Bill White: You have served as the Executive Director of the East Bay Community Recovery Project since 1989. Describe this project.

Dr. Zweben: Marta Rose and I started EBCRP in response to the cocaine epidemic. The feds put $75 million on the table to allow programs with a waiting list of cocaine users to expand services. We were advised and coached by people at the state

level to set up a new corporation with the capability to administer federal grants. Within three months, we trained our staff and our required outpatient treatment slots were full. We had put in psychiatric services and other elements that were unusual at that time, and quickly got in trouble with county staff, who promoted a social model, exclusively if possible. They did not like spending money on expensive professionals and anything resembling a medical model. I was completely naïve about politics at that time, and simply pointed out that this was a federal grant and we were going to do what we proposed (i.e., they could not dictate what we provided). The county tried to defund us, but did not succeed. After the initial grant expired, we limped along until the Office for Treatment Improvement (soon renamed CSAT) was formed and we were able to get continuous grant funding for many years and build on that. Within a few years, the same rigid ideology about "one right way" in our county led them to try to eliminate all Medicaid funded methadone services in the county. This inspired the Sobky v. Smolley lawsuit, that basically stated that if there were a willing patient and a willing provider, the county could not discriminate in this way. It was a Medicaid access issue. The outcome of that suit opened access to methadone in all California counties. The leadership that precipitated the lawsuit left the county and collaborative opportunities opened up for us.

Afterwards, the county departments became more cooperative and interested in us, particularly because we assumed the presence of co-occurring disorders and did not discriminate against people on medications. The CSAT funding allowed us to expand our range of activities. We brought services and community organizing to public housing. We were able to do training in the mental health system about AOD use, and in the addiction treatment system about other mental disorders. In 1994, we received funds to open Project Pride, our residential treatment program for mothers and their children. It was named by the first cohort of clients, as a pride of lionesses. It very explicitly welcomed people on methadone or psychotropic medications. We continued to work with people with HIV and got a variety of CSAT grants to address the needs of that population.

We also branched out with a contract from Federal Probation to provide treatment. This was our first venture in collaborating with the criminal justice system and we have continued this ever since. We work in the jails, with Drug Courts, and with those on probation and parole. For a time, we had a contract with the California Department of Corrections and Rehabilitation. Inmates were brought to Project Pride in shackles (despite our objections), reunited with their young child, and served out their sentence in the treatment environment. We have put a lot of effort into educating criminal justice staff about treatment, and have been pleased to see them become more sophisticated over time. Some had the view that they could solve the addiction problem by perfecting their controls over people, and we tried to help them see the importance of a collaborative effort with the client. There is no question that the leverage of the criminal justice system helps clients to persist when recovery gets tough. When that partnership is working well, it is very powerful.

At some point, the county decided to fund us as a pilot to see if an addiction treatment program could work effectively with people with severe mental illness. Our staff proved themselves capable, and we expanded in this area. We now have several programs for people with SMI, including day treatment, mental health court, and forensic assertive community treatment. We also have one for transition age youth experiencing their first psychotic break. It is called Prevention and Recovery for Early Psychosis, or PREP. It was developed by Bob Bennett, a close colleague in San Francisco, who wanted to bring it to Alameda County. In the first year of data collection, we were able to demonstrate a 50% reduction in hospitalization compared to the previous year, and this year it was 75% lower. Clients were functioning better in other realms. The idea is to see if this model of intervention can allow people to function outside the mental health system later on. At this point, we have

more funding from mental health than substance abuse, and refer to ourselves as a mental health and substance abuse treatment program. We address the full severity range of co-occurring disorders.

More recently, we have focused on employment services and housing. Marta Rose acquired a taste for real estate adventures and secured funding for us to create supportive housing units of our own. She also led the effort to obtain stimulus money (from the American Recovery and Reinvestment Act, 2009), which allowed us to purchase and rebuild a facility for Project Pride. We network with many landlords in the community to provide housing for clients in our various programs. Veterans are the most recent focus of our housing efforts. We have received funding from the VA to participate in the effort to end veteran homelessness. The Bay Area is a very difficult place to locate affordable housing, and increasing the housing stock takes years. It is a significant challenge.

EBCRP's mission is to provide comprehensive and integrated services to meet the needs of clients and their families. We understand the need to provide services well beyond treatment itself and are deeply involved in our community. We completely endorse the idea of a recovery oriented system of care, and use our networks extensively. We are currently struggling to adapt to the changes brought by the Affordable Care Act and hope to maintain our vision for many years to come.

Clinical Response to Evolving Drug Trends

Bill White: Your work has placed you in the center of clinical responses to evolving drug trends—from cocaine to methamphetamine to prescription opioids. What are some of the most important lessons you have learned in responding to these shifting drug trends?

Dr. Zweben: Although recovery from all substance use disorders has common elements, it is important to understand the distinctive features and needs of particular groups and of individuals. Treatment elements should be designed accordingly. The recovery process is similar across all drugs, but people become engaged more quickly if they hear "their story" and feel the clinician understands them. Tolerance of ambiguity is the mark of a good clinician. Ideological purity can do a lot of harm. It is important to remain open to new approaches.

Bill White: You have been a leading advocate on the special needs of women, immigrants, people with co-occurring disorders, veterans, and people who have survived trauma, to name a few. As of 2014, how effectively do you feel the addictions treatment field is able to individualize its services to address the special needs of those it serves?

Dr. Zweben: A lot of good work has been done, but there is still a lot to do to understand which treatment interventions are important for whom, over what period of time. I think that we need to understand more about what's distinctive about serving these various populations and to implement those approaches across a variety of settings. I don't think we know enough about what the really key essential ingredients are. There are many different steps to engaging different populations and I think relationship skills are key. I don't think ethnic matching is the key. What's more important are the relationship skills of the person and their ability to talk to people across cultural boundaries—to really listen until you understand. I think you have to have this partnership where people can tell you where you're off the mark. And some of it just takes a lot of time.

Teaching and Consulting

Bill White: You have also been deeply involved in teaching, training and consulting activities throughout your career. What have you enjoyed most about these activities?

Dr. Zweben: David Deitch and I started a consulting group (PICTEC, now defunct) in 1974 as a vehicle for our training and

consultation activities. We brought in three other colleagues and designed some excellent training packages which we were able to offer in the bay area and sometimes elsewhere. We combined didactic presentations with role plays for skill building and spent many hours improving our approach. We were able to engage staff members without any higher education, and help them become enthusiastic and confident about learning. For me, I benefited from visiting a lot of different treatment environments and striving to understand their challenges.

My consulting, training, and participation on a wide variety of committees allowed me to develop multiple perspectives on various aspects of the addiction field. For example, I participated in the Institute of Medicine's Consensus Panel of Effective Treatment of Heroin Addiction, and saw the power of collaboration between researchers, clinicians, and government and related entities. I worked on several of CSAT's Treatment Improvement Protocols and developed collaborations that are still active today. I am action oriented and the networking opportunities have served me well. It also helps to get a perspective on the challenges in my own program.

Bill White: Could you comment on the current state of preparing people to work clinically in addiction treatment in the United States?

Dr. Zweben: I wish I could be more hopeful about this. We are facing a severe work shortage, and the graduate schools have been slow to integrate addiction treatment into their core curricula. It is often one course, or a two day course tacked on as a pre-licensing requirement. Often, clinical supervisors in the agencies don't know how to address alcohol and other drug use, so they refuse to see the person or think if they make an AA/NA referral, they have done their job in addressing the problem.

I am also very concerned about the non-licensed counselors, many of whom have addiction counseling credentials that represent a great deal of work. Some of the most gifted and skilled clinicians I have ever known fall into this group. For example, EBCRP has a number of programs for people with severe mental illness and substance abuse, and very few professionals could match our counselors in dealing with this difficult population. I have little reverence for advanced degrees alone as a measure of quality, but I have great respect for talent and skills. I hope we can continue to support and develop this part of our work force in the face of the restrictive requirements of the Affordable Care Act.

Writing a Career

Bill White: You have been one of the most prolific writers among modern addiction professionals. How have you integrated writing into your clinical, administrative and advocacy work?

Dr. Zweben: I have always written for a clinical audience. I have mostly written on the weekends, when the phone does not ring constantly. Writing helps me work out my ideas and clarify next steps. It is a compulsion. I can't help myself. I encourage others to work out the formula that is effective for them. For me, it often starts with student questions when I am teaching. I read a lot to keep up with developments, and put important material on slides. Once I have done that, I make an outline. It is easy to write from the slides, though they don't cover everything. I can download journal articles from my home office, and I have a good library at home. I bounce around between various sources and somehow it all gets done. My advocacy positions are often apparent in my papers, and I have tact specialists to make sure I don't go overboard.

Bill White: You have served on the editorial boards of the *Journal of Psychoactive Drugs*, the *Journal of Maintenance in the Addictions* and the *Journal of Substance Abuse Treatment*. What advice would you give to aspiring writers who have hopes of publishing their work in the field's leading journals?

Dr. Zweben: I wish I could be helpful. The standards have changed a lot, and now there is a dominant attitude that data is the only source of knowledge. Many of my favorite of my own papers would not be accepted anywhere today. Don't get caught up in prevailing status systems. I would say, get it written and find a place to publish it. Once it is published, it will generate various interactions with others who share your interests. Writing is a craft; you get better with practice. You can learn a lot from editorial feedback, but some of it is goofy and reflects personal interests of the reviewer. When you read something you like, ask yourself what makes it compelling. Keep writing and keep trying.

Career-to-Date Retrospective

Bill White: What do you think have been some of the most important historical milestones in the evolution of modern addiction treatment?

***Dr. Zweben*:** Well, I think there are a few major points to be made on this. One is the discovery that the early-held belief that involuntary treatment doesn't work was simply wrong. What we know is that retention works. How you got to treatment is far less important than whether you stay and how long you stay in treatment. That is crucial. Nobody comes to addiction treatment one hundred percent voluntarily. No one addicted wakes up one morning and says, "I can hardly wait to give up my drugs." They come under pressure. It is our job to help make this transition from extrinsic to intrinsic motivation.

I think the widespread recognition that co-occurring disorders are the norm, not the exception, is significant. We may not always have adequate resources to provide integrated treatment, but at least we know that is an important goal, and great tools (like Lisa Najavits' Seeking Safety) are available.

In terms of training, I think the topic of relationship skills and rapport is starting to get much more emphasis. If you really look at the research, we have really neglected the area of the therapeutic relationship. Specialized methods, like CBT and MI are great developments, but they don't account for a high percentage of the variance. It's those relationship skills that we need to pin down. As an Executive Director, turnover is very costly. Making a mistake is very costly so we need to know how to hire. I think Bill Miller does a great job with some of what he describes how they set up scenarios in the job interviews and get people to show, using actors, how they would handle the situation so they don't make as many hiring mistakes because some people can be taught better motivational interviewing skills and some people just can't. And so you have to start out right and then you have to help them bring that out and polish what they might already be able to do so that it's smoother.

Bill White: When you look back over your career in the addictions field, what has been most meaningful and fulfilling to you?

Dr. Zweben: Working with the wonderful people in the field. Many have the rebel spirit and their work is a mission, not a job. I feel very blessed to do work I consider important with people I like very much. I have always thought mentoring was important, which is one reason I am continuously in teaching roles. I am a good talent scout and try to coach people along. I managed to be a catalyst (mother hen) to get several prominent people (who shall remain nameless, but they know who they are) to start writing or write more. Publishing has a way of attracting other adventures and I talk with trainees about its importance every year.

Future of Addiction Treatment

Bill White: What is your personal vision for the future of addiction treatment?

Dr. Zweben: My hope is for it to be integrated into primary care, criminal justice, and social services. That would mean that professionals working in those areas would be cross-trained and at least be able to recognize risky use and addiction, intervene

in mild to moderate cases and make an appropriate referral to a specialty program in a relatively seamless system of care. We are a long way from that. I am currently concerned about the merging of organizational entities such that addiction is once again neglected. We have already seen this in the merger of mental health and substance abuse in many communities. A great deal of the technical expertise is lost. These mergers can work if addiction retains autonomy and leadership capacity, but otherwise priorities are determined by those who know little about it and don't recognize the many ways it undermines the success of all other efforts.

Bill White: What advice would you have for someone who is considering a career working in the addiction treatment field?

Dr. Zweben: I cannot imagine a more interesting career that involves such a wide range of possible activities. Whether you are a clinician, researcher, or administrator, the challenges and rewards are great. You have to like challenge and adventure, and be able to accept some failures. Every apparent obstacle has contained an opportunity for me, if I had the frustration tolerance to get there.

Bill White: ***Dr. Zweben***, thank you for taking this time to discuss your life and work.

Dr. Zweben: This has been quite a trip through Memory Lane. It has been thought provoking to look back on all this, and put some of the pieces together. Thank you, Bill, for all that you do for our field.

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