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Recovery-oriented Addiction Psychiatry: An Interview with Dr. George Kolodner

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

Introduction

Dr. George Kolodner is an addiction psychiatrist who has specialized in the outpatient treatment of substance use disorders for more than four decades. He is cofounder and Medical Director of the Kolmac Clinic, an institution that pioneered intensive outpatient addiction treatment in the United States. He is also a clinical professor of psychiatry at both the Georgetown University and University of Maryland Schools of Medicine. Dr. Kolodner also has provided distinctive leadership in the integration of medications and psychosocial support in the treatment of addiction. I recently (November 2014) had the opportunity to interview Dr. Kolodner about his life's work in addiction psychiatry.

Early Training and Addiction Specialization

Bill White: Dr. Kolodner, what circumstances led to your specialization in addiction medicine and addiction psychiatry?

Dr. George Kolodner: I feel like I came in it through the back door. I went into psychiatry with no intention of being involved in addictions, but a couple of experiences pushed me in that direction. When I went into the Navy during the Vietnam era, I was stationed at Bethesda Naval Hospital. The Navy was then in the forefront of dealing with alcoholism in a particularly enlightened way; instead of firing their sailors, they focused on treating them for their alcoholism and returning them to duty. They established a traditional Twelve-Step, abstinence-based alcohol rehab program at Bethesda Naval and in several other naval hospitals. A friend of mine was made the head of the unit, and through him, I saw something I'd never seen in my training. I saw alcoholics recover. A counselor who was really running the unit at Bethesda became a mentor of mine and

explained to me effective ways of working with this population. Some AA members heard that I was interested in alcoholism and paid me a visit. I began to attend AA meetings in the community and saw even more people in recovery. So, that was the professional experience that got me interested. Plus, when I was in the service from '71 to '73, Dr. Morris Chafetz was the head of NIAAA. He was very articulately expressing this notion that addiction or alcoholism was a disease. I thought that that was highly unlikely, but I noticed that people who adopted that attitude had a greater success rate working with alcoholics and so I thought that was something that I could at least try on for size for its practical benefit. Chafetz was the first physician I encountered speaking positively about recovery from alcoholism.

I also had an influential personal experience. I had a friend whose wife was an alcoholic, which at the time I did not know. What I knew was that she was having all kinds of problems and was getting good psychotherapy but wasn't getting better until she began to actually recover from her alcoholism. She revealed to me all the drinking that had been going on—drinking that had been a central part of her problems and that had gone on right under my nose. That taught me that this condition was much less visible than I thought it was. It changed my basic notion that the condition was something that was easy to recognize but very hard to treat into something that was, in fact, difficult to recognize but far easier to treat than I had thought. That really is what got me started. I had a change in attitude.

***Bill White*:** You referenced the pessimism that you'd encountered towards recovery of addiction in your training. Was that pessimism pretty widespread within the medical community at that time?

***Dr. George Kolodner*:** It was so widespread that I had never met a physician who was positive about the treatment of addiction. All I saw or heard in my training was negativity. One of my most respected supervisors said, "Psychotherapy is to addictions as penicillin is to cancer." He was a very psychodynamic, psychoanalytically trained guy, and his comment reflected the view of that period. I have a lot of respect for psychoanalysis, but it has not been that helpful as a primary tool for treating addictions.

Founding of Kolmac Clinic

***Bill White*:** Was your involvement to create the Kolmac Clinic following your service in the military the beginnings of your work in addiction psychiatry?

***Dr. George Kolodner*:** It was. In working with severely ill hospitalized psychiatric patients, I initially focused on treating them with individual therapy and medications. In the process, I noticed that the hospital environment or "treatment milieu" could also have a significant impact on whether or not they got better. A significant body of professional literature had developed on what was called "milieu therapy." In the Navy's alcoholism rehabilitation program, medications and individual therapy played relatively minor roles. The group therapy and treatment milieu appeared to be the primary therapeutic intervention responsible for the positive changes that I witnessed. When I began to attend AA meetings, I thought that the meetings themselves and the social interaction surrounding them created the same type of therapeutic holding environment.

When I left the Navy in 1973, the alcoholism treatment was being delivered in two settings, which were at opposite poles of intensity and structure. At one end were residential programs such as Hazelden and Caron. For folks that could afford it and who could take time off, that was a great alternative. The other extreme was traditional outpatient counseling in public or private sector settings that was very accessible but not very effective. Your average working person who had a job, a family, and private insurance was really

stuck in the middle, being accustomed to private, insurance subsidized treatment but unable to access the more effective residential alternative.

I joined a partnership of psychiatrists who had established a "psychiatric partial hospital" or "day hospital" as an ambulatory alternative to traditional residential psychiatric treatment for severe disorders. It seemed to me that such a treatment setting—structured and intensive enough to create a therapeutic milieu—could meet the needs of what appeared to be an under treated employed population. I assumed that this had been done before so I went to NIAAA and said, "Please tell us who's done this so we can go learn from them and put a program in place here." What they said was that, as far as they knew, it hadn't been done. I found out later that, in fact, it had been done. Dr. Vernelle Fox had established a program for alcoholics at the Georgian Clinic in Atlanta back in the 1960s, in a day hospital setting for public sector patients. I subsequently met her at some professional meetings and confirmed that she was, as far as I could tell, the originator of a model in which patients would stay in treatment for 6 to 8 hours a day. Although she had found this approach to be effective, she had not written extensively about her work.

We decided to focus on treating the blue and white-collar population that was employed by the federal government and its contractors. We designed the treatment program to make it more accessible to them in three ways. They couldn't take off in the day to participate in treatment, so we scheduled treatment meetings in the evening after work hours, creating an "evening hospital." Number two, we made sure that it would be covered by their health insurance plans. Alcoholism treatment programs were excluded by their insurance companies, but our facility was certified as a psychiatric program and the diagnosis of alcoholism was not excluded. The third thing we did was locate the facility at an accessible place—near the beltway and one of the first suburban metro stations outside of DC in Silver Spring, Maryland.

The evening treatment sessions lasted for 3 hours—half the length of the usual day sessions—and could be squeezed between the end of the work day and the beginning of an AA meeting. It turned out that this also disrupted people's routine drinking time. When we started, we were afraid that this was going to be too much for people to work all day, get 3 hours of treatment, and then home to their families. It was certainly demanding but not as overwhelming as we feared. The second issue was the pervasive belief in the field that, if you were really serious about getting sober, that you had to leave your environment and spend all your energy focusing on recovery. That was a belief we had to test once we began.

We got it off the ground with the help of Jim McMahon, who had just retired as Deputy Director of the Navy's alcoholism program. He was working in a federally funded traditional outpatient program and was discouraged by how less effective it was compared to the Navy's residential program. When I told him my idea of this hybrid that would combine the advantages of both inpatient and outpatient, he handed me the first copy of his resume that he had ever given out and came to work for me. The two of us in the Fall of '73 convinced the partners of my psychiatry practice, of which I was not yet a partner, to hire Jim to help me launch this program. The day hospital facility was not used in the evening, so we segregated ourselves from the rest of the staff, who harbored familiarly common negative ideas and feelings about alcoholic patients. Our notion was that we would eventually expand to a full day hospital status by moving from this three-hour format to a six-hour format. There was no name for this three-hour entity—IOP didn't exist at that point—so we billed it as a "half-day hospital visit." We were able to manage it with the insurance

companies because they saw it as a potential means of cutting costs for treatment.

Kolmac Treatment Philosophy

***Bill White*:** How did your view of this model then evolve?

***Dr. George Kolodner*:** We were fortunate that one of the partners had some money for research. This was unusual since we were in a non-academic setting. This allowed us to study the patients that we were working with. When we looked at the data, we were surprised that our patients were doing so well. At first, we thought we were getting a skewed sample of healthier alcoholics. But our data showed us that our patients matched up in severity at the levels similar to those being treated residentially. That was very encouraging to us. Another early milestone was our discovery—confirmed in the field many times since—that patients whose spouses participated in the program did better than patients whose spouses did not participate. Such discoveries allowed us to evolve and mature as a program.

In 1976, we began presenting our findings at professional meetings, but most people thought of IOP as a poor substitute for residential rehab—some still do. We began to discover that there were actually some advantages to getting treatment when patients were still working and living at home, as opposed to being in a more protected environment. They could try out new strategies, learn to deal with triggers and cravings, and have their treatment staff on hand for feedback and support. They could also explore their home community for AA meetings that they found compatible. Another advantage that we found was that our new model could provide more continuity than with traditional treatment, which tended to be fragmented. Historically, patients would be detoxified in one facility and transferred to another one for rehabilitation, which, because it was often geographically remote, made face to face follow up treatment difficult. Addicted patients already have a tendency to terminate treatment prematurely, and this separation of treatment settings seemed to make this problem worse. We were able to do a better job of convincing people to stay in treatment longer by overlapping their participation in all the treatment phases. They would begin working with the rehabilitation staff at the same time that they were being detoxified, and later we would have them stay in the rehab groups until they had attended a few continuing care groups and made a connection with the new group.

***Bill White*:** How did your philosophy further evolve over the years as your population changed?

***Dr. George Kolodner*:** The first group of patients who we found challenging were referred to as being “dual diagnosis.” I was well-trained in psychiatry but had had nothing but negative lessons in addiction. Jim McMahon brought personal recovery and a lot of experience with alcohol treatment programs, but knew nothing about psychiatry. So our notion was that we would bring together our varied areas of expertise. He would teach me about addictions, and I would teach him about psychiatry. So we did every intake together and the two of us ran every group together. In the process, we learned from each other. I began to feel more comfortable working with alcoholics, and Jim became more comfortable working with psychiatric issues. There was a polarized debate raging at that point about the psychiatric issues with alcoholics. Most of my psychiatric colleagues, who couldn’t understand why I would want to work with this population, stated confidently that they had never met an alcoholic who didn’t have a major psychiatric disorder. On the other hand, people from the recovery community were saying, “This is all stigmatization; the incidence of true psychiatric disorders among alcoholics if you exclude

psychopathy is no higher than in the general population—around nine percent."

What we found was that the truth was somewhere in the middle. Most of our patients did not have another psychiatric disorder, but we had more than the nine percent people were touting. We very quickly encountered people who had had excellent alcohol treatment, who had complete acceptance that they were alcoholic and who were actively involved in a Twelve-Step program, but who couldn't stay sober because of another undiagnosed primary psychiatric disorder. One of the first groups we recognized were people with what was then called "manic depression." I had been exposed to the use of lithium during my residency and started finding these alcoholics with previously undiagnosed bi-polar disorder. When I added lithium to their regimen, I began feeling like some kind of magician with their dramatically improved response to treatment. We also identified women with trauma histories, particularly survivors of sexual abuse. The high incidence of this history in women with substance use disorders was not yet widely known. Only after the secrecy was broken about these past experiences were we able to understand some of their alcohol relapses. Our philosophy was to identify those people who had psychiatric disorders and to treat those problems, not sequentially, but simultaneously with their addictive disorders.

Treating Cocaine and Opioid Addiction

***Bill White*:** Dr. Kolodner, at what point in time did you begin to integrate people with drug choices other than alcohol?

***Dr. George Kolodner*:** That was forced on us in the '80s when cocaine became an issue and people regularly presented with a combination of cocaine and alcohol or just cocaine alone. That was when the historical division between those treating opioid addiction and those treating alcoholism began to break down. We began sharing knowledge across these past boundaries, and people like Alan Marlatt introduced us to CBT and relapse prevention approaches that could be used with diverse populations. When naltrexone became available in 1984, I started working with opioid patients. I'd become convinced that we really needed to use pharmacological adjuncts to achieve what the residential programs were achieving through geographic separation. We had already been using Antabuse with all of our alcoholic patients. Even though the literature said that Antabuse had limited effectiveness, we found that it worked very well if we actually observed the patient taking it. We did the same type of observed self-administration with naltrexone for our opioid patients. Although they usually remained abstinent, our overall success with that group was poor, compared to our alcoholic patients, until buprenorphine became available 20 years later.

***Bill White*:** And at present, is there a broad representation in terms of drug choice across alcohol, cocaine, opiates, and other substances?

***Dr. George Kolodner*:** Yes, but alcohol remains the primary substance for about 40% of our patients, and the rest are either a mixture of alcohol and other substances or just purely other substances. In the '80s and '90s, our biggest second sub-group was cocaine. They got up to 45% of our people in 1988. Now, they're down to about 9% and the opioids, which back then were 4% percent, are up to one-third of our patients. Marijuana has been staying at around 20% and benzodiazepines at 10%.

Program Structure and Staffing

***Bill White*:** How would you describe the program components or phases of treatment at Kolmac?

***Dr. George Kolodner*:** The three-hour evening session became what we know

today as Intensive Outpatient Treatment (IOP), but I found that a subgroup of alcoholics and most of our opioid patients required withdrawal management before we could adequately treat them. My original notion was that we were going to have to hospitalize them. In ’73, there were all kinds of detox units around, and I actually became the head of one of the only detox units treating alcoholics in Montgomery County. But two things surprised me. First, if I put patients in the hospital, by the end of their treatment, their symptoms were so low that it was hard to convince them that they needed anything by way of follow-up. Second, I began to cautiously expand the number of people who I attempted to withdraw on an outpatient basis and found this to be quite effective. I had the advantage of the day hospital in that I could keep them there all day and repeatedly observe them in contrast to an inpatient unit where they would be seen by a doctor once a day and seen by the nurses once every few hours. In our day hospital setting, they were being seen every thirty to sixty minutes by me or by my nurse. We discovered we could do a much better job of withdrawing most patients in our office than in the hospital. At first, we put them in a separate detox setting and then after their symptoms were down, we would recommend transfer to our rehab setting, but we found that placing them in a rehab group at the same time we were doing the detox created much higher rates of follow through with continued treatment.

Bill White**:** And is there a phase then that follows the IOP?

Dr. George Kolodner**:** Absolutely. And that’s something we stumbled on as well. When we started, there was no follow-up treatment being routinely provided for patients completing residential rehabilitation programs. The expectation was that this would be accomplished by participating in AA in their home environment. We began to have people come for a twice-a-week group for six months. That was our original model. In one of the sessions, we would see the patients, and in the other session, we would see the patient and his or her spouse. We experimented over the years and one of the things we found was that patients who came twice a week were more likely to think that they didn’t need to go to AA because they were getting everything they needed in our treatment program. So, we cut the sessions down to once a week, partly to try to push the patients out into the community for recovery support. We also found out that six months was really not long enough and that people who stayed longer had better long-term recovery outcomes. So, we extended it to a year and then later we extended it to a year-and-a-half. Now, my preference would be that people would stay for two years, but we found that if we told people that up front, they would get so overwhelmed that they wouldn’t even get started. We don’t lie to them, but we also don’t overwhelm them. Our average is about six months of follow-up participation, with ranges from a few sessions to up to two to three years.

Bill White**:** Has your staffing evolved over these years?

Dr. George Kolodner**:** It has. Since I was not in recovery, I felt heavily dependent on having the other staff members in recovery. At 32, I was also younger than most of my patients and had a credibility problem—they were doubtful that they could be helped by someone who was young and had not had a personal experience with alcoholism. So in the beginning, almost all the counselors I hired were in recovery. The field was not professionalized at that point. There was no counselor licensure or certification yet. I tried to select those people who would be most open to incorporating a psychiatric view. Many of the counselors of that era who were in recovery felt like there was only one way to recovery, which was how they had done it. Whatever symptom the person had, whether it was depression, anxiety,

whatever, was framed as "your disease talking to you." And sometimes, it was. Sometimes, it was something else. So I tried to get people who were somewhat more broadly based, and then I began hiring people with professional training who were not in recovery but who were open to the notion that addicts could recover with the proper support.

Influence of Funding Environment

Bill White**:** How did evolving changes in the funding environment affect treatment at Kolmac?

Dr. George Kolodner**:** When we got started, we thought about seeking public funds, but then I talked to LeClair Bissell, who at that time, was running the alcoholism program at Roosevelt Hospital. She said to me, "As soon as you take any money from the feds, you lose your integrity." She was a very plainspoken woman who would sometimes talk in very black and white terms, but her words worried me. At the same time, the group that I was working with had a very positive relationship with the insurance companies, so we tied our wagon to the star of private insurance knowing we would live or die with it. We've never taken any funds other than fees for services paid primarily through private insurance companies.

One of the first things we had to struggle with was whether to design a program that was going to be affordable out of pocket for our targeted population or design a program that was the most effective. We opted for the latter. When we started, the cost of our IOP was nine hundred dollars—thirty dollars a session for thirty sessions. We've experimented with different lengths of treatment, but our benchmark now is between twenty and thirty sessions, which takes about two months to complete. That costs about five thousand dollars for the few patients who pay entirely out of pocket, but 95% of them use their insurance and pay about one to two thousand dollars.

When we started with the insurance companies, they were beginning to get interested in how they could reduce their hospitalization costs so the outpatient detox IOP model was very appealing to them. We collaborated with Aetna insurance on a study that demonstrated how much money they saved without sacrificing clinical quality. The crazy thing was that after the study was published, Aetna actually stopped covering our level of treatment. For a while, many insurance companies continued to reimburse better for inpatient treatment than for IOP. This changed after investor owned chains of treatment programs succeeded in dramatically increasing admissions into residential programs. The insurance companies responded with managed care organizations (MCOs), which were more willing to pay for IOP. Eventually, the MCOs began to cut back on what they would cover for IOP as well. They pressured us to reduce the frequency of IOP sessions to 3 times a week and shorten the length of treatment to 4 weeks. I thought that it would have been a mistake to let them determine what they thought was adequate treatment, so we stayed with a model that we thought would work, even if this meant that we didn't get paid, because often the patients could not make up the difference. If an MCO became too unreasonable, we stopped working with them entirely. This worked out well for us in the long run because many of the treatment programs that went along with what the MCO wanted had poorer treatment results and had to close. As a survivor, we had better leverage to negotiate with the MCOs, some of which had figured out that it was actually in their interest to encourage addicts to stay in treatment longer. For example, we had one company that was covering detox and IOP, but they wouldn't cover continuing care. They said that was what AA was for. We said, "AA is great, but AA is not treatment." I had this horror that I was

participating in a system where we would partially treat people and then implicitly endorse that they had received sufficient care when this was not the case, so we stopped admitting any of their patients. Six months later, that insurance company came back to us and approved coverage for continuing care after IOP. There's another thing I did with Dr. Sheila Blume that I felt particularly good about. Shelia was involved in both ASAM and APA, and she and I wrote a small piece saying that we valued AA but that AA wasn't a substitute for professional treatment. We argued that for a company to say that AA could substitute for treatment was objectionable and unacceptable. Shelia was able to get ASAM and APA to both sign on to the same document, which was quite a rare event. This position was then adopted by the AMA, which created enough pressure for the insurance companies to back down.

Recovery-oriented Addiction Psychiatry

Bill White: You and your clinic have become well known for a very recovery-oriented approach to addiction psychiatry, and I'd like to explore some aspects of that with you. Could you describe how Kolmac has integrated medication with psychosocial methods of treatment—approaches that have traditionally been viewed as incompatible?

Dr. George Kolodner: We've integrated medications on several different levels. First is the use of medication for withdrawal management. That's not very controversial. The second is using blocking agents, or what might be thought of as prevention agents, like Antabuse. That's not controversial at a professional level, but we heard some argument in the traditional Twelve-Step community against this and in the 1970s and '80s, some programs like Caron actually stopped referring to us for a while because we prescribed Antabuse for most of our patients. More controversial was using non-benzodiazepine psychotropic medications for other diagnoses. At times, that's been controversial but less so in recent years. For a while, there was resistance against lithium and anti-depressants and more recent opposition when we started treating people with ADD with stimulants. But I've always been impressed that the recovery community, when they see that these medications facilitate recovery rather than block it, has eventually become accepting of the positive role medication can play in recovery.

Most controversial at present is buprenorphine. Yesterday, I had a patient who is early in recovery and who had her first sponsor in NA say, "Well, you go to Kolmac, they make you take Suboxone there. You're not really clean. I'll be glad to be your sponsor but you can't celebrate your anniversaries until you are off the Suboxone." I think such communications can kill people. I've had patients under the influence of their sponsors prematurely go off medication, relapse, and die. There is tension between ideologically driven opposition to medication and evidence-driven support for its use with certain patients. This can be a life and death matter—not just an academic argument, and I get very angry when people press my patients to do things that aren't good for them.

Medication-assisted Treatment

Bill White: How would you summarize the evidence on the role of buprenorphine in recovery initiation and recovery maintenance?

Dr. George Kolodner: It's not controversial to use it for withdrawal. It is such a better agent than all its predecessors, and I say that having had to use all its predecessors for many years. Even the folks who were most opposed to buprenorphine now use it to manage withdrawal. My support of the new medications has come from the scientific studies and my own clinical experience since it became available in 2003. Before such medication, our long-term success with people addicted to opioids was

very poor, with rates of recovery far below what we saw among those treated for alcoholism. When buprenorphine came in, I started using it at first just as a withdrawal agent, but our results remained so poor when the medication stopped that I began keeping people on buprenorphine while they were in the IOP, which I continue to regard as an "abstinence-based" program. I had a lot of resistance from my own staff in recovery until they watched people become so much more available to do the work of recovery in the therapy groups when they were medicated, and they watched our completion rates and continuing care participation rates go up. But the question remains, "How long should people stay on buprenorphine?" Nationally and internationally, most leading experts are saying that medication should be continued for at least a year, with many saying the longer the better in terms of recovery stability.

***Bill White*:** One of the controversies right now is about expanding office-based buprenorphine treatment above the current limit of one hundred patients. Do you have thoughts about that current proposal?

***Dr. George Kolodner*:** I do. I was very involved in expanding the limit from thirty patients to one hundred. I lobbied all my professional organizations to help make that happen and to make treatment more accessible. And for quite a while, I was in favor of expanding it above the limit of one hundred patients. In the last year, I've changed my mind about that. There's no question that there are locations where access to treatment is a real problem that needs to be addressed, but what's scaring me at this point is the rapid commercialization of opioid addiction treatment. I've watched the gravitation of investing private equity funds into the addiction world. I've become worried as they've bought up and consolidated treatment programs across the country—particularly methadone programs. My concern when it comes to buprenorphine is that if the patient limit is substantially raised, we will see investment groups with what I would call industrial level expansion. I think that such commercialization could lead to stripped down medication dispensing facilities. I think we've seen that with some methadone maintenance programs, and we could see the same with buprenorphine where profits are maximized by stripping down services other than medication that support the recovery process.

***Bill White*:** There's been such a massive investment in neurobiological research in recent decades. Do you see major breakthroughs in medication-assisted treatment in the coming decades?

***Dr. George Kolodner*:** I would certainly hope so. So much of the neurobiology is fascinating, but we have yet to reap much practical application. One of the benefits I have seen are parents who become more understanding and accepting of their child's struggles with opioid addiction when they see pictures of the brain changes that result from chronic opioid addiction and begin to understand the role that biology plays. But ultimately, you want to see medications improve and elevate recovery rates. Every field of medicine has medications that facilitate recovery, and we just don't have the range of such medications that are available for other conditions. Hopefully, we'll come up with far more effective medications in the near future.

Recovery Support Services

***Bill White*:** There's a real interest now in expanding peer-based recovery support services, particularly in medication-assisted treatment settings. Do you see this as a positive development?

***Dr. George Kolodner*:** I do. There's this funny reverse of the pendulum underway. The early field of addiction treatment was not

professionalized, and people in recovery filled the workforce and used their own recovery as their primary asset in working with patients. But as the field got more professionalized, many of our most experienced counselors were pushed out of the field. I recall the State of Maryland saying to us that they were no longer going to certify us as a treatment program if we kept on those staff clinicians without the required educational credentials, even though they were very effective counselors. One counselor we were allowed to rehire as a "patient advocate." He could no longer call himself a counselor, but he comes and meets with the new patients, talks to them about transitioning to the recovery community, and is a great source of support to our patients. Peers in recovery bring a wonderful level of experiential wisdom and have credibility with our patients. They have so much to offer the treatment milieu if they are people who don't have that rigid notion that "it's my way or the highway."

Bill White**:** In a related area, you and I have talked at some length about the challenges patients can face who are in medication-assisted treatment as they go to various recovery mutual aid groups. Are you seeing any changes in attitudes towards medication among those groups in your area?

Dr. George Kolodner**:** Slowly, but it also depends on the area. There are remarkable regional differences. We have offices in Washington DC and in Baltimore, and in Baltimore, there is a more orthodox recovery community with greater opposition to medications, though there's some of that opposition also in DC. I think I'm seeing a little bit of change in attitudes in both areas but nowhere near what I would hope for. I have a very optimistic view of the recovery community. As I said before, once they see the results, they come to understand that in some people a new medication is, in fact, enhancing rather than inhibiting recovery. That's when they stop objecting to it. Such shifts are just beginning to happen with buprenorphine.

Nicotine Addiction

Bill White**:** A related issue that I know is of concern to you is nicotine addiction among our patients and the attitudes towards nicotine addiction among the recovery support groups.

Dr. George Kolodner**:** Yes. There is this paradoxical piece of resistance in the recovery community to medications while continuing to use tobacco and extolling the myth that quitting smoking will endanger your recovery from other drugs. There's little data to support that and in fact, quite the opposite findings from the research, but it's still asserted as a confident belief. I tried telling my patients, "You know, it's the alcohol and other drugs that brought you here, but it's the tobacco that's going to kill you." That turned out to be counter-productive. These folks are already scared enough. If you scare them more, they just shut you down. My approach now is to just say, "You know, despite what you might have heard, this is really the best time of all to do it because you will never have more treatment support than you do right now. And by the way, I can help you because there are all kinds of things that make this easier if you are willing to try. No one thinks that it is reasonable to stop alcohol or opioids 'cold turkey' and the same goes for tobacco." My dismay is that tobacco addiction is, in every respect, as complicated and severe an addiction as alcohol and heroin are. But the insurance companies won't pay for treatment for tobacco addiction. They've at least gotten to the point that will allow you to use medication. But you can't effectively treat tobacco addiction with the kind of brief programs that the American Lung Association and the Cancer Society provide. They certainly fill a need, but you come out with a very pessimistic view of people's prognosis if all they've ever had is under-

treatment. I would love to have an IOP program focused just on treatment of tobacco addiction. But the closest we can do to that is while people are in IOP for their other addictions, to try and get them to look at tobacco as well.

Addiction Treatment and Primary Health Care

***Bill White*:** There's a trend within current healthcare reforms to mainstream some aspects of addiction treatment into primary medicine and primary psychiatry. Do you see a day in the near future where that may be a reality?

***Dr. George Kolodner*:** I wish I could say yes, but I think that the negativity toward addiction within the medical community is so deep rooted and widespread that physicians who embrace this effort will be the exception. That will not change until you alter the pessimism about addiction that pervades the early training of physicians and increase their exposure to addicts in recovery. Most physicians do not have the experience that I had of being thrown into contact with a treatment program in which you actually witnessed people getting well and staying well. I think the closest positive influence right now is, at least in the state of Maryland, changing financial incentives for hospitals. Hospitals are going to be penalized for readmissions within thirty days and of course, addicts make up a large number of those folks. If we can get in to the hospitals and see these people before they're discharged, we have a better chance of helping these patients and helping the hospitals. What's astonishing to me is that if you get to the highest levels of the non-medical administrators of these hospitals, they are actually startled to hear that there are addicts in their facility who make up such a high portion of the rapid readmissions. When you change the financial incentives, they begin to notice. Then you're speaking their language.

Career-to-Date Retrospective

***Bill White*:** You've been laboring in the treatment of addictions for a very long time now. When you look back over your years of practice, what do you personally feel best about?

***Dr. George Kolodner*:** I feel best about being willing to stand up for what I think is best for my patients, even when that has been unpopular. For many years, I was dismissed for thinking that people could get better on an outpatient basis, and that was a battle I had to fight. Right now, I take a lot of heat for insisting that buprenorphine is a medication that most opioid addicted patients should stay on beyond detoxification. In some parts of the recovery and traditional treatment community, the word is out, "Don't go to Kolmac because they make everybody take buprenorphine." That's a distortion and an over-statement, but it represents the product of my advocacy. There was a time when the managed care crunch-down came when we were doing what we thought was the best treatment that we could do. The managed care companies said, "Well, we know you think this is going to take twenty to thirty sessions, but we're only going to give you eighteen sessions." We actually had somebody come in who was talking about the $180 cost for withdrawal management who actually asked us, "Well, what can I get for a hundred dollars?" What we said to people was, "We're going to stick with what we think works and if that means that you're not going to do business with us, or if that means we're going to give treatment away, that's what we're going to stay with because we think we know more about how to treat people than you do." I think that's allowed us to survive, and I feel good we maintained our integrity through those adverse pressures.

***Bill White*:** The final question I would like to ask is this: is there any guidance you would offer a young physician or psychiatrist who

was exploring specializing in addiction medicine or addiction psychiatry?

***Dr. George Kolodner*:** What has worked for me is giving folks the benefit of the doubt, both patients and organizations, but to not carry it to the level of being naïve. I try to stay open in the face of bad experience. I try to learn from mistakes or so-called treatment failures. People are inclined to get defensive about that but even though working with people who recover is the most gratifying, in some ways, working with people who don't recover is sometimes the most informative. Both can be excellent teachers.

***Bill White*:** Dr. Kolodner, thank you for taking this time to share your life's work and thank you for all you have done and continue to do for people seeking and in recovery.

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