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A Half Century of Elevating the Quality of Addiction Treatment and Recovery Support: An Interview with Dr. David Powell

William L. White

Introduction

Many people have helped shape the modern clinical world of addiction treatment, but perhaps none with a more prolonged commitment to this endeavor or a greater influence than Dr. David Powell. Through his writings, teaching, and consulting, Dr. Powell has waged an unrelenting campaign to elevate the quality of addiction treatment in the U.S. and to carry recovery to the far corners of the earth. I had the opportunity in September 2013 to interview Dr. Powell about his life's work. Please join us in this engaging conversation with a man whose contributions I have long admired and whose friendship I have cherished.

Career Retrospective

Bill White: David, let me start by asking how your own personal or professional experiences brought you into the addictions field.

Dr. David Powell: I was born into a tee-totaling family where my mother signed a pledge against drinking during the prohibition era. I had my first drink of alcohol when I was 19 (I was the White Rabbit at the New York World's Fair in 1964) and I started shortly thereafter to work in the addiction field in 1965 at the ripe age of 20 years old. Five years into this work while I was working at a heroin treatment center, I was heavily using drugs but didn't see that as a problem because I wasn't doing heroin like my patients. I realized I had my own issues to deal with. I entered the field out of professional interest, but those interests became quite personal as I had to engineer my own recovery while working with others seeking this same goal.

Bill White: Could you recount the chronology of the many positions you have held over the course of your career?

Dr. David Powell: I started in the field in 1965 at Rockland State Hospital in New York, working for Dr Nathan Kline, just seven years after he invented Thorazine, the first medication for psychosis. It was great training as I spent one month on the geriatric, "criminally insane," and epilepsy wards. From there, I worked with Rev. Earl Jabey, who was an early writer on spirituality and addiction. From 1967-70, I worked at the addiction unit at NJ Neuro-Psychiatric Hospital, first on the heroin unit, then the alcoholism ward. At the latter, we were giving LSD to alcoholics, so they'd have a "trip" and gain insight into their substance use. Needless to say, the research didn't last long, though access to pure Sandoz LSD was great for me. From 1970-72, I worked at NJNPI and the Rutgers Alcohol Behavior Research Lab with Drs. Peter Nathan, Francis Cheek, and Humphrey Osmond (originator of term "psychedelic" when he

wrote to his friend Aldous Huxley, “to go to hell or soar angelic, just take a bit of psychedelic”). I recruited patients into Nathan’s lab using DSM II. In 1972, Riley Regan invited me to be one of the thunderin’ 100, from NJ. I was at Pinehurst when Will Foster et al. coined the words “employee assistance program.” In NJ, we set up the first statewide EAP.

In 1973, Dr. Bob Stuckey asked me to become director of the largest treatment program in NJ, responsible for a NIDA, NIAAA, and NIMH grant and 75 staff. In 1974, Riley invited me to join the Eastern Area Alcohol Education and Training Program as Associate Director, where we conducted an extensive study of training needs in the 16 eastern states. The top training need was clinical supervision (and continues to be today). We devised a system for supervision, called the Clinical Preceptorship Program, and offered it to the US Navy and US Marine Corps. Now, 37 years later, it is still in place, at 50 USN bases worldwide, the largest and longest running supervision system in mental health and substance abuse.

I left ETP in 1999 after 25 years there and set out to save the world. Prior, I'd organized part of the Soviet-American Conference on Alcoholism in 1989-90. In 2000, I formed the International Center for Health Concerns with the dream of promoting exchanges on alcoholism between the militaries of the world. I met the surgeon generals of 16 nations and got several to agree to exchange information on addiction in the military, including Spain, Portugal, Italy, Poland, etc. While seeking to do so, I returned to China, where I started exchanges in 1979 with a group of 25 world leaders in addiction, including Mark Keller, Frank Seixas, Max Weisman, Earnie Noble, etc. My friend in China, Professor Shen at Beijing Medical University, the godmother of alcoholism in China, asked me to help her start AA there. And that begins the journey of the last 13 years.

Clinical Supervision

Bill White: David, when I mention your name to others who have worked in the addiction treatment field, many immediately think of the contributions you have made in the area of clinical supervision. How did your interest and passion for this issue develop?

Dr. David Powell: In 1975, I was working at the Eastern Area Alcohol Education and Training Program. We completed *Manpower Needs in the Alcohol Field*. The study showed that 57% of the alcoholism counselors did not have any supervision and about 25% didn’t know what clinical supervision was. This was a time where most counselors came into the field because of their own recovery with little academic training. We developed The Clinical Preceptorship Program, a model for training the next generation of supervisors. The idea was that you learn supervision by being supervised. We selected a core group of clinical supervisors who would become our first generation of trained supervisors. That work continued in the civilian world for a couple years and then got picked up by the military in 1976.

Bill White: Could you describe some of your other writing and training activities that elevated the importance of clinical supervision within the field during your career?

Dr. David Powell: I was training a great deal on clinical supervision, and in 1978, Marsha Lawton said, “This is good stuff. You ought to write a book.” In 1980, I published two books on clinical supervision. There’ve been many people that have done excellent work of training clinical supervisors, including [TAP 21A](#), published by the Center for Substance Abuse

Treatment (CSAT) on the core competencies of clinical supervisors. Later, CSAT published [TIP 52](#) on clinical supervision, for which I was blessed to be the chair and lead author.

Since then, I've trained thousands of clinical supervisors. The next step for me is to train supervisors' supervisors. Many more addiction counselors now have supervision, but it is important to differentiate case management and clinical supervision. Most of what I see happening is really more case management: reviewing what's going on for the client. If you're spending most time talking about the client, it's probably case management. A lot of what goes on in supervision is administrative. The cornerstone of good quality clinical supervision is direct observation. We have to watch our counselors work.

In terms of where we've gained and where we've lost compared to 1975 when that first study was done, a 2009 University of Georgia study by Lillian Eby revealed that there have been significant gains in the amount and the quality of supervision being provided, but we are still woefully behind the mental health field in direct observation of our clinical personnel. Most of what we do in supervision still is an "after the fact" review of what went on in counseling sessions, whereas the vast majority in the mental health field has moved beyond that and relies heavily upon direct observation. Now, cyber supervision is being used to watch counselors through the internet. My concern is that we in the addictions field are falling behind. If mental health and addiction services merge, as is happening in many states, addiction counselors will be ill-prepared for this more intensive style of supervision.

Bill White: What have been some of the obstacles that prevented the addictions field from developing more effective systems of clinical supervision?

Dr. David Powell: The number one obstacle is time. We spend a great deal of energy fire-fighting, putting out crises. If we were better able to manage our time, we would create the time for consistent supervision. Failing to do so inevitably shows up in staff burnout and turnover. Our statistics are not good in staff retention. I use the old oil commercial line, "Pay me now or pay me later but you're gonna' pay me." You can pay by providing quality training and supervision or you can pay for staff turnover. The key issue is counselor self-care. How do we take care of our counselors? Honestly, we don't even know how to spell the word "self-care."

Many of the obstacles are organizational and are driven by funding. The two things that inevitably get cut in difficult times are training and supervision, which is cutting off a resource that keeps people in the field. This is short-sighted crisis management, and we pay dearly for it.

Bill White: With the limited resources of time and money, are there things a treatment program can do to elevate the quality of supervision of their counselors?

Dr. David Powell: There are several steps that are important. First, you have to get senior management support to ensure that when funds are tight, they will still provide clinical supervision. You've got to go to the Program Director to sign off on this. Second, you develop policies and procedures that establish a structure for supervision to be followed. Third, we must train a core group of supervisors at an agency. This takes time and consistency, much like parenting does, to be able to say, "This is the way we do this here."

Ironically, the people most resistant to supervision are the people with the most experience because they're the ones that have the most to lose. You've got to win over a few people that would be willing to advocate for these intense forms of supervision. It doesn't cost

any money to do most of this. There are many opportunities for people to get trained in supervision through the ATTCs and various trade associations. There's no financial reason why supervisors cannot get good training in supervision.

Bill White: I've heard you say that as a field, we need to not only train supervisors but move beyond the training to create model systems of supervision. What do you mean when you talk about model systems of supervision?

Dr. David Powell: I've been involved in developing systems for many agencies, including CRC Health Group, Betty Ford Center, Phoenix House, Gateway, Caron Treatment Centers, etc. First, an agency needs to have a clear definition of supervision, such as is in TIP 52. Second, we need to define the key elements of supervision and the frequency of supervision. The basic rule for me is the twenty to one rule. For every twenty hours of client contact, a counselor should have one hour of clinical supervision. This includes a behavioral contract stating how often and when supervision will be provided, and what to expect from supervision. TIP 52 spells out clearly how to organize the work environment to ensure that counselors get the needed supervision.

International Work

Bill White: David, let me take you to another area that I think our readers will be very interested in. How did your work outside the United States begin and how has it evolved over the years?

Dr. David Powell: It's a long chronology. My first trip out of the US, other than Canada and Mexico, was to the Soviet Union in 1974. I boldly asked to meet the person who was the godfather of alcoholism treatment, Dr. Batayan in Moscow, and that started an ongoing conversation that I had with the Soviets for years. That work continued with the help of the Soviet American Alcoholism Conference in 1989 when one hundred delegates went to the Soviet Union. I had this crazy notion. I knew we had a substance abuse problem in the US military. I was sure the Soviets did too. Why can't we talk? Well, it wasn't that simple. It took two years to get the Joint Chiefs of Staff and the White House to approve a visit by a delegation of US Navy personnel. In 1991, six of us met with our Soviet counterparts. In 1992, a Russian delegation came to the US to visit treatment centers.

In the mid-70s, I got an inkling that I wanted to do something in China. It took three years (1976 to 1979), during which time no one was going to China. This is shortly after Nixon's Ping Pong diplomacy and the doors to China first opened. I kept writing to the Chinese asking them if we could address their alcohol problem, and they kept writing back saying, "We don't have a problem with alcohol." Finally, in 1979, I was able to get to Hong Kong and got a visa into China. I appealed to the Chinese government to allow us to bring alcoholism experts from different countries to address their issues. Three months later, I got 25 visas in the mail. In November 1979, the first group of addiction professionals went to China. This delegation included names that I revere to this day: Mark Keller, Frank Seixas and Ernie Noble. For a month, we looked at substance abuse in China. We concluded that, in fact, they were right; they had eliminated their drug problem, however they chose to do so.

That started an ongoing dialogue with China. Every year, from then on, I went back to China. The peak moment for me was in 2000 when Professor Shen of Beijing Medical University Hospital asked me, "I have doctors that want to learn about Alcoholics Anonymous

but I have no money. Can you help me?” With the assistance of AA GSO and San Francisco AA groups, we brought four doctors to the AA’s 65th Convention in Minneapolis. On July 25, 2000, the first official meeting of Alcoholics Anonymous in China, in Mandarin, occurred. Prior to that, there was a long history of AA meetings in English for ex-pats, but the Chinese generally didn’t attend those meetings. That was a critical marker in China. One of my happiest moments was at the 70th AA Convention in Toronto when the Chinese flag came down the aisle in the stadium, with 15 Chinese doctors, my wife, and myself applauding. I felt I died and went to heaven.

There’s been an ongoing interest for me to assist internationally. People ask me, “How do you get in to that?” My answer is, “Find a place that you get excited about. There is a burning need around the world and a growing interest in recovery.”

Bill White: If I’m remembering correctly, the work that you did in China spread to a number of other Asian countries.

Dr. David Powell: I continue to work in Vietnam, which has a significant drug and HIV problem. In 2008, they asked if I would help train their clinical supervisors. For six years, I’ve offered supervision of their supervisors. In 2000, I began training in Singapore where they developed the Asia Pacific Certification Board and are training throughout Malaysia, Indonesia, and other Southeast Asian countries. Southeast Asia is really coming alive with its interest in addiction treatment and recovery. In January 2013, a long-term dream of mine came true as I was able to lead a group of recovering American veterans from the Vietnam War, all of whom went on after their service to our country to work in the addictions field. We met with the Vietnamese military and visited methadone clinics throughout the country. Yes, dreams do come true!

Bill White: And you’ve been recently involved in Turkey.

Dr. David Powell: That grew out of a lunch meeting with a Turkish woman. Halfway through the middle of lunch, I realized Esra Cavusoglu was to try to get me involved in helping them develop an adolescent substance abuse treatment program in Turkey. That was 2008. For the last five years, we’ve developed a 60-bed adolescent treatment facility in Gaziantep, Turkey, near Syria with about 35 boys, mostly street children. They are with us for six months. We’ve developed the Turkey model and information on the program has been published in *Counselor Magazine*. As a result, we’ve recently been asked to expand it throughout Turkey.

Bill White: David, has the work you have done outside the United States offered any insights into the treatment system here in the U.S.?

Dr. David Powell: Great question. We tend to become myopic and view the world only through the lens of the US. One of the big mistakes we make when we go overseas is to think that the rest of the world wants to be like us. They want some of the things that we have, but it’s really important for us to see that there’s a much broader world. It’s remarkable to see other countries that are 20-50 years behind us in treatment system development. I’ve developed a profound appreciation for how far we have come here in the US. In countries such as Vietnam, the word “recovery” doesn’t really exist. There is no image in these countries that people can recover from addiction. When I talk about recovery, they are astonished that somebody wearing a suit can be

in recovery. It helps us to look outside of our small world to freshly see ourselves. We benefit from that experience and the countries we work in clearly benefit from what we have learned.

State of the Addiction Treatment Field in 2013

Bill White: David, we're facing many challenges from healthcare reform, including service integration initiatives, the movement toward recovery-oriented systems of care, and the rise of recovery support services. How do you see some of these challenges that the field is facing right now and where we need to go with them?

Dr. David Powell: We are at one of those significant points in our history—a seismic change. The recovery support movement is one of the most positive trends that is bringing us back to our roots. We are re-engaging the recovery community—something I think we lost over the years. We are realizing again that recovery happens in the community and not necessarily only in treatment centers.

The big train on our track is the Affordable Care Act. We continue to put our heads in the sand and pretend that it's not going to happen. But our healthcare system must be reformed, whether it's Obamacare or something else. Change will bring new definitions of recovery, of treatment, and new locations where treatment will be provided.

Service integration into the primary health system and the inclusion of a chronic disease model has been coming for years. These are all positive trends for us; however, the key will be how we react to them as a field. If we sit back and let the changes happen to us, we could be in dire straits, particularly if the trend is away from residential to partial hospitalization and intensive outpatient care. If we do not develop models in the next few years for partial hospitalization, we could see the same kinds of program closings we saw in the 1990s.

As we move to a chronic disease model, the public perception about addiction may change as people come to see addiction on par with asthma, diabetes, hypertension, and other chronic illnesses. The primary care physician (PCP) will become an increasingly important entry point for addiction treatment. It's incumbent upon us over the next five years to get to love our PCP and to educate them about addiction. A recent study shows that the average PCP's level of comfortableness with hypertension and diabetes is 85 percent. You ask them about depression, their comfortableness drops to 42 percent. For substance abuse, it drops into the teens. Most PCPs receive little training in how to treat addiction. We've got to work with the PCPs and the primary care system.

Bill White: Do you see this call for a shift from acute care models of treatment to models of sustained recovery management and recovery-oriented systems of care as a fundamental shift in the field or a flavor of the month?

Dr. David Powell: It's a shift that's been going on for years but we've not paid enough attention to it. In the long run, this shift in treatment is a positive trend. If we continue to view addiction as an episodic rather than a chronic issue, the best that we have to offer somebody is more residential care with the hopes that maybe this time they'll "get it." You'd never treat diabetes that way. What diabetes treatment program would talk about having a graduation ceremony? One never completes those programs. You're going to manage those conditions for life. We have to change our vocabulary and how we look at it.

Workforce Development

Bill White: Let me take you back to another issue related to the state of the field. How do you see the state of the addiction treatment workforce in 2013?

Dr. David Powell: It is the number one crisis that we're facing. We have an inadequately trained and an insufficient number of workers to meet the needs of the expanding number of people who could be seeking help as a result of ACA. Who will be the caregivers for the people who are going to have coverage for addiction treatment? We are already dealing with a workforce that is overtaxed and undercompensated. We are easily ten years behind in workforce development.

We need more academic training for people coming out of schools of social work, psychology, and counseling. We're training people to do things that they're not prepared for. They need more training in psychopharmacology, the neurobiology of addiction, and evidence-based practices. But we're still sending people to "flavor of the month" workshops. Our educational models have to be more web-based training. We need to find new ways of training people, and it's going to have to happen quickly. There's a train on our track, and it's heading right towards us.

Bill White: Another issue we have often discussed is the aging leadership of the field and the need for leadership development and succession planning. How do you see that particular crisis that we're facing?

Dr. David Powell: We've done a miserable job training the next generation of leaders. We should have seen this years ago and addressed it through leadership development and succession planning. The need for mentorship of tomorrow's leaders is one of the field's most important issues. Old-timers, like me, need to take folks under our wings and mentor them over the next five years. The key step is being able to be replaceable, to train somebody to do what you can do. Another concern is that we are losing our history. The people that got us to where we are, the shoulders on which we now stand, we not only don't know who they are, but we don't seem to care. That is unfortunate. A generation of leaders is ready to turn over the mantle of leadership. The question is who's going to accept that mantle.

Bill White: I'm very interested in how you've done that personally at Yale. How do you institutionalize your own legacy there?

Dr. David Powell: A few years ago, the Yale University School of Medicine saw the need for leadership development. Yale asked me to join with them to develop a program on supervision. (www.supervision.yale.edu.) The first step was to compile what we know about our workforce and put it in one site and make it available to everyone. We're designing workforce development programs in Connecticut, Alaska, Maryland, etc. The long-range vision is to establish an Endowed Chair on Workforce Development in the Addiction Field at Yale School of Medicine. To the best of my knowledge, that does not exist anywhere in academia in the US, someone whose focus is on training people to work in the addiction field, in medicine, nursing, psychology, counseling, social work, etc. If we can achieve that, it will be a major step forward.

Personal Retrospective

Bill White: As you look back on nearly a half century of work in this field, who are some of the people who most influenced you and most supported your own contributions to the field?

Dr. David Powell: We're back into my ancient history with names like Nathan Kline, who I mentioned earlier, at Rockland State Hospital. When I went to Rutgers in 1970, there were Seldon Bacon, Mark Keller, and Bob Stuckey. One of my mentors was Max Weisman, who taught at Rutgers for decades. Others included Frank Seixas from NCA and LeClair Bissell. I honor Riley Regan who had a profound influence on my life. Unfortunately, we lost Riley several months ago. These are the people that have shaped our field. It frightens me when I mention names like Marty Mann and Riley Regan and those in the field do not know who they are. These are the people that have gotten us here.

Bill White: Could I ask you to share a few of the lessons you've learned about how to conduct yourself in this most unusual of professions?

Dr. David Powell: Remember our history. Our history is really important. One of the wisdoms of my grandmother was, "This too will pass." We've been here before, so as we begin to encounter changes over the next years, we'll need to remind ourselves that people in the past got through similar issues to bring us to the present. Although these are difficult times financially, you have to step back and take a longer perspective. We go through cycles in our field and we are in a down cycle now. My friend Dr. Bill Mock reminds us we go through seven down years and seven good years. In the down years, we consolidate. We go back to what's important, which is what we're doing now. In the good years, we spend like drunken sailors.

The role of the recovering community is profoundly important and unique in our field. A milestone memory I have was attending NCA's Operation Understanding in 1976 when Buzz Aldrin, Dick Van Dyke, and 50 other celebrities went public with their recovery from alcoholism. That paved the way for Betty Ford and others to follow. Lastly, I would say, go global. In times of change, we must realize that it's a big world. What we are experiencing needs to be seen in a broader context. By going global, we help others and we gain ourselves.

Bill White: At the time that you and I entered the field, the majority of people working in the field were people in recovery, and then that percentage plummeted in the decades that followed. We're now bringing peers back in to the treatment system in recovery support roles and outreach roles. Do you have any fears that we could replicate the modern history of addiction counseling in this process?

Dr. David Powell: In the 1980s-90s, we credentialed out a number of recovering people in the field. At the Rutgers Summer School in 1970, about 75 percent of the attendees self-reported being in recovery. This year, about ten to fifteen percent so reported. We set the bar where the very thing that brought them into their field, their passion and enthusiasm for recovering people, was rendered secondary to academically oriented licensure. I'm fearful that we're making the same mistake again. We have to walk a fine line. When someone is employed as a recovery coach in an agency, we then have legal liability and ethical concerns. I don't want to minimize

these concerns; however, we have to find a way to do this so we can keep our recovery core and not duplicate our earlier mistakes.

Bill White: Do you have a bucket list of things you hope to yet achieve in the field?

Dr. David Powell: Top of that list is the endowment at the Yale School of Medicine. If we can have that, the work we've begun will continue in perpetuity. The model we developed in Turkey is a model to be replicated throughout the world. The third priority on my list is mentorship. I'd like in the few years that I have left professionally to mentor more people. An important goal for me is to go out gracefully. There is a time when, either for personal or professional reasons, I should step aside for the next generation to take over. I'm very close to that point.

Finally, I realize that none of this has ever been about me. I'm at the age now where people are saying nice things about my career, and I value that; however, Bob Stuckey once said to me, "No matter how famous you become, no matter how many letters are after your name, no matter how much money you earn, never lose sight of the fact that you're in the field to help the alcoholic and the drug abuser. The minute you lose sight of that, you ought to be selling hamburgers." That's the issue: it is not about any of us. It is to keep our eye on the prize, which is what drove most of us into this field in the first place. And the prize is the person who's in recovery and seeing them grow.

Bill White: David, that's a perfect place for us to stop. Thank you for taking this time to share your reflections on your life and work.

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Books by David J. Powell:

Clinical Supervision in Alcohol and Drug Abuse Counseling. New York: Jossey-Bass, 2004.

Game Plan: A Guide to Men's Emotional Fitness. Utah: Central Recovery Press, 2012.

Playing Life's Second Half: A Man's Guide for Turning Success into Significance. San Francisco: New Harbinger Press, 2003.