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Robert L. DuPont, M.D.

On Addiction, Treatment, Recovery, and a Life of Service

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This generation of leaders in addiction treatment is passing. Long-tenured pioneers in the field have retired or will soon retire. For those about to pass the torch of leadership, it is a time to reflect, teach, and mentor. For those into whose

hands this torch will be passed, it is a time for preparation. To acknowledge this generational transition, the author is conducting interviews with some of the modern champions of addiction treatment in the United States. This effort will honor these individuals and acknowledge that their work has made a great difference in the lives of individuals, families, and communities throughout the United States. This series will also give a new generation of addiction professionals and aspiring leaders an opportunity to learn from those who created the field that they now inherit.

The modern field of addiction treatment came alive as a national system of care in the early 1970s through a unique federal/state/local community partnership that continues to evolve today. The first interview in this series is with an individual who was at the center of this birthing and who has continued to serve in this field for four decades. He has been a valued colleague and friend to many. His insatiable passion for addiction recovery is greatly admired by this author. Wherever issues critical to the future of addiction treatment and recovery are discussed, you will hear his voice. Join me below in exploring the life, times, and ideas of Dr. Robert DuPont.

Entering the Field

Bill White: Describe how you chose to devote your life to the addictions field or perhaps how this most unusual profession chose you?

Dr. DuPont: When I left the Harvard Medical School and the National Institutes of Health on June 30, 1968, to take my first job as a

psychiatric physician, I wanted to use my education and whatever skill I could muster to help the men and women in prison. I had worked during my residency in the historic Norfolk Prison in Massachusetts, the prison in which Detroit Red served 6 years for burglary before coming out as Malcolm X. Hooked for life on prisoners and their stories, I was inspired by John F. Kennedy and Martin Luther King, Jr. to devote myself to the cause of prisoners. I wanted to help prisoners and their families, and I also wanted to help communities that were at that time suffering from a major crime epidemic.

I joined the District of Columbia Department of Corrections full-time on July 1, 1968. In less than a year, I became head of community corrections and parole for Washington DC. In August 1969, with a handful of college students on summer vacation, we tested the urines of every man entering DC Jail. We found that 44% were positive for heroin. Furthermore, we found that the year they first used heroin demonstrated the onset of the heroin epidemic that was fueling the crime wave that led to Washington being labeled "The Crime Capital of the Nation." These results were published in the prestigious *New England Journal of Medicine*.

In response to the findings of this study, I started a crash course to learn about addiction treatment under the guidance of Vincent Dole, Marie Nyswander, and Jerry Jaffe. On September 15, 1969, I started the first methadone treatment program in Washington with 25 prisoners on parole. On February 18, 1970, Mayor Walter E. Washington appointed me head of a new city-wide heroin addiction treatment program, the Narcotics Treatment Administration (NTA). Within 2 months, we had 2,000 addicts in treatment in 12 treatment centers.

On April 1, 1970, Chief Judge of the DC Superior Court, Harold Green,

announced the first universal drug testing program in the country. All criminal defendants were given drug tests by NTA, with this drug testing function later being absorbed by the court itself. This assertive approach of intervention became the model for the White House-sponsored TASC (then meaning Treatment Alternatives to Street Crime), the forerunner of most criminal justice programs linked to treatment, including drug courts. This criminal justice system initiative fulfilled my vision of helping criminals reclaim their lives and helping their communities heal from the ravages of the crimes they committed. Addiction treatment was the key to achieving these objectives.

These initiatives helped generate a 50% drop in FBI Index crimes in the nation's capital between 1970 and 1973, and brought 15,000 heroin addicts into treatment at NTA. We demonstrated that successful heroin addiction treatment helped addicts and, when delivered on a massive scale, also helped the entire community. These results were documented in more than 200 professional publications in those 3 years and sparked the biggest change in federal drug policy in the second half of the 20th century. That shift created a balanced approach of traditional law enforcement (the supply side) with a parallel and roughly equally-funded effort in treatment, prevention, and research (the demand side). At the age of 37, I became the White House Drug Czar and first head of the National Institute on Drug Abuse (NIDA). I was hooked for life on the prevention and treatment of addiction; I had found my life's work.

Bill White: What did you learn during this period from Dr. Vincent Dole and Dr. Marie Nyswander and from your own experience about the potential and limitations of medications in the treatment of drug addiction?

Dr. DuPont: Dole and Nyswander were two of the most impressive people I ever met. Dole was the biological scientist and the relentless entrepreneur. Nyswander, the soul of their operation, devoted her life as a psychiatrist to helping addicts. Together they moved mountains by the force of their science, their determination, and their engaging personalities. They were the “irresistible force” that made possible my work and the work of countless others. Even the drug-free community, often at odds from the outset with Dole and Nyswander, has enormously benefited from the major public and private investments in addiction treatment that flowed directly from the work of this dynamic physician duo. Dole and Nyswander played a central role in getting official Washington to support NTA. Later, I learned that Vincent Dole served several years as a non-alcoholic trustee of Alcoholics Anonymous.

Most of NTA’s patients used methadone as one part of their treatment, but NTA also had a large residential detoxification program that was not related to long-term methadone and a variety of outpatient drug-free programs including frequent visits to a counselor and a sophisticated therapeutic community. NTA contracted with many other treatment programs in the community, most of which were drug-free, to provide treatment reimbursed through contracts with NTA. NTA encouraged patients to choose the treatment they wanted and that best fit their needs.

Bill White: At a national policy level at this time, there seems to have been more of a focus on what methadone could subtract by way of crime at a community level than what methadone could add by way of personal recovery and quality of life for individuals and families. Is this an accurate perception on my part?

Dr. DuPont: I got into drug treatment in 1968 to fulfill my initial goal of helping criminals, so I considered reducing crime to be a major public health objective. It is also a major public safety objective. Think of it like reducing drunk driving. That too is a major public health and a major public safety objective. I have never understood the logic that says that reducing crime is not humane and generally valuable, most especially to criminals whose criminal lifestyles not only put the general public at grave risk but also put their own lives and futures at significant risk.

In the late 1960’s and early 1970’s, crime reduction was one of the three measurable goals of drug abuse treatment. The other two were reducing drug use and increasing employment. The original methadone program in New York was studied by Francis Gearing, MD, from the Columbia University Medical School. This independent evaluation was the evidence that methadone treatment worked. No other drug treatment program at the time (and very few since) has had that level of independent evaluation. Gearing’s findings were clear: achieving those three goals went together. When you reduced crime in a group of addicts, you reduced drug use and you increased employment. We never used the word “recovery” in those days, but achieving those three goals constituted a foundation of personal recovery.

Over the past few decades, crime reduction occasionally has been politicized as a “conservative” goal while “addiction treatment” has been defined in contrast as a “liberal” objective. As a lifelong Democrat who worked proudly in the White House of two Republican Presidents (Nixon and Ford), this way of thinking about drug policy made no sense. The conservatives I know support addiction treatment, and the liberals I know support crime reduction. How could it be otherwise? Anyone able to think clearly about addiction and crime must see that

crime and illegal drug use are closely connected and serious human problems that justify major efforts aimed at reducing both of them.

What is too often overlooked is that it took more than medication to achieve those successes at NTA. Medication worked best when it was part of a broader process of psychosocial rehabilitation led by the NTA counselors. That is still the case today.

Bill White: What did you learn in your early leadership of NTA about the role of counselors in the treatment of addiction?

Dr. DuPont: We had a lot of counselors, generally one for every 25 patients, including those in our methadone program. At the time, I thought the more counseling, the better. Only in later years did I ask the question about what the counselors were doing with those addict patients when they met with them. I know the NTA counselors took an interest in their patients and encouraged them to stop drug use, to be compliant with the NTA program, and to not commit crimes. Most NTA counselors were not former addicts and few of them had any formal education in psychotherapy – virtually none were social workers or psychologists. Today, addiction counseling has been professionalized with the introduction of cognitive-behavioral therapy and a variety of well-developed strategies to promote recovery. None of that existed in the early 1970's.

Bill White: One of the things about your leadership at NTA was the emphasis you placed on mobilizing the whole community within the treatment and recovery process.

Dr. DuPont: NTA could not have been more visible to the Washington DC community. We had an independent advisory committee appointed by the Mayor to oversee everything we did. NTA was in the news regularly. I testified before Congress dozens of times each year. NTA had so many

visitors from all over the country that we had to have a full time staff to handle the visits of as many as 20 or 30 people a day. One of our most distinguished visitors was the first term Governor of Georgia, Jimmy Carter, who was so impressed, he flew back to Georgia to set up a statewide program modeled on NTA.

All this attention was not favorable. NTA, and especially our use of methadone, was controversial from the start, leading the local CBS television station to conduct a 1 hour prime-time investigative report that was highly critical, focused especially on methadone. The firestorm was quickly extinguished when both Washington newspapers, the morning *Washington Post* and the *Evening Star*, editorialized in support of NTA and methadone as part of a comprehensive treatment program. It is critical that the larger community understands addiction recovery and that each community institution contributes in its own way to support long-term recovery.

The NIDA Years

Bill White: How did you come to serve as the first director of the National Institute on Drug Abuse?

Dr. DuPont: I was appointed to succeed Jerry Jaffe as Nixon's second White House Drug Czar as Director of the Special Action Office for Drug Abuse Prevention (SAODAP) on June 17, 1973, with the understanding that the office was set to terminate on June 30, 1975. Most of the demand-side activities of the federal government were to be carried on by the National Institute on Drug Abuse (NIDA), which was authorized by the same law that established SAODAP. I started NIDA as Director in September of 1973. Casper Weinberger, the Secretary of Health, Education, and Welfare (HEW), chose me to head NIDA. As if heading two major offices at the same time was not challenge enough, I was also temporarily assigned in 1975 to serve as the acting head of the Alcohol, Drug

Abuse and Mental Health Administration (ADAMHA), the agency to which NIDA then reported in the vast HEW bureaucracy.

I could say that I was chosen because I had done an outstanding job running NTA and played a leading role in drug policy at the time. A simpler answer is that I was chosen to lead NIDA because I was well-known to the White House and the Congress in 1973. I was under their noses in Washington and very visible. That made me easily accessible, familiar, and for many of the leaders in the White House and Congress, a “safe” choice to become NIDA’s first director.

Today, NIDA, part of NIH, is devoted to research on drugs of abuse. When NIDA began – and until the creation of the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1992 – it contained the full range of the federal government’s demand reduction programs including not only research but also treatment, prevention, and training.

Bill White: You were present at the birthing of modern addiction treatment in the early 1970s. How would you compare the collective vision of the pioneers from that era with today’s system of addiction treatment?

Dr. DuPont: In the late 1960s, there were few experts in addiction anywhere except those working at the Addiction Research Center in Lexington, KY, which had been founded in 1935 as the “Narcotics Farm” to provide treatment and conduct research focused on heroin addiction. When the modern drug abuse epidemic swept the nation, there followed an intense search for leaders who could respond to this epidemic. A group of ambitious young physicians, mostly but not all psychiatrists, stepped forward to fill this leadership vacuum, including Ed Senay, Bob Newman, Jerry Jaffe, Herb Kleber, Lee Dogoloff, and Peter Bourne. This group, which never numbered more than about 20, established modern

drug treatment programs in a spirit of inspired competition. Four of these people were the first four White House Drug Czars: Jaffe, me, Bourne, and Dogoloff. NIDA assumed leadership at the Federal level, and the modern drug treatment system, including the leading role for the states, was established.

Never before or since have I been part of such a remarkable outpouring of creativity. It was a unique moment in history for everyone involved. Since that time, addiction treatment has become far more of a standardized commodity. The number of physicians in leadership roles has diminished. Innovation continues in addiction treatment and is probably even greater today than in those early years, but it is more dispersed and much less visible than in the early 1970s when addiction treatment was new and often front-page news.

I single out the uniquely important role of Jerome H. Jaffe, M.D. – the first White House Drug Czar. Among his many contributions, Jerry invented the modern “multimodality” treatment program. This brilliant strategy solved the intractable conflicts between the methadone advocates and the drug-free advocates by combining them into a single program that offered many choices to patients.

At that time, I overlooked the 12-step fellowships (truly the ignored elephant in the living room of drug treatment) and the unity of addiction (as opposed to a substance-specific view of the disease). When I was at NTA, I established an informal ex-addict advisory group of 10 clean addicts who worked for NTA as counselors or in other roles. They were inspiring and contributed greatly to NTA’s success. Years later, I encountered one of these ex-addict advisors and asked him about the other group members. “All dead” was his report. I was puzzled when he told me that most had died,

not of heroin addiction, but of alcoholism. I asked, "Why are you alive and they are dead?" His response shaped my thinking forever after, "I went to AA and NA meetings, and they didn't." In those years, I entirely missed the importance of the 12-step programs and the unity of addiction.

Today, I see these fellowships as a modern miracle and the key to sustained recovery for most, but not all, addicts to alcohol and other drugs. In fact, these programs created the entirely new concept of "recovery," which is much more than mere abstinence. The 12-step fellowships support a new and better way of life. They are about character as much as about abstinence. In these fellowships, people find what is needed to achieve not only sobriety but recovery. I tell my skeptical addicted patients that help, support, guidance – love – is there for them when they are ready to accept it. I see my job as conveying those two messages to every person with alcohol and other drug problems with whom I have the privilege to work, as well as to their families, whom I refer to as Al-Anon. My patients, over the course of many years, taught me that these programs are one of the greatest gifts of America to the global culture.

In addition to missing the value of recovery fellowships, I also missed the most important development in the field, the emergence of the Minnesota Model of addiction treatment. This model combined professional treatment with physicians, psychologists, social workers, and counselors in recovery in a 28-day residential treatment design aimed at facilitating lifelong participation in Alcoholics Anonymous and Narcotics Anonymous. Family involvement was central to this model (and virtually absent from NTA and many other drug treatments then and now). The Minnesota Model, growing out of the 12-step fellowships, never fell for the substance-specific view of addiction and treatment that all pharmacotherapies reflect. The

Minnesota Model from its beginning to this day has had a unitary view of addiction, defining sobriety as freedom from any use of alcohol or unprescribed psychoactive drugs. That revolutionary idea remains unfamiliar to many in our field, even into the 21st century!

Bill White: What other milestones of modern addiction treatment are noteworthy?

Dr. DuPont: Managed care came into the addiction treatment picture in the 1980s to reduce costs. Managed care stopped the growth of residential treatment and spawned the widespread use of Intensive Outpatient treatment. It also reduced the duration of treatment with its obsessive focus on costs. Such shortened length of treatment is at odds with the new view of addiction as a lifelong disease.

Some of the major drivers of innovation in treatment today are in the private sector where the 28-day program has evolved into not just longer stays (90 days becoming commonplace) but into extended care options such as Oxford Houses, and in care management where the Physician Health Programs are setting the standards. The recovery coach model is also extending services from brief intervention to lifelong recovery management. The new care management movement focuses on maximizing long-term recovery outcomes rather than on reducing costs the way managed care does.

There are several promising new models of care management in the criminal justice area, most of which use prolonged, intensive monitoring linked to swift, certain, but generally not severe, consequences. They strengthen one of addiction treatment's weakest links – early termination and a revolving door that has failed to meet the needs of many patients and that has proved to be a tragic waste of limited public resources.

Bill White: One of the many notable things you did at NIDA was set up a national training system for the physicians, nurses, and addiction counselors working in the rapidly expanding network of community-based treatment programs. How important was that early training system to the professionalization of addiction counseling and the evolution of modern addiction treatment?

Dr. DuPont: The Career Teachers Program, which NIDA shared with the National Institute on Alcohol Abuse and Alcoholism (NIAAA), which was established 2 years before NIDA, was one of the most important steps taken in NIDA's early years. That program created a body of academic expertise in addiction medicine and set in motion the developments that would culminate in the establishment of the American Board of Addiction Medicine (ABAM) in 2009. I am proud to be among the first physicians to achieve this new board certification. At NIDA, the Career Teacher program was led by Jim Callahan, who went on to become the remarkably effective executive director of the American Society of Addiction Medicine (ASAM) and who currently serves as the Executive Vice President of the American Board of Addiction Medicine. ASAM has become the home of the new medical specialty of addiction medicine, extending far into the future the work started with the Career Teacher Program. The Career Teacher Program was part of NIDA's national training system that included national, regional, and state training programs for addiction counselors under the overall direction of individuals such as Dr. Lonnie Mitchell and George Ziener. Many of the nation's early generation of addiction counselors were mentored within NIDA's training system.

From Treatment to Recovery

Bill White: You seem to have shifted over the course of your career from an emphasis

on addiction treatment as *the* vehicle of recovery initiation to the view that treatment is only a milestone in a much larger and more enduring process of addiction recovery. Have I accurately read that shift in emphasis?

Dr. DuPont: You have me nailed. I used to think of drug abuse treatment as something like the "treatment" of cigarette dependence today. It is hard; many people fail to stop smoking cigarettes. Mostly, it takes determination and often some help, including pharmacological help, but once done it is, for most people, done. There is a lot of relapse in smoking cessation, but most relapses are early. There are not many people in long-term programs for smoking cessation although there are 50 million former smokers in the country.

Methadone treatment, as defined by Dole and Nyswander, was for life. They made the analogy of methadone and heroin addiction to insulin and diabetes. Diabetics cannot live without insulin, and heroin addicts, in their view, could not live without methadone. Modern methadone treatment did not work that way. Only a small percentage of patients stayed for a long time, let alone for a lifetime. In the early 1970's, I viewed addiction treatment as an important but limited episode in the lives of drug addicts. In stark contrast to my earlier views, I now see addiction treatment as a brief, but often life-saving learning opportunity for addicted patients. Good addiction treatment provides an introduction to lifelong participation in the 12-step fellowships and other forms of long-term recovery support. This view recognizes the lifelong nature of addiction, the lifelong support commonly needed to prevent relapses, and the important role of addiction treatment in supporting lifelong recovery.

Drug Courts and Drug Testing

Bill White: You have been a real champion of drug courts. What is distinctive about this model of intervention?

Dr. DuPont: To be unmistakably clear, the most important innovation in addiction treatment in the past two decades is the drug court. Janet Reno, who started the drug court movement in Miami in 1988, rode the wave to the Cabinet, becoming a revered Attorney General. Remember that I came to addiction treatment from corrections. It was obvious from the start of my career that the criminal justice system had great potential for helping offenders, most of whom suffered from addiction to alcohol and other drugs. The term today is “therapeutic jurisprudence,” meaning using the strong arm of the law constructively and humanely to achieve public health goals.

Today, many people mistakenly believe that the big choice in drug policy is “prison” or “treatment,” pitting the supply side of the drug policy strategy against the demand side as an either-or choice. No drug policy formulation is more destructive than that! Start with the reality that nearly half of all people in treatment for addiction are there because they were sent to treatment by the criminal justice system. Today, the major challenge of drug policy is to find better ways to link the criminal justice system and addiction treatment so that together they can achieve results that neither system can achieve alone. The important choice for the future of drug policy is not “the criminal justice system” or “addiction treatment” – it is “the criminal justice system” *and* “addiction treatment.” That improved linkage is the unique – and immensely valuable – contribution of the drug courts.

The drug policy opportunities for this linkage are bigger even than drug courts, which reach a small percentage of the more than 5 million Americans in their communities under criminal justice

supervision, mostly probation and parole. To help more addicts and to improve public safety, our country needs to use the leverage of the criminal justice system to enforce strict no-use standards for illegal drugs and alcohol as a condition for criminal offenders remaining in the community. HOPE probation, an innovative program in Honolulu, has shown a way to do this so as to reach everyone on probation. By using frequent random drug and alcohol tests linked to swift, certain, but not severe, punishments (a few days in jail), this new program shows, as do drug courts, that this strategy reduces revocations, incarcerations, and new crimes in this high risk, drug abusing population.

Bill White: You have been a strong advocate of the use of drug testing as a clinical tool in addiction treatment. Do you feel this tool is still being underutilized by addiction professionals?

Dr. DuPont: Drug testing is used far too little in addiction treatment and drug testing is often poorly used. Too many people working in addiction treatment today are caught in the view of substance abuse, that relapse is part of the disease, and therefore, relapse to alcohol and other drug use is to be accepted and tolerated patiently until and unless the drug abuser decides to give up drug use. “Reduced use” is substituted for “Abstinence,” as the goal of addiction treatment. Compounding this problem, the goal of treatment is often defined as substance specific. If a patient has a heroin problem – cutting down on heroin use is seen as a legitimate treatment goal while continuing use of alcohol, marijuana, cocaine, and other drugs while in treatment is seen as secondary if not trivial. In this view, abstinence is seen as a far distant goal of treatment.

To me, any use of addicting drugs is incompatible with recovery. That means that for heroin addicts to be in recovery, their

sobriety date is when they last used any illicit or unprescribed drug, including alcohol and marijuana. Few treatment programs today think this way and even fewer enforce this broad no-use standard with frequent random drug tests. The losers from this more tolerant addiction treatment strategy are the patients who suffer more and longer from their addiction as a result of these lowered expectations and this lack of accountability.

Physician Health Programs and EAPs

Bill White: In recent years, you have devoted considerable time to the study of Physician Health Programs (PHPs). What lessons can be drawn from the PHPs for the addictions field and for frontline addiction professionals?

Dr. DuPont: In 2005, I was frustrated by the failure of the leaders of addiction treatment to grasp the simple vision that seemed so obvious to me about how most addicted people get well and stay well. When I discussed this vision with colleagues, I ran into a brick wall: "Where is the evidence?" I struggled with that because it seemed so obvious to me. The "evidence" was all around everyone in the field. Look at the people who have overcome addiction and sustained recovery. They are everywhere in the country today, easily accessible to anyone who cares to look. But, no, that was not seen as evidence. I turned to my own practice where I had worked with many physicians over the years. There, I observed their experiences in their state Physician Health Programs (PHPs). Although these programs had excellent results, there had been no national study to validate these outcomes.

For help, I turned to two long-time colleagues. Tom McLellan was the inventor of the Addiction Severity Index and the dean of treatment evaluation studies in the country through his role as Director of the Treatment Research Institute at the University of Pennsylvania. Greg Skipper was the

distinguished head of the Alabama PHP and a leader in the PHP movement. Tom got funding for the study from the Robert Wood Johnson Foundation. Our biggest challenge was convincing the state PHPs that it was safe to collaborate with our group of outsiders to do this sensitive independent evaluation of their outcomes. Greg helped achieve this goal. Our study could not have been conducted without the sustained and energetic support of the Federation of State Physician Health Programs (FSPHP), a group I came to see as distinguished, dedicated, and innovative program leaders.

Together, we achieved our goals, publishing a continuing series of papers documenting the outcomes of these programs. The most remarkable single statistic from this study came from the drug testing, which for these physicians was random, extensive, and intensive. These addicted physicians were held to a standard of no use of any drug and no use of alcohol for 5 years or longer. That meant that each workday they called a phone number to see if they needed to submit a sample for testing that day. The tests were not the common 5-drug screen but a 20-drug screen, including alcohol testing using EtG to identify alcohol use in the prior 5-7 days. The results: 78% of the physicians did not have a single positive test for any drug or alcohol use over 5 years of testing. Of the 22% who did have at least one positive test, 65% did not have a second positive test. Where else in the addiction treatment field can you find results like that? Those results set an entirely new standard for recovery outcomes, one that every treatment program should aspire to.

Bill White: Your study of the nation's Physicians' Health Programs (PHPs) has influenced your thinking about drug treatment. Do you see areas where those ideas can have a wider impact right now?

Dr. DuPont: A recent study from the Substance Abuse and Mental Health

Administration (SAMHSA) showed that people suffering from addiction to alcohol and other drugs who were referred to treatment from the nation's Employee Assistance Programs (EAPs) stay in treatment longer than those referred from and any other source including their physicians and self-referral. EAPs are powerful engines to identify drug problems early, to refer people to good treatment and to keep them there long enough for them to benefit from treatment. EAPs, like PHPs, manage care and use the leverage of the job to promote recovery. I am proud that in 1982 Peter Bensinger, who headed the Drug Enforcement Administration (DEA) while I headed the National Institute on Drug Abuse (NIDA), created Bensinger DuPont and Associates to provide employee assistance services.

Lessons from Clinical Practice

Bill White: How important has your enduring clinical work been to your evolving views on addiction treatment and recovery?

Dr. DuPont: In my own practice of psychiatry since 1969, I have had the opportunity to work with many families over three generations. This intensive, long-term, and highly personal perspective has been central to my evolving views on the nature of addiction and recovery. My patients have been my teachers and my inspiration.

In particular, they have taught me about the value of sustained participation in a recovery support program. I have come to see that the problem in addiction is not getting addicts to stop using drugs. Every alcoholic and every drug addict has been off alcohol and drugs many, many times. The problem in addiction is relapse, not withdrawal. Detoxification is not treatment. In fact, stand-alone detoxification is commonly a means for addicts to stabilize their drug addled lives so that they can continue their addiction. Detoxification itself prolongs addiction.

What are the strategies available to an addicted person to maintain sobriety over a lifetime? Not treatment, that is for sure. Treatment is always short-term even at its longest – say a year or two, but more often a month or two. The disease of addiction to alcohol and other drugs, meaning the risk of relapse, is lifelong. Only the growing network of spiritual, religious, and secular recovery fellowships meet that core need of addicted people. Those fellowships are lifelong, matching the disease as nothing else does. That profound truth I learned from the experiences of my patients.

Bill White: Could you give an example of any recent lessons you've learned about addiction recovery that have come from your private clinical practice?

Dr. DuPont: The hardest lesson for me is patience. I see plenty of people in the grip of addiction, caught in an abusive love affair with a chemical. Like anyone caught in an abusive relationship, they want to believe they can go back to their lover and that the next time, they will work it out. The therapist's job is to convince them that the next time, the outcome will not be the same; it will be worse. Some of my patients get that right away, but many do not. I tell these skeptics two things. First, that I have completed this phase of my research on addiction, concluding that the problem gets worse over time. Clearly, they need to do more work of their own on addiction by living the painful disease. I caution them that they may die from it, and they are certain to suffer terribly and to extend that suffering to everyone who cares for them. But from that suffering they, and those who care for them, will learn eventually if they are not killed first.

In my practice, I have seen many of the most hopeless cases of addiction descend into depths of suffering I can hardly imagine and for periods of time that seem impossible to endure, only to emerge, almost always with the help of the 12-step

fellowships, into exemplary, happy, and productive human beings. That experience helps me be patient and to never give up hope for lasting recovery.

Future of Addiction Treatment

Bill White: As someone who has played an important role in the modern history of addiction treatment, what predictions would you make about the future of addiction treatment and recovery in America?

Dr. DuPont: Addiction is a powerful and pitiless teacher. I have no doubt that continuing to focus on understanding, preventing, and treating addiction will prove to be an inspiring and rewarding quest for generations to come, as it has been for generations past. Few Americans know that the struggle to cope with the problems caused by alcohol goes back to the earliest years of our nation. The per capita alcohol consumption in the US peaked in the first decades of the 19th century. The 20th century had a major focus on other drugs from heroin, invented in 1898 by the Bayer Company as an over-the-counter cough medicine, to cocaine and marijuana – all plant-based ancient drugs of abuse. More recently, the focus has shifted to synthetic drugs of abuse from methamphetamine to opiates, like oxycodone and hydromorphone. The one thing they have in common is their uniquely powerful stimulation of the brain reward system and the thinking and actions that are triggered by that stimulation. The struggle to understand and reduce the problems of alcohol and drug abuse is more than 200 years old in the United States. Although these efforts have been successful beyond imagining, the challenge remains.

We have much yet to learn about this uniquely human disease. Put another way, addiction has much yet to teach all of us, our children, and our grandchildren often at very personal levels. Addiction is a uniquely human problem. I can confidently predict

that in a hundred years, the problem of addiction will still be attracting a lot of attention and providing priceless lessons.

Maintaining Enthusiasm and Passion

Bill White: You have remained enthusiastic and passionate about your work in this field for more than four decades. Do you have any suggestions for the frontline counselor on how to not be overwhelmed by this work?

Dr. DuPont: My advice to counselors today: Learn from your patients/clients. Help them grapple with the cunning, baffling, and powerful disease of addiction, a disease that is characterized by its hijacking of the user's own thoughts and twisting their lives to fulfill the self-destructive purposes of the addicted brain, what I have called "the selfish brain."

Use your experience, strength, and hope not only to help your patients/clients, but to help you understand your own life and the culture around you. Addiction is a door into every aspect of human knowledge from biology and psychology, to history and art.

Health care is one of the most rapidly growing parts of the modern global economy. Unlike manufacturing and many other jobs, addiction treatment is not easily outsourced because direct human contact is at its heart. Counselors are the embodiment of health care for addicted patients. Most of health care is about mitigating, often marginally, the damage of diseases. In contrast to this experience, recovery from addiction to alcohol and other drugs is unique in two ways. First, the contrast between the degraded and miserable life of a using addict and the life of that same person in recovery is one of the most profound and glorious transformations not only in health care, but in the human experience. Second, the change produced by recovery from addiction is not merely the absence of the disease of addiction. Recovery is the development of an entirely new and a far better life. In other words,

recovery is not about restoring addicts to where they were before their drug and alcohol use. Recovery is about profound improvements in life, in character, in relationships. That transformation is what keeps us in this field. That profound transformation, which we see every day, inspires us even as it helps us improve our own lives and our own characters.

Bill White: If there was one more thing you could accomplish on behalf of the field of addiction treatment in the time remaining in your career, what would it be?

Dr. DuPont: I am a grateful “addict” to the field of addiction. My biggest hope and the goal of my remaining years is to share my joy with others and to thank those who have helped me along the way, especially my colleagues and my patients. I enjoy my life all the more knowing that however long it is, it will be very short. My advice for counselors working in addiction recovery? Treasure every precious minute, not just the good times, not just the happy times. Pain, disappointment, and rejection are all learning opportunities, growth opportunities for you and for your patients/clients. In my life, closed doors have been more valuable to me than open doors. The challenge I have learned is to seize even a few of the many opportunities that abound around all of us all of the time.

Words for Aspiring Addiction Professionals

Bill White: You have spent more than four decades of your life working at all levels of addiction treatment in the United States. What advice would you give to the person considering addiction counseling as a career or to those who are just entering the field?

Dr. DuPont: Keep learning, keep growing. Addiction is a field filled with unending opportunities to learn and to help suffering addicts and alcoholics – and all the suffering people who care for them – including their counselors who share their pain but who also have the perspective that from this suffering can come a deeper knowledge and the promise of lasting recovery. That promise can only be achieved by hard work, guided by the motto “You alone can do it, but you cannot do it alone.” That is true for life, and it is surely true when dealing with addiction in yourself, in someone you love, or in a patient/client.

About the Authors: Robert L. DuPont, M.D., served as White House Drug Czar for Presidents Nixon and Ford and was the founding Director of the National Institute on Drug Abuse. He is the author of *The Selfish Brain: Learning from Addiction*. Dr. DuPont is the founding President of the nonprofit Institute for Behavior and Health, Inc, an organization devoted to finding and promoting new ideas to reduce the use of illegal drugs (www.ibhinc.org). William White is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.