



# Selected Papers of William L. White

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## ***Circles of Recovery:*** **An Interview with Keith Humphreys, PhD** **April, 2011**

**William L. White**

Emeritus Senior Research Consultant  
Chestnut Health Systems  
[bwhite@chestnut.org](mailto:bwhite@chestnut.org)



Keith Humphreys' sustained research, consulting, policy development, and writing activities qualify him as one of the leading pioneers in the modern history of addiction

treatment. His work has bridged the worlds of clinical research, clinical practice, social policy, and the lived experience of addiction recovery. His studies, perhaps more than the contributions of any other scientist, have illuminated the role of community, particularly indigenous recovery communities, in recovery initiation and long-term recovery maintenance. A long-valued colleague and friend, Keith graciously agreed to my request to explore his career and his thoughts about the future of addiction treatment and recovery. Please join us in this engaging conversation.

### **Career Path**

**Bill White:** How did you get from the mountain country of West Virginia to the study of psychology at Michigan State University and the University of Illinois?

**Dr. Keith Humphreys:** I formed this idea as a teenager that I wanted to be a psychologist, which in retrospect, was a strange decision given my family's background and history. Going back through the generations, the dominant occupations of men in my family were miner, electrician, steel worker, engineer, and soldier. I think that my family's emphasis on practicality and fixing things—which you can see in all those occupations—is why I was interested in clinical psychology versus say, social psychology or some other more theoretical area, but psychology was still an unusual choice. I found that psychology brought together for me the “brain stuff” (figuring out puzzles, understanding complex things) and the “heart stuff”

(connecting with people, helping others heal) in a way none of the other careers I considered could do. And it helped a lot that my parents had both attended excellent colleges and aspired for their children to become educated professionals.

I don't think my high school record could have gotten me into an Ivy League school (or into Stanford), and even if I had, my parents, with four kids to educate, couldn't afford it. So, that meant state schools were the pool of opportunities, and within that, I prioritized really big places. I wanted to see more of the world and the people in it, so I only applied to schools that had more undergraduates than my hometown had residents. Michigan State University appealed because it had something like 40,000 students, had an excellent honors program, and it gave me some work-study and scholarships that made it financially possible.

Some people find that the greater autonomy of college versus high school lowers their academic performance and decreases their focus, but I had the opposite experience. I loved all the choices, the freedom to set one's own schedule, and all the amazing things I could learn. As a result, I worked harder than I ever did in high school, where I was frequently bored and disengaged. I was a much better college student than my high school record promised, and I realized that I would be able to fulfill my dream of going to graduate school and becoming a psychologist.

Choosing a graduate school is usually a really tough decision for people, but for me, it was easy because I only got in to one place: the University of Illinois. I wanted to work with Julian Rappaport, and I was fairly naïve about how easy it was to get into graduate school, so I only applied to four places. Luckily, the others said no, and I went to work for Julian in what was and is one of the best psychology departments in the country.

**Bill White:** What influences led you into the addictions field?

**Dr. Humphreys:** I enjoy saying "Like most people, I got into the field for the money." To make ends meet as an undergraduate, I worked a number of low-paying jobs. When I was flipping burgers at Wendy's for minimum wage (\$3.35 an hour), a friend of mine came in looking relaxed, well-dressed, and devoid of grease spatters, all of which I envied. She was a few years ahead of me in the psychology program, and since she was graduating, she suggested I apply for her soon-to-be vacated job on a research project in the psychiatry department. I asked how much it paid, and she said \$4.40 an hour. Wow! She said the research project was about addiction, and I said "for \$4.40 an hour, I love addiction."

That's a true story, but the greater truth lies in why I stayed with something that I started in such a serendipitous fashion. Part of it was that I liked the world of the medical school: all the books, learned people, and the mission of helping people who were suffering (the absence of grease burns was also appealing). Clinically, I found that I liked addicted patients. Every important part of the human drama is there in addiction: hope, fear, struggles with control, death, spirituality, love, relationships, and the possibility of redemption. And in terms of public policy, name any social problem of importance—crime, AIDS, homelessness, domestic violence, child abuse, education, unemployment—and there is an addiction component, a way for someone in our field to find a way in and make a contribution. All those things kept me engaged and still do.

**Bill White:** You have been blessed by a long series of influential mentors. How would you describe their influence?

**Dr. Humphreys:** Blessed is the right word. Bertram Stöffelmayr was the professor who hired me for \$4.40 an hour, followed by Julian Rappaport in graduate school, and then Rudy Moos at the VA and Stanford, where I have spent my entire post-graduate

career. All of them were full professors with established reputations when I met them, and unlike some people who get more self-involved with such success, they were all the sort of wonderful people who wanted to give back unselfishly to the next generation. Early on, what I needed and got from Bertram and Julian was almost like a benediction, i.e., “You, the backwards hillbilly with all your strange ideas and uncouth manner, have a place in our field.” I doubted my abilities and my place well into my 20s, and I didn’t always know how to act in academia—it’s a culture whose norms were a bit alien to me—and my mentors always gave me that reassurance that I belonged and I would make a success of it someday.

What I needed as my career went forward and my self-doubts became less prominent was autonomy coupled with resources. Julian helped me get a graduate fellowship and then didn’t tell me what to do with it. He just said “I trust that you will do good things with this” and probably because I didn’t want to let him down, I did. Later, when I entered the job market, every university at which I interviewed wanted me to write a grant before I’d gotten off the plane, but Rudy Moos had a large center and said that the important thing at first was to get my feet wet, develop my interests, and not write a grant until I was sure it was on a topic that really mattered, and he provided the resources to allow that.

Just one other story about Rudy in regards to mentorship. When I was an assistant professor, I asked Rudy to write a paper with me, and he surprised me by saying no. He said I could use data he gathered and he would critique drafts and analyses, but if we wrote a lot of papers together, I wouldn’t get credit when I came up for promotion. People would think it was all Rudy’s work. I have seen a number of academic careers flounder because the mentor did not have the generosity and foresight that Rudy showed when he made that decision.

**Bill White:** One of the distinguishing characteristics of many of those who have made great contributions to the addictions field is an organizational environment that provides a platform of stability and a stimulus to creativity. How have Stanford and the Department of Veterans Affairs Center for Health Care Evaluation served as that kind of platform for you?

**Dr. Humphreys:** I have talked about Rudy, who over 40 years ago founded the Center that I am now directing. One of his first great decisions was to bring in Dr. John Finney, who has been a mentor and friend to me for years and is justly respected as one of the best alcohol treatment researchers in the world. Around them, Rudy and John gathered a large number of scientists who did excellent research but also put a very high premium on the social ecology of work. They created a norm that no matter how bright someone is or how important his or her work is, being a good colleague is even more important.

That is why the Center has held onto so many scientists for decades, and why the collaborative norm has been so strong. In some centers, when you sit down with, say, three colleagues and ask “Who will be first author on our paper?,” a fight breaks out. Here, everyone says at once “I don’t care,” and if there’s a fight, it’s two people trying to convince the other that he or she should really be taking more credit.

## Recovery Research

**Bill White:** There have been recent calls for a recovery-focused research agenda, and yet more than a decade ago, you embarked on a career that focused on recovery from the very beginning. How did you develop this focus before most of your peers had recognized this as a legitimate arena for scientific research?

**Dr. Humphreys:** I have a contrarian strain in my personality, which has sometimes led me to dead ends but at other times has helped me break out into new areas. During

my undergraduate days, I had absorbed the prevailing academic prejudice that doctors know best, therefore self-help groups couldn't be of any real value—after all, their members didn't even have advanced degrees!

But in the job I had working for Bertram Stöffelmayr, I was getting exposed to the reality of 12-step programs because some of my colleagues on the project and many of the patients we were studying were in recovery. As I hung around people in recovery and some of them took me to open meetings, I began to believe that the prevailing academic prejudice was just that. My contrarianism kicked in, and I wanted to subject that prejudice to tests. I was also driven by my own emotional reactions: I liked the recovering alcoholics and drug addicts I was getting to know, and those that became my friends helped me in my own development as a person. There is a lot of wisdom in AA and NA that has nothing to do with substance use. For example, the Serenity Prayer captures an essential truth about life, and every human being can find some wisdom in those words whether they have any experience with drugs or alcohol or not. As a young person, when I had emotional struggles, (which was not infrequent), sometimes a friend from AA would say “Keith, in AA what we say about situations like yours is...” and it would be just the thing I needed to hear. To this day, I greatly value the personal advice of my friends who are “program people.”

So, that's how I got into recovery research when recovery research wasn't cool. But to avoid being grandiose (see what I have learned from AA?), I would point out that in the late 1980s when I was starting my work, other scientists around the country and at NIAAA were independently coming to the conclusion that 12-step groups and recovery had been underappreciated and misunderstood, and they were designing Project MATCH to learn more. When twelve-step facilitation counseling showed such good results in that massive, sophisticated project, it did more to legitimize

recovery-oriented addiction research than I have ever done in my own efforts.

**Bill White:** How has your training as a clinical/community psychologist influenced your approach to the study of recovery?

**Dr. Humphreys:** The clinical lens is valuable because it helps you tune in to how people suffer and how they can heal. Community psychology adds some important themes to that, namely faith in the power of “ordinary” people (meaning those who are not designated experts) and belief that social contexts and organizations shape us more than the American narrative of rugged individualism admits. One reason why Julian Rappaport and I got along so well is that he had been working with GROW, a mental health mutual help organization, and had already tied that in to community psychology ideas about citizen empowerment and group-based healing. Those ideas helped us find a common frame of reference within community psychology and to work together, even though he was not particularly interested in addiction as a phenomenon in itself.

**Bill White:** There is now considerable interest in the proposition that there are many pathways to long-term recovery from severe alcohol and other drug problems. How far have we advanced in scientifically mapping these recovery pathways?

**Dr. Humphreys:** I am not overwhelmed by what we know. I can point to lots of examples of pathways and research that describes what those pathways are like, but not a more systematic study of how everyone ends up recovered and in what proportion. Measurement is fundamental to science, and you can't measure something until you agree what it is. I don't think we got to such an agreement until the Betty Ford Institute consensus conference and the CSAT Summit on Recovery, and since then, there has not been a carefully-designed national survey asking how many people meet that criteria. We can answer that question for abstinence, but not recovery.

**Bill White:** Between 2003 and 2008, you served as an advisor to the White House Office of Faith-based and Community Initiatives. Did your work in that role alter your views about religious pathways to long-term recovery and the role of faith communities as indigenous recovery support institutions?

**Dr. Humphreys:** The Bush Administration was loathed in much of academia, and I took some guff for advising that office (which my contrarian streak helped me ignore and to some extent even enjoy). But by any objective standard, with the President's New Freedom Commission, the Access to Recovery initiative, and the Domenici-Wellstone Mental Health Parity Law, the Bush Administration was a great time for the treatment of addiction and mental health problems.

When the White House faith office took an interest in addiction, many of my colleagues feared they would ignore scientific evidence. But I was excited because I knew the science was there: A mountain of evidence attests that religious faith of any kind is a protective factor for that helps kids avoid addiction, and a spiritual or religious experience is essential to how some Americans recover from addiction. There was never any question scientifically of whether a contribution could be made by faith-based organizations to recovery; it was more a political and cultural question of how we do that in a pluralistic society with a Constitutional commitment to separation of church and state.

**Bill White:** We conduct elaborate surveys on the incidence and prevalence of alcohol and other drug use and its related problems, but there are few systems available to measure the prevalence of recovery. Is the pronouncement that there are millions of people in the United States in addiction recovery scientifically defensible? What should we be doing to measure recovery prevalence?

**Dr. Humphreys:** When we were setting up the recovery office in the White House drug policy office, I remember calling you and other experts trying to find out the answer to this question. We can pull together from good surveys that there are at most 20-25 million Americans who used to meet formal DSM substance dependence criteria and are now not using drugs or alcohol. But not all those people would consider themselves in recovery. If you start with recovery organizations' membership and do some bootstrapping, you can assure yourself that the number isn't any lower than 5-10 million. The truth is probably in between those two ranges, but even as I say this, I recognize how sloppy these extrapolations are, and that tells me we need to incorporate recovery measures into standing national surveys.

**Bill White:** What do you feel are the other most important areas of recovery research to be explored in the coming decades?

**Dr. Humphreys:** My colleague Chris Timko just received a grant to study AI-Anon, which is the second largest mutual help organization in the field and has received precious little study. The new grant will also give her the chance to study women, who as a population are understudied across recovery research. I would like to see more research as well on people of color.

Finally, I think we need to understand later-stage recovery, what lives are like 10 years on for example.

### **Role of Community in Recovery**

**Bill White:** Your work has been profoundly influenced by the writings and mentorship of such persons as Seymour Sarason, Julian Rappaport, and Rudy Moos. What have you taken from their work about the role of natural community resources in long-term addiction recovery?

**Dr. Humphreys:** Treatment is a very good thing and I have provided it, taught it, and advocated for it. But what all three of those great thinkers (and I would put my friend

Griffith Edwards in here as well) make clear is that in the long-term, most people are made by the broader world and not by short-term treatments. No matter how much I may like a patient, I can't become his or her lifelong friend or advisor or spouse or child—all of those naturally occurring phenomenon will shape the patient's life more than I will. A parallel point is that a decent job and place to live can shape the course of addiction very profoundly, again more than 12 weeks of one-on-one therapy will or whatever it is that managed care is covering these days. To their credit, the founders of AA figured this out a long time ago: You usually can't eliminate a problem that has developed over years and become deeply woven into someone's life without weaving something positive and enduring into his or her life to replace the addiction.

**Bill White:** A few years ago, you used icing and cake as a metaphor for the role of professional mental health services in the mental health of a community, suggesting that the former was the icing and the latter the cake and that mental health professionals error in seeing themselves as the cake. Could the same be said for the distinction between professional addiction treatment and long-term recovery?

**Dr. Humphreys:** That's a good analogy, and again, I really value and have fought for treatment and would not minimize its life-saving possibilities. But most addicted people never receive treatment and those that do receive it don't get very much of it, so other factors tend to explain recovery over time.

**Bill White:** In Philadelphia, we have introduced the concept of community recovery—the idea that whole communities can be wounded by a critical mass of alcohol and other drug problems and that a community-level healing and recovery process may be required to restore the health of individuals, families, neighborhoods, and the community as a whole. Do you see such an idea as a natural extension of your work?

**Dr. Humphreys:** It's too flattering to me to say it like that. What I would say is that in the first place, that's wonderful, and in the second, the concept is a good one because it recognizes that addiction is not something that a person carries around inside himself or herself like a tumor; it's woven into daily life. And when whole communities have had that experience—like you see in some Indian Countries and in parts of Russia for example—the community and its institutions need to be healed, not just individual people.

### Recovery Mutual Aid Societies

**Bill White:** What was your view of Alcoholics Anonymous (AA) before you began studying it as a research scientist?

**Dr. Humphreys:** I viewed it as did most of the professors I looked up to: a well-meaning bunch of amateurs who didn't know what they were doing. I am grateful that I actually met some AA members before I was too far along in my education to learn anything.

**Bill White:** How would you characterize the evolution in the quality of scientific research on AA?

**Dr. Humphreys:** There has been very good ethnographic, anthropological, sociological, historical and participant observation research on AA going back half a century and continuing today—the kind of work that really gives a feel for the experiential aspects. But in terms of convincing outcome studies, e.g., do people actually drink less, that's more recent. The early "outcome studies" would be case reports or clinical observations or single group cross-sectional studies. And often they would misunderstand AA, measure the wrong things, or interpret their findings in odd ways.

About 20 years ago, in no small part due to NIAAA getting involved, there was a quantum leap in the quality of AA outcome research. Studies routinely became longitudinal and prospective. Most of them had comparison groups. AA affiliation, a broader concept than just a count of

meetings, was better conceptualized and well-measured. More recently, high quality randomized clinical trials have emerged (there were some methodologically poor trials in the 1960s and 1970s). And the good news is that as the methods have gotten better, the scientific case for AA's effectiveness has gotten stronger rather than weaker. In short, AA really is a quality intervention for alcohol problems, and that's a hard-nosed, evidence-based statement.

**Bill White:** The question of AA's effectiveness continues to be a subject of debate and heated rhetoric. What can we say about the effects of AA participation on recovery outcomes from the standpoint of science?

**Dr. Humphreys:** Anyone who says AA is ineffective either does not know the science or is grinding an ideological axe. We have as good evidence for AA and 12-step facilitation counseling as we do for any other ambulatory intervention in the alcohol field. Period. As recently as last year, the *Washington Post* published an article by a researcher asserting that there were no randomized clinical trials of 12-step groups. I published a rebuttal noting multiple randomized, NIH-supported studies in top-tier journals—incredible that they were ignored. The science indicates that for people who want something ambulatory and have an abstinence goal, AA should be their first port of call. Does that mean it works for everyone? Of course not—nothing does.

**Bill White:** You have conducted several studies related to the question of AA's cost-effectiveness. What were the major conclusions of these studies?

**Dr. Humphreys:** If AA were for sale for a billion dollars, the country should buy it in a heartbeat—what a bargain! What Rudy Moos and I found in those cost studies is that when people get involved in AA, their health care utilization drops by as much as 40%, but their health if anything is better. We did a VA study that found a savings of about \$6000 per patient the first year after

treatment if the treatment program really pushed AA/NA involvement. VA treats over 120,000 addicted veterans a year—imagine the cost impact of knocking 6 grand off the health care bill of that many people a year, and VA is just a small part of the health care system.

**Bill White:** What have we learned about the so-called “active ingredients” of AA—those elements of AA participation that seem particularly linked to long-term recovery outcomes?

**Dr. Humphreys:** There are a large number of studies that identify “active ingredients” or “mediators” of AA's effect, including an increase in abstinence-supporting friends, greater generic social support, better coping skills, greater self-confidence, and more motivation to change. In the longer term, spiritual change, altruism, and sponsoring others seem particularly powerful in helping people to attain a lasting, enriching recovery.

Mediational research now needs to go the next step and test mediators competitively. We have many studies looking at one or two at a time, and I suspect the same variance is getting explained and re-explained in different ways. It's time for a more comprehensive study of all our candidate mediators of change at once.

**Bill White:** One of the things I most admire about your work is your use of scientific studies to test various popular declarations about AA. There have long been suggestions that AA was inappropriate for women, people of color, people with co-occurring disorders, and other populations. What did you find when you tested these suggestions?

**Dr. Humphreys:** 12-step fellowships had a bad reputation both in many academic settings and with some clinicians when I started my career. This set a low bar for criticism of the fellowships, with almost any attack being taken as true, even when it had no supporting evidence. For example, there were published papers that would show that,

say, an AA meeting somewhere was 60% male and explain it as a sign of sexism and women not liking AA. But at the time, about 65-70% of alcoholics were male, so the fact that AA's proportion of males was lower than 65-70% actually indicated the opposite: women alcoholics liked it better than male alcoholics. There were similar studies that did research in all white communities, and saw that 12-step groups there were full of white people, leading the authors to conclude "people of color don't do the 12 steps." I assume that after they finished their field work, they went out to eat in restaurants in those same neighborhoods and said "Wow, people of color don't eat." Another widely asserted propositions were that you had to be a Christian to like AA/NA and that atheists could not benefit from 12 step groups.

When I studied these questions in diverse samples across diverse communities, the myths about 12-step groups didn't stand up to scrutiny. I was working on the lower east side of Detroit during the crack cocaine epidemic in the 1980s and with Bertram's invaluable assistance, got a chance to look at sizable datasets of people of color and women in the fellowships. That work showed that if you looked in a predominantly African American part of town, African Americans were more likely to attend than were Whites. In contrast, you saw the reverse pattern in predominantly white communities. We also found that women were more likely than men to attend groups. Years later, Rudy Moos, Andy Winzelberg, and I studied the religion question and found that when clinicians refer patients who were atheists or agnostics to 12-step self-help groups, they are as likely to attend as are religious patients.

**Bill White:** You have studied the process of linking people to AA and other recovery mutual aid groups and the attrition in participation within such groups. What recommendations would you have on how addiction professionals and recovery coaches can enhance this engagement and retention process?

**Dr. Humphreys:** You have to frame the mutual help group experience the right way. I like to tell people it's like dating. Not all meetings are alike any more than all people you might date are alike. So, if you go to one meeting and you don't fit in, the wise thing to do would be to try a different meeting rather than conclude you've seen all there is to know about self-help groups and you never want to go again. That makes no more sense than saying I dated one person and it didn't go well, so I gave up on ever getting married.

**Bill White:** You recently completed a pilot study on the role of AA sponsors. What did that study reveal?

**Dr. Humphreys:** The main credit for the study goes to a British physician named Paul Whelan, who was in a research training program at Kings' College London, where I hold an honorary faculty post. He found it strange, as I do, that we have at least a million people on this planet who have taken on this really important role of "sponsor," and we have practically no idea what they do. There literally have been more studies of how hairdressers provide advice than how sponsors help their sponsees.

Paul found two things that I think are important. The first is that while you might think that sponsors would be the people who went through the most hell during the active phase of their alcoholism, they actually tended to be "low-bottom drunks" (as AA would say) with relatively high social capital. The second interesting finding was that there were multiple styles of sponsorship and that sponsors in some sense monitor each other, for example, by knowing who the "step Nazis" are and advising new members that they may match up particularly well or particularly poorly with a given sponsor.

Those are intriguing findings, but there is so much more to know—studying sponsors could be a very rich, decade-long scientific journey for someone wanting to make a mark in recovery-oriented research.

**Bill White:** Your 2004 book, *Circles of Recovery*, stands as the best summation of the status of modern addiction recovery mutual aid groups. Many readers of that book are struck by the great diversity of religious, spiritual, and secular recovery mutual aid groups. Were you also struck by such diversity through your research for this book?

**Dr. Humphreys:** Thanks, Bill, I knew my mother had bought one of the two copies that sold, now I know who picked up the other. To answer your question, the diversity of the organizations is amazing, and I would broaden that even more than you might have been thinking when you asked the question. That is, not only are organizations different from each other, but the diversity of groups *within* any one organization is enormous.

If I can put in a small plug for the book, one of my disappointments was that it was only available in hardback when it came out, which made it too expensive. It's now available in Kindle and paperback form at a much more affordable price.

**Bill White:** So much of what we know about recovery mutual aid groups from the standpoint of science is based on studies of AA. How much do we know scientifically about the adaptations and alternatives to AA? Can scientific findings on AA be applied to these other groups?

**Dr. Humphreys:** NA research has grown and gotten better in recent years, and I think Al-Anon research looks promising in the near future. But we lack any good outcome studies of SMART Recovery, LifeRing Secular Recovery, Women for Sobriety, and many other organizations. Some of the AA research must generalize as after all, there are group influence effects and social support effects in all of them. But there must be some differences as well, and we don't as yet know what those are.

**Bill White:** There has been considerable public and professional controversy regarding Moderation Management. As one

of the few researchers who has actually studied MM, what can you say about MM from the standpoint of science?

**Dr. Humphreys:** Alcohol problems exist on a continuum, and for every person who meets DSM criteria for alcohol dependence or the popular understanding of "alcoholic," there are several people who drink in an unsafe fashion on a regular basis. We can ignore them until they get into so much trouble that they fit well in AA or an inpatient program, or we can try to create a resource that they will use. That is what MM is for.

The most important thing we found about MM was that people were better at picking the resources that fit them than one might expect. We compared people in MM to people who chose AA and found that the former had dramatically lower levels of alcohol consumption and alcohol dependence and also much higher social capital. Those are the people that the science shows have the best chance of returning to moderate drinking. And as you know, despite the current controversy, the founders of AA never doubted that such people exist.

**Bill White:** You have also studied online addiction recovery support groups. What are your thoughts on the rapid growth of online recovery support services and the future of Internet-based recovery support meetings and services?

**Dr. Humphreys:** That whole phenomenon makes me feel old because I wouldn't go online for support about an emotional problem. But what some of our work found is that the current generation of young adults really does like that sort of support, and their attitudes are becoming more normative as time goes on. For that reason, I expect continuing growth in these groups, as well as of professionally designed services that have an online component.

## Addiction Treatment

**Bill White:** You have been involved in many addiction treatment outcome studies. What conclusions have you drawn about the degree of effectiveness of various approaches to addiction treatment?

**Dr. Humphreys:** To my mind, the research shows that the things most researchers obsess about—e.g., is cognitive-behavioral therapy better than purely behavioral therapy versus purely cognitive therapy—does not represent where the action is. Good treatments have common elements, including a relationship with someone who cares about you, some persistence of the treatment over time, and some changes in your environment such that abstinence becomes easier and more rewarding than continued use. Some clinical people are uncomfortable with this idea, but the research shows that some accountability in the environment is very good for people. That includes, for example, drug testing with immediate, certain consequences such as you see in drug courts.

**Bill White:** In one of your published commentaries in *Addiction*, you suggested the need to shift from a focus on treatment intensity to a focus on treatment extensity. What would that shift entail?

**Dr. Humphreys:** That paper came about from pulling together two ideas that many people before me had discussed. The first is that it takes as much money to do a short-term intensive intervention (e.g., inpatient detox) as it does to do a long-term or “extensive” intervention with less contact at each point (e.g., recovery management checkups). The second is that addiction tends to have a chronic course. That led me to think we should reallocate resources away from intensive interventions and into extensive ones. Recovery coaches, extended outpatient care, and recovery management check-ups are all ways to do that. In the best systems, the dollars those interventions save by reducing acute care

would be returned to them to support more extensity in care.

**Bill White:** You have studied both psychosocial treatments for addiction and medication-assisted treatment. Do you see these approaches as antagonistic or potentially complementary?

**Dr. Humphreys:** I see no conflict at all. There is no other chronic disease I can think of where we even ask this question. Bill W. asked Vincent Dole, the methadone pioneer, if he could create a methadone for alcoholics. If Bill W. could be supportive of medication-assisted therapy, it seems to me we could all be equally open-minded.

**Bill White:** You have been deeply involved in evaluating and elevating the treatment of substance use disorders within the Veterans Affairs Health Care System. How has modern addiction treatment evolved within the VA system?

**Dr. Humphreys:** If you trace things back far enough, you will find that most psychosocial and medication treatments for addiction have some roots in the VA, whether it is on the clinical side, the research side, or both. Indeed, for those psychologists who might be reading this, note that modern clinical psychology was essentially invented in the VA after World War II and before that, almost all psychotherapy was only done by psychiatrists—the VA changed that.

There was a big boom of resources and innovation in the VA after Vietnam, which unfortunately waned over time. The “war on drugs” legislation of the 1980s included some poor policies, but it did give the VA treatment resources, which created a second boom of energy and enthusiasm. That too faded over time, to be revived by the current wars and the resources and attention veterans are getting again. Veterans are the one population of addicts that almost everyone feels sorry for, and one of the few good things you can say about war is that it has repeatedly inspired compassion and support for mental health and addiction

care services in the VA and the country more generally.

**Bill White:** Are there innovations that have occurred within the VA approach to addiction treatment that you feel are worthy of widespread replication?

**Dr. Humphreys:** It sounds like special pleading because of my role in it, but I think the VA is the best addiction treatment system in the country. First, unlike everywhere else, you don't have to argue that treatment is a legitimate part of medicine in the VA. The programs are at hospitals, what hospitals do is medicine, end of discussion. Second, because the programs are in a medical system, you can get the supplementary services that just aren't available in many community programs, such as liver tests and psychiatric evaluations. Third, the VA staff are more highly trained and better compensated than their peers in state-supported programs, which creates a basis for better quality (even though it doesn't guarantee it).

When Tom McLellan and I were working at the drug policy office, the VA (as well as the British NHS) is the system we had in mind when we pushed for the medicalization of substance use disorder treatment in the US.

### **Office of National Drug Control Policy**

**Bill White:** In 2009, you took a leave of absence from the VA and Stanford to serve as Senior Policy Advisor at the White House Office of National Drug Control Policy. How did this opportunity come about?

**Dr. Humphreys:** Seymour Sarason always said that to understand what's going on, you have to go "before the beginning," so let me go before I got the call from Washington. I had always been interested in public policy as a way to benefit more people than one could do through individual intervention. But there are few rewards for doing public policy in academia, so I held those interests in abeyance until I became an associate professor. The security of that promotion let

me branch out into the policy world, and I found that I enjoyed the work and the people. As I did this more and more, I got a reputation in the addiction field as someone who was a "policy guy"—knew how the agencies worked, had contact with Congress and the White House, understood regulatory frameworks, stuff like that.

After President Obama was elected, the Vice-President called my dear friend Tom McLellan and asked him to come help shape the administration's drug policy. Biden knew Tom a bit personally, and countless people had correctly told the VP's office what a great leader Tom is for our field. After the call with Biden, Tom called me because, like I said, I had a reputation as a "policy guy." He told me that he would only take the job if I would go with him and help him learn the policy ropes. That meant a lot to me and still does, and I was very willing to accept. Serving in ONDCP with Tom was one of the best experiences of my career.

**Bill White:** The President's Drug Control Strategy that emerged under your tenure at ONDCP marked the first time that recovery was highlighted as a potential organizing framework at the policy level. How was this achieved and what are its implications?

**Dr. Humphreys:** A number of organizations and individuals, most prominently Faces and Voices of Recovery, had begun to pull together recovering people into a movement that demanded recognition. So, part of what we were doing was responding to them as citizens asserting their rights and their value—governments often do the right thing because the populace makes them.

We also had some tremendous structural advantages in establishing that office. The first one was that Gil Kerlikowske, the Director of ONDCP and a former police chief, supported the recovery concept even though it wasn't directly in his wheelhouse (anymore than law enforcement was in Tom's or mine). And he was really good at interacting with and listening to the recovering people we brought in, and he did

some outstanding public service messages about recovery that hit home for many people. The second advantage, and I am not going to break anyone's anonymity here, is that there are an awful lot of powerful people in Washington who are in recovery or love someone in recovery: current and former elected officials, high-level appointees, policy advisors, and lobbyists to name just a few. When the plan to add a recovery component to ONDCP went to Capitol Hill, it was very, very warmly received. As a friend of mine said, AA is the last bipartisan club in town, and people who can agree on nothing else will agree that they want more Americans to experience recovery and to celebrate that accomplishment.

**Bill White:** What do you feel best about during your tenure at ONDCP?

**Dr. Humphreys:** The work on recovery is a big one because I could see how much that meant to people. I would tell recovering people I knew what we were trying to establish and they would choke up—even after many years, the shame and stigma remains in people deep down, and I could see that the official White House recognition was healing that. I think the high-visibility events, like having Gil and Tom at the recovery marches, may also have helped people who were still in the active phase of addiction and needed hope.

But even more important than that was getting substance use disorder treatment and brief interventions into the Affordable Care Act as essential healthcare benefits. That was the work of many, many people inside and outside of government, but I am proud that ONDCP was as an important part of it. Tom and I both believe that no chronic disorder will be more affected by the ACA than will addiction. When I think of that along with us getting extra funds into the President's budget for addiction treatment in Community Health Centers and the Indian Health Service, I feel proud of and grateful for my time at ONDCP.

**Bill White:** What would our readers be most surprised about regarding the experience of working at that level of policy development?

**Dr. Humphreys:** I suspect they would be surprised at how, despite all the polarization, people with different political views can still find a bond of common humanity and work together. Before I went to DC, I helped Congress on the Mental Health Parity Act. That was sponsored by Senator Domenici, a conservative's conservative; Senator Wellstone, a liberal's liberal; Congressman Jim Ramstad, an independent-minded Republican; and Congressman Patrick Kennedy, the scion of one of America's most famous Democratic families. How could four such diverse people agree on a consequential piece of legislation? Because they had all personally been put through the wringer in some way or another by experience with mental health and/or substance use problems. That gave them a basis of common understanding that bridged their political differences.

**Bill White:** During your tenure in the Obama Administration, you worked with Congress on parity for addiction treatment in private insurance, and you worked on increasing coverage of SBIRT (Screening, Brief Intervention, Referral and Treatment) and treatment in health care reform. How do you feel these and other factors will influence the future of the addiction treatment field over the next decade?

**Dr. Humphreys:** Yes, the parity regulations were personally meaningful because they were the result of the law I had advocated for from the outside in the Bush Administration. HHS Deputy Assistant Secretary Richard Frank, a brilliant and good-hearted man, was the straw that stirred that drink in the Obama Administration. What we know is that parity rules will not enormously drive treatment seeking, but they will make treatment more affordable for those who want it and prevent families from being bankrupted when their teenager develops schizophrenia or an addiction, which happens far more often than it should. Those changes in private

insurance coupled with the Affordable Care Act changes I have already discussed should serve to bring addiction care into the heart of medical practice, where it belongs. It should mean more resources, less stigma, and better staff, and it should also mean better medicine in general. So many of the problems doctors encounter in cardiology, psychiatry, and pediatrics are exacerbated or caused by a substance use disorder that no one has bothered to ask about. I think when more doctors see how much easier it is to get good results when you address substance use in every patient, our field will be more greatly valued and will therefore thrive.

### International Consultations

**Bill White:** You have had numerous opportunities to consult internationally on issues related to addiction treatment and recovery, particularly in the UK and the Middle East (e.g., Iraq, Egypt, Jordan, Turkey). Could you describe some of the important lessons you have drawn from these activities?

**Dr. Humphreys:** What I learned the most from Iraq is how grateful we should be for the lives we have. I visited a residential treatment program there with 50 homeless, psychiatrically ill patients, many with concurrent addictions. It had one bathroom and one common room for sleeping. Each morning, they drag the mattresses up to the roof in the hope that the blazing Iraqi sign will kill the bacteria and pests in the mattresses. Minimal staff, no budget for activities, and yet, they were all still trying to make a better life.

I have also learned how arbitrary it is what substances scare us. When I met with some officials and doctors in the Middle East, many of them felt that alcoholic patients were too shameful to bring into a hospital, but heroin addicts were no big deal.

Finally, I have learned that even across cultures, certain basic human experiences will resonate. I took a group of Iraqi

physicians to observe an open AA meeting in England. The AA members were so welcoming of them, and even with the language barriers, I could see the Iraqis relating to the stories that the members were telling. They gave my friend Salih Al-Hasnawi, who later became Minister for Health, a copy of the Big Book as a present.

**Bill White:** We have both witnessed the cultural and political awakening of people in recovery and their families in the US and in parts of Europe and Asia. Do you see this as the beginning of a worldwide recovery advocacy movement?

**Dr. Humphreys:** I would like to think so because it's desperately needed. The wisdom of recovering people is lacking in so many quarters where it could make a big difference, and there are plenty of laws that punish recovering people unjustly and put them at risk for relapse (e.g., denying them student loans, driver's licenses). Recovering people are like that shale everyone is talking about in the natural gas industry—a tremendous hidden energy source that could change the world if we could just figure out how to tap it and direct it productively.

### Publishing Addiction Science

**Bill White:** During the past 15 years, you have been one of the most prolific addiction researchers in the world, as measured by the number of articles you have published in the scientific journals. Could you share any secrets for creating such a prodigious body of professional writing?

**Dr. Humphreys:** Thanks for being so kind. Let me relate three things that may be helpful. First, if you want to hone your writing, you should read good writers as much as you can and steal from them. Read scientists who really know how to lay out a logical introduction or put together a crystal clear results section and study how they accomplish it and what you can copy (not literally of course, but the general structure and style of their writing). Try to learn also from non-scientists. I am reading Anthony

Powell's *Dance to the Music of Time*, a sequence of 12 novels, right now and every now and then, he will have a way of describing a relationship or a person or a place, and I will read it over and over to discern how he did this or that well so I can apply it when I write.

Second, and I know you know this, set aside a time for writing and discipline yourself to use it just for that. I wrote *Circles of Recovery* on Sunday afternoons. Every single Sunday, I sat down to write, and I did not allow myself to get up until I had written at least 1,500 words. I didn't check email, I didn't stare out the window, I just wrote. Sometimes, it was an agony, but that was the only way to get it done.

Third, don't worry about writing perfect prose, just write. Rewriting is much easier than writing, not least because other people's critiques can help you. I think *Circles of Recovery* was about 70,000 words, and I wrote at least 100,000 to get the stuff I was happy with. You have to accept that that is the nature of the beast, or you will never write anything.

**Bill White:** What do you most want to accomplish during your future years in the field? Is there a particular legacy you hope to leave the field?

**Dr. Humphreys:** Oh, God, do I look old, is that what you are saying? What I hope to focus on primarily from here on out are the applications of addiction science in clinical work and even more so in public policy. I am not a grand theorist and will never make a contribution of the sort that is of enduring (or even passing) interest. But to help put laws, policies, and programs in place that make it harder for people to become addicted and easier for them to recover is something I think I can do, and that is the legacy I want to have.

**Bill White:** Keith, thank you for your willingness to participate in this interview and for all you have done and are doing for our field.

**Dr. Humphreys:** It was a delight. Thank you, Bill.

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