



Bringing Thomas McLellan to President Obama's drug strategy team could reposition addiction treatment at the heart of mainstream healthcare.

DDN met a man on a mission

Protagonist of **CHOICE**

Ian Ralph

President Obama's 'deputy drug czar' knows a thing or two about addiction. Before being sworn in as deputy director of the US Office of National Drug Control Policy last August, Professor A Thomas McLellan was director of the Treatment Research Institute – an organisation that he founded 18 years ago to bring greater understanding to addiction treatment and recovery. Alongside 35 years of experience as a treatment specialist, he suffered tragedies within his own immediate family that further convinced him that the US had to completely overhaul its attitude toward drug and alcohol addiction.

Over in London to deliver a lecture at the Institute of Psychiatry last week, he was engagingly clear about the way ahead for his national drug control strategy. 'He's now bringing his skills to bear in the political arena, through a respectful dialogue between scientist and policymaker,' commented Professor John Strang, introducing the guest to his audience of addiction specialists, academics and policy professionals.

Listening to McLellan's talk it becomes clear that his arguments for change are just as valid to the UK. He sweeps through an array of diagrams outlining the way forward for US drug policy. At the heart of his aspirations are better screening for drug and alcohol problems, a major initiative to integrate addiction treatment with mainstream health services, and smarter offender management that will put a wedge in the revolving door back to prison.

All of this is about making treatment more accessible; replacing the stigma of seeking treatment with treatment choices appropriate to any chronic relapsing disease.

'In the US we've been thinking about addiction as just a lot of drug use,' he told his audience. 'And as a result we've been purchasing stupidly. We can't decide if

addiction is a crime or a disease so we've compromised and given them treatments that aren't any good.'

Now it was time to 'close the all-too-large gap between those who qualify for treatment and those who aren't getting it.'

He saw mainstream primary healthcare as being at the centre of this, and an essential target in bringing about culture change. 'Most physicians are not trained in how to treat substance misuse,' he said. 'They don't see it as a disease and don't see why they should look for it.'

While he was committed to making a 'sales pitch to doctors', he acknowledged that it was going to be difficult. Out of the 12,000 small treatment programmes in the US, almost half didn't have a doctor or a nurse and only a quarter had a psychologist. The major professional group was counsellors, which had a 50 per cent turnover rate, so it was no mystery that long-term care was suffering.

The task ahead involved integrating addiction services right into mainstream healthcare, he explained, from early screening through to an active role in their patients' recovery.

Early screening went hand in hand with cultivating 'prevention prepared' communities, with particular focus on adolescence – addiction's 'at risk' period.

'If we don't develop a disorder by the age of 21, we have a very low chance of developing one,' he said. 'If this risk period was identified for diabetes I think they'd pull out all the stops to address it... we need to change the way we deliver addiction prevention services. We need to think sunblock, not Band Aid.'

'And if you can't prevent or intervene, let's treat... I know how important recovery is to you in the UK. Our definition of recovery is a voluntary maintained

lifestyle characterised by sobriety, personal health and citizenship – with or without medication,’ said McLellan.

After his lecture, McLellan explained this definition further to *DDN*:

‘I recognise that 12-step is the most popular way of achieving recovery, but it’s not the only way,’ he said. He demonstrated the complexities of the argument by describing a scenario:

Dr: ‘I want you to be sober. I want you to be of good health. I want you to be a good citizen. But you can’t take any medications.’

Patient: ‘What? What about insulin?’

Dr: ‘Oh I didn’t mean insulin!’

Patient: ‘What about anti-depressants?’

Dr: ‘Oh, I don’t know.’

Patient: ‘What about methadone?’

Dr: ‘Oh no, definitely no.’

This kind of polarised view, particularly around methadone, makes McLellan deliberately judgemental about ‘a field where it’s absolutely clear that we’re not servicing, providing care for, anything close to the number of people that need it.’

Methadone is a medication that has had more evaluation in the US than just about any other, he says, adding ‘there is no reason on earth why a person can’t be on methadone, working, being a good parent and having a normal way of life.’

‘That this has been a battle, that you are either on methadone or you are on the path of truth, beauty and light, is artificial and unfortunate. One of the things that we’re going to do with this new integration, we hope, is that a new batch of doctors won’t have these prejudices, because that’s what they are.’

As far as McLellan is concerned, methadone is just another option in the ‘patient choice’ toolkit, and should be offered alongside other medication, social services, employment counselling and psychiatric services to make up the package of rehabilitative care.

He refuses to let stigma surrounding methadone be a barrier to recovery. ‘I’m now officially wagging my finger and saying not just to Britain, but to the whole damn field: get past this, this is an artificial contrivance,’ he says. ‘People ought to have the opportunity to get the medications and other services they need towards the goal of becoming the well-functioning people they want to be.’

If McLellan’s vision comes to fruition, addiction care will be integrated with the work of physicians. General healthcare will benefit from the expertise of specialists, and the pyramid – with general health care at the top, then mental health below it, addiction services underneath, and methadone and buprenorphine right at the bottom – will be flattened. At the moment less than 3 per cent of all referrals to addiction speciality care come from any part of medical care, a situation that McLellan is determined to change by emphasising the practical benefits for all involved.

‘We’ve got to make marriages,’ he says. ‘And we think the way to do that is business. It’s a good business case for a doctor to pay attention to something he’s been ignoring, and we think it’s good business for addiction treatment programmes to start cultivating medical referrals and working with doctors to support them as they begin a very difficult job.’

This integration will, in theory, deny stigma its opportunity, by treating addiction alongside any other condition.

‘You may know that the relapse rates for diabetes, hypertension and asthma are almost identical to the relapse rates for any addictive disorder – they’re 50 per cent per year,’ he says. ‘And no one puts their hands on their hips when a diabetic comes back and says “I ate half a bucket of fried chicken and I forgot to take my insulin, and now I’m back here.” They just treat them.’

And they treat them for life, which is why McLellan talks of a ‘true continuum of care’ and not ‘30 days of treatment’.

‘I am talking about the amount of care that you need when you need it to restabilise your life,’ he says, ‘and take personal responsibility, hopefully with your family and your community, for the management of your illness – as you would for diabetes or schizophrenia.’

This society-wide vision of treatment includes the criminal justice system, and McLellan has persuasive arguments for politicians who think of incarceration as the only response to drug-related crime.

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‘It’s a sort of “pay me now or pay me later” deal,’ he says. ‘And I believe the data are on our side here. The studies that have been done suggest very clearly that in a prison situation, when you release somebody with a drug problem, they are back and you’re going to do it all over again. It’s a bad business deal.’

Introducing treatment and support to drug-using prisoners in the US has produced dramatic results. Monitoring people who left San Diego jail after finishing a term for drug-related crimes without treatment and support showed that 74 per cent of them were back inside within a year. So, according to McLellan, ‘they changed things and started reintegration work the day somebody gets to jail. They work with the families and the individual, doing assessment, developing training plans, monitoring situations, and they modified the sentence too so that recovery oriented services were part of parole.’ The result? The percentage returning to jail within a year went down to 14 per cent.

‘Seventy-four per cent to 14 per cent is a big deal,’ commented McLellan. ‘Now multiply that by \$36,000 for a prison sentence, \$12,000 for a re-arrest. These are massive amounts of money. That’s the kind of thing that gets politicians’ attention – as long as you replicate it.’

It’s this joined up way of thinking that characterises McLellan’s approach to his job with Obama’s team. Just as he wants agencies, health professionals, families and community to all play their part, he has a clear role for different treatment modalities – as components that could work with other components to make up a support plan for life.

Once again this requires a step back to appreciate the long view – particularly for those with entrenched views who believe, for instance, that a stint in rehab will see addiction off for good.

‘I think residential care is important and necessary, but not sufficient,’ he explains. ‘It is like having a very good junior high school education. But sending somebody out after good residential care with no follow-up and no continued aftercare plan gets you the same results as sending somebody out from jail.’

His comments remind him that there is still a long way to go to re-educate commissioners on this way of thinking.

‘A lot of states in the US will say “We purchase a continuum of care. We purchase detox from him, we purchase residential care from him, and we get outpatient care from him. We’ve got the whole thing.” Well here’s the problem – there are no clear relationships among the group. And that doesn’t help me as a purchaser, that doesn’t help me to help my constituents.’

‘What I really want is to be able to say “I won’t buy from anybody until you show me a package that’s going to meet their needs, because I know that if they’re in care longer and more actively involved they’re going to do better.”’

And once again this charming and mild-mannered man reveals a glimpse of the steely certainty that has earned him this prestigious job: ‘It’s time for true continuum of care,’ McLellan says emphatically. ‘And it’s time for purchasers to purchase the whole damn thing, not just little segments.’

Professor McLellan’s London lecture was hosted by the National Addiction Centre and organised by the Conference Consortium, DrugScope and Drug and Alcohol Findings.