ADDICTION LIVES: PAUL ROMAN

[photo]

Addiction Lives records the views and personal experiences of people who have especially contributed to the evolution of ideas in addiction science. To suggest an interviewee, send a statement of up to 50 words summarizing the person's exceptional contribution to the field to the Addiction Lives Editor: Professor Virginia Berridge, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, 15–17 Tavistock Place, London WC1 H 9SH, UK. Tel +44 (0)207 927 2269; e-mail: virginia.berridge@lshtm.ac.uk

INTERVIEW SUMMARY BY VIRGINIA BERRIDGE

Paul Roman has been a researcher in the alcohol and addictions field for 55 years. He entered Cornell University in 1960, staying through the completion of his PhD in organisational behaviour. It was there he met and worked with Harry Trice, who stimulated his interest in alcoholism in industry. After a year at the University of Georgia, he spent seventeen years at Tulane University, then returning to Georgia.

Alcohol was centre stage in the US in the 1970s. Roman was part of the NIAAA (National Institute of Alcohol Abuse and Alcoholism) circle in its very early days. Its creation was largely the work of Senator Harold Hughes and in its early years it strived to create its own identity in the pre-existing world of alcoholism. Roman discusses the relationship between the new organisation and the National Council on Alcoholism (NCA) which led to the demise of that voluntary organisation.

NIAAA focussed initially on the 95% of alcoholics who were mainstream working Americans rather than the 5% who were termed 'Skid Row'. Occupational consultants were trained and sent out to convince the public and private sectors to develop Employee Assistance Programmes (EAPs) focussed on identifying people with job performance problems, an approach seen as the key to identifying alcohol problems. The unions, however, wanted a singular focus on alcohol in the workplace. Strong tension emerged between programme goals which might not be the same -- the sustained recovery of the individual from his alcoholism, or the successful return to work of an adequately performing employee. An occupational organisation was set up, originally called ALMACA, the Association of Labor and Management Administrators and Consultants on Alcoholism, later renamed EAPA, the Employee Assistance Professionals Association. Most union members withdrew their membership in the early 1990s.

In the early 1980s, President Reagan re-directed the money that NIAAA had been giving in workplace programme grants to the states to decide how to spend. NIAAA had funded many 'demonstration

projects': from 1972-82 it had funded around one hundred such projects which aimed to test intervention ideas which could have broader application. These included services for small businesses, seafarers, longshoremen. airline pilots, and flight attendants.

The whole NIAAA support structure for workplace interventions disappeared, but opportunities remained to support research that might bolster these interventions. A new head of the Prevention Research Branch in NIAAA did not support the idea of such research, taking the view that work drove people to drink, and workplace intervention research slowly disappeared. The Reagan era also saw the merging of the separate worlds of alcohol and drug treatment. This fusion set back the destigmatisation of the alcohol treatment field. The Reagan's war on drugs and the arrival of managed care also impacted on the alcoholism field, forcing the growth of a lower cost outpatient industry and the closure of inpatient centres, some of which had strong referral relationships with workplace programs.

The last 25 years of Roman's career has been spent in studying the treatment field, looking at the adoption of innovations. He has studied the NIDA Clinical Trials Network, a longitudinal panel of private treatment centers and a national sample of therapeutic communities. He comments that naltrexone, buprenorphine and naloxone were around in the early 1970s but it took 40 years to connect the dots. While there has been progress in medication assisted treatment, its use has reached a ceiling which is relatively low. A new epidemic emerged in the face of treatment's attempts at innovation. Stigma abounds and the widely promoted integration of the speciality into the overall health care complex is largely a delusion.

LINK TO FULL INTERVIEW, CONDUCTED BY TRYSH TRAVIS, ON THE SOCIETY FOR THE STUDY OF ADDICTION WEBSITE:

https://www.addiction-ssa.org/knowledge-hub/topic/addiction-lives

ANNOTATED BIBLIOGRAPHY

Edmond, M. B., Aletraris, L., Paino, M., & Roman, P. M. (2015). Treatment Strategy Profiles in Substance Use Disorder Treatment Programs: A Latent Class Analysis. *Drug and Alcohol Dependence*, *153*, 109-115. Doi:10.1016/J.Drugalcdep.2015.05.047

I look back with pleasure on this piece because of the process that went into its development. I was privileged to be working with these three outstanding young scholars. Our goal was to put into perspective the incredibly publicized but shop-worn belief that most treatment for substance use disorders was based on 12-step programming. The findings here show how 12-step concepts are woven into treatment strategies rather than driving them, demonstrating creativity and high clinical sensitivity within many treatment programs rather than some kind of blind lock-step conformity to 12-step principles. We made a mistake in not highlighting that theme in the title of the article, as we had planned to pursue these exciting findings in further papers that are yet to be written.

Knudsen, H. K., & Roman, P. M. (2016). Service Delivery and Pharmacotherapy for Alcohol Use Disorder in the Era of Health Reform: Data from a National Sample of Treatment Organizations. *Substance Abuse*, *37*(1), 230-237. Doi:10.1080/08897077.2015.102869

A large part of our research emphasis had been on the adoption and implementation of medication assisted treatment (MAT). This was an ideal context for studying an organizational innovation because was distinctive and required other organizational changes. The findings seem to be sustained over time, namely that roughly 40 percent of substance use disorder treatment programs will adopt and consistently utilize MAT. This seems to be a "plateau" figure and of course varies by the definition of adoption and use that is applied. From the perspective of the research evidence that we accumulated, it is unfortunate that it is now normative to "condemn" programs that do not use MAT, or do not use it broadly. Caricaturing such programs are primitive or locked in some kind of blind tradition is simply wrong. Our data indicated that centers had their own clear reasons for not using MAT, much of which centered around employing adequate medical personnel, and equally strongly, being committed to a certain organizational culture of treatment. These cultures are not identical such that one can easily describe an MAT and a non-MAT culture. Some proponents of MAT ignore the data about MAT effectiveness, and come close to claiming that refusing to offer it is malpractice. Also unfortunate is the publicity which views MAT as a uniform, single entity when in fact the applications and actions of the medications are very different. This of course is not meant to deny the efficacy of MAT and the impact it has had on many who might not have otherwise recovered, but from the experience of talking to a great many program administrators, it is not the magic bullet that some seem to imagine.

Roman, P. M., Abraham, A., Laschober, T. C., & Knudsen, H. K. (2010). A Longitudinal Study Of Organizational Formation, Innovation Adoption, And Dissemination Activities Within The Clinical Trials Network Of The National Institute On Drug Abuse. *Journal Of Substance Abuse Treatment*, *38*(Suppl. 1), S44-S52.

I was fortunate to receive 10 years of funding from NIDA to conduct a study of the Clinical Trials Network (CTN) that NIDA had formed to use RCTs to jump-start and then sustain the development of new evidence-based treatment practices as well as refining established practices. Since there are no comparable networks addressing other behavior disorders, it is difficult to measure the success of this effort. Our study's basic aim was to compare the implementation of evidence-based practices among treatment centers inside and outside the network, and indeed CTN membership was clearly associated with greater adoption behavior, although the differences were not as dramatic as one might expect. Two observations that became clearly formed over time were, first, the benefits that accrued to

treatment programs through CTN membership that brought them into both a strong community as well as into CTN sub-communities that enhanced overall morale considerably. Our national surveys of treatment programs have repeatedly shown their isolation from each other and the general sense of "normlessness" exacerbated by high counselor turnover and funding insecurities. These result in turn from an external organizational environment riddled with unpredictable and often irrational changes in funding and procedures, in turn resulting from the political and non-professional penetration into US treatment rule-making and resource distribution. CTN membership and participation (the former did not assure the latter) buffered these morale-grinding features of working in substance use disorder treatment. The second observation was observing the failure of "democratic science" that was attempted in the CTN through an initial declaration that researchers and treatment providers would be almost rigidly equal in determining which clinical trials would be launched. While themes of such "participatory democracy" seem to prevail in many quarters of healthcare today, the CTN experience suggests that there needs to be more attention to stubborn impediments that evolve when diversity and equity issues become the pivots for decision-making, invariably blocking compromise with conflict.