**Richard Moldenhauer**

**Narrator**

**Amy Sullivan**

**Interviewer**

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Richard Moldenhauer -**RM**

Amy Sullivan -**AS**

**AS**: This is Amy Sullivan and I am with Rick Moldenhauer at the Department for Human Services in St. Paul at 540 Cedar Avenue. Can you state your name and give me permission to record this interview?

**RM**: Hi, my name is Richard Moldenhauer and I give permission to record this interview.

**AS**: Could you start by talking about where you grew up and what your childhood was like, your schooling, and how you got into your career?

**RM**: I grew up in a little town called River Falls, Wisconsin. I was born and raised there. I had a public education kindergarted through twelfth grade. I also attended college—both graduate and undergraduate—at River Falls. I have a Bachelor of Science degree in Psychology from River Falls and then a Master’s in Science and Education again from River Falls. I spent a large portion of my life there. I currently still reside in Wisconsin. I’ve worked in substance abuse treatment in both Wisconsin and Minnesota. I’ve worked at pretty much all levels there are for substance abuse treatment. I’ve done everything from [unclear] psych dual diagnosis to outpatient to halfway homes, adolescents, adults, pretty much a wide variety of everything like that. I did well in junior high and high school. I’m an only child. I’m married and have children. Kind of the American story I guess.

**AS**: Do you still live in River Falls?

**RM**: I live outside of River Falls now out in the country.

**AS**: Can you talk about your first jobs and how you got into addiction treatment?

**RM**: When I first started out in college I wanted to be a physician—an osteopath. I was originally pre-med. The way that River Falls at that time orchestrated college courses you could be pre-med but you still had to declare a major and minor and things like that. I chose psychology and my interest was really to be a doctor of osteopathic medicine and then focus on psychiatry. Psychology was the logical fit. I took all the biology and chemistry and stuff and gravitated more and more towards psychology.

I finished undergraduate, but when I wasn’t all the way through undergraduate I started to lose a lot of the the biochemistry and doctor part of it and was more interested in the softer science or the behavioral aspects of it. As I maticulated and graduated I turned around and went to graduate school in River Falls with an MSC—Master’s in Science and Education with a focus on Community Counseling.

My first job in human services started in the fall of ‘83 at a residential group foster home outside of River Falls that was all male, court ordered and almost all of them had substance use disorder problems and behavioral conduct problems. They were in court for stuff like that.

**AS**: And they were under eighteen?

**RM**: Yes, all juvenile. In that piece of employment I had contact with in today’s world we call comorbid disorders—dual diagnosis or COD even though we had different terms for it then.

**AS**: What did they call it then?

**RM**: It would depend on who you talked to. Dual diagnosis. At that time there was still a lot of what is primary? What is secondary? What is the initial etiology versus symptomatic outcropping?

**AS**: There was a ranking.

**RM**: Yes, much more than there is today. Depending on who you would talk to a lot of the mental health folks would tell you that the substance use was a symptom of underlying mental health etiology. If you talked to the traditional substance abuse people they would tell you what appears to be mental health symptoms are just a roller coaster on the Jellinek Chart of Intoxication Withdrawal and things like that.

I did that and at the same time I was going to school. When I graduated at that time I then went and enrolled in graduate school. I enrolled in a locked dual diagnosis program that was in Prescott, Wisconsin, which is closed now. That was locked adolescent and adult. It was technically a psychiatric facility all for dual disorder people. You had an increased level of acuity and impairment. This would have been in the mid and late eighties now. The primary substance you would see floating around this area was alcohol—always has been and always will be. A lot of marijuana. Then you saw a more increased smattering of some of the other substances that have now really proliferated. We saw some heroin, some pharmaceutical stuff, but not much. This was on the tail end of the powder cocaine and crack days.

**AS**: Who were the heroin users at that point?

**RM**: Most of the folks that were coming into that facility at that time and the demographics of the time were older people. If you look at today’s numbers the primary demographic are in their early twenties. At that time the primary demographic were much older—in their forties or early fifties.

**AS**: So these were long-time users.

**RM**: Yeah. More long-term users. Heroin at that time was not an initial drug or a gateway drug. Heroin was like the last rung on the ladder. People that were using heroin back in those days in the mid to late eighties were folks who had already gone through alcohol and cannabis and had done crack and everything else. Heroin was the last thing there was for them to move into. In today’s world you see heroin and other pharmaceutical opiates used maybe not as the original substance of introduction, but certainly much earlier in age with a faster onset and more pervasiveness and greater acuity. The heroin that is floating around today—the Bureau of Criminal Apprehension lab, when they do the heroin analysis, they’ll tell you that the purity of heroin today is vastly increased from what it was in the eighties and that timeframe. Heroin purity samples were twenty odd percent pure. Today the BCA does spectral analysis and finds stuff up from eighty percent purity. Today it is cut with things like fentanyl and carfentanil, which makes it multiple times stronger.

**AS**: I do want to talk about that later when we get to it. Can you talk for a minute about the kids that you first worked with? As a freshman in college you weren’t that far from their age. What was it like to work with them? What do you remember of those young men and their stories?

**RM**: It was a little different because I was so much more closer to age in them. I was only three, four, five years older versus some of the other staff at the facility who could have easily been our collective parents’ age. I had advantages and disadvantages to that. You know when you were sitting around listening to the top forty stations? I knew the same music they knew versus some of the other staff who were still from the Buddy Holly to the Beatles timeframes. I was familiar with the terms, the lingo, the music, the culture of that early eighties timeframe versus some of the other staff who weren’t. There were some difficulties with it too in being seen as a staff person or as someone who had a degree of authority in decision making or trying to be involved in the therapeutic process with them because I was so close to their age at the time that the lines had the opportunity to blur. There was a lot of work and effort to delineate the line between Rick as a staff person and Rick that they might see walking down Main Street.

**AS**: Where you could have been their friend.

**RM**: I was of the age where that certainly could have been a possibility. I was someone they could have ran with.

**AS**: After the lockdown Prescott dual diagnosis where did you go from there?

**RM**: I had a number of jobs that overlapped with each other so there’s not a really clean A, B, C. I worked at Metropolitan Clinic of Counseling for a number of years and did EAP [Employee Assistance Program] work for them for GE [General Electric] a number of years out of Eden Prairie. Most of it was telephonic. GE is a huge multi-national, international organization, so a lot of the stuff I did was assessment referral, telephone types of things. I worked on Prairie Island on the reservation for a while doing adolescent youth substance abuse counseling. I worked at Hudson Memorial Hospital doing the same type of thing. I worked at Dakota County Detox. I would have to go back and look at my resume. There are so many to try and remember. I worked at the Veteran’s Home in Hastings for three years before I came here and I’ve been here since 2001.

**AS**: Let’s start with the nineties and your familiarity with what was happening with opiates and heroin.

**RM**: I’ve got a chart going back to about 1995 right now, so I can give you the whole thing from ‘95 to 2016. In Minnesota the number one substance that people come to treatment for has been and forever will be alcohol. It’s a little over fifty percent. When we are talking about what the client themselves identifies as their primary substance as time of admission into the treatment center. The data collection methodology we use is called EAAENS. So, slightly over fifty percent identify their primary substance as alcohol. Over the span of time the second most common type of substance abuse was marijuana up until just a couple of years ago. That was overtaken by pharmaceutical opioids and now has been taken over by heroin and methamphetamine. Cannabis as a primary substance has actually become kind of a B-squad. It is not as prevalent as defined by primary substance at time of admission. Alcohol use is still king of the hill, if you would, but then you have heroin and methamphetamine.

A couple of general trends, if you would, were people that were coming to treatment back in the early mid-nineties still were what were thought of as single substance or primary single substance: they would just drink. Or their primary thing was cannabis, or their primary thing was cocaine. Today, that mono-drug user just doesn’t seem to exist anymore. Today there will be a stated preference for something, but it’s not a drug of choice. It’s more of a preference on a continuum. They prefer A but they use B and or C and or D. It’s more of a question of what is available and what they can get.

Speedballing is really popular in the mid to late eighties and then it kind of went away now, but it has come back again. Speedballing was heroin and cocaine back then but today speedballing is heroin and methamphetamine.

One of the things you notice over time are trends and patterns that ebb and flow, come and go. Alcohol still wears the crown, but then underneath that you see a lot of changes. Where we see a lot of notable changes in particular is in age range. Each substance and each combination has a different demographic. With pharmaceuticals or with heroin what used to be a forty or fifty year old age range back in the eighties now is twenty to twenty-four years old. The age of first treatment episode where the individual identifies heroin or a pharmaceutical opioid is about half what it was twenty, twenty-five years ago. The primary presenting client is much younger. Depending on what part of the state you look at there are specific concentrations for heroin in particular. In and around reservations in particular. The disproportionality of American Indians as compared to prevalence by population is vastly greater than it is for the general population.

**AS**: So even as usage by young, white people has increased it still hasn’t proportionally reached the Native American population?

**RM**: It has. If you look at pure, raw treatment numbers caucasian is the highest for just about everything because eighty-odd percent of Minnesotans identify as white. In the state demographer’s statistics you will see that people that self-identify as American Indian are 1.1 percent of the population in Minnesota, yet when you break it down by drug of choice pharmaceutical drugs versus heroin versus methamphetamine or even general treatment numbers generally speaking when you control for incidents by thousand—in research epidemiology one of the ways we try to demonstrate the prevalence of something in a given population is we make a level playing field. Incidents by hundred or incidents by thousand are just a general way of doing that. So for treatment admissions for all substance abuse American Indians are about eight per thousand versus all other races combined which is a little bit about one per thousand. As you go into heroin or methamphetamine or opiates that goes anywhere from eight to about fifteen per thousand versus other races combined. There is a hugely disproportionate overrepresentation for opiates and methamphetamine for people who self identify as American Indian versus other races in Minnesota. I can send you those slides. You see that played out both as population demographics self identified as American Indian and the geography of Minnesota. Some of those maps you see the darker areas are almost exlusively around reservations. The one exception being Hennepin County, which is not immediately contiguous to the reservation, however there is a very large percentage of American Indians in and around Phillips and Little Earth and that area.

**AS**: Can you back up and say what you said about when you started here in 2001. Can you describe what your job is and what your work is? The word opioid is in your job title.

**RM**: I kind of carry two job titles here. We are a public union, so I am a principal planner. That is my technical job classification according to the union. One of the insular duties I have carried since I started here is State Opioid Treatment Authority, which used to be called State Methadone Authority, and then they changed that title four years ago.

**AS**: Why did they change that?

**RM**: What used to be methadone treatment programs now expanded to other medications besides just methadone. There is methadone, buprenorphine, what was called WAM which is an acronym, you see vivitrol. They wanted to expand the title to be more inclusive rather than just identifying a particular medication: methadone.

**AS**: And to identify what the problem was and not the medication used.

**RM**: It’s a better descriptor of both problem and solution—I don’t like the word solution—intervention instead of just targeting one particular thing.

**AS**: Why don’t you like the word solution?

**RM**: Well, I view addiction of whatever substance it happens to be a multifactoral issue, whatever you want to call it: a disease, a disorder, a maladaptive coping skill. There are a lot of schools of thought and philosophies about that. I don’t think I as a professional or we as an agency have a solution. There is not a single solution. Science isn’t that good. We don’t have the addiction pill to solve or resolve everything. When you look in the DSM-5 addiction, or in today’s world when we talk about substance use disorder there has been a lot of changes in the DSM—the diagnostic and statistics manual. When you look in the current edition you have specified from moderate to severe, and then you have symptom constellations, and certain numbers of all of these mean mild, moderate, or severe. There is a degree of volition involved in that. Passive exposure to something does not qualify as addiction. If somebody who may have intoxication from an inhalant because they work in the industry, but there is not volitional effort on their part to concentrate it—it is passive exposure because they inhaled sewer gas and hallucinated—they are not an addict in the same sense as a fetus that was born with neonatal abstinence withdrawal syndrome because of gestational exposure that child, baby, fetus, will have a recognized withdrawal syndrome, but the baby is not an addict because they had no volitional choice. If mom used while baby was on board the baby got some of the parent compound and the metabolite, versus volitional choice and going out and purchasing and using and stuff like that. I think I am diagnosing. [laughs]

**AS**: It is interesting. What about your job here? What have you been doing and what you’ve seen?

**RM**: Each state has at least one opioid treatment program and it has a SOTA—State Opioid Treatment Authority. There are forty-eight of us right now scattered throughout the country. Part of the SOTA role is to work as a go-between between state and federal agencies that regulate opioid treatment programs. We are the folks that try to knit stuff together for them. In Minnesota right now we have seventeen opioid treatment programs. One of them residential sixteen of them outpatient. They are licensed and regulated by a variety of different agencies both state and federal.

**AS**: When you say opioid treatment programs do you mean what we would call methadone treatment clinics?

**RM**: What used to be referred to as methadone programs.

**AS**: You regulate them?

**RM**: I function as a go-between is one way to describe it. While I do not have actual regulatory authority over them I am the guy that goes around and tries to knit everything together. You will have state and federal level requirements and things and I’m the one that explains and knits everything together. They have a Rule 31 license. By division of licensing they enforce that. They are registered as a narcotics treatment program by the DEA and they enforce that. They have to have an accreditation body like [unclear]. I’m the guy who runs around and knits all of that together. To keep the whole machine working.

**AS**: What have you seen change? You said four years ago the name was changed, but what was happening before that? What is the difference between methadone programs then and now?

**RM**: There are a couple of noticeable changes both in the clientele served and the method of service delivery. The clientele served back if we had had this conversation twenty odd years ago were almost exclusively heroin addicts. You didn’t often find a pharmaceutical opioid addict. Today there are a lot of pharmaceutical opioid addicts. In today’s world a lot of folks coming in and using heroin are the same folks that were coming in four, five, or six years ago that were using pharmaceutical opioids. They started out with vicodin, percodan, and percocet and either as a result of a legitimate medical etiology—sprain, break, or tear—or that was their substance at that time now have converted over to heroin.

There are a couple of reasons for that. There have been changes in scheduling of some pharmaceuticals. There has been an examination by individual practitioners and larger chains of clinics or hospitals around their prescriptive practices. It’s not as easy to get the prescriptive opioids as it used to be. If you have a pool of people that have an active addiction to an opioid and the source of it starts to diminish they will come over here where they can get more, stronger, and cheaper. It is the migration of substance use.

You see a change in the patient profile. It used to be forties and fifties and now it is twenty to twenty-four year olds. The gender changed a little bit but not as much. There was a vast discongruence in racial breakdowns too. It used to be primarily caucasian and some black. Now it is primarily Native American. There has been some shift in that.

From a treatment intervention standpoint methadone and laam were the two original FDA approved medications to used.

**AS**: What is laam?

**RM**: Levacetylmethadate. That went off the market years ago. There was concern about it causing cardiac arrhythmia called QT prolongation. It is gone and you can’t find it anymore. That left methadone as the sole pharmaceutical for a time. Now you have methadone, buprenorphine products like suboxone and subutex and there are different formulations of those. There are tablets, strips, et cetera. There is vivitrol now, which is an injectible. A few others.

Part of the desire to change the name from State Methadone Authority to State Opioid Treatment Authority was a reflection of the changes of both the drug of choice or the primary substance of abuse no longer being almost exclusively heroin and being the pharmaceutical pills as well as the treatment intervention not aimed solely at methadone but methadone and buprenorphine products and whatever the next intervention pharmaceutical happens to be.

**AS**: What is your feeling about how treatment has changed in terms of the twelve-step model from the seventies and eighties? It seems to me that there were methadone clinics and those were people that were totally down and out. There is a huge stigma still around methadone. Can you tell me about what you’ve seen change and what you think about medication assisted treatment today? Where do you see it going?

**RM**: There has been a change in the acuity of the patients as well—the clients if you would—as well as with the age demographics and geographic areas. It used to be that heroin was primarily found in large, major metropolitan areas. You’d see it in Minneapolis, St. Paul, Duluth, and Rochester. Now the maps indicate that it is everywhere. It’s not just the big city drug anymore.

Along with that there have been responsive changes in the system. In the delivery of substance abuse treatment. If you go back the mentality—the zeitgeist—in the early mid-eighties was that everyone went to detox, twenty-eight day resident care, six months of a halfway home and then if that didn’t work it wasn’t because the system wasn’t responsive to their needs it was because they weren’t motivated or they hadn’t hit rock bottom yet.

**AS**: It was the responsibility of the client.

**RM**: This is back when the accepted standard were things like the hot seat. They would put you in a chair in a big circle and just pepper you with statements and questions until you broke down and cried and hit rock bottom. Then they would rebuild you and all this type of methodology.

**AS**: Do you remember the names of some of the therapists that came up with that?

**RM**: If you just searched ‘Minnesota Model’ and ‘hot seat’ you will find a few agencies today that believe in that kind of methodology. It is decreasing. There has been a real awakening in what in today’s world I think is referred to as COD or dual diagnosis and co-occurring disorder. That is the popular term. The work I do as adjunct faculty at the graduate school is they have both a degree or Master’s confirmant in COD as well as a certification program in COD. There has been a real awakening to the idea that you aren’t *just* an addict or you don’t *just* have mental health issues. You can have both at the same time. Often one is in play or interlaced with the other. Part of that awakening is a change or an awareness that the clients coming in today are more acute than they used to be.

In Minnesota we have what is called the Sixth Dimension model. It is a modification of the American Society of Addiction Medicine’s patient placement criteria. You have these six different dimension with a zero to four of severity or acuity rating. People coming into the system today are simply more acute than they used to be. Not only are they younger, but they are more severely affected and impacted at younger ages than they used to be. Some of that can be because of the purity of the drug. Some of it can be because of the social nature of heroin in particular. When you look at different drugs there is a different culture built around. Heroin in particular you see as a community drug. People will individually shoot heroin, but they will also do it in groups in the same vein you see people use marijuana part of the culture of marijuana is you will fire one up and pass it around the room versus tobacco and cigarettes where you don’t see that.

The system itself has become more aware and more responsive to the acuity of the individual clients coming in. A big piece of that acuity is not only the drug itself, but the behavioral correlates that come along with that. There is an increase in mental health symptomology. If you reference the DSM 5 you will see things like ‘anxiety disorder induced by opiate withdrawal.’ There is a period of time where you have mental health symptom constellations that are a product of the intoxication or the withdrawal of the drug. They often respond to medications in the same way. Someone who comes into the emergency room or general medical care that looks like they have generalized anxiety disorder the gold standard in medicine for GAD—generalized anxiety disorder—is to use an an anxiolytic medication like alprazolam or phenazepam to treat anxiety. If you are an addict in withdrawal and you show up with a symptom constellation that looks like that that is the medication you are going to receive with no ill intent by the practitioner. That’s just what they see. That’s what their training tells them to give, which the addict will then use to modulate their withdrawal. They start to feel normal again and the cycle continues.

With opioids you see an increase in a lot of secondary complications that come along with it too. The mental health stuff. You see a lot of additional use of potential addiction through the anxiolytic medications like alprazolam and phenazepam. You see a large incidence of blood borne pathogens with heroin addicts in particular because of route of administration with needles or behavior they may engage in as a product or byproduct of the addictive nature and addictive use of the drug. Hepatitis and HIV and things like that. Mary from RAAN [Rural AIDS Action Network] can speak directly about that. She has a lot of statistics and numbers about that.

**AS**: You were talking about the Six Dimension model.

RM: I can send you some stuff on that. It is a standardized method of assessment that we use for substance abuse treatment in Minnesota and have for a number of years now. It has six different dimentions that look at people more wholistically. It’s not just what is your drug of use, how often do you use it, when did you start using it. As an illustration dimension one is intoxication and withdrawal. Eveyone is rated zero through four. Zero is least impact and four is severe concern. With dimension one we look at intoxication withdrawal. We look at dimension two: biomedical. Does the individual have a traumatic brain injury that would affect where they would go for treatment? Also how treatment services would be delivered to them.

Substance abuse treatment, especially in Minnesota as we have done it with the Minnesota Model where they talk about doing steps one through five and the third week is family week and how it used to be is a fairly academically driven method of service delivery that presupposed a level of cognitive ability on the part of the client that may or may not be there. Now that we have come mulitple generations down stream with what we know about FASD [fetal alcohol spectrum disorder] and neuroplasticity—how things affect the brain and how the brain responds to things—to take someone who has been an active rip and run heroin addict for the last five years and assume that they are going to be able to engage in a fairly literature based experience of reading the twelve and twelve, the schools and models, the Big Book, and completing these work books on steps one through five all in the span of twenty-eight days when you’ve been pumping delotive into yourself every six hours for the last two years—those two are discongruous. They don’t work well together. An individual client may fall behind and may not get their assignments done on time and depending on the sensitivity of the staff they are seen as resistant to treatment or not surrendering themselves. They blame the clients. The clients get frustrated and act out. Then they get washed out of the programs.

**AS**: Then they are back on the streets. So how is this different? When did the Six Dimension model appear?

**RM**: It is about eight to ten years ago that we started doing it in Minnesota.

**AS**: Who is the leader in doing this now?

**RM**: The Alcohol and Drug Abuse division. It is based on the American Society of Addiction Medicine’s model. The Alcohol and Drug Abuse division, which is who I work here for are the ones who drove the idea of accepting a Minnesota-ized version here. Have you heard of the Rule 25 assessment tool? The Rule 25 assessment tool uses that Six Dimension model. When somebody has a Rule 25 done at the end of it you will see that they have a rating in dimensions one through six severity rating from one to four. That is the outcome of that.

**AS**: That’s how if someone is on medicaid they need ninety days or thirty days. They look at the whole picture?

**RM**: Yes, they look at the whole picture. In and of itself it is not a determinate for the length of time of placement, but it does play a role in determining a level of care or type of care. If somebody is looking for an opioid treatment program in particular for heroin that is taken into account during that process. If someone has a traumatic brain injury in dimension two that would be taken into account. If somebody is homeless in their recovery environment in dimension six that is taken into account. There is a whole placement criteria of who goes to outpatient, who goes to residential care and stuff like that based on that assessment. In that Rule 25 tool there is also a mental health screening built into it two. The GAIN-SS short screen.

Substance abuse treatment today I think is looked at more holistically than it used to be. It’s not that you’re just an addict. You can have an addiction and medical problems; you can have addiction and have mental health problems. It’s not A and B or chicken and egg. It’s more of a fused, integrated, co-occuring aspect. I think there is a greater sensitivity to that now. In the eighties you would hear a lot that people’s mental health problems would just go away if they quit using. It doesn’t necessarily work quite that cleanly. Or if you resolved your mental health problems your addiction would magically stop. That just doesn’t happen.

There is a much greater awareness of how brain function is with PET scans and tomography and things like that. In the same sense there is a greater sensitivity that it’s not just cleanly this or that, but there is a fusion of all of it together.

**AS**: And we don’t understand completely how it all interacts. There is more awareness about how complicated it really is.

**RM**: Yes. There is a greater awareness of the complexity. The complexity of individuals and how delivery of treatment needs to be not just a cookie-cutter. You can’t just go to detox and just twenty-eight days of residential and just six months of halfway home. Or that this program is not the solution for everyone every time, every place, everywhere.

**AS**: You see a more flexible, individualized treatment model?

**RM**: Yes.

**AS**: Do you have any thoughts about the schedules and methadone and heroin and its regulation? Is there any chance that it would be downgraded or expanded?

**RM**: I’m not sure what you mean by downgraded. Methadone is a schedule two and buprenorphine is a schedule three now.

**AS**: Right, so methadone is more highly regulated. You can only do it in certain places. Do you see that changing, or methadone programs becoming less stigmatized?

**RM**: There is still stigmatizing to opiate treatment programs. By the DEA methadone is a schedule two. Buprenorphine products are schedule threes. Buprenorphine is a little different in that it can be used in an opiate treatment program and individual practitioners, MDs, DOs with training and additional registration and stuff can also do it out of OBOT—Office Based Opioid Treatment. Part of Buprenorphine’s introduction here in the Drug Addiction Treatment Act of 2000 was to make it more flexible for individual practitioners as opposed to having to go to a program. Methadone programs, whether it is methadone or buprenorphine through that program is still seen by many people as quote unquote harm reduction.

In the eighties you had done everything there was to do and this was just palliative care. You were going to be there forever and this was the only thing left to offer you because everything else had failed. That’s not the attitude that you see today. Individuals may still have that belief. Certain funding streams or practitioners may believe that. Certainly the patient demographic has changed because it’s not just forty to fifty year old guy with three green teeth who has failed abstinence based treatment fifteen times. When you have people that are twenty to twenty-four showing up it’s more acceptable.

There was a real prevalent belief that once you enrolled in an opiate treatment program in the eighties or nineties that you were there for life, but that’s simply not true. Our GAIN data tells us that an average admission to discharge timeframe is around a year and a half to two years right now. Now there’s a number of reasons that can play into that. It can be funding sources, people moving, people simply chosing to leave, people are sometimes removed from a program, administratively separated or discharged. There are a bunch of reasons why, but the fact of the matter is that the stories you hear about people who have been on methadone programs for thirty years are very small outliers at best. That’s not how the system works.

**AS**: Those people are much older.

**RM**: There is a degree of aging out. Back in the eighties when you looked at the average person that was on a methodone program back then had a lot of additional medical complications to them. That’s not tremendously different now. We still see a lot of people that have Hepatitis or HIV or insilulary secondary problems, but there is a big difference between a fifty year old guy with a cirrhotic liver and hepatitis C and a twenty year old person that doesn’t have a cirrhotic liver and may have hepatitis in a system of health care and the ability to withstand that as a function of youth. Forty years of shooting smack versus a year and a half of pharmaceutical opioids are two very different people. The medical compromising of the older person versus the younger person is that the older person is going to hit mortality sooner than the younger person just as a function of physical decay over decades of use versus months or a couple of years.

**AS**: What are you seeing about the positive outcomes with medication assisted treatment? Are you collecting data on that? Are people following clients over a period of time in the state?

**RM**: The short answer is yes, we do. Part of it depends on how you define success. Within that you have people that embrace any of the continuum of a definition of harm reduction. There are people that will tell you that their flavor of harm reduction is that the individual continues to come back, and whether they have intermittent use or continued use and continue to come back for some form of service. The back of the NA chip says, ‘Keep Coming Back.’ As long as you keep coming back, as long as there is the opportunity for continued intervention that’s better than nothing.

As you move along a line of conservative interpretation of harm reduction they will tell you that there is success in a decreased amount of heroin used, or they have stopped heroin use, but they still only ocassionally smoke or drink marijuana, all the way through complete abstinance from any and all mood altering substances, maybe with the exception of tobacco and caffeine. There is a huge continuum along that line. Thirty or forty years ago it was kind of a one stop shop—either you were completely clean, minus tobacco and caffeine, or you were an active junkie. With the increasing complexity of people coming in with a lot of mental health stuff there is a greater acceptance of folks who have comorbid disorders and the use of psychotropic medications, too. It’s not that long ago, and you can still find self-help meetings around here, where they will tell you if you are on psychotropic medication you’re not sober. Or if you’re on methadone or buprenorphine or any other medication assisted therapy you’re not really sober.

There’s nowhere else in behavioral health or med/surg that you see that type of mentality applied. I hold licensure as a drug and alcohol abuse counselor. I also hold licensure as a LPCC—a Licensed and Professional Clinical Counsellor which is a mental health professional by state definition. If I am working with somebody who is a heroin addict and we talk about medication assited therapy and we are talking primarily about methadone or buprenorphine products, if I’m working with someone who is an active hallucinatory psychotic that’s on Seroquel, which is any typical antipsychotic, nowhere in his or her treatment plan do we talk about trading off of Seroquel. Nowhere do we say, “Your life will be much better if you don’t have to keep taking that Seroquel.”

When you talk to folks who have a bipolar disorder we talk about compliance to medication to stabilize mood, not withdrawal from medication to see if you’re all better now. Only here when we talk about active addiction do we seem to find that. Even within addiction there is a bifurcation of that mentality. There are folks who find it completely acceptable for somebody who has difficulty or is unable to stop drinking being on Antabuse Disulfiram there is a real behavioral modification way of trying to address a spiritual disorder. If you take Disulfiram or Antabuse, but you don’t drink alcohol, you might have some of the noticable sideaffects like dry mouth, loose stool, and stuff like that, but really nothing bad happens. If you take Antabuse and you drink you’re sicker than hell and puking that’s completely okay because then you are being punished for your addiction versus taking an opioid repalcement medication where if you are at normal therapeutic dose you are just normal. You’re not high and you’re not in withdrawal. You just feel normal. But then for some reason we have to talk to you about titrading off of that or weaning off of that medication because we know you really want to be ‘sober’ and you can’t be if you are still taking this medicine. Then somehow we don’t want to talk about that with anything else. “You came in today and we checked your diabetes profile and your ANC [absolute neutrofil count] is fourteen right now and your glucose is close to six hundred, but we really want to get you off of that insulin.” You don’t see those kinds of discussions in other forms of health care.

**AS**: Which is a huge stigma and a huge problem. I went to Zurich a couple of months ago and met with the director of an addiction medicine clinic and because they had the needle parks in Zurich in the eighties where they had so many deaths and so much illness and how they treated that problem all on its own using medication and basically have eliminated it. People don’t do heroin very much there anymore. I just got this perspective that it’s really how we perceive it and you were just getting to that with your examples. Do you see any way in the near future where we could change the thinking and attitudes around it? Are we stuck with this hundred year old opium junkie stereotype?

**RM**: I think there are couple of ways and I can give you a few angles. If you go back forty or fifty years it was actually illegal to treat an addict with an opioid. There was one treatment center in the country and it was the Federal Narcotics Farm [unclear]. It was an old renovated prison. Doctors Nyswander and Dole published a landmark paper at the end of the ‘67 or ‘68 about the use of what was then the narcotic replacement was methadone—dolophine—because it has a long half life of twenty-four to thirty-six hours and all the pharmacology about it they were able to maintain addicts. There has been a shift away from incarceration—the Federal Narcotics Farm—you would go there for anywhere from twenty-one days to six months and then you either ‘got the cure’ or you didn’t and you would come back. There has been a shift away from that to the idea of methadone for those people that somehow couldn’t be reached by anybody else.

Then you have the DATA [Drug Addiction Treatment Act] 2000 act with buprenorphine which was a very volitional, intentional act to try to destigmatize the use of medication out of a physician’s office versus going to that clinic. Prior to 2001 the Food and Drug Administration, which still plays a role, had a much larger role in regulation of methadone programs. Under those old rules and 21 CFR 291 505 you could never get anymore than a twenty-one day take home dose regardless of the amount of time you had been on the program.

The Center for Substance Abuse Treatment steps in as the new agency in 2001 with new regulations that are more laxed or more understanding. I think the best example of that is the idea that you could never have more than two weeks of take home medication because all you are going to do is sit around and be stoned anyway versus the idea of getting people to be more normal. There is an eight-point criteria now to get take home doses and among some of those eight-point criteria and among treatment plans today is going to school, going to work, and doing the stuff that ‘normal’ people do so that you don’t just go to the clinic everyday to dose. The idea is to get you to be less and less reliant on the clinic and things like that and more and more engaged in normal ADL—activities and daily living stuff.

Making it more acceptable to have take-home medications, having a degree of expectations that is flexible to individual needs rather than this is how we are doing it and if you don’t like it that’s too bad. I think there are landmarks that show you from the days of the Federal Narcotics Farm up through today where there is a greater empathy and understanding and expanse of the complexity of the individual client or patient, as well as the flexibility required to meet the individual. It’s not just an inner-city drug anymore. It’s not just that old dope fiend anymore. When it’s the twenty year old girl from Eagan shooting smack versus the sixty year old Hmong guy in upper Frogtown those are two very different people. It is the same drug, but the dynamics, the cultures, and the expectations are very differnt. They are all still in Minnesota. They are twenty miles apart from each other. The one size fits all has given way.

I think there is hope. In the same vein there is competing interests. When you look at the DEA they by its nature is an enforcement authority that looks at scheduling and regulation more from a law enforcement standpoint versus DHS issued license Rule 31, which is more soft-science treatment standpoint. Rule 31 is the chemical dependency licensure for Minnesota. There are different agencies that have competing interests in the sense of regulation and the sense of funding.

The one thing you can never control for in any piece of research is who funded it. People fund studies to get answers that they want to get. If they get answers they don’t want they stop funding or they don’t publish it.

**AS**: Do you see any new changes coming down the pipe for treatment in Minnesota?

**RM**: Yesterday President Trump issued an executive order establishing an opioid commission. It just happened yesterday. On that commission there is a variety of individuals and titles. Some of them have yet to be determined, but it’s an interesting make up in the text of the executive order involving the Secretary of Defense. There has certainly been demonstrated change from the Federal Narcotics Farm through this stuff today.

Now, policies are primarily created by politics, and politics gives and changes and ebbs and flows. As a sideline if you look at cannabis right now it has continued to be a schedule one all along here, which by definition is highly addictive and of no medical value. Yet, you have a large number of states that have medical cannabis laws—thirty-eight I believe—and then some of those that have recreational cannabis laws. There is this discongruency between federal scheudling by the DEA and individual states recognizing medical cannabis like Minnesota does, or recreational cannabis like Colorado. What is going to happen with the current federal administration and that state ‘sovereignty’ for medicinal or recreational cannabis is to be determined. People have theories and guesses but who knows.

With the awakening and awareness of what is going on just in the last fifteen years or so with a greater sensitivity to co-occuring disorders, to the interlacing to substance abuse and mental health, the introducation and increasing acceptance of medication as a legitimate intervention—not necessarily a solution, but part of the equation—gives me hope that that can continue. Even though I think that is a pervasive trend—you have pockets of greater acceptance and pockets of deeper resistance to it. There are still folks who absolutely delieve that addicts should go into withdrawal and suffer. They shouldn’t die, but they should suffer because that is somehow going to make them reevaluate before they go and use again. If it was that simple nobody would ever have a second mind crushing hang over when they were an undergraduate. The first time you wrap your head around a toilet and gag your guts out you would never go out and drink again. IT just doesn’t work that way.

There’s no addict booth at career day. People don’t choose this whether it is prescription pharmaceuticals, whether it’s heroin, whatever the drug or the method it is a condition that comes into play and prominence and in my opinion it should be treated as that. To stigmatize, lay blame, and point fingers at this group or that group is simply not true because it’s not that fifty year old carnie guy with green teeth and the body mask of Kid Rock anymore. It hasn’t been for a long time.

**AS**: I don’t know if it has ever been.

**RM**: Right, but people have that image. People have the image of the stereotypic heroin user and they think of Keith Richards. They don’t think of a twenty year old kid who is an undergraduate at the University of Minnesota.

I do adjunct facutly at River Falls and I teach an addiction class at the graduate program down there and *The Voice* is the student newspaper and five or six years ago one of the headlines of *The Voice* was a kid they found dead in one of the dormitories who still had the needle in his arm. He was a young, novice user who was really narcotically naive and got ahold of a hot load and had no idea what the actual strength was. He had an unintentional hydrogenic overdose because he didn’t know. That’s why you see so much overdose with younger people.

When you look at the common profile for heroin addicts and opiate addicts right now they bifuracte pretty cleanly into the young ones and the older guys—I’m saying guys as a term and mean the older population. The older population are the people who just won’t die. They know how to live, how to survive, they know how to come down, and they take care of each other in groups. The young, narcotically naive, novice kids who think they’re superman and bullet proof have no idea that the stuff they just bought from the new handyman across the street is cut with fentanyl and will kill you stone dead. They don’t know that so they solulate it up and fire it in and they have a hydrogenic overdose from it. Dead addicts can’t recover.

**AS**: There is a lot of stuff saying it is the pharmaceuticals that have made this younger generation’s access to opiates and adderall—they aren’t as frightened of drugs because they have been accustomed to them. They have a belief that heroin is just the same thing. Would you say that the pharmaceutical culture we live in has increased their nonchalance around it’s danger?

**RM**: There seems to be nonchalance about it. Younger people today of sixteen to twenty-four or twenty-five are always kind of the petrie dish of that generation’s culture. We have gone through the grunge kids, the emo kids, now you are into the social media, Twitter, and Facebook generation and all that. On that course of line you see a huge, vast influx of various medications, a greater willingness to use pharmaceutical intervention, which is both good and bad. Along with the acceptance of pharmaceutical intervention for an addict comes pharmaceutical intervention and a greater perponderance for things like ADD and ADHD. Back in my day there was not such a swiftness to diagnose someone as ADHD and Ritilin was about the only thing around. Now you’ve got adderall and everything else. There’s a greater buffet line of medicine intervention. The advertisements you see on television, if you even watch commercial tv anymore. You look at magazines with large-scale full glossy ads. There’s a lot of work done from companies for that. I think that is a piece of it.

We also live in a culture whose tag line from my point of view seems to be ‘how fast can you burn and how far can you go?’ Faster, bigger, badder, harder, stronger, whether you’re talking about bycinopril because you’ve got high blood pressure and colesterol or viagra single pack ads. Everything today is flooded by pharmaceuticals. We went through the energy drink craze that was pretty targetted at adolescents, specifically male adolescents.

**AS**: And couldn’t you argue that those drinks are a sort of gateway to other things?

**RM**: There are folks who would argue that. Caffeine is one of the ten categories in the current DSM for addicitive disorder. I think there’s hope for continued if not standard acceptance of individuals who have substance abuse and mental health disorders. I think there’s the opportuity for continued work with medication as well. I don’t think medication is exclusively the answer. I think it’s got to be a combined effort just as you have compelxity of the client you need increasing responsiveness of the treatment system of delivery. Like I said before you can’t control who funds the research and you don’t always get to control the social outcome of political decisions.

**AS**: That makes me think of prevention education. Do you have a role in any of that?

**RM**: Our office does. The Alcohol and Drug Abuse division does have a prevention section to it. There’s not a whole lot that I do.

**AS**: Has it changed from D.A.R.E. [Drug Abuse Resistant Education] program? Are they willing to talk more specifically about the dangers in public school systems?

**RM**: The Alcohol and Drug Abuse division does not directly fund D.A.R.E. and there isn’t any direct federal funding for D.A.R.E. Most of that is what we’ve done. There is money available—in fact Minnesota is one of the recipients of what’s called SPF RX—the Strategic Prevention Framework around Prescrition Opioids. The A and D division upstairs did receive some money from that. They are going to implementing it as part of their prevention strategy and framework this year.

A treatment service delivery model does more with treatment than we do with prevention. When you talk about prevention you are trying to prevent something that already happens. To try to quantify and measure a negative is by its definition is difficult if not impossible versus when we look at numbers and stats and figures of teatment admissions and stuff liek that is all data gathering after the fact. So Joe comes into treatment and we ask Joe all kinds of questions and then we compile stats and numbers versus prevention where you try to prevent those numbers from ever happening.

There is an industry to treatment. There is funding and there is revenue to be created off of it. If you talk about revenue of prevention you are trying to prevent damage.

**AS**: There’s not much money in prevention, is there?

**RM**: Not compare to treatment, no.

**AS**: Anything else?

**RM**: The only thing I have to remind you is that I’m not saying anything as an official representative of the Department of Human Services. There’s truly no way to separate my role as the State Opioid Treatment Authority from our discussion here, but I just want for the record that I do hold those two faculty positions at Adler and River Falls, so I’m speaking in a multi-layered role and some of this is stuff I do in Minnesota, but also with Adler graduate school or University of Wisconsin at River Falls where the course work I teach is the education of young clinicians, especially Adler with their COD program, is the sensitivity about substance use disorder and mental health as a fused individual, which is an Adlerian concept by itself. With River Falls it is guidance counselors and psychologists, so it’s helping assisting or educating future professionals to be more sensitive and flexible and to increase the acuity of people coming in. The volume of medical knowledge seems to double every couple of years now with increases from everything from brain imaging to epigenetics to everything else. WE simply learn more and more at a faster rate. Because we learn more we hopefully have a greater sensitivity for the given complexity of it, and then out of that a need for us to become more flexible in our response with folks. We can’t lock you up for six days of detox and throw you twenty-eight days of residential care and then if it doesn’t work blame you for the failure.

**AS**: Thank you.