**Mark Willenbring**

**Narrator**

**Amy Sullivan**

**Interviewer**

**May 17, 2017**

**Alltyr Clinic**

**St. Paul, Minnesota**

Mark Willenbring -**MW**

Amy Sullivan -**AS**

**AS:** What I have to start with first is you giving me permission.

**MW:** My name is Mark Willenbring and I give permission to Dr. Amy Sullivan to use this material in her book and her project.

**AS:** We are in the Alltyr Clinic in downtown St. Paul conducting this interview. You were saying you’ve been in this field since the 1980s. I want to back up and find out where you were born. Tell me a little bit about your family.

**MW:** I was actually born on the Iron Range in Virginia.

**AS:** Virginia, Minnesota.

**MW:** Virginia, Minnesota: the queen city in the Iron Range.

**AS:** Is that what they call it?

**MW:** Yes.

**AS:** When were you born?

**MW:** 1949. At that time in particular it was a very unique place. It was very ethnically diverse. In Minnesota diversity means a Swede and a Norwegian.

**AS:** And religions, a Catholic and a Lutheran.

**MW:** Maybe Jewish. The way Northern Minnesota developed was it started with the logging industry. When they’d gone through all the original timber they found high quality iron ore on the Iron Range. Mining became the big new industry. Starting with the logging industry the companies would bring in men from primarily Sweden and Finland to work there. They had a similar climate. A lot of Scandinavians, Germans, Italians. At that time that was ethnically diverse. It was a radical place because with the mining industry there were epic labor battles in the 1930s. The steel companies brought in the Pinkertons, the union formed and was very strong. There were bombings, killings, beatings. The whole thing. The place up there became very radicalized. There was actually a neighborhood in Little Virginia which at that time had a population of about 12,000. There was a neighborhood called Finntown. It was probably four square blocks. The president of the American Communist Party, Gus Hall, was born in Finntown. There were a lot of communists up there in the 30s and a lot of wobblies.

**AS:** You are a history buff, aren’t you?

**MW:** A little bit. I’m very political so that’s part of it. That was really the core of the DFL Party. It was very heavily Democratic. The unions prevailed eventually. Because they did they were paid well. These were high paying jobs. That was all across the Mesabi Range ranging from Virginia through Grand Rapids and Hibbing. There was another vein called the Vermillion, there was a smaller one as well. Then in the late 40s the high-grade ore ran out just like the lumber had. Because it was so focused on natural resources it’s always been a boom and bust economy up there. When I was born it went into a deep recession. It was Depression Era; it was twenty five percent unemployment. The place was devastated. Mines were shutting down. That was before I could remember.

**AS:** Did your family work in the mines?

**MW:** No. I was a very atypical ranger. If I was a typical ranger my dad would have worked in the mine or for a mining company. I probably would have too. My father’s family emigrated from Germany. Most of them settled in the St. Cloud, Stearns County area. That’s one of the only places I know where everybody knows how to spell Willenbring. It sounds just like it’s place but it gets murdered in many ways. The best one is Willburding or Will M. Bring.

His father moved from the St. Cloud area to homestead a farm outside of Minot, North Dakota. He grew up in North Dakota in a tiny town on the prairie. His mother died when he was nine. It was a big family. His father married a nineteen or twenty-year-old. His eldest daughters were sixteen and seventeen. The priest in Foxhome, which was the little town nearby, wouldn’t marry them, it was too scandalous. They had to go to Minot and the bishop married them. It was really difficult. Her name was Loretta. It was very difficult for the children. There was a lot of conflict and she wasn’t liked. The two oldest sisters entered the convent.

**AS:** They were Catholic?

**MW:** Very Catholic. I visited the place. It’s still in the family, a dairy farm. A very small house. I can’t imagine nine children in it out in the middle of nothing. They’d take the sleigh in the winter, pulled by horses. For example, my father had to wait after he finished eighth grade he had to wait two years. His oldest brother was going to high school in the town of Foxhome. These days we just drive there but not then. He had a job at the local hotel. Every morning he’d bring around hot water to the rooms.

**AS:** This was your father?

**MW:** No, his oldest brother. He got room and board when he was staying at the hotel so he could go to high school. My father had to wait for him to graduate before he could get that job and go to high school. He did and then he got hired on by the local banker as a teller. That started his career. My mother grew up in Maple Plain which is a western suburb. At that time it was a little farm town. She grew up on a farm outside of Maple Plain. I’ve been there too, still in the family too. Then both of them were just obsessed with getting off the farm. I grew up hearing all the tales of being on the farm.

**AS:** How did they meet?

**MW:** My dad got drafted. He was older by that time. He was well into his thirties. My mother was eight years younger. She went to a business school and learned stenography. She became a secretary for several years in the Twin Cities. She was living in the Twin Cities and one of my father’s sisters lived here. Two sisters and a brother lived here. One of the sisters had some people over and my dad was back here on furlough. He was stationed in Clovis, New Mexico at an airbase. He was in the Army Air Corps. He was on furlough here. I don’t know if he was staying with his sister. Gilly, her name was, invited my mother, Maggie, over. That’s how they met. While he was on furlough his entire unit was shipped to North Africa. Every one of them died in North Africa. He stayed back and his assignment was to stay at the base and keep the records of the company. He was a banker.

**AS:** So he was sent back.

**MW:** He stayed in Clovis, New Mexico for the remainder of the war.

**AS:** It just happened when he was on furlough and then he went back.

**MW:** Then he went back to Clovis and my older brother was born there. Then they moved back to the Twin Cities. I think Dad tried selling insurance for a while and it didn’t work out. There was a job opening at a bank in Virginia and they moved up there. They weren’t rangers. My mother had real big city sensibilities. To her dying day she hated being in Virginia. She always wanted to be in the city. She had wanted to be a nurse. Her father in many ways was a bastard and was abusive to her mother. He just cut her off financially for some punishment or something. She was already accepted to go to nursing school and she couldn’t go. That haunted her all her life. She was very bright. Extremely neurotic, but very bright. He started out as a teller at the State Bank of Virginia which was eventually acquired by Stanley West (pre-Wells Fargo).

I don’t know what happened after that. When I was growing up he was at the bank. He stayed on and ended up being president. There were some very tough times in the middle. He had an early heart attack. The men in his family had early heart attacks. He survived it but I think because of that he was already vice president and he was passed over for the presidency. That was a very bitter pill for both him and my mother. They brought in somebody else to be president.

My mother hated his wife. It was a very difficult time for them. They stuck it through. When this guy left he became president. He presided over a new building there. In my father’s late fifties, early sixties he was the talk of the town. He was very beloved because he really cared about people and really helped people with their businesses.

**AS:** Their farms probably.

**MW:** Not so much farms there. That’s where I grew up. In the early 50s it was like the Depression up there. Then at the University of Minnesota they developed the technology for taconite. I remember going to a taconite plant when they first started. They use magnetic extraction to make taconite pellets, which then could be used in furnaces.

That led to the next boom. The mines reopened, great jobs. The mining companies were such a great tax base. The utilities money in Virginia was very good. They had the first heated indoor pool in the state of Minnesota at Virginia High School. They built this steam plant that heated every house in town with steam. They piped steam to every house in time. When I grew up there it was really good times and thriving. Main Street was just alive and vibrant and thriving. It was a good time to be there. The quality of education was good.

We lived on the edge of town where I could walk into this huge field. I could walk over to the train tracks that the mining companies used. There were big trains around and machinery parts. It was beautiful for a boy. There was a creek there. We would just play there for days and days. Then you could go up into the mining areas. I could actually walk into the woods right from home.

**AS:** How many siblings did you have?

**MW:** Just one, an older brother. Looking back now I’m almost certain I could have gotten into Harvard, Stanford, Princeton, Yale. Berkeley was where I really wanted to go. Neither of my parents had a college education. The high school counselor wasn’t very broad. I had no guidance.

**AS:** Where did you go?

**MW:** I went to the University of Minnesota. I was accepted at Northwestern in Chicago. It was the only other place I applied. My life could have been very different. I took college chemistry at the junior college across the street from the high school. The chemistry teacher encouraged me to apply to Harvard, but he was the only one. I just didn’t know anything about that stuff. My brother was at the University here. I knew the Twin Cities.

**AS:** Are you guys just a couple years apart?

**MW:** Five years. He was already in graduate school in electrical engineering. I came down here. I also knew the Cities. I could drive home. I got a good education.

**AS:** What did you major in in undergrad?

**MW:** I had a double major in sociology and biochemistry. I was in the honors program. My advisor was H. Mead Cavert who for decades was the assistant dean of the medical school. He died recently.

**AS:** Is it Cavert?

**MW:** Cavert, C-A-V-E-R-T. Mead. This will become important. I participated in all the protests. I was a parade marshal in a parade that went from the University to the capitol.

**AS:** The student protests?

**MW:** Everybody was protesting. It went right down Summit Avenue.

**AS:** This is in what year?

**MW:** This was ‘70. Things blew up after the Cambodian Invasion and Kent State. Things really blew up. Students shut down Washington Avenue, barricaded it. I was in medical school at that time. There was a former police sergeant named Charles Stendrick who was really an authoritarian guy. The cops rioted on the protestors, they just went nuts. It was really bad. The University shut down for the rest of the quarter. I was an undergraduate then when that happened. I was a junior. The whole university shut down and they shut down for the rest of spring quarter. What was interesting was that at that time, when I was an undergraduate when I was a junior they did away with student deferments and went to the lottery system.

**AS:** For Vietnam?

**MW:** I pulled a bad number. I was seriously considering Sweden, Canada, CO status. I wasn’t about to go to Vietnam. They retained deferment for medical students. I’m a junior now. At that time there were a few medical schools around the country that accepted some students after three years. University of Minnesota was one of them.

**AS:** So you didn’t have to get an undergraduate degree.

**MW:** Right. I applied to all of these and I got waitlisted at Minnesota. I’m sure the only reason that I got accepted was H. Meade Cavert was my advisor. There was a shortage of primary care physicians. That year the legislature voted to expand the medical programs by twenty-five students. That got me in. I got in there and I was deferred. When I graduated it was over. Otherwise the deferment was granted on the condition that you would serve afterwards as a physician. That happened in 1970, I was accepted. I graduated ‘74 just when Vietnam was winding down.

**AS:** What was your specialization?

**MW:** I went in intending to be a psychiatrist.

**AS:** Did that have anything to do with your mother? What made you interested in psychiatry?

**MW:** I had this image in my mind of sitting in a room with a patient doing psychotherapy. I don’t know where they came from. I wanted to be a doctor from a very early age. Right after I was done wanting to be a priest.

**AS:** A priest or a doctor. I’ve heard this from somebody else I’ve interviewed.

**MW:** My mother had been a Methodist but she converted to Catholicism for my father. It was a requirement but she wasn’t a real Catholic. I didn’t go to Catholic school. My dad was quite pious but he was very quiet about it. My mother wasn’t really a Catholic. We went to the Polish Catholic Church. I went through communion and all of that stuff.

**AS:** You thought you were going to be a psychiatrist and then what happened?

**MW:** I enjoyed all aspects of medicine. By the time I was going to graduate I wasn’t sure what I was going to do. I did a GP internship. It was the last year they were offered. They were called RO internships. Before everybody became a specialist most doctors would have an internship. It was well rounded; you do everything. You do surgery, pediatrics, neurology, psychiatry, ER, whatever.

I did that at what’s now Regions. It was Ramsey Hospital back then. I applied there and at Hennepin. I decided to go to Ramsey. It was a good experience. I still didn’t know what I wanted to do. I started working in the ER there after I graduated. I did that for two years. I also did little stunts in Farmington at a clinic and practiced some family medicine there. I also did some practice at community clinics, the Seward Community Clinic and the Southside Community Clinic.

What I found out about myself was that I was good at all that but even family practice is pretty technical. You do a lot of procedures; you don’t spend a lot of time talking to people. I kept wanting to have more time to talk to people. I really like the Emergency Room. It was a MASH mentality. You related to the staff. You had the repeaters, old Joe who got drunk and fell on his head. You didn’t have lasting relationships with patients. I liked the variety and the excitement. I wanted to stay on there.

This was the time when family practice residencies and emergency medicine residencies were just forming. It was a brand-new thing. I could have gotten grandfathered in in emergency medicine or family practice. My chief at the time there said, “I’m not going to do that because in ten years you’d regret it. You’d be at a disadvantage compared to people with a residency.” It’s not the same. I had to choose between emergency medicine and psychiatry so I decided to do psychiatry. Now that I know a number of people who were emergency medicine docs I’m glad I’m not one. They all burn out at like forty-five and start doing family practice. It’s the shift work. It just kills you.

I wanted to go to the West Coast. I applied to a bunch of programs out there. I ended up at the University of California, Davis in Sacramento. It was at that time a very new medical school. It was the first medical school formed in like fifty years. It was like eight years old. They had just taken over the county hospital. The academic programs were miniscule. The main campus was at Davis. The medical students had their training in Davis, which was just outside of Sacramento. A very precious community. The medical center was in Sacramento proper.

One of the things I like about the program there was in the first year they had this interdisciplinary program where you went through this experience with a psychologist, social workers, advanced practice nurses. You got to know other professions perspectives. It was really, really interesting. I really liked that.

I did my residency. I became very interested in research. I started doing a bunch of it when I was a senior resident. I decided I wanted to try an academic career. At that time it was the Reagan Recession. I went out there in ‘77 and graduated in ‘80. That’s when the recession really formed, ‘84, ‘83. The worst recession until this most recent one. Everybody was laying off assistant professors, no one was hiring them. One of my advisors there said, “Are you interested in alcohol and drug abuse?” I said, “Oh sure. I’m very interested.”

**AS:** Did you participate in the…?

**MW:** No comment. I was never a hard-core druggie. We all smoked pot.

**AS:** More experimental? More social?

**MW:** I liked pot. We drank and partied a lot.

**AS:** But it wasn’t a problem for you?

**MW:** No.

**AS:** Did you have friends who it was a problem?

**MW:** A couple of people whose drug use got heavy but they never ended up in trouble for it. I think they got over it when they grew up. This was 1980 California. It was on the cusp of the cocaine epidemic.

**AS:** So he asks you…

**MW:** If I was interested and I said, “Sure. Why?” I hadn’t ever thought about doing anything in that field. I wanted to do therapy research. At that time the National Institutes on Alcoholism and Drug Abuse were offering what was called a Career Teacher Grant. They would pay your salary for three years as a faculty teacher in medical school if you agreed to develop curriculum on alcohol and drug abuse. They were trying to get more education to medical schools.

**AS:** What was it called?

**MW:** Career Teacher Award. I applied to that from Davis. First of all, by virtue of my applying for it the resident expert on alcohol and drug abuse. The first thing I learned was it’s really easy to be an expert because no one knows anything.

**AS:** This is a moment where they’re creating a program on alcohol and drug abuse within a medical school, is that right?

**MW:** Curriculum.

**AS:** Was it based on twelve step thinking or was it based in science and research?

**MW:** This was funded by the research institutes. Things were very different there but it was based on the current scientific research. It was just emerging.

**AS:** I guess that’s what I’m getting at.

**MW:** It was academically based. The process went well and I would have gotten the award. However, the previous chair who was chair when I went there had built the program on something of a house of cards counting money with an agreement for the department to provide care at all these community mental health centers. The county rescinded that contract and the department was almost entirely dependent on it. He left and there was somebody put in place. All of my mentors were getting canned. All the people I didn’t respect were taking power. The department was undergoing a terrible shrinkage. I could see dark times ahead. I left and they were very unhappy with me for leaving after they supported me with a grant. It turns out they went through ten years really dark. They’re doing well now but it was really bad.

In the meantime, I was looking at other things. I was accepted for a fellowship in therapy research, one of the preeminent psychotherapy researchers in the country, at UCSF. I can’t tell you how badly I wanted to do that. I always wanted to live in San Francisco. That’s what I wanted to do. It paid sixteen thousand dollars a year. Even in 1980 in San Francisco that wasn’t very much money. My wife Katie was pregnant. I have to say leaving San Francisco and turning that down was one of the hardest things I’ve ever done.

I’d applied at various other places. There was an interdisciplinary fellowship at UW Madison. Another interdisciplinary thing. This was even more interesting, an anthropologist, a lawyer, an advanced practice nurse, psychologist, social work. Very diverse. Katie wanted to be closer to her mom as most young mothers want to be. They were in St. Paul. Madison was kind of the perfect distance.

The funny thing that happened is when they asked me what I’d been doing I told them I’d written this grant proposal. One of the main guys in the program there said, “Would you be willing to do that here?” What he wanted to do was support me with the fellowship for two years and in the meantime cultivate a faculty position for me. Part of it was because he was really interested in alcohol and drug abuse too. He wanted to see more of that taught. That only paid about the same amount of money but he supplemented my income by making me medical director of the county detox. The mental health center there, which was very closely tied in with the department, had just taken over the contract to provide county detox services. All these kind of serendipitous things. We moved to Madison. When I got there everybody said, “Oh you’re the alcohol guy.” I said, “That’s an interest but I’m also really interested in psychotherapy research.” After about four months I said, “Oh yeah. I am.” I developed curriculum on alcohol and drug abuse but my best education was at the county detox center.

**AS:** Because you could see it and you talked to people. Is that where you got to talk to people?

**MW:** Yes, but you saw the same people everyday, day after day after day. It really shaped the rest of my career. I really got to understand these guys, some women but mostly men. When they were turning forty they’d be, “I’m reviewing my life and wondering what I want to do with the rest of it. What have I accomplished so far?” They all had very conventional dreams, a house, two cars in the driveway, two kids and a dog. The whole catastrophe. I learned so much from them. This is important from the standpoint of how I ended up doing what I’m doing. I was fresh out of residency. I had all the new stuff. Naturally I concluded the trouble with these guys is they just haven’t been exposed to the right treatment. I’m here now. They’d been through this countless times with fresh young professionals. They were gentle on me. They let me down easily. Some of them even got better for a while so I wouldn’t feel so bad. But after six months they couldn’t hold it. I remember the day I was walking to a bus from the detox center. It was winter with a couple of inches of snow on the ground. I thought, “I’m not doing anything for these guys. I can get a different job or I can figure out how to approach this.”

What do doctors treat in general? Chronic illness. That’s what we treat. We treat degenerative back disease, rheumatoid arthritis, diabetes, hypertension, heart disease, cancer. That’s the bread and butter. Multiple sclerosis, all of these incurable diseases. Right? That’s what doctors do. We treat incurable diseases by and large. Even surgeons do. Maybe the surgery is a specific thing but it’s almost always for some sort of chronic illness. Acute appendicitis is different.

**AS:** There’s the emergency things.

**MW:** Other than that we’re not curing very many people. Well what do they do? They slow the rate the deterioration. They try to achieve remission if possible or get the best response possible if they can’t achieve remission. They try to keep people in remission. They try to minimize the frequency, severity, and length of recurrences. They treat complications. They support the family and the patient. Can I do that?

**AS:** With this population?

**MW:** With drug and alcohol abuse. Yes. Sure. I can do that. That was an absolutely crucial point, the rest of my career has been based on that.

**AS:** Do you remember when this was? In the 80s in Madison?

**MW:** This would have been late ‘80 or early ‘81. I’ve adopted this chronic illness management approach for my entire career. That has really formed the basis of everything I’ve done. They were really into case management so I really became an expert on case management. What that is and what it’s not. It’s really coordination of care. Another way to conceptualize that is even if you can’t treat the disease you can always treat the patient. I finished the fellowship in ‘82. Still looking for a faculty job, still a recession. Madison didn’t have a spot for me. There really wasn’t anything acceptable in the Madison area. I naturally looked up here.

There was a brand-new chair at the U whose charge was to really bring it up to date. To make a much more modern, scientifically based department. Her name was Paula Clayton. She didn’t have a position but she had just hired a new chief of psychiatry at the VA, which had never been an academic place to turn that department into an academic department. The Minneapolis VA is probably the best VA in the country. It operates more like a small medical school itself. It looks, feels, and acts like a university hospital. The faculty are virtually all full time which is not typical. They have kept their identity from the University separate for that reason. Usually what universities will do is they’ll put people on five eighths VA, four eighths university. The VA doesn’t get five eighths. They just basically suck from the VA. That’s not true here. When they built the new hospital here they could have built it on campus but they didn’t. That was the reason. They had a job for me at the VA. In guess what?

**AS:** Alcohol and drug abuse.

**MW:** That’s right. There I was. I was the first faculty member hired under this new mandate to become an academic department. When I got there, there was nothing. There was no psychiatry research. My mentors were people in neuro-endocrinology.

**AS:** Here you are again the only guy and the expert. By now you’ve had some experience.

**MW:** By now I was an expert. I’d been teaching at Madison. I’d read a lot and learned a lot. I got a job. Here’s another serendipitous thing. While I’m negotiating with the people up here and looking at taking the job at the Minneapolis VA one of the guys at Madison who was an expert in psychopharmacology was reviewing a VA grant application. It was to see if treating alcohol dependence with lithium is effective with or without depression. VA does a co-op space with many, many sites across the country. The big studies, very well done, there’s a co-op center to make sure the methodologies are coordinated. Lots and lots of important research is from the VA. He came to me and he said, “Do you know anything about lithium and alcohol?” I said, “Why do you ask?” He said, “I’m reviewing this VA cooperative grant thing.” “Well there’s a couple of small studies that support it but it’s never really been known for sure.” I found out who the PI was, he was in Chicago by the name of Walter Doris. I called the chief of alcohol and drug abuse over at the VA and said, “Are you interested in participating in this study?” He said, “Sure.” I called Walter Doris and said, “Are you interested in another site?” He said, “We don’t have anybody up in Minneapolis.” “I’m going there and I’d love to be a site investigator.” He said, “We need this kind of information from the program.” They provided that. Lo and behold I arrive at the Minneapolis VA with a VA grant. The chief of research there at that time said, “How did this happen? This doesn’t happen.”

That gave me support for four years. That totally launched my career. I published some papers out of that. Then the other thing was it was a yearlong study. We followed people for a year, which was very unusual. Most studies are three or four months. We studied people for a year. I got to track along with these alcohol dependent volunteers in the research study for a full year. I learned about the natural history of alcohol dependence and how recovery went and didn’t go. Most people at that time only saw what they saw in rehab. We can’t learn anything about natural history in rehab.

**AS:** Because it’s a closed environment?

**MW:** And it’s only thirty days long. They had a methadone program there.

**AS:** Is that the first time you worked with opioid addiction?

**MW:** Yes. I clawed my way up. At that time the VA was a wonderful place to work. You got lots of autonomy and different ways to get money that weren’t available at the university. I rose through the ranks. I became the first psychiatrist to become an assistant professor and go to full professor while at that VA. I was the pioneer. Now they’ve got a robust program mostly with psychologists but with some psychiatrists. I was the pioneer that got the whole thing started. I eventually ended up at the national level. I was the co-editor of the first clinical practice guideline for the alcohol and drug and substance disorders for the VA. Towards the end of my time there I was the clinical coordinator for a huge effort to implement evidence-based practices. I really became sort of the most prominent addiction psychiatrists for the VA. I ran the methadone program for fifteen years.

While I was there there was a very, very important thing that occurred about learning about opioid addiction. Almost all of the guys at this time were Vietnam vets who got addicted in Vietnam. There was this one guy in particular, just a sweetheart. Just a really sweet, nice guy. The practice when I got there was they maintained people for two years. If they were doing well they’d taper them off. That was practiced a lot of places at that time. This guy was doing very well. He got married, he was employed, he was doing well. They said, “It’s been two years, let’s taper you off and see how you do.” He didn’t make it through the full detox before he had a recurrence. He lost everything he’d gained in six months. He came back and started the program again. He restabilized nicely, rebuilt everything. Two years later, “It’s been two years. Let’s give this a try.” Same thing happened. Didn’t make through the withdrawal, went through the entire detox period, had a recurrence, lost everything in six months. He came back and by that time I was the director of the program. When he came back that time I said, “Let’s stop doing this.” That’s when I learned. At that time there was more evidence starting to accrue that for most people maintenance had to be lifelong or what I would say is indefinite.

I also at that time really got into pain. I didn’t want to do that. The internal medicine folks, orthopedic folks, physical medicine folks had patients who were opioids for chronic pain that were problematic and didn’t know what to do. Most of them were giving out Percocet. They didn’t know what to do.

**AS:** Most doctors?

**MW:** Yes. Nobody’s taught anything about how to do pain management. Maybe they are now.

**AS:** What year was the pain stuff?

**MW:** That was probably in the early 90s.

**AS:** When prescription pain pills became…

**MW:** Before that.

**AS:** So early 90s.

**MW:** The prescription pain pills started in about ‘98.

**AS:** When doctors are noticing problems.

**MW:** There was conflict with the patients often. They would be frequently running out.

**AS:** People hadn’t put their finger on that yet necessarily.

**MW:** It was problematic. They didn’t know how to deal with it. They refer him to me for a number of reasons. I’m much more of a physical medicine doctor for a psychiatrist. I was an ER doctor. Then in the VA psychiatrists do a lot of physical hands on medicine much more than the private sector. We did our own physicals. I kept up to date. Also, because I knew about opioids because of working with opioid addicted people and the methadone people and things like that. I just really like complex chronic disorders. That’s always been my focus until now. Although it’s still partly a focus. I was like, “Well I’ll give it a try.” I knew more than anybody else I guess.

Turns out a lot of these folks have poorly treated or undiagnosed mental illnesses. A lot of them have personality disorders. They also had really severe chronic pain disorders. Sometimes they had brain injuries. They were an extremely complicated group of people. We developed a very successful program for managing them. They’d come in once a month; I’d work with a nurse. They’d come in as a group. It was a group appointment. Before they came we would write the prescriptions and she’d collect them from the pharmacy. She’d have them there. They didn’t have to go wait in line at the pharmacy. Like the Salvation Army we would bring in people to talk about exercise or nutrition or self-care or whatever. Naturally what happens is they start to talk to each other and they find out they’re not the only one. That’s one of the most difficult things for people with chronic pain. They don’t know anyone else who has that disorder. It’s really isolating. They benefited from it. I was able to stabilize a lot of people who otherwise weren’t. Their function improved and so forth.

**AS:** They were still able to keep their pain prescription?

**MW:** Yes. As one patient puts it, I’m strict but fair. I make my expectations explicit.

**AS:** About how to stay in this program?

**MW:** About what my rules are and what happens if you don’t follow those rules. I follow through. I never make threats. People like that. They like that structure. They like the predictability. All they need is to feel like they’re treated fairly and they’re understood. That’s the most important thing with chronic pain patients. I learned a lot about chronic pain and opioids. I served on a national taskforce that involved clinical practice guidelines for treating chronic pain with opioids. I interacted with a lot of pain experts.

Differentiating addiction from physiological dependence in the context of chronic pain is very tricky. Unfortunately, people with chronic pain who are appropriately taking opiates as prescribed who are benefitting are often labelled as being opioid dependent. There’s a pathological diagnosis of using opioids inappropriately. I devise ways of really teaching that to others. Addiction is drug use that causes clinically significant impairment or distress. That’s the threshold criteria. Another way to think of it short hand is addiction is compulsive, out of control, destructive drug use. If you’re wondering if someone who is being treated with opiates for chronic pain is addicted all you have to do is ask yourself are they better with the pain medication or are they worse with it? If it’s better they’re not addicted. People continue to confuse the fact that you have a physical withdrawal when you stop suddenly with addiction.

**AS:** There’s so many drugs that cause symptoms.

**MW:** Try stopping Effexor suddenly or Zoloft or Celexa. It’s really miserable. That’s why I don’t call it withdrawal anymore. I call it discontinuation symptoms. I never use the word detox ever. It’s withdrawal.

**AS:** And withdrawal is a discontinuation symptom.

**MW:** If I treat it I call it withdrawal management. I don’t call it detox. They’re not toxic.

**AS:** The words we use, let’s talk about stigma for a minute.

**MW:** Let me give you the list of words I never use.

**AS:** You never use addict.

**MW:** Alcoholic, alcoholism, enabling, co-dependency, relapse, of all things recidivist. People will call relapse or recurrences in addiction recidivists.

**AS:** That’s a criminal name.

**MW:** What I ask people is do you call someone who keeps getting hospitalized for diabetes a recidivist? No. Let’s see. Denial, unmotivated.

**AS:** Shame?

**MW:** We’ll talk about feeling shame. They all feel ashamed. Selfish.

**AS:** Self-centered.

**MW:** Right. Irresponsible, immoral. There’re other things that I don’t use that are concepts that are thrown around that are completely wrong. Addictive personality. There’s no such thing as an addictive personality. That’s total fiction. The thing you have to understand about the twelve-step approach to alcohol use disorder is they define everything about you in terms of your addiction to alcohol even twenty years after you stop using alcohol. That’s addict thinking. Everything is attributed. You become your disease. The alcoholic. The person with an alcoholic use disorder. A recurrence of illness.

**AS:** Instead of a relapse.

**MW:** A use episode instead of a slip. Language is extraordinarily important.

**AS:** Did you find in Minnesota being this center of twelve-step treatment programs…

**MW:** We have the Vatican here.

**AS:** You call it the Vatican.

**MW:** It’s a little Vatican.

**AS:** I’ve had people call it the holy land.

**MW:** Twelve-step is the state religion.

**AS:** I’m glad I can quote you on all this. Earlier you talked about gathering people with chronic pain and then realizing that they weren’t alone. Some of the power in the twelve-step environment that it creates is people can get together and start to understand themselves. Do you see value in that aspect of it? Do you have thoughts about the community that it creates for people?

**MW:** Some people do find that helpful. For some people it’s harmful. One of the things we do with our Suboxone patients here is we offer them a choice between seeing a doctor privately for their appointments or we have a group medication appointment.

**AS:** So you’re doing the same thing that you started. You’re treating them as people with a medical condition who could benefit from getting to know other people with that same condition.

**MW:** That is an effect of it. That’s not actually the reason for doing it. One is time. It saves me or another doctor a lot of time.

**AS:** You don’t have to keep repeating yourself.

**MW:** It’s not so much that as fewer appointments. If you have five or six people that would take care of an hour. They appreciate it too and then we charge less. The main reason for doing it was it makes it more affordable. I’m ridiculously cheap. We’re ridiculously cheap here.

**AS:** I think I heard you don’t accept insurance.

**MW:** We don’t.

**AS:** Why is that?

**MW:** There’s several reasons. First of all, Alltyr Clinic is a demonstration clinic. The broader mission of Alltyr is transforming addiction treatment. The business strategy was that whenever you brought this up people would say what’s the alternative to rehab?

**AS:** You made one.

**MW:** Someone had to make one or nobody would believe it. This is a demonstration clinic. This demonstrates how to do twenty first century, scientifically based, professional outpatient addiction treatment. What’s the rehab alternative? Alltyr is the rehab alternative.

**AS:** It’s different than outpatient?

**MW:** Completely.

**AS:** Or intensive IOP?

**MW:** Yes. There’s no such thing as residential treatment.

**AS:** Where?

**MW:** Anywhere. It’s not a thing.

**AS:** What is it?

**MW:** It’s an IOP in a house. Spending twenty-four seven together for all the mythology about it, stuff occurs and the conversations at night is all bullshit. Thirty years ago, twenty-five years ago it was proven in a randomized control trial that keeping them all together in a house had no outcome effect. In 1977 the first randomized control trial done in England proved that intensive multimodal treatment has no benefit over less intensive things one year later. There’s no evidence that an IOP whether it’s in a house or freestanding is an effective treatment. There’s a mountain of evidence that it’s not. Just think about it. A burst of intensive counseling in psychoeducation. I hate the term psychoeducation.

**AS:** What does that mean?

**MW:** It’s just education. They call it psychoeducation to make it sound like it’s a treatment.

**AS:** I’ve never heard of that in all my reading. Who calls it that? The treatment centers?

**MW:** Everyone. Not just in addiction treatment, also in mental health treatment.

**AS:** I can think of some other ways to say that.

**MW:** How is that different from education?

**AS:** It’s all going into our brain.

**MW:** It helps you understand how rehab started and what the intention was. The original idea was there’s a week of stabilization and withdrawal management. Getting your head about you and a couple good meals in you. There’s two weeks of education about, in this case, alcoholism as it is. An introduction to the twelve steps. You incorporate the first five steps of AA. The fourth week is discharge. It was always conceptualized as an introduction to AA.

**AS:** To get you into the program.

**MW:** That’s where the action was. It was in AA. The idea that rehab itself would actually do something was never actually the intention, other than get you engaged in AA.

**AS:** From your perspective, how has this worked with people addicted to heroin and opioids?

**MW:** It doesn’t. We know it doesn’t. There’s no evidence. There’s not one single high quality study that proves effectiveness of an abstinence-based approach to heroin addiction worldwide. Not one. There’s like truckloads, there’s boxcars full of research that have proven that the only effective treatment is indefinite maintenance with morphine or methadone. That is a settled matter. We don’t need any more evidence on it. It’s not scientifically controversial. They’re about equally effective. We don’t need any more studies about that either. You don’t need more than minimal counselling, once a month, on top of the medication. Adding more counseling doesn’t improve outcomes. That’s a settled fact.

**AS:** Unless the person wants it for other aspects of their life, right?

**MW:** If they’re treating anxiety disorder or depression or post-traumatic stress of course.

**AS:** That’s separate.

**MW:** You’re not treating drug addiction. Think of the idea that it’s called medication assisted treatment. Why do you think that is?

**AS:** Because it’s medication based.

**MW:** Why is it called medication assisted treatment? Do we call diabetes medication assisted treatment?

**AS:** No. So this is where you get back to we call it treatment.

**MW:** I’ll get to harm reduction. There’s an assumption if the real meat of it is counseling.

**AS:** Right, because it’s assisted.

**MW:** If anything it should be called counseling assisted medication. Why call it that? Why not call it treatment? Most treatment now is multi-disciplinary.

**AS:** It’s like cancer treatment.

**MW:** Cancer, heart failure. It requires a team.

**AS:** It’s back to the chronic illness model that you’re talking about.

**MW:** Absolutely. Why don’t we call diabetes treatment harm reduction? All you’re doing with diabetes treatment is slowing the rate of deterioration. If that ain’t harm reduction I don’t know what is. Harm reduction is a great term for a national drug control policy. That’s where it was first used. It’s still only appropriate for that as a policy. It’s in contrast to the drug war. Harm reduction is a pragmatic policy that seeks to balance the harms of drug use against the harms of policy and minimize the overall harm to society. The drug war is an idealistic approach where the intention is viewed as more important than the result. It’s like preaching sexual abstinence to teenagers. That you should do that because it’s the right thing to do even though it increases teen pregnancies. It’s very much the same approach. Cost be damned, damage to lives be damned. It doesn’t matter. What’s really important to understanding the drug war is that it’s never been about drugs. People keep saying it doesn’t work so why do we keep doing it? It works politically. The job of the legislature is to keep their jobs to get reelected. It’s worked wonderfully for that. It’s also served as a very nice bridge between the Cold War and the War on Terror.

**AS:** And it incarcerated millions…

**MW:** Of disenfranchised blacks. The drug war has always been intensely focused on blacks right from the start. It’s explicitly racist. You find it interesting that heroin was primarily a problem with middle aged black people the response was prison.

**AS:** Now it’s young white men.

**MW:** It’s treatment.

**AS:** The contrast of the trial that’s happening as we speak is five young, suburban, white males and the black female drug dealer from North Minneapolis is being charged with murder. If you switched it, if they had been selling her the drugs nobody would be on trial. Or if it was five young black men I don’t think the state would bring it against her. We’re at a really interesting moment in how the focus has shifted on heroin.

**MW:** Harm reduction has no place when you’re talking about clinical care. I hope most of us are not doing harm reduction clinically. We do a lot more of that than anybody realizes. That’s not the goal. We primarily provide palliative care simply meaning non-curative care. It’s unfortunate that that term has come to mean end of life care. It’s not. It’s just chronic illness management. The use of the term harm reduction when it applies to clinical care plays into the twelve-step approach. They see harm reduction as giving up on the person. The twelve-step approach is idealistic. They explicitly teach and believe in AA. If you do the program it will work. Period. It’s one hundred percent effective if you do what you’re told. Rehabs do a double dirty because ninety percent or more of their graduates are going to have recurrences. Can you think of any other industry except maybe the military industrial that has been so successful at blaming their customers when their stinking product fails? It’s astonishing. Every hospital has all these quality measures. Primary care doctors are being rated on their treatment of diabetes and depression and asthma and heart failure. Rehabs have no accountability for outcomes at all, none.

**AS:** We blame it on the addict.

**MW:** Guess who’s really at fault here and really complicit? The state regulatory agencies. These are licensed facilities that are allowed to lie to people. They deprive them of informed consent.

**AS:** How so? When they walk in the door? There’s a seventy percent chance you’re going to…

**MW:** A heroin addict walks into a twelve-step rehab. “Suboxone, methadone that’s just substituting one addiction for another. It means you’re not really sober or in recovery. We not only don’t do that here; we will take you off of it if you’re taking it. If you do a twelve-step program it will work.” That’s a lie.

**AS:** That’s the informed consent you’re talking about?

**MW:** What informed consent would be...Here we do something called Minnesota Model or twelve-step rehab. This is what we believe in and we believe it works. However, the evidence shows it doesn’t. There’s no evidence it works. There’s this other treatment that has a seventy percent chance of having you in recovery. We don’t believe in it. That’s informed consent. If you go to an oncologist, when I’m teaching doctors about this, the oncologist knows of a chemotherapy that has a seventy percent chance of putting you in remission but doesn’t tell you about it because she doesn’t believe in it. She prescribes a macrobiotic diet and yoga and your cancer progresses. What would you call that? Malpractice. How long would that doctor be in practice before her license was pulled? About two days. That’s what they do in rehabs. That’s what they’re allowed to do in rehabs. Lie to people. Not only by omission but outright lie to people about what the facts are. The state licensing agencies are totally silent.

**AS:** Why is that?

**MW:** It’s all the same crowd. The licensing agencies are filled with people in recovery typically.

**AS:** Who served on those…

**MW:** Here at the Alcohol and Drug Agency there are licensed professionals every one of them. The state is basically sanctioning deprivation of informed consent. If anybody wants to do twelve-step rehab after being told what the steps are that’s their decision. I’m not talking about imposing anything on the individual. Informed consent means you provide the information a reasonable person would want to know to make an informed decision. I have people come here and they’ve been through six rehabs. This is more with alcohol.

**AS:** I’ve heard of many more even with opioids.

**MW:** With opioids, people who are addicted to opioids know about Suboxone and methadone.

**AS**: They do but they also feel a lot of pressure from people to not be on them. Especially if they are working a twelve-step program and they are on medication. They’re not allowed to talk about it.

**MW:** Tom Price the new head of HHS just came out and said...did you see that?

**AS:** Unbelievable.

**MW:** I’m waiting for, I don’t know who it would be, the Earth is actually flat. Not only is there no climate change caused by humans but it’s also flat. Not only that but the sun revolves around the Earth.

**AS:** We should wrap up, it’s 11:50.

**MW:** I know that. We haven’t gotten to a lot of my most important stuff yet. Can we do this again?

**AS:** I would love that.

**MW:** In terms of the treatment, we haven’t gotten to the treatment. My view of the evolution.

**AS:** Let’s do that. I’ll make an appointment.

**MW:** Actually, email Amanda.

**AS:** Thank you. I’ll stop the recording now.

**MW:** Harm reduction when it’s applied to clinical care is an inappropriate treatment. It plays into the twelve-step idea that you’re giving up on people. You’re setting a goal less than full remission.

**AS:** What kind of things do you consider harm reduction?

**MW:** I wouldn’t even call them harm reduction. I would say at the national level you might describe a drug policy that way. We’re talking about ordinary public health policies.

**AS:** Needle exchange and Narcan are under the umbrella of harm reduction.

**MW:** I wouldn’t call that harm reduction.

**AS:** You think that’s a public health measure.

**MW:** Those are public health measures. That’s like putting people with TB in sanitariums so they wouldn’t spread it.

**AS:** Needle exchange should be seen as just a public health issue.

**MW:** Right.

**AS:** Like giving out condoms for HIV.

**MW:** You’re playing into it. You’re facilitating the addiction. That’s why you don’t want to call it harm reduction. It’s a public health measure. It’s how we reduce the spread of AIDS. Don’t you want to do that? That’s why I don’t use the term. I hate the term. What they really mean by harm reduction is continuing to stay engaged and treat someone who’s not perfectly well. Treating it like a chronic condition. They call it derisively harm reduction. They believe that if you really tried and they really tried you’d be in remission, which is absurd on its face.

It took me thirty years to figure it out. This I learned at NIH when I had to talk about a study of treatment with medication. For a variety of reasons researchers use quantitative rather than qualitative outcomes because they have higher statistical power. They use things like percentage of days abstinent or percentage of heavy drinking days or how many drinking days out of thirty. They can use parametric statistics rather than the way I think about outcomes is no response, response. Interestingly enough that’s where the field of depression studies has come to. They don’t look at if the score on something goes up or down. It’s non-response, response without remission, and remission. The goal is remission.

That’s how I think about outcomes with substance use disorders. The finding on this using this continuous measure was the average on that measure was ten percent less in the drug group compared to the placebo group. The reporters kept asking is ten percent drinking is that meaningful? I’d have to explain it to them, “Your interpretation is incorrect. You’re attributing the mean to every person in that group.” I don’t know if there was even one person there who reduced it ten percent. If you had a whole bunch of people quit it might result in moving the mean ten percent.

**AS:** It’s also how we look at the data.

**MW:** How we interpret the outcomes. This is an extremely common mistake people make of attributing the mean value to every member of the group. Basically, if you have group one and two there’s a distribution along the variables and its mean is here. There’s another distribution line here and its mean is here. There’s a lot of overlap but there’s a lot of up here who aren’t here and a lot of people here who aren’t here. It pulls the mean down ten percent. That’s not what typically happened to people in that group.

**AS:** What would typically happen? That was just the mean.

**MW:** It could be like this. It could be a bunch of zeros here; it pulls the mean down. This person may have gone up. This person went down like that. A bunch of these people went to zero. Some of them didn’t. That’s what you actually get.

**AS:** My humanities brain would say then we should be treating people as individuals.

**MW:** We are. I would point to a graph on that paper. Figure Two, if you look at Figure Two what you will actually see what happened is more and more people in the drug group achieved recovery than in the placebo group. It wasn’t that the average person reduced it ten percent. It was a bunch of people went to zero, reduced it one hundred percent. There were others that reduced it some and others that didn’t. What I finally figured out what to say about this in terms of what is harm reduction is, “My goal for every patient of mine is full remission. What else would it be?” Sometimes we don’t get there. Sometimes we don’t get there right away and sometimes we don’t get there at all. Maybe they’re better in significant ways. Maybe rather than twenty-five heavy drinking days a month they have eight. Is that any better? Yeah! That’s a lot better! That’s how we track outcomes. We track outcomes by continuous variables, drinking days per month, using days per month. You can see incremental progress on a regression. Right?

It would be like saying, in diabetes the primary measure is called the A1C level. You want to keep it below seven. That would be like saying, if you’re keeping your A1C below seven ninety percent of the time but ten percent of the time it’s above the treatment’s a total failure and it’s your fault. Let’s say you came to me and you were wheezing and coughing and I diagnosed you with asthma. You were having twenty bad asthma attacks per month and I prescribed some inhalers. In six months, you were only having three asthma attacks a month. Would you consider that progress? Would consider the treatment a total failure and it was your fault? I’m just pointing out these absurdities. People go, “Yeah, what the hell?”

Here’s another thing that people don’t understand that with all addictions for all but a very few exceptions recovery is achieved through multiple attempts and multiple recurrences. It takes persistent effort over a sustained period of time, sometimes years. The good news being that almost everybody achieves full recovery but not everybody does. When I first started that clinic back in the day this was my first research project. We were able to cut the two-year mortality rate from thirty percent to twenty percent. That’s how sick these people were. One of our mottos here is we don’t just call addiction a disease we treat it like one. Rehab is like sending a diabetic person to a spa for a month then discharging them for support groups and saying whatever you do don’t take medication. God should be enough. Who would have ever thought that very poor quality counseling, pseudo counseling and education for twenty-eight or thirty days would cure a chronic illness.

**AS:** Apparently a lot of people. I’ve got to stop.

**MW:** A couple of other things. We used to treat breast cancer with prayer too. We don’t do that anymore. We shouldn’t be treating addiction with prayer anymore. AA isn’t treatment. It’s a support group. People ask me if AA works. It works for the people it works for.

**AS:** Who want to be there.

**MW:** Who want to voluntarily affiliate. It’s sort of like asking if Catholicism works. It works for Catholics. People come to me with alcohol dependence and have been to so many rehabs. I start them on medication and they get better right away. They say, “Why did nobody tell me about this?” Tragically I just got a new Suboxone patient. She’d been to multiple rehabs and ended up getting a felony charge and doing time in jail. Nobody had ever recommended Suboxone. I started her on it for the first time. When you see it it’s a miracle. After three days they never think about opioids. They feel normal for the first time they can ever remember. They have energy again, they have motivation, they’re happy. She started crying and said, “Why didn’t somebody tell me about this earlier? I could have avoided a felony charge and jail. How many years did I waste because nobody told me about this?”

**AS:** It’s criminal.

**MW:** It is criminal. I’m going to be on NBC Dateline sometime in June. That focuses on alcohol but you’ll hear some of the same things. Look for that.

[End of Recording]