**Carol Fallowski**

**Narrator**

**Amy Sullivan**

**Interviewer**

**March 2, 2017**

**Macalester College**

**St. Paul, Minnesota**

Carol Fallowski -CF

Amy Sullivan -AS

**AS:** This is Amy Sullivan. I’m with Carol Fallowski at Macalester College. It is March 2, 2017. Macalester College, St. Paul Minnesota. Carol do you give me permission to record this interview?

**CF:** Yes. This is Carol Fallowski. I give you permission.

**AS:** The first thing I like to start with is where people are coming from since this project is based in the state of Minnesota. It’s going to look at Minnesota primarily. Can you let me know where you’re from, where you grow up, whether it’s Minnesota or not?

**CF:** I was born and raised in Minnesota, not far from here. My parents got married at the Macalester President’s College. I worked at a dress shop that used be right down Grand Avenue. I’ve been in St. Paul my whole life. I got interested in the addiction field in the school of public health in the 1970s because it was the 1970s and it seemed like everybody was involved with drugs. I thought that was really interesting. I went through the chemical dependency counseling program and with one month left of an internship realized that counseling was the farthest thing from what I would ever want to do for a living. It was too sad for me. I would go home and cry at these sad stories. While you have to be empathetic you really shouldn’t be so sympathetic that you’re reduced to tears all the time. I switched my focus in college and after that because I was also while I was in the chemical dependency counseling program was an undergraduate teaching assistant in statistics and research methods. When I graduated from college I got a job with the government evaluating two-day jail sentences for drunk drivers in Hennepin County which was a very nice fit. Then did a statewide study of plea negotiations. Then did a study on family violence. I just moved into the research field instead of direct service.

**AS:** The topic has remained interesting?

**CF:** Oh yes and then eventually I wound up at the department of human services alcoholic and drug abuse division. From there participated in a national drug abuse epidemiology network of twenty researchers from the country and we were all convened twice annually by the national institute on drug abuse to present our drug abuse reports on those respective twenty cities. They looked at data, overdose deaths, treatment admissions, crime lab data, and hospital emergency room data. I wrote a report on drug abuse trends for the feds in that capacity for thirty years until it sort of reinvented itself in 2014. It gave me a great perspective because we would all get together for four days twice a year as well on emerging drugs of abuse, patterns of use, and populations at risk here as well as in those nineteen other cities.

**AS:** So you just gave an elevator speech of our whole entire interview.

**CF:** So that’s that.

**AS:** I’m going to make you back up if you don’t mind.

**CF:** Here is that most recent report.

**AS:** I think I printed this.

**CF:** April, okay you’ve got it.

**AS:** I just printed that out. I haven’t read it. I’m looking forward to it. I want you to back up and talk about...You grew up in St. Paul. You said drugs were everywhere it was the 70s. Do you have any addiction tendencies in your family? Did you experience any? Did you see people in high school? What drew you to it?

**CF:** I was a sociology major, man and society. Looking at that it was a great social phenomena and statement of popular culture. I do not have any addiction in my family. My mother, my two uncles, and my grandfather all died of tobacco addiction at young ages.

**AS:** It was the time and the place. And you went to the U and you got your Bachelor’s in…?

**CF:** Sociology.

**AS:** Then you got a Master’s?

**CF:** No, I have a BA.

**AS:** That is really awesome. You’re a really smart person.

**CF:** Thank you. I don’t know about that. My grandfather was a very smart person. He was born in Laverne, Minnesota in the Southwest part of the state. The only county without a lake. After he graduated from high school took out a loan and bought the *Rock County Star* newspaper. He ran that newspaper and then he was editor of the *St. Paul Pioneer Press* and then he went and worked at the *New York Times* for a couple of years. Then he went in 1956 to become managing editor of the *Washington Post* and then executive editor and then in 1969 was appointed ambassador to the UN to the United States by Lyndon Johnson. He never went to college. I’ve never really thought that higher education was a prerequisite because that guy was so accomplished. He didn’t do it.

**AS:** This is your grandfather?

**CF:** Yes, who lived until he was ninety-seven. He just died in 2000.

**AS:** What was his name?

**CF:** James Russell Wiggins.

**AS:** Do you have a family? Did you get married? Do you have children?

**CF:** Yes, I’m married and I have two adult children. And I have one grandchild who my son won’t let me put on social media. So there you go.

**AS:** That’s a bummer because you’ve still got a lot of fun when you do that. Some day he will, maybe. Tell me what it was like when you first started doing research with drunk driving, with addiction? Can you kind of back up?

**CF:** How what was?

**AS:** What was it like when you were first studying it? What was the culture like? What was the bureaucracy?

**CF:** Drug abuse?

**AS:** Yes, for drug abuse. I’m looking for some changes over time.

**CF:** Well this is all governmental structure stuff.

**AS:** That’s okay. That is interesting to me.

**CF:** The federal government, for many years, passed through grant monies to states for drug abuse prevention and treatment. They’re called block grants. The state Alcohol and Drug Abuse Agency which in this state is now called the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services is the state agency responsible for dispersing those funds. The funds come from the Substance Abuse and Mental Health Services Administration, SAMSA. The state alcohol and drug agencies vary by state. In some states they’re located in the Department of Human Services. In some states they’re located in the health departments. Here it’s in the state Department of Human Services. That’s sort of the state structure. I was working there at the research unit when I did a study of two-day jail sentences for drunk drivers. That was in 1983. Then in 1986 due to some changes I became part of this drug abuse epidemiology workgroup of the national institute on drug abuse. It’s called the CEWG, Community Epidemiology Workgroup. It was reconnoitered in 2014. It’s called something else now. Then when I would write my very first report, by and large the drugs we had anything to talk about in the state of Minnesota were of course alcohol and then marijuana and then everything else took a remote backseat to those two drugs of abuse in terms of both prevalent abuse and consequences of use.

**AS:** Do you remember what your findings were for the two day? This is basically the old idea that you take the drunk person and you make them jail detox. It’s kind of like a jail detox.

**CF:** I did a time series analysis. It did show to reduce night time injury accidents, I compared Hennepin County to Ramsey County which did not have the two-day jail sentences.

**AS:** Because they’re locked up for the weekend or whatever those days.

**CF:** They can schedule them when they come in but they still have to spend two days. It was an effective deterrent as measured by changes in the rate of nighttime injury accidents.

**AS:** So did they keep it after your report? What happened?

**CF:** The judges kept it up. Then as changes happened in the judge’s appointment it kind of fizzled out. That was my first published article. It was on reducing two-day jail sentences and using time series analysis which is pretty complex. It was interesting. Then I did my first drug report in ‘86. The VA had a methadone program. I think it was the VA had one and Hennepin County had one. There had been one in St. Paul that I kind of came in on the tail end of that. There must have been some problem with it. It had been closed down. There were really only those two. The prevalence of heroin was very low. It was very sporadic. It was as if there would be a short brief supply of heroin and then there would be dry periods. Eventually, I’m just going to talk about these trends in drug abuse. I think as the result of our sporadic supply of what is very low period of heroin it became apparent that the Twin Cities had some of the higher rates of prescription opioid abuse. This is into the 90s.

**AS:** After oxy is approved.

**CF:** No, prior to that.

**AS:** Where were people getting it? Hospitals?

**CF:** From a guy who knew a guy who knew a guy. The source, I don’t recall the source of it. It was interesting to me in looking at the hospital emergency room data that relative to other cities we tended to have higher rates of exposure to prescription medications which was attributed by me and by others to the fact that we didn’t have a constant supply of heroin. To supplant that people would seek out prescription narcotics. That lasted into the mid-90s. Also, when Prozac or fluoxetine was introduced we had one of the higher rates of hospital emergency room episodes involving that as opposed to other cities. I believe it was a carry over to sort of a penchant of drug abusers here for prescription drugs.

**AS:** To abuse Prozac. Interesting. We’re in the mid-90s now and are you still at DHS or have you moved on?

**CF:** I left DHS in 1997 to 2007 I was at Hazelden. Then I went back as director of the state alcohol and drug abuse agency in ‘07 and did that until 2012. In 2012 I hung up my own shingle and now I do education training and consulting. With drug abuse, cocaine then started. When I got into that group in 1986 cocaine was on the upswing and we always met in a different city and then would take field trips. It was my ongoing education about drug abuse. We happened to be meeting in New York City. I think it was in June of 1986. When Len Bias, the aspiring basketball player overdosed on cocaine. We passed around little vials of cocaine. The police came and we all got to look at them and see what it was. We went on a field trip to some treatment program in Harlem. It was my ongoing education about drug abuse because we were together for four days twice a year.

**AS:** Many of the same people?

**CF:** Yes. That was a good learning experience.

**AS:** This is the Len Bias who the law is now...this is his case of his overdose? Where they’re trying to convict drug dealers?

**CF:** Is it? They have a Len Bias Law?

**AS:** Yes.

**CF:** Federal?

**AS:** Well I think so. I think right now there’s a drug dealer named Beverly Burrell who’s being charged with third degree murder of five young men in this area. What I understand is that it’s the Len Bias.

**CF:** That would be him then.

**AS:** So you were New York right after that happened. So cocaine, what about cocaine here?

**CF:** We saw cocaine here. The first time I was quoted. Many researchers aren’t really articulate in explaining things to the public. But I seem to have that knack for it. The first interview I ever had in the newspaper was about cocaine. I know that from looking back at old newspaper clippings. I think I said, “It seems as if everyone and their dog is using cocaine.” I think that’s why the media always still comes to me for good little sound bites. I never really a saw a dog use cocaine. I think that was an embellishment. Cocaine came and rose. I learned how to not only gather data but interpret data because I noticed an extreme spike in people coming in to treatment. With any drug epidemic having people come into treatment is a good thing. It was just such a dramatic increase. Talk to my colleagues across the aisle from me at the alcohol and drug use agency. They’d opened three different federally funded programs for cocaine addicts. Of course you’re seeing these kinds of increases.

**AS:** This might seem like a boring question but can you explain how you got the data to do the research? Are all of the treatment centers supposed to report to you? Can you explain how that process works?

**CF:** We have a system called the Drug and Alcohol Abuse Normative Evaluation System or DAANES. We thought that was so clever. DAANES is a requirement of anyone who receives public funds for treatment in the state. DAANES has two hundred and sixty some variables about patient history and how they came to be there and that includes information collected at intake and at discharge. It also allows us to look at changes in time over number of people coming into treatment for different drug categories.

**AS:** Is this still used today?

**CF:** I can show you. Exhibit 6, this one. Page ten. That is DAANES data. I invented this chart way back in the day. It’s a good way to look at the number of admissions coming in and what the primary drug of abuse is. Then within that what is the gender, race, ethnicity, age, route of administration, we put smoking in there too.

**AS:** On this if you add heroin and other opiates that would be the number two after alcohol.

**CF:** Oh yes. Heroin alone what’s significant now, what’s unprecedented now in this report of April of 2015 is that the percent of heroin admissions exceed the number of marijuana admissions which has never happened. You can see where cocaine has really dropped off to four percent. Methamphetamines is actually rising. The fact that heroin admissions surpass marijuana is a significant plight in the state of Minnesota.

**AS:** Is there someone doing your same kind of work now? Since you’ve left?

**CF:** I still do it.

**AS:** Will you be doing it again for 2016?

**CF:** I don’t know. To be determined. I’ve done it so long.

**AS:** I can help you with it. I’m concerned because the numbers have actually gone up in 2016. There’s been more deaths. They dropped in ‘15.

**CF:** They all come from different public data sources. These reports were unique in as much as they put it all together. By putting various data sources together, collectively they painted a picture that did not otherwise exist of drug trends.

**AS:** Are you talking nationally? No, you’re talking about here in Minnesota.

**CF:** And the people in nineteen other cities that did this. That’s the value of these reports. Now data is much easier to get, public data. It was very difficult to get. DAANES data, treatment data was maintained and I worked on the drug and alcohol DAANES system. That was easy to get always. These other data sources used to be very hard to get. To get crime lab data for Minneapolis I used to have to go and individually record things from three ring binders to write that down. Medical examiner reports I would have to go sit over there in their office in Hennepin County and go through manually pieces of paper. It’s come a long way. My first pie chart was done by putting a coffee cup on a piece of paper and drawing a circle around it because computer technology did not exist to make graphs. It’s come a long way. Data is much better. Some of these agencies have been very proactive in putting their own data together. Some of them including other people’s data. The state monitoring has actually improved over thirty years. You think it would, it has for everything else.

**AS:** There is something about learning how to present it and communicate it to the audiences.

**CF:** Then go to this Exhibit 14. This shows trends over time. That’s that same treatment data on page nine. You can see as a percent of, or these are just raw numbers, of people coming in. But you can see that rise in heroin. You can see that rise in methamphetamines.

**AS:** They’re kind of on a parallel line aren’t they with each other? Other opiates, that is a little more steady there.

**CF:** Then this one, talk about the State Health Department. It always had mortality data. It has started being much more active in the last two years in making that public data, public.

**AS:** Because you wouldn’t necessarily know what the person died from or what the medical examiner…?

**CF:** No, they’ve just become more proactive in making it more accessible. They’ve always had it. They’ve just started because in this state the state alcohol and drug abuse agency is in the Department of Human Services not the Department of Health. Even though the health has the vital statistics. They’ve kind of gotten on board in making it more public and here you can look at overdose deaths in the eleven county metro area versus greater Minnesota for Minnesota residents. Which are the lion share of the deaths. What’s going on, to me the point of this is that it’s not just a metropolitan problem, it’s all over the state. So in the meantime, I’ll just do the short thing of drug trends. When I started in that group I really had nothing to say about it. Everybody really organizes their presentations around drugs. I had nothing much to say about heroin or cocaine. After a few years I thought, “Whoa. I wonder if I’ll ever have anything to say about those drugs.” Then it changed with cocaine peaking out then methamphetamine became a big problem.

**AS:** When would you say cocaine peaked out?

**CF:** ‘86 was a height. I’d have to look. It was somewhere there. For at least ten years now that’s been declining. The thing is it never really disappears. Something else. What makes news in the drug abuse world is large increases. The declines not so much. Then methamphetamines came in and it peaked in 2005. Here as well as nationally. Then has been declining. Minnesota was one of the first states to have state laws about methamphetamine manufacturing. Then thirty-four states total had state laws about it and then the federal law came in. Our senator at the time, Senator Norm Coleman was very active in that and driving that national legislation. That was 2005 and then things with methamphetamines declined for a few years. Certainly there were fewer methamphetamine homemade labs. We had the federal law that restricted the retail sale of products that contain pseudoephedrine. Starting in 2009 or four years later increases started happening again with methamphetamine. It was in 2015 that indicators related to methamphetamine in Minnesota were higher than they were in 2005. Because opioids were at that time capturing the headlines, it didn’t get much public attention. It is still the case that methamphetamine is stronger than it ever was. There’s not that element of labs blowing up and pollution. It’s coming in from Mexico.

**AS:** It’s being made there so people aren’t making it here.

**CF:** It’s a huge problem. Mixed in with all that are the synthetic drugs and synthetic opioid drugs like fentanyl which is a complete game changer. I could talk forever. Ask me a specific question. That’s kind of the overview.

**AS:** I’m just letting you go and then I’ll ask you another question. Can you talk about your time at Hazelden and what you did there? Who were you seeing? Were you still collecting data for Hazelden? Is Hazelden one of those places that has to report to the DAANES?

**CF:** Yes.

**AS:** They do because what public funds do they get?

**CF:** They get some money from the Chemical Dependency Consolidated Treatment Fund, CDCDF.

**AS:** You’ve got a lot of alphabets.

**CF:** The Consolidated Chemical Dependency Treatment Fund is a pool of federal money and state money that is available for people who could not otherwise afford treatment for addiction. Each county in the state gets an allocation from that big pool of money that’s based on a formula. That’s like a population based rate. Each county gets their allocation and then the county administers those funds. In order for a person who’s low income to receive alcohol or drug treatment they have to go to their county human service agency, get a chemical dependency assessment, and then the county determines the severity of problem and matches that with the level of care of services. They also match it with the treatment providers with which they have contracts so they can send patients there. It’s an enormous fund. The state contribution the last time I looked was like probably 2012, it was about over one hundred million dollars were state funds to that. There were some federal funds, some from this block grant. It provides treatment for people in the state. At Hazelden it gets people who come on that. The data systems are good. Almost any treatment program in the state is in that.

**AS:** It’s a good picture, it’s inclusive.

**CF:** Some states have more limited ones and only collect Medicare or is it Medicaid.

**AS:** I can never remember.

**CF:** Some just have data systems that look at public paid clients through their Medicaid. Ours is pretty much all treatment programs report on it. It’s a good snapshot. It’s almost a total snapshot as opposed to a sample.

**AS:** So what did you do there and were you at Center City?

**CF:** Yes, I was at Center City. I came in working in the research department. I did these reports. Then I helped with other different patient studies. They had different studies for different patient groups. I’d take part in that. Then the CEO at the time said I should be in communications. Being in government I never had a CEO. I thought well if he’s saying it I should go do that. Then I worked in the communications. All the time I kept doing these reports.

**AS:** You keep doing them not necessarily because someone is telling you to but because you want to keep your eye on what’s going on?

**CF:** No, because I was a part of this national workgroup. It was only twenty people. I wanted to.

**AS:** You needed the Minnesota data so you could report it to that.

**CF:** I wanted to be a part of that group because it’s a spectacular learning experience going to all the different places we went to in different cities to see aspects of the drug problem. I kept writing those reports. I worked in communications. Then I worked in public policy driving the national Ramstad-Kennedy legislation at the national level. I made trips to Washington. I did that for ten years.

**AS:** How did you find it different moving from DHS into a place as prestigious and well known as Hazelden?

**CF:** It was a breath of fresh air because Hazelden had campuses in Chicago, New York City, Florida, and Oregon. I got a lot of my experience through going to those areas of the country and speaking to different professional and parent audiences about it. That was really a great experience. At Hazelden if you had a good idea it was so welcomed. It was like, “That’s a great idea. Let’s help make that happen.” When I worked in state government two different times as I was a young woman coming up I had some ideas and I’m very outspoken. I would take them to my superior and two different times I had different bosses say, “We aren’t about good ideas here. We’re about doing things the way we’ve always done them. You should know that.” It was very deflating. Working in government is a great experience and I learned so much about how bureaucracies work and how money flows. It takes a certain outlook to maintain long-term in government and I just didn’t have it. I believe you should improve things and quit doing some things. So when I went back to government I went back as the director. I thought, “Now I’ll be in a better position because I’ll be the director.”

**AS:** Were you able to make change?

**CF:** I was able to make some changes.

**AS:** Like what?

**CF:** I freed up some funding for recovery based services like the Minnesota Recovery Connection. There’s another one down in Mankato. We get this block grant money so why not have those. They’re really an important piece. The theory behind them is that when someone’s in recovery, the person in the throes of addiction has lost their friends, their family, their job, their social supports. It’s very hard to go back and integrate into the community. The idea of recovery centers is to provide services to those folks who are just trying to get their lives back in order. Recovery or systems of care is the buzz phrase that they use. I helped start those. I also got some training going. We had at the State Alcohol and Drug Abuse Agency an American Indian desk that really deals exclusively with the American Indian programs. There was a person there who had developed a curriculum to teach non-Indian service providers about Indian culture and how to best deal with Indian clients. I freed up some money and time to go deliver that to different audiences over the state, to correctional workers and different workers in different domains.

**AS:** So Minnesota Recovery Connection started with you?

**CF:** Yes.

**AS:** That’s awesome. You’ve done a lot of talking to parents. Can you talk about how you approach that and what your philosophy was and your strategy? Those situations, where they happened, the response you got. When did you start doing that? Was it while you were at Hazelden?

**CF:** Yes. That’s when it really took off. I had done it before. They had people working in all those cities. They wanted to get Hazelden’s name out there in a high profile way. What better way than to have something for professionals during the day and then they’d something for the community at night? My busiest day in Kentucky I talked to school teachers in the morning, a combination of the Lions Club and the Rotary at lunch and they’d never met together. I said, “Now don’t you boys get in a fight.” Then a law enforcement group at three in the afternoon of regional law enforcement people. Then that evening a community event. I was on the speaking thing. I could do that again. Parents are often the last to know what to do. They may be the first to realize something’s going on with their child with drugs and alcohol or they may be the last to know what’s going on with drugs and alcohol. The challenge really of parenting in today’s age is that the signs and symptoms of drug abuse are very similar to the signs and symptoms of normal adolescence. The list is almost identical. Changes in hygiene, changes in friends, changes in mood, loss of interest in usual activities.

**AS:** Sleepiness, staying up too late.

**CF:** All of these symptoms that are in my book are also the same as the symptoms of an emerging drug or alcohol problem. The key is that when they all happen together, when it’s not spread out over time. When all these symptoms are occurring all at once chances are there’s a drug or alcohol problem involved. Another thing parents don’t realize is that they don’t know how to distinguish, is it a drug or alcohol problem or is it just normal adolescence? Then they don’t know what to do about it. They don’t realize that if their kids are involved in a drug or alcohol problem they will lie about it. They’ll look at you in the face and lie to you. That especially for some parents is just appalling. I say your kids will lie to you and you can hear a gasp in the crowd. “My Johnny would never do that.” It was really an eye opener for me about how parents grapple with this. Not only do they have a hard time identifying it but they don’t know what to do about it and they don’t know about the drug abuse situation today. They don’t know that their little angel just by going to a good private high school can buy heroin now. That would just floor them for as little as ten bucks. They don’t know that their little angel who goes to a public school as early as seventh grade can be offered Adderall in the bathroom or a joint at the football game or alcohol on the school bus. They don’t have a concept of how our culture has drugs and alcohol all over it. We are blanketed in this country with drug and alcohol access at a very young age that we’ve never seen before.

It really was gratifying for me to go all across the country, learn the local problems. Because I was a part of this national monitoring group I could read the reports of my colleagues in those areas before I went to kind of familiarize myself with the numbers and the epidemiology in those specific areas. Then talk to parents and listen to their concerns. I was talking in Cape Elizabeth, Maine which is a hoity-toity suburb outside of Portland, Maine. No one was coming. The school principal had to be convinced to do it. “If we host something on drugs people will think we have a drug problem.” That’s how schools were like and probably still are like. No one was registered to come. We might get twenty-five people there. That Sunday I was speaking on a Tuesday and that Sunday a sixteen-year-old girl got drunk in the middle of the day and drove her car into a tree and killed herself. It was an accidental car accident but she was drunk. Come Tuesday it was standing room only. They had to move it to the cafeteria and an adjacent room. It was packed and you could have heard a pin drop. I spoke first and then we had a panel of the police chief and the school principal and a treatment provider and another woman whose son had struggled with addiction. When the panelist were all through making their introductory remarks a woman stood up and just lost it. Saying, “When is this community going to face the facts about our drug and alcohol problems? How many people have to die? What’s going on here?” She was just really agitated. After the police chief took that question. After it was over I said, “Who is that?” She said, “Her son got killed by a drunk driver fourteen years ago when he was in high school.” It was such an a-ha moment for me because what an example of unless communities kind of step up to the plate about talking about drug and alcohol you’re going to have people like that. You’re going to have this ongoing rage and burning rage inside of people unless they can have some community programs or events or something. Some community to plug into where they get support for underscoring it as a certain problem. We still are so shameful.

Kids who get into trouble in drugs and alcohol. I’ve talked about the parents but the kids themselves, if they get labelled in high school as having a drug or alcohol problem then the parents don’t want their kids to hang out with that person. Even when they get the help they need they don’t get the support for it. They’re still labelled. Minnesota used to have more sober high schools than any place in the country. Now because the failed business model, they didn’t figure out how to make themselves charter schools and spent all their money on transportation. We don’t, we only have six. Minnesota was a pioneer in that area of sober high schools where kids once in recovery could get support for being in recovery. Parents are really key and that’s one of the things that motivated me to write a book. The book is called *Drug Abuse*. I brought that for you too.

**AS:** Thank you.

**CF:** *An Easy to Use Reference for Parents and Professionals.* I said don’t pick a scary title and then *Dangerous Drugs* in big red letters. It’s a guide for parents. It has the signs and symptoms. For every drug it talks about the observable signs of use and then when you should call 9-1-1. It didn’t exist. I felt really good about writing that and going around and talking about it.

**AS:** There was nothing like this. That’s great. Thank you for that. Just getting back, what have you seen change here in Minnesota because of the heroin and opiate pain killer epidemic with parents, with kids? Did you notice a shift with parents here or is it the same as what you were just talking about where people don’t really want to acknowledge that maybe in Northfield or Minnetonka that there’d be a heroin…? Do you think it’s really changed?

**CF:** What?

**AS:** The general response. There’s a lot more in the media.

**CF:** There was stuff in the media about methamphetamine as there is about opioids now. With every drug trend it gets varying degrees of public attention. Every drug epidemic has a certain characteristic about it. Every drug has its own characteristics. The key thing about methamphetamine that was used to drive prevention methods was it rots your teeth and it gives you a sunken appearance. Still parents didn’t think that their little angels could access meth. There’s a drug. We live in a culture where we are rewarded for doing more in less time. It’s a perfect fit with our culture. A strong stimulant, long acting drug.

**AS:** And Adderall is this generation that’s been raised on the ADHD drugs.

**CF:** I’ve looked up a story and I can’t remember when chill pill came into our dictionary. I think it was 2003. You could confirm that.

**AS:** Thank you for reminding me about that.

**CF:** That’s a very good thing to have in a book and I have it. I’ve got a million PowerPoints but I can’t remember which one I put that in. It shows that one thing that’s happened sociologically is the increased use of pills to treat all sorts of medicine. And direct to consumer advertising of prescription drugs that happened in 1989. That sort of direct to consumer advertising of prescription drugs, I’m not sure that ‘89 is the year. I can’t remember the exact year. That really does start this increase in the abuse of prescription drugs non-medically. It still is the case that kids get a lot of their information from television. Especially if you watch the national news, nightly news. Those are all prescriptions but they’re mostly for older people with different body function failures. The thing that distinguishes the opiate problem for me professionally was whenever I would speak to these various professional and community audiences and when I started doing that, it happened a couple times with methamphetamine, it started happening more frequently and regularly with audiences where I was talking about heroin and opiates. Someone would stay back afterwards and tell me that they were the parent of a child who had died from an overdose. The numbers grew so much that at one point I had a dozen emails of parents whose kids had died. I just sent out an email to all of them and said...I would meet with them and talk. It’s such a devastating thing that their family will probably never recover from. I got them all together and I think that’s maybe how Mothers Against Drunk Drivers started. Just letting them know each other.

**AS:** Was this mostly in the state of Minnesota?

**CF:** Yes, it was in the Twin Cities area.

**AS:** Do you remember some of those mothers’ names?

**CF:** Yes. You want to talk to some of them?

**AS:** I’m wondering if I’ve already interviewed some of them.

**CF:** I don’t know. Did you know Star Selleck? She’s good.

**AS:** Yes, and Gloria Englund.

**CF:** And I can’t remember the one I always talk to. I’ll have to look. That’s what changed about that. The thing that distinguishes the opiate problem from other drug epidemics we’ve had in the past is that for each epidemic you have to look at prevention, treatment, and law enforcement. The three prongs of drug policy in this country. Given the pivotal role of prescription narcotics with the opioid crisis we have to look at prevention, treatment, and law enforcement, and the practice of medicine. We have to look at the situation and figure out what we can do about it within the medical community. We have two hundred and fifty-nine million prescriptions written for opioids in a year. In a country of three hundred and twenty million people. We need to look at what we can do to curb that.

At the same time, we have to add that fourth prong, the practice of medicine. It’s not just looking at the conditions under which we prescribe prescription opioids. It also involves integrating the screening for drug and alcohol problems into primary care. With other chronic diseases with behavioral components where you have to change your behavior in order to get better we screen for those. You go to the doctor and you get screened for high blood pressure. If you have high blood pressure the doctor talks with you about your high risk conditions. Obesity the same thing. We screen for that every time we go to the doctor. Asthma is screened for, diabetes. With those conditions about ninety percent of the people who have those conditions receive treatment for it. With alcohol it’s the inverse. About ten percent of the people who exhibit symptoms get treatment for it. That’s due to a number of things. One that the treatment system developed outside the practice of medicine. Secondly there are some people who manage their addiction simply by going to self-help groups. There are a group of medical professionals who seriously believe it’s not really a medical problem you can just go to one of those self-help groups to get better. They don’t really own it. Finally, they don’t get training in addiction even though they are prescribers. Even though they’re more likely to see someone who’s addicted than they’re likely to see someone with some horrible cancerous rare growth. They don’t get training in it. We have a long way to go. It’s as if the prescription opiate problem has brought to light all these shortcomings of all the different systems involved. Getting out of it and turning it around is multi-layered. It’s going to be a multi-year thing. It’s pretty complex. Doctors as a group do not take to being told how to practice medicine. Yet voters in twenty-eight states created this sort of outside of mainstream medicine systems of marijuana distribution. Changes have happened in spite of what doctors want. It’s very multi-layered to address it. I did for the Minnesota Medical Association I travelled around, this was in 2013, the state had me talk to different groups of doctors that they had convened about this opiate problem.

**AS:** What was that like?

**CF:** It was really interesting. I remember particularly one doctor who had said that whenever he tried to reduce, he had a patient who was probably one of those people.

**AS:** That was how he said it?

**CF:** Yes, one of those people. An addict. “Gosh, he’s been my patient for a long time. Every time I try to reduce his prescription or don’t increase it he threatens to kill me or my family.” I said, “I’m no doctor but if someone was threatening to kill me and my family I think that would be a law enforcement issue. Even if it were a patient.” That’s a threat against me. I said, “Did you do that?” This is in a small group of doctors. There are about thirty doctors in a room. He goes, “No. I just write him a new prescription.” I don’t think he’s the only doctor who deals with that. I don’t he’s the only doctor in Minnesota who does that. I don’t think he’s the only doctor in the country who does that. What I learned from talking to these doctors was that when they went through medical school they were taught, don’t worry about prescribing opioids. It’s only one percent are going to get addicted. You know that was from that little note. They really learned that. Then there’s a switch with the introduction of long-acting oxycodone to start using it for the treatment of chronic pain as well as acute. This long term chronic pain, Purdue Pharma they were fined in spite of that. We have the prescription monitoring programs which are good. Still we need to have more education, more integration. The National Institute on Alcoholism and Abuse developed a great curriculum for doctors on how to talk to patients about their drinking. It has little video, if you’re teaching a class this thing is great. When I was at the State Alcohol and Drug Abuse Agency I had our staff watch it for a staff meeting.

**AS:** What’s it called again?

**CF:** It’s at NIAAA.NIH.gov. They’re whole initiative is called “Rethinking Drinking.” Just look for clinical guide for doctors. It shows doctor interactions and one of them for example is a guy who says he drinks but only on weekends but only when he watches football games and doesn’t drink at all during the week. The guy’s presenting with high blood pressure and the doctor says, “Well how many games do you watch a weekend?” “Well if it’s in the season I’ll watch the college games on Saturday and then I’ll watch the pro games on Sunday.” The guy’s watching about ten games and he only has a six pack every game. That’s a lot of drinking. You think a football game does last a long time.

**AS:** It’s just asking that second or third question.

**CF:** The doctor saying, “I could put you on medication for your high blood pressure but do you think you could drink less? Do you think you could limit yourself to a six pack a day on a Saturday or Sunday?” If the person’s not addicted they’re like, “Oh sure.” Those conversations are easy to have. Doctors aren’t really well versed or trained in how to do it.

**AS:** The doctors I’ve spoken to have said there’s also a time issue and a hassle issue. They have less time and they don’t want to be hassled.

**CF:** Chronic pain patients and addicted patients are the most challenging of patients to deal with. This is just screening within the general population. They found extremely good results. The other one is the screening brief intervention and referral to treatment, SBRIT. It was developed by the national government and tested in many different settings across the country both on reservations and in urban areas and in rural areas. Screening brief intervention and referral to treatment involves just a very few little screening questions for people for patients who present for primary care. Sometimes they have it in emergency rooms. Then they found that just doing a brief intervention on them, like the one I just described would qualify as a very brief intervention, that over half of the people changed their drinking behavior. The people who were not addicted. Where else in behavioral health do you get that kind of behavior change? Never. It’s never been that high. It can be very effective in interrupting a person’s progression to addiction. To have a health professional, whether it’s a doctor or one of their people, just say, “You might be going on the road to addiction if you keep this up. Why don’t you just try reducing it for a while.” Then all these other health problems will probably diminish. That’s been really effective. SBRIT, there haven’t been any sites with it here. I wrote a grant when I went to the state and it didn’t get funded. SBRIT is great but it needs to go to more places in the country. Now Allina has a variation of that. Different health plans are starting to integrate it. That’s a huge issue. Just talking to people about it. If you teach this, you know this but you know doctors are trained to believe there’s only 1.5 percent of people would develop addiction. We now know from different studies and from the CDC it’s up to twenty-five percent of the people.

**AS:** To opiates?

**CF:** Yes. There’s even one doctor I know who believes that if you have a room of one hundred people and you give them all Percodan for a month at the end of the month they’ll all be addicted.

**AS:** Who’s that?

**CF:** Dr. Chris Johnson.

**AS:** I was going to guess.

**CF:** Have you talked to him?

**AS:** Yes, I interviewed him. He’s an interesting guy. He’s actually the kind of spokesperson and Evangelist to get the attention of doctors. Those kinds of people emerge as well. In a crisis situation you need the people who are going to rattle your cage.

**CF:** Doctors are much more inclined to listen to other doctors than anybody else.

**AS:** You talked about the parents that you met…

**CF:** I want to finish back about this doctor who said that. I don’t think he’s the only doctor. Another thing that has to change in the medical world in addition to screening, in addition to more reasoned prescribing of opioids for certain conditions. We need to train doctors on what to do with people who are addicted. Many times they don’t know what to do. Again it’s an outgrowth of treatment centers developing outside of mainstream medicine.

**AS:** That’s interesting. What your ideal model be for treatment?

**CF:** Different health plans. We have a crisis in health care too. Each treatment plan has to figure out their own stuff.

**AS:** In an ideal world what would you see?

**CF:** It’s like with any other health condition. Go to your doctor. You’ve got addiction? Go to your doctor. People coming into treatment based on the DAANES data, only six percent of people coming into treatment are referred by doctors. Nobody really wakes up and says, “Oh gee. I’m sick of my life. I think I’ll go to treatment today.” That just doesn’t happen. It’s either family, the criminal justice system, or your employer that says, “You’ve got to do this or else.”

**AS:** If our health care system was functional we would have more access and more time with doctors. If they had more training they would look for signs. The fifteen-year-old that’s wanting birth control to the family nurse practitioner could be screened for other things as well. They could talk about all kinds of things with them. Do you think that opioids have changed anything in the way that we look at addiction or do you think it’s just another drug in the grand march of drugs of the day?

**CF:** I think they’ve put a spotlight on how we deliver treatment and what treatment is delivered. The science is overwhelming that the use of medication in the treatment of opioid addiction is very effective. Yet, treatment providers in Minnesota as well as over the rest of the country have been very reluctant to embrace that as part of their practice. People aren’t getting the kind of help they need. Hazelden was one of the first treatment programs in the state of Minnesota if not the first to use Suboxone in the treatment of their opiate addicted patients. They had a huge influx in the number of opioid patients and they were noticing that they were leaving without staff approval. Once they left a number of them were overdosing and dying. They wanted to do something and introduced state of the art medication assisted treatment. Now people go through a program they have at Hazelden that includes that. Trying to get other treatment providers to incorporate the use of medications in the treatment of opiate addiction in the state of Minnesota was one of my primary goals as a director of the State Alcohol and Drug Abuse Agency. I liken it to pushing a piece of string. It just collapses on itself. I had trainings through the professional association of treatment providers. I had trainings through DHS that we would put on and have different panels of parents and law enforcement and doctors. I did a number of those.

**AS:** Talking about the benefits of medications?

**CF:** Yes, here we are. This is the only drug category, well alcohol there’s some medication too, for which there are effective medications. We want to be science based in Minnesota not based on ideology. Let’s use the science to deliver treatment. There is a lot of barriers to it here. I wasn’t able to do that.

**AS:** When did you start that?

**CF:** 2008. Do I think it’s made progress? What’s that it’s almost ten years. No.

**AS:** Hazelden won’t touch methadone either.

**CF:** Really?

**AS:** They won’t touch it.

**CF:** Still?

**AS:** Suboxone is not really their thing anymore. Vivitrol is their…

**CF:** That’s the same as Suboxone.

**AS:** They won’t touch methadone because they said that’s not their client base.

**CF:** And how many people who are on methadone go to AA meetings or Narcan meetings and are told, “You aren’t really sober.”? It’s very frustrating. The analogy I use is that someone has high blood pressure. They go to their doctor. The doctor says, “Lose weight, exercise, and watch your diet.” Then they go back in a year because nobody really exercises or loses weight. Here it is a year later they still have high blood pressure. Then the doctor says the same thing, “Diet and exercise.” Then the person has a stroke and dies. If you were the family of that person and you knew those prior conversations wouldn’t you say that doctor is guilty of malpractice? He didn’t even mention that there’s a medication for high blood pressure. What kind of doctor are you going to? He doesn’t even mention that. In treatment you have people who go into treatment programs and they say, “This is what we do for treatment programs.” It’s all cognitive behavioral therapy. They don’t even mention there are medications that can really help with the craving. There are medications that you can be on long term that really help manage this disease with behavioral components. They don’t even say that. One of the changes that’s happened is there’s now language in a law that says treatment providers have to inform their patients that there are medications.

**AS:** When was that?

**CF:** A couple years ago. I’m not sure how that’s going. I’ve been at a distance and just reading these list serve emails about the language. Big fights about the language in it from people who do not believe. If this is really a disease you should use what the science says is available to treat the disease, not your personal beliefs about it. “I just don’t believe in that.”

**AS:** Do you think that’s an impact of the Alcoholics Anonymous model or do you think it’s the moral model of addiction?

**CF:** I think it’s both of them. It’s news to me that Hazelden still does not accept patients with methadone. However, I’ve taught at their graduate school and everything. There’s this belief that some of the people who are treatment providers now, back in the day were trained in the belief that a drug is a drug is a drug and methadone is just a drug. Whenever I talk about this publicly it tends to be students who are in the counseling in training programs at different places who say, “I was taught that a drug is a drug is a drug.” I don’t know if there are any programs that have counselor training programs in the state and I don’t know where they’re still hearing that. What also floors me is that just two weeks ago I got a call from a woman about a speaking event that I’m doing. In the course of talking about what I would be covering I talked about this issue. The use of medications and how much resistance there is to integrating them into effective treatment models in the state. She goes, “Oh boy that’s my son. He’s been to treatment twelve times and he’s nineteen.” I thought, “It’s still going on.” I was stunned. That just tells me. This was unsolicited from this woman. He had been to twelve different treatment programs. I said, “Well did anybody ever mention Suboxone to you or Vivitrol?” “No. What’s that?” I gave her the name of a doctor to talk with. I gave her the websites of how to read about these medications.

**AS:** This is someone who’s planning to bring you to speak?

**CF:** Yes.

**AS:** What does she do?

**CF:** She’s a nurse. She’s taken her kid. He’s had twelve formal treatment episodes. It’s never been mentioned.

**AS:** It’s never worked because he’s addicted to opiates.

**CF:** She didn’t know what medications. She said, “He also has mental health problems.” I said, “That’s really common too.”

**AS:** You can stabilize him on methadone or Suboxone. Those drugs have such stigma.

**CF:** That blew my mind. I could not believe my ears. That was two weeks ago that that came up. Totally unsolicited. We were talking about something else. Then she said, “That’s my son.” We talked for twenty minutes about her son. He never had any treatment programs that brought up medications.

**AS:** It’s criminal.

**CF:** It’s horrible. It’s not limited to Minnesota. Yes, people who are addicted are very challenging patients. People are long term chronic pain patients are very challenging patients. But we have to give our medical system and our treatment provider system the tools they need to help these people get better. That’s one thing I realized going to all these events that it’s so polarized.

**AS:** Then you also have the DEA who are involved in the monitoring of methadone and how difficult it is to even prescribe that or have a clinic or the doctors. They’ve changed the law. If doctors aren’t trained how to understand how to prescribe it and monitor it, they won’t agree to have a hundred patients.

**CF:** Didn’t they even up the limit to three hundred?

**AS:** Yes, but who’s going to do it unless they understand it.

**CF:** Doctors, why would they volunteer to treat the most difficult patients.

**AS:** The people who got worse.

**CF:** “I think I’ll get my Suboxone training so I can start treating addicts.” That doesn’t happen either.

**AS:** Even though one doctor I interviewed said he has a great practice. He has very few problems. He is a primary practice physician who has a specialty in addiction medicine. “These aren’t the people coming in the ER who see me. This is after we’ve gotten their lives stabilized. They’re much better.” It’s when are we going to quit the ER scenarios, the overdoses. That’s the mythology around addicts is that they’re just these horrible people.

**CF:** Which reminds me. The things that are different about the opiate crisis are not only that we have to look at the usual prevention, treatment, law enforcement, and the practice of medicine. Also what distinguishes it from other drugs of abuse is that it’s got high abuse potential, high addictive potential, and high overdose potential. Unlike methamphetamine, unlike cocaine, unlike the hallucinogens, just a little bit too much can kill you. That’s what makes it different as well. The final thing that makes it different is this onslaught of China produced fentanyl that is appearing not only in the supply of sniffable drugs whether powder fentanyl has been mixed with heroin as well as cocaine. It’s getting mixed with the supply of powdered illegal drugs. Also it’s being put in counterfeit prescription pills. That is really only in the last year or so. That is implicated in the death of Prince and everyone who becomes addicted to prescription pain medications at some point runs out of the supply that they legitimately get. They seek them out on the black market. They find a guy who knows a guy who knows a guy. People who may be selling these counterfeit pills probably have no idea there’s fentanyl in them. A little too much can kill you. That’s the other thing.

**AS:** That’s the case with the woman who sold to the five.

**CF:** She was selling heroin that had fentanyl in it?

**AS:** Yes.

**CF:** I’ve looked at this death data for thirty years. Historically fentanyl deaths were either like an anesthesiologist diverting it or someone not taking it as medically prescribed. The classic case of that was a death of a guy who had knee pain and then was treating his knee pain with a heating pad. Then he had the surgery and went home and still put on the fentanyl patch and put the heating pad on it. Of course because it’s transdermal it opened it up and his wife found him when she came home from work on the couch with the fentanyl patch with the heating pad over it deader than a doornail. That was just not taking it as prescribed. Those were the kind of fentanyl deaths. Then one case, this was a law enforcement report where kids were trying to roll up and smoke fentanyl patches with a joint on the inside.

**AS:** You’ve heard some stories I bet.

**CF:** I’ve got a ton of them. That makes it new to this wild part of the counterfeit drugs.

**AS:** So now you’re doing the drug abuse dialogs. How busy is that keeping you? Do you want to stay busy? Do you want to keep working in this? How do you feel about it?

**CF:** That’s personal.

**AS:** Sorry.

**CF:** We have a lot more drug education going on because law enforcement drug task forces in order to get their federal funding have to deliver training. We have a lot of non-profits who are delivering training. There’s more training available to people.

**AS:** Then what you experienced in the beginning when you were asked to be in communications?

**CF:** Right. There’s a lot more free training. It’s a challenge doing it as a business.

**AS:** I didn’t mean that as a personal question. There is more education.

**CF:** That’s primarily what I want to do. It’s hard to find a niche in there when people provide it at no cost. I’m still sought out by the media quite a bit and I’m on TV three or four times a month. People come into my house.

**AS:** Well you’re a good sport. Thanks for taking the time with me for this project. Is there anything else you wanted to share?

**CF:** Looking over the course of my career I think it’s very disheartening because the drug abuse situation in my estimation as the trained observer of it is as dire and tragic as it has ever been. Compared to when I got into this thirty-five years ago drugs are more accessible, they’re more dangerous, they’re more unknown. Our public policy response over the past thirty years to me is not as swift as it needs to be or as broad to adequately address it.

**AS:** That ends on a sad note. Your perspective is important. Thank you.

[End of Recording]