**Adam Fairbanks**

**Narrator**

**Amy Sullivan**

**Interviewer**

**August 10, 2017**

**St. Paul, Minnesota**

Adam Fairbanks -**AF**

Amy Sullivan -**AS**

**AS**: This is Amy Sullivan. I'm at French Meadow Cafe. It's August 10th, 2017. I'm with Adam Fairbanks. Adam, will you state your name and say you give me permission?

**AF**: Okay. My name is Adam Fairbanks, and I give Amy permission to do this interview.

**AS**: Alright, do you want to start with where you were born, where you grew up, just a little bit of family history, childhood stuff?

**AF**: So, I was born in Bemidji, Minnesota on July 5th, 1983. My father is Native American enrolled in the White Earth Tribe, and my mom is non-Native mix of various European blood, and I have an older sister. She is thirty-seven, and I have a younger brother who is thirty-one, and a twenty-one year old sister. Both of my sisters are half sisters. My parents went to school—tribal school in kindergarten, Fond du Lac where we moved after I was born. Lived in the Duluth area, and my parents got divorced shortly after kindergarten.

I was a little young, gay person, kind of picked on in school. My parents got divorced, we moved back to Bemidji. I didn't really know I was gay at the time, but was picked on throughout elementary and middle school. Kind of started hanging out with the wrong crowd, but in many ways it was a protective crowd that I was drawn to. I think that was part of the reason why I hung out with these kind of badass Indian girls. They did—they protected me in many ways from the folks that, you know, the non-Native white guys who would pick on me. I was getting in quite a bit of trouble in Bemidji, which is where we moved to from, you know, it was first grade until sixth grade. Started getting in trouble. My mom decided she was going to move us out of the area to kind of get me away from the trouble I was getting into. That of course didn't change my behavior necessarily. I went wherever we went, so. [pause]

We moved to North Dakota, to Grand Forks for a brief minute, then Mayville, North Dakota. Then my grandmother got Alzheimer’s, and my mother wanted to move closer to her in Wabena, so I was there for eighth grade. So eighth grade, you know, I was still kind of getting in trouble. I came out to my mom at the age of sixteen, and I was kind of tired of moving around. I was living in a rural area as a gay man, and it was difficult. And I didn't want to do it anymore, so I told my mom I would like to move out on my own, and drop out of school, and get my GED and go to college. She said she supported that, and so I did. I dropped out at the age of sixteen of high school, went and got my GED, and then I went to St. Cloud State University.

**AS**: So when you say trouble what do you mean by trouble?

**AF**: I think in elementary and middle school it was mostly getting in a lot of fights.

**AS**: Because you were being picked on?

**AF**: Yeah. So getting in a lot of fights, smoking cigarettes, there was some dabbling with alcohol and marijuana, and then when I came out I ended up going into adolescent treatment for a brief minute, and that's when I actually became sober as like a fifteen year old. And then I came out and that's when I went to school and college, and was living on my own in a larger area. It wasn't the Twin Cities, it wasn't a city, per say. St. Cloud is a city, I mean I—

**AS**: Compared to where you were before.

**AF**: Yeah. But it wasn't a metropolitan area. So, I felt a lot safer at that point.

**AS**: Did you live by yourself?

**AF**: No, I did not. I moved in with a boyfriend, actually. And was in school and lived off campus. I was taking some pre-college courses because I got my GED, so I was taking those. I was there for a little while, but then got exposed to Minneapolis, and was like, "Oh my god," I had to move there. [laughs] To be around the rest of the gays. So I did. I moved to Minneapolis. Broke up with that boyfriend and moved to Minneapolis. Kind of was out on my own. Got a job. That's when the on and off again adult learning kind of stuff happened where I couldn't do school full-time because I needed to work and take care of myself, so then I would work, do a job, and then get kind of on my feet in that job, and so I would start school again. Then I would get a new job, so it was like on and off of school. This is like nineteen through the age of twenty. I was just kind of working these odd jobs. I was working at a restaurant briefly. Then a salon for men. I was like a front desk person.

I got into drug use earlier on. I was twenty years old, am thirty-four now. There was probably a full year of substance use with methamphetamine. Maybe it was longer than that. A year and a half probably. I really lost my way at that point. I wasn't going to school. I wasn't really working. My life was really overrun by substance use, drug addiction for methamphetamine. Things fell apart after that year and a half and I ended up going to treatment a couple times. Went to PRIDE Institute for a few days and left, and then went back a month later for a few days, and left. I finally went another month later and completed the program.

After I got out of that treatment I got a job working at a drop-in center called the Aliveness Project. They're an AIDS service organization in Minneapolis that works with people living with HIV. They had a drop-in center and it was an entry level job. I was kind of exposed to that environment just because I knew people who had HIV. The job that I got was working within a small grant with the Minnesota Department of Health—the county. Ryan White counseling did the program. The job was to be in the drop-in center and talk to people about harm reduction and safer drug use. I think my title was Peer Educator. So as a person who had had some experience in substance abuse my job was to talk to other people on how to do that in a safer way.

Well, at the time, I mean this was really early on. It was 2000—I'm thirty-four now so it was twelve years ago. 2005, early 2005. I didn't know anything really about harm reduction. I had heard about it when I was at PRIDE Institute. Kathy Vader is a therapist, and she had a group about it. During that group it didn't really sound like anything more than common sense, more or less. I got that entry-level job, and I read a book. I went to her and said, "How do I learn about this?" And she said, "Read this harm reduction psychotherapy book." So I read it and it made a lot of sense to me. I was like, "Wow." The abstinence based world that was taught to me at the PRIDE Institute I guess made sense to a lot of people because there were so many people involved in that, but I also had understood that there were a lot of people using drugs, so that model didn't work for them. [laughs] My job was to teach those people how to do things in a better way before they were "ready" to be completely abstinent, drug and alcohol free.

I became really passionate and motivated about that model. I was involved in the abstinence based recovery world at that time, and I was apart of this committee for this conference that they held every year called GLBT in Recovery, held a conference, like a workshop. I was on the committee, and I said, "Why don't we do a little workshop in harm reduction?" And they like almost chased me out of there! [laughs] Like they thought I was crazy. They said, "That's enabling people. Telling them that it's okay." It was such a threat. And I was like this isn't a threat. It's a good way to get people into this model that we are all apart of. To keep them from getting diseases. All the public health benefits of harm reduction. People just didn't see it that way, and I think there was just this block from them being able to because then it challenged, I think, their own view around abstinence.

**AS**: Does that surprise you considering HIV—using condoms and safe sex—that you were chased out of the room? Because it kind of surprises me.

**AF**: It did. I was very naive about the whole thing. I just thought people would like get what I was talking about. [laughs] I didn't think I would be so controversial. And it was. It was very controversial. I became very angry and resentful that what I was really passionate about was viewed so negatively by the people, the community that I became apart of.

**AS**: They saw it just as harm reduction just as it related to drug use?

**AF**: Correct. And that's how I presented it, too. Harm reduction is obviously involved in public health, but from the perspective of that conference it was harm reduction and public health were viewed separately to the drug and alcohol abstinence based recovery world. It's like, "Public health makes sense. Of course we support condoms," but we start to talk about public health and drug use/harm reduction—then it's a threat. And really problematic for them. I got angry and was basically like “f” you guys. I care about those people that you're afraid of helping and think that they are just not ready, and I became very passionate. I actually got another job after that at Minnesota AIDS Project shortly after. Nine months later. Probably 2005 still. In the needle exchange program. That's when I decided I was no longer part of that community both their choices of them not really wanting me there, as well as my choice of not really wanting to be there.

**AS**: The AA community?

**AF**: Yeah. I don't know if I'm an anomaly or what. I just didn't need that in order to—I think in that book I read it was just like I could get rid of my urge to use drugs if I made a commitment not to do it. I would just tell myself, you don't use that anymore. You're a non-crystal meth user. You don't do that. That decision removed the ambivalence that I had, and without ambivalence I was just able to be sober. My recovery was based around my passion, and my passion was based around helping people that nobody else gave a shit about.

**AS**: Do you remember the name of that book?

**AF**: *Harm Reduction Psychotherapy* by Patt Denning is the book. So I worked in the needle exchange van of Minneapolis. Driving around this big ambulance with Roger Moore. He passed away, but he worked there forever. Fifteen years or something like that before he died. Running that ambulance around. And there were two needle exchange programs: there was Minnesota AIDS Project, the ambulance, and then there was Access Works, the set site location. It was a store-front needle exchange. You know, you know about Access Works. Well, this was prior to Access Works closing, which was really a big loss for Minneapolis, but after being there being part time—I was under a grant so like thirty hours a week or something like that. They were trying to figure out how to make me full time, and there was a partnership between Minnesota AIDS Project and Access Works, and I think the Red Door Clinic, which is the Hennepin County STD clinic. They had this grant to work with gay men who used methamphetamine to do education on harm reduction. It was a collaborative. I talked to my boss and said, "How's the program doing?" She said, "Not well. We are really underperforming. No one is going to our groups. The people that are going aren't really part of the population."

**AS**: Who was your boss?

**AF**: Kathy Strobel was her name. She was awesome. And so I said, "Well, let me do that! I know all those people!" [laughs] I was involved in that community. I could get them to come to that group. I've always had this high level of confidence in my ability to get things going. One of the people that I know, a colleague of mine, she said, "There's thinking outside of the box, and you don't even really have a box." [laughs] Like it doesn't even exist!

**AS**: You don't feel constrained.

**AF**: I don't. Honestly I think some rules should be changed. They are ridiculous, or they are a barrier to success. And if they can be changed we should try to change them. I think most people operate within, "Oh, these are the rules. This is how we've always done things." And I just don't agree with them. If it's a barrier change it, is the way I look at it. Thinking creatively to get those people to come to the group. There was the little incentive budget, so I said, well, people who use meth need food, so let's get pizza—because it was all we could afford, Domino's Pizza. And we'll do five-dollar gift cards to come to the group.

Over a period of nine months the group was a huge success. It started off with me and just a couple of people. And then the word of mouth got out there, and more people started coming, and more pizza had to be ordered, and the group wasn't specific to—it was a harm reduction group for gay men who used crystal meth, but it was also written in the grant, 'or had used crystal meth' and I was like, I didn't know how that was going to work. How are we going to get people in recovery to go to the group of people who are using? I'm like let's try it. I reached out to a few people and said, "You should come check out this group." I was a recruiter. I was a harm reduction activist, and passionate about that work. Public health person, and recruiter. So I got more people to come. It worked fine. It actually was awesome. It got people in recovery, even in the abstinence based recovery world, to support people who were actively using. And we are all hanging out in the same room talking to each other, and not having it be a threat to the people necessarily. I mean they chose to come to this harm reduction group, so I think it really just strengthened their ability to be sober more than be a threat to their sobriety because it kind of removed that belief that, "I need to completely hide from any risk of interaction with drug use."

By the end of the grant—it was unfortunate; it was so successful—at the end of the grant there were twenty-three people. I think the maximum number we had was twenty-three, and the grant period ended. Things changed. Access Works lost their funding, some of their funding. The grants changed. Red Door Clinic got some money, and so I left Minnesota AIDS Project and I went to Red Door, which is the Hennepin County public health clinic—STD clinic. And that was again an HIV grant. Still in school, still adult learning on again off again.

**AS**: What were you majoring in? What were you drawn to?

**AF**: I was not sure. I was just taking generals, technical college. And then during that time I enrolled at Metro State, which is a four-year college, and I decided to go for like an individualized program because there was no public health at a bachelor's level program in Minnesota, or that I was aware of. So I decided to design my own degree and it was going to be around harm reduction public health was the focus. And with an individualized program you get to kind of use work experience and write essays and work with an instructor to kind of craft your own class around it. So I used a lot of what I had done with work to design the degree and get some school credit for it. Because it was so unique. I mean it was like how else do you get that experience? And I just continued to advance and advance in my career without a degree. Because I had this very specialized niche of working with gay men around substance use, and people didn't—that just didn't exist. Like where do you find somebody like that who has even like direct experience with it themselves? And who isn't a total disaster, right, waiting to happen.

So sadly Access Works closed. The van continued to operate.

**AS**: Access Works closed in like 2009, 2008? Somewhere around there?

**AF**: Yes. So this was after I had started in my career—2005, 2006 at MAP [Minnesota AIDS Project]. I was there for a couple years, and then I went to Red Door Clinic, and that was shortly after I started there was when Access Works—they weren't able to survive on their other grants so then they closed their doors. They got reorganized—MAP got the money—and the needle exchange services operated through the van exclusively in the state. Lee Hertel, who you and I have talked about, was kind of—is it okay for me to talk about this? You'll have to check.

**AS**: I'll check. He's been interviewed one-on-one.

**AF**: Right. He was a participant in that group. The pizza group. And he and I had similar backgrounds, right? And he was so hyper [laughs]. Couldn't sit still, and kind of a big mess.

**AS**: He's almost twenty years older than you.

**AF**: Yes. And I remember like saying, "We need to get more drug users involved in this HIV prevention world because we're losing funding. The needle exchange programs are losing funding. We need to have a larger voice. How do we organize?" And so I talked to Lee and I said, "You should get on this committee, and you should be the drug user. Like the gay, male drug user and represent that community." And he was really, he just wasn't quite sure, and I said, "I really think you could do this. You majored in English, you're well written, you have a lot of energy." [laughs] And so he applied and I don't remember what committee it was, but I think that's really when Lee entered in his role of activism as a drug user activist.

And I went off to the Red Door and started doing HIV testing and working in a clinic setting. I was there for four and a half years. I was on the inside of this cynical world as kind of a government robot doing these HIV testing stuff, but I was always an activist just trying to do stuff on the outside, like influence things. And Lee was one vessel I was able to use to do that. I go, "Did you hear Ryan White? Go to this meeting and you should talk about this."

**AS**: So you would provide him with information that gave him—

**AF**: Yes. That gave him intel. Yeah. And worked to figure how to not manipulate, but change the system internally to move this movement forward because again the reason it was so easy to get passionate about this work was A, I had previous experience with it, but it was so easy to care for people that nobody else gave a shit about. That is why I did it. And that is what kept me really passionate, and like sober. And I had made that commitment, and I wasn't able to do the good work that I was doing if I was a crystal meth addict. [laughs] Some people can. Lee is a good example of one. But I wasn't. I never tried, but I wouldn't. [laughs]

So that was when I went and I called Chuck [Hilger] one day. I met Chuck. Well, actually I met Karen Greensend. She was the owner of Valhalla Place. She was crazy, in many ways, a friend of mine. Crazy in a good way. Motivated. She didn't have a box either. The only other person I've met like that. And she just came and crashed a meeting one day. She was like, "Oh, they're having a drug user meeting over at MAP? I'm going!" She just showed up, and she had started this methadone clinic and was trying to learn about the community and get her clinic going, and it was called Valhalla Place. I don't remember when they opened, but now they're the biggest provider in the state.

**AS**: It wasn't even ten years ago.

**AF**: Yeah.

**AS**: Right, if you're talking about 2009.

**AF**: Yeah. And that's when I met her. I was working at Red Door and we went to this meeting and she was there. We clicked right away and we stayed in touch. I talked to her about maybe wanting to work there. She ran a methadone clinic. It was a really good overlap of public health and a medical clinic and harm reduction and working with drug users. I mean it was a perfect fit for me in my next transition. But it was a private company so it was something I wasn't used to. I was always used to working with non-profits and government.

The time came. I met Chuck. He became the executive director and I reached out to him and I said, "Hey, Chuck. I have this big donation of needles that was provided by somebody across the country that mailed" —I don't remember how honestly I got them, but it was this big pallet full of needles that someone offered me—and I said, "I would like to store them there, because I don't want to put them in my house, at the Valhalla clinic." And he said, "Okay, well I'll talk to Karen." And Karen is like, "Sure, I don't care." And I said, "If I store them there would it be okay if I came once a week and then gave them out? Like on a Friday if I gave needles out to people? And we started a little needle exchange?" And he's like, "Okay, sure." [laughs]

And so that little needle exchange started. I got a bunch of people involved. I used to go to speak at these—the HIV prevention world had interns at the U of M, and public health students. I talked about my passion, and it rubbed off on people and they wanted to get involved. So then I had all these like bachelor's level, sometimes master's level, public health students that were like running this needle exchange program out of a methadone clinic with me with the support of Valhalla Place, and I thought this is a really good way to get people to come in to a clinic setting, become familiar with it, and then enroll in services. It's like a marketing tool. And that was kind of like, oh, I started to get into the business thinking of it as like public health and working within a private company and seeing how we were able to do good but make money.

**AS**: And sustain yourselves, sustain the business because non-profits are so dependent on grants that are the whims of the government.

**AF**: Right. And so I was able to convince them that you should invest money into this because this is good for your bottom line, and it's also good to get people into treatment, which is why we are ultimately here. The CFO of organizations may not think that way, but the people who start the programs do. And that's all the counselors, and clients, you know, they're all about the treatment. So, and I was all about the harm reduction and started the needle exchange.

And then I asked if I could work there. I was hired as their Harm Reduction Services Director, I think was my title, and I was there for about a year. The needle exchange was successful, and I went to a conference. It was a White Earth Hep C conference in 2015, yes, 2015. It was in May. When I was there I got a phone call from Chuck and he was like, "Oh, you know our CFO is bitching that you're just footing around at conferences and not generating revenue for us. You should really ask around and just see if there are opportunities for partnering and doing something with other organizations." So I asked around, and again White Earth is my tribe. I ran into Clinton Alexander, and he's like, "Yeah, I totally know exactly who needs you. There's this new program they are trying to start called the MOMS program, and they're looking for a Suboxone provider." I was like—went over and talked to them and Julie Williams she was the manager. And Mina Spalla, she was the nurse. And they were directed by Tribal Council to direct this program in like three months. And they had everything they needed. They had the counseling, and the mental health, and the nursing. They had everything they needed to run a program they just didn't have the prescribing doctors. And so I said, "Can I be of assistance?" They said, "Well, if you can get prescribing—a doctor for us that would be awesome." So called Chuck and said, "Hey, Chuck these guys need a prescriber. Is it okay to do telehealth? Like how do we do this? He said, "Yeah. If we can get the software to do this let's do telehealth and we'll just start the program."

So then I met with some folks from administration and talked with them and they were supportive of the partnership and wanted to proceed with a contract. We started with a program that had, I don't—I want to say like seventeen days to get the program going and we did it. We met the deadline. I think we did it in fifteen days. So, you know, I worked with—Valhalla Place at that time was a big organization, so I had access to nursing staff, and as a team we put it together very quickly.

**AS**: Was this before they transitioned to Meridian or Alina?

**AF**: Before, yeah this was before. So this was Valhalla Place prior to the Meridian merger. Right around that time actually. So White Earth did this to address the babies that were born exposed to opiates. And were being removed from the home. It was a huge problem on the White Earth Reservation. All reservations really. And this was an approach—they wanted specifically Suboxone. They didn't want to do methadone. This was an approach they wanted to move forward with because it was what they learned was the evidence based way to deal with it. And there was this reluctance, and it was controversial, but there was also urgency and other things weren't working.

The program started. We did the prescribing through Valhalla Place. Patients met with the doctors. We had telehealth and then they got all their treatment and dosing at White Earth. And it was awesome. People enrolled. They were a little nervous at first I think, you know, going to the program. I was the liaison, the point of contact at Valhalla Place so if they had issues they called me and I would address it. And I was really glad to be of assistance to my tribe.

Over time—the program evolved very quickly. Within months they were changing from just the pregnant women and the women with child protection cases to their partners or the men of the women, the fathers of the babies. Then it was everyone who lived in the house. Treat the whole household. And then it was the communities demanding access that were not part of the demographic, and it was really apparent within a short period of time, I want to say six months or so, that White Earth needed to provide these services across the entire Reservation, and there was such high demand that they needed to open multiple clinics.

And so I decided—the Meridian merger had started to happen. I was not exactly sure—I felt uneasy, you know, uneasy about the future, and so I reached out and said, “Hey, I'd like an opportunity to help start those clinics that you've expressed interest in.” And so I was hired by White Earth to do that. And there was a year period of time where we worked towards getting the, I want to say four additional clinics open. Five, sorry. So there were two on the Reservation, then there was one in Bemidji, which is four hours north of Minneapolis. North and east of White Earth Reservation. And then there was Minneapolis next. There was the MOMS Program started in Minneapolis as well as the medical assisted treatment kind of for everybody, Native American clinic here in Minneapolis. And it was very rapid pace that we moved. I mean getting, you know, I recruited a doctor, and helped with some of the clinic design, and how to set up the dosing windows. Just things that I had learned from my work at Valhalla Place.

**AS**: So are the clients coming and getting a dose of Suboxone everyday?

**AF**: Correct.

**AS**: So they're not getting a prescription.

**AF**: Correct.

**AS**: Why that model?

**AF**: Diversion concerns. When you have a lack of access, and something is just becoming available, there is a huge demand for—you know demand is there, lack of access is there, you have a black market for it. It's worth a lot of money. So, what White Earth did, and what I think was a really good idea, was to keep tight control of it until there was broader access. Then once it's readily available people can just go into a clinic and enroll—then you can start to look at giving people take-out medications to have at home because the demand has decreased in fulfilling the needs of the population.

**AS**: So that is a little bit of a different model with Suboxone.

**AF**: Well, it's a methadone model.

**AS**: Right, it's a methadone clinic model—

**AF**: Rather than a prescription, take it home model.

**AS**: Yeah. And are those common around the country that you know of, or is that unique?

**AF**: I want to say it's unique to tribes specifically. I'm not aware of any other Suboxone only programs that have that tight control and dosing policies and limitations.

**AS**: Okay. So that would be a unique aspect of the Tribal program.

**AF**: Correct. And that's what I'm aware of is how they're being operated. Now there are also people who probably go to a physician that live near the Reservation and get a prescription. So there's nothing that would prevent you from being able to do that other than you can't find the doctor.

**AS**: But this also allows clients to be brought into other services and support that they might need.

**AF**: Correct. And White Earth always provided culturally based services. It was about how do we incorporate culture into programming for treatment, and having people that are Native American providing the services. Having it be for the people, by the people. Comfort, and culturally based, and connecting people to something that they maybe have never had access to, or have lost along the way. So that was a really cool part of the White Earth model is connecting culture to treatment. And probably a really important component of how, you know, to make that work for the people who need it. And you know if culturally based treatment isn't what people needed then maybe it's not the right program for them. But it wasn't like cramming culture down people's throats either. It was like this was just our model and this is how we do things. We help you participate in the ceremony, but you certainly need to go to your three hours of group everyday three days a week, or whatever the treatment goals were.

**AS**: Right, there's minimum participation, and then there's other opportunities.

**AF**: Correct. And over time the rules started to become a little bit more like, okay, we can give so-and-so a take out medication. We can be closed on Sundays. We can give people take outs on the holidays. And just over time things gradually started to evolve to more of a—less controlled. And I think that it made sense to happen that way.

**AS**: Do you have any sense of the success rate?

**AF**: Yes. I mean as far as I know there weren't any deaths from the year that I was there for people that were actually enrolled in the program. So that's, you know, opiates can be fatal in many ways, so keeping people on Suboxone and providing treatment is very effective.

**AS**: Was Narcan available?

**AF**: Yeah. We made Narcan available through the programs.

**AS**: So participants could bring it home and have it at home?

**AF**: Yeah. And then Clinton also did like harm reduction work on the Reservation too. So he was doing kind of more true harm reduction, non-MAT [medically assisted treatment], needle exchange work, and Narcan distribution. So, yeah, there was actually a lot of Narcan available. And the other tribe that had significant need and White Earth was providing services to out of the Bemidji program was called Oshkimanidoo, was Red Lake Nation, which is thirty minutes north of Bemidji. So they were going to a White Earth clinic, and traveling because it's a long distance away, so spending time in a van, and having to get from their house to the van, and from the van to the clinic, and then the clinic back home. It was—it is quite the ordeal currently. And I ended my employment with White Earth recently and wanted to be of assistance to Red Lake because they expressed interest in wanting to do a program like that. The need is there. The travel is ridiculous that people have to go through. And I have a very unique skill set to offer. So I was brought on as a consultant on July 12th of this year. So, yeah, I started on July 12th, and Red Lake declared a public health emergency the following Tuesday.

**AS**: Yeah, that's what I was going to ask you. Do they kind of have a plan in place to declare that emergency, and to hire you? I mean were things kind of—

**AF**: I don't know exactly how that came to be.

**AS**: I'll have to find someone to talk to about that.

**AF**: Yeah. I mean, I think I could—

**AS**: That's a really powerful thing to do, as we just saw this last week when we thought the President of the United States might declare opioids an emergency, and he didn't.

**AF**: Right. So, yeah, I don't know. It might be really... I'll see who I can put you in touch with. They declared that public health emergency that Tuesday, and I started [pause in recording].

Red Lake declared the state of emergency. They're looking at two major things within the resolution. And I've asked for support from the Governor's Office and a bunch of other federal agencies to help them address this, I don't think it is specific, but—well, it is. Opiates I know are like the primary focus, and so they're looking at banishment, which I don't know a lot about. That's part of the resolution is banishment. And they're also looking at the Narcan, other public health type things. Medically assisted treatment, that's what I was hired to do was bring on the Suboxone clinic. I work with their chemical health division. And I love starting new things, so it's really fun. I'm in my element right now.

As far as the model I think both White Earth and Red Lake have really great models of integrating culture, and this biomedical drug treatment approach. A Western medicine approach combined with traditional, culturally based treatment. I think it's a good route for tribes to go. I believe that it does conflict a little bit with the traditional way that like alcohol has been addressed. But in my opinion the alcohol use, and all the substances need to be looked at as unique to each other. We can't lump marijuana with heroin. Marijuana doesn't kill people. So, like I think every substance needs to be—services need to be uniquely planned around it. There can't be a one-size fits all approach. Twelve steps is a support group, not a treatment modality. Evidence based treatment is the way to go. Medication assisted treatment has the most evidence. Methadone has been around forever. [laughs] And this daily dosing model, and getting people counseling and medication has been around for a really long time. It's just taken states, and tribes, and different places to get over their reluctance around the controversy of treating substance use disorder with medication. But there's been alcohol medications for a while. Antabuse, I mean why is that okay? [laughs] But then opiates aren't. I guess it's a narcotic, but if it's a treatment that works, and it doesn't get people high, which everybody thinks it does, why wouldn't you use it?

Speaking to the White Earth outcomes of no deaths we're just getting people on their feet, and all that stuff. I mean that doesn't address the larger issue in my mind, which is poverty. I mean that's the true culprit I think of addiction. I think until we address that we're never going to get out of this. Livable wages, getting out of crappy living environments, education, opportunity, jobs. All of those things that make somebody feel valuable, and not living in fear of not having enough. There's so much around I mean people shouldn't feel that way.

So I guess that's what I would say is needed to get over this issue is addressing the way we look at substance use as a consequence of poverty, and we need to address that. Because we can give people Suboxone and we can keep them from using heroin, but at the end of the day they still go back to the same place they were living unless we give them other opportunities. And then we're preventing them from dying but we need to also work towards getting them opportunities to be successful and thrive.

**AS**: And it kind of connects to your own experience when you talked about being committed to something in a new way, or a new thing in your life versus using to continue using. It's about creating...

**AF**: Feeling good about what I'm doing in my life.

**AS**: And seeing a future, and seeing potential.

**AF**: Exactly. I mean when I was using drugs I had, you know I was—my partner says the horizon line that people see in front of themselves, you know, at that time was only a few inches in front of my face. I didn't see very far beyond what was directly in front of me. And then over time as I advanced in my career, and I became more successful and able to move towards being able to provide a much larger contribution in my life, my horizon line really sort of started to grow. In addition to not really having a box, now I don't necessarily see the limitations, you know, the not having a degree thing has never held me back. It's something I'm going to get. I have like two classes left. But here I am again in a situation where I'm consulting, and I have a very short deadline to get this program going and it's like, okay, start and stop, start and stop, start and stop. But it's fine. I don't need it to be able to do what I'm doing, you know.

**AS**: So what do you see in the future for yourself? What do you envision on that horizon?

**AF**: I want to help all the tribes do this.

AS: In Minnesota?

**AF**: In the region. For now the region. I'm still learning. I understand the Minnesota system. How to enroll in health care and [unclear]. I understand all that stuff. Now it's like trying to figure out how does this work? Because health care system with IHS [Indian Health Service] and Tribal Services and all that. It's very, very complicated. If I started talking about it you would have no idea what I was talking about. But figuring out how to do it, how to do it well, and go in and help the tribes that are interested and ready for this sort of thing. It's only a matter of time before all the tribes are having this problem, hearing about how Red Lake and White Earth have addressed the problem, and then trying to find out how did they do this?

**AS**: And then you raise your hand!

**AF**: And then I raise my hand. [laughs] I know how to do this!

**AS**: So, Adam, do you have any mentors? Do you have people that you look up to? You can know them or not know them personally.

**AF**: Yeah. I would say Chuck for sure. Chuck Hilger. He brought me on to Valhalla Place. He and I worked very well together. I'm kind of able to just speak to him openly. Bounce ideas off of him. Swear in front of him. [laughs] He's a wise person. And I'm like young, and ambitious, and maybe need to be slowed down sometimes and think things through. I'm still learning as a young professional. So there's that.

I think also...I don't know. I have some friends in San Francisco that are really doing some amazing work in harm reduction, and just the national harm reduction community in general. There are so many just amazing people doing great things, and advocating for drug users. It's so refreshing to go to those conferences and be like, oh, yeah I can talk about the fact that I believe drug users deserve things and should have a voice. I don't necessarily always speak that way in meeting settings because it's just not always productive. Then I have to sit there and explain things. It's just not worth it. That's not what I'm there for, but that is what I believe. And so being around people like that every two years at the harm reduction conference is like being recharged and reminded.

And who knows. Maybe tribes will at some point, or maybe it's happening somewhere behind the scenes and I don't know it, but will look at legalization. Marijuana, and maybe decriminalization, and putting people in treatment. Increasing treatment. A lot of what other countries have done that are actually really effective. And I would love to be part of that because I believe in it. I think I would be able to do it really pragmatically. And again it's just common sense. But we get so—it's like the moral thing of drug use and it's a choice, and they're bad people, and they don't care about themselves. And it's just not true. There may be times where I felt really bad towards myself. I didn't like myself. But it didn't mean I didn't care about wanting to be alive, or...

**AS**: Or that you didn't love your family.

**AF**: Exactly. I just had lost my way. I think I had a couple of attempts to find my way, and I didn't succeed, and then I did. [laughs] And again it was the opportunity. It was the part-time, eight-hour a week job at a drop-in center and becoming passionate about this one thing. That's what it took.

**AS**: And you couldn't maintain using if you were—

**AF**: Yeah. That was what I needed. There's so many different ways that people can give back. Or maybe it's like just their family is important to them, and they're not like me. They don't need a career that they're passionate about. They just really care about their family, or whatever. But people have to find value in what they do.

**AS**: That's great.

**AF**: So I think other tribes are at a variety of different places. Some are still probably completely against public health strategies, and just can't figure out why their current models aren't working still. Still blaming others instead of trying new things. Because it does go against the values of being completely drug-free, abstinence based community. That was what needed to happen to address the alcohol problem, which has been tearing tribes apart forever.

**AS**: Thank you.

**AF**: You're welcome.