**Dr. Marvin Seppala**

**Narrator**

**Amy Sullivan**

**Interviewer**

**Interview 2**

**January 23, 2019**

**Amy Sullivan’s Home**

**Minneapolis, Minnesota**

Marvin Seppala -**MS**

Amy Sullivan -**AS**

MS: I'm Marv Seppala and I give you permission to record this interview.

AS: This is January 23rd, 2019 and we are at my house in Minneapolis. Alright, let's go!

So, when we left off last time, we were talking about how you went to Drake University and then you had just gotten in to medical school and one of your mentors from Mayo, was it Dr. Shepard?

MS: Oh, yeah.

AS: You were talking about Dr. Shepard and I was making a joke, "Oh, yeah, of course you got in because he was there..." Or I made some kind of comment. I was just listening to that.

MS: [laughter] It's true.

AS: Why don't we open there? You guys had been in Iowa and you were going to move back.

MS: Yes, and Linda needed to do one more year of college when I started medical school. So, she stayed at Drake one more year and I started medical school in Rochester. And immediately, I told all of my peers, it's a small class, just forty people at Mayo per class. It was really nice and intimate, so you get to know everybody well and all the good and bad with that, I guess. So, I just told all my peers that I am in recovery from addiction, which the first week of class, I am just meeting these people on Monday and Friday night I was living with two other guys. One, who I had known from freshman year of college at St. Olaf. We both left St. Olaf and we both got into Mayo, so we roomed together and another guy from Minnesota roomed with us as well. We just decided, well, we had a big apartment. A friend of mine owned a house in Rochester and rented it out as apartments, so he let us use it.

Well, we threw the party at our place on Friday night and I made sure there was not alcoholic drinks, right? But there were all kinds of alcohol. And I am standing by the drinks and a guy who is now my best friend from medical school, comes up to me and says, "Here, have a drink." and I say, "No, thanks." and he says, "Have a drink." And I said, "No, thanks." And he said, "How come?" and I said, "I'm an alcoholic, I don't drink." And he walked away dumbfounded because he'd never met an alcoholic and he finally meets one and it is his medical school classmate and he doesn't even drink. [laughter]

So, it turns out that he now works... he is an anesthesiologist, but he does the whole drug diversion program for the Mayo system because he took a real interest in addiction over time and was really involved.

AS: Interesting.

MS: And then right before Christmas, that first fall, I decided to tell the dean that I am in recovery.

AS: What made you do that?

MS: Well, all of my peers knew, and I was really open about it and I thought I might as well just tell him, you know? In case anything comes up about it, which was... And I knew...

AS: Which was what?

MS: I'll tell you the story. It was really problematic in an odd way. So, I thought that they would hear so I might as well just get it out there. So, I went to his office. I told him I'm in recovery from addiction. I was told not to let anyone know when I applied to medical school, that I was in recovery. I'd never get into Mayo. And I didn't tell anyone, and it was a little hard in one interview, and only one. All of my volunteer activities from college were addiction related. And the family practice doc who I knew, actually, asked me how that came to be? And because these two docs I knew at Mayo told me, they said don't mention a thing or you just will not get in. So, I didn't. I lied to this guy and said, something like "Oh, we had a family issue." Which wasn't a total lie, I was the family issue. [laughter]

And he let it go at that. So, I got through the interviews. So, that was one of the reasons I thought I should tell the dean.

AS: So, that was your conscious that was like, "I better tell."

MS: Yeah, better to just get it out there and let him know that I am in recovery. So, he was this really gregarious Irish guy and I told him, and he just didn't say a word and he had this terrible grimace on his face. He just kind of said, "If we had known that, we would have never let you in here."

AS: Really?

MS: And he never talked to me again. That was it.

AS: Why? Why do they not...

MS: There was just this tremendous bias against it.

AS: That you would someday be a doctor with an addiction problem?

MS: I guess so, that I could be an embarrassment to the school. That someone would find out or that I would relapse or have some sort of...

AS: Did you ever hear of that book called, this is a little off topic, but called "Thirty Rooms to Hide In"?

MS: No.

AS: About a doctor with really severe alcoholism. Okay, it's by one of his children.

MS: No, I don't know that book. Really?

AS: We'll just move on and I will give you a reference for that, because that makes me really curious about why Mayo, in particular, would have that stigma? He was a pretty famous surgeon. He was pretty well known.

MS: It's interesting because during medical school, the Chairman of the Surgical Department was a known alcoholic. And when I was on a surgical rotation, so I am around all of the surgeons. We're going down the hall on Monday morning and there he is, and he's got this bandage across the whole side of his face. And I am with a whole group of residents and we are with our attendant, who was a peer of the Chair of Surgeries in that department. And he says hi to him, and the chair says, "Hi." And he says, "Wow, what happened?", you know because he's got this huge bandage. "Ah, the garage door was going down and I just had to run and jump under it and I just kind of fell and scraped my face." It made no sense at all, you know? I mean who scrapes their face jumping under the garage door?

AS: Yeah, that was quite a leap.

MS: Yeah, it was. And it was known as a really angry guy.

AS: What was his name?

MS: I am blocking out his name, maybe it will come to me. But anyway, he was well known as an alcoholic and I knew of other situations like that, and I was told that one of chairs of the board of Mayo at one time, went into treatment at Mayo for his alcoholism. When he walked in, the whole staff lined up and shook his hand as he walks into treatment. Which didn't really set up a good situation for him or with his peers.

AS: Because everybody knew?

MS: Yeah. So, it was just really odd some of the stuff that went on there. But, nonetheless, that was my introduction to my dean and he never talked to me again. But, other than that, school went really well. And the second year, I am planning on being a cardiac surgeon, because of that lab and because of my experience with that. You know, the guy who influenced me most was a Brazilian (?) surgeon and I wanted to be like him. And, so that was the plan.

AS: So, you enjoyed surgery?

MS: I loved it and I was really good at it because of my experience in the lab. And they let me do things that they never let students do, because I could do it! [laughter] Yeah, it was really neat. So, I was just psyched about it, but I noticed on clinical rotations, all of these people with alcohol and drug addiction underlying the reason that they were in the hospital. Or, coincidental to it, but often underlying their hospitalization. And we weren't diagnosing it, we weren't writing it down even. We were not giving referrals, we were not giving consultations. Nothing that you would normally do for an illness, did we do. So, I was going to this AA meeting in town and the same two doctors who told me not to say anything about being an alcoholic or addicted were at this meeting, they were in my home group. And that's why I asked them, because I knew them from AA. And they said, do not say a word. So, I'm going to the meeting and every weekend complaining about this situation on clinical rotations all over the hospital. There are people with addiction and alcoholism, and we do nothing about it. It is awful. And one night those two took me aside and they said, "Marv, you've got to quit bitching about this and do something about it."

And it was at that point where I kind of opened my eyes to the possibility that I didn't have to be a cardiac surgeon. As much as I liked doing it, I could do this instead. And shortly after I had a psychiatry rotation, and they are all like one-month rotations, I enjoyed it, a lot. I found an attraction to it that I didn't expect, and it was a gate way to work in addiction. So, that's what I did and that is why I changed my mind. All because of that statement and that experience. So, then I needed a place to do that and I wanted to do an addiction fellowship. There were only a few around the country at the time.

AS: A few as in only for a few people or a few different programs that were larger?

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MS: Yeah, only a few where you could do fellowships, that you could do an addiction training fellowship. So, I wanted to do a psychiatry residency and then an addiction fellowship. So, I wanted to, ideally in the same place for whatever reason I thought I would want to stay in the same place. This is a funny part, but I applied to program on both the West Coast and East Coast for psychiatry because I didn't want to stay in the Midwest. [laughter] For whatever reason, I thought that I might as well go to one of the coasts and Linda agreed. I made all of the applications and got rejections from every West Coast school and acceptance from every East Coast school. And I didn't have enough money to go to both coasts to interview in both places, so I was kind of seeking direction and I got it. I went to the East Coast to look at all of these programs. And they either had nothing going about addiction, and or, when I said I was in recovery from addiction and that's what allowed me to go down this path, they were like psychoanalytic programs. So, they just couldn't even tolerate this idea that I would be...

AS: That someone in recovery would want to be in addiction medicine?

MS: Yeah, one guy actually started to do psychotherapy with me in the interview when I mentioned that. It was just bizarre.

AS: Okay, so let's put a time on this. What year is this? Do you remember? For my history of medicine pursuits.

MS: [laughter] It would have been 1984. I graduated from medical school in 1984 and it was that winter and spring leading up to that, that I was doing those interviews.

AS: Would that happen today?

MS: No, not to that degree. But also, this is the basic understanding. I told all of the attendants on the rotation that I was on, I can't remember if it was internal medicine or neurology, but I said "Hey, I'm going to go into psychiatry and specialize in addiction." And he said, "You're throwing away a good career in medicine." And that was the basic feeling about psychiatry in general, but also, even more so about addiction, which nobody did. Like, who would do that, Marv? Why would you even consider it? So, it was like really...

AS: I've heard that story before, from doctors that I have interviewed.

MS: Okay, so it was like really going against the grain.

AS: Yeah, it's like, why would you want to do that? Like, think of who your patients are going to be, was the underlying message.

MS: Exactly. "It isn't even an illness", you know?

AS: Oh right, you had that even.

MS: Yeah, so I get back from the East Coast and I am just perplexed and disappointed because there wasn't a single place that I wanted to go. And I applied to the best programs in the country, you know? It was awful. So, I am walking past the secretarial pool in the medical school...

AS: At Mayo?

MS: Yeah, and I knew a lot of these women because I had worked there and I grew up in the area, right? So, I always talked to them and one of them says, "Marv! Are you going to finish your application to the University of Minnesota?" And I said, "I haven't started one." And she said, "Well I think you have." So, I said, "Sure.", because they helped us with it because we didn't have to do our own applications. Which was really wonderful.

AS: Are you kidding me? I mean why as a secretary? Oh my gosh, you guys were so spoiled back then.

MS: So, spoiled. [laughter] We were. We were just treated really well. So, she said, "You want to?" and I said, "Yes." and she sends it off. And they call me, and I get an appointment for interviews and I am driving up to Minneapolis and I am half way here and it hits me. And I don't know what this is, or what happened, but I'm like, "This is where I belong." It is just overwhelming. And I get to the University and I have to park at the Medical Center and my parking spot overlooks the Mississippi there and eagle flew down below me, because you are on the cliffs, right? This eagle goes by. And I'm like, "Wow, this is amazing." It was funny because I get this sense that this is where I belong, and then I got anxious like, man, now I really got to perform this interview. But then, I realize that this is where I belong, so it doesn't matter! [laughter] However, it was just like, this is where I belong. And then the eagle. And I go in, and the interviews go fantastic, they've got an addiction fellowship program. If I perform well in the residency, I can do that in my fourth year rather than adding a fifth year. Because the whole fourth year they have are electives at the U. Which is like, oh my god, that is amazing. I can get done in four instead of five years. So, it was where I belonged and it's where I went. And they had great people at the time, and a really robust program and a lot going on. I mean, it was fantastic. So, I had a great experience.

AS: So, who were your mentors there?

MS: Joe Westermier was one. He oversaw the whole addiction department at the U, at the time and later became the Chair of Psychology at the University of Oklahoma and then came back and was Chair of the VA here in Minneapolis. And he was a true academic and over three hundred publications and books and stuff. We had a Southeast Asian Mental Health Clinic and a Southeast Asian Opium Clinic at the time, because the church sponsored a lot of refugees after the Vietnam War and that included a lot of Hmong, and with those folks, a lot of opium addiction. And they basically brought it here and there were opium dens all over the Twin Cities.

AS: There were?

MS: Oh, yeah. There probably still are.

AS: In the Seventies? And Eighties?

MS: Yeah, Eighties now, but starting after the Vietnam War, so late Seventies into the Eighties. And so, he set up programs during the Vietnam War. He was a family practice doc and later went into psychiatry. He spent a lot of time over in Southeast Asia during the war. And he actually spoke Hmong, Vietnamese, Thai, and Cambodian. I mean, he was an amazing guy. And so, he was a true mentor and really knew addiction and really Twelve Steps stuff and had a really great program at the U.

AS: I suppose he's passed?

MS: No, he is still around, here in town.

AS: Oh, my goodness, wow.

MS: He'd be worth talking to. He still does some stuff at the VA, so that would be a place you could easily get a hold of him if his number isn't available. I don't have a home phone number, I just call the VA to talk to him. So, he was tremendous. And then, Mark Willenbring. Do you know Mark?

AS: I've interviewed him. Twice! I had to interview him twice, too! [laughter] I was going to ask if you knew him.

MS: Yeah, Mark was at the VA. Yeah, we're good friends. We get together a couple times a year and have supper to talk over stuff. But he was closer to my age than Joe. Mark was early in his career and at the VA and was my attending when I did my addiction rotation. And for just a couple weeks oversaw some of my work during psychiatry rotation, too.

AS: That is fantastic. I love that... for my storytelling. It is! To have that connection is really incredible.

MS: So, it was those two, primarily, who really mentored me in remarkable ways, really beneficial. And John Brantner was a psychologist at the U who did die some time ago. But he was part of the group that developed the MMPI. And John was in recovery but also just this really brilliant, eccentric psychologist and his main focus was thanatology, so death and suicide.

AS: Wow. It's called thanatology?

MS: Yeah. And he, because he was in recovery, but also a really well-known therapist. I mean, really, really well respected. Joe Westermier was one of my psychotherapy supervisors. You would do that for a year. Every hour of therapy, I had to have an hour of supervision, which never happens anymore. And one year, I had John.

AS: So, what are you saying? Repeat that again, what you had to do with the program.

MS: If I did an hour of psychotherapy with someone where I was providing the psychotherapy, I'd have to go do an hour of supervision about that hour of psychotherapy.

AS: You mean, you would have to go and talk to one of your supervisors about what had happened in that session? Hour to hour?

MS: Yeah, and some of them required that I record the sessions. Some required that I write every single word down during the session. Just writing away and trying to talk at the same time. I learned how to do that really well, because it was so frequent that I had to do that. That's hard. [laughter]

AS: That's really hard. You can see, I'm not doing that.

MS: No, the recording is a lot easier. Yeah, so those two both did that for me for a year. The addiction fellowship, more than anything else, well first... I was in my training during a time when psychoanalyses were still really a major aspect of psychiatry, but the biologic psychiatrists who were coming in, and the University had hired a biologic psychiatrist as a chair, Paula Clayton, and she was trying to change the department. So, they were both still there though, and they were waring with each other basically. Which seems like that kind of conflict could be a difficult time to train, but it was wonderful because you got to hear everything. I got both sides of this whole issue and training from both sides, and the understanding of things from both sides. And there was still an emphasis on psychotherapy and biology. So, I thought it was awesome. Some people didn't and they thought it was difficult that way, but I just loved it. And, I got both, which is what I wanted. I wanted to be a therapist more than handing out medications, anyway.

AS: So that is also just on the cusp of when medications took over psychiatry?

MS: Yeah, oh yeah.

AS: So, that's the mid-Eighties?

MS: Yup. '84 to '88 I am in my training and while I was there... While I was in medical school, just to kind of put this historically, I guess, someone in infection disease came to give us a lecture one day down at Mayo. He said there that there is a new illness that we had just been informed about, and it was HIV. It didn't even have a name when he told us about it. It didn't have a name, we didn't know anything about it, not sure what is going on.

AS: This is when you were in med school?

MS: Med school. Then in my residency, I saw the second patient with HIV at the University because the first patient attacked a nurse and just got psychotic and took her pin off her shirt and tried to puncture her with it and infect her basically. He was just psychotic. So, they decided every person with this disease, again, I think they were calling it AIDS by then, but I'm not sure. I can't remember when it kind of transitioned. So, they said that they had to have a psychiatric consult before anything else happens, because of this first episode. Because no one knew this disease. And so, I had to go in. Well, they made us wear space suits basically, because no one knew what this disease was or how it was transmitted. So, I had to cover myself with, you know, protective garments and gloves and a helmet type thing. I mean, everything. Not a breathing apparatus, but you know... I'm a psychiatrist walking in like that. And after a couple times of that, I just said screw it, because no one was getting sick that I saw. But still, no one knew, but it was so disruptive. But at the same time, the pathology department at the University of Minnesota, refused to take the blood samples from these people. Refused to study the blood samples because they didn't know if they were at risk or not. And so, in medicine, isn't that your job?  I mean the essence of risk... shouldn't you be the ones wanting to figure this out? They didn't want anything to do with it. They refused. So, there was so much controversy going on about this.

AS: That is such a powerful story.

MS: Isn't it? It is really bizarre that that went on. All kinds of weird things like that. And so, what else? I was mentioning something else.

AS: We were talking about... I was asking you about when the shift to medications in bio-medical psychiatry? I was going to ask you, when did Prozac enter your story?

MS: During my residency. It was released for use. So, it was the same kind of story. All of the sudden, there is a new... all we had were the old tri-cyclic antidepressants basically and the old anti-psychotics. They all had a lot of side effects and people hated taking them. And they worked, in fact, even now, sometimes those old antidepressants are used as the backup in nothing else works. But that was all that there was. And then suddenly, there was this new medication, Prozac. So, I just happened to be on a rotation working with the psycho-pharmacologist in the department at the time when Prozac was released. So, I'm like right on top of it and get to learn all about this new medication and stuff and its potential.

AS: But you were at the same time also being trained in therapy?

MS: Yeah, so it was wonderful. Because to me, that is still what a psychiatrist should do, both. And yet, a lot of training programs have put psychotherapy behind. It is really weird.

AS: Or completely separated them.

MS: Yeah, or just biological. Just let the psychologist do it or something, I don't get it. They want to just do psychopharmacology which... It is really a wonderful and useful tool, and necessary. And I suspect... The brain is a new organ of study, right? There was taboo against even opening the skull and studying the brain, and yet, the rest of the body, you can open and look at and study and do whatever you wanted. And so, it' been only recent that we've really had that opportunity. It is really complex. And so, we are way behind in a way, but it is also a brand-new field, which is one of the things that did attract me to psychiatry, it's like wow, this is... there is nothing known about this whole field. It is really wide open, and I had thoughts about academics at the time. Which, because my parents didn't pay for any of my education, I had so much school debt that I couldn't go into academics.

AS: You thought about academia for a minute and then realized that you had to be more practical? [laughter] That was a good decision probably.

MS: Yes! I just couldn't do it. Well yeah, the school debt was enough that I had to make decisions in terms of income to pay that off. [laughter]

AS: So, at this point, do you have any children while you are in residency? Or what's happening?

MS: Yeah, well, during my internship, I had to do a rotating internship in St. Paul Ramsey to start with. So, my first year was at St. Paul Ramsey with all of the internal medicine and family practice people doing internal medicine feeds, ER, all of that stuff, just in case you'd decide to bad psychiatry and... but it also gave you a really solid foundation in medicine. It gave me that. And, during that, I was on all every other night in the hospital and our daughter was born. [laughter]

AS: Oh, that is so much.

MS: I know, and she didn't sleep well. So, I'd be up all night and get home and be woken up regularly. I think I was just...

AS: And then Linda on the nights that you were gone, not sleeping, she was really not sleeping either.

MS: I know. It was probably tougher than I noticed at the time.

AS: Yeah, you were both sleep deprived.

MS: Yes, terribly. And then later, Adam was born in my third year of residency. It was down to every third night then. But it all worked out, you know? You just do what you have to do.

AS: It's true. You look back on it and you can't believe that you did it. It's good that when you're in it, you just have to keep on moving forward. [laughter] Okay, so your residency is over.

MS: So that's my background. My background is in...

AS: It's also on the cusp.

MS: Yeah, it is on the cusp of all these new medications, all of this promise, but you know, from my own bias and my own recovery, I think psychotherapy is really important.

AS: Right.

MS: So that's my background. My background is in...

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MS: Yeah, it is on the cusp of all these new medications, all of this promise, but you know, from my own bias and my own recovery, I think psychotherapy is really important.

AS: Right.

MS: And I've got this experience when I got sober of the spirituality of the Twelve Steps and the science of working in that lab, and then my college and medical school experience and residency. So, there's these somewhat diverse influences going on. But I think they left me in a remarkable position because I was open to all of that, and not, in a single lane, kind of. And I think that allowed me to do a lot in my career, that I would have maybe not otherwise been able to do, like Core Twelve, actually. And when I finished training, I was looking for a job and had hoped to work for Hazelden and they didn't have any openings for a psychiatrist...

AS: Because they didn't have a psychiatrist? Or?

MS: No, they did have a psychiatrist. They used consultants, just like a few hours in the evening and they were guys from the VA that I knew.

AS: So, the preeminent addiction treatment center in the state did not have a psychiatrist on staff?

MS: No, not on staff. Yeah, they were using these consultants.

AS: Can you explain why that is? Just for people reading this?

MS: Oh, sure. So, they had a pretty big psychology department and a lot of full-time psychologists. So, it was still a psychotherapy oriented mental health program. But there were still plenty of folks coming in that had medication. So, they had these psychiatrists come in the evening, you know, it was a consulting job, so you work all day at the VA and you head up to Hazelden for a few hours in the evening, see a bunch of patients and make sure they are okay on their medications or look at the psychotic books or someone that is suicidal and do what is necessary. So, that was the bulk of the job. Then, I knew that the guy who was running the addiction program at the VA was Dick Heilman And, I don't know if Dick is still in St. Paul or not. I don't know if he is alive. I think so. But Dick was long term recovery guy, really committed to the VA and to Hazelden. So, I worked under him during my fellowship. So, he was actually a mentor too. I should have mentioned him earlier. And he was a mentor in that... really about recovery itself and what people needed spiritually and interpersonally to get there, you know? He... I remember telling me that group therapy was just as important as surgery and you cannot interrupt it.

AS: Wow.

MS: Yeah, which I thought was a really nice way of describing just how important the work was, that you are doing with people.

AS: Yeah, it is. That is profound.

MS: It is, yeah. And he was always really interested in my life beyond medicine. Like, how was I leading my life and that sort of thing.

AS: Like who you were as a person?

MS: Yeah, yeah. Exactly.

AS: That's a good mentor.

MS: It is. [laughter]

AS: I agree.

MS: So, I couldn't get a job here, and being born in Seattle, I somehow must have somehow imprinted on the Northwest. And I thought, let's move to the Northwest, it would be fun to go out there. And Linda was game [laughter] and so I was looking for jobs in these psychiatric throw away journal things and there was a little ad for Portland. This little hospital there that was a dual diagnosis hospital, which was unheard of at the time in 1988. But they had a program and they needed a psychiatrist and when I went out and interviewed and everything and they not only wanted me to do in-patient work there, they would set me up in an office right next to the hospital to have a private practice and they could be, like the medical director had this little adolescent program about twenty minutes away.

So, I had all of these, like three different positions in one job, basically. I didn't understand... I had to bill you know? To get paid for all of this stuff in the hospital which was all new to me. It all worked out fine because the other guys told me how to do it and who to use if I wanted to or do it myself.

AS: So, were you... was the adolescent part of the job a surprise to you? Or had you been drawn to it because of that?

MS: Yeah, it was. But that wasn't described until I got out there for the interview. It was the dual diagnosis, but the dual diagnosis hospital had both an adolescent and an adult program. So, it was right up my alley. That's how I was trained. I knew psychiatry, I knew addiction and I got the job.

AS: What was that little hospital called?

MS: It was Pacific Gateway. It no longer exists.

AS: It got eaten up?

MS: Yeah, by a bunch of condos.

AS: Oh, the hospital is even gone?

MS: Yeah, it's gone. It was this great program when I was there, run by people who really recognized the necessity of treating both the mental illness and the addiction in concert, you know? In an integrated manner, way back then before people were doing that and they were like writing about it and stuff and teaching all about it all over. And doing some great stuff. So, I just had a ball there, but the hospital was for profit, which I didn't understand at that time. I just wanted a job and didn't know the difference, really.

AS: So, what did that mean?

MS: Well, it got purchased by another hospital system and then they started to change what was going on, and then was purchased by another on and it got even.... and the program kind of slowly deteriorated, and people started leaving as a result. Staffing diminished and then it got purchased by another. And I had left, to do other things. First, we were only there a year and a half, and we came back here for three years and we lived in Hopkins because I got a job at Hazelden as one of those consultants, but at the adolescent program. So, that was my first job in the system, but it was like twice a week for three hours maybe.

AS: And you moved back for that?

MS: I know!

AS: For a six-hour a week job?

MS: It was crazy because I had this great situation going, I moved back to this and I had to pull all of these other jobs together. So, I had a job out in Waverley, a treatment center called Waverley. It was Hubert Humphrey's old home.

AS: Yeah, I think there is still one out there.

MS: Oh, yeah, yeah, there is. I got a job doing consultation there and at Wayside Women's, I was doing consultation for them. A couple half way houses and a bunch of programs. I was just doing like five or six different consulting jobs a week to get forty hours.

AS: You were like a traveling salesman.

MS: I was! I would go and I would do my psychiatric evals for them and help them out and provide medications and therapy.... and I was the only one doing it in a lot of these places, you know? Because there are no mental health services at a lot of them, and I was it. So, I got... the good news is as a result, I got a really broad experience, really fast. And I went back to Oregon and just kept doing that kind of thing. I failed to mention, one of the jobs that I got. I moved to Oregon in summer of '88 when I finished training. January '89 a treatment center opened there, called Springbrook. Which is now Hazelden's Springbrook.

AS: Right, I was going to say, is that the same place?

MS: [laughter] It is! So, it opened and they tried to just treat physicians. And within a year and a half went bankrupt doing so. They didn't treat anyone else, only physicians, right. And the doc who was running it was just spending all of this money and not getting enough patience. And so, went bankrupt and one of the businessmen who had invested initially, owns the biggest dental supply company in the world, in New Borg, Oregon, right next to Springbrook. He was involved from the start. Then, he bought everybody else out and reopened it and had it as a treatment center for anyone, with a specialty for physicians.

AS: Oh, right.

MS: And it did much better. But, so when we.... I finally realized that I'm not getting anywhere with Hazelden, it's just this six hour a week at most. So, we decide that we love Oregon and that we were going to go back, and we went back.  And then I did the same thing there, multiple jobs. Springbrook was one of them, I did Pacific Gateway for a little while, I worked at that adolescent place for a little while, then I worked at a women's program, I worked at a Native American program. I did consulting for the Board of Medical Examiners and you know, on docs who have addiction and stuff like that. And then I did some for the nursing board, too. Just throwing all of this stuff together, again, trying to get a forty-hour week or whatever. And, [laughter] there still really weren't full time jobs in addiction for docs. Hazelden still didn't have any and even Springbrook. Springbrook and a couple of full-time docs. They had a detox area and they liked more of a medical model, because it was started by a doc, you know. So, they had a couple, but not psychiatrists.

AS: Did they also focus on other professionals like pilots or? People who need like licensing?

MS: Yeah, they did. Yes. And it was really kind of a natural that way, because all of the stuff in medicine with licensure issues was similar in the other professions. It worked out really well. And those groups got along well too. There were a lot of similarities. A bunch of attorneys.

AS: Yeah, I had another doctor say that pilots and doctors, like they would rather die than lose their license.

MS: Oh, yeah. Man, absolutely.

AS: That it is so meaningful to their identity... that threatening that, usually gets people into treatment.

MS: It does, it really does.

AS: Or that the idea of losing...

MS: Both are so highly trained in one thing, that...

AS: Right, what would you do?

MS: Yeah, what would you do? I know docs who have been working in restaurants and all kinds of stuff, because they have no other skills, really. Although, I also know some who did do, that were like techy guys on the side and they had been able to, during a period without a medical license go work for, you know, a tech industry doing something.

AS: Right.

MS: But, there's not much.

AS: Okay, so are we in the Nineties now?

MS: Yup, early to mid-Nineties.

AS: And you're still on the West Coast?

MS: I moved back here, this is a horrible tale, in some respects. Hazelden, right after we moved back to Oregon, six months later I get a call from one of my friends at Hazelden and he says, "Marv, we finally decided that we want a medical director for the company." And, I said that I would be interested. I foolishly said that. I just had this struggle with myself and with Linda, you know...

AS: Because meanwhile, how old are your children at this point? You have two daughters?

MS: A daughter and a son.

AS: A daughter and a son, okay.

MS: And so, they are in grade school. Second and fourth grade, maybe. And, so '95 I move back. It took nine months for them to decide after I interviewed, and they finally gave me the job. Then we moved back, I only moved back for nine months. The job was so undefined, and I just hardly did anything. I had no oversight of anything and no responsibility for anything.

AS: So, you just sat around? [laughter]

MS: I saw patients a lot, like a psychiatrist, but nothing else of use to them. It wasn't what I had in mind, and so, I just left and took the family back. They came for just four months. Luckily, the four months was a fall from the start of school to Christmas, and we were back. They were both in grade school at the time and they both just finished the first year of a two year with the same teacher, same classmates. So, they missed just one part of that, and they came back to the same classmates, the same teacher and everything just fell right into place. It was really a tough time.

AS: So, would you say that Hazelden wasn't really ready at that point?

MS: Yeah, I never... the president at the time, Terry Spicer, I think he talked to me once.

AS: So, they didn't really understand why they should have a medical director?

MS: So, I was the first full-time doc hired and I left because they didn't have anything really going. And it was really hard to do, to leave. Because I had given up so much to get there and drag my family around the country for a second time.

And all because, probably because... and there is still some of this. I'm sure that, because of my own treatment at that place, there was a commitment to it, you know, that otherwise I probably wouldn't have. And a connection to it. And some, perhaps, even a feeling that I owe them somehow.

AS: Interesting.

MS: Yeah, so...

AS: And you were still feeling that twenty years later. Right?

MS: Yeah. Oh, yeah, absolutely.

AS: That is pretty powerful.

MS: I mean I didn't get sober right after treatment, but they opened my eyes... and they kind of gave me my life.

AS: No, but... right, right, the place.

MS: So, yeah it is really powerful. And so now I get to live in Oregon and work for Hazelden.

AS: So, how did that happen?

MS: So, in '95, nine months in that job. I am the medical director of Hazelden. And at the time, just a couple sites. Minnesota, Center City and Plymouth, and St. Paul, and then we had a place in Florida at the time, as well. And I was the medical director of all of that. So, basically the same job that I have now...

AS: Wait, that was the job you left that was so.... unfulfilling?

MS: Yeah, yeah. Cause they had no idea what they were doing, at the time. With a doc, you know? So, we go back to Oregon, same situation.

AS: You go back to doing all of the consulting, piecing...

MS: Yeah, piecing all of this together, and the private practice that kept growing. It got really big which was kind of neat.

AS: Yeah, well I bet by that point you were also a special kind of psychiatrist, if people weren’t able to get...

MS: Yeah. That's true. People started to recognize their needs, yeah.

AS: But did you continue that model of talking, spending more time talking with your patients, than just prescribing them medicine.

MS: Yeah, so, about half of my time I was spending doing psychotherapy and the other half doing medications and still, talking more than my peers were, with patients on medication, so it was really nice.

AS: Right, right. So, I can see why that would make you popular.

MS: Yeah, yeah, and people come to me and say "I go to my doc and he sees me for five minutes and just gives me a prescription, and you talk to me. So, I'm coming back." I heard that repeatedly.

AS: Oh, I'm sure. I'm sure.

MS: And I also did psychotherapy for real, you know.

AS: Right, it wasn't just trying to be nice and listen patiently for a few minutes.

MS: So that went well and then, I was kind of involved behind the scenes, telling folks at Hazelden, that same guy who asked me to come back for that job, he became like a COO at Hazelden. They didn't call him that. And he and I were talking, and I said, "You know, the guy who owns Spring Brook is kind of interesting in selling it." He doesn't... It was that guy who owns this big dental company, and he just kind of lost interest. He was in recovery, that's why he did it, but now he just wanted to get rid of it. And no one was buying it. So, I said, "You guys outta consider it. It's a great program." So, he came out and looked and then they never did anything about it. And then a new president came in, who was just there a year. It didn't work out well, and the board, you know, kind of got rid of him. I don't know the details, but he came out to visit. I talked to him a lot about it and he thought it was a good idea. So, he decided to buy it. And we're a non-profit and they were a for-profit, so it required all of this juggling about that, legally. But, while he was there, he brought Linda and I out for supper with he and his wife and he asked me if I'd consider coming back as the medical director. I said that I will if I can stay here and do it from here. And he said sure. And he came out of hospital administration, so he really knew docs and medicine and he had a whole different perspective on how to run Hazelden and we had never had a person like that.

AS: And you said he only lasted for a year at Hazelden?

MS: Yeah, only a year. But it was mostly interpersonal stuff that didn't work out. It was problematic stuff, not because of his perspective. Yeah, unfortunate stuff, but sometimes it happens that I can't mention.

AS: That's fine, I understand.

MS: But so, he asked me one day if I would be interested, and the next day, I have the job. So, it went from nine months that first time, to overnight and I had the job.

AS: And that's 1990...?

MS: And they didn't replace me when I left in 1995. This is 2001 when they purchased Spring Brook and they get me.

AS: And they hadn't replaced you in that whole time from 1995... they didn't have a medical director?

MS: No.

AS: Marv, that is just a crazy story.

MS: It is! Isn't it? So, I become the medical director, well now I am the chief medical officer. They changed the title, but it is the same job, it is just bigger now. So, I'm going back and forth. The day I start my job, they invited me out to a board meeting, and that was my start day. And I get to Center City and walking toward the board meeting I run into a board member, Ellen Brier, and we're just talking, and I've never met her, we're walking to the meeting, and the guy who hired me is not there. And they announced that he is no longer at the organization. This is my first day on the job. And Ellen Brier, the woman who I just met walking in, is the interim CEO. Ellen Brier has never been a CEO of anything, has no health care experience, comes from Godiva Chocolate.

AS: [laughter] Oh my gosh.

MS: So, I start when she starts. So, this goes on and she is... one of my neighbors in Oregon, I did a lot as a neighbor and then we did a lot of fishing together, and he was a CEO of an international computer firm out of LA and then they had moved to Phoenix. He was doing basically what I was doing, working elsewhere. I asked him if he would help me out as a business mentor and he did, and after a couple of years, probably three years, he told me that I needed to get out of there because she was going to run the company into the ground. And I couldn't do it, I just held on until 2007, really trying to emphasize quality of care and outcome measures of our patients. We gotta know that what we are doing work and we gotta prove that it works and be able to stand on that.

AS: How was that received?

MS: It was well received by the clinical people, you know? But, not necessarily by her and her ideas for the organization. She was more focused on the money and didn't really want to put money into doing something like that.

AS: She didn't want to put money into you all proving or trying to study whether what you were doing was working?

MS: And we were already doing some outcome studies, but I wanted to really enhance that...

AS: You wanted to do that because you were trained in science.

MS: Yeah, yeah. And so...

AS: But you're saying that it was the leadership at the time, not the culture of the 12-Step Minnesota Model?

MS: Correct. Yeah, and I will admit, the councilors in general... I'm blocking out the word for it... It was like an apprenticeship program.

AS: Right, the peer training. Alcohol and drug counselors, that's their whole history.

MS: Yeah, they had a whole certification program at the time and you just kind of come and become an apprentice for a year and then you could be a counselor and get licensed and everything. It was an oral tradition.

AS: Right, like a peer coach.

MS: But there wasn't much in the way of academics associated with it. Nothing like the grad school now, but the training program started in the mid, I think '64. It's old and established. But, without the academics, there was not a learning culture at Hazelden. Coming out of Mayo and the University of Minnesota, I mean, there are lectures every day, all day long you could go to on all of these different specialties, diseases, all this stuff. And that sort of culture wasn't in place, and they were kind of just resting on their morals and starting this Minnesota Model and all these remarkable things that they had done, but they weren't really pushing anything that was new. I was wanting to do that. I thought about... I left in 2007, and before I left, I was thinking to myself that we really outta consider this medicine, the only one for opioid use disorder.

AS: You mean methadone?

MS: Suboxone. Methadone was available, but that is so highly regulated and [not-audible] and Suboxone was just coming around and I thought maybe we should consider it. I had already been involved in really driving medicine for alcohol use disorders, only Naltrexone and Antabuse and then Acamprosate were used.

AS: Acamprosate?

MS: Yeah, it is another medicine for alcohol. It hardly ever works, maybe ten percent of people? When I say that, just today we had a lecture by video by one of the leading researchers down at Mayo. A cancer researcher who now is a genetics researcher actually, really an internal medicine doc. For cancer research, he started using genomic and metabolomics to try and figure out responses to medications and who would respond to what. So, he did that for antidepressants and now he is helping out in the psychiatry and addiction department. And we applied with them to [inaudible 58:33] alcohol abuse and alcoholism for a grant to study Acamprosate for alcoholics to see if we can define biologic markers that would predict response. So, we're doing this...

AS: Wow, that is so interesting.

MS: Because if ten percent respond, and they respond well of those that respond, it works. But, say you were an alcoholic....

AS: But why would you? Here try this, you have a ten percent chance.

MS: It probably won't work, but if it works it will work great. Who wants to do that? It's expensive and you gotta take it three times a day, well that's not going to happen.

AS: No.

MS: But, if we could define who it works for, and you could just do a blood test and you can go, "Hey, this will work for you.", that's a big deal. It'll take four or five or six years. We just started...

AS: Wow, that's great.

MS: Yeah, it's really neat.

AS: Okay, so 2007 you leave. You were already thinking about why don't we use these... because at that time, we're already seeing the consequences of overprescribing of opioid pain pills. And you were on the West Coast.

MS: I was doing lectures about it.

AS: Right.

MS: And ASAM even, the American Society of Addiction Medicine, I described the stuff that was going on. And no one was listening. Yeah. Cause you could see in the national data trends, we were starting to see it within Hazelden with the number of people with opioid use disorders is increasing. People at Hazelden and people on the ground, they were recognizing it. We're talking about it. I'm trying to bring attention to it and give them lectures about it and writing, not articles for research or anything, but just writing about it and doing interviews about it. People were not paying any attention. So, I go out to Portland. I needed a job, and a couple of nurse-practitioners I knew had just started to work with a woman who ran a home health service and they were going to do detox in people's homes. Which is done in the UK and in Australia, it's really common. And so, I thought that'd be really interesting. I'll work with them and we can also start an out-patient program, because those people will need treatment. You can't just detox them. So, we'll do out patient, help with the detox, figure out how to do this and see if we can prove it useful and convince insurers to use it. It'll be cheaper in the home, if we do it right. So, we got all of that going, but I decided in the out-patient program that we would do Suboxone, Vivitrol wasn't available, Naltrexone hadn't been approved for opioid use disorders yet, it had for alcoholism, so I started prescribing that, and convincing the councilors who were all from Spring Brook, basically.

AS: They were your councilors that you had worked with at Hazelden?

MS: Yeah, we stole them kind of. And they came to work for us. They decided it would be more fun to try and get a new program off the ground and I convinced them that we should do this thing where we provide a real 12-Step, abstinence-based treatment programming, just like you normally would, just like background in treatment is, with the use of suboxone, this new medication for opioid use disorders because it looks really promising. I think we should try this. And initially, they were just aghast that anyone would want to give that medication to patients, but after a few patients, and the whole excitement of getting it going, they just got totally supported.

AS: Because they were seeing really good results?

MS: Yeah. Yeah, people kind of settled down... I mean it wasn't all good. There were problems and people didn't keep coming and abused their Suboxone or whatever. There was a whole gamut of things happening, but most people did well. And so, we established that program and I did it for two years. And unfortunately, the woman who had that in-home health company that owned this whole thing, basically was going bankrupt. And not telling us and trying to just... she was just a mess kind of. All of the sudden, it was in dire straits. At the same time, Mark Mishuck had been hired at Hazelden.

AS: Who is he?

MS: He is our CEO.

AS: Oh, okay.

MS: Yeah, sorry. [laughter] It's okay! You shouldn't know.

AS: Sorry, I didn't study up on that! [laughter] You never know what I remembered and might have picked up. But that wasn't one.

MS: So, I get a call from his assistant, Karen Colander. Karen is an old friend, I've known her for fifteen years or something. And she says, "Marv, Mark is coming out to the northwest and he wants to meet with you. So, he and his wife want to take you and Linda out for supper."

AS: Here it comes.

MS: And I'm thinking, why does he want to talk to me? And she doesn't know. She says, "I don't know." And I'm thinking well maybe he just wants to know the history or something that I know. Honestly, that's what went through my head. And cause when I left, I forgot to tell you this, when I left, the woman who was CEO, Ellen, was absolutely furious with me for leaving. And, I also told the board why I was leaving, I wrote them a letter that, she's doing this, and my thoughts are quality. If we're going to make money, we have to, but we gotta have a quality program.

AS: Right.

MS: And I'm being roadblocked for trying to accomplish these things. So, that of course wasn't the brightest thing to do. I had never left a job and I didn't know how, and I did that.

AS: Right, and then she read the letter.

MS: Right, of course. She withheld my mail, she told people they couldn't email or call me.

AS: Wow.

MS: Oh yeah, she was really upset. But, within a year, she was fired by the board. And then they had an interim, and then they hire Mark who comes out of hospital administration, and he is in recovery. And so, he is coming out and I am working in this program, but it is going bankrupt and I am trying to figure out what I am going to do next, but I've got a bit of a private practice starting and I can't keep things afloat. And he comes out, and half way through the meal after we have just been talking about addiction and treatment and Hazelden and all of that, he offers me my old job back. [laughter]

AS: You can't get away from the place!

MS: I can't! Actually, one of my peers, Val Sleighmaker who oversees the grad school and research and stuff, she tells me it is my Hotel California. [laughter]

AS: Seriously! [laughter] That's really good actually. That's very poetic of her.

MS: It is! So, I tell them that I'll do it and I'll move back to Minnesota, because I think I better in order to get this done right. But Linda says, "Okay, I don't really want to leave Oregon."

AS: For the third time...

MS: We both love it there. I know! So, she kind of stays at home and fixes up our master bedroom and master bath, which the realtor said we should do. It's 2009 and the downturn has already started. And she does that, takes about six months and she's going to sell the house, while I am already out here, and the house is worth even less than before we did that. So, we say the heck with this, this is okay, it's not that bad living apart, we'll just do it a little longer and see what happens. So, she stays in Oregon and I was here in Minnesota first living in Center City and then in White Bear, just renting. First, I was living in a friend's house, they just let me stay there because they moved to the Southwest. Whenever they visited, I would just get out for a week or whatever. And then, it went on for almost four years living like that.

AS: That's hard.

MS: And finally, I just told Mark, my boss and CEO, this is just too much. I have to do something different. And about at the same time we were starting to negotiate with Betty Ford, so we would have a bigger presence on the West Coast, and he agreed that I should just be able to work out there and work out of the office there and come here regularly. And that's what I've done since. Before I left in 2000... yeah, before I left, we hired our first full-time psychiatrist.

AS: Oh. For here in Minnesota.

MS: Yeah, Steve. Here in Center City. Springbrook had full time people. And I had worked there full time for a period of time before I was hired by Hazelden that first time, or that second time. [laughter]

AS: That's okay. We'll try to make a timeline or something. I'll get your CV.

MS: [laughter] So, basically, when I was talking with Mark about coming back, I said that I have been doing this in-home detox stuff which is exciting, but more exciting is that I have been dealing with opioids and I think we ought to consider this and go down this path with Suboxone. And he says, "That makes sense to me." And he comes out of hospital administration. Of course, it makes sense, a doctor tells me, "Here is the research and here is my experience."

AS: And here's what we need to do!

MS: And it was still not getting attention nationally. I mean it was, but it wasn't.

AS: This is in 2009?

MS: Yeah, 2009 I come back and finally, it's kind of exploding, and I am still talking about it. And we haven't done anything yet, I gotta do all kinds of other stuff as well, getting back involved there and getting some things taken care of. And then, I decided let's do it. And I had to convince the board because it is really controversial for our group.

AS: I'm sure.

MS: I would bet about half of the board or more were older alcoholics in recovery and had biases about medicines, like buprenorphine.

AS: Right, any medicine.

MS: Yeah, oh yeah. But we already had full mental health services with full-time psychiatrists now.

AS: So, people understood that there was a need for psychiatric-based medications.

MS: Yeah, and they'd already gotten the medicines for alcoholism in place before I had left.

AS: At Hazelden?

MS: Yeah, so...

AS: Oh, I didn't know that you guys were doing that.

MS: Yeah, so the foundation... Yeah, we did that around 2003 maybe. So, Naltrexone came along, we decided to do that, with rare use of... Oh god, what's the stuff that makes you puke if you drink.

AS: Anifuse.

MS: Anifuse, yeah. We hardly ever use it because it is so dangerous in a way, and then Acamprosate came later, so we added that. We had already established that. I came back and started to talk about this. The board chair at the time was a catholic priest from inner-city Minneapolis. He had been a really high-level administrative priest and then kind of got that out of the way in his career and then kind of went to real street level type work. A lot with the homeless and with other organizations like that. Father Michael Connell. And he was wonderful. Because of his experience with all of that, he had seen the opioid crisis. He was also in recovery, but he had seen it for what it was in inner city Minneapolis. He thought that we should do this too and was really supportive. So, I had the support of the CEO and the support of the board chair, spent a bunch of time educating the board, and then they voted unanimously to support doing this and going down this path.

AS: In 2012?

MS: It was probably 2011 when they actually supported doing it. So, I started my plan in January of 2012 and pulled that team together and we took people from all parts of clinical from all sites on that team to kind of get this figured out for the organization. Initially, one of the councilors who I asked to be on this team, he said to me when I asked him, "Is this a good career move, Marv?" Because no one knew.

AS: For him or for you?

MS: For him. Yeah, should I even be on this team if I am going to be suggesting that we use this medicine in this organization, what's going to happen to me? And others, I got a four-page, single-spaced email from one of our councilors in St. Paul. Because it had leaked out, this was about a month and a half project with the team. We we're communicating about it, we were just planning to figure it out. We were actually just reading the literature.

AS: Right. How could we do this?

MS: Right, and I had already done it in that outpatient program. Basically, the whole model was already established in the outpatient program and we're just going to put it into Hazelden, kinda. And yet, I had to convince people of it's worth, so I thought I would just use the literature. It made a huge difference, because I had everybody read a couple of papers about the early research on Suboxone and how it was working for people and they came back and had to present their two papers and everybody did their two papers, or three or whatever. And they were all like, wow, this is kind of hard to refute when you read this stuff and you hear all of this. So, it made it huge difference.

AS: What was the four-page email?

MS: Oh, sorry. It was why we should not do this and about, maybe two and a half years ago now the woman who wrote it came up to me at one of our leadership meetings, basically the one we are having tomorrow and gave me a big hug and actually, with a tear in her eye, said "Thank god that you had us do this. It works so well." [laughter] Yeah, so it was wonderful because I didn't pick people that I thought would support it, I picked people I thought could get it done and decided that the research itself and my experience should help, you know win the day of whether we should do it or not. We already had the board approval, so we were going to do it. We're doing it. We're going to do it.

AS: Right, and... it's happening. And are you going to be...

MS: Are you going to get on board or not? And I had one of our main kind of national speakers, Fred Ulmquist, ran the renewal center at the lodge at the time and Fred is like an AA, Twelve-Step professor.

AS: [laughter]

MS: Also, his parents were professors and he wore bowties and he teaches like a professor, you know, he just does. And he's wonderful and really bright. I've known him a long time, we're old friends and we've worked together on the alcohol medication thing. I asked him if he would help because I wanted to have his AA-cred for the staff, of course we're doing the right thing. So, Fred comes along, and he get on the team too, for the Suboxone, and Fred's wife, I'd known this but forgotten, Fred's wife Paige was in recovery from heroin use. And Fred was also in recovery, not from heroin. So, he knew that whole side of heroin and he said "Absolutely, I want to be involved in this. I want to help." And Fred, there's a book "The Twelve Steps and Twelve Traditions" and the third tradition, there is a description, a full paragraph, of all of the people who really early kind of established when they went to AA who should not come to these meetings. And there is a whole list, includes "fallen women", whatever that is.

AS: Yeah, that's classic.

MS: And then on the next page or two, it says we realize that to limit anyone from coming, could possibly sentence them to death and they decided against any limitations. And Fred had brought that to our team, which we used throughout anything we did.

AS: When people would start to push back?

MS: Even before, we just had Fred get up and describe that and say, "Hey, we are going to do this, and we need to. This is a precedent set by the founders of AA." [laughter] And there's no limitations to medication that are described in AA.

AS: Why do you think that that myth persists? Because I hear so many stories of people who've struggled with whether they tell their sponsor that they are on Suboxone or on Methadone, because there is still this idea that... Why does this myth persist if it is in the traditions?

MS: There's even a pamphlet from AA about medical care and the use of medication and it says that it is between you and your doctor.

AS: So, why would this...?

MS: I think it's because historically, the medical profession has addicted a lot of people to a lot of different medications and sold a lot of medications as if they were not addicting.

AS: So, there is basically a distrust of the medical profession, which I understand in the history of medicine very well.

MS: Okay, that's it. That's the main reason, that's why it has nothing to do with the treatment of addiction and alcoholism.

AS: Not for a long time.

MS: Yeah, and finally they start to. But during my residency training, one of the other faculty members in psychiatry was studying Xanax for alcoholism and saying it was a safe mediation.

AS: Oh.

MS: Yeah, and people back then thought so. Not that long before that, TIME Magazine's cover was "Cocaine is not addictive". So. And I knew it was, I used cocaine.

AS: Right, it's like smoking cigarettes isn't bad for you.

MS: My god! It was really addictive. And, you know, all of us within recovery knew this stuff was so terrible. So, I think that that was what it was. A distrust. And there was a real distrust in Methadone, even though it was remarkably useful.

AS: Well, because it got associated with crime and inner-cities and people of color.

MS: Yeah. But also, most of that was because of the for-profit methadone maintenance programs that were established and still are all over the place. Because once you get someone on methadone, they keep coming back and you get money from them.

AS: Oh. And they are for profit?

MS: They are. Most of them. There are some that are not-for-profit, most of them are for-profit. And they don't provide all of the services that are supposed to be done in methadone. Yeah, so all of these wrap around services, well not in those programs. They hand out methadone all day long and that's it.

AS: Well, that's another extreme that is just as, I think, just as problematic as just saying "Twelve Steps are going to heal you." ... from opioids.

MS: It is. Absolutely. And every time they have looked at people that are on long-term methadone and they stop, they relapse. Well, if you've got nothing else but methadone, of course you are going to relapse!

AS: Right, right. If your life still is horrible... things are the same.

MS: It's the same! So, I've always... that was the beauty of suboxone. Is that, it's not under the same regulatory requirements as methadone, so you can do it right from your office, which was fantastic.

AS: Right.

MS: You don't have to have all of the licensure for methadone either, which is really onerous. And our board, there was still bias about methadone and I had had experience in a couple of different methadone maintenance programs. One, my training at the VA and one, I consulted at and did psychiatric work for in downtown Portland. So, I knew that there was a real utility to methadone, and I had seen the research. It was kind of like... but I also knew a lot of people who had a history of heroin, who were sober in NA and either had used methadone for a period of time and stopped or had never done it and now were sober. So, I had that experience too, that it is not absolutely necessary. But in our setting, there was no way that we would have done methadone.

AS: Right, I totally understand that.

MS: Partially, because of the onerous nature of the regulatory system. And we do this in people's offices, and we knew that they could get the care later, easily. So, vivitrol had been approved so we said we were going to do both medications. I didn't have experience with vivitrol from that practice, because it wasn't approved when I was there, so this is new, but it makes so much sense to use both. So, we decide that's what we're going to do right from the beginning.

AS: You mean to offer both?

AS: Yeah, so people could have a choice. It is always nice to have a choice among medications, for any illness. And for docs, that's better to have the opportunity for more than one or two... but the guy who asked me if this was a good career move, and Fred, who was our AA professor and I, decided that the three of us would do training forums around the organization about this whole program that we are putting together. Doing that mainly. And the first one we did was at Center City. It was in our biggest room in the grad school, and there were over one hundred people there, standing along... and we're thinking, in preparation we were thinking that we need flak jackets because... [laughter] everything, this is going to be awful. And it wasn't. But we each talked briefly, about five to ten minutes each and then we opened it up for discussion because we wanted a forum, we wanted an interaction, we didn't just want lecture about this. So, I went first and talked about the medication, which, you know, I just had to get it out there and describe both medications and why, and a little information about the research. And then Scott the councilor talked about, you know, how it would affect treatment and what we would do that way. And then Fred talked about why we should do this, even in a Twelve Step based program.

AS: Right.

MS: And he used the stuff from the Third Tradition. [aside] My phone has gone off a couple of times.... It's Linda, it is probably nothing. [laughter] But so, the first run, all of these people, Scott in his section right after me, I led the meds, he says, "How many people here have had a patient here die of an overdose after treatment?" Three quarters of the room raised their hands. Now, there was a lot of overlap among those. One patient could have been ten people, you know.

AS: Right, but it was a person who they had touched... who they had been working with.

MS: Right, three quarters of the room. And you could hear a pin drop. It made our whole argument, in one question. Then Fred talks, and we open it up for discussion and I'm thinking, okay, here it comes. We get softball question after softball question and support for this program and that we need to change that people are dying. You know, "This makes so much sense." Somehow, we're going to do it, type questions. And then, we're ten or fifteen minutes into the questions and one of our most conservative councilors raised their hand and I am thinking, now it's going to start, this is the flapjack. And she stands up and she says, "My daughter," she was twenty-eight or something, "went to residential treatment three times for heroin, relapsed after each treatment right away, could not get sober until she started taking suboxone. And now she has been sober three years, she's part of my family again, she now takes of her children and I don't have to anymore, she has a job, and she is doing wonderfully." And no one knew. She hadn't told anyone. And she just got up and gave this testimonial and it was like, we couldn't have asked for anything better to say and it was just from the most unlikely person in the room, just this big book thumping woman who, who no one ever thought would ever support this. And it was the most incredible description of the utility of this medication that you could ever hear. And her daughter went to AA, right? And took the medicine. It turned the entire conversation... there wasn't any griping, let alone absolutely anarchy. There were certainly pockets of people who didn't agree, but they didn't talk in that meeting and they kind of got silent as we went down this path and just silently just tried to disrupt things. It was amazing. It was the absolute opposite of what we were expecting.

AS: That's incredible.

MS: Yeah, and it told me, once again, the passion of our counseling staff, our clinical staff-- our docs and nurses as well and councilors --- is so tremendous. They just want to do what is right for our patients. And we finally said, here's what we should do for this particular group of patients, and... [aside conversation about incoming phone call].

AS: So, what would you say... So, I know that you did, just in the interest of time, you did a webinar, this is how I started to reach out to you, because you did a webinar about what has happened in the few years since you started. Okay, so I could watch that and then get a lot of your answers.

MS: Okay, yeah, that would tell you how we did and what our early results were.

AS: Okay, that is good to know. What would you say...? I have a couple things. What would you say to people who still say, "Hazelden is a dinosaur."?

MS: [laughter] I laugh, nowadays because man...

AS: You must have heard that.

MS: Oh, yeah.

AS: And this is in the context of the opioid epidemic.

MS: We were talking about it this morning actually, because a couple of our folks who are out on the East Coast, I don't know if they are in Rhode Island or in Connecticut, and they are talking with the executive director of the AAA, the American Association of Addiction Psychiatrists. And this person in this group that we are talking to, they think that we are a dinosaur, that we're just living in the past. They have no idea what we were doing. They had no idea about Core Twelve, they know nothing about our treatment, they just made all of these assumptions based on twenty years ago and what we were like. As if somehow, we had never changed. You know? And they were able to tell them all of this stuff, and when they left, they said, "Oh my God. We had no idea." Thanks for coming.

AS: Yeah, thanks for showing up.

MS: [laughter] Yeah, so now I tell them about Core Twelve, about the research project that we have completed that we are trying to get published. We still haven't heard from the publisher. We submitted the paper and asked for the edits, we submitted the edits.

AS: To which publisher? To a scientific journal?

MS: Yeah, Journal of Substance Abuse Treatment. The right one, right? [laughter]

AS: Yeah, you picked the right one there.

MS: Yeah, so we're hopeful. It was a naturalistic study, so it didn't have double-blind controls with the medications, which it a bit unfortunate for a study because you don't have the controls that you might want. But we were told when talking to several researchers that both medicines have been adequately approved to be effective, we just need to see what they are like in practice. So, that's what we did!

AS: So, what does that mean, naturalistic?

MS: That the patients get to choose which medicine, we don't force that on them.

AS: You don't demand that? Because that's what I... reading that short piece from 2013, that patients can continue to choose, if they want just abstinence or if they want one of these drugs.

MS: And that's still the case. And we recommend that they take one of the two medications.

AS: But how much... okay, okay.

MS: Every single person with an opioid use disorder, we recommend the medication. They can refuse it. That's the deal.

AS: Because we have...

MS: You can't force it on them, we can, and we do continue to try and convince them, because this conversation is right when they get into treatment during detox it starts. And we're continuing to try and tell them to try the medicines. We will their family, not necessarily successfully because a lot of the times, family are not involved at all and they don't want anything to do with the person anymore, or, they just... "We didn't bring them there for that." Especially that suboxone stuff, because there are real biases about it. And we have to do a lot of education about it there, and even then, they might say that we're not going to support that. "We just want them sober."

AS: Have you noticed a difference between what happens at Plymouth versus Center City, in terms of opioid addiction?

MS: To a degree. One of the main things, the one big difference we noticed right of the bat, is that some of the younger people especially misused suboxone on the street. And some of them, to me that's not a big deal, if it's just that they are using suboxone...

AS: But they are trying to use it between?

MS: Yeah, detoxing themselves... But if they are injecting it or something, that would suggest that we're not going to give it to them. Because people certainly do that.

AS: How do you inject suboxone? It's a liquid?

MS: You could. It is a liquid, well you can turn it into a liquid really easily.

AS: Because it's the little sublingual...

MS: Yeah, it's either a tablet or a film. You just put some warm water on it, and it goes right into a solution. But also, you're not supposed to be able to inject it because it's got Naloxone in it, it's supposed to block your receptors and put you into withdrawal. Suboxone is really tightly bound to those receptors and might not let that happen. It's really a weird thing. Yeah, so some people actually do inject it and get high off of it. Most people don't try for that reason.

AS: What are you guys doing with Naloxone and Narcan?

MS: We give that to every patient that has an opioid use disorder.

AS: When they leave?

MS: Yeah.

AS: When did you start doing that?

MS: At the latter part of installing this whole system. So, it's been going on for quite a while now. What else? Shoot.

AS: Sorry, I interrupted you.

MS: I can't remember what I was going to say, that's okay.

AS: That's bad oral history. It's a violation.

MS: [laughter]

AS: I'm in trouble now.

[Aside, moving cat away from interview]

MS: I can't remember what I was going to say, but when we went public about this, we got just lambasted by other treatment programs and, especially, Twelve Step program type treatment.

AS: By saying that you were going to use medication?

MS: Mm hm. They said we were... We heard form a real kind of prominent AA person in the Twin Cities that were ruining AA. We were told we were turning our back on our entire heritage and ruining the treatment field, that we were, and me in particular, were ruining Hazelden.

AS: Is this a public document?

MS: There was some in the media, but I don't know. You would have to ask Jeramiah. He might be able to dig some of that stuff up.

AS: Who is Jeramiah?

MS: Jeramiah Gardner is our PR person.

AS: Oh, okay. Well because that is kind of the opposite of what I was... That's the opposite of some of the things that I have heard.

MS: And now it's changed. Now it's really switched.

AS: No, but I mean that you weren't doing enough.

MS: Oh, sure.

AS: And when you do it, you're criticized by people for not doing enough.

MS: It was both, we were getting both.

AS: But, let's talk about that for a second... Oh, go ahead.

MS: In the same month, I was told that we were ruining addiction treatment of this type, you know Twelve Step, abstinence-based treatment, and it's not going to work what we are doing, by one person from a different treatment program. And a couple weeks later, told by a doc in St. Paul that we weren't giving enough people Buprenorphine and we shouldn't even be giving Vivitrol to anybody. And neither were true at the time, he just was making assumptions and of course, the other one wasn't true either. It was ridiculous. And that was just constant for a while, that sort of stuff. In spite of the fact that we were doing... We were the first of the major addiction treatment programs to do this. We weren't this first program to do it, but we were the first to write about it and the first to get it out there in the media, to really bring attention to that issue. I have trained all kinds of people who were from other treatment programs, some of whom couldn't even tell their treatment program when they were coming to visit us and learn about this. Yeah, they didn't dare. Some who were trying to convince their board that we should do this, but you know, they couldn't and still wanted to learn how we were doing it and stuff like that. It was really weird. I didn't really care, because we were doing what we needed to do, and it was so exciting.

AS: For your patients.

MS: Yeah, and patients were getting better, and it was really useful and wonderful.

AS: Does your program support people staying on Suboxone for some amount of time or are they encouraged to get off before they leave?

MS: Well, initially we said we only wanted to use it for some period of time, like a year and a half, two years or something. Until you get into good solid recovery, and then if you want to get of the medicine, just fine. I still think that is a useful tool for most people probably. Not all by any means. And yet, the Federal Government doesn't agree, and a lot of researchers say, "I can't take people off of their medication." But the truth is, medication adherence study shows us that two weeks of an antibiotic, less than half of people do that without stopping it early. It's terrible. And all of the suboxone studies, those early studies we used in that literature review, show that less than fifty percent of people were staying on it. And they were really quitting early. So, our goal became... We want to keep people on it, keep them engaged in treatment, and that's where we shifted our model because we wanted people to stay engaged with us long term who had opioid use disorder. Not in residential, we wanted residential to get into out-patient in St. Paul and stick around in this program, getting the medicine there, living in a sober house, you know, stick with this long term. And, we will help you figure out if you should stop the medicine or not, and we will support you all along the way. So, Core Twelve became this really kind of long term out-patient program. Now there are over two hundred people in St. Paul in this program.

AS: Oh, wow.

MS: Yeah, it's great. And that's where we ultimately resulted in... in our whole model. We saw the utility of a residential stay for stabilization, followed by long term out patient, during which the people could transition from professional care to self-care over months and years, if it was necessary. And it gave us the opportunity to maintain involvement and support ongoing use of medications, and ultimately, if they wanted to get off, we could be there to help them with that and insure continued support. Because so many people stopped anyway, to me, that was just an essential feature of this. And I knew that the craving of opioids goes on so long, I didn't want to say, "We're just going to do four weeks of treatment," or whatever, now our average is about three, and then say...

AS: Oh, really?

MS: Yeah, in residential. Our average in out-patient after that is now like several months. And for our Core Twelve folks, our initial Core Twelve group was going two years later with all of the same people still there. I mean, they didn't want to stop. And they were all going to Twelve Step meetings and doing all of this other stuff, but they still really appreciated what they were getting there. And so, my bias was... There's literature on physicians with addiction and a lot of them are opioid addicts, and a lot of those are fentanyl addicts, so even more powerful drugs that what they have on the street. They are taking pure fentanyl. And a high death rate for those folks as well. But, in most states, they were not allowed to use Suboxone and go back to practice medicine. But also, they had the highest recovery rates recorded in any literature because of all of the long-term monitoring.

AS: Oh right, so you could use that monitoring model...

MS: It was two-fold. I must be getting tired, I can't remember anything.

AS: That's okay, I understand. You have been talking for two hours. You should be running out of words.

MS: [laughter] So, contingency management is an evidence-based practice for addiction. The biggest contingency, the easiest to understand what this means, is if a physician or a nurse or anyone that requires a license, like a driver, a semi-driver or a pilot, if you're going to go back to your work, you can do that as long as you do this, this, this, and this, too, and we'll let you maintain your license. If you don't do any of these things, we are taking your license away. If you relapse, we are taking your license away. So, that's a contingency management, that's an evidence-based practice. Sometimes, a different type of contingency, and when we used this at St. Paul, if everybody shows up for group today, we'll have a pizza party next time we meet, and we'll supply the pizza. And the thing is, when we did that, they were all supporting each other. "You gotta go to group we want that pizza party." Right? They are calling each other and texting, "Get to group!". So, it supports abstinence, it supports continued involvement. So, we were using that. So, for the docs, its contingency management, they could lose their license to practice medicine, as well as that long-term monitoring that I think results in the really high outcome rates. And even for those with opioid use disorders, although a lot of the data is a little skewed because some people drop out, ones with opioid use disorders and they weren't used in the final analysis, but still, they've got seventy-five or eighty percent abstinent in five years.

AS: Really? Wow. That's great.

MS: It's incredible. Yeah, but most of them can't use suboxone and go back to work. There are a couple of states that allow it, but most states won't.

AS: You mean for doctors?

MS: Yeah, these doctors cannot go back to work on Suboxone. So, I knew of that literature and I knew all kinds of people in NA, who, like I said earlier, have either never used methadone, or used methadone and stopped and now are sober. So, I know that people with opioid use disorder can stay sober without medication. And I don't know who is who, so that's one of the reasons that we recommend everyone take one of the two medications, but it also is one of the reasons, initially, that I thought we should support people who want to stop medication, at some point. That only after their really good recovery, because the risk of relapse is associated with the risk of overdose and death. So, it can't, we can't, be undisciplined about this. We've got to really make sure that we are only supporting that, if they are in solid recovery, and even then, there is still a risk. We've had all kinds of people stop the medications and we've had some stay on the medications.

AS: Right, it is just so personal.

MS: Right. We don't know who is who.

AS: And you haven't been able to test that.

MS: No, and I would like to. That would be a great research project, but it would be really hard to do and take a really long time. It would still be worth it.

AS: Okay, just one more question. Do you need to go?

MS: No.

AS: So, if you could change something for the better right now, if you could change something right now regarding addiction treatment, what would it be?

MS: If I could just suddenly change something?

AS: Is there anything?

MS: I guess the main thing would be to allow access to anybody to have addiction treatment and as long as they needed addiction treatment.

AS: To have it for as long as they need it?

MS: Yeah, and in a system like our own, where they start with residential if they need it, they go to day treatment, they go to out-patient, intensive out-patient and have long term follow up.

AS: And that's if they have the insurance or the funds.

MS: Well, if I get to change anything the funding is somehow provided so anyone can access treatment and they can have the treatment they need.

AS: Okay, that's what I knew you were getting at.

MS: Which is hard to get. It's hard to get the treatment you need.

AS: Well, and to have it be consistent based on people's insurance situations.

MS: Yeah, it is. It's still hard for us.

AS: It depends on who your insurer is whether you can even go to Hazelden or not.

MS: I know, yeah. Now most, all of the major national insurers cover us now, we're partnered with. Ninety-two, ninety-three percent of our patients use their insurance.

AS: Is that recent?

MS: That's the last couple years now.

AS: Yeah, that's what I wondered.

MS: It's a big change from... Oh, this is what I forgot earlier. So, Betty Ford Center, so we merged with them shortly after, in like 2014, we initiated this program in 2013. Some of the most vocal folks against us were Betty Ford Center. It was mostly, if you could say if we have competition in the addiction field, it was the people who thought they were our competitors were the most vocal against us, trying to get patients to go there instead of going to us, basically. But also, they just didn't agree with us.

AS: I was going to ask you how the Betty Ford merger happened, and how well that went.

MS: Well, so, the first meeting...

AS: Like philosophically.

MS: Yeah, the first meeting of the Betty Ford center board with our president and CEO Mark Mishick, he told me that I needed to go along with him because they were so concerned about this new program Core Twelve.

AS: They needed you to explain it? How did that go?

MS: Yeah, and on their board was Tom McClelland, who is a major addiction researcher, now semi-retired, who has been supportive of medicines all along, but he couldn't convince them or the rest of the board about it. So, I go in and told them what we've done and why.

AS: And he's like, "See what I've been telling you!"

MS: Yeah! And basically, we did it because people were dying. People were dying of addiction and in overwhelming numbers that we have never seen before, and we have an obligation to do everything we can to help and that's what convinced me more than anything, and what convinced our staff more than anything. And the medicines work, and they work well, and that helped a lot in convincing. But the Betty Ford folks, their board actually agreed and still went through with the merger. It took over a year before their staff would even consider it. And it required a lot of them coming to visit to see what it was like in action and to meet our patients.

AS: So, they're very new to the Core Twelve Program? Within a couple years.

MS: Yeah. It might be three now or so for them, but it took a while. And they were really biased initially, but now they just love it too.

AS: So, what was the impact, and you might not know this, but what was the impact on staff at Hazelden when these deaths started happening and how were you finding out about them? Were you finding out through the grapevine or how was it?

MS: Well, it depended on how long they had been out of treatment and probably circumstances with their families. If they were still involved with us, we were absolutely finding out. If they weren't involved and patients who were still in our system were involved with them, we would find out through the patient once and a while. The family would tell us regularly. We have a quality review committee, which is like a peer review committee in a hospital that has to review every sentinel event. It would be like a death, a very bad outcome, an injury, a medication error, stuff like that. And so, I oversee that, and I am the liaison to our quality committee to the board, and so I was seeing everyone we were aware of, we reviewed. Which is really hard.

AS: Was there a time when there were a lot of them?

MS: It didn't suddenly peak, it just kind of slowly got to become more and then it kind of leveled off, but it's been... before that, before this opioid crisis, we hardly had any deaths. I mean there would be a suicide now and then, I mean we were not reviewing regularly deaths all the time, no, and now we are, which is horrible. But I can't prove this. But the numbers are so much more now, in terms of the numbers of people with opioid use disorder than it was at the start of all of this. And although we have more death, I think we would have way, way more without the use of the medication. I can't prove it, I suppose I could try.

AS: Well, hasn't evidence-based medicine already proved it? I mean, do you have to prove that it is you?

MS: It has, there is proof. There is proof in the literature. However, in our research study of Core Twelve, there were two-hundred and fifty-nine participants and they basically, almost a third in each group, a third on Naltrexone, mostly vivitrol, a third on Suboxone, and a third who refused medications. There were three deaths over the 2013 to 2017, in that two-hundred and fifty-nine people. One used buprenorphine and two used naltrexone, nobody with no meds. It goes against anything that we would have thought would have thought would have happened.

AS: Nobody with no meds?

MS: Nobody. We don't have all of the deaths because somebody could have died and not told us. I am intending to do... we lost a couple of people in our research department, so I haven't been able to carry this out, but I want to study like a thousand of our patients with opioid use disorder and look at all of their deaths through the social security death index, because they have gotten really much better by defining death by overdose. And then I could look back and see who was on no meds, who was on Suboxone, who was on vivitrol. I won't have the detail of how long they took it after treatment or anything, so I am not sure how much it will be helpful, but I will at least... No one has published anything like that, looking at death following addiction treatment, and that is so important. Because every single treatment program in the country is experiencing this. When we first started talking about this, I was talking about death and overdose at every single discussion that I had about it, because it is so necessary to the discussion if you are going to change your whole model, you have to have a good reason. There is no better reason. And nobody would engage in a conversation about that. No other treatment program, no other providers. They wouldn't even bring it up with me. And I would ask sometimes.

AS: And when you say treatment programs, you mean those usually based on Twelve Step programs? You weren't talking to addiction medicine doctors who were already using it.

MS: Any, any. I was. Yeah, to all.

AS: They didn't even want to talk about the death rates.

MS: No. No.

AS: Why do you think that is?

MS: At ASAM there was more and more discussion about that over the years, but I think people were so used to a field that barely ever had deaths that they just didn’t know what to do about it. And the other thing is that most treatment centers do no outcome studies. They do no follow up of their patients.

AS: Well, that's what really shocks me in my whole process of what I have been studying for this.

MS: Yeah, it's horrible.

AS: I don't even understand how that is possible.

MS: It's amazing. It's ridiculous. And so, if you assume that everyone is doing great and put on your website that ninety-percent are abstinent at one year, you can't look and see who died. Man.

AS: Right. Well and how can you even prove that people were abstinent.

MS: You can't. Yeah, you can just call them and ask them... [laughter] or don't even. Or just take that, say it's ninety-percent.

AS: Just say it, right.

MS: Because you can't know and there's no group that is ninety-percent, ever. [laughter] Even in treatment it might not be ninety-percent.

AS: Right, exactly!

MS: [laughter]

AS: Even when they are in the building.

MS: Yeah, yeah.

AS: Anything else that you want to say?

MS: Ah, man. Oh, just a little bit more about... you know, so I was talking about how we switched from basically a programmatic model and it wasn't all Core Twelve, there was other influences going on, but Core Twelve was the major influence in switching this through-out the whole organization. Part of it was going down a path of insurance, you know, and trying to work with insurers.

AS: Oh, okay.

MS: So, changing from, you're coming into treatment for four weeks whether you need it or not, right? Four weeks is it. Maybe you can stay for six, but four weeks of treatment and then you are leaving and there won't be any follow up. And that's what I had in 1974. Betty Ford was still doing that when we merged. Yeah, and there are some longer-term programs for the people that could afford it, because it was purely private pay, but hardly anyone could afford that. And there are still all kinds of programs doing that nowadays, private pay and long-term treatment. And some of that probably gets better outcomes because it is long term treatment.

AS: Because it is long term, right.

MS: It's just that no one can afford to do that, or like the one-percent can, I guess. And so, so now our model is that residential is for diagnosis and stabilization, and not just diagnosis if your substance use disorder, it's all the mental health too.

AS: It's about all of the mental health, right, right.

MS: And then, we want you to go to day treatment with sober housing in IOP, intensive out patient, prior to sober housing and then we want you seeing a counselor or somebody once a week, or every couple of weeks for a while. It's a chronic illness, let's be sure that you are really stable and that you've got a foot hold in recovery. So, that's how we started and how, because of the long-standing nature of the craving, like I said earlier, and other factors, and the high relapse rate with opioids, I wanted long term involvement. And insurance of course doesn't want to pay for that.

AS: Right.

MS: Shortening residential reduces the cost dramatically and allows for longer out patient.

AS: Oh... Right, right.

MS: Yeah, cause then you can shift your cost to the out-patient and get it really long.

AS: So, you were part of that, that thinking?

MS: Oh yeah, that's Core Twelve, that's was our thinking. We've got to keep people...

AS: Oh, that came out of Core Twelve? That has now been applied... you've seen the benefits for people who don't have opioid issues.

MS: Yeah, yeah, it's become our model as a whole now. Long term care for people. And there were other influences. It wasn't just me, but I was doing it both for Core Twelve and suggesting we do it because it is a chronic illness. [laughter]

AS: I know, yeah. So, what are you...?

MS: I mean my own experience was four weeks of treatment in 1974 and relapse in five days, no care of any kind, told to go to AA...

AS: No support groups, right.

MS: Which I didn't go to.

AS: And you were also a teenager.

MS: Yeah, yeah.

AS: You think of all of the risk factors.

MS: There was no professional...

AS: There was nothing for you.

MS: No, there wasn't anything available.

AS: So, what would you say your most proud of in your work?

MS: I would say Core Twelve itself. I am most proud of that for my entire career. Although, one thing I am doing right now comes as a close second.

AS: What's that?

MS: And over the long run, may be more important, I don't know but I've instituted a program that we can FIT. It's Feedback Informed Treatment and it is in our electronic health record where we have a portal for our patients. And they can go into that portal and we want them every week to fill out these objective tools about how they are doing. And they are in the literature, the research literature, all of these tools, well, not all of them. Three of them are in the research literature and are associated with positive outcomes from treatment. They've been used individually, never in combination. And then we added two tools that are used in primary-care. One for anxiety and one for depression and the new understanding of addiction as a disease is one of... initially it is all about positive reinforcement, "it feels good, I am going to do it again". Then it becomes negative reinforcement, "I feel so bad but when I get high, it's relieved". And that negative reinforcement is a release of negative stimuli. And so, the whole kind of new neurobiological theory of addiction is that it is negatively reinforcement associated with a combination of depression and anxiety and angst that is sort of driving continued use and driving relapse. And so, no one has ever measured to see if anxiety and depression are high... do people have more relapses? Or if they are low, do they have less?

AS: Right.

MS: And it is not necessarily anxiety and depression that are true anxiety disorders or mood disorders, it's just that negative affective state that is associated with addiction. And so, we added those two so we can do that and see, but also to see if they are predictive by themselves. So, now we have all five of these, we're asking our patients to fill out weekly.

AS: Woah.

MS: And they fill it out online, it goes into their chart and we're working with our electronic health record provider so it'll come up as a graph so you can see it over time, but then the next thing is we'll be figuring out interventions based on certain scoring.

AS: Things that they say? That they report?

MS: Yeah, to see if they are doing great, not going to change much, if they aren't then we better do some changing and what exactly that we change and what makes a difference. It is going to take a decade or more. That may...

AS: That might overshadow. [laughter]

MS: So those two I am very proud of.

AS: What's interesting about that though is that also has a really hopeful...

MS: It does! [laughter]

AS: That's a very positive... I don't know how to say it. It has a positive overlay to it, versus the intensity of the opioid epidemic which is that you are trying to prevent death.

MS: Exactly.

AS: This is a program where you are trying to like, keep people supported and feeling loved and cared about, right? Whereas with Core and with the opioid epidemic, we're just trying to keep people alive so that they might get better at some point.

MS: True. In fact, one of the medicines...

AS: It makes sense to me why would you excited about this. Sorry, you were going to say?

MS: But still, Core Twelve is currently the best thing I have done in my career. [laughter]

AS: Yeah, that's really good.

MS: Although, I did really like individual work with patients. This is probably more important in an overall scheme of things and probably has already effected more people than I ever could have by myself. So, yeah.

AS: That's great. Thank you so much.

MS: Oh yeah, thank you.

[End of recording at 2:06:02]