**Paula DeSanto**

**Narrator**

**Amy Sullivan**

**Interviewer**

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**At Minnesota Alternatives**

**Spring Lake Park, Minnesota**

Paula DeSanto -PD

Amy Sullivan -AS

**AS:** This is Amy Sullivan. I'm in Spring Lake Park, Minnesota at Minnesota Alternatives with Paula DeSanto. Paula can you state your name and say that you give me permission?

**PD:** This is Paula DeSanto and I give Amy Sullivan permission to record today.

**AS:** Thank you. One of the things I like to start off with in the interviews is kind of just to get more of a full picture of who you are. I'm interviewing you because you're a professional in the field but I'm also trying to get a sense of people's journeys to where they ended up. If you could just give me a little background. You can spend as much or as little time on it as you want. Where you grew up and stuff like that. Who you are.

**PD:** What inspired me to be doing what I'm doing?

**AS:** What inspired you.

**PD:** I grew up in Rochester, Minnesota. I was, I am, the daughter of a physician. My father's a physician who worked for the state hospital down in Rochester. He was not in the field of psychiatry per se but his job was to be the primary care doctor for the internal medicine doctors that took care of the patients that were at the Rochester State Hospital that got physically ill. I was born into a home that was actually on the state hospital campus. We would go to the hospital, that was back in the days when the boundaries were all blurry. We would be taken to the hospital. We would be attending events that they had at the hospital with the patients. My mother tells a story once when we walked into a bathroom in a hospital and apparently there was feces all over the wall. I looked at her and I said, "I'm not cleaning this up." She says, "No, you don't have to. That's okay."

There were times when we would be at home, it was an open campus back then, it was much more of an asylum and patients were free to roam about. The patients would come into our home. She shared a story once where a patient came in and immediately went to the drawer and was rummaging through the utensils drawer. She got quite alarmed, she thought maybe he was looking for a weapon. It turns out he wanted a bottle opener. There are some interesting stories then. I have memories of my father bringing patients home. They would have a bunch of cuts on their arms. I was curious about why they would do things like that. It set a clear impression that people with mental illness are people that are in trouble and aren't to be feared or aren't pathological or somehow different than us. They're just ill. Both my parents were very compassionate people. There was just a culture of compassion in our home. That was kind of early experience with mental health issues. We did not have any experience with substance use disorder dynamic in our family. Neither of my parents used drugs or alcohol at all.

When I was a young child I was pretty independent and willful and was good at negotiating. I was quite certain I was heading for a career in law. I just assumed that was what I was going to do. I went to a couple years of community college in Rochester then moved up to Minneapolis to start at the U of M to continue on towards a bachelor’s degree in political science with the anticipation that I was heading towards some kind of prelaw program. Then on a whim decided to take my college tuition money and go on a road trip. I took the quarter or semester off with a friend, went out to Arizona and just had a lot of fun. Then some sort of epiphany occurred to me and I decided I didn't want to be an attorney. Instead I wanted to be a social worker.

**AS:** What year was this or what year were you born?

**PD:** I was born in '61. Graduated high school in '79 and moved up to Minneapolis in '81.

**AS:** This is the early 80s that you go on this road trip. That's awesome. Do you have siblings?

**PD:** I do, I come from a family of five girls.

**AS:** Where are you in the family?

**PD:** I'm number two. Some other kind of interesting stories; I was caught in the seventh grade with marijuana in school because it was around and a lot of people were dabbling with it in the seventh grade. I was wanting to be kind of a leader. I bought some pot and a bunch of us were going to go to a movie that night and go and smoke some pot and try it out. It really was very experimental at that time. We were young. We were in the bathroom smoking cigarettes as well. The things we did at young ages. I had this bag of pot in my lunch bag. We got caught smoking cigarettes and they found the pot.

**AS:** There's probably more going on here. We're going to take a look.

**PD:** Curiously though I was sent to the assistant principal's office and he said, "I'm calling your mom." I said, "Let me call her." I got on the phone with my mom and she was a very rational person. She said, "What's going on?" "I'm in the principal's office. I got in some trouble." She said, "Smoking in the can." I said, "Worse." "Drugs?" "Yep." She came and picked me up and I was just sent home for the day. There actually weren't any consequences from the school except that they wanted me to be evaluated by a counselor for drug and alcohol problem I guess. I remember that night I went home and my dad took me out to play tennis instead of going to the movies. We went and played tennis and I told my parents it was experimental. I wanted to kind of be cool so I was the one that bought it. I had money. We were all going to go do it but I didn't have a problem. It was true. It was a true story. They accepted it. The counselor called a couple months later saying to come in for an evaluation. I told them I didn't need it and my mother supported me so I never got the evaluation.

It did launch a fairly longstanding experience with cannabis. I was blessed with this, my father's from the Philippines, he came from the Philippines to Minnesota to study medicine. As a result of some of my Asian ancestry I lack and enzyme that breaks down alcohol so I have a constant state of Antabuse in my system. If I drink I get rashy or uncomfortable and my heartrate increases. So I don't drink. Alcohol was never my thing. A lot of my peers were in to alcohol at early ages as they were into cannabis and speed and LSD and mushrooms. I dabbled pretty hard from kind of junior high through high school. I had the good fortune to have enough common sense and supportive home and family environment that I really never got into trouble. I was able to maintain my academics and I started working at fifteen in the food industry. Despite having a pretty intensive with substance use, I bet I was stoned almost every day for three, four, five years. I managed to not get in much trouble.

**AS:** And you didn't get caught again.

**PD:** I didn't get caught again. Curiously by the time I graduated high school I pretty much had outgrown most of that stuff and was able to stay out of it.

**AS:** What about your sisters?

**PD:** They weren't. They didn't venture. Maybe a little casual alcohol use but they were pretty, and a little bit of pot dabbling but they didn't like the experience with cannabis that I did. They stayed away for the most part. There really wasn't any direct intro through my siblings or my parents. When we start to talk about nephews and nieces and second generation there's more stuff going on.

**AS:** What about your mom. You said your dad came from the Philippines to med school. Where's your mom from?

**PD:** My mom is from northern Minnesota, small town called Breckenridge near Fargo. She's got German ancestry and she was working in Minneapolis as a secretary. She hadn't had a college education and they started dating and she got pregnant and they got married. That's kind of their story. They kept trying to have a boy and five girls later.

**AS:** My parents did the same thing, they tried. They stopped after three.

**PD:** After three girls? That question comes up frequently about what's your history? Are you in recovery? I get that a lot from people, from clients. I say, "I have a pretty extensive experience with drugs and alcohol but I was fortunate that I really never ended up developing symptoms of an alcohol use disorder." I might have maybe had one or two. I don't think it was ever really anything beyond mild.

**AS:** Your life didn't spin out of control as a result. It didn't take over your life.

**PD:** Right.

**AS:** I want to come back to that later when you're talking about clients. We'll just try to remember that about why is it that in this field people feel like the person that they're talking to or confiding in has to have had that same experience to effectively relate and treat to them when in all other aspects of psychotherapy and medicine we don't expect, we don't have that expectation. Maybe we can talk about that a little.

**PD:** Do you want to briefly cover it now?

**AS:** Let's just talk about that now.

**PD:** That was a design of the field. The field was created typically by people initially who were in recovery.

**AS:** The Minnesota Model.

**PD:** Exactly. When it started they chose to adopt AA.

**AS:** And help people help others.

**PD:** Absolutely that was a key part of it. The system created that phenomenon. Clients don't really cling to that. My response to them typically is, they may be curious but I typically say, "You know, while I appreciate that's a concern for you and that you feel that might help me better identify with you. I think that there are lots of ways for me to be able to identify with you. That's why having an open heart and a good skill set. I'm a woman, you're a man. I can't identify with that fully. I'm not your parent. So you're saying that anyone who comes in here with a mental illness, if I don't have that mental illness I can't help them. If I don't have that personal background, I can't help them. There's no way we can walk in everybody's shoes. What matters more is that we're people that are really interested in trying to help you. We're compassionate. We're welcoming. We have skills. We have some skills that we can offer you if you want them. Skills and knowledge."

**AS:** Then they kind of back down. Would you say part of that, the way that's been created has to do with stigma and the power of stigma? That if I haven't battled with addiction myself they might see that as there being some stigma because stigma is so strong against it around us?

**PD:** I don't know if it's stigma so much as the system has created this idea that there's normies and there's abnormies. You somehow are a group separate from us. If you don't actually have this thing they've convinced you that you have. This genetic disease, this abnormal brain that makes you unique. We're all kind of in it and if you're not in it you're separate from us. I think that unfortunately that traditional 12 Step disease based approaches have created that divide. They created it and fueled it. That language still comes up. I'm like, "What?" We spend a lot of time pointing out our commonalities and how blurry those things really are. The difference between someone with a substance use issue and not and how things happen on continuums and different levels of severity. Client today, staff tomorrow. Staff today, client tomorrow. It's really very blurry. We all have a lot of the same conditions.

**AS:** It's just how they impact our lives.

**PD:** I think more and more that we recognize the environmental factors are significant. In terms of the stressors that people are struggling with in the environment that they're in in terms of their ability to navigate a lot of the challenges. We're looking at really highly stimulated people today. I think it creates a lot of unsettled nervous systems out there. I think that's hard too. Everyone's all amped up all the time. They get their first drink or their first benzo or their first opiate.

**AS:** And they finally calm down.

**PD:** Right.

**AS:** Let's go back to your epiphany or your moment on the road trip where you decided that you wanted to do social work and not law. You had moved from wanting to maybe be a police officer to lawyer. You always wanted to do something for people?

**PD:** Yes.

**AS:** It just changed.

**PD:** Being a lawyer was really being an advocate.

**AS:** You were moving towards that.

**PD:** Definitely.

**AS:** What happened after the road trip?

**PD:** I think I just had a chance to slow down a little bit and kind of reevaluate where I was heading. While political science was interesting to me I think I realized it was about human relationships. I went back to the U and changed my major from political science to human relationships. Then I started a different course.

**AS:** By that point you were what? A junior?

**PD:** I was.

**AS:** Then where did you go from there?

**PD:** Then I finished up the human relationships program at the University of Minnesota and then right on the heels of that I started working in the field of mental health in 1981. Right when I moved up here I got a job as a mental health worker without any training, without any degrees. I just got a tech type job in a big large residential facility. They hired me quite frankly I think because when they asked me, "What's the difference between mental illness and mental retardation?" I knew the difference. I think that was my credential. I started working in a big facility, a two hundred bed facility in St. Paul as a mental health worker. That just kind of launched my career and I've been doing it ever since. I finished my undergraduate work and I was working by then in a higher level position as a mental health counselor once I got my bachelor’s degree. That went right into a master’s degree.

There was an employer that I had that was very innovative and very person-centered in her approach and she pursued work coming out of Boston University, the Center for Psych Rehab, Dr. William Anthony's work. Back then it was highly progressive. The idea that there's a patient movement out there. That there's an approach toward mental health care that doesn't fit the positions in charge that it really is the person that should be in the center and the doctor and the medical team are one part of that. As a patient my goals, my wants, and my needs should be respected in this process. That was the heart of this work coming out of Boston University. I entered a master’s program at the support of my employer at the time to get a masters in psychiatric rehabilitation counseling.

**AS:** Did you do that in Boston or did you do that here?

**PD:** It was both actually. I went out there for intensive course work and all the clinical work was done here through transcription and actual CDs and cassette tapes.

**AS:** Cassette tapes, not even CDs.

**PD:** Record and play buttons.

**AS:** You'd get your course content that way.

**PD:** I'd get my clinical work, yes. It was a program that was designed for working clinicians. The work was done on audio and sent to my instructors to evaluate. Then I'd be flying out there periodically for intensive coursework. It was kind of a half, half.

**AS:** Pre-internet.

**PD:** Exactly.

**AS:** Pre online course work. We moved around back then.

**PD:** That kind of helped solidify some credentials anyway. Then I worked for that organization for eleven years. I ended up working as a director, developing a new program. It was called, supportive living services that basically provided an assertive case management type service to people where you go out into their homes and help them manage their mental health issues in their homes. Very boots on the ground, community based, do what it takes. That was after working several years in the residential intensive mental health. It was all mental health really. I worked for that organization for eleven years.

Then I got head hunted by the department of human services to go out to Anoka Metro Region Treatment Center. They were at that time moving from their old state hospital campus to their new multimillion dollar facility. The commissioner was spending millions of dollars to build this new state hospital. My job was to transition, help them transition their clinical services from a kind of highly medical outdated model to a person centered progressive model as they moved to their new state of the art facility.

**AS:** Do you remember what year this is?

**PD:** It would have been about; I can look at my resume.

**AS:** That's okay. You can give it to me later.

**PD:** Let me see, early 90s.

**AS:** May I ask you a question about the history of mental health? In the 80s Reagan puts all kind of mentally ill people back out. Would you say your career at this point kind of reflects what, you were going from an institution into people's homes? Did you see positives and negatives? We tend to only think of New York City and all the mentally ill. Do you remember any of that? I find that part really interesting.

**PD:** Definitely.

**AS:** It was probably really good for some people and really horrible for others.

**PD:** Absolutely. I think any time you run into an everybody needs the same thing kind of thinking you're going to run into trouble. The assumption back then was everyone needs to get out of the asylums and in apartments on their own. For a lot of people that was the last thing they needed. Granted there was the development of group homes. The group homes back then weren't actually homes. People could be in them if they needed to be in them. When I first started in mental health, in residential mental health people could be in them for years. They were really a place, they were transitional homes and then you could go when you wanted to go, when you needed to go, when there were resources to accommodate your next step.

**AS:** But you could also just stay.

**PD:** Yes, you could stay long-term and they'd redefine them to ninety day programs. A sort of intensive treatment, residential treatment. With the idea then ACT teams, assertive community treatment, wrap around teams, supportive living services like the programs that were developing would help people transition from state hospitals to more group homes, short term residential treatment into long-term stays in communities in their apartments. Good, yes absolutely but most people probably would prefer to have their own places and be able to be active members of their community. For a lot of people with severe substance use issues and mental health issues living alone in an apartment was not considered to be an environment that they're going to desire. It just led to isolation and a return of symptoms and a lack of community. They weren't naturally prone to community integration. The community wasn't welcoming. That continues today.

There's some kind of pendulum that moves all over the place but there's definitely some recognition that we need to have long-term community type settings for people. It's not the idea that everybody needs to be alone in an apartment is the best option. Congregate living, with lots of supports on site where services can kind of come in and out of people's lives based on their current acuity. That way have people that can be available twenty-four seven if needed but not programming them if they don't need the programming, being flexible. There's been lots of heroes up there who have advocated for a return to some more of that community housing models, cooperative housing, supportive housing. There's a lot of regulations now that prohibit it because you can't have too many people living together or you move into these institutes for mental diseases clauses that prevent you from actually developing programs that house people with disabilities. They want to be integrated. We could go on and on about that.

**AS:** Then there's all the zoning and the neighbors and people who don't want those people in their neighborhood.

**PD:** Right. My job was to actually close two of the units at the state hospital and open up then two sixty bed units, one in Bloomington and one in St. Paul. Then transition the rest of the units to a facility. Integrate their mental health and substance use disorder care and bring patient centered state of the art services to the state of the art hospital.

**AS:** At this point are you an administrator?

**PD:** Yes.

**AS:** You've kind of worked into that. You're not dealing directly one on one with residents.

**PD:** I did a fair amount. I had a primary treatment unit that was a psychiatrist and a social worker and some other disciplines and I was the treatment director on the unit. So I did a lot with the units. The two sixty bed units I was hands on there trying to direct the care as well and then trying to get the hospital to do stuff differently which continues to be an ongoing struggle. It was real apparent to me that while the intentions from the department of human services might have been good in terms of we really want a person centered, state of the art, mission driven services but there's so many conflicting interests because we had also had a public safety medical model. It was a very difficult system to try to change because everybody's worried about risk and liability.

AS: Are people hurting themselves or hurting other people?

PD: I did that for five years and then said, "Oh boy. I'm not committed to them." Another epiphany. It was. I had a dream that if I stayed at that job I was going to get cancer. It was one of those really, really obvious messages and so I listened to the dream. I gave them a year's notice and I left. I worked my ass off for another year and gave up wrapping up these projects I was deep into. Then I moved on. I went traveling for six months and then got a job with People Incorporated which is a very mission driven pretty state of the art mental health organization. I worked for them for nine years directing a campus on the North side of Minneapolis. I had a nice integrated network of services there that I helped develop and create and led a big capital campaign and built buildings. That was great. I thought that was probably where I was going to end up retiring. Then I had another epiphany. The universe keeps kind of just telling me what to do.

**AS:** You listened.

**PD:** It was a Sunday afternoon and I was in the tub and this message said you need to open a drug and alcohol treatment program. What are you talking about? You need to do this. Alright. At that point I was feeling pretty discouraged about having worked in mental health for decades now and seen the revolving door. All the stuff you talk about in your chapter, inaccessibility and the same things over and over that repetitive nature of things. This is a continuous loop, barriers to access, unwelcoming, one size fits all, blaming the family, all the stuff. I saw it and I saw it firsthand, I heard about it from clients over and over. It's just like how long are we going to keep blaming the client for the system's failure?

I'd been trying to champion mental health person centered care for all of my career really. Mental health has been enormous strides towards moving toward a patient to patient recovery movement which is impactful. I think we've come a long way in mental health in terms of making that a rehabilitative experience and much more person centered. We have a long way to go. But with drug and alcohol we were still stuck in the 50s. There we were. There I was. I guess in 2009, April basically given marching orders. We opened that September and here we are today trying to recreate the system.

**AS:** Who would you say your marching orders come from in your epiphany?

**PD:** I think they're just universal.

**AS:** Something bigger than yourself.

**PD:** Yes. I think I'm here to provide service and to give guidance. I think that we all have access to that if we tap into that flow and listen, if we're willing to listen and be open. I think I appreciate you emphasizing that because I think that probably is what kind of keeps me going. I just trust that we're doing what we're supposed to be doing and we're doing the best we can.

**AS:** In the moment where we are.

**PD:** Exactly. That's all you can do. I'm not guided by fear; I'm not guided by liability or worry. Let's just do the best we can to create an environment where people feel welcome and comfortable so they can get out of survival mode and start to open up and trust and heal. Whatever that looks like. Do the best we can with that. I just have an enormous confidence that if it all comes tumbling down then it’s time to do something else. My survival doesn't rely on anything. I trust that regardless I'll be okay. I have two operating principles: how's this going to read in the *Star Tribune* with big decisions? Most times it reads fine. It'll read okay. How will it read? That's kind of how we make decisions. Most of what we do I think you can justify pretty clearly. It doesn't fit the norms or the rules or always the safest routes but builds a hell of a good argument. I can sleep with that and worst case scenario it all comes tumbling down, I'm going to be okay. There's other stuff to do. That keeps us in the flow. When you're in the flow the universe helps you. It just does.

**AS:** Were you raised in a religion at all? Did your parents model this or did you kind of just get this as you grew?

**PD:** My father's Catholic and he tried to impose it upon us but my mother she's a self-proclaimed atheist. She didn't support him. No way he's going to round up five kids and take care of it. There was this attempt at Catholicism but the closest we got to a church was the bingo hall probably.

**AS:** So you didn't really have a formal religious education to speak of. That's really interesting. Okay so 2009 you started Minnesota Alternatives. Did you get your PhD?

**PD:** No.

**AS:** You did not get your PhD. Okay so tell me how did this come about? You thought "I'm going to open up my own clinic."

**PD:** I had been doing program development for a long time. My first job I was quickly into leadership roles and development programs. The state hospitals development programs and people incorporated my job as to develop programs. I know how to do it. I know the rules. I know how to work the process of getting a program. I just kind of started networking to figure out where would be the best place to do it. At that time, because of a rich history working in Anoka County it seemed like this would probably be the easiest place. That's where we started. We started in Columbia Heights in 2009 and moved up here to expand in 2011, into Spring Lake Park.

**AS:** Now we're talking about Minnesota Alternatives?

**PD:** Correct.

**AS:** Just for the record here.

**PD:** Minnesota Alternatives, that's what it's been ever since. The model has been evolving as we continue to get feedback from the clients about what's helpful and what's not helpful. We had a basic structure and the structure that we used was kind of drawing from my heroes. Certainly William Anthony and person centered care. Gabor Mate in terms of understanding trauma and attachment and the power of environment. I'm a fan of Mark Lewis, Joe Rispenza the concepts of being able to evolve your brain and looking at neuroplasticity and our capacities to harness, our ability to train our brains. Marshall Libhann has done a lot of skills and my training of Boston University was very skills based and helping people develop recovery visions, rehabilitation goals they call them.

Basically was a vision. What does that vision look like? What do we do to help you realize that vision? Very person centered. You decide and we help you figure out how to get there. That's always the paradigm with which I've worked. That continues to be the center of everything we do. We build in more educational information about what's the best of the best and ways to help support people through a lot of trauma work for example and individual therapy. Helping also with accountability. If people need accountability we can do that too. The system’s heavy on accountability that's not the piece that we emphasize but for a lot of people that's what they want.

**AS:** The addiction treatment system?

**PD:** Absolutely. Probation and addiction treatment are in bed together. What's with that? That's just absurd how that developed. We kind of think about these pillars of therapy and counseling and welcoming and comfortable and really priority on engagement. Then we have education which hopefully is science based state of the art with a heavy emphasis on true informed decision making so that people know what the risks are. Let them know the opportunities and the risks and they get to decide. Heavy emphasis again on harnessing the powers of neuroplasticity and then overcoming well-worn pathways from addictive behaviors or any behaviors that we've been caught in for a long time. Support, education, and accountability. People really want accountability and we can do that. We can do that if they need it. That has been the goal for the last nine years, is to offer an alternative for people other than traditional treatment. Our program's open ended, people get to decide how long they come, how often they come, what they do while they're here. If they want to just come for skills fine. If they want to stay for the process, the goal is that everything we offer people participate in because they find it helpful.

**AS:** If the 12 Step program doesn't resonate with them you have other options.

**PD:** Yes, and if it does that's fine too. A lot of people actually are working the 12 Step programs and coming here. They're not mutually exclusive.

**AS:** What about medication? How have you approached that?

**PD:** We are not a provider of methadone but we have prescribers who can prescribe sabaxone and there are addiction psychiatrists who can prescribe sabaxone and or any other medications that help reduce recurrence or severity of recurrence. We're big proponents of medications if people want them. We have found them to be incredibly helpful along with psychiatric medications.

**AS:** Do you work in conjunction with methadone clinics? Is there a continuum of care or do people have to have those separate services, can what they do here count for what they might have to do at let's say Valhalla?

**PD:** Absolutely. We work real closely. We have a lot of clients who are at Valhalla and so there’s release signed and then we coordinate the care. It works really well because a lot of the clients that we work that they're working with they're fairly complicated. There might be a lot of complex medical issues involved as well. We bring in primary care. Then we kind of work together in terms of how we can best support people. It works so well because they several paradigms in terms of trying to reduce barriers to engagement and keep them coming. And harm reduction. When people ask what your program philosophy, I don't throw out harm reduction because people think all kinds of things when you say that. I say, we are person centered, meaning we embrace a whole range of goals from abstinence to harm and risk reduction. People get to decide.

I think that idea, that people come because they find it helpful. We teach skills on a regular training curriculum like you would go to college. If you demonstrate that if you get this you, you're integrating it then don't go to that class that day. You don't need to be there, it's not relevant to you. If you want to go because you want the reinforcement because you learn through repetition, fine. If you want to go because you want to support your peers in learning and be an example, fine. You don't have to. You don't have to do stuff that you already know.

**AS:** It keeps people from feeling bored and resentful.

**PD:** Exactly. Ironically what we find is that most people don't want to stop. We have to push, gently encourage people out.

**AS:** They're feeling very heard and at home here.

**PD:** Why would I stop coming to something that helps me grow? Why would I stop? You've got a good point. We really try to validate that for people but we have services on site. As people are getting ready to go and have got it, they've really developed mastery, they have gained or regained control of their lives then we say, "Why don't you start dabbling with some support services." Just start going over there while you're still actively in treatment and check out some of the support services.

**AS:** But that you also offer here.

**PD:** Yes, through the non-profit. Try those then that's what helps people.

**AS:** What do you offer there? Are there names of programs?

**PD:** Yes.

**AS:** What are those called?

**PD:** There's a co-ed, these are all led by peer specialists these are people who have gone through some clinical cure specialist training. There's a co-ed group on Monday nights they call it a peer support group. Tuesday we offer group for family and loved ones based on CRFT, the Community Reinforcement Family Training. Wednesday they're gender specific. There's a men and women's group. Also peer support groups. Thursday we have Smart Recovery. Then Friday is movies and a meal. You can just drop in from four to eight Monday through Friday and just hang out.

**AS:** Just be there.

**PD:** It's all anonymous. There's no paperwork anybody needs to fill out. We don't require that they prove that they have any kind of diagnosis. It's free. It's like an AA club in that way. There is no expectation that you have to say anything about who you are. There's no paperwork tracking you.

**AS:** This is a boring question but how are insurance companies dealing with this program?

**PD:** Well, really well. Curiously, you'd think they'd start to say, "You know what? That has been there three years, I think it's time." But they don't. We have yet to have an insurance company cut anybody off. I think because it's outpatient care and they understand that.

**AS:** It's counseling. It could be one on one counseling and group therapy. Do you offer group therapy?

**PD:** Both. I think that because it's not five days a week, five hours a day people might come once a month. People might come...

**AS:** Someone here is saying, they're here so they get billed?

**PD:** Absolutely. The health insurance companies understand that substance use disorders on the severe end are not episodic, typically, and don't just kind of go away. It's a long distance through the whole process. It's a severe mental illness. Generally, people need to have the opportunity to move in and out of services fairly seamlessly if their acuity changes, if their needs change. To have a system that says, "We'll hang in there with people long term as they go through the ups and downs of their illness and then keep them engaged." I think four years was our longest client. The health plans, they're like, "We love that. They're still engaged. It's keeping them from more higher cost services or emergency rooms." We're in network with all the health plans and I think if you ask most of them they say we're a good provider.

**AS:** Did you have to sell this to health insurance companies or you just started it?

**PD:** They were thrilled. The health insurance companies are fed up with everybody getting the same old same old.

**AS:** And relapsing.

**PD:** Not seeing any outcomes. We've been measuring outcomes.

**AS:** That's at thirty, forty thousand dollars a pop.

**PD:** Exactly. High cost and ineffectiveness. We've been tracking outcomes from the beginning and we have really strong outcomes.

**AS:** Do you know those off the top of your head? You can give them to me later.

**PD:** Probably close to sixty percent successfully complete. That shows reduced use, it shows higher quality of life. It shows less consequences as a result of use. It shows that they're making changes, moving along the process of change. We've been doing twelve month follow up. It's ninety some, high ninety percent of people are out there living with reasonable to high quality of life and not problematic use. Probably half of them at any given time might still be using.

We just did another big evaluation; we just did another big call to try to get twelve-month post follow up response in terms of how people are doing. We've been able to get maybe close to two hundred people and they're doing really well. They're doing well. We've been tracking outcomes from the beginning. We're just doing another, we have all our 2016 outcomes that are all being compiled and all the client feedback. Every time somebody is discharged we do an admission and discharge survey to assess these things pre and post and at twelve months. We have data. When I went to a health insurance meeting and they have all these providers come and they're like, "We want to talk about your outcomes" and nobody had anything. They had admission and discharge stats but nobody was measuring...

**AS:** The other providers?

**PD:** Yes, they were like no clinical outcomes.

**AS:** How can they get away with that?

**PD:** Exactly. Right? I got three minutes Amy. Are we getting close?

**AS:** Sure.

**PD:** I'm looking at this and we've kind of gone through most.

**AS:** I forgot to ask you.

**PD:** I got through most.

[Heavy machinery noise in background]

**AS:** Let's sit over here a bit. Well it's only making a little bit of a buzz on here. I think we're still recording.

**PD:** I'm mostly curious about what it is.

**AS:** You talked about your best practices. If you could predict something that would happen, something good to happen regarding addiction treatment what would it be? Or change the system somehow what you see where there would just be a huge shift? What's going to take?

**PD:** I think we have a mental health system that we can use to model things after. Mental health has a lot of community based services. Therapists see people long term; you don't cut them off because they have problems with their symptoms. You should be able to see your counselor long term. You should be able to get wraparound services in your home if you need that level that would include a prescriber and a nurse and a counselor and a therapist. That you have prescribers who are available to you long term that when your symptoms become more severe they don't cut you off. If you need outpatient programs that you should be able to move through them fairly quickly without having to go through complex assessments. You should be able to stay engaged with them long term. A much more robust peer support system so that we've got peer support centers.

**AS:** Places where people can go when they're struggling or just want to have company.

**PD:** And have outreach workers too so that their peers can go out in people's homes and reach out.

**AS:** Really model it like much of what we do...

**PD:** With mental health. We should be able to do a lot of the medications in primary care. One of my big questions right now, and I'm working closely with Allina with this, is that we help support their primary care providers to provide medications to help reduce recurrence and that they really start to robustly serve this population. The way that we can support them is that we kind of do these warm handoffs or agree to these long term partnerships. And say, "If you've got someone that you see in your clinic and you're worried you call us. We'll go see that person. We'll check in with them. If you want us to monitor their medication, we'll come down to the clinic and get their meds."

**AS:** Instead of having two separate silos that don't really communicate with each other. More coordinated efforts between it.

**PD:** Absolutely and whether that's if we're co located which I think would be the logical thing to do, that we actually co locate right in the clinic. If they have somebody that they see and they want to refer them they can just send them down the hall and a very welcoming drug and alcohol or co trained mental health professional will start to talk with them about their needs. Then not assuming that everybody needs treatment but they would get referred to a mental health therapist or they just do some early intervention kind of prevention.

There's a lot of people that come through the drop in. I started talking to one of them and it’s like, "You know what. You don't need treatment. Here's a rethinking drinking booklet, here's some information on Naltrexone, here's some strategies. Here's a screen so you can actually monitor when you've gone from recreational into problematic use. Here's actually the screen they would use to determine here's the symptoms and if you have two or more you're kind of moving into trouble. Look at all this. Call me." A lot of people are like, "Oh God that's so helpful." As opposed to "You've got to come in and get this three-hundred-dollar assessment."

**AS:** And then go away for thirty days and disrupt your family.

**PD:** Or this assumption that if you're an outpatient and you have a use episode that you need residential. That's the most absurd thing I've ever heard about.

**AS:** You're in outpatient, you relapse, and then you have to head back in.

**PD:** To residential. We accept goals other than abstinence because there's this whole theory of cross addiction that if once you have an alcohol problem you automatically have an opiate problem. Or if once you have a cocaine problem you automatically have a cannabis problem. It's not founded. It's inaccurate.

**AS:** It's not based in scientific evidence.

**PD:** It's not based in our neurophysiological capacity.

**AS:** The Minnesota Model, that's why you opened this place. Is to offer something different.

**PD:** The other thing is I'm not trying to covet this. I want this approach to be available to anybody who wants to try any parts of it. I do lots of training. I give information out. I don't require that you go through these high cost trainings in order to use the stuff. I wrote a book that's just very simple. Take it, use any of it, any pieces of it you want. Call me. The more that people just dabble with the ideas. If you're just starting to dabble with the idea of it, letting someone stay in your program without embracing that goal of abstinence and you feel a little bit uncomfortable about it call me and I can help give you some reassurance that it's going to be okay. This is how you can cover your butt if this is what your concerns are. It's happening. There's lots of providers now that are lining up, if you will, starting to try different things. The response to this program has been overwhelming. We cannot keep up. We cannot even come close to keeping up.

**AS:** How many people are you serving right now?

**PD:** Probably one hundred.

**AS:** Then you're opening a second location in St. Paul. When does that open?

**PD:** Hopefully in February. At any given time, there's a waiting list which is awful.

**AS:** But your capacity here is one hundred?

**PD:** About.

**AS:** Will that be about the same there?

**PD:** Probably a little less, it's a smaller space.

**AS:** Thank you Paula.

**PD:** I just want to say. Amy what I really appreciate about your article is I just want to comment that I really like your ideas about mothers feeling empowered to start to challenge the status quo. All the judgement that the system gives, the blaming the parent, and your comparison to having a child in the military. All your energy is just wondering is this person going to make it through the day. Your priority is to preserve life. At what point, how long can you do that? Then it becomes your own survival questions.

**AS:** Which is what we talk about in the rooms in Nar Anon. Okay my life is out of control now because of this. And what you're saying is we don't have to get to that point.

**PD:** Right, hopefully not for sure.

**AS:** It's what most people get to.

**PD:** How do we help support people?

**AS:** The addicts are told when they hit their bottom, then I'm going to funeral more often than I really care to. For people who shouldn't be dead.

**PD:** Absolutely. We're also a distributor of NarCan too.

**AS:** Good.

**PD:** I just really recognize and appreciate how you package this in terms of really helping people understand what it is to be a parent of someone who is struggling to help preserve their life. How do they stay well enough to survive that experience or even better how do they stay well enough to become an agent for change?

**AS:** Thank you for that compliment. That means a lot to me. I really respect what you're doing here. I wish I'd known of you some years ago. How it's unfolded is how it's unfolded. She's alive and doing well, thriving with medication assisted treatment I should say.

**PD:** That's good.

**AS:** It's been a lifesaver. I'm the preacher for it. I tell anybody.

[End of Recording]