**Mary McCarthy**

**Narrator**

**Amy Sullivan**

**Interviewer**

**April 14, 2017**

**Minneapolis, Minnesota**

Mary McCarthy -**MM**

Amy Sullivan -**AS**

**AS**: This is Amy Sullivan. We are at Cafe Southside in Minneapolis. It is April 14th. I am with Mary McCarthy. Mary, do you give me permission to record this interview?

**MM**: Yes.

**AS**: Can you start with where you grew up and your childhood, early adulthood, your life?

**MM**: Sure. I was born in Washington, D.C. It was kind of a crazy story so I won’t go into a lot of detail on that, but there was a lot of conflict in their relationship when I was little. They were breaking up and getting back together a lot. In about second grade my mom got a job offer in Colorado Springs. She worked for HUD [Department of Housing and Urban Development], so we moved to Colorado. He ultimately ended up leaving her at that point in time and she lost her job. A whole bunch of things happened, which brought us to Minnesota.

The next year we ended up living in Minnesota. It was third grade spent until sixth grade here. Then we moved up north. She was in a series of not great relationship with, ironically, people who were addicted primarily to alcohol. At least that’s what I knew at that time, which was forty years ago. My sister is forty-two now, and she was born during that period of time.

My parental family background is two families of raving alcoholics. My paternal grandmother started off the day every morning with a screwdriver or a Bloody Mary and ended the day with gimlets and martinis. She was kind of buzzed perpetually. My mom’s side of the family had a lot of alcoholics, primarily the men in the family who were also abusive at times. My grandmother had grown up in Chicago and left an abusive husband. She moved to Iowa. There are a lot of family secrets. My mom kind of reinvented herself around the time I was born and continually thereafter. That is a whole other story that we won’t record! From an anthropological standpoint it is kind of an interesting story. There has been a lot of abuse in them.

As I mentioned those two relationships after I was born that produced my sisters were both with people who were struggling with alcohol and maybe other substances too. One of those individuals I don’t have contact with deliberately. At the last count he had twenty-three children. I’m not lying. One story is there were a couple of families with multiple kids, like four or five, and at one point he had beaten them so severely that another mom had to take care of the kids while the other mom was in the hospital. A lot of that kind of behavior.

When I was younger there was a lot of violence because of the drinking. When I was thirteen I ran away from home and went to live with my dad. At that point we were living up north on the reservation. I went to live with my birth father and stayed with him for a year and a half.

**AS**: Your birth father is from the reservation?

**MM**: No. My stepfather is. My birth father was out on the East Coast. I moved back to Maryland and was in Maryland for a year and a half and then I came back to Minnesota and that’s where I finished high school and did all of that. Ironically, after I ran away a lot of stuff changed. The use didn’t change, but the abuse that I experienced changed. There were benefits to it I guess. If you are familiar with the ACE Study [Adverse Childhood Experience] I score an eight, roughly. That kind of gives you a sense. The fact that I operate and function is probably a pretty good thing. I smoke cigarettes, but that’s it. Sometimes I think that is part of the reason it is so hard for me to quit. Looking at trauma as we have in the last few years has brought that to the forefront for me.

Continued through high school a couple of episodes of drunken fights and things like that in my home. I started to get to a point where I could stand up to it to some degree. I had two smaller sisters that I was protecting. In the meantime both of my grandmothers had died in that period of time, which was really traumatic as well. One of them I think was driving, or had only ever been the partner of someone who was drinking. She had kind of grown up with that as an adult woman, but I had never experienced something like that. The grandmothers even though they had their issues didn’t seem to transfer that a whole lot.

**AS**: And they were important to your growing up.

**MM**: Yes, but they both died when I was ten. They died four months apart and it was traumatic. I am actually the namesake of one of them. The drunk one, I hate to say it, I was her namesake and was her only grandchild. It was devastating for me. Both of them at the same time. I still mourn them to this day.

Ironically my stepmother, or my stepfather’s mother, within that same eighteen-month period of time was killed in a car accident on New Year’s Eve and everybody in the car was drunk. My whole extended family, all of the adults, were in the car when the accident happened. It was a lot of trauma around use and drinking. I’ve gone through my stages of drinking too, but have never had an issue with it other than throwing up when I drink too much. I saw a lot of those patterns, whether it be of the abuse or anything, so I kind of tried to stop some of those.

Interestingly enough we also are a very marijuana cultured family. Something I grew up with. It was never, “Oh let me see if I can get my hands on it!” It was never any kind of ideation like that. I just had access to it and had a really clear understanding of it. As an adult I adopted it as an episodic habit and now actually use it medically, not legally medically, but for medical purposes and will probably smoke pot until the day I die. Being totally frank with you. I think that that is a harm reduction technique. When I am working with clients I have especially those addicted to methamphetamine or other things I counsel them, and this is partly based on direction from our medical director and partly based on my own knowledge, that “smoke a joint instead and see if that gets you to the place you need to be rather than doing something different.”

I had two marriages. My second marriage ultimately was with somebody addicted to methamphetamine. I did try that a couple of times. I don’t know why. It was the stupidest thing in the world because I can’t take Sudafed, so why would I ever think I could do something like that? Growing up on the reservation you get to that place where, “you’re not going to tell me I can’t do something.” There is, for lack of a better word, a machismothat goes along with that regardless of your gender identity. Where we grew up was pretty notoriously known for being—they call it ‘little Chicago.’

**AS**: Where is that?

**MM**: On Leech Lake. It is pretty well known in certain instances for the kind of activity that goes on. There are stories of Al Capone being there and having a cabin. My grandfather apparently toured him around and guided him and went hunting and fishing with him. There are a lot of different elements and people are kind of in survival mode. That mentality and of course being in a very, very sick relationship. “You can’t tell me I’m not going to do it!” Hated it with a passion. What I appreciate about that experience is I’m not talking out of both sides of my mouth. I haven’t done a dance or had an issue, but I’ve had the experience. I can honestly say I know what I’m talking about from that standpoint.

A huge majority of my extended family is dealing with addiction of methamphetamine. With my stepfather—that’s the father of my youngest sister—there are twelve children. Out of the twelve of us two are now gone, have passed away for different reasons. Two are incarcerated in federal prison and both had raving addictions prior to that. Two others had addiction and are in various stages of recovery. When it came down to it out of the twelve of us there were only two that could really claim sobriety out of twelve kids. One of the two of us drinks and I smoke pot, so some would question whether that’s true sobriety. My point is that over half of us have gotten to the point where it has had a true impact on life overall. Children have been lost when elements of addiction have come into play.

When I see that impacted in my nuclear family—extended or otherwise—that’s a real frustration for me. Fortunately my birth children are pretty good for the most part. They grew up with the same thing as I did as far as their understanding of marijuana and knowing it was around and not having a push one way or another. I certainly did not ever sit down and smoke with my kids until they were adults. Once they were adults and were making their own decisions—that was a different situation. My oldest daughter is going to be thirty. I’m not going to dictate what she does or does not do. She’s a big girl now. One of my children is completely sober, one hundred percent, and has no desire to ever use. It is just a spectrum of things. I go from a standpoint of transparency and honesty and I’m not going to bullshit around. I may not be willing to admit some of the things I’ve done, but I’m not going to deny them or lie about it.

I have been an only child for the first ten years of my life and I was very secluded. My mother would go party and do things like that so I would spend a lot of time alone. Then I got these two sisters I ended up taking care of. Not long after that I started having my own children. My youngest is now twenty and in the last year or so I have gotten to a place for the first time in my life when I have actually been able to worry about me, outside of the normal mom and kid stuff. I’m fully responsible for myself and it is incredibly liberating. Now if I could just get the rest of them to stop taking my money, time, and energy I’d be in good shape.

Overall I’ve come out relatively unscathed and have learned a hell of a lot. It has been quite the experience. Now I’m working with my children. A great example was my daughter was going to go pick up my alcoholic stepdad last night from the rez and bring him down. She looked at my Wednesday night and said, “I can’t do it. I talked to him and he is buzzed up and I just can’t deal with it.” She loves her grandfather to death. They are very connected, but she has now been able to establish that pattern and see that she can just go with him and have fun, but she sees the consequences and understands the impact of it. We talk about it. We have talked about it with him now because part of it is unlearning our enabling behaviors of the past.

The interesting thing for me was when I was in my second marriage and working at DIS [Department of Information Services] in the HIV field part of my responsibility was doing training around HIV systems and we incorporated methamphetamine because it was such a big deal. We had expertise from Mia Weber who was at the Methamphetamine Resource Center, and she came to do the trainings with us. As I was dealing with all this stuff personally I was also getting education professionally, so what is interesting to me is that my two lives have taught me —my personal life and my professional life—in this role have collided unbelievably over the last ten years or so. That’s kind of a benefit when we are talking about the opioid issue because I already have experience with the other epidemic crises in my opinion and have had those conversations and dealt with personal things that you have to reconcile. I think it takes a lot of strength to do this work. If you have any of your own internal baggage it hampers that. I’m grateful that I’ve gotten to do some of that and can be more clear headed.

I also understand that the Native American community is overrepresented in this issue and because of my connections and my family I have a personal interest as well and desire to help the entire community. Not only that, but I grew up in that environment and I understand how you move forward in that community trying to assist.

So many people try to silence the issue, for example the opioid response. Everybody is talking about the opioid response. To my point exactly, “Fine. Get somebody sober. Then what the fuck are they going to do?” Especially if they are dealing with issues of sexual orientation or identity or any number of things. How do you talk to them in a way that says sobriety is the way to go? And these are the reasons why. All on top of the physiological effects it has on your brain. So you already feel like shit and then you want to say, “Oh there is a better life” and I am realizing that as I talk to my younger children that are millennials.

In addition to the whole epidemic of abuse there is also this whole thing understanding that this ‘adulting’ thing sucks and what is the benefit? Why do I have to work my ass off to pay bills and accomplish nothing? There is a whole different ideology going on with this group of people that are younger. If they get hooked into that messaging about using and it makes them ‘feel better’ I believe we are going to have an even harder argument because they are already saying, “This grown-up thing is fucked up. Why am I working my ass off to not accomplish anything or not have the things I want? You have raised me in a society where I am going to get everything I want at least information wise and all of these things are right at the tip of my fingers, but this work thing means you don’t see progress all the time.” If I hear one more person say, “I don’t like doing that.” When did we ever get to say we don’t like doing something? Are you kidding me right now?

**AS**: You see the generational difference as contributing towards the current epidemic particularly with opioids?

**MM**: Absolutely. Across the board. I think everybody is looking for their buzz of choice. Part of it is about access and part of it is about history. With the extended family my stepsiblings grew up with my alcoholic stepfather, who I love to death, and their mother who would take anything. She liked to inject anything. We found a needle in their couch fifteen years ago before this was even on the radar. That whole community of folks—there are a lot of people who are episodic users. I carried that woman, not literally, but in her wheelchair, to treatment, three different programs. I remember specifically being at the ER at HCMC [Hennepin County Medical Center] and saying, “What is your drug of choice?” Because I let her get shit faced before I took her in. That was the only way they were going to take her. She didn’t answer the question so I answered for her and said that she was an opportunistic user. Vodka is her drug of choice, but she will take anything. She said, “That’s right!”

My point is that when you get to that level where you just need to be inebriated it’s not going to matter what it is. She was doing pills. One of her best buddies that was using at that point in time was a woman my age that I went to school with and she's actually a couple years older than me. She was on the verge of dying. She is on an oxygen tank and has been for years. My stepsister a year ago had heart valve replacement surgery and now has a pig valve in her heart. She’s forty-two years old and has no teeth. No one in that part of the family has teeth. My twenty-two year old nephew is waiting to get dentures and is so emaciated and so out of it. Not only that but he can’t maintain sobriety. He was in a halfway house here and got caught using K2. It’s not about making good choices, it’s not about going back to that to get the buzz, it is “this is what I have access to and what is available.”

**AS**: What did he try to do after the halfway house? Right?

**MM**: He tried to come to my house. Right.

**AS**: Going back to what you were saying about having support systems.

**MM**: Right. I had a conversation with him and I said, “Why were you successful at treatment?” “Because I was at Moorhead in the middle of nowhere and I didn’t know anybody and I couldn’t get anywhere. We could go to the Y [MCA]. So I’d go there and work out wherever I wanted to.” That’s not a realistic idea of what life is going to be. I believe that that program is setting him up for failure because they were giving him access to things that he wasn’t going to be able to touch. Not only that, and here is a very key piece that I have been coming to, but he’s now sitting in jail. He blew a court date. They had a warrant and he turned himself in. My daughter used these words exactly, “He’s just going to stay there and bounce through all of his charges because it is housing.” I think that is a key aspect of all of this. People end up seeing these things as housing.

There are many people I know who have HIV who have gone to treatment to attain sobriety and they get released and are homeless. If you are going to release someone and they are homeless how do you expect them to not get triggered? DHS has changed Rule 31 a few years ago to include HIV training and education. We had a conversation with them a few years after that and I talked to Rick Moldenhauer and I said, “Do they talk about sexual health in groups or any treatment?” “The programs might or might not.” “When you get out of treatment one of the first things you probably want to do is get laid. If you’ve never gotten laid without being high then that is a trigger for relapse. Is it not?” A light bulb went off in his head and he went, “Oh my God.”

We started doing HIV and chemical health systems trainings based on that. The training that was developed went along with the matrix model that the state uses in doing assessments and things like that so that people could understand the correlations between different levels of use and their sexual risk. That has not necessarily been successful in the long run because it is a whole other area of expertise that the counselors need to have around HIV and sexual health. And there is the reluctance to have those conversations, yet it has been identified. All of those corollaries and those triggering factors relate back to it which is why I think there is such a deep connection in those two fields of work that go very hand in hand.

My background, interestingly enough years ago, was in the legal field. I worked for a trial-consulting firm. Prior to that it was with a computer consulting firm. I have had a variety of administrative jobs more in business management.

**AS**: Did you go to college?

**MM**: I did go to college. I crashed and burned my first year, so then I supplemented and took classes here and there. I was lucky because when I turned nineteen that was the legal drinking age, so after my first year of college—it had been recommended that I take a break after my first year to go and find myself because BSU [Bemidji State University] wasn’t letting me come back for a year. I was working full-time and going to be the next rock star at Pizza Hut and loving life. I was legal at the same time so I was partying like a rock star and it was fun. It was a blast. Then I transferred to Brainerd and hated it. I spent as much time as I could going back to Bemidji, and ultimately got frustrated and went back to Maryland to visit a friend. She said, “You should move back here!”

So six months later I did. I went back to Maryland and we engaged with all of my friends that I had lived with there before and connected with my first husband and started having kids. That little, brief period of time.

**AS**: That was where you met your husband?

**MM**: I met my husband when I was thirteen and then we reconnected when I was twenty. Then we started having kids. I stayed there for about four or five years. By that time we had gotten married and we had two children. The relationship completely fell apart. It was the end of the eighties and the early nineties, so being out East when the job market collapsed. I don’t know if you remember Reaganomics—it pales in comparison to the nightmare we are living in now—but at that time we thought that was the worst thing. When George W. Bush starts looking good and even he’s saying it—fuck my life.

Anyways, I made a decision at that point that I knew I could come back to Minnesota and raise my two children, I was by myself, and I had family support and friends and other things. We moved back here and moved to the cities because I knew it was going to be more marketable for me to get a job. From there we just rebuilt our lives. My first husband subsequently followed us here and we ended up having our third child together, and then finally called it quits. After that we tried and tried, but he had a hard time not having more than one relationship at a time. It doesn’t work when you have three kids.

Ironically, I had planned to be a stay at home mom, and when I found out about his shenanigans—I actually had been offered a position and I called them back and thankfully it was still open. I had this amazing experience of working with a child-consulting firm that was very socially progressive. They only worked with personal injury plaintiffs and criminal defendants. Basically whomever the underdog or one that was least advantaged in the situation was—doing things like jury selection, helping attorney’s prepare for trial, mock juries and things like that. I learned a ton of information and made a lot of connections. I also worked in a small non-profit in the same organization. In small organizations people tend to go a little batshit crazy. When you’ve been doing the same thing—they were stuck in founder mode. They didn’t know how they were going to move forward. After a period of eight years I got totally frustrated and had to leave. It was really fun, but then these crazy women that I was working with that don’t think about five years from now—there was no business planning or anything like that.

I finally got frustrated and interesting enough heard about a position in Hennepin County and HIV from two different people that I had a lot of respect for and both recommended me for the position. I applied for it and ended up getting it, which is what got me into HIV. This will be my sixteenth year working in HIV. I started in 2001. I have been here for sixteen years. I spent my first four or five years working for the planning body, so I learned all about the federal funding and evaluations and things like that. Then I moved to DHS where I was a training coordinator and a contract manager. I started to see the program side of it and the government administration side and then was more familiar with that.

Three years ago I think it will be now my mom passed away. Some things happened over the course of that period of time that was just like the straw that broke the camel’s back. Interestingly enough this position I’m in right now had previously been posted, but they hadn’t found someone, so they reopened it and I was at that place where I knew I needed to start applying even though I wasn’t sure what I was going to do. I have to start applying. Completely impetuous. It was week one of grieving after my mom died. Complete bullshit wrong timing, but it was the motivation I needed. I submitted my application.

**AS**: It is still called RAAN, right? Rural AIDS Action Network?

**MM**: Right. I submitted my application and ended up getting a phone interview and one thing led to another and the next thing I knew they were offering me the position. It was just one of those wow kind of things. I was so desperate for change that I just jumped on it, not fully thinking through it. It’s a really different thing because you have the livelihoods of eighteen people in your hands.

**AS**: Like their salaries and careers?

**MM**: Yeah. The biggest stressor I have is ensuring that these folks get to continue to keep working. The good thing is they are an amazing team of people and if something ever happened I know they would be fine and continue on.

**AS**: Could you describe the network?

**MM**: We are actually celebrating our twenty-fifth anniversary this year. I am super excited. The organization was started by a woman named Linda Brandt who saw a need for services for people living with HIV in greater Minnesota. She actively worked to start building these networks. The network model, while it may still not be exactly as she envisioned, I think we have retained it in spirit. What I love about it is we are regional. All of our staff with few exceptions live in the communities they work in. They understand what is available and how to access programs there. They also, for the most part case managers in particular, already know resources and services available. They have a broad array of experience that they brought with them. Some of them were working in mental health in the past doing case management, some are experienced in the [Wyvern] system. They all have this different breadth and experience that they bring with them.

I just recently wrote a proposal where I figured out that even though we have some fairly new staff to the agency collectively we have over seventy years of experience working in HIV and providing services. I probably am a little bit off in that estimate, but that’s what I can safely say and that makes me really proud to understand that we have the breadth of experience that spans twice what the epidemic has been around for, which I think adds value. It makes us able to be scalable in our responses that are related to the same group of people. I challenge that a lot of the clients that we work with are folks that other systems are connecting with on a regular basis; people that are dealing with substance use, people that are dealing with mental health issues, people that are homeless and experiencing a whole lot of other health related disparities.

Part of our HIV work has included Hepatitis C, primarily testings, but we took it to another level because that was highly unsatisfying for staff. We are really more actively working to connect people who test positive to care and follow them for a little longer, even though that falls outside of our grant parameters, because that is how we do business. We are about relationship building and meeting the needs of the individual. There’s nothing worse than giving someone a diagnosis that they are unfamiliar with and then just walking away. I don’t know if it is statewide, but I believe it is, our positivity rate for Hepatitis C is thirty-nine percent, which is kind of off the charts. We are one of the highest in a community based setting that there can be. We are getting results. We know we are working with the folks that are impacted. The wonderful thing is we are not testing people positive for HIV at that same rate. In fact our HIV rate is incredibly low, including the population of people that chooses to inject. Our syringe program we are not identifying people that are HIV positive, but we are identifying Hepatitis C. We know that our HIV prevention efforts are being successful.

I don’t know if you are aware of this, and Maggie can confirm my statistics, but approximately fifty percent of people who inject acquire Hep C within six months of beginning to inject. My mother in law, or stepmother that I mentioned earlier that I took to treatment was Hep C positive. Not a big surprise. She got tested in a methadone clinic, so it wasn’t great, but it was just another little extra-added layer because she chose to keep using, so of course her health wasn’t what it could have been. I’m pretty sure she never got treatment for it. I am digressing and going back.

**AS**: Where are the communities that you have offices?

**MM**: Right now we have offices in Mankato, St. Cloud, which is our central office and main location, Moorhead, Grand Rapids, and Duluth. All of those locations for the most part we offer prevention and care services. They usually have a prevention worker and a case manager so we can represent both sides of the HIV spectrum. Duluth and Grand Rapids are split where care is in Grand Rapids and Duluth is prevention. We are probably going to be adding some more here and there.

**AS**: How are you funded?

**MM**: We are funded primarily through federal and state grants. A lot of it is federal pass-through money. All of our case management programs are funded in white funds. We get state money from MDH for prevention related work, which includes a small carve out for some syringe supplies. That is the one contract where our syringe program is specifically listed under. As long as we are using state funds they can pay for the supplies. As you know there is a ban on federal money being used for syringe supplies. It is ludicrous. They loosened it up a year ago where we can actually buy staff time with federal money for the syringe program, but we can’t buy supplies. It is just goofy.

This DHS proposal that is out right now and due for submission next week is a grant that is based on the Cures Act [21st Century Cures Act, 2015] money that was released last fall. It is an attempt to really respond to the opioid crisis. The interesting thing, like I was saying before, was that group that we work with that is pretty much reflective of a bunch of different areas, and because of that a couple of years ago we were asked to start distributing Narcan, some people call it Naloxone, for opioid reversal. When we got that grand we started diving into that area a little bit more. They already have that exchange so it made sense and was a great fit for there.

The next year we added on statewide distribution, so now we have Narcan in all of our offices and all of our staff have been trained to distribute it and train others in its administration. Now we have been able to take that statewide and because of that DHS has recognized us as an entity to work with moving forward with the Cures grant money. They have applied for over five million dollars a year and we have been targeted to receive a big chunk of that. The intent of that would be to expand our intent services because my goal since I walked in the door has been to have services all over the state. Basically replicating the program we have in Duluth, which I think I am going to say publically is the gold standard. I believe it is. We have more hours than any other program that I am aware of. We are open thirty hours a week on average. We create an environment where people can come in. I provide socks, mittens, gloves, and blankets for everyone because staff will meet these clients where their needs are. Some of them don’t have access to water because they are homeless, so when that happens we get them water.

**AS**: It is responsive to the particular needs of the clients in those areas of the state.

**MM**: Yes. And Maggie and James are really great. They just started it as an after school program, and it really does make sense. In the middle of winter there is a pot of water going for people to have hot tea. Sometimes folks have been roaming around all night, or whatever the case it. It is one place in their lives they can interact and not have any judgment passed on them. They can come in and have their needs met, sit down for a minute if they need to, get a cup of coffee, sometimes there are other treats. The staff have collected and they have boxes of all the little shampoos and personal care items. We collect those from hotels when we stay and donate them back to the program because sometimes—you wouldn’t believe what a little bottle of shampoo or conditioner can do to somebody. We go to the dollar store and pick up little bottles of nail polish and stuff like that because sometimes that’s the most interaction where somebody has had where they are treated like they are any normal person. It is amazing.

What I love about it is when I go up there and work, whether I am covering or just hanging around, I am almost invisible. They don’t recognize me as somebody that’s not there everyday because they get the same level of treatment and that is what they have been acculturated to. They are just as open and offer sharing with me than they are with any of the other staff. It’s really interesting to see that dynamic at play because it proves to me that we have garnered a lot of trust.

**AS**: Do you know how many people you serve?

**MM**: Not deliberately—I walk around with this because I was so impressed. This is a survey that I just completed a few months ago. Apparently it is done pretty regularly, but they had missed it in ‘14. This page is talking about syringe distribution specifically in ‘14, but it was very limited questions. That was page one. It was just our basic detail and information. This is just some demographics. There is a specific page I am—right here it starts into distribution.

**AS**: 254,610 syringes out—

**MM**: In one location in one year. That’s Duluth.

**AS**: 1,584 participants. That’s just Duluth?

**MM**: Yeah.

**AS**: Twenty syringes per person average.

**MM**: That is a total estimate based on nothing other than a rough estimate.

**AS**: 204,000 [syringes] were returned.

**MM**: I’m really impressed with our numbers. We average three thousand dollars a month just in syringe supplies alone at that location. We know we are being affective.

**AS**: Of the people that come in, do you know how many go into treatment?

**MM**: I don’t. We track it anecdotally, and Maggie and James track it in their heads, but we don’t track it deliberately because it is not a principle of harm reduction. It is understood, and this is where Maggie may be contrary to me, and I would go with what she says, it is understood that treatment for harm reduction participants is generally more effective and more successful with them because they’ve already gone through all the precontemplation and when they get to that stage of going into treatment they generally are more ready for that stage. Part of it is that prep work that goes into that. Tracking it can’t tell you one hundred percent.

What I can tell you is that I have a picture on my phone that I can’t share of a mom and her baby. The mom was driven to treatment by Maggie, when she found out she was pregnant, the baby and her are both fine. They are together. The baby is thriving. They came in on her first birthday to play with Steph. I am getting goose bumps. Maggie didn’t know who it was until she heard her voice. When she heard her voice and when she recognized her and knew who it was because she had changed so much and mom and baby were doing amazing. We know of two moms and babies that have successfully been dropped off at treatment and are still together. We hear outcomes here and there. Steph stopped tracking the number of reversals that they were getting from Narcan because it was so depressing. In the first roughly three months that we were doing Narcan distribution there were seventy-five reversals. That means that seventy-five people that might have died that we had a hand in reversing—those numbers were too staggering to keep track of. I think they had program fatigue. Understand these folks—Maggie’s background is an artist.

**AS**: What do you think for the future? Is there a point where you would consider tracking those numbers?

**MM**: We absolutely need to. It is not acceptable.

**AS**: Right. It’s not that you don’t want to, it’s that you have limited staff.

**MM**: Absolutely not. Part of it is that and part of it is as a staff we can’t physically track anymore of these. It is too painful. We hear these stories all the time.

**AS**: You need another person or two.

**MM**: You may have heard this before, but there are some fabulous program staff that are not necessarily the strongest people on the admin side, and that’s kind of how you want them. In fact that was part of my conversation with Maggie this morning, “You guys need to shore up your admin stuff because you’re not reflecting what you’re doing.” They had just found a stack of papers that had never gotten entered. I had said, “Your numbers are not accurate because we have been on an upward trajectory the whole program and we are down. Your numbers are wrong.” It’s that mom with the eyes in the back of your head thing. I tell them all the time, “You guys! I know, see, and hear everything. If you think you are getting away with something I find out about it!” So the same with the numbers and then poof, two months later guess what? “Oh, we found the papers!”

**AS**: Can you talk about the current political situation and tell us what you are going to focus on?

**MM**: In light of the current political situation, particularly with so many people in power that do not necessarily believe in sexual health education and the importance of that, I have started thinking strategically that because the opioid response was one of those things that is so neutral and truly bipartisan because so many aspects of society have been impacted that we might have to step back our really visible HIV and Hep C work approach and really focus more on our opioid work from a political stand point moving forward.

So far what I have realized is our composition did not change a lot with respect to the actual state of Minnesota. We did not get much shift in the folks that were elected, so we have been in these environments for a long time. Federally, I think we are going to have a much different impact because we don’t know what is going to happen and it’s just a crapshoot.

**AS**: What about the Cures money?

**MM**: The Cures money is going to explode and really help up approach the whole opioid epidemic. With that we will bring our HIV and Hep C work along with us because in my estimation they go hand in hand. If I am trying to encourage people to keep medication on hand so they don’t overdose or someone they love doesn’t overdose then why don’t you get tested at the same time so we can see what other stuff is going on. Part of that is being actively a part of a community and engaged in the response. Again, that’s where the benefit of my staff being in these communities brings their own passion into their work in that community.

To be honest some of them are reluctant with the Narcan stuff. I think they feel uncertain about it and we have that same dynamic. Our staff is very reflective. I have people that are very progressive and really have a good handle on things in a larger sense and how those things interact with each other. I have some folks that are from a small community and have the intent to keep doing that work in that community and don’t always have a broad view of the world for lack of a better way to put it. That’s a very small portion; my point is we are very reflective and represent that breadth as well. I think that is important because it is a challenge if you have someone that is not capable of doing the work at a certain level, but there is also a time when those individuals are appropriate for a different aspect. You know what I mean? It is that give and take.

**AS**: Also for example if you know don’t someone who has been saved by Narcan you don’t understand. You almost have to be in direct contact with it to understand why that would be important to keep that person alive.

**MM**: Yes. I think a lot of the people I am referring to who have that resistance are because they haven’t had that experience.

**AS**: Exactly. It’s not because of a lack of desire or of humanity or care for other people, it is just not understanding. Like many people don’t understand harm reduction and needle exchanges as a link to health.

**MM**: I also think that you can’t challenge everyone’s personal biases and I do believe that some of it is “I don’t know if I want to work with *those* people.” Not understanding that we work with everybody. I think there is a fear. I don’t know what it is about folks who chose to inject, I really don’t know. I am confused as to why that is a different dynamic of use than other substances. Some of these same people with consume shit tons of alcohol, and in my estimation that is just as bad if not worse because alcohol has killed billions of people in a variety of ways.

**AS**: I see it as a hierarchy of stigma. I’ve been thinking about how there is a hierarchy of stigmatizing because even addicts stigmatize others. Alcoholics stigmatize addicts.

**MM**: In sexual health the gay community totally stigmatizes the bi community. From gender and orientation. If you think about it, you’ve learned this since grade school, you always want to pick on somebody that’s lesser perceived than you. It’s a pecking order that we have learned very early on. I was guilty of it myself. I was always the fat girl. I remember in high school there was one girl that was fatter than me and I was fucking grateful. I was like, “Thank God for this chick because otherwise I would be the biggest one.” You know what I mean? I was guilty of it myself. I’m just saying. I think being fat is still one of the most stigmatized things period, across the board.

**AS**: One more thing. Would you describe your typical day as the director of Rural Aids Action Network?

**MM**: Holy buckets. Well here is the interesting thing. We were on lean. We run really lean and that is because I am all about not doing anything that we can’t sustain, whether it be for staff or client. Even though I’m willing to take risks I’m very practical when it comes to making decisions. We clearly could use a whole other level, like a middle management type of person. There are just a lot of things we don’t get done. I’ve used this analogy before with one of the counterparts of this HIV agency. I was talking to a program manager and I said, “It’s an imbalanced conversation because generally it would be ED to program director talking but I don’t have a ‘you’ so you get me.”

My week or time frame could consist of anything. I spend a lot of time in meetings, whether it be about HIV planning or other aspects of the HIV world—grant management, things like that. I’m involved in a lot of meetings and committees about that. The opioid response—I participate in a couple of harm reduction groups with chemical health professionals about our response. I spend a lot of time doing overall administrative functions, dealing with HR things.

I have a leadership team that involves three other people. We just had a retreat this week and went to the financial sustainability conference yesterday. Part of it is developing a team at the same time who are all coming along together because we are also de facto doing a succession plan. Who is going to be the next person to take over, and I have already identified that person. I am doing development because I value development across the board and the staff. We are always looking for opportunities that people can get involved in.

I am very much into relationship building so a lot of times it is projects like yours where we can be of some kind of assistance. Part of our mission is to educate and advocate for people living with HIV and I don’t feel like I can do that unless I am talking about that very actively with everybody. It relates to all aspects of life. I just participated in an AIDS Action Day.

Some of it is reconnecting with other people in the community. It is interesting because I am very connected to the Metro community of providers and other folks, so I have the benefit of getting to work with them. I get to work with clients because of other work I have done in the past. I don’t get the benefit of being able to be in one of those communities all the time, so I’m not super visible to everyone we are working with, but I hope to be approachable. It’s kind of like the best of both worlds. I can literally be running from one end of the state to the other and meeting with people about various things and program stuff, or covering for them even sometimes. Then at home a good chunk of the day can be spent on the phone. I don’t talk to family on the phone anymore. The last thing I want to do is make a phone call.

**AS**: Because you are checking in with six different offices.

**MM**: Right, or we are strategizing issues that are client related issues that come up. There are programmatic related issues. We have reporting, so I oversee and am responsible for all the staff too. I’m not responsible for all of them directly, but I supervise all the program folks and the Narcan stuff because so much of that is legislation related right now and it’s beneficial that I’m in the Cities because then I can just go to the meetings and do what I need to do. Plus, I have my previous connections to other aspects of the world. DHS was a phone call to me saying, “Do you want to distribute Narcan?” because I have this longstanding relationship with chemical health area.

Part of it is who I have been and what I can bring to it and I have this amazing team of people. The case management coordinator for example has been with us for ten years. We have two case managers that have been with the organization for ten years. They can give me the perspective and historical standpoint. Then the leadership team helps guide my decision making on some of the bigger, problematic stuff. This expansion of the opioid project was my dream child when I started working for the organization. I said I wanted to be able to expand the work that we were doing and put some syringe exchanges in all of the offices. We methodically started doing that. Our Mankato location is primed and ready to go and all we need are the funds. We have the physical space; we have the go ahead from our landlord. That is the other thing—

**AS**: The newest one is in Mankato?

**MM**: It will be once we get everything going and get some funding that is tagged to be the next one. We learned that diabetics are selling their syringes to folks that are using. When you talk about the public health implication of it, it is staggering. When you have nurses coming to you and saying, “Will you please open a syringe exchange?” it illustrates the need.

That is one of the places I have had staff for ten years, so she’s got a long-standing history and is very approachable and that is one of the things that is beneficial about our regional model. We connect with folks. It is really popular because people like to do the work in other areas and they want to partner with us all the time and one of the things I am very clear with is I can do a one-time event or something, but I don’t want you tip-toeing in our areas and then leaving because you don’t come back.

**AS**: What do you mean a one-time event?

**MM**: Well, like Minnesota AIDS Project will say things like, “Let’s do this, let’s do that.”

A great example is there’s a syphilis outbreak right now in Mille Lacs, I think I told you about that, and so we have been doing these weekly events on each of the districts on the reservation. Minnesota AIDS Project was involved as well and one of the proposals someone had was they do two events and we do two events to mitigate staff time and I said, “Absolutely not. We are going to be at every one of those events because they are never going to come back out here and interact with this community whereas we are. We will be at every one of them because that is an investment that we will make.” That is about relationship building.

I went and did Narcan distribution at two of the events and I’m going to the fourth one next week. At the two events I gave out seventy kits. One of them was to a person that took twenty kits. The interesting thing was I was connecting with the actual people who are using and are connected to the using community. The Health Department has been talking to tribal folks and so the Health Department is a little removed and the tribal folks are very much removed, so they are having all these conversations that are going to result in nothing. What we are doing is building the relationships at the ground level and getting our name out there so that people know. It is preemptive for the Cures money, so it is a colossal tax on my schedule right now, but I think it is a good investment in that relationship building and continuing to do that work, because we are going to continue giving out Narcan no matter what.

We are also working with the drug courts on the SAMHSA [Substance Abuse and Mental Health Services Administration] grant where they are doing care fares and testing with drug court participants, so that’s going to be super exciting to see how that comes out too.

**AS**: You will have entry with all those people who have been—

**MM**: For testing. It is kind of a backwards way of doing it with the response. With the drug court they are supposed to be on contract. We are supposed to distribute Narcan, so I was on a call with the administrator of the program on Tuesday. I was like, “Okay, so this whole Narcan thing—we are kind of confused.”

**AS**: They don’t want needles?

**MM**: No, they don’t want needles, but the fact that they were even willing to give it out to the participants—that program is running more on a harm reduction model. They aren’t automatically kicking people out. It is a different approach.

**AS**: What did you do when they started doing that?

**MM**: This is very recent. Our contract isn’t even signed yet and there have been three fares already.

**AS**: So it is recent that they are changing their tune.

**MM**: I’m not sure they are changing their tune, but it’s what their tune is now. I thought it was interesting. I hope this has been helpful.

**AS**: It has been great. Thank you.