**Stephanie Devich**

**Narrator**

**Zachary Malett**

**Interviewer**

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Stephanie Devich —**SD**

Zachary Malett —**ZM**

**ZM**: I just need you to say your name and say you're okay being recorded.

**SD**: Sure. This is Stephanie Devich, and yes, I'm okay with being recorded.

**ZM**: So where Amy has historically started is just talking a little bit about you. A question she likes to start with is what was your childhood like?

**SD**: [laughs] My childhood. I grew up here in Minnesota. I grew up in Minnetonka. Only child. Parents were together, and no communication in my home. We just didn't talk about anything. So when I started using alcohol at the age of thirteen dad kept that hidden from mom when I got caught.

**ZM**: At thirteen?

**SD**: Yeah, at thirteen. And he never said a word to her. He just cleaned up the vomit. [laughs] So I learned early on if mom doesn't find out think are okay, and how to keep a secret. From there it just, for me it was drug abuse after that. I went on to weed, pot, or LSD, PCP, mushrooms, and kind of continued on. I graduated from out here, but I was high on graduation day. [laughs] Yeah I was on PCP when I walked. So, yeah. My childhood, you know, no abuse. Some verbal abuse and such, but my family history on my mom's side definitely a lot of mental health and drug addiction problems. All on my mom's side.

**ZM**: Where you aware of this when you started experimenting, or not?

**SD**: No. Saw it later on. I noticed it with my mother. I recognized it now that she had a problem with alcohol. Her mother definitely, and I know my aunt had prescription painkillers were her thing for many years. So she's part of the opiate problem.

**ZM**: What happened after graduation?

**SD**: After graduation a few years later I moved to southern California. I had done some traveling to San Diego and decided after we had that Halloween blizzard. You're probably too young to know about that one. [laughs] But in like 1991 where we got hit with like a foot of snow and I decided to get the hell out of here so moved the day after Christmas that year and moved to San Diego, but all I did was bring my own stuff with me, for the most part, so it was just me bringing my problems and unhappiness along with me and started using methamphetamine out there. Got very much into using whatever was in front of me. It did not end well for me in California. [laughs] California I have six felony convictions from living out there. Sales charge, transportation of narcotics, went to prison for a couple years in California. Got out of prison June 30th, 2009. Moved back home on parole [unclear] in Minnesota. I was on parole here because they transferred me up here and California parole ninety days later I moved back out here. Got off parole after a year. Started using again. Crack cocaine was my thing. I tried heroin. Did opiates for a little while. It wasn't really my thing. I definitely liked the upper thing. Crack cocaine, needle abuse, like everything. I overdosed on cocaine. Died. Wound up in a hospital ICU for several days. Woke up in handcuffs. Went to prison from there.

**ZM**: That was back here?

**SD**: That was back in California and then moved back up here. Then moved back out here shortly after I got out of prison. Did a couple of years in the prison system in California where they set you up to fail. Send you with two hundred dollars gate money when you get out of prison and nowhere to go. [laughs] As a drug addict and a drug dealer there's only, you know, I don't really have too many options of things to do. So, I tried to get out here as fast as possible and move back out here and started using about a year later again. And put myself in treatment. While I was in treatment I applied for school, and wanted to become a drug and alcohol counselor. [laughs] Figured who better! All based on a journal I had written in prison and I was reading it while I was in prison and one of my goals was to become a counselor and I thought, sure, why not?

So since then I have my license in alcohol and drug counseling from Metro State. Bachelor's from there as well as a certified prevention professional, and have been working at Valhalla Place for two and a half years after working somewhere else a little bit. So I've been in the field going on four years now I think with internships and everything.

**ZM**: Great.

**SD**: Yeah. [laughs]

**ZM**: You've only been working for four years, but what do you see?

**SD**: What do I see? I guess where I really started to notice things in, you know, I saw this in California when I was living there because I was selling drugs out of a house holder. It was like a low-income kind of housing thing where a lot of people were getting medications. So they were trading their medications for cocaine. And so they would trade me oxycontin, things like that. And I would take that, trade them crack for it, and go and sell the opiate medications to somebody else that would go and sell them to rich, affluent housewives in [Loyola], California area which is pretty affluent. So I saw it back then and how it was really affecting people, but I saw more of the upper class people using it. Heroin wasn't really something I saw too much of. I used heroin for about a month when I lived in California because it was just what was out there for the time, but it was black tar back then. But I remember the friends I used with having to need it on a daily basis getting sick, and us having to drive around just to get ten dollars worth of heroin. And slapping people around. The old way of trying to reverse an overdose. Throwing them in my bathtub in cold water, and things like that. Trying to bring them back. And luckily that apparently worked. [laughs] Because it really doesn't.

So I saw it out there, but I guess I started to see it more when I came into the field, and in my internships a few years back that more and more people were coming in for opiate use. For treatment. And I think that's when my harm reduction stance changed, because I went into treatment where it was like abstinence based. You go to NA, you go to AA. That's the only thing that's going to work for you and if you don't do those things you're going to die. That kind of stuff. Those were like the messages I heard from going to those meetings. And I stopped going because I didn't want to live in fear the rest of my life. I had lived in fear all my life as it is. And I just thought if this is what I have to do forever, and the other thing is like meditation and some of this other stuff isn't good enough. I don't want to do that. It didn't make sense to me. So I stopped the NA thing years ago and started implementing harm reduction in my own life. I drink alcohol. But I don't use drugs. I just can't use illicit drugs because I don't do them well, or I do them too well depending on how you want to look at it. [laughs] I've had enough of those. I'm still around luckily.

But I think I saw in my internship like I said was that I had a lot of clients coming in that weren't willing, or weren't ready to stop using everything. And so I was referring people to places like Minnesota Alternatives, which is more of a harm reduction program. I don't know if you've heard about that. I heard of Minnesota Alternatives. I went to a conference out here called MAARCH [Minnesota Association of Resources for Recovery and Chemical Health] years ago early on in school. Paula DeSanto is the owner, former owner I believe of Minnesota Alternatives, which is like a harm reduction based program where they teach people how to lessen their use. Because if I don't want to quit drinking completely, but I want to learn how to drink three alcohol drinks a night, or whatever it is and be successful that's how they work instead of kicking them out of treatment because you haven't stopped. And so it had a lot of people coming in that just weren't ready to stop all drugs. And for me to set them up into my program or to an inpatient program knowing that they're going to need to use and they're just going to get kicked out made no sense to me. So I was referring outside of the company I worked for [laughs]. I was like it's not about my treatment; it's about their success.

So I decided to look into a different realm, and wanted to do something that was more harm reduction and methadone was really interesting to me. I kept seeing like I said more and more clients coming in that had either been on methadone or were using heroin or prescription pain killers who had lost a ton of people in their lives based from overdose, and I just thought this is where I need to be. And came to Valhalla Place two and a half years ago now almost. What else do you want to know? What am I seeing now?

**ZM**: Could you just describe more of what you do at Valhalla? And what Valhalla does?

**SD**: Absolutely. Valhalla is a medically assisted treatment program, so we provide methadone or Suboxone to patients that are opiate dependent for at least one year. So they have to have been abusing an opiate for a year prior to even being eligible for our program.

**ZM**: Is that like regular—daily, weekly?

**SD**: You know, it depends on the person. So whether it was something they were maybe originally getting prescribed, and they're supposed to take three of them a day and now they're taking maybe six or eight or ten. But they're seeing withdrawal symptoms when they don't have them. Or if it was heroin on the streets. Things like that based on use, and not being able to use as prescribed. Or if it's illicit use and having withdrawal if they don't have their substance around. We can come in and help them with giving them methadone, Suboxone, which can eliminate the withdrawal and the cravings so they don't have to use those substances anymore.

**ZM**: And the year cut-off—is that just an arbitrary line?

**SD**: Yeah. It's kind of a weird line that's drawn in the sand that, you know, now it's kind of hard because there are people that will call that are at eleven months, but they just don't qualify for the program. I believe that's federal. Like a federal guideline that there's this magical number that a year I have to have been abusing these things. Even though some people can do a lot of damage in six months. Especially now with what's out there. They just wouldn't be able to qualify for the medication. Their insurance won't, and they're not appropriate for treatment here, which sucks.

**ZM**: Do you see people attempting to fabricate—

**SD**: Yes, oh absolutely.

**ZM**: How do you tell?

**SD**: Absolutely. Every now and then we will see people who come in—because we do a screening process with everybody whether it's over the phone, or they physically come in here. A lot of times, especially in certain communities, the Native communities especially some of the reservations where they don't have treatment options. They really don't have the resources out there. We will sometimes see families trying to come in, or sending their family members here, and they go through the screening process and you can kind of tell they've been coached on what to say. But if you word things differently, and I've been trained enough to—and being a former...when every word that came out of my mouth was a lie in the past, I'm pretty good at seeing when people are not telling me entirely the truth, or don't know what to say. So I can word things a little bit differently. There have been times in the past where I've done a chemical health assessment on them first to just kind of get what they've been using, get some more information versus just the screening process of it. And they haven't been coached enough for that. So then I can see, you know, you're not going to qualify for our program. I think the bigger idea hopefully is that they're family or somebody is trying to get them in here so that maybe they can get the medication for another family that can't get here, or doesn't have the insurance, but for us to admit somebody that doesn't need this program, all we're doing is opening a door to something that's going to cause more harm. Especially if they're an opiate naive person or not, using opiates to start them on methadone or Suboxone is just going to...cause an addiction problem they didn't have.

We do a little bit of things around that. For the most part I think people are calling because they know it works, and they don't want to do this anymore. We answer our phone here twenty-four hours a day. If the phone rings and somebody's trying to get in here on a Sunday night and they qualify for our program we'll try to get them in on Monday or Tuesday morning and get them their medication, and start them with counseling here.

So, my job here is a counselor here. I am an LADC, licensed alcohol and drug counselor. I'm also a certified prevention professional through the Minnesota board out here as well. But I still created a new job a year and a half ago or so here, so I'm like the harm reduction specialist is my title [laughs]. Sort of that I made up. I saw a need in the community, not only in our facility, but outside of here where people weren't getting Naloxone. They didn't have the education; not understanding why medication assisted treatment is so beneficial for opiate addiction. Colleges, even the colleges I went to—we didn't talk about methadone or Suboxone. We didn't talk about harm reduction in school. It was like a five minute little thing. I see how beneficial it is right now especially with what's going on in the state. That there's a huge need for education out there, so I've spent my own free time educating myself as much as possible. Going to conferences, flying to San Diego last year for the harm reduction conference. Just trying to get as much information as there is on harm reduction services, be it there's more than just needle exchanges. I spend probably about forty percent of my time outside of my office doing Narcan trainings throughout the state. We are the largest provider of Naloxone in the state of Minnesota.

**ZM**: Valhalla?

**SD**: Yeah. We dispense, last year, over six thousand kits I believe. We provide Minnesota AIDS Project with their Narcan. Rural Action AIDS Network. I've been working with Little Earth, the Native American community over in South Minneapolis for about a year and a half now. I used to sneak in Narcan through people I knew lived there, and teaching them how to reverse an opiate overdose, but the tribe at the time wouldn't really let it happen. I couldn't actually go do a training for the community. We just kept sneaking it in because people were dropping like flies. They were overdosing daily over there and nobody was doing anything about it, and the community was begging for help. I've got friends who live there, I've got a lot of clients over there. I really have a great passion for the Native American community. So, over the past year or so I've probably donated four hundred, five hundred kits to Little Earth. Last year—reported to me, not 911 calls, because they don't call 911 too often—we had eighty-six opiate reversals. I only know of a few deaths over there so far. It has made a huge difference.

There're certain areas in Minnesota, especially the rural areas, but some of the poorer areas, where they don't have the services and no one is doing anything about it. And Little Earth is one of those places that I think just continues to get the short end of the stick because they don't have the resources. And they're a poorer community. They're all Section 8 GRH [group residential housing], so low-income housing. Just in the neighborhood the park is infested with needles. People are actively using and overdosing all over the place. It's just—something's got to give. So I try to give as much of my time to them as possible because nobody should have to die from this shit.

**ZM**: Succinctly put.

**SD**: Yes, yes.

**ZM**: I just had a follow-up about Valhalla. Who funds it?

**SD**: Minnesota is amazing. We are really lucky in this state because treatment is funded through most insurance companies. So, whether somebody is straight Medical Assistance and they don't even have a provider yet, if they're straight Medical Assistance whatever county they're in will pick up the tab. We fill out some paperwork, have them sign some stuff, I do a chemical health assessment on them, I shoot it over to whatever county they're in, and say hey, they need methadone or Suboxone, will you pay for it? And they'll sign off on it. The counties will pay for it. If they do have state insurance, say Medica or Blue Care through the state based on low income that will pay for it. If they're private insured most times that pays for it. Sometimes there's co-pays. And every now and then you get people that don't have an insurance even though we're supposed to and they'll pay out of pocket. But if they're low-income or no-income we cannot take their money. We have to fill out the forms and do the stuff to make sure their county will pay for it. We can't legally take somebody's money that doesn't have the capabilities. It's like twenty-two thousand dollars a year, which—

**ZM**: And I'm assuming anyone working here wouldn't—even if it wasn't a requirement.

**SD**: No. So we just kind of go through the rigmarole to get them whatever coverage they need to get the methadone or Suboxone. Methadone for sure will be covered by all providers. Suboxone—it just depends because it's more expensive. And so then the county won't pay for it. [laughs] Yeah. So, there are certain barriers. Like especially Hennepin County, that's the county we're in, the largest county in Minnesota, and they will not pick up the tab for Suboxone.

**ZM**: What's the price?

**SD**: Methadone costs about eighteen dollars a day. Suboxone is twenty-six. Nine dollar difference, or so. But if you figure on how many people are currently in treatment, and maybe how many people they're funding—thousands and thousands of dollars. You know? Residential treatment program, thirty days—if people are sending people to there they're shelling out eight grand a month. Year's worth of dosing. If they're paying for that for a year or even six months you're looking at three, four, five, six thousand dollars. You times that by however many are in treatment. In our clinic alone I think we have about eleven hundred clients just in this clinic alone active dosing right now. Valhalla is the largest provider of medicated assisted treatment in the state of Minnesota. And there are seventeen programs in Minnesota. We have currently now four. We were recently merged with Meridian Behavior Health. So Alliance was another methadone clinic that's now ours. And then Pinnacle up in Brainerd is now ours as well. So they're all turning into Valhalla's.

Valhalla is—I'll give you a background of Valhalla's because the story is awesome. [laughs] Valhalla is Norse mythology, but it's basically the fight between good and evil. Our former owner was a patient on methadone at another clinic. He was a business owner, had a tremendous amount of finances and things, and just didn't like how he was treated at the other clinic that he was at. So he had missed an appointment with his business partner and he was supposed to fly out to Arizona and was late for their meeting. When he got there she was like, "This is baloney. We can't keep doing this. This is a hassle. What do you want to do?" He said, "I want to open my own clinic." And so that's how we were built. We were built on somebody that gets addiction because they've been there. Understands methadone, and had an opiate problem, which I think makes us different than a lot of other places because we're really about the client. We're about the people, the person.

**ZM**: If you could in more detail describe your experience in treatment versus the treatment at Valhalla.

**SD**: I think—my experience as a client in the past? I've gone to treatment in California on a couple of occasions. I think three maybe? Three or four out there. My experience out there was that I was the same as everybody else. We all did the same stuff. Nobody asked me questions about my history, or maybe trauma, abuse, things that I had been through. It was cookie-cutter treatment. We were all the same. We all did step one, two, and three. It was a lot of abstinence-based for sure.

**ZM**: Was it like Minnesota Model, twelve-step?

**SD**: Minnesota Model for sure. Absolutely. But, they throw around words now and you hear 'client-centered' or 'client focused' or whatever it is, and that wasn't really the case. We were all the same. So I never got treatment that was catered to what I needed. I got treatment that was catered to what people thought I needed. And they thought I needed the same treatment as the next guy right next to me. And that doesn't make sense because we've all got our own story. And the same expectation that I've got to quit everything right now. That's a lot of pressure because if I look at it and I had had a magic medication to get me off of crack cocaine because there's minimal physical, a lot of mental that came with it, but I still got to smoke some weed along side of it I might have been like, okay, I can do that. I can do one. But that wasn't an option. You get kicked out. You use and they kick you out to the curb. And what else am I going to do? I'm going to go to the same thing I've always done. I'm going to pick up again and continue to use.

My experience out here I think was a little bit different, but I think it was because I was different. And I think I was ready to do something different. I realized where the ball had been missed in the past and went and like [unclear] and said, this is what I need. And told them the things that I had been through because I knew those were certain things that I know if I didn't work on I would get help on them and really put forth a different effort. Although, the programs I went to were still Minnesota Model for the most part.

**ZM**: Right, so it required a change in your attitude.

**SD**: I think so. I think a lot of it was because I was ready. I don't think necessarily that a person has to—I think that people can still be successful if they're per say mandated to treatment because it's jail or probation that's making them go. I mean the choice is still theirs because unless they're in a locked facility they can walk out. There's still, even back then on probation you're required to go to treatment pretty much every time. It's not that I didn't learn anything. I still remember some of the things I learned. I just probably wasn't there at that time, but I didn't feel like an individual. I just felt like a number. And being from the prison system I didn't really need to be another number. I'm cool on that.

**ZM**: Right, so that was mandated out in the state of California?

**SD**: Yeah.

**ZM**: Something that I'm currently interested in and researching is just were those costs borne by the state of California?

**SD**: Yeah, California paid for those things there. They have something called Prop 36, which funds for treatment and it comes with like the criminal justice system somehow gets it out of that. [laughs] So those were all paid for.

**ZM**: Were those treatment courts?

**SD**: I did not do drug court. Drug court out there is different than drug court in Minnesota. Drug court out there you're mandated to. They choose you to go to drug court. Drug court in Minnesota—you choose to go to drug court. **I sat in courts at times in California when I was waiting to go to probation and out there is was extremely shaming if you had came in a couple minutes late to court you were handcuffed immediately. You were arrested if you'd missed dates. If you used you were incarcerated for thirty days. When I've sat in on drug courts and worked with my clients even on drug courts out here it is so uplifting and supportive where the clients choose to be in this program. For one, they know how long the program it is, so they say, yeah, I want to do this. Even if they pick up, they use, they relapse, whatever it is they don't get kicked out. They don't get arrested. They continue to work with the team of the people they have. They are like, what did you miss? What do you need? When they graduated I've seen the judges come out from behind their chambers and give them tokens and certificates and hug them and treat them like they're real people. You don't see that super disconnect and that power differential out here as you did in California. It's just something that if I had a choice between that and Minnesota I might have been more successful a lot faster.**

**ZM**: So in Minnesota it's not contingent on sobriety?

**SD**: Not necessarily. Yes, they want you to be sober, but you're not necessarily going to go back to jail.

**ZM**: Right. My understanding of treatment court was if you break sobriety you're incarcerated.

**SD**: No. If you continue, yes. But out here they will work with you on certain things. Maybe you need to do treatment. Maybe outpatient isn't enough so they'll continue to monitor these things and what's going on with you. Then they earn phases and things like that. Then I believe at the end of their time their record is expunged. Which is great. [laughs] If you've got some charges on you like I do that would be great to have that stuff disappear. It's really empowering here in like how the clientele moves up. In certain phases they have to write a letter on why they think they've earned that phase increase for drug court and why they shouldn't have to come to court as often or whatever the phase increase stipulates. **Yeah, out here it's just completely different. It's about the person. Everybody's different, and I think that we've missed the mark, especially the Minnesota Model. I think that they've just thought that everybody is the same, and addiction is all the same, and it's really not.** There's some brain chemistry and science behind it and genetics and things like that, but the stuff we go through in active addiction isn't the same as what the next person went through. Even if our story is exactly the same how I perceive it and how somebody else does can be two totally different things.

I think we've missed out on specializing on certain things and having more involvement when it comes to trauma, and being more open to even the THC thing. If you smoke weed you get kicked out. I think we need to be more open minded, and that's why Valhalla I think it completely different. Even if you're still actively using you don't necessarily get kicked out of here. We'll work with you. We've got a 'it depends' model. [laughs] There's a lot of 'it depends' here. Ideally we ask for one source of opiate, so that means us. If you're choosing to get your medication from us that means you cannot be picking up prescriptions from another provider. So we will check to make sure. We'll run their names in a prescription monitoring program [PMP] to make sure they're not picking up opiates from a provider. Things like that.

**ZM**: Is that a statewide network?

**SD**: Prescription monitoring is actually a program that actually is all over the United States. Anybody can use it. Anybody can run a PMP on somebody. Any provider. You need to have some credentials. But any doctor, any prescriber can run somebody's name to see if they've been picking up prescriptions or whatever it is.

**ZM**: That was post oxycontin bullshit?

**SD**: Yes. So now a lot of states are mandating that if they are going to write a prescription for an opiate that they run a PMP on somebody. Minnesota does not have that. It is still an option. We do it anyway. But the average prescriber doesn't necessarily do that and then we have a lot of shoddy prescribers out here.

**ZM**: Still?

**SD**: There are still some out there, yeah, absolutely. There are some names that we see and we're like, oh we cringe when we see they are picking up a prescription from somebody. Some of the pain clinics, some of the prescribers out there still definitely need to the DEA pay them a visit sometime in the near future. The difference with us is that we don't necessarily kick you out based on elicit use. If the opiate thing still isn't working maybe we'll refer you to a higher level of care, which could mean outpatient on top of working with us here going to like groups. We have an outpatient they would attend for like three times a week for nine hours total. If that's not working maybe we do look at residential treatment, but that doesn't mean you stop here. You still work with us. You still get your medications.

**ZM**: This is medication and some counseling at Valhalla?

**SD**: Yes. So, federally, methadone clinics are required to do counseling. **It's not just what I've been called, a legal drug dealer. They think the clients just come in here and get their medications, walk out, and there's no treatment involved. They are required for the first fourteen weeks to meet with their counselor for at least fifty minutes a week. We do a creative treatment plan with them, we do a chemical health assessment, or a Rule 25, on them just to get a baseline and see where they're at.** If funding were to drop we have that done. We can shoot that off to the county. And then we update them yearly to kind of see where they're at and where changes have been made.

After the first ten to fourteen weeks they're required by the federal law to meet with us for at least one time a month for fifty minutes. If they are willing to do that, then yes, you can earn a spot up in here as long as you qualify in the other areas, too. You have to have counseling with it. There's a reason why we use. There's a lot more to it than that. We do provide the counseling and there're groups and a lot of other things here that they can get. Mental health services, and such, as well from us if they want to do that.

We don't freak on THC. **For us, clients can continue to smoke their pot.**

**ZM**: Does it even come in any kind of chemical analysis?

**SD**: We do do drug screens on them, and it will show on that. Obviously if the county is picking up for the treatment costs here sometimes they have a problem with it. If the THC use is not interfering with their life—I think sometimes the county people that maybe don't spend a day in a clinic such as this don't realize that for us—most of these clients aren't sitting smoking bongs everyday, and I think a lot of times that's they're perception. Somebody that may have THC in their system. **But for us I see a client that may have walked in here on day one with a two gram a day IV use habit of heroin that six months later maybe has used twice. But, that's a huge success, but they've smoked pot the entire time.** So, when you're looking at drug screens a lot of times across the board that's a failure. For us that's a huge success. You're not going to overdose on that. There's no 'harm'. The risk over harm is so much lesser that many of my treatment plans say I'll smoke more weed instead of shoot heroin. Cool. Smoke all the weed you want. My friends smoke pot and own businesses, and they're able to function and do their job everyday. If that's the lesser of the risk, if that's the worst thing someone's doing, smoke the fricken weed. If it's unmanageable then we discuss it. I have some clients that realize it has become a problem. Great, then let's look at stopping your weed. Let's stop the THC use as well.

There's a lot of other drugs we see as well. **The amphetamine use has made a huge comeback recently. A lot of that I think is due to the strength of the opiates out there. The reports I get from a lot of my clients is they hate how high the high is because of the fentanyl that's in there.** They're like, I want to be high. I want to be well. I want to be high, but I don't want to be falling out high. So, then I use some meth because it kind of evens me out and gets them a little bit more leveled out on that end. You know, the opiates that we are seeing out there—it's insane. **The stuff that I'm seeing, that I'm hearing, the education I'm doing with the carfentanyl now being out there. I saw that coming last year. I knew that was going to hit us eventually. Ohio had two hundred and some odd overdoses in a small amount of time. So I've been talking about carfentanyl with my clients and the education that I do outside of here since August of last year waiting for it to hit us.**First of all it was cheap. You could get it for two thousand dollars from China and send it over here. When it wasn't classified it was super easy. I'm a former drug dealer, so I would have been all on board if I could have gotten crack really cheap from somewhere else sent to me. It would have been an easy deal.

But the potency of the stuff that's out there right now, and I saw a carfentanyl overdose December of last year because it took eight shots of Narcan to revive somebody. Luckily when it happens in front of me and I have as much Narcan as I want I'm able to save somebody's life. But the average person is going to have one kit with two doses. By the time 911 gets there and they've got maybe two nasal things there the chances of them surviving still are slim to none. They're not going to be able to do that. This kid, you know, with the amount of shots I put in him plus the EMTs coming along he never should have survived. He never should have survived, and there's no doubt in my mind it was carfentanyl. And the five we've had this year I knew two out of the five people. And now we're waiting on five more pending that we're hearing that probably is.

I know when it comes to this epidemic, and I use that term loosely, I think it's going to get worse before it gets better. I hate to say that. I would love to say this year things are going to get better because we're paying more attention, and because we have more access to Naloxone and things like that. The reality is the drug is too fricken potent out there right now. It doesn't matter how much Naloxone I walk around with. If there's carfentanyl in it, or the amount of fentanyl in there, or noscapine that's now in the stuff. There's too many fricken types of opiates that people are getting their hands on. Noscapine is called C3. It is normally used for cancer patients after chemo for a pain reliever. But it has hit Hennepin County in December. Last year Hennepin County put out a little blip that it was out there. December 2016. So, that was being sold as heroin. The prescription painkillers are being sprayed with liquid fentanyl. We had the liquid fentanyl bust in November of last year.

Nothing is getting any better. We are taking notice because this epidemic—because a lot of more rich, affluent, white people are dying from this disease. It's become a more noticeable problem because people are speaking out. I think that people are speaking out or people are potentially being more heard because a lot of times who they are. Families from Little Earth are losing handfuls and handfuls of their loved ones in that community. No one has been listening to them for years about what's going on. But, if I speak out and I live in Edina, suddenly I get heard. As long as people are hearing something and saying something now and we're doing something I'm all for it, but I think we could have done something about this a long time ago.

I've watched it just escalate. The numbers are skyrocketing. The amount of deaths that I hear about on a daily basis from the clients that I work with—it's unbelievable. The numbers that we have for here aren't true numbers of how many people have died. Because not everybody first of all are going to do tox screens on everybody. We don't know how many people are truly dying from the opiate itself. They look at complications in other things. I think our numbers, and I don't even have the totals yet for 2017, but I'm guessing in the seven hundred for Minnesota statewide. For Hennepin County one hundred and fifty three. It went up to thirty-nine percent from 2015.

**ZM**: I noticed that when I was driving up here there was a billboard.

**SD**: Yes. No Overdose Hennepin County. So, I'm working with the sheriff's department. Hennepin County decided to do something this year to do kind of a no overdose thing and do as much education as possible.

**ZM**: This is paired with mandating EMTs and firefighters carry Naloxone?

**SD**: It is kind of paired with that, and then just doing as much—**right now what I'm seeing is that the billboards are out there, we're doing monthly meetings where a lot of providers and people such as me and parents of people that have lost their loved ones, police departments showing up with what we're doing, but I think everyone's afraid finally. They should be because for the longest time it's been this whole NIMBY thing, not in my back yard, that if it doesn't affect me, it doesn't affect me. But it does. We are losing everybody.**Every time you turn around it's another person. I've lost too many fricken clients. We've lost too many here, and the reality is we've lost way less here as a clinic than my clients have lost with people that are not currently here, and that should be maybe in treatment. But I think that because they're getting the treatment services and things like that and they have access to Naloxone with us, all those kind of things, and they are very much educated by the staff here, and the use obviously isn't as big as a problem as if you weren’t here, but I think that we're still missing the mark.

**ZM**: Is there protocol for Naloxone distribution for clients?

**SD**: For us to give to clients?

**ZM**: Is that allowed?

**SD**: It is allowed! So, if you are any sort of treatment provider, treatment program you can administer Naloxone as part of Steve's Law. There are some kinds of stipulations that you fill out some little form and it's written in you variance in your program thing saying, we can administer Naloxone in my residential treatment program so they have it. I go and do a training. They fill out this little form. That way they don't get a fine for—the reality is if they get a hundred dollar fine versus somebody dead I'd rather pay the fine. There are stipulations that other programs have to do in order to administer Naloxone. For us we have a variance because we have prescribers. We have a doctor that prescribes a medication, it is basically a [unclear] medication in here. Because Naloxone is now available anywhere, any pharmacy, over the counter. Any pharmacy. It used to only be CVS pharmacies. I don't know. They are the only ones that kind of have an open mind. [laughs] I don't know! They were the only ones that were willing to test the waters even though not that many of them had it. You would have to call and make sure and then explain to them what it was half the time. Shit show. **But now any pharmacy in the state of Minnesota can give out Naloxone. They just have to have a prescriber.**If they don't have one they can use the medical fricken—the main medical guy for Minnesota. Whatever it is.

But for us because we have a standing [unclear] medication our doctor prescribes it. All we have to do is train the client. Train the trainer kind of thing. I train the client on how to reverse an overdose. I fill out a little bit of a form. I don't really get much information I just want demographics on where it's going. The year they were born, culture. I want to see where it's going. I want to know where it's going and then I want to know if you used it I want you to come back and tell me. I want to know how fast it worked. The more and more I know it was successful the more and more I can get it out there.

We dispense a huge amount. This year alone, what is it May 1st now? I've dispensed probably thirteen, fourteen hundred kits so far this year. Yeah. Huge amount of them come out of here. Clients know that I am the self-proclaimed Narcan queen. [laughs] Narcan girl in the community.

**ZM**: Still the drug dealer!

**SD**: [laughs] That's right. I'm dealing drugs on a different level now, though. A completely different level, which is funny because on Sunday I met a friend of mine the last place I ever used at. I met him at Cub Foods. What he was bringing me was the auto injectors for Naloxone because they're expired and I give them out to some other people that are out on the street. Because they still—

**ZM**: Is that like through your position at Valhalla, or do you just do that to do that? Training and stuff.

**SD**: It's now my job. It is now part of my job. But before it was something that I just started doing almost a year and a half ago. A year and a half ago I had my first client overdose.

**ZM**: And you were like, I don't want to do that again?

**SD**: Yeah. I sat here until eight-thirty at night. We leave at two o'clock in the afternoon. I was here until eight-thirty at night waiting for his family to call me and tell me if he was alive or not. I couldn't go home until I knew what I was coming into the next day, or if I needed a day off, honestly. I couldn't leave. I thought to myself, if I'm feeling like this and this is my client I can't imagine what a family member, or somebody that really knows somebody personally on a different level than I do—even though I probably know more about my client than their family does quite often—but how it affected me feeling and waiting to find out if they were okay or not that nobody should fricken have to feel like that. So I started to go just kind of haywire with the Narcan thing.

**ZM**: How did you transition that into a part of your job?

**SD**: A lot of it was with Little Earth. I went a did a training with them finally. I'd snuck it in a few times, and did a big training for the community there. Then started doing some education at the colleges. MCTC, and Century College. Got some of my professors talking about medically assisted treatment. By word of mouth people started hearing my name. It turned into a bigger, way bigger than I expected. My caseload got dropped because this is part of my job now.

I was just kind of doing it on my own time. I had a full caseload. On Sunday's or at three o'clock in the afternoon, or if it was in the middle of the day I would schedule my work around it, and I would just do whatever it took to make sure I got this stuff out there. I was just like this is it. I found my niche. And then talked to, you know, our bigger bosses and things like that. Chuck Hilger, who is one of my bosses here and the VP of our program here. He knew what I was doing. He gave me—he pointed Amy in my direction! It was something that I just—we were missing it. Where else do you get Narcan from? The average person is not walking into a fucking CVS pharmacy and saying, "Can I get Narcan?" Because first, I'm going to be judged. Do I have to give you my name? Am I going to have to pay for it? An active user sure as hell isn't going to go and get Narcan from a pharmacy. They're not going there to get their needles anymore because they usually don't give them to them. So, why would they go.

I just started doing as much with the clients and the staff here and just, yeah. Word of mouth. I've trained from here to Kenyon police department, which I didn't even know the town of Kenyon existed. Very small, like a thousand people. I went and trained their narcotics unit, the police department, and the first responders, but the first people to respond in a small town like that are the police. So, they all have our Naloxones. I've been to Kenyon, I've trained as many treatment programs as possible. Meridian did not have Narcan at all in their patient residential sites open until I came along. I was like, "This is bullshit. If we're going to work together you guys have to have that." I've trained all their staff, all their nursing, all their residential programs have that.

**ZM**: Are they an abstinence based sobriety—

**SD**: They're abstinence based, absolutely. But that doesn't mean people don't die. So, I was like, you know, we still should have that. And have been educating more about harm reduction and methadone. I was at RCCS—restoration, counseling, and community services I think it is—last week doing Narcan training with them. MAT, methadone assisted treatment 101, kind of education with them. Anybody that's interested. I do EMTs, I do Save-A-Life Corporation, which is like first responder classes a couple times a month. I just come in, spend thirty minutes doing Narcan training, talk about opiates, and get out. [laughs]

A lot of it originally was volunteering. **It's like I said no one—to start my day off is checking to see how many of my clients didn't dose the day before. And if they're not normally people that miss days in a row, if I notice that they've been gone two or three days and that's not their normal m/o I start looking through the jails to see if they've been arrested. And then I look at obituaries. And the fact that my day starts at 5:30 in the morning with me looking at obituaries to see if I recognize any names is bullshit.**That shouldn't be my job. That shouldn't be anybody's normal day. It just really, really shouldn't. Until we do something and really address the problem and fill the gap and talk about this stuff it's not going to matter. We're not going to make a difference. We haven't talked about it. **We ignore it. We ignore drug addiction. There's so much fucking stigma that comes along with that.**

**ZM**: Especially with something that's so prevalent.

**SD**: Yeah. Addiction is not going anywhere. Hasn't gone anywhere in forever. **It's not going anywhere now so why should I have to be anonymous? And why should I be shamed because I'm on methadone or Suboxone if I go to a twelve-step meeting? Why can't I say that I'm using this as a tool along with treatment.**

**ZM**: Is that not accepted?

**SD**: Not so much. **Depends on the group, but they quite often get shamed and told that they're not clean. We try not to use words like clean and dirty here because if I'm clean that means at one point I was dirty. As a person that's been in active addiction and has shamed themselves to death nothing you say can do any worse than what I'm telling myself all day long.** So I don't need that from people that are supporting me. You can't tell me how to recover. The only way to not recover is to die. It doesn't matter. I don't fucking care how you recover if it's a light bulb and some methadone and a plant is going to work for you then do it. I don't care. Or if smoking pot is going to do it for you, or if the risk is going to be less than the IV use and I'm going to start smoking it, and then hopefully maybe I slow down and I go a different direction and I add methadone into the mix or IV treatment, or it's Teen Challenge. I don't care. I don't care. But I think that we've told everybody that there's one way to do things and that's the only way to do it. The reality is that's bullshit. **We have extremely high success rates. Medication assisted treatment is extremely successful for long-term use. Most people need to be on methadone or Suboxone for at least a year.** Anywhere from 365 to 442 days is the research I've done. But it took you a year to qualify for this program, it's going to take you probably about a year to get your life together.

**ZM**: Is that the average length you see?

**SD**: It all depends on the person. Some people are here for a year, year and a half, a couple years. Then they are kind of ready to titrate or taper off of the medication and go on their merry little way. Some people have no intention of ever leaving and that's okay. And some people don't know, they say they're not quite done yet, and decide to back out for a little while, and then they come back. And we always just hope they make it back. We have a lot of clients that readmit to our program over and over again. And shit, I'm just thrilled when they walk back in the door and they know they made it because a lot of them aren't.

We need to do something different out here. I think education is a huge part of it. Educating and being honest. I think the education piece needs to be done by people who get it. People who have been active users—even the ones that are actively using. People who are maybe on methadone and are doing well. People who maybe still are actively using. And then the families. By people who get dirty and see it. Because the suits, and society, or people that maybe trained in certain things but don't see it all the time. I think we ignore a lot of stuff. I think we've been ignoring it for a long time. Even the fucking war on drugs. That worked out real well. [laughs] "Just say no." I'm a product of "Just say no." It didn't work. What that did was gave people the idea that you had a choice.

**ZM**: I also think it was a race thing.

**SD**: Absolutely. It didn't work. And, "If you just say no you'll be okay." But if you say yes then you're weak because you had a choice to say no. And that's what it freaking put on everybody because society still sees a thing, "Why can't you just quit?" Why would you need another medication? Just stop. It doesn't fricken work. Having to explain that to my father years ago, you know, when you said you were going to quit smoking and then by six a.m. you're at the Holiday gas station buying another pack of cigarettes—that's how I am with crack cocaine. I can't not stop it. And so if, you know, for him to try to quit smoking you guys have one of those little inhaler things—that's my methadone. He was like, oh, this is like my methadone. I was like exactly! That's harm reduction. That's less harm and you're weaning yourself. However you've got to do it I don't care. It absolutely works.

I think we need more access to treatment. I think that we need programs—for the opiate piece—we need programs that accept everybody no matter what medication they're taking including methadone and Suboxone because not everybody does. And I don't think it's fair that you can make a deciding factor on what somebody is taking for their medication because you're going to take them if they're taking lithium or gabapentin and those are abused drugs. They can cause sedation, they can cause a combination of things if you take them with other fricken medications. So who are you to say we can't take them because they're on methadone. We'll take them on methadone, but they have to be on sixty milligrams or less. Well who the fuck are you to say what that person's magical dose is? Because you don't know anything about them. I think you should leave it up to the experts such as us and our doctors and things here to make that decision before you say they can't come to our program. Because then again you're outed and there's that shame and that stigma of, well, I'm not good enough to go to that program. Only a couple of them will take me. No sober living's will take me. It's just not fair. **We're alienating a huge population of people that the most amazing people I've ever met in my entire life that don't have a fricken fighting chance because we won't allow them to based on judgment and a lack of education.**There's my soap box.

**ZM**: That ties in nicely to where I wanted to go. Do you have any other policy changes that you would like to see in an ideal world where Steph was in charge?

**SD**: In an ideal world where I was in charge I'd get a raise! Then I think that naloxone should be with every first responder, police included, because quite often they are first to the scene and not every police department carries them. I'm speaking Minnesota only—we should be able to open the doors to anything. Continue to educate each other. This should be in the school systems. We should be educating clinicians going into the field. I think that the doctors and the medical field needs to be educated on what's going on out there. I don't think they really have a clue, and when another person comes in on an overdose there should be a referral process going through. There isn't one. You're usually in there for about three hours and then you get discharged.

It depends on the program, the facility. North Memorial starting the eighth of this month will be giving out an optional Narcan kit to anybody that comes in on an overdose. That comes with some referral information and stuff like that. So, they're finally getting it. But even talking to the providers there in the emergency department: why are we giving them needles? Is the response. So, there's always this stigma and lack of education. We're like, well, this would be partially cost, but this is the reason because dead people don't recover. That's my short answer for you, but why would we not? Because this could be your kid.

I think that the problem is not enough of us have been affected. And that's shitty that we all have to fricken have lost somebody or see somebody struggle in order for this to be a big deal. Because we just don't know. I think that we need to—Minnesota being the land of ten thousand treatments we have a million and one treatment programs that anyone could get into, but I think Narcan should be on site at every single one of them, they should be opening the doors to anyone on medication assisted treatment, I think our detox processes of people are going to straight detox and doing a detox program instead of doing MAT or anything like that—it's scary. I think having to wait to get in is a huge barrier because if I'm going to have to wait two weeks to get into freaking detox? I'm not going! Forget it. And the perception of addiction that I need it right now—that's why we answer the phone all the time—is that you don't care. Well, they didn't answer the phone and they only answer Monday through Friday from eight to four. Well, two weeks from now? That person might be dead two days from now. So the urgency and trying to just get people straight through. And that's part of the policy piece here. A straight shot from that phone call they make that maybe there is a bed waiting in a detox and maybe then we give them that option to do you want to start on Suboxone or methadone? Is that something that interests you? Get them started on that because the withdrawal while waiting to get into treatment you're not going to stay. You're going to walk out in two days if you last that long. So from that getting them set up and somewhat stable, or at least somewhat comfy for a few hours out of the day, and then going from there to any treatment program if that's something they need. But having everyone's doors open and the problem is there's always going to be a waiting list for treatment because there's too many clients and not enough programs no matter how many we have out here there's always going to be a wait list, and then there's going to be the ones people want to go to or are referred to more often than others.

For us for the opiate piece there are certain areas—no one's going to take anybody that's in withdrawal. We have to figure out, you know, we're referring people to treatment there's dimension one, which is all about withdrawal. And if they're at too high of a number they're not going to take them. You've got to go to the hospital first. Well, great. I've missed my bed. No one's going to hold a bed for you because they're going to put the next body in there. So, we're just missing a lot in order to do so. I think we all have to act like I guess the AIDS crisis, which you know took us forever to fucking recognize too.

**ZM**: At least the nomenclature of epidemic harkens back to that sort of level of—also level of ineptness to deal with it currently. Just to sort of sum up it sounds like you're recommending an integration of harm reduction into the already prevalent Minnesota Model, twelve-step in-patient as well as on-site withdrawal? Maybe?

**SD**: Maybe. If they could figure something out like that that would be great. If somebody was willing to do that. At least always having special beds available in like St. Joe's or Fairview for people that don't want to get on medication assisted treatment. Yeah, something to that effect. Or if they're going from one treatment to another, especially for the overdoses, if someone overdoses there should be an automatic phone call. Let's make a phone call to this place. Or at least, you know, here's a card. Call these people. It doesn't have to be Valhalla. This isn't a plug for us, but you can't just have somebody come in from a near death experience and say, alright see you later. Nothing. Even quite often when people overdose they don't know or remember what's happened, but the family knows what's happened. We see it. We're affected by it. Society as a whole has a huge fucking ripple effect. So then why aren't we doing something?

**ZM**: Aren't there similar requirements for suicide attempts and things like that?

**SD**: There are some, yeah. Similar things. You hold them for seventy-two hours or ten days depending on the situation. If there's going to be some serious medical problems coming along with it then why aren't we holding them for ten days? And then we go from there to the next thing and setting them up with psychiatric help? Like you would for a suicide then why wouldn't you set them up with treatment and whatever and having choices. People need to have choices.

**ZM**: I think the agency is crucial.

**SD**: These are some choices. What sounds good to you? Because when I have a choice I'm much more successful.

**ZM**: Even if they both don't sound great at least you are picking.

**SD**: Exactly. At least one might sound better than the other. Our clients walk in and they aren't mandated to treatment here. Nobody says you have to come to treatment at Valhalla Place. I think there was maybe one person that probation said they had to come here. Our clients come in because they want to come here. Wherever they are in the state of change. Whether they are here just because it's going to fill in the blanks between their use, or because they really want to stop. However they get here they get here and they fricken walk in, which is the hardest thing for someone to do is say, you know what? I can't fricken do this anymore and I need some help. And when somebody does that we should be high-fiving them and giving them kudos and support and acknowledging that instead of shaming and making them feel like shit because you couldn't just quit. So, we're missing a lot of stuff.

And we need a whole lot of money. Narcan, grants, all kinds of stuff we pay out of pocket. Not everybody can afford that. Oh, and the jail system. That's my biggest goal is the jail and prison system. Naloxone is in there, but New York has an amazing program out there that all their jails and prisons, and I think they have fifty-four jails and prisons in New York state, but prior to an inmate being released they have the option of having a Narcan training and having Narcan in their property. How fricken amazing is that? The highest risk of people coming out is treatment and jail of overdose, so why wouldn't I set them up to protect them and having their family be trained as well? Why wouldn't we have that? And then why should we cut them off cold turkey if they're on methadone or Suboxone when they get incarcerated? Yeah I made a mistake, yeah I did this and that, but all I'm doing is setting them up for failure if they're in there for three days, ten days, three years if I don't have any treatment and no coping skills I'm going to get out and do the same damn thing. Opiates don't go away short term. And they don't go away because you're in a bubble. "Well, you've been in jail for two years. You'll be fine." I did prison for a couple years. I still wanted to smoke crack when I got out. So, the craving process when I'm in a safe little bubble was sights and smells and sounds our memory sticks to those things, so why wouldn't we start somebody up even if you're not doing them while you're incarcerated. But sending them up prior to that. "I saw that you maybe used opiates in the past." They talk to somebody about, you know, medical people there and some of the treatment programs. Setting them up with something is an option coming out in our jail programs.

**ZM**: Have you attempted to speak with anyone?

**SD**: Shit. I've gotten into Create, which is an out-patient program out here but they do Telasis, which is the Hennepin County jail. Kind of gotten in that door there.

**ZM**: You've been sneaking in Narcan to prisons?

**SD**: A little bit! I'm trying to get in. With the state and the counties there are all these kind of hoops you've got to jump through. I only need one. I need one fricken jail to get on board. And if it's successful the rest will follow because we love to copy each other. So if I can just get one program.

**ZM**: No one wants to be that jail though.

**SD**: No, so I've got to find the right one and get the right person that'll at least hear me out and let me show what New York has done because they have an amazing program. We would eliminate recidivism as well. Along with the death toll that comes along with it. But, showing some care and compassion on the way out because they're people. Yes, you committed a crime but you're still a fricken person. We still feel, and we still bleed the same. I think we forget about that just because we have made some mistakes in our lives.

I would love to get in there and have a Narcan program. Send that out there. I would love medicated assisted treatment to be allowed in the fricken jails continued. If they arrest one of my clients why should they get cut off cold turkey? I shouldn't have to write letters to the judge to beg him to get them out, which I've done. But the only time a person will get their methadone or Suboxone is if they're pregnant. And once they have the baby they're cut off. So, you're going through the trauma of having a baby in jail in handcuffs, not having the baby with you because you're going back to jail after delivery. So you've got a shit ton of trauma and are also going into withdrawal a couple of days later. It doesn't make any sense.

It's very successful to have a baby while on methadone or Suboxone. I work with pregnant clients. Better than nothing. Better than nothing, and it works. But that's the only time we give a reprieve is if that's the case and they are pregnant. I have a client in Shakopee prison right now. We delivered her medication. But when she has the baby three to five days later she'll be done. I can't imagine what that's going to be like for her on top of what she's already going through. And then being in the prison system on top of all of that.

**ZM**: Is it hard to just separate your job from emotional investment?

**SD**: I've gotten better at it. I've gotten much better at it because I've learned that I can't take everybody's stuff with me or I'm not going to be able to function. I have to take care of myself. So, I have learned over the years that at the end of the day I try to leave my stuff in my office, and then go back and be Stephanie and take care of Stephanie. I can't take care of everybody all the time. My job isn't to take care of them. It's to support and guide them and be there for them and listen to them and make sure they know they're heard. All those things. There have been times where you've got to really let go.

We're great here. We're extremely supportive of each other. If I need a break I get a break. When I've lost clients or found things out in the middle of the day and I'm like, "I'm out. I have to go." Or, "I have to go do something. I'll be back in an hour because I just need a little bit of time to get out of here and decompress." And we get a great amount of PTO, so we get a lot of time off which is nice. Most places don't that amount of time off that we get here. They do want us to take care of ourselves because it's hard. It's a hard job.

**ZM**: When I moved from just studying this in an academic sense last semester to actually doing interviews—this is the first I have conducted on my own—but I sat in on a trial run with Amy when she was interviewing another parent in NA and I was floored. I was wrecked for the rest of the day. I was like how am I going to be able to do this? This is insane. I can't even imagine.

**SD**: It's hard. But there are times when we sit with our clients and I'm crying and they're crying too. And then there's bad times. I have a client who's terminally ill, and I know it's coming sooner than later. And he's always like, "Why are you crying?" And I'm like, "This is hard for me! Because I'm trying to prepare for your death." How can I prepare for that? Because I'm trying to grieve and you have to allow me my grieving process, too. And that he could understand, but he was trying to not deal with it in his own right, and I can't imagine being in his seat.

I think it's important that they see that we're real people, and not a machine. I'm human, and I do share my story when it's going to be good for the client. If it's something that's going to help them to connect, to realize that they're not alone and it's not going to be harmful then absolutely I will share stuff if they ask me certain questions. I don't have anything to hide. If it's going to help them absolutely. Because I've been through a lot of shit. I share my story when I go to treatment programs and speak a lot of times. I wouldn't wish my story on anybody, but I think they need to know I have been there. I know what it's like to sit in that chair. I know what it's like to be you. I know what it's like to have a record. I know what it's like to be judged. I know what it's like to have labels all over me. And guess what? I got a job, I have an education, I have a career all after I did all that other stuff. I think I'm proof to many people that you can get out. And you can do something different. Don't let society, or your background, or whatever it is write your freaking path because it's bullshit. If I had done that I'd be dead by now. There's no way I would have made it.

**ZM**: It seems like the whole individualized and humanized and personal element is what you do at Valhalla.

**SD**: Yeah. I think so. I think a lot of programs do that too, but I think it's just very individualized. The same thing can happen, the same person here—like two clients in the same situation going on, but the circumstances still could be different. This is a newer client. This one's been here for two years, so they know these things. This one maybe doesn't. So, as I said we have our 'it depends' thing around here. "Well, this guy, this is what you guys did." "Well, this is different." "But it seems the same." Well, it's not.

Our job is to fight for the client. Sometimes there have been times when fighting for the client means I have to discharge because it's a higher risk for me to have them continuing treatment here than it is to let them go. That one sucks, but at the end of the day I have to protect myself, protect my company, and protect that person. I work with some more difficult patients. I also am working with clients that are committed; they're on a full chemical dependency commit. They go into law facilities sometimes at Care Anoka, and I am one of the counselors that was going there for them, and so we provide them they're medication and then I go and see them and meet with them. In order to commit you've probably done a lot of things. Numerous overdoses, suicidal attempts, hospitalizations, in and out of the systems. Things like that. You're either really good at what you do or not so good at it depending how you want to look at it. But those are some high risk patients. I have to make sure they're safe. Sometimes saying methadone is not appropriate for you anymore because I have to make sure you're safe is my decision. I'm always hoping I'm making the right decision for everybody.

**ZM**: That's the difficult part of the job. Not having a road map really.

**SD**: I have to weigh the ficken pros and cons, and what's going to be less harmful. Sometimes the less harm is saying, "You can't. This isn't going to work for you anymore." And letting them go, and hope that they find another way. It's a hard fricken job. I'm surprised I didn't cry today. I'm usually a squishy one. [laughs] Every now and then certain stories... But I'm extremely passionate about making a difference out here.

**ZM**: I can tell. Is there anything else you think would be important to know?

**SD**: Dead people don't recover. No stigma. My little hashtags: Carry Narcan Now! That's what's important. And thank you for letting me hopefully be a part of this because this is important. And I'm glad that patients such as mine are going to be heard in this project. This is amazing. Because they need to be heard. Thank you.