Rae Eden Frank
Sue Purchase
Narrators

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Interviewer

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Sue Purchase	**-SP**
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RF: I was cussing and slamming doors. I was like, "Everybody get the fuck out!" [laughs]

AS: So what happened?

RF: That was one time that I had to kick everybody out. I came back from the weekend and it was just a laptop that I left sitting on my desk like I always did. I unlocked this—but I mean people really didn't steal stuff from there that much. Maybe they did. What was there to steal? Maybe that's was *the* thing. There it was. That was the something to steal.

We had been open on Saturday and I hadn't been in. Maybe I usually took it with me on the weekends? I don't know, but I came back and my computer was gone. I was fucking pissed off. That was probably the angriest I got of anything that happened there. It was because I had no idea who it was, there was no way to figure it out, there were no cameras in the place. Everything was backed up, and so it wasn't an information loss. It was the principle of it more.

SP: Crazy things would happen. There was one, I think it was a Christmas Eve because we had a security system and an alarm. I got a call and it was at midnight. Somebody had put their fist or the bowling ball that was on the gutter went through the plate glass window. Cops—there was always a response. Let's see. Sometimes out of being naive and helpful, holding onto people's methadone for them with an agreement that, well, you couldn't bug me at home, you couldn't do this, you couldn't do that. The methadone would be here, but there was always some sort of shenanigans with that. Holding onto people's money occasionally. Somebody broke into my office because they stole the outreach bag and other stuff once. I think we thought Chuck Lowden had done it.

It was one stop shopping. I mean really: it was services for drug users. Welcoming, and not sterile. They met their peeps there. Oh my God. Ian always described it as a very delicate ecosystem, and it was. Figuring that out. It's not a one-size fits all approach. It's really based on the individual. Trying to figure that out and how do you handle it? Not easy, but always trying.

AS: Would you say that the description that Teri Morris gave of their place sound like—

SP: Let's see, what did Teri say about it?

AS: Strong coffee, space, not getting upset if people decide they are going to come in and rearrange all their earthly posessions out of their bag—

SP: That's exactly it. I can just picture it when people are rearranging their early possessions. Absolutely, yes. We definitely had strong coffee.

RF: Always coffee. People could always come and use the bathroom.

AS: Was there a shower in the bathroom?

SP: No, but Jeff Parr and Mikkel Beckmann tried to talk me into it one time. It's like, "No, no, no, no. That cannot happen." There was a need, but that gets into something that is just really difficult to manage. You'd have to install a shower and—I used to run Direct Services at Catholic Charities and the showers were there. You'd knock on the door, "Five more minutes!" [shouting] People hang out in the shower, there's just another element of supervision, staff, oversight. Really we were providing a whole lot to people. Things that maybe we weren't funded to do or had thought of. People would come in and they would have a need. So really trying to address the need in the best way we could. I don't think, in hindsight, that we offered a lot of "no's." We aimed to please.

AS: [to Rae] How was your leadership there influenced by Sue? How long did you guys work together?

RF: I started in 2000 or '99.

SP: '99 I think.

RF: What year did you leave?

SP: I left in 2001.

RF: Really? That soon after?

SP: I think I really needed a sabbatical, but I left.

RF: To answer your question—

AS: Was there a point where you had to depart, or did you always just kind of hold the original idea?

RF: I think even hearing Sue talk about things like that there are certain limits and boundaries because I think I struggled with—personally my framework was twelve-step. That was my own

recovery. That's not how I wanted to operate. I didn't want what worked for me to make an assumption. I knew that that doesn't work for everybody. Sometimes then going to the other extreme then of them like not having any boundaries or parameters. I think it's always been helpful to hear you talk about, "Oh no. We're not doing a shower. This cannot happen here. This has to go." So, knowing that there were limits and boundaries. There was a container even within harm reduction.

SP: I always thought of it as flying by the seat of my pants. I had no real idea. Making it up as I went along. Trying to balance that out, because then if it really is an individual approach, how many rules can you have up front? We had a list—I think it might have been in one of those notebooks—remember the big piece of paper that hung when you came in? You couldn't have guns in there. Couldn't assault people. [laughs] Respectful. There were expectations about treating people with dignity and respect. That was supossed to be upheld. There might be "no's" but in the way they get delivered I don't know.

AS: Did you find that it was difficult for you to bridge the idea within yourself with twelve-step? Being around drug users? Did that affect you at all? Twelve-step program is pretty cut and dry. But you were able to keep that boundary that 'this is just what works for me'?

RF: This is just what works for me. Yeah. I think it was more—yeah. I'm trying to think of an example or story. It's been a long time. For a while it was so much a part of my life because I was always doing something. Either harm reduction, or chemical health, or doing this or that and now that I'm not doing it my context is so different now.

Part of my story is about needle exchange being a huge contributor to my health status and having not contracted HIV or Hepatitis. That's such a huge part of my story too that it just made sense to me. There wasn't a way that it didn't make sense.

AS: One of the sessions we're in—we talked about this afterwards I think—about the connection that I was seeing, or maybe I was talking to Teri. The connection between the harm reduction model and then how people in groups for loved ones, twelve-step groups, detatch. There're some parallels in those two groups that I found really fascinating. Apparently there is a book, *Over the Influence*, by—

SP: Patt Denning. She's a harm reduction psychotherapist.

AS: —promoted this idea. It just occured to me while I was listening to one of the presentations. I was like, wow, this is how we try to live as loved ones of people struggling. We have to try to find a way to just support them, love them, we want to keep them safe, but we can't force them to stay safe. You can't force someone to not use a needle two or three times, or share, or whatever. To me, at least in the past, they've been portrayed as antagonistic—am I right in thinking that they're starting to overlap a little bit? Like a Venn diagram. There might be this place—I think about naloxone.

RF: A lot has changed too.

AS: People are starting to see that we really wish that our kid was alive.

SP: There's definitely a shift in thinking. You want to save your child and you realize what's at stake.

AS: When have parents of decesased drug users gone to state legislators—

SP: Not until they're white.

RF: Not until the kids are white.

SP: White, wealthy kids. I think that—

AS: So you think it is really a class issue.

SP: Very much so. Yeah. We were pioneers. We were trying to figure it out. I've said this probably more than once during the interview. We were not the West Coast. We were not the East Coast. There was an estimated number of injection drug users in the Twin Cities metropolitan area in 1996 that was something like six to ten thousand injection drug users. The information, the data that that's based on was hospital emergency room visits, treatment admissions, and I don't remember if it was coroner reports—I think there was something else. Certainly treatment and ER. Nobody really knew.

There was a guy early on—maybe early nineties. His name was Rich Needles, and he was at the University of Minnesota. He started a study. He always had sort of a, well sort of a questionable reputation. Then he went to work for NAYA, and I'm not exactly sure what happened there, but nobody knew a lot about Minnesota and what was happening. There is an assumption, you know, 'Minnesota Nice,' we don't have drug users here, we don't have this, we don't have that. Developing that program was so much in the dark. Everything about it was new to Minnesota. Harm reduction was really new in the United States. We didn't really have anybody that had—you know, similar geographic location, maybe Dan Big in Chicago, but that's a major urban area and he's got other things happening. It really was making it up. Trial and error. See what works. Try to have as much people involvement as possible. A collective of sorts. Honoring participants. Learning from them.

I think certainly Chuck Lowden is a wonderful example. I knew Chuck because I had been working at Catholic Charities in Direct Services, showers in the morning. Chuck would come down in the morning. He was always crabby. He was on methadone. He used to be an altar boy in the Catholic Church. Every morning he would come down and he'd be crabby. Every morning I'd say, "Good morning, Chuck. How're you doing? Good morning, Chuck. How're you doing?" Then I'd do outreach down at the shelters. Curry Avenue. I'd see Chuck down there and oftentimes he was sprawled out there on the sidewalk on the nod. We got to be buddies. He went to the methadone program in Maplewood. He brought brochures to put up in the methadone program. Brochures about Women With a Point. There was a needle exchange. It was brand new. He would refer to it as our program. Some people would want to correct that and say, "Oh, it's not really your program, Chuck." It's like, yeah, it is Chuck's program.

So that people felt welcomed, and included, and that they participated in something meaningful that brought something to their life that benefited others when you're just a dirty junkie and homeless. All of that. What a difference it made for people. It made the world a better place. It generated goodwill.

Like pharmacy access. I remember doing those surveys and I was in some upper, lower, three-floor duplex, triplex in northeast Minneapolis, and people are getting high and I'm doing surveys, asking them questions. They'd be like, "Oh, Sue. I'd love to volunteer for you someday when I'm sober." It's like, well, you can volunteer now. Don't steal from me! No punching! [laughs] But that they were welcome. That they were important. That they mattered. That was really it. It was such grass roots harm reduction across the nation that, you know, it was all touchy-feely warm stuff. Organizing, user organizing, drug user organizing.

RF: So empowering. The people who would come in. That feeling of being welcome and that feeling of mattering. Having a place to come and have a cup of coffee and get information and share information.

AS: Just have someone treat you like a normal person.

RF: Not judging.

SP: And they didn't have to scare up a bunch of in formation if they didn't want to. We collected, what was it? The unique identifyer. Asking for the first initial of their first name, first initial of their mother's first name, and date of birth. We'd ask for race, zip code, drug of choice, and maybe syringes if they were returning. Always explaining that they didn't have to offer up that information if they didn't want to. They would still receive services, but also explaining why it was important to collect that data because if they would share with us it would go into a grant application and help us get more money to help us rpovide more services. It was constantly education on every front so that people were informed consumers. That was important. Empowered consumers. It was successful.

RF: It was very successful. I mean years later people coming back and saying what an impact that had on them. That space. And it was the space, too. It had it's own—I mean with the plants, and the piano, and the couches, and the paint on the walls, the way it was brightly painted. Everything about it was just really like, "Come in. Welcome."

SP: Inviting.

AS: I had somebody reach out to me from the Facebook page about the History Harvest when my phone number was on there very briefly. That freaked me out because that was public and I've had all these weird men trying to Facebook friend me. No one tried to call me beacause we caught it. In that short window a forty-year-old woman called and said, "I have a connection to harm reduction. I've never told anybody my story. I can't come that day I have to work. Do you want to do an interview?" She told me on the phone what her connection was but I quickly forgot until I was sitting there interviewing her a couple weeks ago. Her dad died of complications due to not being properly treated when he went to the hospital. He was having strokes but they knew

him as a drug user, so they just gave him some Percocets and sent him home. They thought he was lying about his headache. He was actually having strokes. Ten days later he ends up at Unity. They're very kind to him. She has to make a very difficult decision to unplug him. She was raised by him. He was a firefighter. She went back to his home and collected all of the needles, and somehow found out about Access Works. In 2009 brought a whole bag or container to your place. I don't know when it was. She said, "I walked in and I don't know what I was expecting but it was really calm, there were couches, people were sitting there." She said, "Can you take these?" Someone, whoever greeted her said, "Yeah, we can take those. Are you okay?" She was surprised that anyone asked. She said, "My dad just died." Whoever it was kept saying, you know, "Are you okay? Do you want to talk?" That just really stuck with me. I got total chills when she was telling me this. I was like, "Oh, that's why you called me." I thought that was a really powerful story. It stuck with her that there was this place where people were really nice and she had had a horrific experience.

RF: Getting some closure with that experience from her dad, too.

AS: From a complete and total outsider perspective I thought that was really interesting.

SP: Yeah. It was a cool place. It was the hottest gig in town. I don't think any place like that exists anymore.

I was up on White Earth for the conference, and the last session I went to was a MAP [Minnesota AIDS Project] session on needle exchange. I missed the first fifteen minutes. I've got the print out at home of their presentation. They're talking about what they do every single day. On Monday's they have Narcan training and hand out Narcan. The woman behind me from RAAN [Rural AIDS Action Network] she's like, "Oh, is it only available on Monday's?" And they answered, "Yes." My hand went up, and I just was like, "That's reprehensible!" [laughs] I was pissed. They were trying to explain—I said, "Oh, does there have to be a research component attached for people to get it?" Oh, I was mad. He talked about staffing: it's this, it's that. I was like, "Yeah. Whatever." I know MAP. I couldn't stomach it and I had to leave.

The woman had friended me on Facebook the day before that. She was at this conference. I had looked at it and then I had deleted it. After the conference she sent me a message talking about, I don't know, she'd always respected my work or something, and she wanted to talk more about their program, and she'd looked around and I was gone. I acknowledged that. Didn't say much. When I got to the event on Saturday she was the first one there.

RF: She works at MAP? Is she new?

AS: New to what?

RF: New to working there?

AS: One of my students interviewed her and felt like it was a compelling story. She said when she gets students, interns from Hazelden, she has to re-educate them about what it's like to work at MAP. Around addiction and harm reduction. Did you re-friend her?

SP: I don't think so. Certain people just have a vibe, and it's just like I don't want to have anything to do with that. I don't know. It makes me wonder, so everybody—harm reduction gets thrown around and there's overdose stuff and Steve's Law and all of that. It's Narcan availability, but is it harm reduction?

AS: I'm going to come to their defense and say, yes, it is harm reduction because they're child isn't dying. There're moms who have their addict children living in their homes, or their children in recovery and they've got their Narcan on their dresser. That is harm reduction.

SP: Sure, sure. That is, just like the syringe is, but is the program—that handing out the Narcan or the Naloxone.

AS: No, I don't think they would call themselves harm reduction.

RF: And when it's certain—you have to come here—

SP: That's what harm maximization—I may have said that in there, too.

AS: Harm maximization? What do you mean?

SP: If you're only going to hand out Narcan on Mondays, and it's not available anywhere else and people use drugs other days of the week that's not harm reduction. That's just like the example I said about Dave and the needle. That it's a needle exchange, and it's certainly a harm reduction strategy, but the program wasn't really harm reduction. There's a whole principles, and practices, and philosophy behind it all.

AS: You think that part of it has just been pulled out?

RF: I would say it is more palatable for the mainstream.

AS: That one aspect is just being pulled out of the whole of harm reduction. As if we were just going to do step one.

SP: Right, we are just going to do this strategy, but that doesn't necessarily mean it is a harm reduction based orgainzation. I mean in many ways it's almost like looking—

AS: I don't think it is a harm reduction organization. I don't think they would say that.

SP: MAP?

AS: Steve Rummler Hope Foundation.

SP: They don't really provide direct services. Aren't they sort of policy—

AS: They are policy but they do Narcan trainings all over the place. They educate officers, security guards.

RF: Okay. And do they provide the Narcan, too?

AS: Yes. They provide the Narcan. You can make a donation. One of the people who came on Saturday, Stephanie Devich, she had a shirt that said, "Got Naloxone?" on it. She's in our picture. She's in the pink.

SP: I wondered who that was.

RF: She looked familiar but I couldn't place her.

AS: I haven't read her interview. She was the first person I had a student interview. She I think has really spearheaded—she was giving Narcan away. She brought a whole bunch of stuff for Lee [Hertel] and was upset that he was gone. She's an interesting person. I think she got hired there to do harm reduction—she works at Valhalla. She has kinda taken it to the streets. When I see her stuff on Facebook about what she's done—she's very active on Facebook. She's gone all over the place.

SP: Doing trainings and getting Narcan out into the community which is awesome.

AS: She's got syringes.

SP: She's got syringes, too?

AS: When my daughter was there—went to Valhalla because I was desperately trying to get her into treatment—she and her now husband went and they left with clean needles. They left with this little brown paper bag. I remember going into her room after they had left to see what was in there. I was so pissed! I was just done with it.

SP: So she works for Valhalla? I don't understand everything that's going on in Valhalla, but I'm getting pieces of information.

RF: Adam started something. I thought Adam Fairbanks—

AS: He's not there anymore. He works for Little Earth.

SP: Is he at Little Earth or up at White Earth?

AS: He's in Minneapolis.

SP: If he's over at Little Earth that's awesome. I was surprised that Adam wasn't up at White Earth. I think Nick Metcalf might be working over at Little Earth as well. That's good. I just don't understand the whole Valhalla thing and how some of that stuff works.

AS: Well, it's fascinating because Valhalla just got bought by Meridian, and Meridian has been bought by some big investor group in New York.

RF: Why did Valhalla sell? I guess money, right? Have you ever met—

SP: Karen Greenstein.

RF: I was going to say this Jewish, very New York Jewish—that's what I remember about her.

AS: Well, I think it's clear there's a lot of money to be made.

SP: I think they sold Valhalla for fifty-five million.

AS: Fifty-five or five?

SP: No, I think the number was fifty-five. Who just told me all this? Chuck Hilger?

AS: He works for Meridian now.

RF: He works for Meridian now?

SP: He brokered the deal.

AS: He did. He brokered the deal.

RF: I wonder how much he got.

AS: He left. He was upset with the way things were going, got a job, and then—I don't know what happened. I can't keep it straight. What I'm wondering is is MAP just going to go the way of treatment centers. Just trying to make money off of people.

SP: I think that certainly is already happening.

RF: I think it's definitely already happening.

SP: I think there has to be a variety of options. I don't think that overdose is going away and that is the driving force behind all of it. I think you and I talked about Teri Morris's presentation when she's talking about how—not Teri Morris's presentation, it was Maya's. Were you in Maya's? So that fentanyl and carfentanil isn't just in heroin but pressed Xanax bars and methamphetamine and everything across the board. And with no way of knowing. How do you stop that? How do you stop the death? If you look at drug trends and what they've been over time—so I would say starting women with a point certainly there was heroin around, but you saw much less heroin—more methamphetamine, some cocaine. Then you just start seeing that gradually change, whether it was because we were becoming more connected with the population, but you just saw it change. How drug trends happen and that idea of what goes up must come down. Amphetamines, opiates—

AS: And now meth is coming back up.

SP: Oh my god.

RF: And prescriptions.

SP: And prescriptions then in the mix. And that's not changing. They're reformulating.

AS: They just received a 750 million dollar fine for false advertising.

RF: Purdue?

AS: Yeah, and they're still going strong.

SP: And they are just terrible. But all the systems at play, and then if we have politics that aren't going to support health and human services in this country, and in many places—Minnesota is very good in that there is ready, available access to treatment. Many states don't have it. Colorado doesn't have it.

AS: Texas has hardly anything.

SP: No, and you just watch the body count. It's awful. So I just wonder are there harm reduction programs? Where can people hang out? Apparently MAP's program is in a parking lot at Gethsemane.

RF: I saw they have a little office or something on University now in St. Paul. That's their business office? And then they have the parking lot. Do they have a van?

SP: I think they still have the mainline van.

RF: But not a place to go hang out.

SP: No, no. Apparently, remember [Amy Moesher]? I just ran into her at White Earth. I didn't recognize her at all.

RF: She was MNTAP?

SP: I think she was at MDH for a while. She looks completely different. I didn't recognize her. She's lost sixty pounds, she wears her hair really short.

RF: She's not the director of the Aliveness Project now, is she?

SP: Yes. Apparently they have a needle exchange program, but I don't know much more beyond that. I think that—the [unclear] Clinic? Do they still have a needle exchange?

RF: I think so.

SP: That's Roxanne Anderson—

RF: There on Chicago

SP: And 38th.

AS: I just had an interview there. Not with them, but with Mary McCarthy from RAAN.

SP: Well, Ian would be really good. I haven't been in contact with Ian for years, but—

AS: What's Ian's last name?

RF: Noire?

SP: What was his wife's name?

RF: Can't remember.

SP: She had a beautiful name. She was a dancer.

RF: He took her last name I think. He was Ian Christianson, or something.

SP: Yeah, Ian Christianson. He'd be a good person to talk to. He'd be a really good person to talk to. I believe he used our services as a she.

RF: He transitioned after that.

SP: So, I think there's a lot of needle exchange happening.

AS: Sounds like it might be under the radar, it's just incorporated into programs where it's not *a* program, but it's been normalized in a way. It's a service that's considered available. That makes me think about why someone like Sarah Gordon would introduce you by saying you're the reason there's harm reduction in Minnesota.

SP: Wasn't that a beautiful introduction?

AS: She said that at her talk at White Earth. I thought Sue was going to cry. It was really, really sweet.

SP: It was really wonderful.

AS: It is interesting how these ideas that seem so extreme—what Minnetonka housewife soccer mom could you have ever imagined would be a proponent of Narcan?

SP: Oh my God, yes.

AS: What I'm saying is it's like when we think of marriage equality. Gay people being allowed to get married? When I was in high school in the eighties—

SP: It seemed so far fetched.

AS: People were'nt even out in high school in the eighties. So to think about how quickly we can actually change, but I don't know. I think it's a powerful thing.

SP: There was a woman when Well's Fargo Bank and Norwest merged—did I tell you this story? She lived in a high rise. We did a lot of delivery. She lived in a high rise in Minnetonka. She was a trainer and she was sent out from California. She had—oh my God. Lived in this swanky apartment, but it was dark. Boxes everywhere like things don't get unpacked. She likes to inject heroin. Generally on average that's a three to five times a day of injecting, but she had obsessive compulsive disorder and so she used to inject multiple times little bits, little amounts. She talked about being in Well's Fargo in downtown Minneapolis in the bathroom and having a co-worker walk in on her getting high in the bathroom. It struck me as so funny because you have these assumptions, right? They were just blown out the window.

The independent psychologist. His name was Craig. I got a call from the Red Door Clinic. He was part of the U of M cocaine study. He had a wife. He'd had three overdoses and he needed clean syringes, so I'd made an arrangement at the end of my day that I'd stop at his house. He lived over by Diamond Lake Road. Not to say that I hadn't been to some nice places, but generally there's an assumption of where you're going. Double checking the cars in the driveway and the address. I get invited in for herb tea and they've got all the syringes, the barrels washed and laid out on paper towels on the coffee table. They're showing me track marks on their arms that are just horrific. They've got great big points and great big barrels. It's just like, "Oh." Getting a little history on them. How did this happen? They'd gotten the syringes through—the wife was a vet tech. She accessed syringes there. They talked about how they weren't pot smokers or anything. She said, "Craig was coming into his fortieth year and he wanted to experiment a little bit. He remembered a college sweetheart that used to inject cocaine so that's how we got started." I'm like, "Okay!" [laughs]

RF: Just kind of coming into it in that way, right.

SP: That's your story. You can tell it however you want. It doesn't—it flies in the face of the general narrative. And so to make assumptions about who people are, and what neighborhood they live in. I remember talking about him specifically in a meeting, and not by name, but there were people that thought he should be reported. And I was like, well, that's not what I'm here for.

AS: Reported to whom?

SP: Some licensing board. I think that he really thought there are some junkie-chic elements about it. He in the beginning wasn't comfortable coming to the needle exchange. He didn't want people seeing him come in there. Yet, I think he really—there's some sort of coolness about it or something. Urban Outfitters had done some t-shirt or something referencing drug use, injection drug use because I called and complained about it.

RF: Didn't some of their models—I remember something.

AS: In the nineties there was heroin-chic. Did you see the thing in *City Pages* a few years ago? I saved it. This woman told her story, and yet wanted to be a model and they ended up doing this photo shoot of her where she basically looked like she was—

SP: Emaciated, strung out.

AS: Laying on rocks.

SP: That's horrible. Irresponsible.

AS: Curt Cobain.

RF: A lot of glamorization. Why did this delivery stop?

SP: I don't know if we were short staffed—

AS: You weren't doing deliveries when you were there?

RF: No. Sherry and I would do HIV tests—we would go out and do HIV tests in people's homes, but right when I started the deliveries stopped, and I don't know why.

SP: I think that there might have been a staffing issue.

AS: Was anyone ever in danger in those situations? Did going to people's homes put you at risk?

SP: I don't think so. Not ever. People were really good to me. I remember initially when Tony and I just started doing home delivery the idea was that you'd try to go in two's, but that just wasn't happening. You'd meet in an area that you felt mutually comfortable. Generally outside in a parking lot, but that would change too, you know?

AS: So you did the home delivery from the beginning?

RF: Before the store front.

SP: Way before the store front.

AS: Before 2001 when you got there. What did you do that was different? Did you start the wound care clinic?

RF: I don't know what was happening around wound care earlier on.

SP: I don't remember seeing a lot of abcesses here.

AS: [to Rae] You did.

RF: Yeah, so we had developed relationships with the Neighborhood Involvement—NIP—up on 25th and Hennepin, and then the CUCH Clinic, but specifically—and Brandon was really instrumental in that. He had met some of the doctors there and developed a relationship, and so we were able to send clients directly, or participants, folks directly there with abcess or other types of wound care. They didn't need an appointment. They didn't need to give an explanation.

SP: Walk-in care.

RF: Yeah. And then for a very short time, but I can't remember any specifics, and I don't remember who the doctor was, but we got him involved and made a connection—oh, now I can picture who it was—but I can't remember his name. I can picture him.

SP: Are you talking about that little crazy doctor?

RF: Oh God there were so many. There was Peter, whatever his name was.

SP: He's the one?

RF: No, but I'm thinking of—

SP: Who was it? Erik Meininger?

RF: Erik. Because he had some students at the U of M. He worked at the CUCH Clinic. Community University Health Care Clinic.

SP: It was off of Franklin, wasn't it?

RF: Franklin and Bloomington. We had an arrangement with some doctor interns to come and do wound care, but that was just available from Monay from 12 to 2. They could come in. I think we had them come in for a few rotations and that's when it got really hard for them to coordinate, and Brandon was able to make the connection at the NIP Clinic. We never got any funding for that. It was all just kind of—

SP: We made some really wonderful connections in the community.

RF: So many really good connections, yeah. Kevin Sitter—where was he working?

SP: Oh my God, Kevin Sitter was the founding board chair. He was at the Red Door initially, and then he was over at Clinic 42.

RF: He changed Sharon and I. The HIV tester trainers. I remember he'd come in.

AS: When did you start doing HIV testing?

RF: That was when I got hired was when they'd gotten a grant from the CDC. It was a new grant and a new program.

SP: New building. Rapid expansion.

AS: What new building?

SP: We had the building next door: 11 and—

RF: We never really used that address because all the mail was still—

SP: 11 West.

RF: It was kind of odd because they had tried to see if we could get a wall or something, like a door built.

SP: Some access.

RF: Because you have to go out and in. It ended up being there were offices over on the other side. That all happened in that same time, then. You hired Sharon [Mendaluci]. She might have commented—

SP: Sharon didn't come to the thing [conference]. I don't know where she's at with things. I thought about her today. I haven't seen her this side of town.

RF: I haven't seen her. I've talked to her. I've Faecbook messaged her every once in a while to check in and chat and stuff. That was a big deal because it was funded by the CDC specifically to target injection drug users. Even though there couldn't be any syringe exchange—we couldn't do syringe exchange, there's kind of like this whole artificial wall.

AS: Right. They can walk next door and get needles.

RF: Us as staff—

SP: If Rae was paid—if her salary was paid with federal dollars she could not do needle exchange.

RF: The rent for the square footage it needed to be—the square footage of rent to cover my office space that was not paid for by syringe exchange funds.

SP: Jules was at the event on Saturday. Did you see him? Remember Jules the bookeeper? Jules Friedmann. Jules was the first accountant. And then after we started getting those big grants then we got—

RF: It was MAP for Nonprofits, but it was that woman.

SP: I can picture her face. She was awesome.

RF: What was her name? Burnell?

SP: Burnell!

RF: She was there for a long time. She was really good. Really able to track and separate.

SP: We had a half million dollar budget in four years. That was a lot of money to manage. And a lot of political money to manage. And then people in the community—I was telling her earlier how it is always a competitive process, and that that piece around competition was difficult. When I came back remember you had the relationship going with Recovery Resource Center. I think it was MAP—Kathy Strobel.

RF: Oh right, Kathy Strobel was there. That was Heidi Camer from—I forgot about that. There was a grant through SAMSHA [Substance Abuse and Mental Health Services Administration]. It was funding for Hepatitis testing or vaccinations? Must have been vaccinations.

SP: Hepatitis B maybe?

RF: It must have been A or B. I can't remember. There was also testing involved, but there wasn't an oral test—or was there? God, this is so—was it just oral testing for Hepatitis C? I can't remember. I am going to have to look back at that. There's probably in those files that I gave you. That's the HCV something something. I was like, "How can we get access to this money?" At that point there was no money for Hepatitis C, or any kind of hepatitis. It was all focused on HIV prevention. You had to have a connection with—it was very clear in the guidelines that you had to have a connection with an abstinence based treatment program. I had known Heidi from something, and I knew she was pretty—maybe Heather knew Heidi—there was some connection with Heidi at RRC, and she was willing to work with us. We wrote this grant together. They had to be the fiscal manager. They had to hold the money. We had a staff person out of that.

SP: I think Tom Stevens worked there.

AS: What was RRC?

SP: Recovery Resource Center.

RF: Right next to 18th and Chicago.

SP: They're a big service provider. I would imagine they still are.

RF: I think that was what funded Tommy's position. I think that was the deal. MAP got a staff person, RRC got a staff person, and we got a staff person. Then we would do these clinics. We would do vaccinations and testing.

SP: Testing happened in the jails. Or in the work house. Education happened. I did education for years in the work house on Saturday mornings. That was nice because you'd have an opportunity to meet people. They had a contract that HIV education had to happen. Making that contact when women were still locked up meant that they had a place to funnel out to for a resource. We did a lot of work.

RF: Those connections again. Even that there was a joint grant between RRC and Access Works.

AS: There's competition, but there's also a lot of collaboration in Minnesota between organizations.

SP: I think there's more than what there used to be because the money has really in many ways gone away. Funders, the people, really encouraged that collaborative relationship that you have to. There was a change and a shift in there. I think the place where competition was really encouraged was through the Minnesota Department of Health originally. They defined it as a competative process. You had to write a good grant. That was hard.

[general chatter, end of interview]