Jack Martin
Narrator

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The Bakken Museum
Interviewer

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Jack Martin	-JM
Kristen Reynolds	-KR

KR:	00:07	Alright, can you state your name for me for the record?
JM:	00:11	Yeah, my name is Jack Martin.
KR:	00:13	Thank you so much, Jack. Also, can you state the name of the organization you work for?
JM:	00:20	...I work with Southside Harm Reduction Services in Minneapolis.
KR:	00:24	Awesome, thank you. We are going to talk to you a little bit today about who you are, your background and how that relates to the work that you do at Southside. Could you tell me a little bit about your early life, culture, and how you became interested in community health work?
JM:	00:42	I was born up in Bethel, Alaska. Everyone on my dad's side lives up in Alaska, but we moved down to Minneapolis when I was three or four. We moved to northeast Minneapolis, and I grew up right behind the Quarry Shopping Center. My mom is a primary care doctor—she does this currently and did this when I was a child. My dad did carpentry and all sorts of odd jobs here and there. I spent all my childhood in Minneapolis and going back up to visit Alaska because my mom and dad split when I was fairly young. I'd go back and visit my dad and that side of the family up in Alaska. We would go fishing and see relatives. I think there was a time when I didn't visit right after they split. And then a few years later, people would come up, pinch my cheeks, and say, "I remember when you were a little baby." Everyone would say they knew me, and

I just had no idea who they were because this was when I was a little kid.

02:09 I went to public schools in Minneapolis, and then went to college in Madison, Wisconsin. I went to UW [University of Wisconsin] Madison and then came back to Minneapolis and started working at the Native American Community Clinic. I was interested in medicine and public health. When I was a kid, I really liked the idea of giving back to community and wanted to figure out how to have an impact in a positive way. Then also a part of that was trying to figure out what kind of career would work out in Alaska, if I wanted to go back to a rural area. All of my family and my dad live in a very small village called Aniak.

03:19 There are about five hundred people who live there, and the only way to get there is by flying. There's just not a lot of jobs there. There are also very severe public health aspects to living out there. There are lots of mental health issues and colon cancer, on top of very low access to healthcare and historical trauma. At the time I did not conceptualize it that way, but there is historical trauma and poverty. All these different things drew me towards public health. Something that had pushed me away from public health was that my mom was always working and typing away on her charts. She always told me about how horrible that aspect of medicine was and said, "Don't go into medicine" [Laughs]. Then, when I went to college, I decided that I wanted to go into medicine. My goal was to become a doctor. I did all the pre-med classes and then ended up coming back to work in Minneapolis.

04:46 My interest in public health was a combination of the health disparities and needs that existed on my dad's side, also with generally wanting to have a positive impact in community. I also looked at the positive aspects of the work that my mom did. She pushed me away, in some ways, when she told me she didn't want me to become a doctor. Still, being a doctor was very much a part of who she is. There were also many positives. That was the early life stuff.

KR: 05:32 I have two questions. One, you mentioned that there was historical trauma in your dad's village. Would you mind giving us some context? And then two, you also said that you didn't articulate it that way or you came to understand

		that later. Can you also talk about how you came to understand these things as historical trauma?
JM:	06:00	Definitely, or at least I'll try. Some of the things that I view as historical trauma are tied to colonialism. There is so much poverty and lots of health issues, which is connected to the work that I do now. That's how I identified alcoholism and substance use [in Alaska] as being tied to historical trauma over time. With these dynamics, you see familial relationships also play out over time. Thinking back in terms of lack of healthcare, my dad was one of thirteen brothers and sisters. My dad passed away in 2015, and at that time, he was one of two siblings who were still alive. He was fifty-six when he died, and he was one of the younger kids in the family. There's were people who died from various sicknesses, violent deaths from working outside, and all other sorts of reasons. There's lots of historical [traumas] that build and lead to a lot of the inequities and health disparities I see in that village. I think that some of those experiences really tied in with the work that I do now and bringing a connection between the two. What was the second question?
KR:	08:19	The second question was how did you begin to associate those things with historical trauma?
JM:	08:25	It's been slow and over time. Having grown up largely with my mom, who is white, it took me longer to learn about colonization and the history of America in terms of the current health disparities that exist. It was through conversations with people in community and in school that I kept hearing all the different perspectives and tidbits over time. Some of the other stuff has been a lot more recent, in the last five to ten years. Especially doing the work I do in Minneapolis, which I'd love to talk about more. I [learned] very slowly over time.
KR:	09:37	I hope you don't mind me saying this, but you said earlier that you turned thirty. So, you're talking about a period of early twenties to twenty-five that you're beginning to make these connections between things?
JM:	09:52	Yes, I was making those connections more concretely. Especially growing up having my own personal traumas and not wanting to dig into it too much. I had a more

avoidant style, but I started to dig into that stuff in my early twenties.

KR: 10:14 You said that you left here and went to UW Madison. What'd you get your degree in?

JM: 10:25 I got my degree in biology with a focus in neurobiology. There was a time when I thought I wanted to do research, but it turned out I didn't. I had a minor in Global Health. I wanted to do one in public health, but they didn't have a public health degree. I think Global Health was the closest [thing].

KR: 10:49 You graduated around when?

JM: 10:59 At the end of 2015.

KR: 11:04 Then you came back to Minneapolis, and you said that you worked with the Native American Community Clinic. Would you mind talking about that period?

JM: 11:16 I would love to. A couple months after I graduated, my dad passed away. I went back to Aniak to visit with family for some time. Then I came back to Minneapolis to try to figure out what I was going to do next. At the time, I didn't want to jump back into school. At the time, I was planning on going to med school and thought that I would eventually want to move out of the state within a few years. I looked for jobs that aligned with med school or potentially public health related [jobs]. From there, I applied to various places and got a job with the Native American Community Clinic as a Data Analyst.

12:22 That job [involved] looking at public health trends and clinical data. It got me experience working in a clinic. Working at the Native American Community Clinic was extremely formative for Southside—for the work that I currently do, and for understanding of Minneapolis and the health disparities that exist here. Then my job grew into grant management and working more closely with providers than I thought I would, which was great. They were flexible. I think they had some idea that it was a newer position. They had some idea of what they wanted it to be, but they were open to having me explore various paths.

	13:23	And one of those paths was syringe exchange. During my time at the Native American Community Clinic, I met Jack Loftus, the co-founder of Southside, and Nikki [Giardina], who is still a nurse at the Native American Community Clinic and is on Southside's Board. We noticed a lot of people coming through the clinic who were actively using, largely Native women, and weren't ready to stop. We were trying to figure out what resources were available for those patients and realized there weren't very many available in the south of the city. I think there was one at Red Door downtown, I think the Aliveness Project operated there. But it might have been just us. There was another one, farther north at a treatment center called the Valhalla Place.
KR:	14:36	Can I pause you quickly? When you say far north, do you mean north of the Twin Cities?
JM:	14:40	Just slightly outside of the Twin Cities, in Brooklyn Center. It was too far north from where we were at the clinic, especially for the folks that were coming through with limited access to transportation and not wanting to go to a treatment center to get syringes. But anyway, we knew that there were a lot of folks that were actively using and didn't have access to a lot of harm reduction services. We wrote a grant, with approval from clinic administrators, to get a small amount of funding from the Department of Human Services to open a syringe exchange, or syringe service, programming.
KR:	15:33	When you say small, what do you mean?
JM:	15:37	I'm trying to remember the total amount. I think it was somewhere between $4,000 and $8,000 for supplies. We started up, we purchased supplies, and we let people know. Pretty soon, we found that the syringe exchange program in the clinic was incredibly busy. People were constantly looking for supplies and Naloxone. I think it really helped that the Native American Community Clinic was this trusted, community clinic that has a good reputation with a lot of the folks that would use a syringe exchange. And has a good reputation overall in the community. We found ourselves blowing through that small budget we had. After two or three months, we had to shut down the syringe exchange because we went through all the supplies. Then

there were also the challenges of running a syringe exchange in a primary care setting.

16:56 It was supported. We had a lot of support from the administration, and they were all awesome. But there are just challenges, especially with staff that aren't used to working with folks that are living outside and actively using. We were running a strategic exchange alongside a comprehensive primary care clinic that's busy on its own. We had to shut it down. As were shutting the syringe exchange at the Native American Community Clinic down, Jack Loftus and I decided we wanted [to start our own]. We knew where to buy syringes and knew where to get Naloxone. We started with our own money, buying syringes and getting donations of Naloxone. We got a small flip phone and some business cards. We told people to call us if they needed any supplies. We were like, "We probably can't do this for very long, but just kind of as a bridge if we can try to figure something else out." So, we gave out the number to that flip phone. Within a very short amount of time, we found ourselves getting calls and texts regularly. We delivered syringes, Narcan, sharps container, and condoms to folks across Minneapolis. We started mostly in South Minneapolis. We'd then find ourselves doing that until sometimes two in the two in the morning after working the full day. The need was just immense, and it spread like wildfire.

KR: 18:57 I want to ask a couple questions if I could. You said a lot there. One is more of a curiosity. Why a flip phone? Was there a particular reason why you went to a flip phone?

JM: 19:06 There was a very particular reason; it was cheap. We didn't have a lot of money [Both laugh].

KR: 19:12 No, that's fair. I was just wondering if there was some axis of tracking or surveillance that you all were cognizant of.

JM: 19:19 We were aware at the time that it wasn't quite legal. We did know that we were operating in a very gray zone, and we weren't sure how long it could keep happening or if we would get into any trouble. I think we mostly did the flip phone because it was cheap, but we did have worry around surveillance and the police either trying to stop what we're doing or harassing the folks that we interact with.

KR:	20:01	Great, and two more follow up questions. One, how did you make the decision to start adding onto the services? Because you said you started off with syringe exchange and Narcan, and then you were also handing out condoms and other things. How did you begin to identify other ways of support?
JM:	20:23	We are really lucky because syringe exchange, at that time, was one of the more well documented public health interventions. Largely because of its controversial nature, there was a lot of public health research into syringe exchange and its efficacy. The research overwhelmingly supports syringe exchange and its effectiveness in reducing Hepatitis C, HIV [human immunodeficiency virus], reducing overdose deaths, and connecting people to other services—including treatment. Alongside that, there are resources that people help syringe exchanges get started. There's some written stuff out there, but there's also a lot of folks, even in Minneapolis, who have history of running syringe exchanges. They have strong thoughts and opinions about how syringe exchanges should and could be run. Those folks are also very supportive. In talking to those folks, we learned as much as we could about the overall [public health benefits].
	22:07	HIV is one of the things that's most cited as being reduced with syringe exchanges. HIV is transmitted not just through sharing syringes, but also through unprotected sex. Having condoms is a very logical thing there. As we are doing the work and talking to people, it is just very clear that there's so much overlap within this world with either trading sex, using drugs to enhance feelings of pleasure during sex, or sex work. If you are a sex worker and need to see a certain number of folks to make the money that you need to get by, then meth is great at keeping you going, and it helps with your job. There is definitely an overlap. In doing this work, it became very clear from reading literature, talking to service providers, and asking folks what they wanted from us, we found very clear ways to expand programming.
KR:	23:47	You said you started working at the Native American Community Clinic in 2015, or so?
JM:	23:56	It was 2016, I believe.
KR:	23:57	So, you're doing all this work at age twenty-three?

JM: 24:03 Yeah, I was pretty young… I don't know how long I was working at the clinic before we started Southside at the very end of 2017. I think the syringe exchange at the clinic started in 2017 and ended in 2017. They do now have a syringe exchange there again, but I was young.

KR: If you feel comfortable answering this question, I'm curious how you took care of yourself. This is heavy work.

JM: 24:48 That was one of the big problems with all of this. I was not really taking care of myself, and Jack Loftus wasn't either, I think. It quickly became much more than a full-time job. Doing the work at the Native American Community Clinic full time and then also starting this nonprofit, there was not enough time engage in self-care. There was a lot of boundaryless work at the beginning, and that led to a fair amount of burnout that I was dealing with for a very long time. Sometimes I look back and think, "Would I be able to start Southside again now". And I think, "Hell no. I would not be able to do that. It's just too much work." That said, what is amazing and beautiful about Southside is that Jack and I put in a lot of work, but it was a coming together of so many different community members.

26:10 We started doing this just by ourselves, but very quickly we got support from folks that we knew at the Native American Community Clinic. We also got support from people from the general community. I remember one of the first times we got supplies, we thought, "Oh, we need bags to put this in some random stuff." We stopped at Cub Foods and bought a bunch of baggies, paper bags, and other random things that we didn't think of before. This lady stopped us in the line and said, "What are you buying all of this for?" We explained what we were doing, giving her a short and not specific explanation. She was like, "That sounds awesome. Is there any way I can support that?"

The work we can do through Southside impacts people everywhere. Whether or not you use drugs, there's people in our communities that are actively using and there's so many people that want to support this work. We've been very fortunate that it has been a community effort and there's camaraderie. It would not have been able to happen without so much support from so many different people.

KR: 27:40 Wow, that's a beautiful story to share that somebody just randomly said, "This is great. How can I help?" I'm glad that despite the intense emotional and physical labor, there has been a network of support, and it seems like a network of care there too. You also mentioned some of the challenges you were running into with syringe exchange at the clinic, and likely beyond. I'm wondering if you can share any failures you've had. If you don't want to think about it in terms of failures, you can also think about it in terms of challenges with Southside.

JM: 28:19 That's a hard one. In terms of challenges, burnout is definitely one of them. I don't really want to go back and think about things as failures necessarily because I feel that we often tried to do the best with what we could at the time. Looking back, I definitely wish I had set healthier boundaries earlier. Not just for myself, but also for all of the other people who were part of Southside in the beginning. That was really, really huge. One of the other big stressors for Southside was the transition from being completely volunteer run, which we were until 2020. Then we transitioned into a blended staff and volunteer model. When we first did that, we put almost all of our staff time into frontline work.

29:51 The only administrator-type position was myself, as Executive Director. That was one thing that was not sustainable, and I think led to internal frustration and tension. There's so much admin and other support that's needed when you start hiring people. We thought we would be able to manage it collectively, but we should have just hired a lot more support and admin folks. That's one of the bigger ones. Looking into the future, we really want to keep thinking about how we can better reduce overdose deaths, reduce transition of HIV, and help connect people to care. Something demoralizing is that year after year, almost since we started, is that overdose deaths have been going up. When we started, it was right when fentanyl was becoming ubiquitous across the drug supply—especially with the opiate drug supply.

31:11 That is one thing that can feel like a failure in trying to understand what impact we're having. That is one thing that can feel like a failure in trying to understand what impact we're having. We do know that overdose rates are rising year after year because of fentanyl and synthetic

opioids, which are so much stronger and so much more unpredictable than heroin was. That is something we want to be more intentional about addressing in the future. We want to be more intentional about overdose prevention education. Not just reversing overdoses but preventing overdoses from happening in the first place and doing more work around HIV and the linkage to care. I think one of the most powerful things that we do as an organization is build relationships with people and build trusting relationships with people. That really is one of the reasons why that's so powerful.

When people use drugs, there's so much stigma that is associated with drug use and people don't feel comfortable accessing healthcare. They don't feel comfortable accessing clinics. They don't feel comfortable going to lots of different places for fear of judgment, fear of getting kicked out for whatever reason, fear of losing kids, and so many different things. To be trusted within that is huge. We are supporting and connecting people to resources that hopefully are less stigmatizing and less judgmental than other places. We can be honest about the kind of care people will and might receive at these different locations. Being able to connect people to care because of those relationships is huge, and something we want to expand into more.

KR: 33:23 I'm curious. We like to ask people, "What does it take to be an innovator in medicine and technology today?" I was speaking with someone yesterday who also had worked in community healthcare, and she said, "Well, I don't think that my work is particularly innovative." That was striking to me. I want to ask that question to you. Do you view your work as innovative? And behind that, what kinds of innovations do you think are needed in medicine today?

JM: 33:58 If it's okay, I'm going to take that question to mean what's needed harm reduction.

KR: Yes, that's fine.

JM: I can think more about the medicine one too. The question, "are we being innovative?" I think the answer is yes, in Minnesota. There's lots of amazing work being done across the world in the realm of harm reduction, which is much

more innovative than what we're doing, and what we even could be doing. I think that we really want to keep following in the footsteps of those other organizations that are doing amazing work. Some of the first things that come to mind is the amazing work that's happening in New York around overdose prevention centers, which are also known as safe injection sites even though people do more than inject drugs there. The overdose prevention sites in New York have been long running syringe exchanges in physical locations that now have additional services, including a space where people can go and use their drugs. There's space for people to inject, there's space for people to smoke, and there's space for people to insufflate, or snort, their drugs.

35:46 And then onsite, there are people who can respond to overdoses. It's an amazing intervention that really builds off syringe exchange and reduces overdose deaths, especially in the area that they're in. There's been no recorded death from an overdose in an overdose prevention center in the world, and they've been operating for decades at this point. That is one huge innovation.

I think that it's similar in the syringe exchange model in that it's not just about having a place for people to inject drugs, but it's about building connections to other services. It's not building a place where people who use drugs can be, but it also is. Everywhere right now, there's no place for people who use drugs where they can just be people—they get kicked out of public places, clinics, and any sort of store. The main exception is private homes, but then even then, the police can be called and that sort of thing.

37:22 Creating space for people who use drugs sounds simple, but it's innovative and essential. Doing this work, you also have to be aware that the war on drugs, or the criminalization and prohibition of drugs. This is driving the shift from having heroin be ubiquitous, to then fentanyl being ubiquitous, and now other stronger synthetic opioids. That's really driving the increase in overdose deaths. An innovation that's being explored, in Europe and in Vancouver, Canada, is where people are prescribed diacetylmorphine or fentanyl. Diacetylmorphine is very similar to heroin, but I think nowadays folks prefer fentanyl. It's also the only thing that's around. Having people switch from the fentanyl that they're using on the

		streets or something even stronger, to something that's about as strong as heroin is not feasible.
JM:	38:37	Having decriminalized prescription fentanyl and diacetylmorphine would do wonders. Right now, one of the main things that's killing people is the fact that people don't know what's in their drugs. When people know what they're using, they can use extremely safely. For example, fentanyl is often talked about as this very scary drug, which it can be, and is in a lot of situations. But it's used safely every day in clinics and hospitals where people are. No overdoses happen when it's used in the correct dosage and people know what they're getting. If the drug supply were as uncertain in clinics as it was on the street, it'd be such a huge catastrophe. I think that's another big innovation that we see, but it isn't anywhere close from happening in the United States.
KR:	40:08	You've been impressing upon me. Just the sheer amount of knowledge that you developed since you've started doing this work. I'm curious who has supported you in this? Who are your mentors helping expose you to these things happening around the world and helping you develop a self-care routine or setting boundaries?
JM:	40:39	So many people. I think one massive source of knowledge that needs to be mentioned first is the folks who are using drugs and the people that use our services. There are not many people who know how to inject, how to manage your drug supply, and how to navigate the complications of being dependent on drugs more than people who are actively using. We've learned so much from folks over the years and some of the initial people who have impacted the work that we do. There's Lee Hertel who runs Lee's Rig Hub in Minneapolis. So many others at Native American Community Clinic. Sue Purchase who ran Women with a Point and Harm Reduction Sisters up north [in Duluth]. She was on our Board and was our first Board Chair. There are countless others because of the lovely and wonderful harm reduction network across the United States. People are the most generous and kind to support our work, and we try to support the work that they do. There are countless people.
KR:	42:38	I think it's beautiful that you have this network to do this work here. Because you answered so many of these questions already in your responses to the other questions,

I'll pivot if you don't mind… You mentioned that your work with the Native American Community Clinic was a formative experience for you. I'm curious that you mentioned that there are primarily Indigenous women who came into the clinic when you first started the needle exchange there. I'm hoping you wouldn't mind sharing how your relationship to local indigenous communities has shaped your work.

JM: 43:50 Sure. I think there's no way to quantify it. For such a long time, the majority of folks that we saw [at NACC] were Native, and most Native folks we saw were women. Like I said, we always learn so much from those using our services when talking about harm reduction and navigating this complex system. We do most of our outreach in East Phillips, which is along the "Native corridor," I think they call it—it has Little Earth, which is the only HUD [U.S. Department of Housing and Urban Development] funded, race-specific affordable housing. But we work with a wide variety of Native folks. We are constantly working with people from the community. There are so many folks that we work alongside, or that are a part of Southside, that are a part of the community and do so much amazing work.

45:29 That's very much a part of the work that we do. We support folks who are doing similar work, but maybe don't identify as being part of Southside, who supply syringes, Narcan, and all that stuff. One thing that really underlines the work that we do is the looking at overdose death disparity is Minnesota. We have the worst overdose death disparity in the nation. Native Americans are dying at now at a rate of ten times of that of white Minnesotans. Black Minnesotans die three to four times that of white Minnesotans. Those disparities are horrible and inform our work. I think with NA [Native American] community, there's also pushback to harm reduction. I think lots of people, or some people, view harm reduction as enabling or harmful.

46:50 There is pushback, but there's also so much support in that folks know and see the value in the work that we do. The stigma can kill, and Naloxone access keeps people alive, as well as our work to connect people to services. One of the first harm reduction conferences that I went to was right when Southside first started. It was the White Earth Harm Reduction Summit. We went up to White Earth and got connected to Clinton [Alexander], Frank, Maya [Doe-

		Simkins], and Sue Purchase. All the people were very supportive.
KR:	47:50	You said you got connected to Clinton, Frank, and a lot of other people through that first White Earth conference?
JM:	47:58	Not all of them are Native, but it's a Native-focused harm reduction summit.
KR:	48:06	Okay, I wanted to clarify who the people are… I'm going to ask you two last questions. You said you transitioned to being volunteer and staff run in 2020. Was it COVID-19 that triggered this change? Was it the uprising, or was it something else?
JM:	48:36	It was largely us trying to make Southside sustainable and continue existing, while also thinking about what impact we have and what impact we can have. During that time, we were applying for a lot of different grants and writing with some staff time, but trying to keep it mostly volunteer run and only having staff to make sure that we could achieve all the grant objectives and support the organization. It felt so unsustainable with it being volunteer run. There was an insane amount of work it took to order everything, manage all the supplies, and then do all the administrative stuff. I think we ended up getting just more grants than we thought we would, so we had to hire people to make sure all those grants were working.
	49:52	This also tied in with the idea of questioning why are we doing this work and what impact are we trying to have. We felt that if we really wanted to have the impact that we say that we're going to have, we need to hire staff to keep this thing going, to keep things running, and deepen our services. It was a hard decision that not everyone wanted necessarily, but I think most everyone was fine with it, for the most part, and understood why it was happening. But it was challenging, especially as I was just a data analyst before who with supervisory experience.
KR:	50:50	You were really learning on the job how to manage people. It's hard work. I like to ask folks as we kind of wind down if there's anything that they want to share that I didn't ask any questions about.

JM:	51:29	I talk about this stuff all the time, but I could also talk about this forever. There's a lot of stuff, but nothing is jumping out. In terms of medical technology, you asked about innovations in terms of medical care. Looking at primary care through a harm reduction lens is exciting. Just because someone is using drugs does not mean that we shouldn't care about their vaccinations, getting their diabetes under control, or all these other primary care things. I think that that is one innovation that is happening in a lot of places in Minneapolis, primarily Healthcare for the Homeless, Native American Community clinic, some doctors like with CUHCC [Community-University Health Care Center] and other places. It's a really exciting thing. I think it's also important for folks to understand that harm reduction is an intervention based around meeting people where they're at, wherever that is. It's a phrase that's commonly said like it's a truism, or phrase that's thrown around. But it's actually very, very accurate. And following that, what do you apply it to? It's not just drugs.
	53:22	It's a spectrum of many different interventions. We can apply it to many different aspects of life. In framework of drugs, it's often thought about as only being for people who are actively using. People say things like, "Why would we fund harm reduction when we should be funding treatment?" I think the way that we view harm reduction is not in a way where those two ideas are butting heads. They work well together. Harm reduction actually is a spectrum and can exist for people that aren't actively using but are not ready to stop all the way. Or for people who never want to use again and haven't used for years. There are harm reduction strategies that work well in treatment spaces too. I think it's important for folks [to understand] that syringes are just the point [Both laugh]. There's much more to it than just that.
KR:	54:33	Thank you so much, Jack. I appreciate that you took the time to share your story and your work with us today. I'm just reflecting on when I lived in California, and I started learning about restorative justice and harm reduction. I think some of the work that folks were doing there was very much focused on the fact that people are not disposable. I think that everything that you've talked about today really gets at that point—that we still have a responsibility to care about each other. I really appreciate

the work that you do and the work that your organization does in the community.