NATIONAL COUNCIL for Mental Wellbeing

Community-driven Harm Reduction Innovation and Adaptation

June 29, 2022 from 3-4pm ET
Q&A Follow-up

Presenters

- Alexander/a Bradley, MPH, HIPS (alexandra@hips.org)
- Tamara Oyola-Santiago, MA, MPH, CHES, Bronx Móvil (bronxmovil@gmail.com)

Q: How many people work for your organizations and how are you funded?
Tamara: As a mutual aid collective that began in 2018, we rely heavily on volunteers and community members who provide knowledge, resources and time. Our first funding was in the summer of 2020 to provide harm reduction services as many organizations closed due to COVID-19. The first funding covered the cost of car rental, PPE and nutritional support for the participants. We now have two main funding sources, the city and state departments of health, plus several smaller grants. We now have 2 FT folks and the rest are a mix of volunteers and PT staff and consultants. Our Community Leaders, our name for peers, are hired as consultants.

Alex: We have a little over 30 employees. We also have peer educators and secondary exchangers who work with the organization on an incentive basis. In addition to folks who are paid, we have several dozen volunteers and a handful of interns who staff the outreach shifts, assist with answering our 24-hour hotline, and help with packing supplies. HIPS is disproportionately funded by local government grants, but many of those grants are funneled through the state from SOR (state opioid response) federal funding. We have a few private grants, as well as a grant from SAMHSA.

Q: Could you share what your budget and funding look like? There seems to be a lot of flexibility in how your funds are expended to do the great work.
Tamara: Our baseline budget in FY22 is around $220,000. The smaller grants allow for the flexibility of program provision, such as the hiring of the Community Leaders, who due to the challenges of living on the streets may not be able to have a structured schedule and the necessary documentation for PT and FT work. By using their knowledge of the community and the peer network of people who use drugs, much of the work is flexible, and based on what they can do and when they can do it. The volunteers and members of the mutual aid collective are aware of the economic inequity and decenter themselves in funding so as to mobilize such funding to the people most impacted by the war on drugs (the participants).

Alex: Our organizational budget at HIPS is roughly $3 million. There is some flexibility in the way we can spend our money, but also a lot of limitations, especially with the grants that either we receive directly from the federal government or the SOR grants funneled through DC government. The funding that we have for syringes is actually quite limited, and we have had problems with securing enough local-specific dollars to keep up with the volume of syringes we need. We also do a tremendous amount of direct fundraising to pay for things like safer smoking kits, as well as relying on in-kind donations for the food we distribute. Private funders are our most flexible – they mostly support our clinical services.

Q: What can we do to help you (and other harm reductionists) in your cause?
Tamara: Much of the "soft" funding that allows for the flexibility of provision of services and pay for participants comes via personal donations. This type of funding also pays for Community Leaders' direct support and urban living supplies such as clothes, food, bottled water and hygiene kits. I think grassroots harm reduction organizations can use this individual level of funding support so that we can meet the needs of participants outside of the formal deliverables that many bigger funding sources require.

Alex: Seconding everything Tamara said. Additionally, pushing for policy and advocacy advances at both the national and local level. If political movement happens in one place, it tends to spark and spur progress in other places, and provides an example for jurisdictions that may be more hesitant to step up. So a win for one state, county, jurisdiction, etc. is often a win for all, as it makes progress seem more possible and achievable.

Q: How do you think harm reduction should be separated more in funders'/backers' minds from abstinence-only modeling, in the sense that harm reduction programming is often stifled when financial backers and municipalities view the concepts in harm reduction as "enabling"? For instance, a harm reduction program in my area won't back any program to distribute fentanyl test strips because "they are enabling people to use."
Tamara: Super challenging reality. Abstinence / no use is part of the harm reduction umbrella, but it is one of many options. Perhaps we should emphasize that abstinence is part of the harm reduction model and that by giving folks the tools for change, then agency and empowerment towards a recovery process is enabled. The strips are a survival tool so that the person can then mobilize for health and wellbeing when they are ready. In fact, the tool itself is a harm reduction strategy that can prevent death.

Alex: Agree with Tamara. This really goes back to the very difficult, long-term work of doing community education not just for program participants, but for the community more broadly, including stakeholders, funders, etc. Stigma reduction is harm reduction. We have to keep standing up for harm reduction as a concept and as a practice, and that includes debunking myths around harm reduction as enabling. The more vocal we are about the facts, realities, and harm of stigmatizing people who use drugs, the less people will be able to avoid the drumbeat of change.

Q: What efforts do you think can be made to create a greater level of cohesion between levels of government from federal to the individual doctor's office? I feel that the greatest issue in pushing harm reduction, as one of the 4 main pillars of Canadian federal drug strategy since 2006, is the fact that each province has such power to make their own divided decisions to not follow. For example, British Columbia has so much compared to Ontario (a distant number 2), and other provinces and territories have hardly anything.
Tamara: The answer perhaps lies in grassroots, community leaders, who can be the messengers, the connectors between all the levels mentioned. They can communicate about what happens at the grassroots level. Almost like a community board or speakers' bureau. The difference in power between provinces and cities is something to address; it happens in the USA too (and is part of the feedback we

received with this webinar as both HIPS DC and Bronx Móvil are in urban spaces where harm reduction is supported in ways that do not occur in other parts of the USA.)

Alex: This is absolutely a huge problem in the United States, too. There are states where syringe exchange is still illegal, places where naloxone distribution is barely funded, etc. It's hard to give any other answer than for these changes to be codified at the federal/national level. But in the meantime, as larger-scale progress is absolutely more difficult to achieve in many cases, then grassroots and community-driven support (and resistance) can really make substantial change. The unfortunate reality is that change is not going to come on this front without pressure. The voices of the communities affected must be lifted up to put pressure on people in positions of power to make changes.

Q: Our very small coalition that practices harm reduction holds a yearly community summit in our rural area. We want to include the voices of PWUD, but they are afraid to speak out publicly (for good reason, e.g., stigma, fear of arrest). How can we work to incorporate the voices of PWUD without causing harm?
Tamara: Collect voices via oral history and arts and crafts. Also, pictures can be a tool to tell the story of your organization and the participants. See Photo-Novella | Engage and Empowerment through photo novella: portraits of participation.

Alex: Seconding Tamara – relying on de-identified methods of storytelling can be a huge opportunity for getting people's stories out there. Get voice recordings of folks telling their stories, transcripts of interviews with program participants, and/or qualitative data from research projects to help illustrate the stories of individuals without putting them at risk (or as much risk).

Q: In your work at Bronx Movil, have you encountered undocumented individuals? If so, what are some of the specific barriers you see in this community?
Tamara: Yes, one of the needs we see is harm reduction with workers. Many use pills for pain but are not necessarily injecting. Tailored harm reduction in Spanish at stops, parking lots and other corners where workers are picked up for day labor and is a need for sure. Many may be housed but their work is street-based, so mobile harm reduction programs could address this community of undocumented workers.

Q: Do you have the model that you use for community engagement and collaboration documented? Is it something you can share?
Tamara: We do not have it documented except via presentations like this one. But you can email bronxmovil@gmail.com and we can share what we have.

Alex: I also don't really have a specific document.