National Collaborating Centre for Infectious Diseases

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MANITOBA HARM REDUCTION NETWORK

Report of an Evaluation of Manitoba Harm Reduction Network Services in the Context of the COVID-19 Pandemic

January 2022

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The National Collaborating Centre for Infectious Diseases

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National Collaborating Centre for Infectious Diseases
In partnership with Manitoba Harm Reduction Network

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An Emerging Syndemic

Since COVID-19 was declared a pandemic in March of 2020, extensive public health resources have been directed to identifying cases, curbing transmission, and carrying out vaccination campaigns. This focus has undoubtedly saved lives; it has also reduced the attention paid to other public health crises in Canada, including epidemics of sexually transmitted and blood-borne infections (STBBI) and the opioid and stimulant overdose crisis. The pandemic has put people who use substances (PWUS), particularly those impacted by structural and colonial violence, in a precarious situation, exacerbating the health inequities experienced by this population (1–4). Intersections and interactions between the overdose crisis and the pandemic have manifested as a syndemic, a clustering of health and social conditions, that has worsened outcomes for people who use substances (1,3) . These conditions include COVID-19 itself, mental health issues, changes in substance use and increased overdoses, and STBBIs (5–7).

Consumption of substances has increased nationally in response to the pandemic (1,8): 47% of participants in one qualitative research study indicated increased use in response to "[stress related to] loss of employment or fear of catching the virus" (1) pg. 4). Negative mental health impacts from the pandemic have been shown to be heightened in people who use substances (9–11), and "Canadians with past and current mental health concerns reported greater increases in substance use during the pandemic, and those with past and current substance use concerns reported more mental health symptoms" (2) pg. 13).

Many individuals who use illegal substances face multiple axes of marginalization – for example, poverty and inadequate housing – which intersect to increase their vulnerability to COVID-19 (6,10,12). Crowded or insecure housing makes adherence to public health guidelines regarding distancing and isolation difficult or impossible, increasing the risk of infection (6,10,12). Those with substance use disorder are significantly more likely to become infected with COVID-19 due to their socioeconomic situation and lifestyle factors, and more likely to receive substandard medical care if infected (10,11,13). People with substance use disorder also have significantly higher prevalence of chronic cardiovascular, kidney, liver, lung and metabolic diseases, all of which are risk factors for severe COVID-19 manifestations; substance use itself can interfere with immune function (10). Symptomatic COVID-19 infection can also result in a higher risk of drug overdose and death (13).

Surveillance data from the Public Health Agency of Canada (14) indicates that there was a significant increase in opioid toxicity deaths in 2020 in comparison to 2019. During the period of

2020 when public health guidelines were in place, there was an 82% increase in overdose deaths compared to the same time period in 2019 (15). The vast majority of these deaths were accidental. Substance-related hospitalizations (in relation to alcohol, cannabis, opioids, and stimulants) have increased by 5% (15). The risk of using substances significantly increased during periods of border closures, which caused a decrease in the illicit drug supply (1,4,16,17). These closures coincided with an increase in deliberate contamination of substances with fentanyl or synthetic benzodiazepine, as drug dealers tried to stretch their products (18–20). This increased the potency of some drugs and heightened the risk of overdose poisoning and/or death (1,18). During periods when certain drugs were unavailable, many people who use substances switched their preferred substance, or changed the frequency of their consumption, both of which increase the risk of overdose (1,21).

The pandemic has decreased the availability of medical care and social services for PWUS. Many in-person services have shifted to operate at reduced capacities in accordance with public health requirements, or as a direct result of the reassignment of staff to COVID-19 efforts (11,13,17). Other services have shifted to online modalities, which people experiencing houselessness, and/or who do not have mobile platforms, are unable to use (20,22). Furthermore, the pandemic has limited the ability of harm reduction sites to serve as spaces for community and to help people cope with the challenges of the pandemic and grief due to overdose deaths (17) . Service providers themselves are facing stress from potential COVID-19 exposure during in-person operations, in addition to inadequate training and support for the shift to online work (22) .

The redirection of public health resources towards the pandemic has severely limited STBBI testing (13,23,24). The pandemic also led to reduced availability of harm reduction services, and resulting challenges obtaining safety supplies (1,17). An online survey from the Public Health Agency of Canada in early 2021 found that many people who use substances had difficulty accessing harm reduction services: the primary reasons were reduced operating hours and capacity, pandemic public health guidelines, and “fear of… stigma, discrimination, or violence” (25). About half of the respondents had limited accessibility to HIV testing, Hepatitis C testing, or other STBBI tests, more than 80% could not access drug checking services, and almost 60% could not consistently access needle and syringe distribution programs (25). Although there is no nationally available data for case numbers, the AIDS Program South Saskatchewan reported that infection rates have skyrocketed for HIV, Hepatitis C, and syphilis (26). Manitoba has also reported high rates of syphilis, even though testing capacity has been limited (27).

Manitoban context

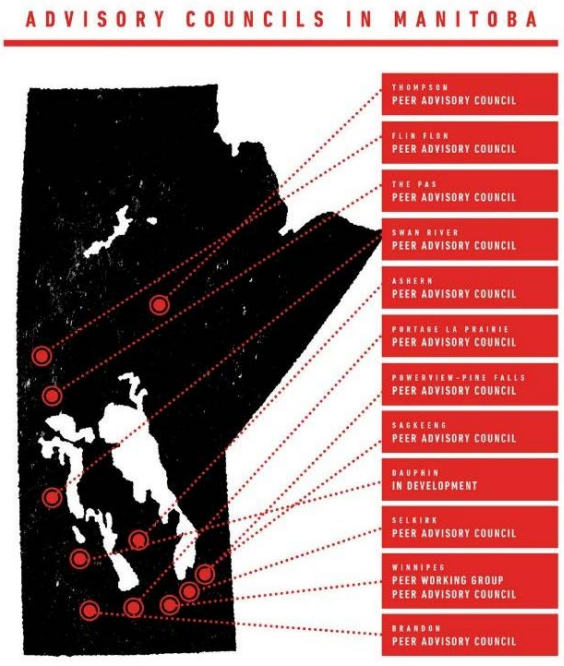
Manitoba, the focus of our evaluation, does not have current, publicly available data on substance use harms: the most recent information available is from October 2019 (14,18). However, initial data from Manitoba's Office of the Chief Medical Examiner in April 2021 indicated that there was an 87% increase in overdose related-deaths in 2020 in comparison to 2019, and that 68% of those deaths were related to opioids (19). Indigenous Canadians are disproportionately impacted by the overdose crisis, due to the continuing effects of racism, colonialism, and intergenerational trauma (28). In Manitoba, First Nations people have also been disproportionately impacted by COVID-19: as of November 11, 2021, 10,604 of the total 64,701 cases in the province were on a First Nations Reserve (29,30). Targeted vaccination and community education campaigns led by First Nations have improved these rates significantly, but they point to the underlying determinants of health that increase the vulnerability of Indigenous Manitobans to this syndemic.

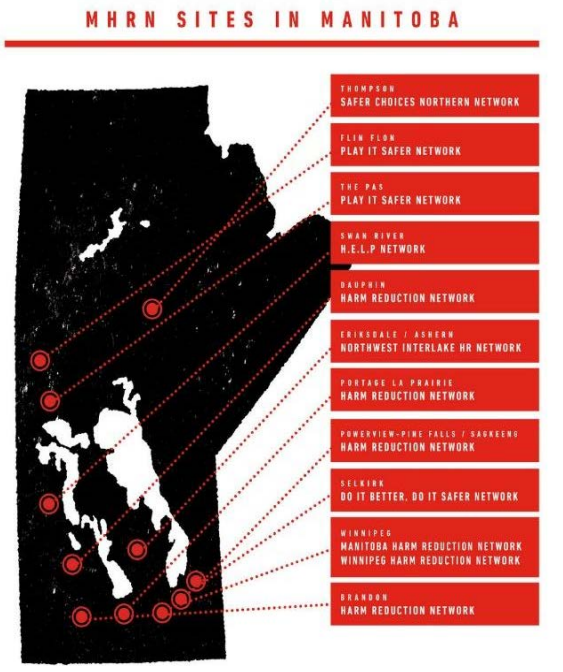
The Manitoba Harm Reduction Network (MHRN) is a province-wide organization that works towards equitable access to harm reduction supplies, reducing the transmission of STBBIs, and systemic social change (31). The MHRN consists of 11 regional networks and 12 advisory groups made up of peers (people with lived experience) and staff, who develop partnerships and conduct research, education, advocacy, and policy work tailored to the specific communities in which they work. They use a harm reduction framework which centres people who use substances and which is rooted in social justice (31). Although a non-Indigenous organization, MHRN strives to use a decolonizing lens and uphold the principles of reconciliation.

Overview of the Evaluation of Services

The National Collaborating Centre for Infectious Diseases (NCCID) and MHRN worked together to conduct an internal evaluation of services. The aim of this evaluation was to determine the impact of the pandemic on harm reduction services in Manitoba and identify best practices for harm reduction providers. A Knowledge Keeper agreed to join the project, to increase cultural safety for Indigenous participants and to offer her insight and expertise as a community leader. In May 2021, an initial meeting took place with all parties, to develop questions for semi-structured interviews with staff and with peers (people with lived experience who provide guidance on MHRN's work). Questions for staff focused on how the pandemic affected: the delivery of harm reduction services, their work with partner organizations, the number of people using harm reduction services, and their own workload and mental health. Questions for peers were similar, but also included probes about changes to: housing and income source, individual substance use, ability to access socio-medical services and traditional supports like elders, experiences of violence and discrimination, and their role with the MHRN. Peers were compensated for their participation and able to receive support from both the Knowledge Keeper and MHRN staff at any point in the evaluation.

Over the subsequent three months, a series of conversations took place with MHRN staff and peers from Brandon, Flin Flon, Dauphin, North West Interlake (Ashern/Eriksdale), Pine Falls, Swan River, Sagkeeng, The Pas, the Southern and Eastern Network (which includes Selkirk), Thompson, and Winnipeg. Maps showing the location of MHRN sites and Advisory Councils are below (31).





Anonymized notes were taken during these sessions, followed by qualitative data analysis using the software NVivo 1.5, with the goal of identifying common and divergent themes from the different conversations. To maintain anonymity, as well as for analytical purposes, regions were categorized as urban or rural based on their 2016 census population counts. Brandon and Winnipeg were considered urban areas, with populations greater than 45,000 in the 2016 Census. All other regions were described as “rural” – these included rural municipalities, towns, and small cities with populations under 15,000 in the 2016 Census (32). Following the initial analysis of the data, a validation session was held to give staff and peers the opportunity to provide feedback on both the findings and the proposed best practices.

Staff Findings

The following section describes the changes that staff saw in their work environment due to the pandemic, and the impacts that these changes caused in their work and personal lives.

Changes to work environment

Staff were unanimous in agreeing that the pandemic caused major, predominantly negative, changes in the way that they work, during a time of increased need in the community. Staff from both rural and urban regions noted that need for harm reduction services either stayed consistent or increased. At the same time, public health guidelines meant that Peer Advisory Council and Network meetings had to shift to a predominantly online format, reducing participation from peers. Staff met with peers in smaller groups, or one-on-one, when public health guidelines permitted in person meetings. However, the effort needed to coordinate multiple one-on-one or small group meetings significantly increased staff workload. Digital modalities were a poor substitute: many peers do not have personal telephones or internet connections, and rural peers in particular commented that these technologies were unreliable or unavailable in their regions. When virtual meetings were possible, there was a learning curve for some staff in using technologies like Teams or Zoom. Many found it challenging trying to gauge which technology would be both appropriate for a meeting and available to peers, and indicated that training was needed in this area. Staff also commented that they were not always sure about protocols and expectations for in-person meetings during lockdown periods, particularly when lockdowns were applied differently in different regions of the province.

Changes in partnerships and outreach

The work of the MHRN is done through partnerships with external organizations and service providers like public health nurses. The pandemic has fractured many of these partnerships, due to organizations closing, redeployment of staff, changes to hours, and cancelled events. All networks indicated that they had experienced disruptions in STBBI testing due to nurses being redeployed. STBBI testing was extremely limited in many rural settings throughout the pandemic. Education and outreach on harm reduction were also negatively impacted by nurse redeployment; some regions had to discontinue these activities entirely during lockdowns. Staff frequently commented that they were trying to fill in the gaps left by organizations that had reduced their services during the pandemic: *"it's a failure of public health [...] local organizations [have had to] step up".* Simply determining what services were still available in their communities created significant work for MHRN employees: *"in the past [you] could know*

what services are available in your area. Now you have to check and see if things are open, if hours have changed, you just don't know. [The services] are not reliable anymore". However, there were some partnership success stories that took place as a result of the pandemic. In one urban location, social service organizations provided multiple services and harm reduction supplies at a single community hub: this reduced potential contacts for PWUS, and ensured that there was always one location that could provide support/supplies during lockdowns. Sex workers lost employment during the pandemic but were not eligible for government support programs: one urban MHRN network collaborated with a sex worker organization to coordinate and promote a GoFundMe campaign to provide financial support to 96 sex workers. One rural network also worked with a partner agency to initiate a counselling program for sexual assault and violence survivors during the pandemic.

Changes in funding, priorities and workload

Many staff commented on how funding for pandemic-related initiatives affected their work; some staff brought this up multiple times during our conversations. Funding availability varies between networks, but financial resources have generally been constrained during the pandemic. When funds are available, they have often been earmarked for pilot projects related to the pandemic. The resulting increase in short-term, new projects has been challenging for staff who are already coping with major changes in their regular work: the majority of staff agreed that these projects had significantly increased their workload, increased administration time, and reduced their ability to do core work. All staff noted that their workloads had increased tremendously, and staff members from both urban and rural networks said that they worked into the evening and/or on weekends to get their tasks done. Many commented on feeling high levels of stress and burnout: *"the way things are is not sustainable".*

Changes in mental wellness

The challenges of heavy workloads have been compounded by isolation from family/community supports and from the support of colleagues. All staff have been affected by grief and loss through their work at the MHRN, and this has increased in *"frequency and impact"* during the pandemic, as overdoses have affected peers and community members. One staff member explained that *"many of [our] coping strategies [such as] gathering, sharing, and connecting to others have been removed."* Staff miss having each other to talk to, grieve with, or *"just [cry] in the office together"*. The pandemic has highlighted the *"importance of team meetings and having time together [to] see how everyone's doing",* for many staff.

Peer Findings

This section describes how the pandemic affected the lives of peers, as well as their substance use and harm reduction practices. It also explores changes in the social, medical, and traditional services and supports they were able to access.

Substance use

Disruptions to the drug supply, and resulting changes in costs of drugs, characterized the first year of the pandemic. Concurrent police crackdowns on various channels of drug production and distribution in Manitoba further reduced supply and increased prices. Peers in most jurisdictions reported an increase in fentanyl-laced drugs, and peers in some jurisdictions reported that methamphetamines were more difficult to access at the beginning of the pandemic, driving the price up. The price has now normalized, but many people who began using heroin, crack or cocaine during this period now use these substances as their drug of choice. Peers also reported interruptions to prescribed drugs such as hydromorphone and opioid treatments, due to increased difficulty meeting with physicians, changes in provincial prescribing practices made during the pandemic, and reduced hours for services that supply prescriptions. Some peers increased their use of methamphetamines or heroin as a result of the difficulty getting these medications. Many peers had themselves overdosed or had friends/family overdose during the pandemic; they attributed this to both the increasing toxicity of the drug supply and to "switching" drug of choice in response to price increases and shortages. In general, peers thought that substance use - both their own and that of their friends/family - had stayed the same or increased: "there has been an increase in drug use throughout the pandemic in order to cope with stress, anxiety, and isolation; […] it's the same thing with friends and family."

Mental health

Mental health was a significant challenge for peers, many of whom were affected by suicide during the pandemic (both their own incomplete attempts and completed suicides of family and friends). The majority of peers described loneliness and isolation due to restricted contact with family, friends, other peers, and networks of support. At the same time, peers needed to provide more emotional support to others, which became harder due to public health restrictions. Increased anxiety was reported by many peers, which they attributed to concerns about safety for themselves, their family, and friends, and fears about contracting COVID-19. Peers often reported that gatherings continued, in order to avoid the risk of using substances alone, but stated this was a source of anxiety about COVID-19. (Generally, those who used

substances alone before the pandemic continued to use them alone throughout the pandemic, and those who used substances in communal settings before the pandemic continued to do so.) Some peers reported a loss of interest in hobbies, including hobbies like beadwork that provided a secondary income source, due to changes in their mental wellness. Other peers indicated that their mental health would have been better if they had been able to take part in structured recreational activities; a gap created by changes in the availability of social programs.

Socioeconomic conditions

The pandemic negatively affected the economic and social conditions of peers' lives, particularly housing and personal finance. The majority of peers reported a change in their housing situation as a result of the pandemic, and there has been a dramatic increase in peers who are unhoused. A reduction in available low-income housing, a decrease in the availability of housing supports, and changing income are the primary contributing factors. In response to public health guidelines, distancing measures and overwhelmed social supports, emergency housing programs were reduced during the pandemic and fewer spaces were available to peers. For some peers, not having a phone or internet connection further decreased their ability to find housing. Of those peers who are housed, many live in high-traffic and/or multi-generational housing, and do not have personal control over who enters their home: this was a source of significant anxiety about contracting COVID-19.

The majority of peers experienced deteriorating finances during the pandemic. Many peers reported losing employment and employment opportunities during the pandemic, but their incomes were also reduced in other ways. Social services like food banks, churches, and clothing donation sites closed their doors temporarily: this meant that peers had additional expenses for necessities. Additional expenditures directly related to COVID-19 (such as needing to pay to use digital technology, or for masks and sanitizer) were significant additional financial burdens. Most concerningly, many peers reported that they lost EIA/B or Disability payments throughout the pandemic. This was primarily because peers were unable to see health care providers to obtain necessary supporting documentation. Some peers received CERB, and they found that it was sufficient to support them financially; however, there was uncertainty about whether they were qualified for it, and anxiety about having to repay it if they were found to be ineligible.

Access to medical services

Use of necessary medical services by peers decreased during the pandemic. Booking appointments became more challenging, since appointments were limited, walk-ins were not accepted, and few peers have access to a personal telephone or payphone to make a booking. Many medical services moved to telephone appointments rather than in-person appointments, which further restricted access, since the majority of peers do not have the use of a phone. When telephone services were used, peers indicated the experience was not equivalent to in-person services. Virtual services were not a viable alternative, as most peers have neither an internet connection nor a device. Many said that they had avoided medical and social services for these reasons.

Certain medical services were harder to use than others. The majority of peers said that testing for STBBI was not available to them during the pandemic: this was primarily due to nurse redeployments and cancellation of community clinics for people who use substances. Peers in rural areas frequented reported having no access at all to STBBI tests throughout the pandemic; peers in urban areas reported decreased opportunities for testing as well, but this experience was less uniform. It was also more difficult to see specialists: peers particularly commented on the challenges of meeting with psychiatrists. Psychologists, counsellors and therapists, who largely shifted to virtual modalities for meetings, were also much less available to peers. Many peers avoided dentistry because of a perceived risk of contracting COVID-19. Peers also noted non-residential services and acupuncture were unavailable during the pandemic. The NIHB continued to provide transportation to medical appointments for suboxone treatment, which was very helpful.

It was harder for peers to find medical professionals who had experience with or understanding of harm reduction during the pandemic. In general, peers said that health care providers are inexperienced in this area; during the pandemic, this was very challenging for those who wanted advice on how to safely switch drugs due to changes in drug supply, or who wanted to use substances in the safest possible way. Other peers commented that they base their decisions about accessing medical care – particularly in hospital settings – on which provider is on staff. Their rationale for this is that not all providers are supportive of the concept of harm reduction, and these practitioners are not able to give helpful advice about minimizing harms. In past, peers have been able to ask advocates (often MHRN staff) to attend medical appointments with them. Peers said having an advocate reduces experiences of discrimination and helps to ensure that they understood their treatment options. During the pandemic, this has not been allowed in hospitals or clinics, which made some peers feel less safe using medical services.

Access to harm reduction and community services

Prior to the pandemic, peers were able to obtain harm reduction supplies and other necessities, get testing for STBBI, make social connections, and receive help with a variety of tasks through MHRN and MHRN partner services. The shift to virtual services during the pandemic made it more difficult for peers to participate in these activities, even when MHRN staff were able to solve issues of technology availability. Virtual services were described by one participant as "a poor substitute" for human contact. One-on-one meetings took the place of group meetings when restrictions allowed, but peers missed the knowledge exchange, camaraderie, and support of others who use substances. Smaller group meetings reduced the range of opportunities available to peers: activities like bringing in an Elder, or doing capacity building training, were less frequent. Drive-by meetings were somewhat successful, but peers missed the ease of "just walking in". Outreach services suffered during the pandemic. Most peers described a drop in the availability of outreach programs, the absence of public health nurses, and event cancellations and changes as provincial restrictions shifted in response to case numbers. Urban centers indicated an increase in deliveries and drop offs of harm reduction supplies.

Although many pandemic-related service changes were hard on peers, there were some positive modifications. Consolidation of services in a "community hub" – which happened in several locations in the province – was very useful for peers, since it minimized potential COVID-19 exposure and facilitated the use of multiple services. Provision of harm reduction supplies at community service sites was also useful. All of the peers who received care packages through MHRN found these useful: these packages were tailored by MHRN staff for each peer and included things like gift cards, winter clothing, food, cleaning supplies, personal protective equipment, traditional medicines, tampons/pads, harm reduction supplies, and money. The Flin Flon Network piloted a locker program in collaboration with primary care nurses which was very successful. Each peer was assigned a locker outside of a primary care facility; primary care nurses would regularly deposit harm reduction supplies and care packages prepared by MHRN staff in these lockers for pick-up. The program was well-received as a safe, socially-distanced way to obtain necessities. Fentanyl test strips were also available through the locker program, which was appreciated by peers. A community mailbox program run by a partner organization was similarly beneficial.

Other valuable initiatives focused on developing the leadership skills and individual capacity of peers. These included training programs on how to use naloxone to prevent overdose, and how to administer CPR. Given restrictions on gathering, many peers were involved with disseminating harm reduction supplies to their community throughout the pandemic. Peer-led

initiatives in both urban and rural settings were very successful, and they increased community referrals to the MHRN networks. Peers said that they enjoyed being able to support their community in this way; they also tried to help others and fill gaps in services by sharing food/clothing/necessities, providing childcare, and cleaning houses/shelters. Peer-led projects were a source of practical support, pride, and social connection, all of which were beneficial.

Access to traditional supports

Many of the peers who are Indigenous use, or would like to use, traditional supports such as Elders, Knowledge Keepers, traditional medicines, smudges, and sweats. During the pandemic, Elders and Knowledge Keepers were much less available to peers. Many peers were concerned about risking the health of Elders by meeting with them in person, and telephone or virtual meetings were not an option, since peers did not own or have ways to use these technologies. In addition, many peers said that Elders were overwhelmed by the need to support others during the pandemic, and were less available. Finally, many of those who met with Elders prior to the pandemic met them in group settings and at events – when these events were cancelled or postponed, the connection was lost. Access to traditional medicines was still possible for the majority of peers; MHRN staff were able to provide traditional medicines through partnerships established independently by each site. However, urban centers typically had more reliable access to these medicines, and staff commented that there were challenges getting medicines that had been collected in the right way.

Experiences of discrimination

Virtually all peers face discrimination in their daily lives based on their use of substances, and for many, based on class and/or race as well. These experiences of discrimination – particularly discrimination based on substance use – worsened during the pandemic, due to public perceptions that PWUS are more likely to be infected with COVID-19. Substance use also became more visible in communities, due to shelter closures and the above-mentioned increase in houselessness, which many peers thought contributed to the discrimination they faced. Some peers reported that during the pandemic they had more difficulty gaining employment, because they were known by the community to use substances, even if they had relevant experience and training. Many peers reported disturbing incidents of discrimination in hospital settings. These included assumptions of substance use when sober, denial of medications based on the belief they were drug-seeking, denial of breast-feeding to a sober woman based on the assumption she had consumed substances, and hospital staff telling patients they would overdose and die.

Conclusions

The pandemic has disproportionately affected people who use substances in Manitoba. These impacts are cross-cutting, affecting all aspects of the lives of the peers who shared their stories with us. Negative impacts on substance cost and availability, housing, finances, availability of medical, social and traditional supports, and the loss of personal relationships and community support has disrupted the limited stability that this group had prior to the pandemic. Staff who work with PWUS are struggling as well, overwhelmed by loss, shifting priorities and changing restrictions, and drastic increases in workload. These challenges are not limited to Manitoba or the MHRN; as outlined earlier, this is an issue across Canada, one that needs urgent attention to protect and support some of the most vulnerable members of society, and those who work with them. Based on the findings outlined in this report, a related plain language summary has been developed. This document explores both structural and incremental changes that can improve outcomes for PWUS in Canada. It is available on the NCCID website.

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