Promising Practices for Harm Reduction in the Context of Multiple Pandemics: Results of the Manitoba Harm Reduction Network Evaluation

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MANITOBA HARM REDUCTION NETWORK

Introduction and Methods

For people who use substances (PWUS) in Manitoba, the pandemic has led to poor mental health, more houselessness, less financial stability, higher risk substance use, and fewer harm reduction services, particularly sexually transmitted and blood-borne Infection (STBBI) testing.

Discrimination and the effects of colonization shape health outcomes for PWUS, and these effects have increased during the pandemic. The pandemic has also increased the vulnerability of PWUS to overdose and STBBIs.

NCCID and MHRN identified a need to develop promising practices for harm reduction in the new context of the pandemic. In summer 2021 we conducted a participatory evaluation of harm reduction services in Manitoba. PWUS and MHRN staff contributed to the development of interview questions. Semi-structured interviews were conducted over three months in 11 regional networks. We used NVivo1.5 to identify common and divergent themes in the data. Results and findings were validated with PWUS and MHRN staff.

Two publications on the results of the evaluation can be found online, at www.nccid.ca. These are:

- Summary of Findings from the 2021 Manitoba Harm Reduction Network Evaluation
- Report of an Evaluation of Manitoba Harm Reduction Network Services in the Context of the COVID-19 Pandemic

A Knowledge Keeper provided insight and support to participants

MHRN: Manitoba Harm Reduction Network. MHRN coordinates and supports harm reduction in Manitoba.

NCCID: National Collaborating Centre for Infectious Diseases. We provide infectious disease knowledge translation for public health audiences.

STBBI: sexually transmitted and blood-borne infection

PWUS: people who use substances

Findings: Lives and Livelihoods

The pandemic made life harder for PWUS, particularly in the areas of mental health, housing and personal finance. All PWUS who participated in the evaluation had been affected by overdose during the pandemic, their own or those of loved ones. Many were also affected by completed and incomplete suicides. Elders, psychiatrists, and counsellors were no longer available for groups, and many were not available in-person, which made it harder for PWUS to receive support.

The financial situation of most PWUS deteriorated during the pandemic. This was because: they were laid off or lost opportunities to do contract work; they lost income assistance or disability benefits; food banks and clothing donation sites closed; and because they had new expenses. PWUS who received the Canada Emergency Response Benefit (CERB) said it let them find safe housing and meet their basic needs, and that this improved their mental health. Most PWUS were uncertain if they were eligible for CERB, and this uncertainty was a source of stress.

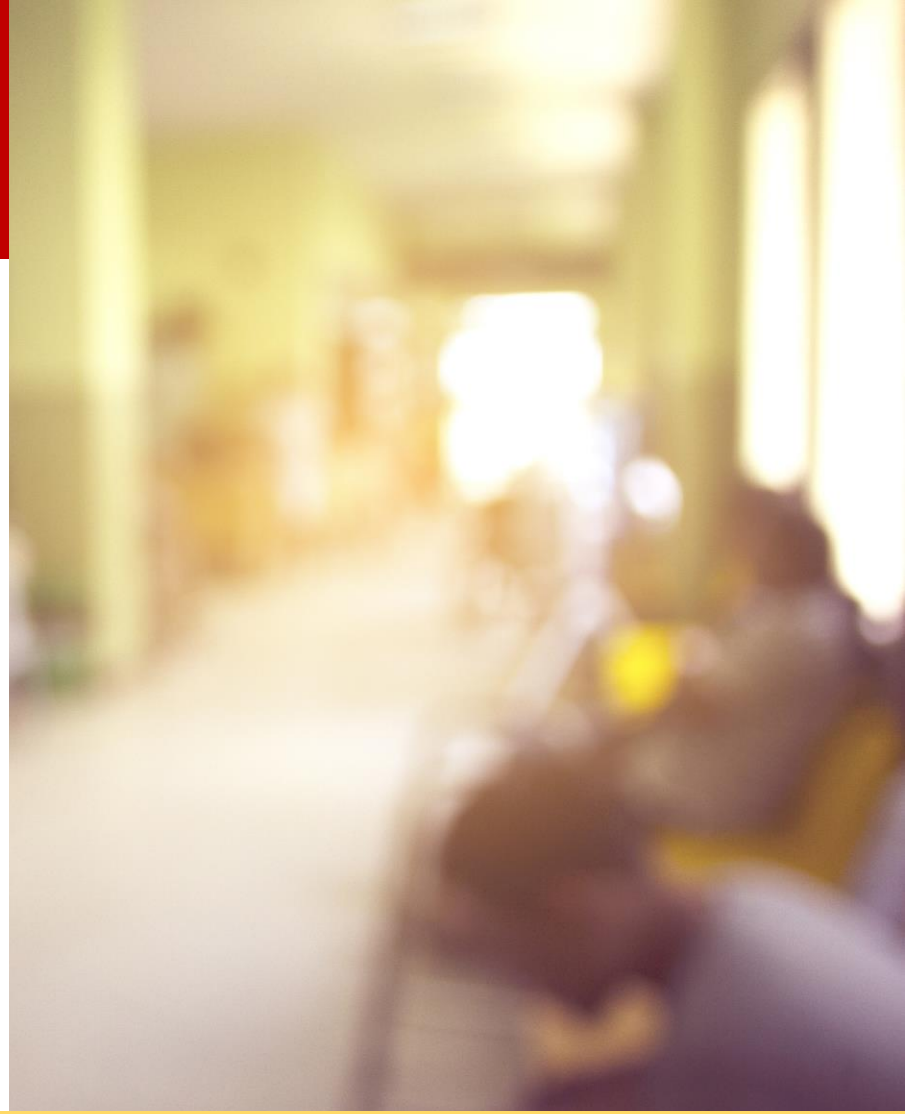
Substance use: The rate of substance use increased or stayed the same during the pandemic for most PWUS. Risk of substance use increased due to disruptions to the drug supply, and adulteration by dealers. Many peers began using heroin, crack or cocaine instead of methamphetamines during this period. Peers also reported interruptions to hydromorphone and opioid treatments due to the pandemic, due to difficulty seeing medical practitioners.

Many PWUS became houseless during the pandemic. Low income housing was less available and many shelters, emergency housing, and housing support services were closed. Some PWUS were evicted because landlords were concerned that substance use would facilitate the spread of COVID-19.

Findings: Medical and Social Services

All PWUS said that STBBI services were difficult to find and use in Manitoba during the pandemic. MHRN staff attributed this to clinic cancellations and nurse redeployments. Mental health services were also hard for PWUS to find and use. Few PWUS own an internet-connected device or telephone, so the shift to virtual and teleservices and lack of walk-in appointments disproportionately disadvantaged them. Several PWUS lost income assistance and benefits because they were unable to make appointments to get paperwork signed. Other PWUS were unable to meet with healthcare providers to get prescriptions for methadone or suboxone. Many people in this situation relapsed to using higher-risk street drugs.

The pandemic also made it harder for PWUS to find medical practitioners who did not discriminate on the basis of substance use, simply because fewer practitioners were available. The absence of medical advocates due to pandemic restrictions made experiences of discrimination in hospitals worse. Numerous PWUS asked emergency medical practitioners how to safely switch substances because of the disrupted drug supply, but practitioners did not know this information. This suggests a need for training in harm reduction medicine, including topics like switching and tapering substances and relapsing to street drug use.



Staff experiences: The pandemic significantly increased the work of all MHRN staff. Closed STBBI clinics and community services made referrals much more challenging. Staff struggled with uncertainty about safety protocols and changing public health restrictions. All staff experienced loss and grief due to overdose deaths during the pandemic, and this was made harder by the absence of in-person connection with coworkers. New project funding was available to respond to these challenges, but created more work for staff. Best practices for telephone and virtual harm reduction are needed. Harm reduction agencies can support staff by offering regular, online conversations to cope with grief, facilitated by a mental health professional. Funding agencies should consider putting additional money into baseline operations, not pilot projects.

Discussion: Promising Practices

MHRN implemented several initiatives that improved outcomes for PWUS during the pandemic. Some of these initiatives are low-cost and transferrable to other jurisdictions. These included tailored care packages based on individual needs assessments; contactless lockers to distribute supplies, PPE, and prescription medications; peer-based overdose prevention programs; and community partnerships to provide harm reduction supplies in various locations to minimize contacts. Peer-led harm reduction supply distribution was also very successful and improved the mental health of PWUS who took on this role. Providing cell phones for appointments, training PWUS in virtual spotting, workshops on applying to CERB, and virtual conversations with Elders for mental health support were suggested by PWUS but have not yet been implemented by MHRN.

The health inequalities faced by PWUS are structural in nature, and the evaluation identified structural opportunities to improve health outcomes as well. These include: eliminating medical discrimination on the basis of substance use; training medical personnel on safer substance use; recognizing reconciliation as essential to mental health; ongoing investment in emergency housing; and ending enforcement-based approaches to drug use, which can lead to drug shortages, substance switching, and overdoses. Public health should consider implementation of safe supply distribution systems like MySafe, which provide contactless, continued access to prescription medications. These changes have the potential to significantly improve health for PWUS.

STBBI testing and treatment: Continuing STBBI services during a pandemic is essential. Although testing decreased during the pandemic, case counts for many STBBI increased in jurisdictions across Canada; this suggests that actual cases are significantly higher, and pre-existing syndemics are worsening. If STBBI services need to be paused, redeployments should be for short periods. In these circumstances, public health should focus on testing, tracing, and treating PWUS, who are at higher risk of infection and may have more complex cases. This can be done most easily by continuing to provide community clinics in partnership with harm reduction or community service agencies. Continued investment in STBBI healthcare and the general healthcare system is needed to increase surge capacity and prevent long gaps in care.