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A RAPID RESPONSE

Gender and Addiction-related Intervention among Individuals in Situations of Social Precarity in the Context of a Pandemic
(GID-COVID Project)

November 23, 2020

GID-COVID Project: Gender and Addiction-related Intervention among Individuals in Situations of Social Precarity in the Context of a Pandemic
Knowledge Synthesis: A Rapid Response (November 2020)

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1. BACKGROUND

This knowledge synthesis has been produced for practice settings that offer harm reduction and treatment services to individuals in situations of social precarity, whose health and social needs are complex. It also falls under the Canadian Institutes of Health Research (CIHR) novel coronavirus (COVID-19) rapid research funding opportunity, launched to contribute to the global response to the COVID-19 outbreak. Part of this involves addressing gaps in the mental health and substance use response to COVID-19 and identifying the relevant interventions. Here, our knowledge synthesis and related knowledge mobilization plans will help to build the evidence base needed to provide municipal, provincial, territorial and federal decision-makers with timely, accessible and relevant data. The following report touches therefore upon three main areas: the impact of the health crisis on various at-risk populations; service delivery; and the development of guidelines.

Given the urgency and time-sensitive nature of the response, our findings are necessarily based on a narrative synthesis informed by the methodological framework and procedure developed by the Institut national d'excellence en santé et services sociaux (INESSS) for rapid responses to COVID-19. We also draw on the main scientific papers and practice guides issued by various groups along with the expert opinions of professionals, administrators, practitioners and those with experiential knowledge of the matter (psychoactive substance users).

2. INTRODUCTION

Individuals with problematic substance use in situations of social precarity run a higher risk of contracting COVID-19 than the general population; they are also at greater risk of severe illness should they become infected. Underlying these risks are the preponderance of chronic health conditions among this group and the challenges of applying health measures to their everyday contexts. In addition, experiencing the pandemic may also trigger or aggravate psychosocial crises in people with concurrent disorders. A further consideration is the World Health Organization's observation that the social fallout from COVID-19 hits women even harder (economic insecurity, single parenthood, violence, barriers to accessing services, etc.). Factoring gender into efforts to improve addiction-related services in the context of a pandemic is therefore paramount.

Taking into account gender and sexual diversity**,** our **research questions** are as follows:

1. In terms of overall health, service needs and service availability, how does COVID-19 affect people with problematic psychoactive substance (PAS) use in situations of social precarity?

2. In a pandemic situation, which addiction-related interventions and services best meet the health and social needs of people in situations of social precarity?

2.1. What health recommendations are best suited to the living conditions of marginalized or at-risk individuals? What interventions could support the implementation of these recommendations and the overall well-being of these populations?
2.2. What service provision practices and features are liable to reduce the risks associated with PAS use in a pandemic context, but without jeopardizing the harm reduction strategies applied prior to the health crisis?
2.3. In terms of both addiction and general wellness, which service provision practices and features are most apt to foster recovery in the context of the pandemic?

The project ultimately aims to develop guidelines for improving addiction-related services in a pandemic context, taking into account the health and social, gender identity and sexual orientation needs of individuals in situations of social precarity. A broad range of stakeholders—researchers, decision-makers, practitioners and people with experiential knowledge of PAS use—will be mobilized in a collaborative approach aimed at issuing joint recommendations.

3. PROJECT TEAM: A RESEARCH-PRACTICE SYNERGY

The GID-COVID project took place from May to November 2020 as part of the Canada Research Chair in Gender and Intervention in Addiction (CIHR, 2020–2024). Chairholder Karine Bertrand, PhD, is a full professor in the Université de Sherbrooke's Addiction Research Study Program. She is also Scientific Director of the Institut universitaire sur les dépendances at the Centre intégré de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal (CCSMTL-IUD). The GID-COVID team includes researchers who are active on the Chair (Mathieu Goyette, Jorge Flores-Aranda, Marie Jauffret-Roustide and Julie Loslier) and/or the international GENDER-ARP (CIHR) project on addiction, health risks and social precarity (Goyette, Flores-Aranda, Jauffret-Roustide, Loslier and David-Martin Milot). Two CCSMTL-IUD staff members are also part of the team: in-house researcher Vincent Wagner, who recently came on board; and Dr. Marie-Ève Goyer, clinical assistant professor in the Department of Family Medicine at Université de Montréal and a practicing family physician with expertise in addiction and urban health. Spanning the fields of psychology (Bertrand, Goyette), community health (Flores-Aranda), sociology and drug policy (Jauffret-Roustide), family medicine (Goyer) and public health (Milot, Loslier, Goyer), the team's wide-ranging expertise enables an interdisciplinary approach to the issues surrounding COVID-19 and addiction.

The principal knowledge user is Martin Camiré, associate director of the CCSMTL-IUD's addiction service continuum. Under the IUD's mission of supporting provincial addiction practices, he sits on various knowledge mobilization committees in addition to serving as clinical co-director of RISQ (Recherche et intervention sur les substances psychoactives), a hub of inquiry to which a number of Chair researchers also contribute. Dr. Loslier, another knowledge user, is the Directrice de santé publique (DSP) for the Montérégie region. As head of the provincial addictions committee that brings together all DSPs in Quebec, she is actively engaged in managing the COVID-19 response. A further knowledge user is Dr. Goyer, through her various roles as family physician at the CCSMTL-IUD, scientific director of the IUD's Clinical and Organizational Support Team in Addiction and Homelessness and head of the addiction response unit at Montréal's Royal Victoria Hospital, whose focus includes homeless persons who have contracted COVID-19.

Lastly, the team includes three peer researchers who have been actively involved since the start. Caroline Leblanc and Chelsea Grothé both work in the areas of homelessness and addiction, through either direct action or peer-based harm reduction projects. Leblanc is also a doctoral candidate in the Université de Sherbrooke's Addiction Research Study Program. Grothé, in turn, contributes to the GENDER-ARP project, which documents the long-term recovery of substance users living in situations of social precarity. Carl Tardif, our third peer researcher, is currently in the Université de Sherbrooke certificate program in addiction and also contributes to GENDER-ARP.

4. METHODOLOGY

The research is participant-driven and applies an empowerment evaluation approach (Fetterman, 2014; Wandersman et al., 2005). Informed by the INESSS (2020) methodological framework for rapid responses to COVID-19, it has two components: 1) a narrative synthesis of the literature, and 2) expert consultations. Participatory research methods engage the various stakeholders at every stage of the process.

The project team—a mix of university and peer researchers as well as knowledge users working in public health and health and social services—has drawn on the findings of both components to issue its recommendations.

4.1. Narrative synthesis

Drafted six months into the project, our knowledge synthesis has been structured and its preliminary findings, issued based on the INESSS rapid-assessment methodology. The literature review, in turn, was guided by the research questions presented in Section 2.

4.1.1. Identifying the publications

The librarian at the CCSMTL-IUD's Centre québécois de documentation en toxicomanie (CQDT) helped us identify keywords for the following concepts: addiction, COVID-19, SARS, influenza A (H1N1), mental health, homelessness, social precarity, gender, sex, and gender and sexual diversity (see Appendix 1). Influenza A (H1N1) and SARS were selected for their similarities to the COVID-19 pandemic and potential utility in guiding the response to the ensuing health crisis. A comprehensive literature search was conducted using databases on the EBSCOhost and OVID platforms: Academic Search Complete, CINAHL, MEDLINE, Psychology & Behavioral Sciences Collection and PsychINFO (see Appendix 2). Further documents of interest were retrieved by consulting the bibliographies of the selected publications as well as by seeking input from experts and researchers. Lastly, we monitored CINAHL, MEDLINE and PsyInfo to identify any relevant new studies on homelessness and addiction.

4.1.2. Document selection criteria

Publications were required to meet the following criteria:

a) Be originally written in English or French.
b) Address the impact of COVID-19 on harm reduction and treatment services for individuals with problematic psychoactive substance (PAS) use in situations of social precarity or vulnerability (i.e. homelessness, mental health).

c) Appear in a peer-reviewed journal or publication that had been vetted by scientific bodies, government authorities, professional associations or PAS users.
d) Preprint articles, editorials, literature reviews and other studies were also deemed valid if they met certain qualitative or quantitative criteria.
e) Be published within a specific date range: 2020 for COVID-19; and between 2002 and 2019 for influenza A (H1N1) and SARS.
f) There was no limit on geographic origin.

Publications that did not bear on COVID-19, SARS or influenza A (H1N1) in connection with addiction, mental health or social precarity as well as those written in languages other than English or French were excluded.

During the review, we noted that gender and sexual diversity had been but little addressed in the selected studies (this process is described later). To address this gap and flesh out the findings, we launched a second phase to identify documents on COVID-19 in relation to gender and sexual diversity. Such texts had to address the impact of COVID-19 and/or of harm reduction and treatment services based on gender or for 2SLGBTQ+ people. The keywords associated with the concepts of "gender," "gender minority" and "sexual minority" are listed in Appendix 1.

Team members browsed the databases, selected the documents and identified grey literature. The search yielded 1,074 articles from the databases and 120 documents from institutional grey literature. Experts and researchers submitted 49 articles, while 38 articles were retrieved through ongoing monitoring of new publications relevant to our topic. A search on gender and sexual diversity yielded 150 documents, 39 of which related to 2SLGBTQ+ people and 111 of which related to women. A total of 246 documents provided the data that forms the basis of this report.

4.1.3. Data extraction and synthesis

Data extracted from the full texts were collated in an information retrieval grid by two research professionals and four research assistants, with the former cross-checking the data extracted by the latter. The inclusion (or not) of gender and sexual diversity was systematically analyzed in all texts, for example by extracting findings referring to the specific realities of men, women and 2SLGBTQ+ people. None of the documents were assessed for methodological quality; limitations were reported only if pointed out by the authors. Narrative synthesis was favoured for analyzing the collected data. Documents were grouped and analyzed by topic to highlight the key findings associated with each question, objective and population.

4.1.4. Quality assurance and validation

The principal investigator progressively validated the document selection, methodological transparency and the final version of the rapid assessment. The research team provided input on the research questions. Their views, shared at a meeting and by way of a form listing what

respondents felt were the key points, have been used to round out the findings of the literature review.

4.2. Expert consultations

The key stakeholders in Quebec consulted about the impact of COVID-19 on PAS use and the recourse to harm reduction and treatment services have academic, professional or experiential expertise. Their input in conjunction with findings from the analysis of pan-Canadian and international literature has made it possible to provide recommendations that address the needs of service providers and affected individuals both in Quebec and more widely across Canada.

The academic experts consist of the project team's eight university researchers and three peer researchers. The latter have been consulted at every stage of the research, including with regard to expanding the list of references, developing data collection tools and drafting recommendations. They were also invited to weigh in on the research questions.

4.2.1. Recruitment

Using both snowball sampling and the expert sampling method (Angers, 1996), guided by partners of the Canada Research Chair in Gender and Intervention in Addiction, the key stakeholders were recruited for individual semi-structured interviews lasting 45 to 60 minutes. The interviews took place online or in person, based on the applicable health measures at the time. The professionals were given the option of being interviewed or completing an online survey that included questions from the interview guide.

A total of 15 service users took part in the semi-structured interviews. To be eligible, they had to 1) be 18 or over; 2) have experienced problematic psychoactive substance use (CAGE-AID) in the last year; and 3) be living in a situation of social and/or economic precarity (i.e. residential instability, employability instability, issues related to mental or physical health, social adaptation or severe PAS use).

Of the 46 professionals who contributed to the project, 18 participated in the semi-structured interviews, while 28 completed the online questionnaire. To participate, they were required to: 1) be a service provider, clinician or administrator; and 2) work with clienteles with problematic PAS use and concurrent disorders. The sample size let us achieve saturation for our specific aims. The project was approved by the CIUSSS de l'Estrie-CHUS research ethics committee.

4.2.2. Data collection

The interview guides (aimed at service users and professionals) and online questionnaire (aimed at professionals only) addressed the following topics: COVID-19 and its effects, PAS use, recourse to addiction-related services, public health measures, service user needs, harm reduction and

treatment service availability, and gender and sexual diversity. These data collection tools had been the subject of prior consultations with project partners and had also been pre-tested with four young adult substance users in situations of social precarity who are on the TAPAJ research project panel. For the sample profile, the service users completed a socio-demographic questionnaire (age, sex, gender, sexual orientation, ethnicity, education, etc.) and the professionals, a socio-professional questionnaire (study level/program, role/duties, area of intervention, clientele served, etc.).

4.2.3. Data analysis

To start with, the team's four research assistants were tasked with producing a summary of each interview based on the topics addressed. The research professional then thematically analyzed the interview summaries to identify the main findings. Gender, sexual diversity and gender diversity were systematically taken into account through the identification of findings that relate to the specific realities of men, women and 2SLGBTQ+ people. These results were regularly discussed with the project partners. Descriptive analyses of the sample's socio-demographic and socio-professional characteristics were also produced.

4.2.4. Participant profiles

Of the 46 professionals who took part in the semi-structured interview or online survey, 29 identified as female and 17 as male. Over three-quarters (n = 35) had university training (certificate/undergraduate/graduate). Three had completed college; four had completed high school; and four had answered "other." More than two-thirds (n = 30) had studied in a social sciences field such as addiction, delinquency, psychology, psychoeducation, social work, theology or sexology.

The professionals reported working in the following regions: Montreal, Lanaudière, Estrie, Capitale-Nationale, Mauricie, Montérégie, Saguenay-Lac-Saint-Jean, Bas-Saint-Laurent, Centre-du-Québec, Laurentides and Outaouais. They were also asked about their working environments. The vast majority (n = 35) worked in a community setting; the rest were employed in the health and social services network (CISSS/CIUSSS), private practice, for an NPO or in academia. Half (n = 23) were frontline service providers; almost one-quarter (n = 11) held a managerial position; and the remainder worked as coordinators, administrators, independent contractors, volunteers or association representatives.

Among the 15 service users, almost half (n = 7) reported being assigned as female at birth; the same number (n = 7), as male; and one person, as not knowing their assigned gender at birth. Over half the sample (n = 8) identified as men and slightly more than one-quarter (n = 4), as women. One person was non-binary, one was questioning and a third, genderfluid. Just under half (n = 6) identified as heterosexual, four as pansexual and most of the remainder, as asexual, bicurious, gay, queer or demisexual, with one person reporting that they were questioning their sexual orientation. All participants said they were born in Canada. Almost half (n = 7) identified as Quebecers and/or

Canadians. A little over one-third (n = 6) identified as Caucasian, one respondent identified as First Nations and another, as having no ethnic identity.

The service users were also asked where they had lived the longest in the past three months. For half the sample (n = 8), this was their current dwelling. The rest had stayed in a supervised apartment, community housing, at their parents', in a rooming house, at a shelter or on the street.

This group was also asked about their substance use in the last 12 months. In general, they were habitual users (e.g. daily, weekly or monthly) of one or more of the following: tobacco, alcohol, cannabis, cocaine, sedatives, sleeping pills and opioids. Lastly, they were asked about their service use over the same period. Those most commonly used were supervised injection sites (SIS), support groups, outpatient addiction therapy and follow-up, sterile equipment/overdose prevention sites and opioid agonist treatment (OAT) clinics. A small number of respondents reported using respite care, sobering centres and inpatient drug treatment services.

5. RESULTS

This section begins by presenting the highlights and recommendations that were formulated in response to our first research question (Objective 1) based on an analysis of the literature review and expert opinions from researchers, practitioners and people with lived experience of social precarity and PAS use. A more detailed analysis is presented thereafter. For Objective 2, we start with the recommendations, followed by an analysis of the literature review and expert opinions that served as a basis for the co-construction of the recommendations.

5.1. Impacts of COVID-19 on health and services (Objective 1)

In terms of overall health, service needs and service availability, how does COVID-19 affect people with problematic psychoactive substance (PAS) use in situations of social precarity?

5.1.1. Highlights and recommendations: the impact of COVID-19

Highlights

- ✓ As is typical of epidemics throughout history, the COVID-19 pandemic severely and disproportionately affects marginalized populations who struggle with chronic mental and physical health issues and social vulnerabilities such as homelessness.
- ✓ Individuals in situations of social precarity with problematic psychoactive substance use also tend to suffer from chronic associated conditions (e.g. HIV, asthma, lung disorders) that compound the risk of COVID-19 infection.
- ✓ Despite the importance of clear health messages to protect these particularly vulnerable populations, their day-to-day living conditions can make health measures challenging to apply. These measures may also increase psychological distress and distance them from harm reduction resources.
- ✓ Disrupted or decreased access to harm reduction and treatment services is particularly worrying in terms of the accrued risk of overdose for persons with an opioid use disorder.
- ✓ Disrupted or decreased access to addiction treatment and related services (e.g. mental health, harm reduction, housing, shelters, community resources that address living conditions and support basic needs) can also aggravate social isolation and distress, thus raising the risk of suicide.
- ✓ Changes to the illicit drug supply chain (reduced availability of certain substances, price surges, decreased product purity/dangerous filler ingredients, etc.) may increase the associated risks such as withdrawal, overdose or the adverse effects of using other, more dangerous substances.
- ✓ Disrupted or decreased access to harm reduction and treatment services due to COVID-19 may cause some service users to feel abandoned by the system at a time when their support

needs are intensified and when the pandemic context may increase the risk associated with substance use.

Highlights specific to gender and to gender and sexual diversity

- ✓ The pandemic has exacerbated health- and gender-related inequities that were there before the crisis.
- ✓ Substance-dependent women, who already face tremendous barriers to treatment services—for example, through a lack of childcare (the role of single parent more typically falling to women)—tend to use such services less than men. The COVID-19 pandemic may increase these barriers.
- ✓ Given the gender gap in income and family responsibility, pandemic-related lockdown measures have greater economic and social consequences for women, including increased domestic violence and heightened financial stress.
- ✓ With regard to preventing HIV and other STBBIs, the pandemic poses specific health risks to men who have sex with men (MSM), including reduced or suspended screening services and decreased support from community organizations.
- ✓ For the 2SLGBTQ+ community, social distancing may aggravate isolation and psychological distress by barring access to safe spaces where sexual orientation and gender identify can be openly discussed and revealed.
- ✓ The pandemic has indirectly but adversely affected mental health among 2SLGBTQ+ people through a range of factors, including difficulties in accessing mental health support; financial stress; the closure of gender identity-related safe spaces; risks related to revealing sexual orientation; postponements to sex reassignment surgeries; and the limited availability of gender-affirming medical treatments.

Our recommendations

- ✓ Since treatment services are essential in a health crisis, reassigning their clinical and administrative staff to other areas should be kept to the necessary minimum. Support to these services should also be increased so as to ensure their availability and avoid disruptions that may lead to otherwise preventable complications or deaths.
- ✓ Social and psychological support for substance users in situations of social precarity must be seen as essential in a pandemic context.
- ✓ Adequate support should be ensured for community organizations that reach these populations and that offer high-threshold services, a harm reduction-based response, support targeted to basic needs (access to food/housing, more stable and recurring funding), and clinical and administrative support.

- ✓ Alternative approaches to criminalization must be encouraged to avoid worsening the plight of substance users in situations of social precarity during the current health crisis.
- ✓ Certain services developed during the pandemic in response to increased and/or changing needs should be maintained after the crisis so as to better meet the needs of individuals in situations of social precarity.
- ✓ Stable, predictable and recurring funding for service providers should be prioritized to support the sustainability of these initiatives.
- ✓ Evaluative research must be carried out in cooperation with practice settings to improve these initiatives and foster both their continued existence and their transfer to different regions and contexts.
- ✓ Harm reduction and treatment organizations must be allocated funds to develop strategies—uninterrupted psychological and clinical support, flexible work arrangements (telework), adequate/available PPE—that promote the well-being and safety of their clinical and administrative teams.
- ✓ The specific needs of women must be addressed by factoring gender focus into all COVID-19 planning and organizational policies.
- ✓ Pregnant women, parents who are mainly responsible for child care and mothers in different situations should receive services in priority (e.g. prenatal prevention and psychosocial support, access to child care to reduce service barriers, parenting skills development).
- ✓ Strategies to reach and engage women and 2SLGBTQ+ people must take into account their specific realities and needs.
- ✓ Given the COVID-19 lockdown- and social distancing-related surge in domestic violence, women's shelters should remain open and accessible during the health crisis.
- ✓ Harm reduction and treatment services aimed at women and 2SLGBTQ+ people must give particular consideration to and offer psychosocial support for violence, which is potentially exacerbated in a pandemic context.
- ✓ Community and front-line services for sex workers, particularly services that focus on economic issues, addiction and violence, must be kept available throughout the health crisis.
- ✓ During the health crisis, financial support must be offered to informal workers (e.g. sex workers, panhandlers) and income support provided to those who must stop working for family reasons (e.g. to provide child care).
- ✓ Support services for basic needs, including food, should be part of the gamut of harm reduction and treatment services.
- ✓ In keeping with a syndemic approach to public health aimed at better understanding the experience of drug users, priority must be given to policies that support access to income and housing in order to lessen the health inequities and social precarity that become even more marked during a health crisis.

5.1.2. Key findings from the literature review: the impact of COVID-19

The documentary sources consulted as part of the literature review have enabled us to meet Objective 1 of this rapid response in the context of COVID-19.

Increased physical vulnerability and environmental exposure due to COVID-19

In terms of physical health, the literature highlights the elevated risk of COVID-19 infection, transmission and severity among people with addiction disorders in situations of social precarity, who have a high prevalence of medical co-morbid conditions. Some authors underscore the heightened vulnerability and cumulative risks of infection and death among homeless people and PAS users (Baggett et al., 2020a; Banerjee and Bhattacharya, 2020; Barbieri, 2020; Becker and Fiellin, 2020; Cumming et al., 2020; Deilamizade and Moghanibashi-Mansourieh, 2020; Kar et al., 2020; Lima et al., 2020; CRISM, 2020c; Miyawaki et al., 2020; Peate, 2020; Rosenthal et al., 2020; Schrooyen, 2020; Wood et al., 2020). Furthermore, the chronic conditions that often accompany problematic substance use—COPD, asthma, etc. (Armitage et al., 2020)—put these populations at higher risk of HIV infection (Sutherland et al., 2020). Marsden et al. (2020) point out that the weakened immune response resulting from such conditions makes substance users more likely to experience more severe COVID-19 disease than the general population. Miyawaki et al. (2020) observed higher hospitalization rates among homeless versus non-homeless populations after comparing inpatient records between 2007 and 2012, a period spanning the 2009 H1N1 influenza pandemic. These findings were corroborated by Schrooyen et al. (2020), who found the COVID-19 hospitalization rate in Belgium between March 3 to May 28, 2020 to be three times higher among homeless people than the general population.

Some authors have documented the challenges to screening for and treating COVID-19 among homeless shelter/transitional housing staff and residents, who are more at risk of contracting the virus (Banerjee and Bhattacharya, 2020; Baggett et al., 2020a; Kuehn, 2020; Maxmen, 2020; Mosites et al., 2020; Tsai and Wilson, 2020). Certain findings on COVID-19 testing in U.S. homeless shelters are based on a CDC investigation conducted between March 27 and April 15, 2020 with staff and residents at 19 shelters in Boston, Atlanta, San Francisco and Seattle. A high percentage of staff and residents tested positive at shelters that had identified at least two cases of COVID-19 two weeks prior to screening, with results ranging from 17% to 66% for residents and 16% to 30% for staff (Kuehn, 2020; Maxmen, 2020; Mosites et al., 2020).

Various factors play into the high prevalence of COVID-19 observed in these studies. The difficulties of complying with preventive measures in shelters like social distancing, hand-washing or self-isolation have been linked to reasons that include overcrowding, lack of sanitary facilities or limited information on the virus (Albon et al., 2020; Banerjee and Bhattacharya, 2020; Coughlin et al., 2020; Cumming et al., 2020; Kuehn, 2020; Lima et al., 2020; Mosites et al., 2020; Rosenthal et al., 2020; Schrooyen, 2020; Wood et al., 2020).

Psychosocial impact of the health crisis

The literature also underscores how preventive measures like social distancing and confinement affect the mental health of the general population. In a September 2020 study in Quebec, one in five adults showed symptoms compatible with generalized anxiety disorder or major depression. This prevalence rose to 37% among young adults aged 18 to 24 (Généreux et al., 2020). One in 10 adults also reported having felt stigmatized, an experience that in itself doubles the risk of anxiety or depression.

Psychological distress is all the more acute among homeless populations and psychoactive substance users during the health crisis, with anxiety, stress, panic, boredom, social isolation and behavioural addictions cited as the most common effects (Armitage et al., 2020; Kar et al., 2020; Knof, 2020c; Gunnel et al., 2020). In a context of rising financial stress and decreased service access, the uptick in COVID-19-related distress is cause for concern, with some experts fearing a corresponding hike in suicide rates (Gunnel et al., 2020). In the same vein, a U.S. study reported that 42% of young people experiencing homelessness who frequent harm reduction organizations had difficulty accessing mental health services (Tucker et al., 2020). The same study indicated alarming levels of distress, with symptoms ranging from hopelessness (48%) to anxiety (44%), loneliness (38%), depression (36%) and sleep disturbance (34%). A Montreal cohort study among 60 young adults aged 16 to 30 in situations of social precarity who use harm reduction services noted a similar range of psychosocial impacts, including boredom (73%), heightened anxiety/depression (50%), rising conflicts with friends/family (28%) and feelings of social isolation due to lack of contact with a loved one (25%) (Bertrand et al., 2020).

Currently, the accrued distress of people in situations of social insecurity is due in particular to mounting financial difficulty and the correspondingly reduced ability to meet basic needs (food/housing) (Bertrand et al, 2020; Cumming et al., 2020; Deilamizade and Moghanibashi-Mansourieh, 2020; Rosenthal et al., 2020; Tucker et al., 2020). A further concern is the potential for a rise in homelessness due to job loss among people who already struggled with financial insecurity prior to the pandemic (Coughlin et al., 2020; Deilamizade and Moghanibashi-Mansourieh, 2020). Here, the Montreal cohort study reported the following pandemic-related impacts: financial loss (38%), difficulty meeting basic needs like food (25%), job loss (38%) and greater difficulty finding housing or accommodation (45%); 15% also said they felt targeted by the police or had received more fines (Bertrand et al., 2020). Other studies conducted with similarly vulnerable populations during the health crisis note rising risks of stigmatization and discrimination (Cumming et al., 2020; Deilamizade and Moghanibashi-Mansourieh, 2020; Rosenthal et al., 2020; Tucker et al., 2020).

Impact of the health crisis on psychoactive substance use

Confinement also affected PAS use among the general population. The Global Drug Survey, carried out last May and June with 55,811 residents of 11 European nations, showed increased alcohol (43%) and cannabis (39%) consumption (Winstock et al., 2020). Stress, depression and isolation were the reasons most cited for increased cannabis use among persons with mental health

issues. Conversely, the use of certain substances—MDMA, cocaine, amphetamine and ketamine—fell by roughly one-third, which can be attributed to reduced availability and/or price surges (Winstock et al., 2020). A UK study in April 2020 showed that, while a significant percentage of the population was drinking less during lockdown, heavier drinkers had maintained their level of consumption (Knopf, 2020c). In France, studies on PAS users and service providers between March and May 2020 revealed the following lockdown-related effects: a) alcohol overuse among polysubstance users, not just those in situations of social precarity but also the more economically well-off; b) overuse of cannabis and cocaine as self-medication for the anxiety caused by confinement; c) overuse of opioid substitutes in stable patients with large supplies of take-home medication; and d) a decrease or even end to substance use among occasional drug users (OFDT, 2020a; OFDT, 2020b).

In Canada, the pandemic appears to have mainly increased psychoactive substance use, with some differences. Alcohol consumption rose by 20% to 26% in the general population, but fell by 9% to 12% among heavy drinkers (Canadian Centre on Substance Use and Addiction and NANOS, 2020; Canadian Red Cross and Léger, 2020). Conversely, alcohol consumption in Quebec increased among heavy but not moderate drinkers (EDUC Alcool, 2020). Data on Montreal collected by the INSPQ between March and May 2020 suggest that while 22% of Montrealers were drinking less, 33% had increased their alcohol consumption, (Ibrahima et al., 2020). More worryingly, the percentage of those who drank daily had risen from 11% to 27%. As for cannabis, 37% of respondents said they had increased their use during the pandemic, while 15% reported a decrease. The percentage of daily or near-daily users rose from 21% pre-pandemic to 34% during (Ibrahima et al., 2020). Bertrand et al. (2020) noted similar trends among young people in situations of social precarity, 43% of whom said they had increased their PAS use and 73% of whom reported drinking more, citing stress (28%), depression (33%) and boredom (37%) as the main reasons. Close to one-third (32%) of this cohort also reported decreased PAS use, due either to financial difficulty or reduced availability of the substance in question.

Various authors have underscored how the pandemic, with its border closures and social distancing, has transformed the illicit drug market. Newly curtailed access to certain street drugs has heightened risk levels in Canada and Europe, including the risks associated with both withdrawal and resorting to more dangerous substances (CCDUS, 2020a; EMCDDA, 2020b; OFDT, 2020a; OFDT, 2020b). In Canada, the pandemic is seen as causing decreased or changes to drug availability; price surges (or drugs sold at the same price, but more diluted); and more drug adulteration (CCDUS, 2020a). Outreach workers in Montréal spoke to the press about this situation in June (Radio-Canada, 2020). Along with the decrease in drug quality, the closure during lockdown of three of Montreal's four supervised injection sites may account for the spike in overdoses reported by outreach workers.

The rising number of overdoses in Canada during the pandemic is well documented in the official statistics. In Quebec, the Institut national de la santé publique (INSPQ) reported higher numbers of deaths following suspected overdoses from opioids and other drugs between April and June 2020 (INSPQ, 2020d). Of the 559 deaths linked to suspected overdoses (opioids and other drugs) in 2019–2020, mortality was highest between April and June 2020. A similar increase was observed in April and May 2020 in British Columbia and Ontario (CCDUS, 2020a; PHO, 2020).

The pandemic's effect on services

Though the health and social needs of people with substance use disorders are often intensified in a health crisis, COVID-19 has effectively reduced access to harm reduction and treatment services in many places around the world (Becker et al., 2020; Deilamizade et al., 2020; Green et al., 2020; Harris et al., 2020; Lima et al., 2020; Woods et al., 2020). The barriers to specialized treatment for people with opioid use disorder, for example, numerous to begin with, become more acute in times of crisis (Green et al., 2020). Disruptions to addiction services also increase the risk of overdose (Becker et al., 2020). People experiencing homelessness and addiction may have trouble complying with the health measures implemented in service points or even accessing such services, which often suspended, reduced or transitioned to telehealth (Green et al., 2020; Lima et al., 2020). As with other health and social services, telehealth only underscores health and social inequities for people in situations of social precarity, who tend to have more difficulty accessing this delivery mode (Harris et al., 2020; Wood et al., 2020). The situation can also affect their children, who may be disadvantaged by the online education methods launched in response to the pandemic, due to problems accessing the required technology (cell phone, computer, Internet) (Deilamizade and Moghanibashi-Mansourieh, 2020).

Service disruptions and reductions in these areas have fallen hard on those who most need them, which is consistent with the essential nature of such services. Public Safety Canada's guidelines for "essential services" during the pandemic include:

> *Workers who support food, shelter, and social services, addictions treatment and outreach, supervised consumption sites and other necessities of life for economically disadvantaged or otherwise needy individuals, such as those residing in shelters or children in care.* (Public Safety Canada, 2020)

As the first wave of COVID-19 made inroads on public infrastructures, Quebec, as with elsewhere, has found it increasingly difficult to keep such essential services available to the vulnerable populations who need them.

All the same, the adaptations imposed by COVID-19 have yielded a number of positive results. Various practices created in response to the crisis have been deemed adequate for the needs of problematic PAS users and may be continued beyond the pandemic (INESSS, 2020a). Emerging practices and adapted services will be discussed below as part of the response to Objective 2.

The differential impact COVID-19 with respect to sex and gender

The COVID-19 pandemic and its associated health measures have had a differential impact based on sex and gender (Wenham et al., 2020a). The gendered impact of COVID-19 varies along physical, emotional, social and economic lines. For example, in terms of physical consequences, COVID-19 disproportionately affects men, whose hospitalization and mortality rates are higher (Antonello et al., 2020; INSPQ, 2020g; INSPQ, 2020h Lopez-Atanes et al. 2020; Rozenberg et al., 2020; Walter and McGregor, 2020; Wenham et al., 2020a).

The virus affects women differently. To begin with, women are both more exposed to and infected at higher rates by COVID-19 than men (Gausman and Langer 2020; INSPQ, 2020h). Indeed, essential and front-line workers, particularly in the health and social services sector, are overwhelmingly women (Lopez-Atanes et al., 2020). A number of authors have documented the psychological distress of female health care workers on the front lines of the pandemic (Chowdhry, 2020; Horsch et al., 2020; Li et al., 2020; Lopez-Atanes, 2020; Uytenbogaardt, 2020a). Similarly, women who are pregnant or have just given birth use health resources regularly, thus increasing their risk of exposure to COVID-19 (Bowleg, 2020; Gausman and Langer, 2020; Sharma et al., 2020b; Wenham et al., 2020b**).**

The literature also points to the rise in domestic violence against women, which many authors see as a deleterious effect of confinement and social distancing (Bradbury-Jones and Isham, 2020; Greaves et al., 2020; Kofman and Garlin, 2020; Ndedi, 2020; Roesch et al., 2020; Sacco et al., 2020; Sharma et al., 2020a; Telles et al. 2020). In terms of the emotional impact of crises like natural disasters or pandemics, women are more likely to experience mental health issues such as post-traumatic stress disorder, mental distress, anxiety, fear, sleep disturbances and negative mood alterations (Gausman and Langer, 2020; Greaves et al., 2020; Liu et al. 2020b). Economically speaking, COVID-19 has reinforced labour market disparities by disproportionately affecting job opportunities for women, with job losses largely affecting sectors where women workers predominate (Alon et al. 2020). School and child care centre closures also strongly impact working mothers, particularly low-income single mothers (Alon et al. 2020; WHO, 2020; The Lancet, 2020; Wenham et al., 2020a).

Different orders of social inequality account for why health measures like confinement affect women more markedly than men in terms of overall wellness and economic repercussions (WHO, 2020, The Lancet, 2020; Wenham et al., 2020b). If women in general tend to have more precarious incomes, greater domestic responsibilities and more barriers to social services, the stigma surrounding addiction only serves to accentuate these barriers for women with problematic substance use (Pederson et al., 2014). Taken together, these findings underscore the vital need to consider the specificity of women's needs by creating effective, equitable policies and interventions in response to COVID-19 (Sharma et al., 2020b; Wenham et al., 2020a).

There is little documentation to date on how COVID-19 affects women substance users, who are particularly vulnerable to overlapping behavioural, domestic, economic and/or mental health issues. Day and White (2020) point out the prevalence of intimate-partner violence in contexts of alcohol and/or drug use, presented in the literature either as an indicator or causal factor of domestic violence (Telles et al., 2020). Furthermore, the ASAM (2020d), drawing on a study of pregnant women with opioid use disorder, shows that those who test positive and have clinical symptoms of COVID-19 have higher rates of preterm labour (20%) and caesarean delivery (80%), in addition to a higher risk of severe COVID-19 outcomes, compared to non-pregnant women. Sher (2020) highlights the invisible collateral damage of COVID-19 linked to excessive substance use during confinement, including the high risk of unwanted pregnancies and development of fetal alcohol disorders. The experience of women with intersecting vulnerabilities (housing insecurity, addiction, mental health, domestic violence) is described in a publication by the Barcelona-based

harm reduction program Metzineres that has documented the experiences of women and gender non-conforming people during confinement. The program's residents—substance users (70%), victims of domestic violence (90%) and mental health sufferers (45%)—reported on the poorer quality of drugs on the illegal market; increased insecurity, loneliness anxiety and paranoia during lockdown; and fears of physical and emotional harm. They also mentioned disruptions to outpatient treatment and rehabilitation centre access, some adding that fears of reprisal and arrest have pushed them to purchase drugs in areas where abuse, violence and sexual assault are rife (Metzineres, 2020).

In sum, none of the scientific publications identified thus far have allowed us to precisely document how the pandemic specifically affects women substance users compared to men. The various papers reviewed on COVID-19, addiction and homelessness only rarely take gender issues into account.

The pandemic's differential impact with respect to sexual and gender diversity

There is evidence to suggest a high prevalence of problematic substance use among 2SLGBTQ+ populations compared to the general population (Abdulrahim et al., 2016). If the COVID-19 crisis has reinforced health inequities among vulnerable populations, this includes men who have sex with men (MSM) (Sanchez et al., 2020) and other sexual and gender minority groups (Brennan et al., 2020; Carrico et al., 2020; Community-Based Research Centre, 2020b; Hafi et al., 2020; Harkness et al., 2020; LGBT Foundation, 2020; REZO, 2020; Rogers et al., 2020; Rosa and Acquaviva, 2020). In April, a U.S. study (Sanchez et al., 2020) involving 1,051 MSM documented the adverse impacts of lockdown in terms of general wellbeing, social interactions, money, food, substance use and alcohol consumption; it also examined how COVID-19 affected access to screening, prevention and treatment services for HIV and other sexually transmitted and blood-borne infection (STBBI). Compared to older MSM, those aged 15 to 24 were more likely to report pandemic-related impacts. To complete the picture, Hafi and Uvais (2020) describe the various mechanisms behind the pandemic's pronounced impact on 2SLGBTQ+ people: 1) the closure of social spaces like bars and community groups, which lessens access to social support and aggravated feelings of isolation; 2) the ensuing severed ties with the 2SLGBTQ+ community, which stands to significantly increase psychological distress and possibly the risk of suicide, particularly since sexual orientation is often kept hidden from family; and 3) public health measures that fail to take into account the increased prevalence of high-risk behavior and problematic substance use among 2SLGBTQ+ people, while medical knowledge on the links between sexual activity and COVID-19 remains incomplete at best.

While the literature documents pandemic-induced disruptions to sexual health services and the resulting decreases to STBBI screening, HIV treatment and the distribution of STBBI prevention materials, we cannot as yet surmise an increased prevalence of STBBIs in the general population, and even less so among 2SLGBTQ+ populations. This knowledge gap will need to be filled to better adapt harm reduction measures to the needs of 2SLGBTQ+ people in the context of COVID-10.

The pandemic has caused income and quality of life to drop more sharply among sexual and gender minority households than among the general population. Findings from studies in Canada, the U.S. and the UK suggest that between 32% and 53% of 2SLGBTQ+ households lost income through reduced work hours or job loss (Brennan et al., 2020; Community-Based Research Centre, 2020b; Egale/Innovative Research Group, 2020; Harkness et al., 2020; Sanchez et al., 2020). The literature also documents the rise in social discrimination, domestic violence and feelings of insecurity among 2SLGBTQ+ people (Global Drug Survey, 2020; LGBT Foundation, 2020; Perez-Brumer and Silva-Santisteban, 2020; Pimentel, 2020). Perez-Brumer and Silva-Santisteban note the escalation of police violence and discrimination toward transgender people in Peru following the enactment of stringent, gender-based government policies to restrict population mobility and access to essential services. Other factors helping to erode the mental health of 2SLGBTQ+ people during the pandemic include difficulties in accessing mental health support, economic stress, the shutting-down of social spaces, threats to reveal sexual orientation, and the deferral of sex reassignment surgeries and gender-affirming treatments (Brennan et al., 2020; Carrico et al., 2020; Community-Based Research Centre, 2020b; Hafi and Uvais, 2020; Harkness et al., 2020; LGBT Foundation, 2020; Pimentel; 2020; REZO, 2020; Sanchez et al., 2020; Van der Miesen et al., 2020; Wang et al., 2020).

To conclude, the combined effects of COVID-19 on people struggling with problematic PAS use in situations of social precarity point to the importance of a syndemic approach to public health if the crisis is to stop exacerbating the disparities that affect certain population subgroups (Bambra et al., 2020; Rouleau, 2020). The fact that COVID-19 interacts synergistically with a cluster of associated medical and psychosocial problems magnifies the already-disproportionate vulnerability of certain groups, including persons with problematic PAS use as well as those who are homeless or at risk of becoming so. Our response to the current health crisis must counter this reality by developing policies to improve the living conditions of these groups, including access to income and housing support.

5.1.3. Key findings from the expert consultations (academics, professionals and experiential experts): the impact of COVID-19

The experts consulted as part of this rapid response considered the pandemic's effects, particularly its differential impact by gender. What follows are their main observations on how COVID-19 has affected the health and wellness of people with problematic substance use in situations of social precarity. Comments that take into account gender and sexual diversity were a particular focus of our analysis and have been flagged with the symbol "!" below.

Impact on overall health (social, mental and physical)

⇒ Concerns were generally greater about the adverse effects of confinement than about the risk of COVID-19 infection. Many of those with lived experience were more concerned with transmitting than with contracting the virus.

⇒ The noted increases to PAS use, overdose risks and high-risk behaviour may be linked to the challenge of finding safe places for substance use along with rising drug costs, diminished product quality on the illegal market and reduced access to sterile equipment.

⇒ Resurgence of old patterns of problematic substance use; more frequent relapses after prolonged periods of abstinence; an increase in withdrawal symptoms and cravings

⇒ The addiction recovery process was slowed.

⇒ PAS users are more vulnerable to the effects of COVID-19 given their numerous co-morbidities (e.g. HIV, HCV).

⇒ Disruptions to harm reduction and treatment services affect the ability to meet basic needs (shelter, food, hygiene, hydration, socializing). Shop and restaurant closures, in turn, have worsened hygiene- and health care-related difficulties in addition to reinforcing feelings of loneliness. The pandemic did not always negatively affect lifestyle. Some experiential experts mentioned its positive aspects, like being able to take "me time" or start projects.

⇒ Lockdown-related cuts and closures to mental health services had varying effects on substance users in situations of social precarity, including social isolation, anxiety and depression, greater disarray, psychosis, sleep disturbances, feeling of powerlessness, disruptions to the working routine, irritability and PTSD symptoms.

- ! 2SLGBTQ+ people (including gay, bisexual and other MSM) may experience solitude and isolation to a greater extent than the general population; lockdown measures tend to exacerbate these issues.

⇒ Substance users in situations of social precarity experienced a significant drop in income. COVID-19 transformed the informal economy (panhandling, sex work, etc.) and greatly reduced both black-market and legitimate job possibilities. Some lost their jobs temporarily or permanently. Decreased income was a source of stress and had a direct impact on basic needs like food and shelter.

- ! Lacking the means to pay her rent, one participant reported having to draw on funds received from a transgender organization that had been earmarked for facial hair removal.
- ! One participant described how lockdown measures had complicated sex work, given that clients expected certain health measures to be applied and the fact that she had no space in which to meet her clients. Having had to stop work as a result, she found herself homeless a few weeks later.

⇒ People with Web-access difficulties before the pandemic experienced growing complications with the onset of confinement, as store closures made online shopping a necessity and the Internet emerged as the main means of breaking through social isolation.

⇒ Substance users in situations of social precarity who failed to comply with public health measures were subject to social profiling, sometimes leading to brutal and stigmatizing run-ins with the police and/or penalties (e.g.: street kids fined for gathering at a place of residence, fines for not wearing masks, etc.). However, some of the professionals and experiential experts mentioned greater tolerance on the part of the police force.

- ! One homeless trans woman noted positive developments in police attitudes towards her and more generally towards homeless people.

⇒ Violence and aggression rose among homeless people, particularly in the shelters. Conversely, some experts also commented on the solidarity between homeless people.

- ! Transgender people were more likely to be exposed to this kind of violence. Given the general paucity of resources, and with everyone bundled together regardless of sexual and gender identity, visible differences could give rise to tensions.

! Women and their children have been increasingly exposed to sexual and domestic violence, particularly during lockdown-related school closures. Mothers found themselves isolated, suddenly lacking recourse to child care or the support of their usual networks.

! Sex work during confinement became more dangerous. The lockdown-precipitated drop in trade made some workers more inclined to accept clients prone to violent behaviour. However, others said their clientele had become more regular since the start of the pandemic, making it possible to limit their number of contacts.

! As money-making possibilities dwindled, sexual exploitation and harassment by pimps increased, a situation that affected Indigenous women in particular.

! The pandemic has adversely affected the sexual health of gay, bisexual and other MSM, many of whom do not live with their sexual partner(s). Lockdown has magnified both stigmatization and the fear of judgment about sexual practices. The fact that health measures tend to strictly prescribe social relations in times of crisis—including periods when police are apt to hand out fines—can aggravate pain and guilt for some 2SLGBTQ+ people and make it harder to be open about sexual orientation. This new reality compounds the problem of reaching these populations to offer harm reduction tools and resources, particularly with regard to risky sexual behaviour.

! Stress rose among the general population, particularly in relation to parenting. The latter particularly affects women, who are more likely to be single parents and responsible for dependents. The health crisis may worsen problematic PAS use (and its attendant issues) among pregnant women and women with alcohol dependence, thus weakening their ability to take care of their children. These various issues, exacerbated by parental responsibility in a context of diminished social networks, have increased barriers to aid, which in itself is often ill-suited to parenting needs.

Impact on services

According to our experts, the pandemic has had a markedly negative impact on services, with service cuts or disruptions in particular affecting people with problematic PAS use in situations of social precarity:

⇒ Service availability has been significantly limited by certain public health measures—for example, physical distancing requirements that interfere with intake capacity.

⇒ Decreased intake capacity due to COVID-19 health measures may lead to closures of certain closed living environments (e.g. inpatient therapy, detox/rehab programs, addiction-related housing resources, drop-in centres, housing resources for homeless people, shelters). Access may also be denied to some based on a risk factor assessment. Furthermore, some service users may be reluctant to use housing resources if they have fears about contracting COVID-19 or objections to the measures they must comply with to gain access (physical distancing, masks, screening, 14-day isolation, etc.).

⇒ Harm reduction and treatment services have been more difficult to obtain, especially during the first wave of the lockdown (March to June 2020). A number of drop-in centres and supervised injection sites (SIS) closed, as did some organizations that distribute protective

materials and sterile equipment, leaving the remainder less geographically accessible to some users.

- ! A homeless trans woman noted her growing service access difficulties as of the start of the pandemic. Women's shelters became off-limits to her due to her overly masculine appearance; shelter access in general became more complicated; and services were cut or disrupted at local community organizations that help people apply for food, financial and housing assistance. The approach of winter has intensified her concerns.

⇒ As lockdown measures came into effect, psychosocial support for people in inpatient treatment programs or who use housing resources could be stopped or reduced if users had contracted COVID-19 or been in contact with someone who had tested positive. Such situations were apt to trigger or aggravate crises in vulnerable individuals or otherwise compromise their recovery.

⇒ Opioid agonist treatment became harder to obtain for many. However, one experiential expert said some doctors would prescribe safe supplies in addition to methadone.

⇒ Service providers saw new faces, more diversified user profiles and rising numbers of service requests. Some professionals noted a surge to clienteles undergoing significant psychological distress, first-time homelessness and/or more severe psychological and addiction-related issues. Remote and online services tended to attract younger clients.

- ! Others reported increases to the number of women and 2SLGBTQ+ people seeking assistance from them.

⇒ Services have been adapted to remote delivery, either by phone, online or through teleconsultation (e.g. AA/NA support groups by videoconference with psychosocial follow-up by phone). A number of resources combined street-based outreach work with distance or online interventions. Some professionals reported losing contact with clients who lacked access to phones or videoconferencing technology.

⇒ Services were more restrictive, more impersonal and less user-friendly, which limited their usefulness for some experiential experts or reduced their desire to use them.

⇒ Significant downsizing in the health and social services network has impacted the provision of regular addiction, prevention and overdose monitoring services. Furthermore, the mass mobilization of public health departments across Quebec in response to COVID-19 has left substance use cases untouched since March 2020, despite increased drug use and rising numbers of overdoses.

⇒ Wait times for provincial health and social services (doctors/psychosocial support) varied, with some being longer than usual and others, shorter. In the face of escalating needs, the wait list for psychosocial services was very long.

! Services for mothers of young children who had ongoing or previous problematic substance abuse (e.g. the CIUSSS Centre-Sud-de-Île-de-Montréal's Rond-Point program) were maintained, as were opioid agonist treatments. Demand in both cases was higher during the pandemic.

! Two services—condom distribution and SIDEP clinics (HIV/STBBI screening centres for sex workers and the 2SLBGTQ+ community)—were suspended at the start of the first wave of COVID-19. The reassignment of SIDEP nurses to public health as part of the pandemic response has also jeopardized the connections between healthcare professionals and marginalized populations.

⇒ Accessibility issues during the pandemic include geographic accessibility to the resources that have remained open and access to information about addiction, mental health and

homelessness services. At homeless encampments for people who do not use shelters, many feel this information little addresses their real needs, despite the presence of outreach workers.

⇒ Social activities aimed at breaking through isolation have been suspended.

⇒ Peer-support services were suspended during the first wave, a period marked by uncertainty and adaptation.

However, the experts also pointed out the pandemic's positive impact on certain services:

⇒ New clinical and administrative initiatives were developed quickly in response to increased and changing needs of people in situations of social precarity (specific initiatives are discussed below under Objective 2).

⇒ Many of these initiatives, hailed as relevant and necessary, should continue after the health crisis, which has served as an innovation accelerator for mitigating the pandemic-related difficulties of people in situations of social precarity.

Impact on professionals

The health crisis has adversely affected professionals who work with marginalized and at-risk populations, mainly in community settings and within the health and social services network:

⇒ Staff reassignments and cuts to services in the face of escalating client needs have had varying effects on clinical teams: exhaustion, anxiety about safe practices, concerns about contracting COVID-19, absenteeism, workforce reductions.

5.2. Adapting interventions and services (Objective 2)

In a pandemic situation, which addiction-related interventions and services best meet the health and social needs of people in situations of social precarity?

Below are the three questions related to this objective that have guided the process:

a. What health recommendations are best suited to the living conditions of marginalized or at-risk individuals? What interventions could support the implementation of these recommendations and the overall well-being of these populations?
b. What service provision practices and features are liable to reduce the risks associated with PAS use in a pandemic context, but without jeopardizing the harm reduction strategies applied prior to the health crisis?
c. In terms of both addiction and general wellness, which service provision practices and features are most apt to foster recovery in the context of the pandemic?

For each question, we will first present the recommendations, followed by the knowledge synthesized from the literature and the expert consultations.

a) What health recommendations are best suited to the living conditions of marginalized or at-risk individuals? What interventions could support the implementation of these recommendations and the overall well-being of these populations?

5.2.1. Recommendations: COVID-19 health measures

Our recommendations

- ✓ Tools to prevent and control COVID-19 outbreaks must take into account the realities of inpatient addiction care and the related housing resources (shelters, crisis services, residential withdrawal management, etc.). Such tools, which must also support clinical staff as they adapt and implement the prescribed health measures, should be created by people who are familiar with these environments.
- ✓ Confinement must not disrupt treatment for inpatient rehab or housing resource users; rather, they must receive ongoing psychosocial support to cope with what is a highly destabilizing situation. Investment must be made in human and material resources (e.g. access to suitable alternative accommodation) to prevent service disruptions in this particular situation during the health crisis.
- ✓ Homeless people should not undergo confinement in shelters that offer no addiction treatment programs. If exceptional circumstances make this the only option, then these people should have access to a safe supply to counter their addiction.
- ✓ COVID-19 infection prevention kits that contain sanitizing supplies, protective equipment and personal care products (e.g. hand sanitizer, masks, soap, deodorant, shampoo, feminine hygiene products, toilet paper, etc.) should be distributed to people in situations of social precarity, taking into account sex and gender.
  - Raise awareness of and educate about pandemic-related health measures.
  - Avoid stigmatizing people who take risks or hold differing beliefs about health measures: adopt a humanist, harm reduction approach that enables them to make changes to their behaviour at their own speed and that takes their personal concerns into account.
  - Provide clinical/professional teams with ongoing training on health measures as these develop.
  - Ensure that organizations have sufficient hygiene products and protective equipment to distribute to all clients.
  - Employ street workers to distribute these materials to people who do not or who rarely use harm reduction and housing services.
- ✓ Adopt a participatory approach by inviting service users to think about how health measures could be implemented to meet public health measures.
- ✓ Establish warm and hot zones or separate spaces (temporary shelters/hotels) to accommodate people in situations of social precarity who have contracted the virus, show symptoms, are awaiting COVID-19 test results or are in isolation. See to it that they receive the psychosocial support they need during confinement.
- ✓ Set up new housing resources and shelters, extend opening hours, offer suitable accommodation for users with pets, and reconfigure existing shelters to comply with physical distancing requirements. The aim is to provide adequate protection whether or not service users have been diagnosed with COVID-19, taking into account the health

measures in effect and the coming winter.

- ✓ Promote hygiene with regard to drug use equipment and personal protective equipment.
- ✓ Provide better access to COVID-19 testing through personalized support for substance users in situations of social precarity when screening is required to comply with public health measures.
- ✓ As far as possible, adapt showers, toilets and laundry rooms to trans/non-binary people and make them more accessible to homeless people.
- ✓ Ensure the safety and protection from COVID-19 of front-line and outreach workers.

5.2.2. Key findings from the literature review: COVID-19 health measures

In Quebec, the Institut national de santé publique (INSPQ) and Ministère de la Santé et des Services sociaux (MSSS) issued a range of tools and guidelines for adapting COVID-19 preventive practices to at-risk or marginalized populations, including substance users and homeless people. The proposed measures are consistent with international recommendations (see Karamouzian et al., 2020; Knopf, 2020a; Vecchio et al., 2020). While the government puts forth the same measures—hand washing, physical distancing, respiratory etiquette—that apply to the general population, the greater vulnerability for substance users of severe infection and/or poor outcomes is underscored. The provincial guidelines, in keeping with the recommendations of Karamouzian et al. (2020), also stress the need to minimize the sharing of substance use supplies such as pipes or e-cigarettes. To facilitate compliance with physical distancing, both the Quebec government and the international scientific literature urge the use of remote services where possible (Karamouzian et al., 2020; Knopf, 2020a; Vecchio et al., 2020). However, Karamouzian also underscores the need for tailoring public health messages around self-isolation and physical distancing toward marginalized populations, for example, people who live in shelters or are involved in sex work. Vecchio, in turn, points out the potential negative effects, including higher risk of overdose, use of the medication by others and greater rates of misuse, associated with increased access to take-home medication for people with opioid use disorder. Putting dedicated human and financial resources toward substance users who are more marginalized and in situations of vulnerability, such as people in treatment for OUD, is recommended in order to adequately monitor harm reduction (Vecchio et al., 2020).

The literature also offers recommendations in terms of tailoring COVID-19 prevention measures to substance users. Karamouzian et al. argue for expanded government investment in harm reduction services. Such investments should focus on ensuring that harm reduction packages include more sterile drug use equipment, sufficient sanitizing supplies and educational materials adapted to COVID-19. The same authors also highlight the importance of preparing emergency plans to offset disruptions to essential services due to employee absence (e.g. access to prescribed medications, supervised injection sites and overdose prevention sites) as well as of developing treatment continuity plans (e.g. permitting online visits, phone-based refills, extended prescriptions, etc.). Vecchio et al. (2020), in turn, argue for prioritizing dedicated distance

(phone/video) services for new patient assessment and triage and providing online social and psychological support, which they consider essential services for substance users in situations of social precarity.

The Institut national d'excellence en santé et services sociaux (INESSS) produced guidelines to promoting compliance with COVID-19 precautionary and protective measures among people in vulnerable situations (INESSS, 2020b). Such situations include homelessness and substance dependence, complex realities for which health measures must first be adapted if they are to be adopted. A first principle put forward by the INESSS and supported by ethicists is that messages aimed at vulnerable populations should be delivered in a timely, accessible and appropriate manner, not just to encourage these people's active participation in choosing the measures to be put in place, but also to respect individual rights and dignity. In concrete terms, this can mean finding suitable times to deliver the messages—for example, during activities providing food—as well as using positive reinforcement to motivate compliance with the measures (INESSS, 2020b). Particularly regarding opioid use disorder management, a participatory approach in which peers work with stakeholders is another way of providing emotional and practical support and thus fostering the achievement of personal objectives (Goyer, Hudon et al., 2020b). The INESSS (2020b) also highlights the importance of adapting measures in such a way that refrains from merely emphasizing the social inequalities experienced by marginalized or at-risk populations. Though few protocols at present are adapted to these populations, the INESSS offers a number of recommendations to guide thinking in this area, a core tenet of which is to avoid requiring behaviours that are difficult if not impossible to implement. For example, frequent hand-washing is all but impossible for homeless people, who lack regular access to the required equipment and facilities. Similarly, for people living in shelters, health protocols require a certain flexibility and a balance must be struck between respecting personal rights and freedoms and the ability of a facility to make exceptions—for example, allowing people with a tobacco addiction to go outdoors to smoke. A final INESSS recommendation is to ensure ongoing staff training for health measures, which are liable to rapidly change.

5.2.3. Key findings from the expert consultations (academics, professionals and experiential experts): COVID-19 health measures

The experts shared their thoughts on how public health measures and messages should be adapted and applied to the realities of PAS users in situations of social precarity. These measures tended to be more difficult to apply to the everyday contexts of such individuals, some of whom also resisted putting them into practice. According to the experts, the main challenges and issues related to applying the health measures were as follows:

⇒ Just as with the general population, opinions on risk levels and the legitimacy of the health measures proposed varied from one person to the next. Some found the measures important and necessary; others considered them exaggerated or even inappropriate. The risk of COVID-19 contraction was seen as relative by experiential experts who grapple with housing

instability, substance use and overdose risks; some placed it very low indeed on their list of concerns.

⇒ Some professionals reported expecting a degree of flexibility from government and public health authorities regarding how the measures would apply to their organization, since absolute compliance would entail service closures, leading to significant distress and disorder among users. COVID-19 infection risks also needed to be balanced against the psychosocial issues (overdose, anxiety/depression, loss of bearings, loneliness, etc.) exacerbated by the health crisis. A further consideration was the potential for conflict between measures like confinement and pre-COVID recommendations like not using substances alone so as to lessen the risk of overdose.

⇒ For people in inpatient addiction care or using housing resources, confinement in a context where users had contracted COVID-19 or had been in contact with someone who tested positive could lead to disrupted or reduced psychosocial support, thus possibly triggering or worsening a crisis state and/or compromising the recovery process.

⇒ Some service users felt the public health measures interfered with their rights; others felt them to be alarmist. Still others expressed mistrust toward the government, even embracing conspiracy theories to account for the fact that so many had been marginalized by the system.

⇒ Some experiential experts recognized the importance of putting the health measures into practice and said they would just adjust. In the words of one participant: "If I could get used to living in the street, I can get used to anything."

⇒ The question of wearing masks elicited a varied response among the experiential experts: some recognized its importance; others did not. The vast majority found masks to be poorly adapted to their day-to-day realities (limited access to masks, breathing issues, discomfort/sweating when under the influence of certain drugs, difficulty making contact with motorists when panhandling, etc.). One professional expert suggested setting up artisanal mask-making activities to encourage their adoption among users.

⇒ Compliance with social distancing measures can be difficult for homeless people, due in particular to crowding at shelters and other resources, including emergency resources.

⇒ Substance users in situations of social insecurity can have trouble with the 14-day isolation period recommended in certain situations, due to its impact on mental health and withdrawal. One experiential expert hospitalized for COVID-19 compared the compulsory isolation period to a prison term: "If I had killed someone, I'd be entitled to one hour outside [referring to prison], whereas in hospital, this wasn't allowed." Furthermore, hotels were available only to people who had been tested, whereas not everyone will have the opportunity to be tested, while still others resist the prospect altogether.

⇒ Some professionals reported that clients who did not comply with health measures could be barred access to certain organizations, which constitutes a barrier to services among the most marginalized populations.

⇒ A lack of sanitizing supplies (hand sanitizer, masks, etc.) that would enable compliance with health measures and better protection for front-line workers was observed in Quebec at the start of the pandemic.

! In Quebec, health messages regarding sexuality in the context of COVID-19 were issued late (June 2020) and pertained only to heteronormativity and cisnormativity, not to gender and sexual diversity.

To overcome these issues and challenges, the experts offered up possible solutions:

⇒ Take a cautious approach to applying health messages to avoid generating outbreaks in vulnerable settings or infecting workers who provide essential services to PAS users.
⇒ Set up sanitation stations and where possible, provide access to toilets, showers, drinking fountains and laundry services. Adapt toilets and showers to trans and non-binary people.
⇒ Distribute hygiene kits and protective equipment among marginalized and at-risk populations.
⇒ Establish cleaning and disinfection protocols to limit COVID-19 transmission in resources.
⇒ Support community organizations by providing the protective equipment needed for their activities.
⇒ In summer and during warmer weather, offer activities and services outdoors (e.g. public parks, counters/kiosks at facility entrances, etc.).
⇒ Divide teams in two so that one half could take over in the event of contamination.
⇒ Facilitate screening by setting up mobile testing clinics in "hot zones" and by training SIDEP nurses to test for COVID while also testing for HIV/STBBI.
    ! Work with women's shelters to promote COVID-19 testing for women. In an initiative developed jointly by the Direction de santé publique and women's domestic violence resources, confidentiality concerns (i.e. the importance of not revealing shelter addresses) were addressed by have testing carried out at a neutral location. Shelter workers invited women to get tested, then referred them to the appropriate site.
⇒ Set up service corridors with the Centres intégrés de santé et services sociaux (CISSS) to isolate cases in non-residential settings (e.g. a service corridor between housing facilities and isolation sites like temporary shelters or hotels). "Warm zones" could be set up to accommodate individuals showing COVID-19 symptoms, providing them with testing and a safe place to stay before redirecting them to the appropriate health care resource. Applying a protocol when symptoms appear could be helpful.
⇒ Set up an environmental and health crisis alert system that takes into account clients' cultural differences and language barriers.
⇒ Raise awareness about health measures among service users. People in situations of social precarity are not always able to be well-informed or obtain accurate, up-to-date information. Given the rapid spread of COVID-19 in residential settings and the greater vulnerability to complications from the virus among some users, health and distancing measures must be implemented with rigour and innovation, despite the inherent challenges of such environments.
⇒ Ensure close working relations between CISSS/CIUSSS and harm reduction, mental health and homelessness resources so that public health guidelines can be adapted as they evolve.

b) What service provision practices and features are liable to reduce the risks associated with PAS use in a pandemic context, but without jeopardizing the harm reduction strategies applied prior to the health crisis?

5.2.4. Recommendations: harm reduction services

Our recommendations

- ✓ Maintain in-person access to addiction services and reinforce their capacity and resources, prioritizing people in psychosocial crisis situations (particularly those lacking easy access to technology) and with a view to keeping the lines open with people in situations of social precarity, who need ongoing human contact.
- ✓ Facilitate the safer supply of controlled psychoactive substances.
    - Provide additional take-home supplies of opioid agonist therapies, taking into account the patient's state of health and the associated risks (stability, safety, diversion, etc.).
    - Adapt the remote prescription model.
    - Reach out to those who do not have access to treatment.
- ✓ Train and ensure expanded access to naloxone and screening tools like fentanyl test strips to mitigate the risk of overdose and increase safety for substance users.
- ✓ Open supervised consumption services (alcohol, cannabis, opioids) in shelters and other temporary accommodation resources set up in the context of COVID-19.
- ✓ Keep supervised injection sites open and support the harm reduction resources that set up such services.
- ✓ Extend the opening hours of some centres to compensate for reduced intake capacity.
- ✓ Offer respite services at supervised injection sites.
- ✓ Invite peer helpers to supervised injection sites to create a less "medical," more informal atmosphere.
- ✓ Refer clients to online supervised consumption services (mobile apps or peer-to-peer videoconference support groups) when supervised injection sites are inaccessible (depending on times/regions).
- ✓ Implement high-threshold access for inpatient addiction care programs and other internal services (emergency housing, medium- and long-term accommodation, drop-in centres, etc.) that welcome PAS users in situations of social precarity.
- ✓ Ensure access to sterile equipment by setting up mobile distribution units and considering home delivery if necessary.
- ✓ Minimize the sharing of substance use supplies and psychoactive substances.
- ✓ For clients who lack the means of remote access, focus on outreach and street work to reach the most isolated.
- ✓ Expand the concept of "outreach work" to include home visits, street corner meetings, visits to encampments, etc.
- ✓ Adopt an inclusive, people-centred care approach for 2SLGBTQ+ people.
- ✓ Practice approaches that take into account gender and sexual diversity:
    - Trauma-informed/anti-oppressive
    - Support for parenting and consideration of children's protection needs
    - Maintaining contact with sex workers through social networks or by phone

5.2.5. Key findings from the literature review: harm reduction services

The documentary sources consulted in response to the question of adapting harm reduction services in the context of COVID-19 are listed in the themed bibliographies.

Shortly after the implementation of public health and confinement measures, guidelines were issued by various institutional resources working in addiction or health and social services. These publications aimed to help addiction professionals working across a range of treatment settings better meet staff and substance-user needs, promote care and service continuity and limit the spread of COVID-19. In Canada, at the request of the federal government, the Canadian Research Initiative in Substance Misuse (CRISM/ICRAS) issued a series of six national practice guides addressing the urgent needs of substance users across a range of care settings (telehealth services, rehabilitation centres, residential facilities, drop-in centres) and a self-isolation scenario (CRISM, 2020a; CRISM, 2020b; CRISM, 2020c; ICRAS, 2020a; ICRAS, 2020b; ICRAS, 2020c). In Quebec, the MSSS developed tools to help adapt addiction treatment and homeless services during the crisis (MSSS, 2020a; MSSS, 2020c). The clinical and organizational support team for addiction and homelessness run by Dr. Marie-Ève Goyer, in turn, drew on the work of the British Columbia Centre on Substance Use (BCCSU) to produce a clinical guide on substance replacement therapy practices for prescribers in the COVID-19 context (BCCSU, 2020a; Goyer et al., 2020a). Guidelines on opioid use disorder management during the crisis have also been issued by various provincial professional orders (Collège des médecins du Québec, Ordre des infirmières et infirmiers du Québec and Ordre des pharmaciens du Québec, 2020). In general, the literature review yielded a great many sources that have shed light on the adaptation of harm reduction strategies in the context of COVID-19.

Many North American and European practice guides conclude that, in the current health crisis, practices must be altered to ensure a safer supply of controlled substances (ASAM, 2020; BCCSU, 2020a; BCCSU, 2020b; CCDUS, 2020a; Collège des médecins du Québec et al., 2020; CRISM, 2020a; Goyer et al., 2020a, GREA, 2020; L'équipe de soutien clinique organisationnel en dépendance et itinérance, 2020a; SAMHSA, 2020d; SAMHSA, 2020e). There is also general consensus about setting up supervised consumption services (for alcohol, cannabis and opioids) in shelters and other forms of temporary accommodation implemented in response to the pandemic (Buchnea et al., 2020; INESSS, 2020; CCDUS, 2020a; CRISM, 2020b). Lastly, a number of authors stress the imperative for keeping supervised injection sites open to prevent overdoses (Buchnea et al., 2020; INESSS, 2020; CCDUS, 2020a; CRISM, 2020b; Goyer et al., 2020a).

Various studies call for the development of telehealth practices that use information and communication technologies. For clients who were willing to use them, remote services (phone consultations, videoconferencing) could be applied to a range of care contexts, including outpatient rehab, withdrawal management, opioid agonist treatment (initiation, reinduction, monitoring), remote prescription (benzodiazepines and psychostimulants, refills), detection, referral and early intervention (ASAM, 2020b; Clay; 2020; CMQ, 2020; CMS and SAMHSA, 2020; CRISM, 2020a; EHRA, 2020; GREA, 2020; Harm Reduction Coalition, 2020; INESSS, 2020b; Goyer et al., 2020a; MSSS, 2020c; Public Health England and Department of Health and Social Care, 2020; SAMHSA, 2020a; SAMHSA 2020c; UNODC; 2020).

With regard to telemedicine, some authors point out the unexpected risks and impacts of transitioning to remote care, including its potential to further marginalize substances users and people in situations of social precarity. The risks identified were tied in with patient challenges—access to technology, computer literacy, Internet connection reliability, etc.—and the abandonment of virtual group therapy (Arya and Gupta, 2020; Banducci and Weiss, 2020; Bossi et al., 2020; Harris et al., 2020; Hser and Mooney, 2020; Knopf, 2020a; Leppla and Gross, 2020; McKiever et al., 2020; Rogers et al., 2020; Satre et al., 2020; Wilson et al., 2020).

Some of these risks are highlighted by McKiever et al. (2020) in their report on transitioning to telehealth services during the COVID-19 confinement and reopening periods in the U.S. (April 1 to May 26 and May 27 to June 25). Carried out with a cohort of 13 pregnant American women with OUD who attend an outpatient program, the study presents the unintended consequences of the switch from in-person to virtual-only meetings. One finding of note was the significant drop in attendance (21%) of the virtual group therapy sessions, which was three times less than that of both the in-person sessions prior to confinement (67%) and the combined (virtual/in-person) sessions during reopening (68%). Reasons cited included poor digital literacy, unreliable Internet connection and the inability to access virtual sessions in a location appropriate to patient privacy regulations (women living in shelters or other accommodation resources). The data also reveal increased craving scores among six patients as well as a significant increase to the total number of patients requiring more medication-assisted therapy dosages during the period of virtual-only sessions. An overdose was also recorded in one previously stable patient (McKiever, 2020).

The literature reports other issues related to online addiction interventions, including difficulties detecting signs of distress or intoxication and online privacy and security concerns (Galea-Singer et al., 2020; Harris et al., 2020; Leppla and Gross, 2020; Rogers et al., 2020). Though distance interventions are encouraged by practice guides issued in response to the pandemic, some institutional resources support maintaining in-person services in situations of acute vulnerability or elevated risk of harm (MSSS, 2020c). Nonetheless, recourse to telehealth services is not without benefits. For example, a pilot project launched in February 2020 by an Ontario community resource has since developed into a 24-hour overdose prevention line, effectively breaking through the isolation caused by lack of access to services such as supervised injection sites (Grenfell Ministries, 2020). Remote intervention may also make opioid agonist treatment more flexible, for example by extending the dosage periods for which take-home supplies are issued (ASAM, 2020a; ASAM 2020b; MSSS, 2020c; SAMHSA, 2020f).

The literature also highlights effective practices that have emerged in different areas worldwide. For example, in a pilot study on infection risk mitigation in congregate settings, Bodkin (2020) cites the measures—increases to the number of shelter beds, three additional hotel sites and a temporary men's shelter—applied in response to the growing accommodation needs of homeless people in Hamilton, Ontario. Spaces within the shelters were also used for short-term isolation while awaiting COVID-19 testing results; and the shelters were reconfigured to foster social distancing (Bodkin et al., 2020). Other authors point to measures to improve hygiene, including indoor disinfection, portable showers and thermometers for temperature screening (Tobolowsky, 2020). The imminence of winter has brought the need to maximize environmental health initiatives to limit the spread of COVID-19 in homeless encampments. The National Collaborating Centre for Environmental Health has issued public health guidelines to this effect

(NCCEH, 2020), while Hud Exchange offers alternative approaches to winter sheltering during the pandemic (Hud Exchange, 2020).

5.2.6. Key findings from the expert consultations (academics, professionals and experiential experts): harm reduction services

Suggestions from the experts on how harm reduction services could be adapted to the pandemic include the following:

⇒ Multiply and broaden interventions by outreach and psychosocial workers, particularly the latter, who have privileged access to and have forged strong bonds of trust with vulnerable populations.
⇒ Use telehealth tools (phone/video consultations, live chat, discussion groups, Facebook page, etc.) to keep the lines open with clients. Barriers to access must be taken into account; by the same token, essential in-person services must remain open and/or telehealth support provided to vulnerable populations.
⇒ Distribute more harm-reduction and other protective supplies to prevent substance use-related risk behaviours. Improve access to such supplies by keeping distribution sites open, setting up new sites and/or offering home delivery.
    ! More specifically with regard to gay, bisexual and other MSM, ensure that harm-reduction supplies continue to be distributed to prevent risky substance use and sexual practices, particularly in settings like saunas (if open) or "underground" sex parties on private premises.
! While distributing harm-reduction supplies, promote condom use to prevent HIV/STBBI and keep SIDEP services available (screening for gay, bisexual and MSM and for sex workers).
⇒ Keep supervised injection sites that had been in operation prior to COVID-19 open, and extend their opening hours.
⇒ Innovate to better meet the needs of PAS users and promote compliance with confinement measures—for example, by offering online supervised consumption spaces or remote consultations with addiction professionals/outreach workers.
⇒ Be flexible with regard to existing public health policies and ready to make exceptions as needed (e.g. temporary supervised consumption spaces).
⇒ Facilitate access to a safe drug supply, particularly by streamlining access to opioid agonist treatment and take-home doses, as well as improving access to physicians who prescribe this type of treatment.
⇒ Keep psychosocial services running in family medicine groups, specialized clinics and private practice.
⇒ Promote tolerance in housing resources, shelters and drop-in centres toward people with mental health symptoms who are under the influence of alcohol or other substances, as well as toward couples or people with pets.
    ! More specifically with regard to 2SLGBTQ+ people, increase the tolerance threshold in housing resources and shelters by welcoming people of all gender identities and offering them a space where they can feel safe.

⇒ Support confinement measures by setting up supervised consumption services (alcohol, cannabis and opioids) in housing resources and shelters.
⇒ Set up outdoor living spaces (e.g. encampments) for people who cannot or do not wish to use shelters or other housing resources. With street and outreach workers on hand, such spaces could effectively help curtail the spread of COVID-19 and prevent overdoses by making on-site consumption supervision and sanitation stations available. Note that any such encampments must be adapted to the coming winter.
⇒ Continue supervising overdoses and case investigations.
⇒ Trauma-informed approaches, adapted in general for substance users and homeless populations, are also recommended for women and 2SLGBTQ+ people who have been subject to repeated trauma. Anti-oppressive approaches, which examine the oppression experienced by 2SLGBTQ+ people and how it affects general health and substance use, are also useful in a harm reduction context.

c) In terms of both addiction and general wellness, which service provision practices and features are most apt to foster recovery in the context of the pandemic?

5.2.7. Recommendations: services fostering addiction recovery

Our recommendations

- ✓ Develop service corridors between addiction specialists and community-based harm reduction organizations.
- ✓ Promote care, service and treatment continuity by offering psychosocial support via telehealth services (access to Internet/smartphones, digital literacy, access to meeting locations conducive to confidentiality, etc.) to individuals with whom it is possible to communicate in this manner.
  - Equip organizations for distance interventions.
  - Provide professionals with training and support with respect to the ethics of using remote technologies and the intervention strategies to adopt.
  - Refer people in crisis who would otherwise have to wait to receive service to a helpline.
  - In compliance with public health measures, offer in-person psychosocial services to people who lack access to a smartphone, the Internet or computer equipment.
- ✓ Front-line and outreach work with the most vulnerable populations is to be prioritized in a pandemic context.
- ✓ For self-help groups like AA or NA, maintain a baseline of in-person activities while offering online options (e.g. videoconferencing). Recognize such services as essential.
- ✓ Developing new client intake and response strategies is imperative, particularly for those at risk of severe outcomes who are in situations of social precarity and have complex

health and social needs (e.g. people with OUD, concurrent disorders, experiencing homelessness, young alcohol/PAS users in crisis or distress).

- ✓ Set up strategies for meeting the basic needs (i.e. general health—food, money, housing, socialization, etc.) of service users and their families.
  - Food aid, clothing donations, tents, etc.
  - Meals
  - Employment assistance services
  - Short-term financial support and income generation opportunities (low-threshold/high tolerance employment)
  - Hygiene services (e.g. access to showers) and sanitary stations (e.g. public toilets and sinks)
  - Socialization activities (outdoors when possible) or group meetings by videoconference
  - Access to telecommunications tools/Internet
- ✓ Keep support services open and available to victims of domestic and sexual violence. Increase capacity and financial support for social services and local organizations that help domestic violence victims and 2SLGBTQ+ people.
- ✓ Implement approaches (particularly trauma-informed approaches) that take gender and sexual diversity into account and are adapted for people with problematic substance use in situations of social precarity.
- ✓ Offer gender-specific Web-based interventions to women in both mixed-care settings and women-only environments that allow children to be present.
- ✓ Expand access to contraception during the pandemic and maintain access to STBBI screening, treatment and follow-up for those likely to present or who show symptoms related to HIV or STBBI.
- ✓ Ensure gender transition treatment and follow-up care and make such treatments accessible to people wishing to undergo reassignment.
- ✓ Establish interdisciplinary, intersectoral collaborations to facilitate access to housing, addiction and mental health services and professionals. Work with community organizations to meet the general health needs of service users.
  - Foster communication between the health and social services network and regional decision-makers, municipal authorities and community organizations.
  - Foster communication between the police force, paramedics (ambulance/nursing staff) and community organizations.
- ✓ Support teams who work in harm reduction and treatment.
  - Provide psychological support to staff involved in the care of vulnerable populations.
  - Set up procedures for "venting" (e.g. staff meetings).
  - Recognize the work performed by staff through financial incentives.
- ✓ Involve people with lived experience in implementing the adapted services.

- ✓ Retroactively assess the COVID-19 health crisis to better meet the needs of people with problematic substance use in situations of social precarity in the event of a future pandemic.

5.2.8. Key findings from the literature review: services fostering addiction recovery

The documentary sources consulted regarding the services that foster addiction recovery and overall wellness in the context of a pandemic are listed in the themed bibliographies.

Working with the Institut universitaire en dépendance (IUD), the INESSS recently issued a notice regarding recovery for people with problematic substance use and/or experiencing homelessness in the context of COVID-19 (INESSS, 2020a). The paper highlights some of the creative and effective responses to the health crisis that should be maintained thereafter, including: developing remote services and mobile clinics; opening emergency beds and accommodation; increasing funding for community organizations; adapting opioid dependence management; developing effective intersectoral or interdisciplinary collaborations; and setting up trauma-informed training and practices for staff, community resources and care providers.

To forestall or remedy homelessness, some cities have met community group requests like boosting housing assistance for families in transition or issuing eviction-and-foreclosure moratoriums (Coughlin et al., 2020). Similarly, in the UK a £3.2-million emergency fund has been made available to municipalities and community organizations to support self-isolation among homeless people as a means of helping contain the spread of COVID-19 (Kirby, 2020).

Regarding service delivery in the context of a pandemic, various resources worldwide have transitioned from in-person to virtual (teleconsultation and online) services (Armitage and Nellums, 2020; Bossi et al., 2020; Knopf, 2020a; Knopf, 2020d; Leppla and Gross, 2020; Lin et al., 2020; Galea-Singer et al., 2020). Though telehealth applications show a certain promise in terms of reaching and maintaining contact with patients, there is wide consensus that in-person contact is sometimes essential. Examples of this include acute crises when distress levels are high, or situations such as users who lack access to the required technology or a setting conducive to confidential discussion.

The comprehensive approach to health recommended by some to promote addiction recovery in situations of social precarity is all the more important in a pandemic situation, where health and social needs are intensified. Such an approach entails setting up service corridors between community-based harm reduction and specialized addiction care settings (Tan and Chua, 2020). In light of the pandemic's severe impact on living conditions, many authors also bring up the need for strategies through which the basic needs—food, money, housing, socialization, etc.—of users and their families can be met (Buchnea et al., 2020; EHRA, 2020; Goyer et al., 2020c; INESSS, 2020a; Public Health England, 2020).

With its compounding factors of confinement and economic stress, the pandemic has also exacerbated violence, particularly among people in situations of financial instability, where

interpersonal relationships are more likely to be unequal. The risk of intimate partner violence, already greater toward women and 2SLGBTQ+ people, is all the more so during a health crisis. As a result, there is consensus that domestic violence services should be considered essential in the context of the pandemic (Greaves et al., 2020; Bradbury-Jones and Isham, 2020; Pimentel, 2020). Harm reduction and treatment services should be able to identify victims of domestic violence, the better to provide adequate assistance and point them toward the resources most liable to help.

5.2.9. Key findings from the expert consultations (academics, professionals and experiential experts): services fostering addiction recovery

Suggestions from the experts on how to better deliver addiction services to people with problematic PAS use in situations of social precarity are as follows:

⇒ Keep inpatient and outpatient rehabilitation services open, despite the challenges related to public health measures (e.g. finding alternative accommodation; increasing the number of beds where possible; developing new telehealth and outpatient services). The current wait list for addiction services is long. Should these services close or their intake capacity diminish, those awaiting care and treatment might need to be hospitalized, which risks putting a strain on other health and social services resources. One suggestion is therefore to open day respite centres with extended hours and detox units for individuals with special needs (e.g. withdrawal).

⇒ Provide remote access to psychosocial and health professionals. Distance services and interventions, whether online or by phone, help maintain contact/social ties with support settings; they also keep bonds of trust intact in the face of the many pandemic-related upheavals to daily life. Teleconsultation would appear to be a promising initiative. In internal environments, telehealth technologies (tablets/computers) could be made available to users.

⇒ During confinement, ensure that people with problematic PAS use in situations of social precarity receive psychosocial assistance tailored to their needs and realities. This suggestion was raised by a number of experiential experts, who advocated for extended psychosocial support to cope with the anxieties provoked by the health crisis.

⇒ Provide a support tool that can assess the changing dynamics of substance use in the context of the pandemic (e.g. increased use of one PAS vs. decreased use of another, consumption settings, consumption frequency) and adapt the response accordingly.

⇒ Provide a support tool that can assess the psychological health of addiction service users and adapt the response accordingly.

⇒ Provide a support tool that can accurately assess precarity (and any possible new dynamics thereof) in the current context and apply a responsive, updated approach.

⇒ Keep AA/NA-type support groups “in person” insofar as public health measures can be followed; if not, then arrange to have such meetings available by videoconference. While the in-person experience was considered more humane and rewarding, the professional and experiential experts agreed that videoconferencing had certain distinct advantages: keeping group members connected and enabling more frequent meetings, higher attendance and a greater geographical spread, new online-only clienteles, etc.

- ! Online support groups have reportedly increased the potential for sexual violence against women, despite warnings and attempts to shut down chat sessions. One professional remarked: "Videoconferencing can spark inappropriate behaviour. For example, I'd never heard of guys masturbating at a physical meeting, but during a videoconference, yes. There can also be videos, misplaced photos or corrupted files."

⇒ Provide health and social services professionals with training on implementing adapted services for PAS users.

⇒ In inpatient settings, encourage service users to volunteer to forestall boredom. Many professionals believe that activities of this, which kind keep them engaged and occupied during confinement, can help with problematic PAS use.

! Provide targeted support for single-parent families (especially single mothers) through programs like the CIUSSS Centre-Sud-de-l'Île-de-Montréal's "Jessie" program. Addiction support services that work closely with the DPJ (Quebec's youth protection system) can better support mothers with problematic PAS use. With the pandemic, the number of requests related to PAS use and family/parenting issues has mushroomed.

! See to it that any service reorganization does not come at the expense of services that could specifically meet the needs of women, men or 2SLGBTQ+ people.

A number of the academics and professionals highlighted the importance of a holistic approach to addiction recovery. All the expert groups consulted offered the following suggestions for improving the overall health of PAS users in situations of social precarity:

⇒ Open or maintain the availability of homeless hotels, shelters and overflow units during the pandemic.

⇒ Keep shelters open on a 24-hour basis and assign a bed to each user so that they do not have to continually find a new place to sleep.

- ! Prioritize a trauma-informed approach in housing resources during the pandemic.

⇒ Permit tents to be set up at approved sites designated by municipalities. Ensure that each approved site has sanitary facilities and avoid the forced dismantling of tents. Plan well in advance to provide the appropriate assistance to homeless people during the winter, especially those who are reluctant to use shelters.

⇒ Equip resources with outdoor sinks and make water, soap and toilets accessible.

⇒ Open food banks in targeted neighbourhoods and distribute or offer to deliver food supplies, clothing, equipment and tents.

⇒ Increase community actions to financially support clients. However, a number of professional experts criticized the Canada Emergency Response Benefit (CERB).

⇒ Implement social activities to reduce isolation—for example, an outdoor get-together.

! Keep resources open for women who are victims of intimate partner violence.

⇒ Offer reintegration services by supporting access to affordable housing, RAMQ, employment, etc.

⇒ Offer transport services to get users to the various service points.

6. CONCLUSION

This rapid response has set out to provide practice settings with timely support in the context of a global health crisis. People with problematic substance use in situations of social precarity are at higher risk of COVID-19 infection and severe outcomes, a reality that underscores the need to provide them with clear and continuous information about the public health measures to counter the spread of the virus. Priority must be given to planning strategies that promote ongoing access to harm reduction and treatment services for the most vulnerable populations. These measures—which extend to remote intervention, intake procedures, classifying outreach work as an essential activity and partnership agreements between public and community harm reduction and treatment organizations—must give specific consideration to PAS use as well as to issues related to homelessness, financial insecurity, sexuality and the living conditions of marginalized populations like sex workers.

The harm reduction activities vital to maintain in the context of a pandemic relate to overdose prevention (including consumption surveillance), safe supply and HIV/STBBI prevention. Outreach work and remote services are to be promoted in the current context. Partnerships between addiction services and those that support basic needs (food, housing, income) and better living conditions are essential to maintain if not develop during COVID-19.

Investment is needed to support harm reduction and treatment workers, not just to provide access to the appropriate technologies, but also to training and supervision. Such funding would help clinical practices better adapt to the specific issues surrounding addiction in situations of social precarity and, on a broader level, support remote intervention. Investment is also needed to support access to harm reduction and treatment services. Taking gender into account in adapting services to the COVID-19 pandemic is essential if we are to prevent existing health inequities from merely increasing, particularly those that affect women with problematic substance use and gender and sexual minorities.

7. REFERENCES*

***See also Appendices 4, 5 and 6 for the themed bibliographies**

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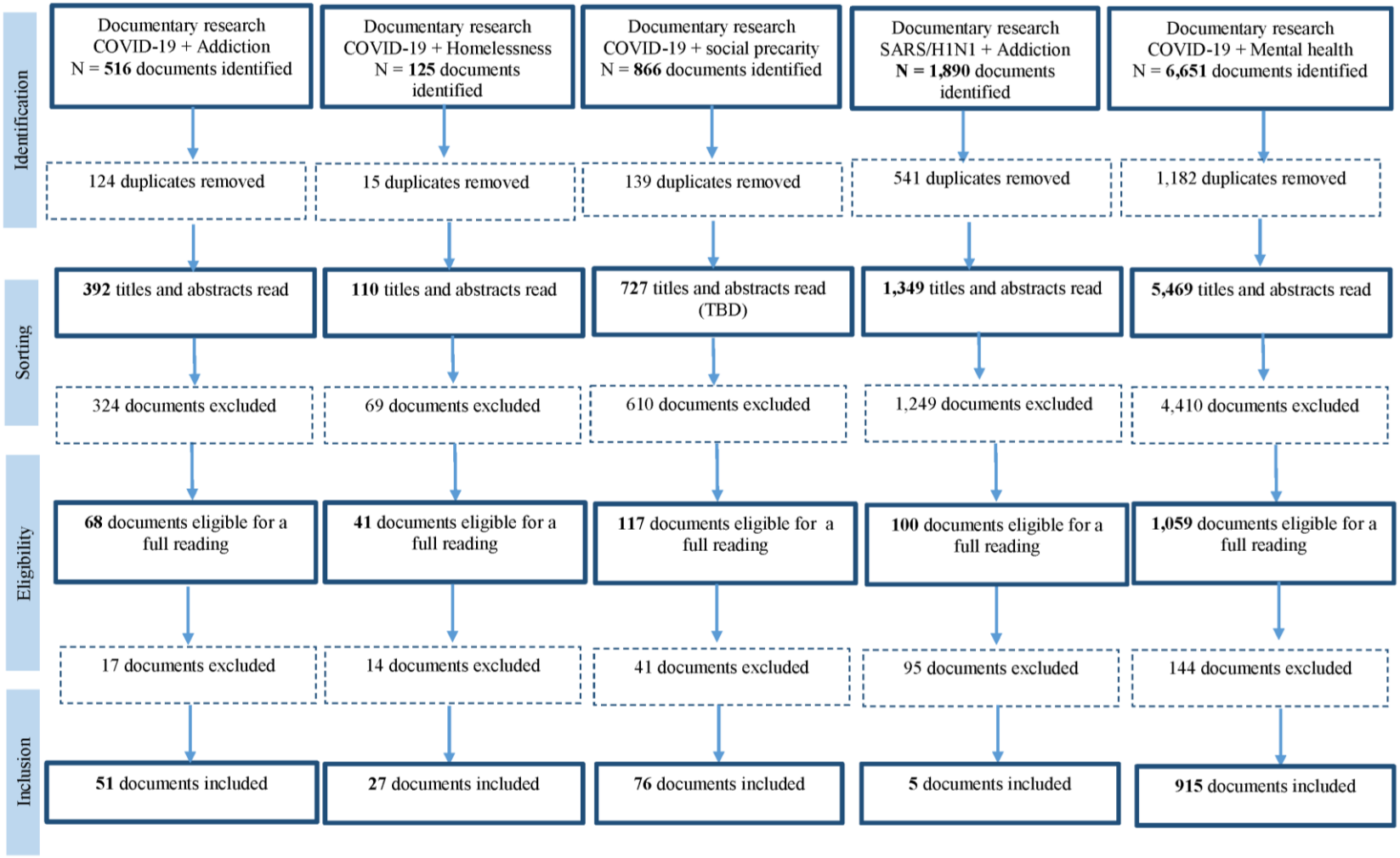
APPENDIX 1: CONCEPTS AND ASSOCIATED KEYWORDS

Concepts	Keywords
Mental health	(Psychiatr* OR psycholog* OR mental* OR anxious OR anxiet* OR emotion* OR depressi* OR stress* OR distress* OR borderline OR bipolar * OR phobia* OR antisocial OR narcissis* OR histrionic OR PTSD OR trauma* OR schizo* OR impulsive* OR psychos* OR psychotic* OR mood OR panic OR obsess* OR compuls* OR somatic* OR parano* OR avoidant OR insomn* OR (personality adj (problem* OR disorder* or trouble*)) OR resilien* OR "well-being" OR Neuro* OR Neurocogn* OR "mental health" OR "psychosis*" OR "schizophrenia*" OR "impulsivity*" OR "anxiety*" OR "personality risk*" OR "hopelessness" OR "psychological distress" OR "depress*" OR "negative thinking" OR "depressed mood" OR "depressive symptom*" OR "negative affect")
Homelessness	(homeless* OR "street life" OR (liv* N3 street*) OR couch surf* OR HDD OR hous* instab* OR hous* unstab* OR houseless OR unstab* hous* OR fix* abode OR on the streets OR precariously housed OR provisionally accommodated OR roofless OR rough sleep* OR (street adj (people OR youth) OR street-involved OR unsheltered OR without a home).
COVID-19	("SARS coronavirus 2" OR "SARS CoV 2" OR "SARS-CoV-2" OR SARSCoV2 OR "SARS Cov19" OR COVID19 OR COVID 19 OR COVID-19 OR SARSCov19 OR 2019nCoV* OR nCoV* OR "WN CoV" OR coronavirus OR corona virus OR "severe acute respiratory syndrome coronavirus 2" OR "wuhan seafood market pneumonia virus" OR "wuhan virus" OR "chinese virus")
Alcohol, cannabis and other PAS	(alcohol* OR drinking OR Cannabi* OR mari?uana OR THC OR tetrahydrocannabinol OR CBD OR hasch* OR Substance* OR drug* OR opioid OR stimulant* OR inhalant* OR cocaine OR coke OR freebase OR crack OR amphetamine OR meth OR methamphetamine OR MDMA OR ecstasy OR XTC OR speed OR depressant* OR downer* OR sedative* OR benzodiazepine* OR anxiolytic* OR hypnotic* OR poppers OR "love drug" OR GHB OR mescaline OR ketamine OR opiate* OR fentanyl OR heroin OR opium OR narcotic* OR methadone OR hallucinogen* OR phencyclidine OR PCP OR salvia OR mush OR mushroom* OR LSD OR acid OR solvent* OR "synthetic drug*" OR "street drug*" OR doping OR "performance enhancing drug*")
Social precarity	(low income* OR "marginally housed" OR "precarious conditions" OR "social vulnerability" OR "social vulnerab*" OR "economic insecurity" OR "single parenting" OR "social insecurity" OR "social needs" OR "complex needs" OR "food insecurity" OR "marginalized people" OR "disadvantaged people")
SARS and Influenza A (H1N1)	"severe acute respiratory syndrome coronavirus" OR SARS OR "the 2003 outbreak" OR "pandemic influenza" OR "H1N1" OR "SARS Virus" OR "influenza A Virus" OR "Grippe A" OR "H1N1 outbreak" OR "H1N1 2009 pandemic flu" OR "pandemic flu"

Gender and sex	"gender" OR "gender-specific" OR "gender-responsive" OR "gender-based" OR "gender-relative" OR "women" OR "female" OR "woman" OR "cisgender women"
Gender and sexual diversity	"sexual and gender minorities" [MeSH Terms] OR intersex persons [MeSH Terms] OR transgender persons [MeSH Terms] OR bisexuality [MeSH Terms] OR homosexuality [MeSH Terms] OR homosexuality, female [MeSH Terms] OR homosexuality, male [MeSH Terms] OR transsexualism [MeSH Terms] OR "Gender Identity" [Mesh] OR "gender minorities" [Title] OR "gender minority" [Title] OR "men who have sex with men" [Title] OR "sexual minorities" [Title] OR "sexual minority" [Title] OR Asexual* [Title] OR Bisexual* [Title] OR Gay [Title] OR GBMSM [Title] OR Homosexual* [Title] OR Intersex* [Title] OR Lesbian* [Title] OR LGBT* [Title] OR MSM [Title] OR Pansexual* [Title] OR Queer* [Title] OR Transgender* [Title] OR Transsexual* [Title] OR "sexual orientation" [Title] OR "Sexual orientations" [Title] OR "Sexual identity" [Title] OR "Sexual identities" [Title] OR TGNC [Title]

APPENDIX 2: DOCUMENTARY RESEARCH AND DATABASE SELECTION



APPENDIX 3: NATIONAL AND INTERNATIONAL INSTITUTIONAL RESOURCES, PROFESSIONAL AND USER ORGANIZATIONS AND GROUPS ON HOMELESSNESS AND ADDICTION CONSULTED

Country /Region	Institutional resource
France	Institut national de la santé et de la recherche médicale (INSERM)
	Institut national de prévention et d'éducation pour la santé (INPES)
	Observatoire français des drogues et des toxicomanies (OFDT)
	Mission interministérielle de lutte contre les drogues et les conduites addictives (MILDECA)
	Fédération addiction
	Instances régionales d'éducation et de promotion de la santé (IREPS) (Nouvelle-Aquitaine)
	AIDES https://www.aides.org
Belgium	Open Repository and Bibliography (ORBi)
Switzerland	Groupement romand d'étude des addictions (GREA)
	Addiction Suisse
United States	American Psychological Association
	American Society of Addiction Medicine
	National Institutes of Health (NIH)
	Substance Abuse and Mental Health Services Administration (SAMHSA) (www.samhsa.gov)
	U.S. Department of Health & Human Services
	National Alliance to End Homelessness (www.endhomelessness.org)
	Rand Corporation (www.rand.org)
	Harvard Health Publishing https://www.health.harvard.edu/blog/covid-19-and-the-lgbtq-community-rising-to-unique-challenges-2020043019721
Canada	Health Canada

	CATIE (https://www.catie.ca/en/home)
	Centre for Addiction and Mental Health/Centre de toxicomanie et de santé mentale (CAMH) (www.camh.ca/fr/hospital/Pages/Home.aspx)
	Assembly of First Nations (AFN)
	British Columbia Centre on Substance Use
	Canadian Agency for Drugs and Technologies in Health (CADTH) (www.cadth.ca/fr)
	Canadian Alliance to End Homelessness (CAEH) (http://caeh.ca)
	Canadian Institute for Substance Use Research (CISUR) (https://www.uvic.ca/research/centres/cisur/index.php)
	Community Action Group on Homelessness (www.crmhaa.ca/c-a-g-h; www.cagh.ca; www.roadhomefredericton.com)
	Fred Victor (www.fredvictor.org)
	Here to Help (www.heretohelp.bc.ca)
	Homeless Hub (http://homelesshub.ca)
	The Canadian Centre on Substance Use and Addiction (CCSA)/Le Centre canadien sur les dépendances et l'usage de substances (CCDUS) (https://www.ccsa.ca/)
	Vancouver Coastal Health (VCH) (www.vch.ca)
	Wellesley Institute (www.wellesleyinstitute.com)
	Canadian Drug Policy Coalition (https://www.drugpolicy.ca/covid-19-ressources-en-reduction-des-mefaits/)
	Canadian Research Initiative in Substance Misuse (CRISM) (www.crism.ca)
	Community-Based Research Centre (CBRC) (www.cbrc.net)
Quebec	Ministère de la santé et des services sociaux (MSSS)
	Association québécoise des centres d'intervention en dépendance (AQCID)
	Institut national d'excellence en santé et services sociaux (INESSS)
	Institut national de la santé publique du Québec (INSPQ)
	Institut universitaire sur les dépendances (IUD)
	Association des intervenants en dépendance du Québec (AIDQ)
	Réseau de recherche en santé des populations du Québec (RRSPQ) (www.santepop.qc.ca)
	Centre de recherche de Montréal sur les inégalités sociales et les discriminations (CREMIS) (www.cremis.ca)
	Dépendance, itinérance et COVID-19, http://dependanceitinerance.ca/

	Maison L'Exode (www.maison-exode.org)
United Kingdom	Department of Health and Social Care
	Public Health England
	National Institute for Health and Care Excellence (NICE) (www.nice.org.uk)
	Social Care Institute for Excellence (SCIE) (www.scie.org.uk/Index.aspx)
International organizations	World Health Organization (WHO)
	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
	United Nations Office on Drugs and Crime (UNODC)
	European Commission (https://ec.europa.eu/info/index_fr)
	EUROTOX (https://eurotox.org/)
	European Federation of National Organisations Working with the Homeless (FEANTSA) (www.feantsa.org/fr)
	International Drug Policy Consortium (IDPC) (https://idpc.net)
	Coalition Plus (www.coalitionplus.org)

APPENDIX 4. THEMED BIBLIOGRAPHY: ADDICTION AND PRECARITY

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APPENDIX 5. THEMED BIBLIOGRAPHY: GENDER, WOMEN AND COVID-19

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APPENDIX 6. THEMED BIBLIOGRAPHY: GENDER, SEXUAL DIVERSITY AND COVID-19

Scientific literature

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