INTRODUCTION

The World Health Organization declared an international public health emergency on January 30, 2020 and measures to control the COVID-19 pandemic were implemented that have altered patterns of social and economic life and have generated unique challenges for people who inject drugs (World Health Organization, 2021). People who inject drugs (PWID) are considered vulnerable to COVID-19 transmission because drug procurement and consumption activities generally necessitate social contact, which may compromise...
hygiene and physical distancing practices, and because the greater likelihood of incarceration or homelessness increases incidental exposure risks (Iversen et al., 2020; Jenkins et al., 2020; Vasylyeva et al., 2020). Other demographic characteristics, such as increased prevalence of pre-existing illness and socioeconomic disadvantage, may increase vulnerability to more serious illness from COVID-19 (Marel et al., 2021; Melamed et al., 2020).

People who utilise harm reduction services have been exposed to health education about infectious diseases and behaviours to reduce risks, and this exposure may provide some benefit in understanding and adapting to the threat of COVID-19, including prioritising hygiene practices (Schlosser & Harris, 2020). As many PWID experience pervasive stigma and social exclusion, social distancing is a practice that many may be familiar with or even prefer (Neale, 2008; Schlosser & Harris, 2020). Despite this, protective measures and risk factors among PWID appear to be similar to the general population, and this knowledge does not necessarily translate to a willingness to fully comply with the COVID-19 recommendations such as social distancing, home isolation and vaccinations as seen in a study conducted in Sweden between July 27 and October 2020, where 232 clients of needle exchange programs responded to COVID-19 Health Literacy Questionnaire and 779 CoV-2 IgG antibody tests were performed (Lindqvist et al., 2021). PWID face structural barriers to vaccination such as inadequate access to transportation and mistrust of health services which may impact vaccine uptake (Fisk, 2021; Vasylyeva et al., 2020).

COVID-19 has affected entire systems of health service provision globally, including the redeployment of staff and resources and the implementation of infection prevention and control protocols (Ambigapathy & Krishnamurthy, 2020; Razai et al., 2020; Sohrabi et al., 2020). Harm reduction facilities are considered to face particular challenges in response to COVID-19 (Dunlop et al., 2020; Khatri & Perrone, 2020; Sarosi, 2020; Tyndall, 2020). However, previous responses to pandemics, such as the HIV and SARS-CoV-2 pandemics, have meant that harm reduction principles and responses could benefit from lessons learnt for early implementation of public health measures among vulnerable groups (Gravett & Marrazzo, 2021). In particular, Australia’s comprehensive and early response to HIV prevention among PWID has been internationally recognised as effective in preventing the spread of HIV within this community (Madden & Wodak, 2014). Harm reduction services and staff are, therefore, well placed to respond to COVID-19 and to be flexible and adaptable in implementing substantial changes to service provision during this unprecedented public health challenge.

In Australia, recommended and implemented adaptations for harm reduction services have included minimising service disruption by reconfiguring premises to accommodate physical distancing, implementing or upscaling remote channels of equipment distribution and consultation and providing take-home naloxone and COVID-19 health and safety education in service encounters (Dunlop et al., 2020; van de Ven et al., 2021). The global scarcity of personal protective equipment in the early stages of the pandemic posed obvious challenges for healthcare workers (Livingston et al., 2020) together with the ever-changing and fluid nature of information around transmission risks and vaccinations (Zhang et al., 2020). Data from online surveys, focus groups and administrative data involving 36 AOD across Australia found that adapting services to meet COVID-19 safety measures led to changed workloads and increased responsibilities for staff (van de Ven et al., 2021). AOD and needle-syringe program (NSP) staff also faced increased uncertainty due to the ongoing possibility of resources being redirected away from work in the AOD treatment settings to COVID-19 specific areas, such as testing centres (Searby & Burr, 2021). By remaining open, the potential risks relating to COVID-19 transmission for both harm reduction centre staff and clients were ever present as documented in a paper by Roxburgh et al. (2021) on strategies implemented by supervised injecting facilities in Australia. Dunlop et al. (2020) further notes, this all creates obvious concerns for frontline staff during a particularly challenging time when continuing to deliver treatment services to PWID during the pandemic. This research assessed the impact of COVID-19 on staff working at harm reduction and drug and alcohol services within the first 9 months of the pandemic. It focuses on how these staff feel their work and delivery of key services has been affected by the COVID-19 pandemic and whether they perceive their service has been able to adapt to these changes and increased risks. This research also assesses staff’s fears in relation to working at their service during the pandemic and whether they feel safe and comfortable in their workplace.

What is known?

• COVID-19 has had a major impact on health services generally and on harm reduction and alcohol and other drug (AOD) services in particular
• COVID-19 restrictions and requirements around social distancing disproportionately affect people who inject drugs (PWID)
• Harm reduction services face challenges in responding to COVID regulations whilst continuing to provide services for PWID

What this paper adds?

• Harm reduction and AOD services adopted innovative health service strategies including peer
• postal and outreach distribution of needles and syringes and take-home naloxone
• Infection control education was built on clients’ pre-existing knowledge around infection control for blood-borne viruses
• Staff felt able to meet the needs of the client despite changes in service provision and COVID-19 regulations
2 METHOD

The research consisted of both quantitative and qualitative data collection methods, with the aim of using the survey data to inform in-depth interviews. Survey data collection was undertaken nationally across Australia with staff in the overlapping AOD (alcohol and other drugs) and harm reduction sectors. Researchers worked with a peak national AOD organisation to advertise the study as well as posting a link to the survey on an e-list for workers in the harm reduction sector. Data collection occurred over 5 months from July 2020 to December 2020. The survey took approximately 15 min to complete. In addition to the survey, in-depth interviews were conducted with staff at three harm reduction sites in New South Wales. Approval for this study was obtained by UNSW Sydney Human Research Ethics Committees (HC200415) and Community Mental Health Drug and Alcohol Research Network (CMHDARN).

2.1 Survey

2.1.1 Changes implemented in service

The questionnaire included 16 items on the types of changes that occurred at their service for example, ‘online ordering and posting fitpacks’. There were six further statements appraising how these changes had been implemented at their service, for example ‘leadership has handled decisions around changes in the service due to COVID-19 effectively’. The statements were scored on a 5-point Likert scale from strongly disagree (1) to strongly agree (5).

2.1.2 Feelings about workplace

The survey included six items focused on participants’ feelings about their workplace during COVID-19, for example, ‘My workplace makes me feel safe from COVID-19.’ These were answered from strongly disagree (1) to strongly agree (5).

2.1.3 Perceived changes in client practices

The survey included 12 items around how participants felt clients had changed their practices as a result of COVID-19, for example, ‘Clients are using/injecting more drugs’. There were also five items that dealt with feelings towards clients during the current pandemic such as ‘I do not want to have as much face-to-face contact with clients as I used to before COVID-19.’

2.1.4 Increased risks

Participants were asked whether they thought they were more at risk of contracting COVID-19 compared to others because of where they worked, scored from ‘no risk’ (0) to high risk (5).

2.1.5 Fears of working during COVID-19

The survey included 11 items which were summed to create a Fears of Working during COVID-19 Scale. This measured participants’ fears around working at their service during COVID-19, for example, ‘I am not afraid because my workplace has put in good social distances measures to prevent COVID-19 from spreading’. Responses were on a five-point scale from ‘strongly disagree’ (1) to ‘strongly agree’ (5) with higher scores indicating greater fear around working at their service during the pandemic ($\alpha = 0.852$). It is important to note that throughout most of the collection period which was early in the pandemic, there was no COVID-19 vaccine available and consequently, there are no questions on this included in the survey.

2.2 Data analysis

Quantitative analyses were conducted using SPSS version 26. Descriptive data outlining the sociodemographic characteristics of the sample and their thoughts and attitudes about COVID-19 and the management of COVID-19 infection at the different AOD services are presented. Relationships between continuous variables were assessed using Pearson's product-moment correlation. Two-tailed significance was set at $\alpha = 0.05$.

2.2.1 Interviews

Interviews were conducted with 16 staff at three harm reduction sites. Thirteen worked in services located in metropolitan Sydney and three worked in services in regional NSW. Nine worked in frontline NSP roles having daily contact with PWID, and seven had managerial and/or clinical roles. Ten participants were interviewed in-person and six by phone because of COVID-19 restrictions. Participants were interviewed between September and December 2020. Interviews were semi-structured, conducted by three of the authors and lasted approximately 30–45 min. The interview guide contained questions related to personal impacts (COVID-19 knowledge, effects on life and fears) and work impacts (service changes and perceived impacts on clients), as well as demographic and work history information. Interviews were audio recorded and transcribed. Transcripts were de-identified and analysed in NVivo version 12. Themes were generated using the processes outlined in thematic analysis (Braun & Clarke, 2006), including both deductively defined themes and inductively generated themes grounded in the interview data. Information was coded using domain themes consistent with interview guide questions, and content analysis was conducted to identify staff practices, experiences and perceptions across the data.
3 | RESULTS

3.1 | Quantitative data

A total of 207 participants completed the survey, with 115 participants (57%) living in NSW and most being female (72%). Almost half (49.3%) of the participants worked at a harm reduction program with one-third working in the same position for more than 5 years. Almost two-thirds lived in a capital city (64.5%), worked in a service delivery role (63.2%) and were employed full time (61.4%). (See Table 1).

When asked about their perceptions of the level of risk of contracting COVID-19 because of where they work, 14 participants (7.3%) believed they were at high risk and 46 participants (24.1%) felt that they were more at risk compared to other work environments. When asked whether they were scared of contracting COVID-19 from clients, 111 participants (58.1%) reported they were not scared or that they had as much chance of getting it from a client as any other person. An additional 60 participants (31.4%) responded that their service had taken enough precautions to keep them safe.

Participants were asked about changes that had been made to their workplace in response to the pandemic. Most (79.1%) felt that many changes had been made; yet, only 89 participants (46.8%) felt that enough changes had been implemented in the service to help clients during this time, with 68 participants (35.8%) feeling that a little more should be done to help clients. The most common change that had been implemented was COVID-19 screening of clients and temperature taking before entry to the service (62.8%), followed by more outreach by telehealth (48.79%), closing client ‘hang out’ or lounge spaces within services (48.31%), reduced client numbers due to social distancing (47.83%) and allowing clients to take more fitpacks (45.41%). More than half (55%) of participants reported that their jobs had changed quite substantially and that they were happy with decision-making by management around changes in their service due to COVID-19 (55.5%). (See Table 2).

The survey assessed staff perceptions of the impact of COVID-19 for their clients as well as participants’ feelings towards clients during the pandemic. Over one-third (36.8%) felt that clients were no longer getting as much attention and face-to-face time with staff. Whilst almost two-thirds of participants (61.1%) felt that their current relationship with clients is the same as it was before COVID-19, 32% of participants did not want to have as much face-to-face contact with clients. The most commonly reported perceived change in client practices by staff was a reduction in accessing face-to-face...
services (64.3%), followed by clients taking more needles and syringes (39.1%) and clients drinking more alcohol (33.8%). Other changes reported were an increase in the use of vending machines (26.6%), increase in the use of telehealth services (24.6%), clients using/injecting more drugs (18.8%) and increased distribution of take-home naloxone (17.9%). Only 3.4% of staff participants reported that they felt that there has been an increase in sharing of needles and syringes. (See Table 3).

3.2 | Staff feelings about their work environment

Of sample, 108 participants (61.7%) agreed or strongly agreed that their workplace made them feel safe during the pandemic with most participants (84.5%) agreeing or strongly agreeing that their workplace had adopted good social distancing practices. However, 106 participants (61.2%) felt that not everyone followed social distancing at work and a further 70 participants (45.2%) felt that there was a greater divide between clients and staff.

The Fear of Working during COVID-19 Scale was used to measure staff’s fears around working at their service during the pandemic. Data indicate that more than one-third (37.5%) were afraid of contracting COVID-19; however, only 40 participants (22.7%) were afraid of catching COVID-19 because of the setting they worked in. Correlations were undertaken to assess the relationship between different measured variables and gain a better understanding about fears around working at the service. As seen in Table 4, there was a significant negative correlation with both age and the length of employment. The younger the staff member and the shorter amount of time they had been employed, the greater their level of fear of working at the service during COVID-19.

3.3 | Qualitative data

Staff participants reported a variety of changes to the way harm reduction services had been offered that expands on the quantitative findings. Whilst some of these changes were described as ‘hard work’ (Alex, NSP worker), others such as the innovation of outreach work were viewed positively and as something that should be continued post COVID-19 risk.

3.3.1 | Changes to NSP spaces

All staff reported the need to rearrange the space within the NSP to meet physical distancing requirements and safety measures by shutting down socialising spaces and increasing surveillance. Indoor NSP spaces were mostly blocked off with clients being triaged outside and few allowed in. One NSP located on hospital grounds was moved to a different location on site in order to make room for COVID-19 services. Participants described how their services were ‘cleared out’ (Keith, clinician), ‘blocked off’ (Indigo, harm reduction worker) or operated ‘in a hut’ (Jamie) and that they need to ‘just hand stuff over the table’ (Indigo). Staff described the impact of these changes on the social spaces within the NSP:

[Clients can be in the service in a sort of hang out space that we’ve got, even if they’re not necessarily seeing a counsellor or doctor or any clinician …just building that relationship with people, so they get to know you and feel comfortable … I guess that really has all changed. (Jamie, harm reduction worker)]

The loss of socialising space was reported to have drastically reduced the opportunity to build rapport and trust with clients and to provide extra health and social care, a role that many staff see as a unique contribution of NSP services. The reduced access to socialising spaces was seen to have negative consequences for clients and to be associated with increased practices of surveillance, something that staff participants worried about. For example, the practices associated with COVID-19 triage were seen by some as problematic: asking clients ‘a million questions’ (Indigo) before they get into a service, the requirement to wear a mask and have a temperature check, usually

| TABLE 2 | Staff views on changes that have been implemented as a result of COVID |
|-----------------|-----------------|-----------------|-----------------|
|                  | Strongly disagree/disagree | Neither agree nor disagree | Strongly agree/agree |
| Leadership has handled decisions around changes effectively | 22 (12.6) | 21 (12) | 132 (64.4) |
| Staff have been included in decisions about changes | 67 (38.3) | 26 (14.9) | 82 (46.8) |
| I struggled to work from home and found the changes to be isolating | 39 (39.8) | 32 (32.7) | 27 (27.6) |
| I felt supported by management in the transitioning to working from home | 19 (19) | 22 (22) | 59 (59) |
| I am unhappy with decision-making by management around changes | 95 (55.5) | 29 (17) | 47 (27.4) |
| My role at work has changed quite substantially as a result of COVID-19 | 51 (30.6) | 24 (14.4) | 92 (55) |
using a handheld temperature scanner to the forehead. Staff viewed these practices as necessary but also as potentially scary for clients and as negatively impacting their rapport:

It’s 100% masks all the way and the nurses are encouraged to wear scrubs and I believe that created the sense that there was ‘workers’ and there were people who were using the service and I think that changed perceptions around power. (Monika, counsellor)

You’ll run through the COVID screening questions and people will roll their eyes and say, ‘this is the third time today that you know I’ve had to go through this’ and it’s frustrating for people (Jamie)

According to staff, by making NSP settings COVID-19 safe, most opportunities for staff and clients to socialise were removed. Clients were required to have specific reasons and appointments to be at the services. This, together with the added surveillance, had severe impacts on NSP staff to provide warm, welcoming and ‘low-threshold’ services which has always been seen as the success of NSP service provision.

3.3.2 | Expansion of self-help services

As noted in the survey data, one of the main ways that NSP services countered the negative effects of shutting indoor spaces was to enhance self-help services. This involved moving existing vending machines to higher traffic areas, adding more vending machines, reducing the costs of vending machines or making them free of charge. One staff member described a free of charge ‘help yourself’ counter that was set up in high traffic locations as a vertical wall-mounted Perspex rack containing fit packs. Many staff participants acknowledged that the expansion of self-help services enabled more privacy for clients, promoted a sense of self-determination and enabled rapid increase in distribution and expansion of locations. One staff participant identified how an unintended outcome of the expansion of self-help services was that ‘it stopped a lot of fears’ held by ‘management’:

because they’ve worked so well, it has stopped a lot of those fears from people thinking that you know people are going to come in and grab everything and it’s like, well so what if they grab everything, that’s what it’s there for. (Indigo)

The move to self-help services has successfully challenged previously held notions that NSP clients cannot be trusted with free access to equipment. As one staff proclaimed ‘it would be hard now for management to say we don’t need them [self-help services] because I think we can back it up with stats and numbers gone out’ (Lyle, harm reduction worker). COVID-19 has provided an opportunity to debunk some myths about PWID and prove that things can be done differently.

3.3.3 | Active outreach

All staff reported that their existing outreach services were adjusted and upscaled whilst some services were even able to introduce entirely new forms of outreach. These outreach services included: in-person mobile outreach in which workers would travel to clients’ homes or other health and social services, outdoor COVID-19 safe pop-up clinics, telephone consultation and postal NSP whereby staff would post fitpacks to clients. Staff at suburban and regional-based services reported already having well-established outreach, which was continued with extra services added, whilst inner city services shifted most of their service provision to this model.

In-person mobile outreach was used not only to deliver fitpacks, medical consultation and counselling services but as COVID-19 testing services as well. In the inner city, outreach clinics were set up as COVID-19 testing sites for street-based clients, providing opportunities

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**TABLE 3** Staff perspective on changes in clients’ practices as a result of COVID

| Responses | n (%) |
|-----------|-------|
| Clients are accessing face-to-face services less | 133 (64.3) |
| Clients are taking more needles and syringes | 81 (39.1) |
| Clients are drinking more alcohol | 70 (33.8) |
| Clients are using vending machines more | 55 (26.6) |
| Clients are using telehealth services more | 51 (24.6) |
| Clients are using/injecting more drugs | 39 (18.8) |
| Clients are taking more naloxone | 37 (17.9) |
| Clients are accessing the services more | 18 (8.7) |
| Clients are taking more water | 14 (6.8) |
| Clients are taking more spoons | 12 (5.8) |
| Clients are taking more filters | 9 (4.3) |
| Clients are sharing needles and syringes more often | 7 (3.4) |

**TABLE 4** Correlations with fear of COVID Scale

| Fears around working at service | Fears around working at service |
|-------------------------------|-------------------------------|
| Gender | 0.154* |
| Age | −0.174* |
| Time in current role | −0.200** |
| More at risk because of where they work | 0.517*** |
| Changes implemented enough to help clients | 0.246** |
| Scared of contracting COVID-19 | −0.544*** |
| Reduction in number of clients | 0.156 |

*p < 0.05.; **p < 0.01.; ***p < 0.001.
for staff to check in with clients about equipment needs and general well-being: ‘we made sure that a lot of the outreach COVID-19 testing sites that we did outreach to before COVID-19, so it’s okay because our clients are familiar with and feel safer’ (Leah, harm reduction worker). In this way, NSP continued to offer the ‘one-stop shop’ model of care by offering COVID-19 testing along with other services to a clientele that might not otherwise get COVID-19 tested.

Telehealth for mental health counselling was seen to be especially important to address the depression and anxiety that had been intensified for some clients due to COVID-19. Continuing to offer telehealth counselling as an ‘informal’ and relaxed model of care was viewed as important for future service delivery:

I like the idea that I might continue to offer counselling in a variety of different ways. I think that the demographic [we work with], their triggers around authority is quite high and when you sit down formally and have a sit down talk formally, it reinforces the things that they are uncomfortable with and informal options have worked better for some. (Monika)

Whilst some services already had an existing postal NSP, other services introduced a postal option. This allowed staff to take orders online and by telephone and for fitpacks to be posted to clients or delivered in person. This was again reported by staff as a positive by-product of COVID-19 that should continue post the pandemic as it provides ‘an extra service’ alongside the range of other options to meet clients’ needs. COVID-19 has provided an ideal experimental environment to trial postal NSP: ‘it’s something that [we] has been wanting to do for a long time, but so that’s a blessing from COVID-19 kind of. They finally gave it the green light’ (Leah).

3.3.4 | Service changes made possible by staff

The majority of staff recounted how the changes to service were rapidly implemented citing reasons such as staff and clients were already familiar with viral risk reduction methods; staff leaders responded rapidly and, most importantly, frontline staff worked incredibly hard. Staff from several locations identified how the blood-borne virus risk reduction messages they used with clients in the past had laid excellent foundations to promote COVID-19 safety:

What I find interesting about COVID is that it’s really aligned to harm reduction principles anyway, harm reduction principles in any effect...to activate and orientate the staff around COVID is to actually be very harm reduction focused. (David, management)

That was also very opportunistic around washing your hands and, you know making sure that your area is clean and your hands are clean before you have a shot. So those messages that we’ve always given out, but I suppose had a little bit of oomph behind them now. (Indigo)

Past harm reduction messages provided a starting point to work with clients around COVID-19, making service changes easier to manage. However, staff participants described that the initial stages of the pandemic and the accompanying shift in service provision had a lot of ‘teething problems’ and that nurses, in particular, worked beyond expectation to keep clients safe:

I do outreach with the nurses whenever they require me too, but I feel like with this COVID-19 thing going on, they have definitely been working way beyond their usual hours. Like, I’ve heard of them going out in the middle of the night to top up vending machines, going out on their off days, just to top up the vending machines and checking that all these things are still working in the community, so they are working outside of their normal hours for sure, absolutely, yeah. (Keith)

4 | DISCUSSION

The findings from the study describe the changes that harm reduction and AOD staff reported have occurred in their services as a result of COVID-19. The survey data show that whilst there was some level of fear and concern around managing COVID-19, the majority of staff felt secure and supported in their work environment during the pandemic. It is likely that this feeling of security aided them in being flexible to adopt new strategies at work including initiating an array of important services such as outreach and postal NSP services and telehealth. Further those who were younger and had spent less time working at the service showed more concern and fear around COVID-19 in their workplace, felt they were at greater risk because of where they worked and were more fearful of contracting COVID-19 from clients. Given these findings, it is important that management is aware that less experienced staff may require additional support, particularly with the ever-evolving nature of the COVID-19 pandemic, the potential for snap or ongoing lockdowns and concerns around new and potentially more infectious strains of COVID-19.

Both the qualitative and quantitative data illustrate that services were able to adapt quickly in uncertain and uniquely challenging situations, reflecting an agile and well-supported work environment, able to pivot under pressure with staff continuing to provide essential harm reduction services to clients. Staff felt they were able to respond to the new and trying circumstances of the early stages of the pandemic, especially given that practical messages around the COVID-19 response were similar to those already in place for BBV prevention. Thus, staff felt that their services were able to continue to provide core services to clients with some modifications in delivery. In addition, they were willing to take on additional
responsibilities to ensure their own safety and that of clients including conducting temperature checks and screening questions, whilst also adopting novel service provision strategies to reach clients during lockdowns. Staff described a range of innovative ways that they had reworked services in response to COVID-19 threats. The main response involved closing down indoor NSP spaces and staff worried that this had a significant impact on their capacity for rapport-building with clients.

Harm reduction sites have the potential to be critical health and social care access points for people who would otherwise may have very little to do with mainstream health services, allowing staff opportunities to engage with those harder to reach and provide opportunistic counselling and healthcare (McMillan et al., 2021; Williams et al., 2019). Staff concern about the closure of socialising spaces highlights that this is a key aspect of many harm reduction services as this client group may have limited opportunities to socialise in a welcoming environment. In response, self-help services were scaled up, and the frequency and quality of outreach work was expanded. In addition, the use of online ‘counselling’ was introduced and this was described by staff as positive, being both less formal and more relaxed and thus comforting for people who were feeling particularly anxious or depressed.

Staff had particular concerns regarding the well-being of clients during the pandemic and that the reduction in face-to-face activity would be significant particularly for socially isolated PWID. Additional staff concerns were raised in relation to the newly implemented restrictive practices and social distancing measures which they feared could potentially dissuade clients from accessing services. On the other hand, in the context of these rapid and difficult required service changes, staff participants noted that COVID-19 had provided a positive experimental environment where they were able to implement models of service delivery that they had not previously been able to trial such as take-home naloxone and peer distribution of injecting equipment. Whilst known to be effective in increasing the reach of equipment provision, the practice of peers distributing sterile equipment to other PWID is still criminalised in many jurisdictions in Australia (Brener et al., 2018; Bryant et al., 2019). However, under the social distance conditions implemented in response to COVID-19, peer distribution has become an important additional mechanism for PWID to obtain injecting equipment, enabling service providers to encourage a practice which is known to occur anyway. The new practices around NSP service provision also illustrate a slow moving but fundamental ideological shift in the way harm reduction and AOD clients are being reconceptualised and harm services are being delivered. For example, the redeployment of NSP distribution, from its traditional format of a worker handing over equipment to remote and self-serve channels, challenges previous deficit views of PWID as a source of danger to the public and demonstrates that NSP clients can be trusted with free access to bulk equipment (Bryant et al., 2019). In addition, staff reports of no known instances of inappropriate stockpiling further reinforce these shifting assumptions about PWID and support our prior research highlighting how PWID act in ways to protect themselves and their social networkers to prevent injecting related harms (Brener et al., 2018).

A key point raised by participants is the shift to viewing harm reduction facilities as a ‘one-stop shop’ which includes things as outreach equipment distribution and offering COVID-19 testing opportunities. This is in keeping with the precedent of decentralising other health initiatives for PWID, such as moving hepatitis C treatment from tertiary liver clinics to community settings (Norman et al., 2008), and highlights the importance of flexibility to provide additional services including COVID-19 information and testing whilst continuing regular services. Staff felt that this service delivery model should continue post COVID-19, especially as the pandemic has provided the impetus to establish that services are able to adapt to these changed service delivery models. Having harm reduction and AOD services operate as a one-stop shop would allow services to also provide healthcare more generally, whilst possibly even offering further opportunities such as providing COVID-19 vaccines via outreach. Using a service that is considered credible and trusted by the community to carry out this important vaccination work is recognised as valuable in increasing COVID-19 vaccine acceptability (Bryant et al., 2021; Rance et al., 2021; Schoch-Spana et al., 2020).

This research has a number of limitations which must be noted. The data were self-reported and it may be that those more likely to have adjusted well to challenges of the pandemic are the staff who responded to the survey. This research was conducted at a particular time during the earlier stages of the COVID-19 pandemic and prior to the emergence of the highly transmissible delta variant, but perhaps at a time of greater fear and uncertainty about the course of the pandemic. Additionally, the research was conducted prior to the development of COVID-19 vaccines and hence, no questions were asked about vaccine acceptability nor about working practices with vaccine-related guidelines or restrictions in place. Finally, interviews were conducted at harm reduction facilities which are known to be responsive to the needs of their client group and findings may be different in less well-resourced areas or less supported healthcare environments. Despite these limitations, this research offers a staff perspective on the impact of COVID-19 on harm reduction and AOD services and provides insights into staff fears, concerns and beliefs about how their service and their clientele fared during the 1st year of this pandemic. Overall, according to these participants, it appears that the harm reduction and AOD services have been able to implement COVID-19 infection control strategies, whilst maintaining and expanding service access through remote and innovative strategies. The services we collected data from, whilst stretched, responded innovatively and appeared able to recognise and act to meet the needs of their clients in work environments where the majority of staff felt safe and supported.

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CONFLICT OF INTEREST
The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS
Brener is the lead author and was involved in all aspects of the research including developing the research instruments, the design of the analysis and writing up of the paper. Horwitz and Caruana conducted data analysis and contributed to drafting of the results and to the literature review. All authors contributed to the design of the interview schedule, the data collection and in reviewing full drafts of the paper. Bryant and Rance were involved in the conceptualisation of the broader research and the data analysis and contributed to reviewing drafts of the manuscript.

DATA AVAILABILITY STATEMENT
Data are available on request from the author.

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