“We figured it out as we went along”: Staff perspectives of COVID-19 response efforts at a large North American syringe services programme

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Abstract
Syringe services programmes face operational challenges to provide life-sustaining services to people who use substances and those who have substance use disorders. COVID-19 has disrupted operations at these programmes and is a threat to people with substance use disorder because of severe poverty, de-prioritisation of COVID-19 safety and high prevalence of comorbidities. This phenomenological qualitative study describes 16 in-depth interviews with staff of one of the largest syringe services programme in North America—Prevention Point Philadelphia, located in the Kensington neighbourhood of Philadelphia, Pennsylvania. Interviews were conducted from December 2020 to February 2021, audio-recorded, transcribed and coded to develop a thematic framework. Participants were mostly white (71.4%) and female (68.8%) with a median age of 31.5. Three main and four sub-themes related to the impact of COVID-19 on the syringe services programme were identified: (1) COVID-19 altered services provision (sub-theme: select service changes should be retained); (2) unclear or absent COVID-19 response guidance which compromised mitigation (sub-themes: COVID-19 messaging was difficult to translate to practice, learn-as-we-go); and (3) staff and clients experienced elevated mental anguish during the pandemic (sub-theme: already limited resources were further strained). COVID-19 presented complex challenges to an organisation normally strained in pre-pandemic times. A staff culture of resourcefulness and resiliency aided the syringe services programme to balance client needs and staff safety. However, staff experienced a serious psychological impact, largely attributable to being unable to find reprieve from the stressors of COVID-19 and the difficulties associated with navigating and acting-on contradictory public health messaging. Staff also shared a belief that the relaxing of some pre-pandemic barriers allowed staff to link clients more readily with services. Syringe services programmes should embrace the potential for lasting changes to health services delivery brought about by wide-scale changes in service provisions because of COVID-19.

Keywords
COVID-19, harm reduction, needle exchange programmes, SARS-CoV-2
1 | INTRODUCTION

Syringe services programmes (SSPs) provide life-sustaining care to people whose substance use is health harming, including referrals to housing and medical services (Centers for Disease Control and Prevention [CDC], 2019). These programmes are also recognised by the World Health Organization [WHO] (2004) as an evidence-based strategy to reduce infectious disease transmission among those who inject drugs via the provision of sterile syringes and testing and treatment services. Staff at these organisations are integral in the delivery of programmes that address the syndemics of substance use, infectious disease and poverty by providing harm reduction strategies to clients, which are proven to reduce the prevalence of a number of infectious diseases including HIV and hepatitis C (CDC, 2019; Des Jarlais et al., 2005; Holtzman et al., 2009; Ruiz et al., 2019; WHO, 2004). As community-based havens, SSPs are also a conduit for accessible and culturally informed messaging about various topics including HIV prevention, family planning services and safer drug use practices (Szalavitz, 2021). For many who access SSPs services, staff at these organisations are often the first point of contact in times of crisis because clients frequently utilise available services and trust these organisations (Treloar et al., 2016).

With more than 80 million reported SARS-CoV-2 cases and 985,000 reported deaths in the United States since late 2019 (Dong et al., 2020), Coronavirus Disease 2019 (COVID-19) has caused significant economic and social life disruptions. Of the approximately 309,000 confirmed SARS-CoV-2 infections in Philadelphia, PA, 11,364 have been reported in the Kensington Philadelphia neighbourhood, the study location, and the all-time positivity rate in Kensington is 9.5%—one of the highest in Philadelphia (Dong et al., 2020; Philadelphia Department of Public Health, 2022). Kensington is also the epicentre of health-harming opioid use and accidental overdose in Philadelphia (Philadelphia Department of Public Health, 2021; Whelan, 2020). This onset of COVID-19 has fostered a socioecological context in which prioritisation of subsistent needs may supersede protection from COVID-19 (Rhodes, 2009). Health-harming substance use increases the risk of homelessness and housing insecurity (Fazel et al., 2008; Thompson et al., 2013), which can limit bathroom access (Philadelphia County Medical Society, 2020). Furthermore, people with substance use disorders (PWSUD) may have limited financial resources to buy personal protective equipment (Speer, 2016). Together, these factors exacerbate COVID-19 transmission and infection (CDC, 2021), and are associated with a higher rate of hospitalisation and death due to COVID-19 (Wang et al., 2021).

Given the vulnerabilities that PWSUD face, SSPs are an important site of focus when assessing how best to protect the lives of those at risk of COVID-19. But essential service providers, such as SSPs, have had to drastically modify operations to integrate COVID-19 mitigation strategies while continuing to provide basic services with a minimal pause in operations (Frost et al., 2021). An analysis of operational changes at 65 U.S. SPPs during March 2020 found that most programmes (84.6%) remained open as essential service providers while reducing hours (Bartholomew et al., 2020), indicating that SSPs staff across the United States had to quickly adjust to unprecedented changes without a pause in operations.

Preliminary evidence suggests that SSPs altered workflows to preserve and protect public health while continuing to address the needs of clients during COVID-19 (Bartholomew et al., 2020; Bond, 2020; Glick et al., 2020; Whelan & Newall, 2020). However, little is known about how COVID-19 mitigation strategies were implemented in SSPs and even less is known about how staff perceive and were impacted by these changes as they serve as the first point of contact for vulnerable clients who need services (CDC, 2019; WHO, 2004). To address this gap, we conducted a phenomenological qualitative study to understand the impact of and response to the SARS-CoV-2 outbreak from the perspective of staff employed at Prevention Point Philadelphia (PPP) in Kensington Philadelphia—one of the largest SSPs in North America, distributing nearly 6 million syringes in the fiscal year 2020–2021 (PPP Executive Director J. Benitez, personal communication, October 28, 2021). Approximately 50,000 people utilised PPP in 2020 to receive clothing and food, housing referrals, medical care including HIV and HCV services, medication for opioid use disorder treatment and case management services (PPP, 2020b). As a result, they were on the front lines of continued service provision amid COVID-19. Understanding how SSPs mobilised and responded to COVID-19 and how mitigation strategies affected the way staff provided services is essential for informing recommendations for future response efforts.

2 | MATERIALS AND METHODS

Sixteen in-depth semi-structured interviews with a purposeful sample of PPP staff across departments were conducted by our
This research (protocol number 27637). The Temple University Institutional Review Board approved due to scheduling complications. No participants withdrew or refused participation. Participants received a $25.00 e-gift card as an incentive. Interviewers had no prior relationships with populations that use substances. JP is a trained journalist, and AH is trained in psychology. Interviewers had no prior relationships with participants. Participants received a $25.00 e-gift card as an incentive. The Temple University Institutional Review Board approved this research (protocol number 27637).

2.1 Data collection

Demographics gathered included gender, race and ethnicity, age, educational attainment, job title, length in job and length of time working with PWSUD. Additionally, a four-item instrument asked participants to indicate how the COVID-19 pandemic impacted personal life with regard to work/school participation, economic situation, physical health and mental health from 0 “has not impacted at all” to 10 “has majorly impacted”. Interviews were conducted via the teleconferencing software Zoom, audio recorded and attended only by the interviewer and interviewee. Interviewers documented notes during data collection to assist with guided discussion. Interviews occurred from December 2020 to February 2021 and ranged in length from 29 to 44 min.

The interview guide drew from the RE-AIM Implementation Framework dimensions, including examining whether services were used (Reach), how effective changes to services were (Effectiveness), how well staff adapted or believed PPP adapted to changes (Adoption—setting and staff level), the implementation of those changes (Implementation) and current behaviour/attitudes about COVID-19 mitigation (Maintenance—individual and setting levels; Glasgow et al., 1999; RE-AIM, Improving Public Health Relevance and Population Health Impact, 2021a, 2021b). To operationalise this, guide topics included: general work history at PPP; knowledge about COVID-19; PPP’s organisational response to COVID-19; awareness of COVID-19 by PPP clients; barriers of communication for PPP clients; and strategies utilised to maintain operations during a crisis to inform future practice recommendations. Participants were invited to offer final thoughts at the end of the interview.

2.2 Analyses

Medians and interquartile ranges for continuous demographic survey variables with frequency and counts for categorical variables were calculated via SPSS Statistics for Macintosh, Version 25. Audio files were transcribed verbatim by a member of the research team. Transcripts were not returned to participants. Applied Thematic Analysis (Guest et al., 2012) with a phenomenological underpinning informed the extrapolation of meaningful patterns across the data to identify practice implications and broaden the transferability of findings. Transcripts were read independently in groups of four by the analytic team (PJAK, JP and AO) to generate emergent patterns and a codebook. The codebook was reviewed mid data collection, and it was determined that no new codes were identified beyond those identified in the first half of data collection. However, additional interviews were conducted to capture the breadth of code meaning. Meaning saturation was achieved by Interview 16, and the last quarter of interviews were redundant (Hennink et al., 2017; Saunders et al., 2018). Two coders (JP and AO) independently coded transcripts, assessed intercoder reliability and reached 80%. Discrepancies were decided through discussion and disagreements were resolved by PJAK. Coding was accomplished using Dedoose, version 9.0.17 (Sociocultural Research Consultants, LLC, 2021). Participants did not provide feedback on the results. The Consolidated Criteria for Reporting Qualitative Research (COREQ) was followed to report findings (see Appendix S1; Tong et al., 2007).

Analyses addressed the following research questions:

RQ1: How were services at PPP impacted by and modified in response to COVID-19?
RQ2: How did PPP staff receive communications about COVID-19 and associated mitigation strategies?
RQ3: How did COVID-19 and mitigation strategies impact PPP staff?
RQ4: What can organisations like PPP do to prepare for public health crises that present similar challenges posed by COVID-19?

3 RESULTS

Represented departments included: infectious disease and overdose prevention services, social services including housing services and the medication for opioid use disorder programme, community engagement, drop-in (i.e. waiting room services), family planning and clinical services. COVID-19 majorly impacted participants’ mental health (Mdn = 9.00, IQR = 7.00–10.00) and work/school participation...
elevated mental anguish during the pandemic (sub-theme: already limited resources were further strained). Table quotations by research question and theme. Percentages reflect those who responded to this question.  

Demographic characteristics of participants (TABLE 1) 

| Characteristic                                | Value | %  |
|----------------------------------------------|-------|----|
| Gender                                       |       |    |
| Female                                       | 11    | 68.8|
| Male                                         | 4     | 25.0|
| Non-binary                                   | 1     | 6.30|
| Race and ethnicity*                          |       |    |
| White                                        | 10    | 71.4|
| Black or African American                    | 2     | 14.3|
| Latinx                                       | 2     | 14.3|
| Educational attainment                       |       |    |
| High school or general education diploma equivalent | 2     | 12.5|
| Some college                                 | 2     | 12.5|
| College degree or more                       | 12    | 75.0|
| Age, Mdn (IQR)                               | 31.5  | 28–38|
| Length, in months, working at Prevention Point Philadelphia, Mdn (IQR) | 24.0 | 12–36|
| Length, in months, working with people with substance use disorder, Mdn (IQR) | 42.0 | 36–120|

Abbreviations: IQR, interquartile range; Mdn, median; N, number of staff.
*Two participants did not disclose this information; thus, number and percentages reflect those who responded to this question.

3.1 COVID-19 altered services provision

When it became clear that COVID-19 posed a serious threat to PPP operations, leadership assembled an inter-departmental working group to strategise a contingency plan that balanced safety and service provision:

We immediately broke out in work groups that focused on COVID. All staff at every level joined groups and pitched in and everybody came up with, you

Syringe exchange distribution was moved from the basement, which provided privacy and protection from the public, to operating out of the side of the building directly visible from Kensington Avenue, the main street where PPP is located, which heightened staff safety concerns. The Narcan distribution schedule was also disrupted because this service was provided as syringes were distributed or exchanged. Disruptions to the exchange programme negatively impacted clients that had established one-for-one routines consistent with their use patterns, as one staff shared concern: “They got used to having the amount of syringes and Narcan that they were getting before, and it’s not sustainable for us. So now people are really struggling with how they’re gonna get these resources.” [P2].

In accord with social distancing guidelines, capacity restrictions were placed on the building. The drop-in centre, described by one participant as “the heart of the organization” [P1], where between 40 and 50 clients would gather at a time, was forced to shutter. With the drop-in centre closed, it became more challenging to reach clients for service engagement. Participant 9 shared that “It’s just not as easy to catch people anymore” referring to the loss of the drop-in centre as an opportunity to engage clients. Additionally, most services were provided outdoors. This proved difficult during winter months because warming shelters are congregate settings that present added transmission risk. One participant reflected:

The working group was chiefly concerned with balancing emerging mitigation guidelines and the unknowns about COVID-19 transmissibility with the praxis of PPP to provide harm reduction services in an accessible manner:

In March [2020] I remember everyone in leadership just sat in a room and we were like ‘what does it mean to be a harm reductionist during this pandemic?’ ‘How do we reduce harm, and how do we reduce harm when there’s multiple things to reduce the harm of?’ [P8]

Operations like substance use disorder treatment, HIV testing and referral services were disrupted or reconfigured which left a resource void in some situations. The syringe exchange was also reduced from 5 to 3 days of operation a week. To account for this disruption, staff over-dispensed syringes to meet demand and to reduce the frequency that clients returned:

…we encouraged participants when they came to the syringe exchange to get 2 weeks’ worth of supplies to the best of their ability because we didn’t know what it was like from day to day, what was going to happen, whether we were going to have to really shut down, whether we were going to be able to get supplies, whether staff were going to have the PPE to be able to keep doing this. [P7]

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### TABLE 2 Themes and related quotations

**Theme 1: COVID-19 altered services provision**

“$\text{To immediately change our services where we were able to still get a high volume of works out, Narcan out. We immediately moved the syringe exchange to a safer location. Everything happened rapid fire. We immediately measured the shelter and moved folks and separated them.}$” — P3

“We ramped up wound care because people, they are less likely to go to a hospital. We have our own wound care nurses that are seeing people.” — P2

“The fact that COVID is still a means that it is harder for people to access housing.” — P8

“We made the decision about the density of our shelters and whether or not it made sense to continue 24/7 operations versus a 12- or 16-h model. We erred toward the idea that if we closed the shelters for some time every day that would allow more time to disinfect and disperse people. I’m not sure ultimately if that was the right decision. I do not know if we will have the data to understand whether that was right or wrong.” — P1

“The syringe exchange was in the basement. We cannot do that so having a syringe exchange in this sort of quasi-outdoor area has been probably the most successful transition because the other services I feel like have not adapted that much. It was just kind of like they were not happening … I think the syringe exchange was really the only thing where we really changed the way it was done and made it safer.” — P4

“The building was totally closed so the drop in wasn’t open anymore for people to hang out in which is a pretty big deal because there so many people that go there.” — P4

“It’s harder to make people feel safe because we do not have a drop-in center where we can control who is in there and who is not because everyone is outside.” — P9

“We still are operating kind of from the inside out. We were still offering clothes and food and case management and letting people use the phone but outside.” — P11

“Meals are all outside. Mail services have increased like wildly during COVID. We hand mail outside from a door so instead of people coming into the drop to pick up their mail we handed it out the back door.” — P13

“We started doing more work outside or in the doorways around the building.” — P5

“We still have limited capacity so in the cold winter months we can still only let so many people in. People are standing outside freezing because COVID is still a thing.” — P8

“We did rotating schedules, so a lot of people started working 3 days a week just to have less people in the building.” — P9

“We had A team and B team. A team worked Sunday, Monday, Tuesday, and team B worked Wednesday, Thursday, Friday. The idea was that you were just working with the same people to reduce potential contact.” — P15

“People come from all over to access the syringe exchange services. I think like some of the places that were more underground just do not have much resources because of maybe their suppliers or whatever. It brought a lot more people to the syringe exchange.” — P9

**Sub-Theme 1: Select service changes should be retained**

“I also think that the lessening of restrictions overall with MAT [Medication Assisted Treatment] is a good thing always.” — P10

“I hope that we collect less data … I see it as sometimes this massive barrier in terms of being able to disseminate the volume that people need to keep themselves alive and safe. It’s this precarious balance between right where the state and city want all of these questions answered. I have this big form and they are all these kind of barriers. We’ve been able to lower a lot of our barrier to distribute more supplies. I hope that sticks around.” — P7

“I like that we are rotating when it comes to staff. That’s something to adapt to and I kind of feel like [it’s] the future.” — P12

“I’m hopeful that we can continue to do our meal services after COVID-19 is over because the ZIP code is still very much the most impoverished ZIP code.” — P5

“We got the safety team during COVID-19 … They’re super supportive. They’re very loving and caring of our community, and it’s nice to just have that extra support. It would be cool if we could keep them.” — P2

**Theme 2: Unclear or absent COVID-19 response guidance which compromised mitigation**

“Our leaders have completely abandoned us to the business interests and we are going to die because of it.” — P1

“We’ve had like, no backup federally. At a state level there’s been at least some good support for programs. It sounds like not nearly enough because they [the state] need more from the federal government to be able to distribute.” — P7

“We got everybody wearing PPE. We established early, in the beginning with PPE shortage we established a tool, a set of protocols for how to disinfect PPE.” — P1

“In the beginning it was a lot of panic. I think that goes with like, you know, in the beginning, there was lack of just knowledge in general about COVID and the uncertainty with our government’s response and all of that.” — P8

“All those restrictions seem very like capitalist. How can we pretend like we care while still making sure that people are out spending money? Especially during the holiday. They’re putting all these restrictions on gatherings and on how close people can stand to each other, but they are still doing Christmas Village downtown, which is calling a whole bunch of people in one space. It just seems like whoever is in charge does not really care about the people.” — P2

**Sub-Theme 2: COVID-19 messaging was difficult to translate to practice**

“When the health department puts up posters saying ‘wash your hands’ and they shut down the bathroom and handwashing station, what the hell are people supposed to do?” — P1

“There’s like a lot of misinformation, or you know, conflicting information about the efficacy of face masks or how much PPE you need. So that’s kind of always changing.” — P9

“Some folks do not have the means to practice everything around COVID because they do not have the space to do their social distancing.” — P5

“When the people that you are hanging out with are your only seeing you, know, in the beginning, there was lack of just knowledge in general about COVID and the uncertainty with our government’s response and all of that.” — P8

**Sub-Theme 3: Learn-as-we-go**

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“When the people that you are hanging out with are your only protection in the world, you are not going to socially distance from them.” — P1

(Continues)
TABLE 2 (Continued)

| Statement                                                                                                                                  | Source |
|--------------------------------------------------------------------------------------------------------------------------------------------|--------|
| “In the beginning there was really limited resources like hand sanitizer and stuff like that. Trying to figure out how to get enough resources for people was interesting. We paid a lot of money for hand sanitizer from people that were selling it at crazy rates at that time.” | P9     |
| “There was no place to have showers because all there was like two places that would let people take showers. There was no place to go to use the bathroom. It was really hard.” | P2     |
| “Trying to allow for social distancing within the shelters there were no new beds opening up. There are people who like were wanting access to a shelter bed or had been making contact with outreach trying to get in who could not because there was no space.” | P11    |
| “People come to Prevention Point all the time just asking if they can start treatment (MOUD) or talk to a doctor about starting treatment or get information about it. Right now we are just like stretched so thin that we cannot really—I cannot really do that. That is like a huge challenge.” | P10    |
| “The drop-in is open inside now, but in a very limited capacity ... it’s getting colder. People want to be inside. We have a very like softly enforced like you can stay for 2 h and then cycle out so other people can come and get warm. It’s really difficult to tell somebody to leave.” | P11    |
| “At the shelters we stopped intakes and reduced our capacity ... We lost 20% of our beds because we did not have the room.” | P13    |
| “I do think that it [COVID-19] has put strain, but we have worked really hard to not have that impact our participants or like the care that we provide.” | P10    |
| “External mental and behavioral health referrals we do not have in house at this time, so that was really impacted because a lot of other places like closed down completely, or the capacity was like reduced significantly. So, folks were not, and like some still are not, able to attend behavioral or mental health.” | P15    |
| “During the early months of the pandemic most clinics in the city stopped taking people and just were doing only telehealth. We were one of the only clinics that was still operating in person. We saw a pretty steep increase in people wanting to start the [STEP] program.” | P10    |

TABLE 2 (Continued)

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Today’s the first code blue we’re having and we’re freaking out. We don’t know what to do. There’s not enough space for people and COVID restrictions have severely impacted how much warming shelter space is available. [P2]

Staff also worked on a rotating schedule to reduce exposure risks. While schedule adjustments were intended to reduce building occupancy, the adjustment had an unintended consequence of placing additional burden on staff who remained entirely in-person. A staff member from housing shared:

What’s really affected my work, especially in housing and shelter, is like so we’re at work. Like shelter case managers and shelter line staff. Everything is still moving, especially in regard to someone getting matched to a housing subsidy with a program. But like the supportive housing worker is completely remote so they need to get ahold of the participant while the person doesn’t have a phone. How is that gonna happen? It’s gonna happen through us.” [P13]
3.1.1 Select service changes should be retained

Some staff reported that the relaxing of pre-pandemic barriers to access certain services, such as frequent urine drug screens for participants in medication for opioid use disorder treatment, improved service provision for existing clients. This was also seen in other areas. One participant noted the significance of what once was a lengthy bureaucratic process becoming more navigable:

But, in some ways, everything being shut down has made my job easier because a lot of the hoops we've had to jump through for clients in getting their ID documents and stuff like that, and trainings and stuff like that has gone to virtual. I don't have to be out in the field going into government buildings, trying to get them together. [P15]

Telehealth was also widely adopted to continue service provision and reduce in-person exposure. This allowed providers to meet clients where they were, which ultimately expanded access to healthcare “I think like telehealth is here to stay and I think it is great, I think it really, yeah, I've said it before, but it just increases people's ability to access care …” [P15].

3.2 Unclear or absent COVID-19 response guidance compromised mitigation

Decision-making processes to incorporate mitigation strategies into practice were complicated by convoluted, incorrect and contradictory local, state and federal COVID-19 guidelines. And while PPP leadership assumed responsibility for operational continuity, some mitigation practices could only be implemented with sufficient resources such as capital to purchase PPE. Despite best efforts, staff shared a collective sense of abandonment by the government during a time of unprecedented uncertainty, and reported having to look towards internal resources to continue operations:

We had a little at the very beginning, but eventually all three levels of government collectively decided that they were not interested in providing the material support that would have been necessary to fight the pandemic. They gave up! And we've had to fend for ourselves. [P1]

Ultimately, ambiguous guidelines, insufficient response efforts and, in some cases, inaction entirely from the government undercut the agency of PPP to make informed, safe and practical decisions regarding service provision. One staff provided a cogent example of how inaction from localities left questions unanswered around winter shelter access:

3.2.1 COVID-19 messaging was difficult to translate to practice

Staff sourced information about COVID-19 predominantly from official institutions (e.g. CDC) or health departments that produced guidance specific to keeping homeless populations safe. Word of mouth was often shared as a means by which staff, and clients especially, learned about COVID-19: “I would say a lot of it was word of mouth. A lot of our folks don't have access to a phone …” [P15].

While information on mitigation and protocols was generally available to staff, messaging was not always clear, accessible or actionable. A staff member shared, “All the information I have access to [is] … confusingly fractured in some ways just across the country and across the board.” [P11]. The constant “do this, not that” messaging, although partially reflective of evolving epidemiologic evidence, was challenging for staff to relay to clients, who often lead chaotic lives:

In the beginning the rules would change all the time. So, we'd be like, ‘Come over here.' And then tomorrow, ‘Oh, you have to be over here'. Then the next day we're in a different spot so people were very upset. People thrive on consistency, especially when your life is chaos. [P2]

Staff found COVID-19 messaging at odds with overdose prevention and safer use messaging: “What we tell people who use drugs is 'don't use alone. Stay close to people.' Then COVID comes around and we're like 'Keep six feet apart from each other. Don't get too close.' Being proximate to people is actually lifesaving. COVID throws a whole wrench in that.” [P8] Staff also noted that government messaging was occasionally inconsistent with the actions of the government, citing a city-promoted holiday shop despite "safer at home" health department guidelines. This disparity between messaging and action undercut staff credibility to convey the importance of mitigation strategies to clients.

3.2.2 Learn-as-we-go

Mixed communication necessitated a learn-as-we-go approach to protocol refinement to navigate the deluge of messages from government and PPP leadership. Senior-level staff shared a willingness to listen to feedback and most "boots on the ground" staff
believed feedback was received as one participant shared: “Do I feel like I had a say? Yeah, I did. I’ve expressed concerns and you know they’ve respected those concerns.” [P16]. Yet some staff did not always find this reflected in how the evolving protocol was communicated: “I feel like line staff very often felt like they just were told that these things were happening. I think having more input from the ground up too because it felt like much of a top-down approach” [P7].

3.3 | Staff and clients experienced elevated mental anguish during the pandemic

The drastic yet warranted adjustments to workflows and the economic and social disruptions caused by COVID-19 further heightened the psychological toll staff experienced working at PPP. Moreover, the pandemic occurred during two other public health crises—rising overdose deaths and instances of violence. This worsened what was already a mentally taxing work environment. One participant shared:

It’s been like a really hard year at Prevention Point like um aside from COVID like we’ve had like an unprecedented amount of like deaths in part, like participants we’ve lost so many participants and also staff members this year … It just seems like everyone’s super burnt out. [P13]

Staff equated this psychological burden to trauma: “A lot of us are feeling vicarious trauma or just the trauma that we witnessed in the past few months. I can’t even imagine how many frontline workers are going to leave this pandemic with PTSD.” [P8]. Another participant spoke with a sense of grief, sharing that they could not bear to face the quantity of loss as they worked through the pandemic:

…I just don’t even want to look at numbers. I don’t want to know what’s going on. Just I, you know, I just want to know what’s going to make it better. What can I do to help the community, to make this better? I got the vaccine. I’m just like what else can we do? Tell me. [P12]

Some mitigation strategies are in opposition to the community-oriented nature of Prevention Point. For example, physical capacity limits and social distancing were especially contrary to the spirit of Prevention Point. Communicating the need for these mitigation strategies amplified the psychological burden experienced by staff and clients. One participant offered that “A lot of people come here to see their friends, to be with community, and to come inside and sit and drink coffee. We took that away—the social aspect.” [P2] Moreover, staff characterised capacity limits and social distancing as dehumanising to clients who regularly experience ostracisation by society:

It feels hard to center that [mitigation] when there’s so many other things happening in people’s lives and when someone like runs up to you with no mask on and they want to tell you that, I don’t know, they just got robbed or something. In that moment it feels really hard to be like, pause, tell me your tragic story after you put your mask on appropriately. That just doesn’t feel natural. [P8]

3.3.1 | Already limited resources were further strained

COVID-19 increased the subsistent needs of clients and this further strained staff who felt the pull of organisational constraints. As one participant shared “I think that would be the biggest barrier is this like lack of resources to point them towards.” (P13). Importantly, this is not necessarily different from the operational baseline, but COVID-19 added another layer of complexity in providing services to an already under-resourced population.

Because PPP was unable to provide all services that clients needed, staff leveraged relationships with external service providers to link clients with housing, food and some medical care. But COVID-19 disrupted this chain as external partners paused operations while PPP did not:

One of the hardest things is that there are all of these hubs of access to services and so many of them have had to limit their capacity. That leaves a lot of gaps in places that people were used to being able to like go inside, used to being able to get a meal. Everything has changed and that’s really frustrating. [P16]

These disruptions were significant to PPP clients who faced additional and sudden navigational barriers to service access. Staff were highly aware of this elevated burden on clients and tried to fill gaps in external service provisions to minimise the impact on clients’ lives. Staff felt that these constraints exacerbated their stress levels:

A lot of professional health workers were not coming in to perform regular services, so we had that issue. And there was just a lot of stress on staff and myself to try to accommodate for the lack. [P14]

4 | DISCUSSION

This research details how a large SSP adapted operations to protect staff and clients from COVID-19 while continuing to provide harm reduction services, and how sudden yet necessary adjustments impacted staff. Like other SSPs throughout the United States, the
COVID-19 pandemic dramatically altered operations at PPP and service changes were made to balance client needs with mitigation strategies (Bartholomew et al., 2020). Our findings indicated adaptability, resilience and resourcefulness among PPP staff, which aligns with qualitative studies of other U.S.-based SSPs' COVID-19 response efforts conducted during the pandemic's onset (Frost et al., 2021; Wenger et al., 2021). This is similar to the historical origins of SSPs in the United States, which were established out of the urgent need for communities to mobilise against infectious diseases, specifically HIV/AIDS (Szalavitz, 2021). Nonetheless, this period of intense crisis further burdened staff who were already navigating service provision in a low-resourced, high-demand setting.

The COVID-19 pandemic further strained resources, exposed and exacerbated weakness in the healthcare infrastructure, which resulted in a perceived sense of abandonment by government agencies. It is of note that PPP is one of the largest SSPs in North America, yet staff expressed dismay regarding the limited resources available to them to work with, similar to the experiences of healthcare providers in low- to middle-income countries (Moitra et al., 2021). Adding to frustrations was pressure from local governments to navigate ordinances without sufficient capital to do so. Resource depletion was felt most acutely in the day-to-day operations and amplified staff feelings of insufficient resources to meet employment demands that were commonly felt prior to the pandemic. This raises the question of how staff at lower-resourced SSPs navigated and were impacted by COVID-19 challenges. Further amplifying staff stress was that SSPs rely significantly on one-on-one and other “warm handoff” strategies to provide harm reduction services to mitigate the impact of health-harming substance use (Pennsylvania Department of Drug and Alcohol Programs, 2021), but necessary COVID-19 mitigation strategies complicated this ability.

As official messaging about COVID-19 mitigation strategies evolved, uncertainty among staff increased regarding how best to communicate about and act on protocol adjustments. Message strategies evolve during times of crisis (Coombs & Holladay, 2010), but failure to follow established principles of crisis communication can be devastating and further exacerbate crises (Zaremba, 2010). Indeed, PPP staff noted great difficulty translating contradictory messaging into practice, retelling the troubling experience of interpreting unclear public health guidelines while simultaneously acting as messengers themselves to clients. Effective crisis and emergency risk communication techniques were inadequately followed, particularly at the U.S. federal level, during COVID-19 (Overton et al., 2021). The absence of a clear communicator, disjointed timing of messaging and public displays of discrepancies within levels of government violated crisis communication principles (CDC, 2018), which ultimately clouded staff's decision-making processes and may have amplified the cognitive and psychological burden conveyed by this sample.

Our data detail response efforts from the perspective of staff through the worst of the U.S. epidemic (i.e. winter 2020 through 2021; Dong et al., 2020), allowing for staff to reflect on how changes to services impacted staff and clients over time. During this time, staff internalised shortcomings in their ability to provide services to clients, which was personally and professionally difficult. Many of the staff indicated that COVID-19 exacerbated already high levels of stress caused by working in a chaotic environment and serving clients with significant needs. Several noted that some mitigation strategies, such as social distancing, despite being a form of harm reduction, was contrary to institutional values of PPP that are rooted in a come-as-you-are approach (PPP, 2020a). This may partially account for the mental anguish reported by PPP staff during interviews and in the COVID-19 impact measure, which is consistent with the mental health impact of COVID-19 on frontline workers (Moitra et al., 2021; Prasad et al., 2021). The complex reality of never being able to escape the pandemic caused mental and emotional exhaustion that was elevated by day-to-day stressors, particularly because COVID-19 created an environment in which staff had no “repite” or outlet for processing stress. This suggests that expanded mental health services could be beneficial. Retrospective investigations that explore how staff at SSPs did or did not feel mental health needs were addressed during COVID-19 are warranted, as findings could inform future mental health crisis response plans.

4.1 | Implications

Recommendations for future response efforts are timely as the COVID-19 pandemic and opioid epidemic claim an unprecedented number of lives and SSPs are expanding in scope and numbers (Ahmad et al., 2021; De Jarlais et al., 2020; Dong et al., 2020). Staff shared that retaining established partnerships, expanding mental health resources, adopting modified work schedules and adjustments to workflows (i.e. outside service provision) should be lasting changes. Shifting exchange services from the basement to operating outside quickened access to syringes, and reduced the movement of sharps indoors. Furthermore, telehealth services were helpful in reaching patients for medical appointments, which tracks with the growing consensus that telehealth services should become a long-standing tool in the delivery of health services for PWSUD (Hughto et al., 2021). These adjustments expanded available resources to clients, lightened staff burden and could be scaled up or down depending on the needs of clients and staff. The North America Syringe Exchange Network (2021) website could be mobilised as a web-based rapid-response hub accessible to SSP staff to exchange ideas and collectivise resources to respond to emergent threats to the wellness of staff and clients of SSPs. Ultimately, these changes are an opportunity to permanently remove some barriers to healthcare services for PWSUD. This is aligned with Aronowitz et al.’s (2021) qualitative investigation of harm reductionists serving PWSUD in Philadelphia, underscoring the urgency of this moment for lasting change.

4.2 | Limitations

Our findings are not necessarily transferrable to rural, smaller or non-U.S.-based SSPs, which may operate under different organisational
dynamics and were subject to local COVID-19 regulations. While our team maintained confidentiality, it is possible that staff opted to decline participation out of anonymity concerns. Staff with particularly critical opinions or traumatic experiences may not be wholly represented. Furthermore, responses were subject to greater than typical variation during data collection due to the rapidly evolving COVID-19 pandemic and response effort. For example, staff became eligible to receive a COVID-19 vaccine during data collection which may have affected responses.

5 | CONCLUSION

Examining COVID-19 response efforts through the lens of staff of a large SSP informs how other organisations that serve PWSUD can best communicate about an outbreak, develop standing plans and procedures should another outbreak occur, better support the well-being of frontline staff and ensure the safety of both clients and staff while still offering essential services to those most in need.

AUTHOR CONTRIBUTIONS

Patrick J.A. Kelly contributed to data curation, formal analysis, investigation, methodology, project administration, validation, visualisation, writing—original draft preparation and writing—review & editing. Jenine Pilla contributed to data curation, formal analysis, investigation, software and writing—review & editing. AnnaMarie Otor contributed to formal analysis, software and writing—review & editing. Ariel Hoadley contributed to investigation, validation and writing—review & editing. Sarah Bauerle Bass contributed to conceptualisation, data curation, funding acquisition, investigation, methodology, project administration, resources, supervision, validation and writing—review & editing.

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CONFLICT OF INTEREST

The authors have no conflict of interest to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Additional supporting information may be found in the online version of the article at the publisher’s website.

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