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International Journal of Drug Policy 90 (2021) 103076

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Editors' Choice

Essential work, precarious labour: The need for safer and equitable harm reduction work in the era of COVID-19

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ARTICLE INFO

Keywords:
Precarious employment
Harm reduction
Occupational safety
COVID-19
Opioid overdose

ABSTRACT

This commentary highlights labour concerns and inequities within the harm reduction sector that hinder programs' ability to respond to converging public health emergencies (the overdose crisis and COVID-19), and potentially contribute to spread of the novel coronavirus. Many harm reduction programs continue to support people who use illicit drugs (PWUD) during the pandemic, yet PWUD working in harm reduction programs (sometimes termed 'peers') experience precarious labour conditions characterized by low wages, minimal employee benefits (such as paid sick leave) and high employment insecurity. Along with precarious labour conditions, PWUD face heightened vulnerabilities to COVID-19 and yet have been largely overlooked in global response to the pandemic. Operating under conditions of economic and legal precarity, harm reduction programs' reliance on precarious labour (e.g. on-call, temporary and unpaid work) renders some services vulnerable to staffing shortages and service disruptions during the pandemic, while also heightening the risk of virus transmission among workers, service users and their communities. We call for immediate policy and programmatic actions to strengthen working conditions within these settings with a priority on enhancing protections and supports for workers in peer roles.

Introduction

The coronavirus (COVID-19) pandemic has rapidly altered the way we live and work, and in doing so has exposed and intensified long-standing health and social inequalities. The health and economic fall-out of COVID-19 has been uneven, with job losses and COVID-19 cases disproportionately concentrated among those working in low-wage service sector jobs (International Labour Organization, 2020). Workers in essential frontline roles have been particularly vulnerable to COVID-19 given their close and frequent contact with potentially exposed populations (Zhang, 2020). The occupational hazards of frontline work appear to be greatest for those in precarious jobs characterized by little security and control over work, and minimal employment benefits such as paid sick leave and health benefits (Stanford, 2020). Racialized and migrant women in particular— who are over-represented in precarious frontline jobs such as nursing aides and personal support workers—are contracting and dying from COVID-19 at significantly higher rates than other healthcare workers (Gould & Wilson, 2020; Guttman et al., 2020; National Nurses United, 2020).

Harm reduction programs are another sector that has been profoundly impacted by COVID-19 (Harm Reduction International, 2020a), yet the labour experiences and vulnerabilities of workers in these programs has so far been afforded little attention. Here we use the term harm reduction to refer to non-coercive policies, programs and practices that seek to reduce health, social and legal harms of drug use, drug laws and policies (Harm Reduction International, 2020b). Harm reduction programs include, but are not limited to, supervised consumption services, drug checking, overdose prevention and response programs, safer supply initiatives, non-abstinence-based housing, and education on safer drug use (Harm Reduction International, 2020b). Especially in fixed-location services such as supervised consumption sites, workers in harm reduction programs work in close proximity to others and perform 'high contact' work (e.g. relationship building, non-violent de-escalation for people in crisis, injection assistance, and resuscitation), that may increase their risk of infectious diseases such as COVID-19. The risk of exposure is likely greatest during overdose response, when workers may perform aerosol-generating medical procedures such as rescue breathing, and often have limited time to

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https://doi.org/10.1016/j.drugpo.2020.103076

augment personal protective equipment (PPE) (Elton-Marshall et al., 2020).

In particular, harm reduction workers who themselves use drugs (sometimes termed 'peer' workers) face distinct social, economic and health risks related to their work that have so far received little consideration within broader debates about essential work and the pandemic (Dechman, 2015; Greer, Bungay, Pauly, & Buxton, 2020; Kennedy et al., 2019; Kolla & Strike, 2019). While the extent and scope of peer labour in harm reduction varies considerably across jurisdictions and programs, PWUD increasingly perform frontline roles within these programs, including direct service provision (e.g. overdose response, distribution of naloxone, syringes and crack kits, HCV screening), education (e.g. HIV and overdose prevention, naloxone training) and other forms of psycho-social support (e.g. health system navigation, peer support groups) (Kennedy et al., 2019; Marshall, Dechman, Minichiello, Alcock, & Harris, 2015). The need for the labour expertise of PWUD within harm reduction programs has only increased during the pandemic, as lockdowns and physical distancing measures have disrupted service delivery in many regions and created new barriers to accessing services (Bartholomew, Nakamura, Metsch & Tookes, 2020; Collins, Ndoye, Arene-Morely, & Marshall, 2020; Schlosser & Harris, 2020; Whitfield, Reed, Webster, & Hope, 2020). As has been the case during previous and concurrent epidemics (e.g. HIV, opioid overdoses), the social networks, expertise and labour of PWUD have been instrumental to adapting services to these new challenges and filling gaps within formal public health systems (Faulkner-Gurstein, 2017; Kennedy et al., 2019; Kolla & Strike, 2020; Marshall et al., 2015). Informally and formally, PWUD have mobilized during the pandemic to distribute supplies within their networks, perform outreach work, and disseminate rapidly changing information about COVID-19 and public health measures (Harm Reduction International, 2020a). The risks of COVID-19 exposure to PWUD in these roles is likely heightened considering they perform high contact care work in community settings where physical distancing is difficult (e.g. shelter and housing-based support) and PPE is limited (Schlosser & Harris, 2020). Despite the essential and high risk nature of this work, PWUD in peer roles have not been widely recognized and treated as essential workers, often lacking the supports and employment protections available to other frontline providers (Greer et al., 2020).

In this commentary, we aim to highlight how precarious and inequitable working conditions within harm reduction programs are likely hindering service delivery during the pandemic, while also threatening to contribute to spread of COVID-19 within communities already disproportionately impacted by intersecting structural harms of criminalization, poverty and discrimination (Carter & MacPherson, 2013; Room & Reuter, 2012). We draw primarily on evidence and examples from the Canadian context, where the labour of PWUD has become increasingly central to harm reduction programming. We call for immediate actions at policy and programmatic levels to establish safer and more equitable working conditions within the harm reduction sector, including macro level changes (e.g. drug decriminalization and welfare reform) and programmatic efforts to enhance employment security and supports for PWUD in peer roles.

Working conditions and precarious labour practices in the harm reduction sector

Previous research highlights the rewarding and empowering aspects of harm reduction work, including its important role in building and sustaining networks of mutual support among PWUD (Bardwell, Kerr, Boyd, & McNeil, 2018; Faulkner-Gurstein, 2017; Pauly et al., 2021; Wagner et al., 2014). However, activists and researchers are raising alarms about safety and working conditions within programs (Dechman, 2015; Greer et al., 2020; Kennedy et al., 2019; Kolla & Strike, 2019; Shephard, 2013). Several studies find significant burnout and psychological distress among frontline workers responding to converging crises of poverty, housing, opioid-related overdoses, and now COVID-19 (Bardwell, Fleming, Collins, Boyd, & McNeil, 2019; Kennedy et al., 2019; Pike, Tillson, Webster, & Staton, 2019). Routine exposure to traumatic events (e.g. overdose, violence) and loss of community members to overdose exacts a high emotional toll on workers (Boyd et al., 2018; Kennedy et al., 2019). Chronic understaffing, inadequate supports, unpredictable schedules, and lack of control over working conditions have been flagged as structural issues exacerbating the already stressful nature of frontline work (Greer et al., 2020; Rigoni, 2020).

There is evidence that working conditions are particularly poor for PWUD in 'peer' roles (Greer et al., 2020). Peer programs facilitate PWUD involvement in harm reduction programming, typically offering flexible and stipend-based employment for PWUD in outreach, education and other support roles (Marshall et al., 2015). While these positions provide important forms of low-barrier employment, PWUD in peer roles have few job protections or benefits (e.g. vacation and paid sick leave), and face significant barriers to transitioning into higher paid and more secure employment (Greer et al., 2020; Shearer, Fleming, Fowler, Boyd, & McNeil, 2019). Previous research highlights how PWUD working in harm reduction programs can be viewed and treated differently than employees not defined by their drug use, including being limited to 'tokenistic' participation and subject to increased surveillance due to negative stereotypes of PWUD as untrustworthy and/or unstable (Broadhead, Heckathorn, Grund, Stern, & Anthrony, 1995; Bryant, Saxton, Madden, Bath, & Robinson, 2008; Rance & Treloar, 2015). Of particular concern, PWUD performing similar work to other support workers are sometimes unpaid or compensated through non-monetary incentives such as gift cards (Bardwell et al., 2018;. Greer et al., 2018; Greer, Buxton, & Group, 2017; Marshall et al., 2015).

Precarious, inequitable and hazardous working conditions are not inherent to harm reduction programs, but rather the result of unfavourable economic and socio-legal environments. The lack of stable and sufficient funding for harm reduction programming is a key contributor to this precarity (Penn et al., 2011; Rigoni, 2020). The majority of harm reduction programs globally are initiated and implemented by civil society organizations (CSOs): non-governmental and not-for-profit groups that range from small self-organizing collectives of PWUD to highly professionalized and bureaucratic non-governmental organizations (Harm Reduction International, 2020a). While these CSOs may receive funding from state or international donors to deliver services, these funding arrangements are often short-term, project-based and insufficient to cover all operational costs. A 2018 Harm Reduction International report found that, from 2007 to 2017, harm reduction funding in low and middle income countries fell 87% short of targets set by the United Nations HIV/AIDS programs (UNAIDS) (Cook & Davies, 2018). Even in higher-resourced settings, harm reduction programs for PWUD are subject to high levels of political scrutiny and funding precarity that render them vulnerable to abrupt defunding and closure (Kerr, Mitra, Kennedy, & McNeil, 2017; Russel, Imtiaz, Ali, Elton-Marshall, & Rehm, 2020; Strike & Watson, 2019). Funding instability and shortfalls also present challenges in equitably allocating and compensating work within harm reduction programs. Community organizations routinely report that the purchaser-provider agreements that typically fund 'peer' positions systematically under-value the costs of recruiting, supporting and maintaining PWUD workers who are taking on expanded roles and responsibilities within these programs (Brown et al., 2019; Penn et al., 2011; Rigoni, 2020).

Drug prohibition and its enforcement further fuels the precarity of harm reduction programs and their workforce. The criminalization of drug use and state violence towards PWUD—including mass incarceration and heightened surveillance of poor and racialized communities—systematically harms the lives and livelihoods of PWUD, contributing to high rates of poverty, housing instability and unemployment (Room & Reuter, 2012; van Olphen, Eliason, Freudenberg, & Barnes, 2009). Laws criminalizing possession of drugs and paraphernalia also

force harm reduction programs to operate underground or in legal 'grey zones' (Davis, Derek, & Samuels, 2019; Harm Reduction International, 2020a), with many unsanctioned supervised consumption and syringe distribution programs run by unpaid volunteers at risk of criminalization for their work (Davidson, Lopez, & Kral, 2018; Lancaster, Seear, & Treloar, 2015; Marshall et al., 2015). The criminalized and/or legally precarious status of these programs precludes them from receiving the funding and resources required to deliver these programs, shifting the burden and costs of this work largely onto PWUD and their communities.

Operating under these conditions of funding and legal precarity, CSOs are pushed toward precarious employment models that favour part-time, non-unionized, casual, low-wage and unpaid labour (Baines, Cunningham, & Sheilds, 2017; Michaud, Maynard, Dodd, & Burke, 2016). PWUD may be more compelled to accept precarious roles due to the considerable social and structural barriers limiting their opportunities within broader labour markets, including criminalization, housing insecurity, and stigma toward drug use (Boyd et al., 2018; DeBeck et al., 2007; Richardson, Wood, & Kerr, 2013). The systemic exclusion of PWUD from formal employment through criminal records checks and drug testing further limits their labour market opportunities (Bourgois, 2002; Boyd et al., 2018; Greer et al., 2018). Casual, stipend-based roles in harm reduction may also be one of the only low-threshold jobs that allows PWUD to generate income without losing eligibility for welfare benefits and other support (Greer et al., 2020). Together, these structural arrangements render PWUD vulnerable to economic insecurity and labour precarity, limiting their ability to refuse hazardous, low-wage and insecure work.

Implications for delivering care during a pandemic

Within the context of these structural constraints, harm reduction programs' reliance on unpaid, low-wage and precarious labour is likely hindering their ability to deliver services during the pandemic. The COVID-19 pandemic has produced another layer of responsibilities (e.g. sanitation and social distancing measures) on a workforce already struggling to contend with limited resources and worsening housing and overdose crises (Grinstein-Weiss, Gupta, Chun, Lee, & Despard, 2020; Slavova, Rock, Bush, Quesinberry, & Walsh, 2020). We can expect that precarious labour arrangements will contribute to staffing shortages as workers weigh the considerable risks of COVID-19 exposure and other pre-existing occupational hazards against the minimal job benefits and protections (Greer et al., 2020; Kennedy et al., 2019). Workers who remain in their roles, particularly PWUD in precarious peer roles, may be compelled to take on additional shifts or perform unpaid work to fill staffing shortages, further contributing to work-related stressors and burnout.

Poor working conditions and precarious labour arrangements may also be understood as structural risk factors for the spread of COVID-19. The lack of adequate physical distancing infrastructure and personal protective equipment are obvious risks facing under-resourced programs (Karamouzian, Johnson, & Kerr, 2020; Nguyen et al., 2020). However, employment practices also play a role. As evidenced by outbreaks in long-term care facilities, the lack of paid leave and employment protections can compel frontline staff to continue working in hazardous conditions or when they are sick, driving transmission among workers, their families, service users and the broader community (McGilton et al., 2020; Stanford, 2020). Part-time and casual workers are more likely to hold multiple jobs, or pick-up shifts at different buildings within an organization, helping the virus to spread across sites. The potential for significant outbreaks is amplified in housing and shelter-based programs where crowded and poor living conditions impede physical distancing and hygiene practices (Maru, Maru, Bass, & Masci, 2020). The morbidity and mortality from these outbreaks may be considerable within communities of PWUD, who are more likely to have compromised immunity and pre-existing conditions (e.g. chronic obstructive respiratory disease, viral hepatitis) that increase risk of severe illness from COVID-19 (Wang, Kaelber, Xu, & Volkow, 2020).

What can be done to improve working conditions?

Establishing safer and equitable working conditions necessitates first recognizing work performed in harm reduction programs—including that performed by PWUD—as essential and high-impact labour to be compensated and protected. It is both impractical and inequitable to expect PWUD to engage in hazardous frontline work for free or minimal compensation, particularly when they are at heightened risk of developing severe complications from the virus (Marsden et al., 2020; Mukherjee & El-Bassel, 2020). Wide-reaching reforms to social security measures will likely be necessary to truly mitigate harms of precarious employment and COVID-19, such as implementation of basic income regimes or expansion of employment insurance systems to include precarious workers (Stahl & MacEachen, 2020; Stanford, 2020). Drug decriminalization is also urgently required to disrupt the role of criminalization and incarceration in PWUD's pathways to economic insecurity and precarious labour (Boyd et al., 2018a). Further, the abolishment of laws and policies that criminalize possession of drugs and harm reduction tools (e.g. syringes, naloxone) would help bring more harm reduction work into the fold of standard employment that is subject to regulations regarding pay and working conditions.

At a more proximal level, program funders and operators can take immediate steps by limiting precarious labour practices and strengthening protections for those in nonstandard work arrangements. While it is important to maintain a continuum of employment options in the harm reduction sector (Marshall et al., 2015; Penn et al., 2011), much more can be done to strengthen protections for peer workers in part-time, on-call and temporary positions. Of critical importance to the COVID-19 pandemic, PWUD in peer roles should have some job protections, benefits and paid sick leave so they may take time off if they become sick or burnt out. Increasing staffing levels will be important, given the likely need for workers to quarantine due to COVID-19 exposure. Human resource services and psychosocial supports are also urgently needed for workers that face considerable stressors related to their work (Kennedy et al., 2019; Kolla & Strike, 2019), and are likely experiencing heightened challenges during the pandemic with housing, childcare, substance use, and access to services (Marsden et al., 2020).

Increased and stable funding for operating organizations will be required to adapt programs to COVID-related measures and equip workers and service users with adequate personal protective equipment and disinfectant materials (Chayama, Ng, & McNeil, 2020; Heimer, McNeil, & Vlahov, 2020); this includes masks, gowns, eye protection and gloves, as well as training to support safe and effective use of tools during aerosol-generating medical procedures (Elton-Marshall et al., 2020). Program budgets should enable programs to renovate or relocate services to facilitate physical distancing, as well as adapt service models to meet people closer to home through mobile, outreach, and housing-based approaches (Elton-Marshall et al., 2020; Kolla & Strike, 2020; MacKinnon, Socias, & Bardwell, 2020). Safer supply initiatives that distribute regulated opioids and other drugs will be important complements to these models, supporting PWUD to self-isolate and limit in-person contact (Back, Robinson, Sutherland, & Brar, 2020; Tyndall, 2020). To reduce the risk of workers contracting and spreading COVID-19, programs operating multiple sites should consider staffing models that allow workers to fulfil hours at a single site. Importantly, PWUD must be involved at all stages of developing and implementing safety plans, including through leadership roles, to ensure they meet the needs of these workers (Rigoni, 2020). Research on the evolving long-term impact of COVID-19 on the working conditions of PWUD could offer increased adaptive solutions alongside these measures.

Ultimately, many of these changes may not be achieved unless PWUD have a strong voice in negotiation with employers and funding bodies. Unionization efforts are underway in some cities, but face significant im-

pediments under the restraints of drug prohibition and because stipend-based peer workers are often not classified as employees (Smart, 2020). Strengthening worker power and creating conditions conducive for collective organizing will be key to improving working conditions and enabling precariously-employed PWUD to exercise their labour rights (Lewchuk & Dassinger, 2016).

Conclusion

Governments and public health systems have largely failed to foster safe and equitable working conditions for harm reduction workers at the frontlines of converging public health emergencies. PWUD continue to do essential and high-impact work throughout the pandemic, including frontline work that places them at higher risk of COVID-19 (e.g. overdose response), yet often do so with fewer resources and less compensation than other frontline workers. We must ensure that PWUD can continue to do this essential work by providing them with sufficient supports, employment protections, paid sick leave, and personal protective equipment for them to perform their jobs safely. On a macro level, the abolishment of laws, policies and practices that criminalize, punish and otherwise negatively impact PWUD are needed in order to minimize their labour precarity and strengthen their economic security. Increased and stable investment in health, social and harm reduction services is further critical to fostering safe and secure working conditions. Improving working conditions in these ways will help keep our communities safe during COVID-19, while also enabling positive changes to service delivery that will have long-lasting benefits beyond the present pandemic.

Role of the funding source

The funding sources for this study had no role in the study design, collection, analysis and interpretation of data, the writing of the article, or the decision to submit it for publication.

Declarations of Interest

None.

Acknowledgements

This study was supported by the US National Institutes of Health (R01DA44181), the Canadian Institutes for Health Research, and the Vancouver Foundation (UNR17-0299). Michelle Olding is supported by a Vanier Canada Graduate Scholarship and Izaak Walton Killam Memorial Doctoral Fellowship. Jade Boyd is supported by the Michael Smith Foundation for Health Research (MSFHR)/St Paul's Foundation/BCCSU Scholar Award. Ryan McNeil is supported by a CIHR New Investigator Award and a MSFHR Scholar Award.

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