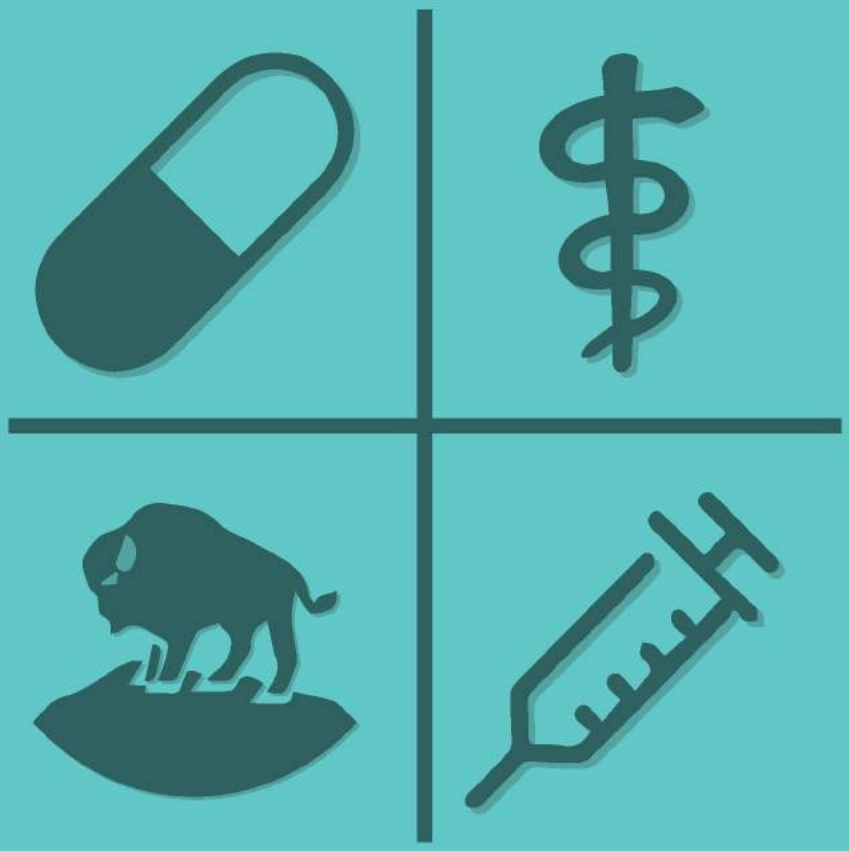

Harm Reduction Saves Lives

Provincial Lobby Day Backgrounder - 2019

Student Advocacy Committee advocacy.umanitoba@gmail.com

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Table of Contents:

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1) Executive Summary

Manitoba has witnessed recent outbreaks of sexually transmitted and bloodborne infections due to an increase in substance use. This problem requires concerted action by the provincial government to address the upstream factors and resultant consequences related to substance use. At the population health level, harm reduction strategies have been shown to be very effective. The body of evidence suggests that harm reduction strategies offer a promising path forward, connecting substance users with resources that help prevent negative health outcomes.

Harm reduction is defined as:

> "a set of strategies and tactics that encourages people to reduce harm to themselves and their communities, through the sharing of relevant information, facts and practical material tools that will allow them to make informed and educated decisions. It recognizes the competency of their efforts to protect themselves, their loved ones and their communities (1)."

Harm reduction saves lives. The consensus among community organizations, frontline workers, physicians, health care providers and medical students is that Manitoba needs to act to reverse current negative health trends and better serve all Manitobans. We ask the Manitoba Government to:

1) Develop a centralized harm reduction supply network and fund grassroots community harm reduction efforts;
2) Conduct a feasibility study to assess the need for supervised consumption sites in Manitoba that prioritizes consultations with marginalized communities disproportionately affected by substance use;
3) Develop a Manitoba harm reduction strategy focused on minimizing the harms of substance use that explicitly commits the government of Manitoba to non-partisan action to ensure continuity between governments;
4) Create a province wide campaign aimed to destigmatize substance use and promote harm reduction strategies.

The aim of this document is to highlight the gaps that exist in the current harm reduction framework in Manitoba and examine what can be done to improve supports for those in need.

2) What is Harm Reduction?

I. National and International Approach

Population health is a complex product of factors extending far beyond access to health services. Aspects that contribute to individual and population health include: access to healthcare, the physical environment, education, finances, stigma, and cultural perceptions of communities. Addressing social determinants of health through preventative medicine and improved access to healthcare can prevent or temper most disease states. Canada's Federal/Provincial/Territorial Ministers of Health agree that a greater emphasis needs to be placed on promoting health and on preventing or delaying chronic diseases, disabilities, and injuries (2).

Internationally, health promotion and prevention are recognized as essential pieces of a high-quality healthcare system. While we have the knowledge to prevent or delay many health problems, Canada's current health system is mainly focused on diagnosis and treatment of disease (2). To create a healthier population, and to sustain our publicly funded health system, a better balance between prevention and treatment must be achieved.

II. Theory

The harm reduction model can be adopted by governing bodies, service providers, health care professionals, and individuals themselves. Harm reduction is pragmatic - it recognizes that everyone engages in some form of risky activity, and that taking steps to reduce risks within these activities is best practice. Harm reduction and health promotion are one in the same. Examples of harm reduction include the use of seat belts to reduce the effects of vehicular collisions (3); using sunscreen to reduce damage from sun exposure (4); and banning smoking in enclosed public spaces to reduce the tobacco related harms from second hand smoke (5). Lastly, providing safe disposal of used needles into needle drop boxes, which benefits communities as a whole by decreasing the number of discarded needles in public spaces (1).

The harm reduction model is non-judgemental and practical. It acknowledges that non-medical use of psychoactive or mood-altering substances is a near-universal human cultural phenomenon (6). Promoting safer methods of risky behaviour provides people with the education and tools needed to make healthier choices and reduce potential harm (7). People who use substances remain entitled to their basic human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, freedom from arbitrary criminalization, and freedom from judgemental or degrading treatment (8). Harm reduction does not take a punitive approach towards people who use drugs and instead promotes responses to drug use that respect and protect fundamental human rights.

III. Fundamental Pillars

The tailoring of harm reduction interventions to address drug use in a community must take into account specific factors which may render people who use drugs particularly vulnerable, such as age, gender, and incarceration. (8) Appropriate interventions can be developed by adhering to basic pillars of harm reduction.

The first pillar of harm reduction is the commitment to “meet patients where they are at”. This principle means respecting the patient’s decision to seek care and avoiding passing judgment on risky behaviours. This approach provides a safe space of engagement for individuals, their partners, and their communities (9).

A second pillar of harm reduction is a focus on facilitative interventions grounded in the needs of the individual. This approach recognizes that people have more success when they incrementally modify their risky behaviours instead of attempting to completely eliminate the behaviour as a first step. Harm reduction practitioners acknowledge the significance of any positive change individuals make in their lives.

The final pillar of harm reduction is a commitment to patient-centred care. Patient-centred care promotes accessible, flexible, culturally responsive, and non-judgmental services. The goal of the healthcare team should be to educate the patient about their rights and to allow them to make their own informed health decisions.

There have been many different harm reduction programs developed through the use of these basic principles. Strategies that have been implemented with success include education, mobile outreach, low threshold access to health/social services, proactive enforcement policies, needle exchange with distribution of harm reduction supplies, methadone maintenance treatment, supervised consumption sites (SCS), supervised inhalation sites for crack cocaine use, heroin prescription, and street drug testing with early warning systems (2; 9).

IV. Conclusion

Harm reduction is a term that encompasses a broad range of programs. It is focused on meeting individuals “where they are at”, promotes incremental change, and uses a patient-centred model of care. Harm reduction theory recognizes that significant change comes from small individual adjustments made across a population. Most importantly, promoting a more equal balance between diagnostic/reactive treatment and preventative measures would significantly benefit Manitoba’s healthcare system.

3) Economic Benefits of Harm Reduction

I. Substance Use and Infection Trends

A multi-year analysis spanning from 2007-2014 conducted by the Canadian Institute for Substance Use Research surveyed the economic costs associated with substance use in Canada. When all the costs were considered, including health care, lost productivity, criminal justice, and other direct costs, the study determined that in 2014 substance use cost the country $38.4 billion dollars, breaking down to $1,100 per Canadian (10). Healthcare related costs alone due to substance use amounted to $11.1 billion or $345 per person in Canada (10). This research supports prioritizing policy level cost effective strategies that maximize individual and population level health outcomes. Harm reduction strategies are practical solutions to public health issues and are capable of addressing this need.

Over the past year in Manitoba, injection drug use has emerged as a significant public concern. Subsequently, sexually transmitted and bloodborne infections (STBBI) have become a greater threat to public health (11). People who inject drugs (PWID) face unique health challenges. Most notably, the reuse of contaminated needles and other injection equipment put PWID at an increased risk of acquiring bloodborne infections. A WRHA report from 2018 outlines the association between methamphetamine prevalence and an increasing incidence of HBV, HCV, HIV, and syphilis in Manitoba (12).

The rising prevalence of STBBIs, and the negative economic impact of acute and chronic management of these infections must be taken into account when determining an appropriate course of action. Rather than solely covering the cost of post-infection management, harm reduction interventions present the most cost-effective, proactive solutions in the face of rising transmissible infection rates by preventing the spread of STBBIs.

II. Economic Case Study: HIV in Manitoba

HIV illustrates how transmission rates and treatment costs of STBBIs combine to produce significant fiscal burden for the healthcare system. While it is understood that needle sharing is not the sole cause of new HIV infections, it is a major driver of increased transmission. In Manitoba in 2016, the incidence of HIV was 9.1 per 100,000 or 116 new infections (13, 14). Health care expenditures associated with the lifetime management of chronic HIV are approximately 800-900% greater than those for HIV negative individuals (15). The estimated lifetime management cost of HIV is $250,000 per person (16). The 116 new cases of HIV diagnosed within 2016 can be expected to cost the Manitoba healthcare system $29 million, a monetary sum sufficient to fund the full-time occupancy of one hospital bed for 94 years (17). In comparison, UNAIDS estimates the average cost of needle supply programs fall within US$23-71 per person per year (18). After conversion to Canadian currency, the estimated $29 million required to care for 116 people with new HIV diagnoses (the incidence of 2016), could cover clean injection equipment for 305,263 people for one year.

Proactive management of HIV transmission through harm reduction strategies such as prophylactic antiretroviral therapy and needle exchange programs have been shown to effectively reduce viral transmission. Research conducted in Vancouver from 2006-2013 determined that harm reduction services such as needle distribution and prophylactic

antiretroviral therapy were responsible for preventing 3,204 people from becoming HIV positive (19). At a cost of $250, 000 per person for life-long HIV care, preventing 3,204 people from contracting HIV would save $801 million in healthcare expenditures (16). When implemented in Australia, needle exchange programs decreased the incidence of HIV by up to 74% in a ten-year period which reflects a savings of $1.4-1.55 for every one dollar invested in the program(18). Given the low cost of needle supply programs and high-quality evidence related to their efficacy, NSPs are one of the "most cost-effective public health interventions ever funded" (18).

In addition to the cost-savings of HIV prevention, the incidence and cost of treating other bloodborne infections such as hepatitis B (HBV), hepatitis C (HCV), and syphilis must also be considered. Between 2002-2011, 384 new cases of HCV - a chronic bloodborne infection - were reported in Manitoba (20). Life-long treatment of chronic HCV costs an estimated $64,494 per person (21). Current estimates for costs regarding treatment of HBV and syphilis could not be obtained, however rates of both HBV and syphilis are increasing as a direct consequence of injection drug use (22). Notably, in Manitoba, the incidence of syphilis increased 400% in 2017 from 2013 and this dramatic trend is expected to continue (23).

4) Harm Reduction Strategies in Manitoba

I. Patient Services

To date, Manitoba does not have a clearly organized and dedicated approach to harm reduction. The recently published VIRGO report recognizes that current services and supports offered by the province are unable to meet the growing demand, suggesting the system is being "stretched too thin" (24). The VIRGO report states that the 2016/2017 allocation of 5.1% of the provincial healthcare budget ($506.3 million) to substance use disorders, addictions, and mental health falls short of the 7.2% Canadian average. Manitoba has the second highest prevalence of substance use disorders amongst Canadian provinces and therefore should be allocating more than other provinces. This is echoed in the VIRGO report, which states that increasing the funding for substance use disorders, addictions, and mental health to 7.2% (the national average) of the healthcare care budget is not sufficient for the need of the province (24).

There are currently only a handful of harm reduction services available in Winnipeg, with even fewer being offered throughout the rest of the province. While both the Winnipeg Regional Health Authority, and Manitoba's Chief Provincial Public Health Officer have published position statements affirming benefits of harm reduction, none of the regional health authorities in Manitoba have a coordinated harm reduction strategy (25). The WRHA operates a few harm reduction programs, such as providing the funding for clean needles, as well as the Healthy Sexuality & Harm Reduction program, which, in partnership with Street Connections, offers mobile distribution of safe sex supplies, STI testing, and nursing care amongst other services (26, 27). While these programs are a step in the right direction, they are focused on specific health challenges and there is no overarching provincial strategy to direct and connect them.

Many of the harm reduction services currently available have been developed independently by community organizations. Notable harm reduction service providers in

Winnipeg include the Manitoba Harm Reduction Network (MHRN), Sunshine House, and Nine Circles Community Health Centre. Nine Circles provides healthcare, harm reduction materials such as condoms, safer drug use kits, and access to naloxone kits (28). The MHRN is an independent organization that partners with regional networks to ensure provincial scope and responsiveness to individual community needs (29). These cross-province partnerships include health authority representation, social and community service organizations, and community members. Additionally, the MHRN hosts nine peer advisory councils, which are made up of those with lived experience in their region to inform their work. Finally, the MHRN offers educational services for institutions, health care providers, frontline works, and the general public.

II. Provincial Funding

In 2017-2018 Manitoba's health budget was 6.68 billion dollars, of which $126,000 was allocated to the WRHA for harm reduction supplies. This figure has not increased since 2014 (30). Currently, only 0.00002% of the provincial health budget goes to substance use related harm reduction supplies (31).

While harm reduction funding has been unchanged, WRHA expenditure on harm reduction supplies has been increasing yearly, reaching $430,000 in 2017/2018 (32). Over the past three years the number of needles distributed has more than tripled to 2 million and data suggests this number will continue to increase (24).The discrepancy between provincial funding and WRHA need is unsustainable, and has only been possible by re-allocating from other programs within the WRHA (32).

5) Where Does Manitoba Stand

A comprehensive discussion and evaluation of harm reduction strategies implemented by other Canadian Provinces can be found in the appendix. Table 1 shows which provinces have adopted specific harm reduction strategies. It should be noted that information regarding harm reduction strategies in the Territories was not found and therefore was excluded from Table 1.

Table 1: Harm Reduction Strategies Across Canada

	SCS or similar program	Mandate/ Guideline for Harm Reduction	Province Wide Campaign/ Comprehensive Public Information
Manitoba	No	No	No
Saskatchewan	No*	No	No
Ontario	Yes	Yes	Yes
Alberta	Yes	No	No
British Columbia	Yes	Yes	Yes
Quebec	Yes	Yes	Yes
New Brunswick	No	No	No
Newfoundland	No	No	No
Nova Scotia	No*	Yes	Yes
P.E.I	No	No	Yes

*awaiting final approval

Table 1 indicates that the Manitoba harm reduction framework lacks key features seen in other provinces. Saskatchewan's demographic and increasing rates of infectious disease is very similar to Manitoba and can be used to compare harm reduction strategies. For several years Saskatchewan has had a provincially run central needle distribution program that receives $562,000 per year. Although they have not increased the funding to their program since 2013/2014, there is increased engagement with the program and pressure to increase funding (33). In 2010 there was an effort in Saskatchewan to curb their growing rates of HIV. 18.5 million needles were distributed between 2011 and 2015 via a new provincial supply system (34). As of 2018, this program will be expanded to include funding for inhalation supplies (35).

This kind of provincial distribution program closely resembles the model that was suggested within the VIRGO report (24). The report states that Manitoba's healthcare system should be guided by harm reduction principles, including a centralized needle distribution and naloxone provision program (24). Since 2013 there has been a 1200% (15 vs 207 visits per month) surge in meth related emergency room visits (36). This drastic increase has resulted in the current meth crisis narrative and is an ideal time to focus on bolstering funding for harm reduction programs (38, 39).

I. Intersection of Substance Use and Communicable Diseases

Evidence based harm reduction initiatives are inexpensive, practical, safe, and have a positive impact on individual and community health (40). The Platt et al. Cochrane Review meta-analysis found that combined needle and syringe programs (NSP's) and opioid substitution therapy (OST) programs are associated with a 74% reduction in HCV acquisition risk (41). OST has also been found to reduce HIV acquisition by 54% on average among people who inject drugs. Secondly, needle exchange programs have been shown to be both cost-effective and cost-saving. NSP, OST, and antiretroviral therapy (ART) are cost-effective in the short term, and cost-saving in the long term (37, 38, 39). Thirdly, take home naloxone kits are effective in reducing overdose deaths (42).

There is an established relationship between substance use and the spread of infections like HIV, HCV, and HBV. People who inject drugs are 59 times more likely to get HIV than people who do not inject drugs. (43). Among people who use IV drugs, 11% have HIV and 68% will contract or have had HCV (44, 45). The high rates of IV drug use in Saskatchewan have resulted in a concentration of HIV in people who use or have used injection drugs and in 2017, 67% of people newly diagnosed with HIV have used IV drugs. (46) As demonstrated by Insite, the supervised consumption site in Vancouver, improving access to clean needles can help reduce transmission of bloodborne infections (47). As a result, Insite is estimated to prevent an average of 35 cases of HIV per year. (48) The lack of response by the Saskatchewan government to increase funding for harm reduction supplies has been a factor in the worsening HIV rates. Manitoba unfortunately faces similar problems and the prairie provinces in general have the highest rates of HIV, HCV, and other STIs like chlamydia and gonorrhea.

In 2018, the WRHA distributed 2 million needles at a cost of $430,000. This figure has increased 30-40% annually since 2013 in terms of demand. While demand for needles has increased dramatically, harm reduction supply funding has not. Funding for harm reduction supplies have not changed since 2014-15, remaining at $126,000. To make up this budget shortfall, funds were diverted from other public health programs such as upstream population health interventions (32). It is estimated that Manitoba will require 4 million needles in 2019 to meet demand, which will increase the strain on our current system (49). If Manitoba does not invest in meaningful harm reduction strategies now, the effects of substance use on our community will continue to worsen.

6) What Can the Manitoba Government do?

To create healthier populations and to sustain our publicly funded health system, a better balance between prevention and treatment must be achieved. We ask the Manitoba Government to:

1) Develop a centralized harm reduction supply network and fund grassroots community harm reduction efforts;
2) Conduct a feasibility study to assess the need for supervised consumption sites in Manitoba that prioritizes consultations with marginalized communities disproportionately affected by substance use;
3) Develop a Manitoba harm reduction strategy focused on minimizing the harms of substance use that explicitly commits the government of Manitoba to non-partisan action to ensure continuity between governments;
4) Create a province wide campaign aimed to destigmatize substance use and promote harm reduction strategies.

7) Why Should the Manitoba Government Adopt These Asks?

I. Develop a centralized harm reduction supply network and fund grassroots community harm reduction efforts.

There are many ways in which the Manitoban government can take tangible steps to promote harm reduction and reduce the negative health outcomes of substance use across the province. For instance, expanding the Rapid Access to Addictions Medicine (RAAM) clinics hours of service, increasing the number of safe needle drop boxes throughout the province, ensuring adequate distribution of clean needles and other safer drug supplies, and promoting the training and use of naloxone kits are all strategies that will save lives and reduce rates of bloodborne infections such as HIV, HCV, syphilis and endocarditis. Failing to meet the need for these essential services is directly contributing to increased rates of STBBIs in Manitoba. Currently, there is little to no data on harm reduction requirements in Manitoba - epidemiological data collection and population health surveillance are under resourced research areas in Manitoba. However, according to data from the WRHA, in 2018, 2 million needles were distributed in Winnipeg, while the WRHA only received funding for 740,000. This created a funding gap of $300,000. In order to meet the demand for clean needles, funding had to be diverted away from other harm reduction services; services needed by Manitobans. Insufficient data not only leads to supply issues but also leads to inefficient buying. Most provinces in Canada have established a harm reduction supply distribution network that tracks and anticipates the demand for harm reduction supplies and uses bulk buying power to maximize cost efficiency for the needed supplies. In addition, this network can help local distribution sites design and fund health and social services for people accessing the supplies (50). Manitoba is one of the few provinces without one of these supply networks.

There are several models that could be helpful for Manitoba including Ontario and British Columbia's Harm Reduction Distribution Programs (51, 52). The Ontario Harm Reduction Distribution Program (OHRDP) is a not-for-profit, provincially funded organization that aims to improve access to harm reduction supplies. The OHRDP accomplishes its goal by providing supplies to needle exchange sites operated by the Ontario equivalent of regional health authorities at no cost. The OHRDP does not offer patients harm reduction supplies directly but supports centres that do. This model has demonstrated effectiveness at preventing needle sharing (52). The BC government has developed a "Best Practices" document highlighting the important aspects of harm reduction distribution programs, including policies and procedures, assessment and monitoring, and supply purchasing and distribution (51). This document could help the Manitoba government establish its own harm reduction supply distribution program.

The current approach to harm reduction in Manitoba is largely disorganized. The WRHA is currently a leading distributor of harm reduction supplies in the province, while community organizations lead the way in offering harm reduction programs that community members feel safe accessing. Additional resources need to be given to these networks so that they can expand their services. These networks have expressed interest in providing services such as naloxone training for families, organizing community clean ups, increased peer engagement, advocacy and educational opportunities, crisis intervention, and peer-to-peer counselling. These organizations have long standing, trusting relationships with their communities, and providing them with the opportunities to expand their programming is an effective way to increase access to harm reduction services. The recent Safer Consumption Spaces Working Group Needs Assessment document has demonstrated there is great interest in harm reduction programs amongst those with lived experience, including supervised consumption services and better access to harm reduction supplies.

II. Conduct a feasibility study to assess the need for supervised consumption sites in Manitoba that prioritizes consultations with marginalized communities disproportionately affected by substance use

The evidence demonstrating the effectiveness of supervised consumption sites (SCS) continues to accumulate. Across Canada, several provinces have opened multiple SCS and are seeing the net benefits of these sites. These benefits include reduced incidences of HIV and HCV among people who inject drugs (PWID's), decreased overdose deaths, and increased participation in addiction support services for traditionally hard to reach populations (53, 54, 55). Several myths exist around SCS such as; "they promote and will increase drug use", "they will bring more drug activity to the area", "they will increase crime". All of these claims have been disproven. There have been studies that have demonstrated no increase in crime, drug-trafficking, or drug-related activity in the area surrounding an SCS (56, 57). In direct contrast to the myth that SCS promote and increase drug use, studies have shown they actually reduce injection drug use by up to 23%, as well as frequency of other drug habits such as smoking crack (58). By effectively preventing the harms associated with substance use, SCS create cost savings for general society. There have been several studies that have examined the cost-effectiveness of Vancouver's first SCS, Insite. These studies have consistently demonstrated that Insite is cost-effective, by preventing 35 cases of HIV per year and 3 overdose deaths, leading to $6 million in net societal cost savings after accounting for the cost of the SCS (49). This study did not look at the cases of syphilis, endocarditis, and HCV that are also prevented, which means the savings are likely much higher.

The drug use patterns in Winnipeg are not the same as Vancouver's downtown East Side, where Insite is located. Insite's location is unique because there is a large concentration of PWID in a small area, which likely plays a factor in Insite's effectiveness. This does not mean that PWID in Winnipeg will not benefit from a SCS. Cities such as Edmonton and Toronto both have more dispersed drug use patterns, similar to Winnipeg. These cities elected to create multiple SCS throughout the city to meet the needs of the PWID's in their city. Both of these cities conducted thorough feasibility studies to determine the need for SCS. Edmonton invested $750,000 in a consultation and feasibility study called the "Access to Medically Supervised Injection Services Edmonton" (AMSISE) (59). Toronto, in partnership with Ottawa, created the TOSCA report (60). Both of these are studies that consulted with community members and conducted research to establish the SCS model that was right for each city.

The provincial government has an opportunity to capitalize on the path carved by similar cities such as Edmonton and establish a SCS feasibility study in Manitoba. One of the few benefits of being last in harm reduction supports is that much of the research has already been completed, which will likely reduce costs associated with a feasibility study. In addition, the *Safer Consumption Spaces: Winnipeg Consultation and Needs Assessment*, has already begun the process. This study demonstrated that 81% of PWID's are willing to use a SCS**.**

The Provincial government is asked to undertake a feasibility study to assess the need for a SCS here in Manitoba. **This assessment should include, at minimum, an assessment of local drug-related harms, existing services, willingness to use a supervised consumption sites among local people who inject drugs and support from key stakeholders.** Harm reduction practices need to be put in practice in ways that are culturally, demographically, and gender appropriate.

Our consultations highlighted the lack of information that is currently available on substance use in Manitoba. In order to develop new and effective harm reduction services for those facing substance use disorders, crucial information must be gathered from a diverse range of communities. Indigenous peoples, those with lived experience, those belonging to the LGBTQ+ community, and those experiencing homelessness are just some of the communities who have been left out of the conversation around harm reduction in Manitoba. It is especially important to be mindful of the intergenerational impacts of colonization such as trauma, poverty and substance use. Collaboration with Indigenous communities, traditional healers, and Elders should be an essential part of the consultation process to ensure services are respectful of Indigenous cultural knowledge and practices. Services must be provided in a way that does not inadvertently perpetuate systemic racism and discrimination.

There is evidence to show that harm reduction promotion not only benefits individuals but is also beneficial to the community. Entire communities benefit through reduced crime, increased safety, and greater equity for marginalized members of society. The improved health and functioning of individuals and the net impact on harm in the community are notable indicators of the successes of harm reduction (61).

Although critics of the SCS model claim that SCS foster drug use, the evidence shows that the number of people using drugs intravenously is not increased by opening a SCS (55). SCSs are evidence-based interventions that can provide significant community benefit. When placed within a broad continuum of harm reduction services they reduce morbidity, mortality and public disorder.

Firstly, regular use of SCS has been associated with a reduction in syringe reuse and drug injection in public places. Secondly, regular SCS use has also been associated with increased access to health education on safer injection practices (62) and fostered the use of sterile injection materials and disposal of used materials (63; 64. Thirdly, SCS use was associated with an increase in referral to treatment centres for substance use, initiation of

withdrawal management programs (62), and initiation of methadone therapy (65; 66; 67; 65; 68; 69). Lastly, quantitative research has found that SCS influence PWID's access to care "by building more open and trusting relationships with staff, facilitating engagement in safer injection education and improving the management of injection-related infections" (70).

III. Develop a Manitoba harm reduction strategy focused on minimizing the harms of substance use that explicitly commits the government of Manitoba to non-partisan action to ensure continuity between governments

The Canadian Harm Reduction Policy Project (CHARPP) report created by the Canadian Institute of Health Research did a comprehensive analysis of harm reduction policies in all the provinces. The report found that Manitoba has no clear definition of harm reduction across government documents, nor an overt commitment to harm reduction initiatives. (71) The lack of clear policy regarding harm reduction has led to a stagnation in community harm reduction supports and puts Manitoba at least eight years behind most other provinces. Interestingly, the same report found that Ontario has an equally poor harm reduction policy. However, their harm reduction supports are much greater than Manitoba's, having several SCS's and a harm reduction supply distribution network. The CHARPP report suggested that the effective delivery of harm reduction services, despite poor government policy, could be attributed to one document; the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability. This document is unique because it established a requirement that stated: The board of health shall collaborate with health care providers and other relevant partners to ensure access to, or provide based on local assessment, harm reduction programs in accordance with Substance Use Prevention and Harm Reduction Guideline, 2018 (72). The CHARRP report indicated that the strong language used in this document ensured there was a commitment to harm reduction initiatives, despite poor government direction and policy.

As outlined throughout this document, Manitoba is failing in the delivery of adequate harm reduction services. Part of this failure can be attributed to the lack of clear government policy over the last ten years. Creating a government document, similar to the Ontario Public Health Standards, with language that states a strong commitment to harm reduction, will help Manitoba move forward in serving the population better. A provincial harm reduction framework that sets clear targets and mandates access to harm reduction supports would ensure that no Manitoban is left behind when it comes to services for substance use disorders. Harm reduction approaches are evidence supported and should be available to all patients who need them. A strong and clear commitment to a harm reduction framework by the government would begin to address the lack of available services for Manitoban communities outside of Winnipeg and send a clear message to community organizations about the long-term goals of the provincial government.

As part of the fall 2018 cabinet shuffle, the Manitoba Minister of Justice was given the additional responsibilities of directing and managing the delivery of addictions care in the province. Language was added to Minister Cullen's mandate charging the ministry to: "modernize and improve the delivery of addictions and mental health services in Manitoba and reverse patterns of substance abuse and criminal involvement, with an emphasis on strengthening services for crystal meth addictions".(73) In every other province in Canada the Minister of Health has the primary responsibility for developing a governmental approach to

mental health and addictions. British Columbia has taken further steps, creating a stand-alone Ministry of Mental Health and Addictions. Manitoba now stands alone in empowering it's Minister of Justice to address the broader societal problems of addiction.

Through conversation, the office of Manitoba Justice indicated a willingness to collaborate with Manitoba Health. While this is an encouraging sign, having a provincial harm reduction strategy in place would provide clarity for community organizations about the role of Manitoba Justice in addictions care going forwards.

IV. Create a province wide campaign aimed to destigmatize substance use and promote harm reduction strategies

The public's perception of substance use is a major issue that needs to be addressed. While the medical community and many community organizations agree that substance use is a medical issue, many continue to stereotype substance users as immoral, weak-willed, or as having a character defect requiring punishment or incarceration(74). This perception is dangerous because stigmatizing any disease keeps those afflicted from getting help and prevents those surrounding the individual from acknowledging the existence of a problem. This attitude, that substance use is a moral failure rather than a medical concern, is diametrically opposed to harm reduction principles. Moralization of substance use encourages societal apathy at best, and the deliberate harming of substance users at worst. Combatting this attitude through educational programs builds support for harm reduction, as well as compassion for substance users.

Manitoba does not currently have a province wide campaign or comprehensive public information program about substance use. A province wide campaign should be aimed at promoting harm reduction strategies, dispelling myths, and providing information to Manitobans where there are gaps in knowledge. Specifics such as supervised consumption sites, discarded needles in public spaces, and criminal activity should all be discussed. Public concerns can be mitigated with an educational service tasked to correct misconceptions. A "Public education campaign should be based on an interdisciplinary view of substance use and emphasized treatment effectiveness, as well as include descriptions of the role of brain physiology and function (e.g., pain systems, anxiety circuits, mood systems, and behavioural and psychosocial aspects)" (74).

8) Conclusion

In 2018, Manitoba witnessed a dramatic increase in injection drug use and subsequently saw an increase in transmission of sexually transmitted and bloodborne infections (11). As the use of injectable drugs in the province continues to increase, the need to address and implement harm reduction strategies as a matter of public health is becoming increasingly important. Manitoba has the second highest prevalence of substance use disorders amongst Canadian provinces and without intervention this number will only increase (24).

Harm reduction focuses on meeting people where they are at, helps to destigmatize substance use, and allows for the formation of better relationships between people who use drugs and the healthcare system. Strategies such as a centralized supply program and safer

consumption sites provide an opportunity to help those who are the most marginalized and allow the province to provide better care for all Manitobans.

Moving forward, it is imperative to address the subject of substance use within the province using evidence-based harm reduction solutions. We are asking provincial government to help with: increased funding to grassroots harm reduction organizations, conduct a feasibility study assessing the need for a supervised consumption site, develop a provincial harm reduction strategy, and to create a provincial campaign to destigmatize substance use. All of these initiatives cannot happen in isolation and it is essential the province continues to consult with stakeholders including Indigenous communities, people with lived experience, and populations living in rural and remote communities.

Manitoba must not turn its back on people who have been subjected to racism, violence, poverty, housing insecurities, and other traumatic events. It is only through research, collaboration, and understanding that we can make Manitoba a better community for all.

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10) Appendix

I. Community Voices

The Student Advocacy Committee began this project believing we needed to advocate for the establishment of supervised consumption sites (SCS) in Winnipeg. As we consulted community organizations throughout the city it became apparent that opening a SCS would not be an attainable goal until the basic harm reduction needs of communities were met. The following is a highlight of the themes we gathered in our consultation with community members and organizations, as well as a list of the organizations consulted.

All organizations, except for the Winnipeg Police Service (WPS), were ideologically in favour of SCS and all endorsed a neighbourhood approach which is an approach involving several smaller SCS throughout the city that would serve the unique needs of each community. All organizations emphasized that it would be essential to consult people who use drugs on what they need and whether they would find a SCS helpful. When asked if they thought a feasibility study is needed in our city, the response was a unanimous yes. The community organizations' support for SCS was based on evidence that showed that the more harm reduction services available, the greater the scope of people that are helped and the better the health outcomes.

All organizations that deal with distribution of harm reduction supplies in some capacity indicated difficulties and worries about obtaining enough supplies, such as needles. Many of these organizations indicated Manitoba needs a Harm Reduction Supply Distribution Network; this type of network provides homogenous buying and distribution power and leads to better data collection regarding which harm reduction supplies are needed. Manitoba is one of the few provinces that does not have a Harm Reduction Supply Distribution Network. It is believed that this distribution network would highlight the funding gap for harm reduction services by showing what is needed and what can actually be provided at this time. It was hypothesized that the lack of central distribution and data collection is one of the primary reasons Manitoba is seven to eight years behind on harm reduction support.

Other notable concerns that came up in our conversations included the lack of harm reduction services outside of Winnipeg, and the need for drug checking services across the province. As is the case with most of our health care services, harm reduction services are mostly Winnipeg centred. This is leading to a disparity of harm reduction supports for those in need in our rural communities. Drug checking services would help prevent people from taking incorrectly labelled drugs and potentially compromising their safety. A recent survey demonstrated that the majority of cocaine in the city contains meth. In addition, the drug carfentanil, a drug 100 times stronger than fentanyl, has been found for sale on Winnipeg streets. If someone purchases carfentanil but believes it is fentanyl, their chance of overdose increases dramatically. Drug checking services were proposed as a way of thwarting these dangers, as well as providing an additional bridge to care.

Ka Ni Kanichihk expressed the importance of having Indigenous leaders at the centre of discussions regarding harm reduction services for our communities. Indigenous leaders and Elders should be viewed as experts on Indigenous issues and need to be consulted accordingly. It is also important to acknowledge that the Indigenous community is a diverse community and one Indigenous voice does not speak for all. Ka Ni Kanichihk also expressed

concerns with the popular framing of meth use in Manitoba as a 'crisis'. Although they feel that meth use has had a tangible effect on their program and its outcomes, they feel the term 'crisis' is sensationalist and stigmatizes meth users.

In our conversation with the WPS, they expressed serious safety concerns regarding meth and are concerned about the safety of all people accessing a SCS if meth is being used in the facility. We asked other frontline organizations who see people under the influence of meth in their facilities on a daily basis what their experience has been regarding safety and they stated that the vast majority of people under the influence are not dangerous.

After extensive consultation with community organizations we believe we have a better understanding of some of the needs of our community. It is clear that there is an apparent need and demand for a Manitoba Harm Reduction Supply Distribution Network as well as increased funding for harm reduction supplies and strategies as a starting point for change.

We would like to sincerely thank the following organizations for honouring us with their time:

Ka Ni Kanichihk
Main Street Project
Manitoba Harm Reduction Network (MHRN)
MHRN
Selkirk Peer Advisory Council
Winnipeg Police Force
Winnipeg Regional Health Authority (WRHA)
9 Circles

We would also like to acknowledge the lack of Indigenous centred organizations on our consultation list. Winnipeg is located on the traditional territory of the Anishinaabeg, Cree, Oji-Cree, Dakota, and Dene Peoples, and on the homeland of the Métis Nation. It is extremely important that Indigenous voices are heard and included in discussions regarding the health of our communities but unfortunately, due to scheduling issues and inability to reach certain organizations, we were unable to consult with a diversity of Indigenous voices prior to the making of this document. Indigenous communities are disproportionately affected by the experiences that lead to substance use such as poverty, homelessness, and violence and frequently do not have access to education, safe drug supplies, peer support and counselling, among other harm reduction services.

II. Intersections with Mental Health

There is a clear intersection between mental health and substance use disorder (SUD). Studies have shown that 53% of people diagnosed with a SUD have a concurrent mental health disorder(75). The treatment of a co-occurring mental health disorder with a substance use disorder (SUD) is very difficult; these individuals have higher rates of relapse and poorer treatment outcomes (76). The 2016 Interim Report and Recommendations on the Opioid Crisis in Canada by the Standing Committee on Health proposed a recommendation endorsing the use of an integration treatment approach of SUD's and mental health disorders. Recommendation 29 stated "That the Government of Canada work with the provinces and

territories to ensure treatment for active drug users is available to address the underlying mental health issues that may contribute to or exacerbate drug addiction (77).

In Manitoba, the need for integration of mental health services and treatment of substance use disorder has been recognized; the province invested $477,208 in co-occurring addiction and mental health in 2016-2017 (24). Premier Brian Pallister outlined the need to improve coordination of mental health and addiction services in his 2016 throne speech and yet, despite this recognition and investment, the VIRGO report still identified a gap in the services for co-occurring substance use abuse (SUA) and mental health (MH). The report noted barriers called "slippage", which is when a patient is unable to receive concurrent treatment for their SUA/MH due to policy barriers. For example, patients can be denied entrance into a SUA treatment program because of the medications they are taking for their mental illness. The report deemed these types of policy barriers as "…not acceptable under the tenets of treatment and recovery support for co-occurring disorder" (24).The VIRGO report further highlights that the functional separation of SUA and MH services has resulted in patients not getting the treatment and care they need, instead cycling through various health care providers (24). The recommendations in the VIRGO report regarding the integration of SUA and MH highlights the need for increased access to treatment for both SUA and MH, the need for the development of integrated centralized intake and the development of community-based programs.

III. Other Provinces

British Columbia:

British Columbia (BC) is a national leader in the delivery and infrastructure of harm reduction services, being the home of the first supervised consumption site in North America, Insite, the only province to offer injection opioid agonist therapy (iOAT), and developing a system of crack pipe vending machines. The CHARPP report found that B.C. has a consistent definition of harm reduction shared by all levels and agencies of government and has institutionalized the harm reduction approach through clear, coordinated programs and policies, as laid out in the guiding document BC HRSS Policy and Guidelines. The province has developed a harm reduction service website hub, Towardtheheart, that is utilized by several other provinces, including Manitoba. B.C. has annual data collection and surveillance regarding all harm reduction services, and actively consults with people who use drugs to ensure the services are meeting the needs of those accessing help. The well-defined, well-coordinated approach to harm reduction across the province is likely contributing to the reduction in overdoses and HIV cases throughout B.C. (78,79).

Alberta:

Alberta has recently opened four supervised consumption sites across the province after a consultation process and feasibility study in which the province invested $750,000 (80).The Minister's Opioid Emergency Response Commission recommended the development of an injection opioid agonist therapy option, which was approved November 2017 and is currently in development (81,82). The CHARPP report found that Alberta has a poorly defined definition and approach to harm reduction and criticizes the province for looking at substance

use from the narrow lens of addiction and mental health, rather than acknowledge the role of harm reduction. Despite the current utilitarian view of substance use, the provincial government has continued to expand their harm reduction services.

Saskatchewan:

Saskatchewan has the highest rates of new HIV and HCV infections as well as the highest rates of hospitalizations due to opioid poisoning of any province. The province has seen little advancement or expansion in providing harm reduction services. Saskatchewan currently does not have a supervised consumption site, although AIDS Saskatoon plans to open a supervised consumption site this fall. The CHARPP report found the Saskatchewan harm reduction policy was sparse, with no clear definition, guidance or approach. Currently, the availability of opioids is outpacing the availability of resources to treat opioid use disorder in the province
(83,84).

Manitoba:

Manitoba is experiencing growing rates of methamphetamine use. This increase in meth use has been associated with a rise in injection drug use. Manitoba has the second highest rate of new HIV cases in the country (85).The CHARPP report stated "… little improvement has been made in the past decade to increase policy commitments to harm reduction at the provincial level" (86).According to the report, Manitoba has no consistent definition or approach to harm reduction. In addition, those organizations that do mention harm reduction, do not follow the internationally recognized principles of harm reduction. The Canadian Centre on Substance Use and Addiction (CCSA) stated that Manitoba has limited common data collection processes and poor inter-agency data sharing when it comes to substance use and addiction (71).The lack of harm reduction services combined with lack of information on substance use in the province makes it difficult to form a full understanding of the drug use problem in Manitoba. Anecdotal evidence from conversations with front-line community organizations suggest that the current supply of needles does not meet the demands of the community. These organizations also indicate that that rates of endocarditis are increasing and that emergency visits regarding substance use have increased.

Ontario:

Ontario has recently opened 13 safe consumption sites and currently has 18 waiting for federal approval. The CHARPP report stated that Ontario has no clear harm reduction policy, nor a standard harm reduction definition. In addition, very few provincial documents openly support a harm reduction policy(87).The Ontario Public Health Standards document does mention harm reduction a few times and notably mandates that the board of health provide access to harm reduction services. This may explain why the province of Ontario is continuing to expand harm reduction services despite not having a strong harm reduction policy, which may demonstrate the power of having at least one clear government document on harm reduction.

Quebec:

Quebec has three supervised consumption sites and one mobile unit operating out of Montreal (88). As of Nov 10, 2017, any Quebec resident aged 14 or older can obtain naloxone for free from a pharmacist(89). Quebec has multiple Injection Equipment Access Centres (CAMI) across the province, which can be accessed through multiple health care institutions, as well as pharmacies, drug rehabilitation centres, and community organizations, though what services are available varies between sites (90). CAMIs offer safe injection supplies, safer inhalation supplies, access to care and treatment, information and education, counselling, STI vaccination, STI screening, and referral to specialized resources for STIs and addiction. In 2015-2016, greater than 2 million needles were distributed through the injection equipment access centres (91). The CHARPP report notes that while policy documents do not clearly define harm reduction, policy is consistent across documents, and embody the principles of harm reduction (92). Methadone and Buprenorphine are both listed in the province's drug plan formulary (93).

New Brunswick:

The CHARPP report found that policy around substance use in New Brunswick is limited, but what is in place is of high quality. While there is no commitment to harm reduction in New Brunswick policy, much of the language of the existing policy is in line with harm reduction principles (94). Needle exchange services are not directly funded or run by the government, but rather offered through non-profit organizations in the province. One of these organizations is now also offering safer inhalation kits. Methadone and Buprenorphine are both covered by the provincial drug plan (95).

Nova Scotia:

Nova Scotia offers needle exchange services, methadone and buprenorphine, and street outreach, though the funding for these services is inconsistent (96). In 2017, the Nova Scotia government developed their Opioid Use and Overdose Framework (97). As part of their strategy, take-home naloxone kits became available at participating pharmacies for free (98). There is some community push for a supervised consumption site (99).

Prince Edward Island:

The province took over funding and distribution of safe injection supplies in 2009, though some non-profit organizations continue to provide supplies as part of their services (100). Methadone and buprenorphine are both available. Free naloxone kits are available (101).

Newfoundland and Labrador:

Needle exchange services in Newfoundland and Labrador are run by a non-profit organization (102). There is only one methadone clinic in the province. Take-home naloxone kits are available (103).

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