HARM REDUCTION SERVICES IN MANITOBA:
A CONSOLIDATING REPORT AND CALL TO ACTION

Manitoba Harm Reduction Network

MANITOBA HARM REDUCTION NETWORK

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Land Acknowledgement:

The MHRN and all of our sites are located on Indigenous land. Specifically, we are located on Anishinaabe, Ininew, Anishininew, Dene, and Dakota land and are also in the homeland of the Métis Nation. Our central office is in Treaty 1, and we have been invited to work in Treaty 1, 2, 3, 4 and 5 territories. As a non-Indigenous organization, we are committed to the principles of reconciliation and are committed to integrating the TRC calls to action into our work.

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Executive Summary

Manitoba is at a critical juncture in addressing the ongoing substance use and mental health problems in our province. There are overlapping epidemics of poverty, trauma, substance use, and overdose fatalities; these issues affect some individuals and communities more than others. The province's Indigenous communities are disproportionately impacted by these overlapping epidemics due to the compounding historical and ongoing impacts of colonialism. Most recently, the COVID-19 pandemic has exposed the many gaps and weaknesses in our existing health and social systems. For people who use substances (PWUS), and their families, the impact has been devastating.

Many people in Manitoba, including individuals allied with health care, municipal and provincial governments, social agencies, businesses, and harm reduction groups, are rallying together to increase harm reduction services for people who are experiencing problematic substance use. Specifically, there is support for managed alcohol programs and supervised consumption services in Manitoba as harm reduction measures that not only save lives, but provide socially marginalized people with access to health care and social services. These types of harm reduction programs also reduce the burden on emergency services and health systems.

In this report, we review the literature about the merits and various models of managed alcohol and supervised consumption services, citing evidence from numerous peer-reviewed studies. Then, we describe 15 recent reports and position statements that discuss the growing problem of substance use in Manitoba and point to a range of solutions. We highlight the key findings of each of these reports. We analyze recent local data that indicates the need for greater harm reduction services in Manitoba. We believe the information and voices from these reports and data are crucial for helping people who use substances in our province.

The literature review and results of our analysis promote our conclusion that more harm reduction programs are needed to alleviate the harms of the ongoing substance use crisis in Manitoba.

We conclude with our recommended *calls to action* to the municipal and provincial governments for helping people with problematic substance use. These recommendations are:

1. **Renew Manitoba's Provincial Substance Use Strategy**
2. **Generate Timely Substance Use Death and Overdose Statistics that are Made Available to the Public**
3. **Create a Harm Reduction Task Force**
4. **Establish More Low Barrier Housing**
5. **Conduct an Environmental Scan and Quantitative Needs Assessment**
6. **Implement a Managed Alcohol Program**
7. **Introduce Supervised Consumption Services**
8. **Introduce Drug-Checking Services**

Our team hopes the municipal and provincial governments will read through this report and recognize the numerous community organizations in Manitoba that work tirelessly to help people who use substances. We hope that all readers of this report will contemplate the numerous merits

of harm reduction programs as progressive, compassionate, and cost-effective mental health strategies and consider our call to action for increasing harm reduction programs here in Manitoba.

Introduction

Overdose Crisis

During the years spanning 2016 to 2019, over 19,000 Canadians overdosed on illicit and injectable drugs nationwide (Government of Canada, 2019). This accounted for an astounding 11 deaths nationwide every single day in 2019 alone (Government of Canada, 2021). Canada continues to see a rising trend in overdose fatalities. For example, between April and September 2020, 3351 people died of drug overdoses. These numbers represent a staggering 120% increase from the same time frames only a year earlier (Government of Canada, 2021).

Over the past six years, Manitoba recorded approximately 1,000 overdose hospitalizations each quarter (Manitoba Health, 2019). In Manitoba, drug related deaths jumped from 199 in 2019 to 372 in 2020 (Chief Medical Examiner's Office, 2020). With the onset of the COVID-19 global pandemic, substance use patterns changed due to supply disruptions, which resulted in an increased risk of overdosing (Ali et al., 2021). The injection of illicit drugs may not only be lethal but can also ravage communities with dangerous infections, such as HIV, hepatitis C and syphilis. Painful skin lesions, movement disorders and the worsening of psychiatric conditions are also noteworthy consequences (Jawa et al., 2021; Voce et al., 2018).

This ongoing tragedy has renewed discussions about the need to expand evidence-based interventions for people who use substances. Best practices in addressing the harms associated with substance use include a multipronged approach. In this report, we focus on the merits of two harm reduction programs: Managed alcohol programs and supervised consumption services.

Harm Reduction in Manitoba

Manitoba is at a critical juncture in addressing the ongoing substance use and mental health problems in our province. There are overlapping epidemics of poverty, trauma, substance use, and overdose fatalities; these issues affect some individuals and communities more than others. Indigenous communities are disproportionately impacted by these overlapping epidemics due to the compounding historical and ongoing impacts of colonialism (Chee Mamuk Aboriginal Program, 2010; Levine et al., 2021; Winnipeg Regional Health Authority, 2016). Structural racism, colonization and intergenerational trauma are associated with adverse health outcomes (Gone et al., 2019), including substance misuse. As well, an increasingly poisoned drug supply has been contributing to sharply rising morbidity and mortality rates related to substance use (Singh et al., 2020).

Most recently, the COVID-19 pandemic has exposed the many gaps and weaknesses in our existing health and social systems. For people who use substances (PWUS) and their families, the impact has been devastating. Many people in Manitoba, including individuals allied with health care, local and provincial governments, social agencies, businesses, and harm reduction groups, are rallying together to increase harm reduction services for people who are experiencing problematic substance use. Specifically, there is support for managed alcohol programs and supervised consumption services in Manitoba. These harm reduction measures not only save lives but also provide socially marginalized people with access to health care and social services. These

types of harm reduction programs also reduce the burden on emergency services and health systems.

Many groups and individuals have been working for years to stem the tide of harms and overdose deaths related to substance use, only to face a lack of support from the provincial government. In this report, we identify the growing problem of substance use in Manitoba and point to a range of solutions, including both managed alcohol programs and supervised consumption services. While these services may be considered controversial to some, many Canadians view them as a compassionate and evidence-informed approach to helping people experiencing problematic substance use. The general consensus about problematic substance use is: People are using substances for a reason—for example, to cope with pain—and that reason is not going to go away overnight. By keeping people alive, through overdose prevention and greater harm reduction measures, people can live another day, make a different choice tomorrow, and live a healthier life with ambition for the future. By keeping people safer, we can also relieve pressure on emergency services, law enforcement, and health systems.

Purpose

The purpose of this report is to consolidate the documented work done to date to advance harm reduction in Manitoba. In the past five years, a total of *15 reports* and other documents have identified the need for increased harm reduction services for people experiencing problematic substance use, including the need for managed alcohol programs and supervised consumption services. Unfortunately, despite these reports and the numerous voices of advocates and people who love someone who is experiencing problematic substance use, *these reports have not resulted in an increase in services*. The purpose of this report, then, is to demonstrate to both the City of Winnipeg and the Province of Manitoba that the time to introduce lifesaving and cost-saving supervised consumption services and managed alcohol programs is long overdue.

Organization

This report has been compiled by representatives of several organizations serving people experiencing problematic substance use in Manitoba. It is organized as follows. First, we present brief overview of harm reduction. Then we present a brief literature review about managed alcohol programs and supervised consumption services. Then, we list and describe the key findings in the reports written to date which indicate the need for enhanced harm reduction services here in Manitoba. We also analyze data from the City of Winnipeg's Open Data Program. Last, we recommend next steps, including implementing a managed alcohol program and safe consumption service. We believe the information and voices from these reports, and our recommendations, are crucial for helping people experiencing problematic substance use in Manitoba.

Abbreviations

In this report, several acronyms will be used:

BBI	Bloodborne Infection
DCR	Drug Consumption Room
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
Insite	The name of the Supervised Consumption Service in Vancouver
MAP	Managed Alcohol Program
OPS	Overdose Prevention Site
SCS	Supervised Consumption Site/Services
STBBI	Sexually Transmitted and Bloodborne Infections
PWUS	People Who Use Substances

Harm Reduction

Harm reduction refers to the policies, programs, and practices that aim to minimize the negative health, social and legal impacts associated with substance use (Harm Reduction International, 2019). Harm reduction begins from the assumption that substance use is an "inescapable fact rather than a moral issue," and therefore it is important to help people reduce the negative consequences of substance use rather than to try to eliminate it (Klein, 2020).

As put forward by Harm Reduction International (2019), the principles of harm reduction are:

1. Respecting the rights of people who use substances and treating people who use substances with compassion and dignity.
2. A commitment to evidence that shows interventions to be practical, safe, and cost-effective.
3. A commitment to social justice and collaborating with people who use substances.
4. Avoiding stigma and meeting people where they are.

Harm Reduction International (2019) describes the goals of harm reduction as:

1. Keep people alive and encourage positive change in their lives.
2. Reduce the harms of drug laws and policies so that they are not detrimental to the health and wellbeing of people who use substances and their communities. Stigmatization, criminalization, and discrimination lead to negative health outcomes.
3. Offer alternatives to approaches that focus exclusively on prevention and cessation.

Harm reduction encompasses a range of health and social services and practices that apply to substance use. These include supervised consumption services, managed alcohol programs, needle and syringe programs, non-abstinence-based housing, drug-checking services, overdose prevention, and more.

Harm reduction is not a "one size fits all" for individuals or communities. From an Indigenous perspective, harm reduction is community-driven, culturally safe, and responsive to community needs; it honours and acknowledges the wisdom, culture, strengths, and resiliencies that exist within Indigenous communities (Levine et al., 2021). Indigenous harm reduction is not limited to substance use; it is a broader concept and a "way of life"; it is "love, non-judgment, and non-interference" for people who are suffering (Interagency Coalition on AIDS and Development & Canadian Aboriginal AIDS Network, 2019, p. 10). An Indigenous approach to harm reduction focuses on opportunities for connection and establishing relationships with community members who use substances (Chee Mamuk Aboriginal Program, 2010). Traditionally, knowledge and skills are passed on to others through informal daily activities and through the roles of Indigenous women as natural leaders in their communities; the role of peers is also key (Chee Mamuk Aboriginal Program, 2010; First Nations Health Authority, 2020). Effective harm reduction approaches for Indigenous peoples are highlighted by the First Nations Health Authority (n.d.; 2013), the Interagency Coalition on AIDS and Development and Canadian Aboriginal AIDS Network (2019), Aboriginal Standing Committee on Housing and Homelessness (2017), and CATIE (2020).

Managed Alcohol Programs

Managed alcohol programs (MAPs) were developed as a harm reduction strategy, paired with housing programs or homeless shelters, for people experiencing chronic homelessness and severe alcohol dependency (Aboriginal Standing Committee on Housing and Homelessness, 2017). MAPs help reduce the various harms associated with alcohol dependency by providing measured portions of alcohol to residents (or clients) throughout the day (Parkes et al., 2020). The regular provision of palatable alcohol allows people to focus on other aspects of their lives, including achieving stable housing. (Many individuals experiencing homelessness drink non-beverage alcohol like rubbing alcohol and mouthwash, as they are easily obtained and low cost; however, non-beverage alcohol has many health risks and makes individuals very sick.) MAPs are a compassionate response that improves the quality of life for people experiencing chronic homelessness and alcohol dependency. MAPs are also cost-saving because people in these programs tend to have fewer encounters with law enforcement and emergency services (Pauly et al., 2013b).

Alcohol use disorder is common within many populations in Manitoba. From a public health standpoint, problematic alcohol use was responsible for over 14,000 deaths in Canada in 2014. In Canada, it is reported that alcohol use accounted for $14.6 billion dollars of costs to public services expenditures in 2014, with $3.2 billion being attributed to the costs of police, courts, and correctional services (Canadian Centre on Substance Use and Addiction & Canadian Institute for Substance Use Research, 2018).

Alcohol use is associated with large health care related costs. In Canada, 34% of substance use related hospitalizations were attributed to alcohol use with over $4 billion health care dollars spent on alcohol-related health issues in 2014. Public finances were spent on alcohol-related emergency department visits, hospitalizations, and physician-billed time connected with alcohol-related injuries (Canadian Centre on Substance Use and Addiction & Canadian Institute for Substance Use Research, 2018). Alcohol use has serious impacts on a person's mental health and well-being, with chronic alcohol use often linked to mental health conditions such as depression, anxiety, and post-traumatic stress disorder (Public Health Agency of Canada, 2015).

In many Manitoba communities, ongoing concerns regarding the prevalence of homelessness and public intoxication, and the rise of the consumption of non-beverage alcohol, has led to local interest in a MAP. An informal MAP has been pursued by at least one Winnipeg inner city agency. Given the high rates of alcohol intoxication among people who experience homelessness, and the high rates of emergency service usage, Winnipeg and other Manitoba communities could benefit from one or more MAPs to help keep people safer and reduce emergency service usage. Combined with housing, MAPs have been proven to reduce encounters with police and paramedics and can be an important component of maintaining housing stability (Hammond et al., 2016; Vallance et al., 2016).

Goals of Managed Alcohol Programs

Managed alcohol programs use a harm reduction approach to help reduce the harms related to chronic alcohol use by providing program participants with smaller, regular, and measured doses

of regulated beverage alcohol (i.e., wine or spirits) throughout the day in a safe setting, under the supervision of trained staff (Vallance et al., 2016). The guidelines for MAPs vary on factors related to participant eligibility requirements, alcohol dispensing frequencies and dosages, funding models, primary health care services, housing supports and socio-cultural elements (Pauly et al., 2018). Ultimately, MAPs are intended to promote safer use of alcohol, prevent acute withdrawal symptoms and complications of severe alcohol use disorder, prevent the consumption of non-beverage alcohol, and provide support to help people improve their quality of life, health, safety, and interpersonal relationships (Canadian Institute for Substance Use Research, 2020).

Benefits of Managed Alcohol Programs

MAPs Reduce Encounters with Law Enforcement and Paramedics

People in MAPs tend to have substantial reductions in rates of police contacts and hospital admissions (Ezard et al., 2018; Hammond et al., 2016; Larimer et al., 2009; Pauly et al., 2013a). Studies vary in the reduction of police encounters, ranging from a reduction by 41% (Vallance et al., 2016) to 51% (Podymow et al., 2006). MAPs also decrease program clients' use of hospital emergency rooms, in one study by 35% (Podymow et al., 2006). MAPs are associated with savings to the public sector. The provision of adequate housing and supports to help regulate alcohol use can be a cost-beneficial way to address homelessness for people experiencing severe alcohol dependence. When factoring in the social and system costs of homelessness, it is estimated that there is a saving of between $1.09 and $1.21 for every dollar invested (Hammond et al., 2016).

MAPs Help People Stay Housed

MAPs are often coupled with homeless shelters or housing programs and as such, MAPs help people who would otherwise be homeless stay housed. This low-threshold approach—which doesn't require a person to be sober before they have shelter—enables people to gain access to other health and social services that may be offered within the program, thus increasing their control over their health (Canadian Institute for Substance Use Research, 2020).

MAPs Help People Be Healthier and Improve their Quality of Life

People in a MAP have better access to healthy food and have increased access to health care services. By being housed, and having regular access to dedicated health professionals such as nurse practitioners, people are able to gain control over their health (Pauly et al., 2013a). People in a MAP also are able to reduce their alcohol related harms and reduce or stop their use of non-beverage alcohol (Pauly et al., 2013a). When alcohol is unavailable or unaffordable, many people experiencing alcohol dependence turn to non-beverage alcohol or illicit drugs (Erickson et al., 2018), both of which have considerable health risks. Individuals who have access to a MAP as part of their housing are more likely to reduce their alcohol use and remain housed (Larimer et al., 2009; Stockwell et al., 2021).

MAPs are Cost-Effective and Saves Taxpayers' Money

There are steep personal and societal costs associated with problematic alcohol use. Heavy alcohol use, binge drinking, and consumption of non-beverage alcohol are all associated with high rates of police and paramedic engagement, emergency department usage, homelessness, legal service utilization and homeless shelter usage—all of which are costly services (Hammond et al., 2016; Podymow et al., 2006). Each of these factors is associated with costs to the public and have been demonstrated to significantly decrease once a person experiencing problematic alcohol use is part of a MAP. MAPs have been shown to provide a strong return on investment, ranging from $1.09 to $1.21 for every dollar invested (Hammond et al., 2016). In an Australian study of a residential MAP, potential savings to the hospital from a 15-bed residential MAP were estimated at $926,483 AUD per year. As well, crisis housing (homeless shelter) cost-savings were estimated to be around $350,000 AUD per year. Cost savings are generated by an increase in stability for people in the MAP, which lessens their reliance on public services, emergency care, and negative interactions with police, and decreases the harms that accompany problematic alcohol use, particularly in the case of non-beverage alcohol consumption.

Models of Managed Alcohol Programs

Residential and Supportive Housing

A residential MAP combines the need for housing with the need for harm reduction and access to a safe and measured supply of alcohol. Regular doses of alcohol are dispensed throughout the day.

Shelter

Some homeless shelters have a MAP and people who are experiencing alcohol dependency can opt into a MAP at a shelter.

Drop-In or Day Program

A drop-in model of MAP is not paired with housing but with another service such as a drop-in centre or day program that provides services and supports for participants.

Trade-In (Illicit Alcohol Exchange)

A trade-in program will exchange people's non-beverage alcohol for something potable, which has much fewer health harms.

Co-op

In a MAP co-op, program participants work together to brew alcohol. As well, they are also eligible to access a certain amount per day (Bryans, 2019).

Indigenous Healing

Indigenous peoples in Canada have experienced decades of trauma and devastation. A reconnection to Indigenous culture along with traditions can help to promote healing (Aboriginal Standing Committee on Housing and Homelessness, 2017). Culture and spirituality are not only a key form of treatment but the context of healing itself.

Informal

Sometimes an individual has an arrangement with a long term care facility or community agency with which they are involved, whereby the person can secure alcohol that is kept on site for that individual.

Acute care

Substance use is a significant cause of patients leaving the hospital against medical advice before they are discharged. The expectation of abstinence while hospitalized is a barrier to hospital care for people who are dependent on alcohol. People with severe alcohol use disorders are at a higher risk of poor outcomes and clinical deterioration, in part because of the inability to abstain from alcohol while in the hospital (Brooks et al., 2018; Hill et al., 2018). Physicians in acute care settings can provide alcohol prescriptions to dependent patients to minimize withdrawal symptoms while in hospital for care (Bryans, 2019).

Supervised Consumption Services

Manitoba is one of the last provinces in Canada, and Winnipeg one of the last major Canadian cities, to pursue a supervised consumption service, a life saving intervention that requires a special exemption from the Government of Canada. In fact, Manitoba is the only province west of the Maritimes that does not have a single province-supported supervised consumption service, leaving health care agencies and advocates for harm reduction services scrambling to stem the tide of overdose deaths on their own.

Supervised consumption services (SCS) provide a hygienic and supportive environment in which PWUS can use substances under the supervision of a health care professional, a trained allied service provider, or a peer (i.e., person who formerly used or currently uses drugs), without the risk of arrest for drug possession (Government of Canada, 2020). SCS exist as part of a continuum of addiction and harm reduction services (Stancliff et al., 2015) and have demonstrated several benefits to PWUS. SCS provide a safe, welcoming and accepting space for people experiencing problematic substance use; often these individuals have nowhere they can spend time and no place where their behaviour is exempt from criminalization.

The objectives SCS aim to fulfill include: improving access to health care services for PWUS; improving PWUS's health; enhancing the safety and quality of life within local communities; providing an environment for safer drug use; and reducing the negative impact of public drug use (Schatz & Nougier, 2012). Evaluations of SCS to date have revealed that these services are effective in reducing public disorder (Kennedy et al., 2017; Wood et al., 2004), unsafe injecting, risky behaviours causing infectious disease transmission, and overdose morbidity and mortality, as well as in promoting access to health and social services (Kennedy et al., 2017). SCS have also been found to be a cost-effective strategy to reduce the burden on emergency services (Bayoumi & Zaric, 2008; Lloyd-Smith et al., 2010).

Purposes of Supervised Consumption Services

Supervised consumption services are sometimes called "safer injection facilities," "safer injection sites," "drug consumption rooms," and "overdose prevention sites." In addition to reversing overdoses on site, SCS also provide many other services, including access to health care, referrals to treatment, and access to housing. These services have several merits for both individuals who use substances and for population health: rates of bloodborne infections are decreased, overdoses are reversed immediately on site, costly acute and emergency care services can be avoided, and people who use the service can be connected with a range of other services such as housing and substance use treatment programs.

The purpose of SCS is to provide a safe space for people who use substances. Drug use is most visible in urban inner city neighbourhoods, but it is still a widespread and common problem in many rural and remote communities across Canada. People experiencing problematic substance use are often from marginalized groups, may be experiencing homelessness, and may have been recently released from a health or correctional facility (DeBeck, Kerr, et al., 2012; Scherbaum et al., 2009; Semaan et al., 2012; Wood et al., 2005). In one Ontario study of individuals willing to use a proposed SCS, 94.1% had been homeless at least once, 60.6% were unstably housed, 49.7%

were dependent on a food bank or shelter for food, 49.8% had been banned by police from a part of the city, and 57.1% had not completed high school (Shaw et al., 2015). Broadly across Canada, 28.2% of people who use substances reported being homeless for at least six months out of the year (Government of Canada, 2021), further suggesting that SCS may be of benefit across the country. Moreover, PWUS utilizing SCS suggest that these facilities attract the most socially marginalized of the PWUS community (i.e., homeless or housing insecure, people who inject in public). These individuals are also more likely to engage in high-risk drug use (e.g., more frequent episodes of overdose and daily drug injection), suggesting that these facilities were successful in attracting and providing service for marginalized and hard-to-reach populations (Potier et al., 2014; Wood et al., 2005).

Benefits of Supervised Consumption Services

SCS Reduce Deaths from Drug Overdoses

SCS are highly effective in preventing overdose deaths (KPMG & NSW Health, 2010; Latimer et al., 2016; Marshall et al., 2011; Rapid Response Service, 2014). In a Vancouver study, overdose deaths were reduced by upwards of 35% within a 500-meter radius of the consumption site (Ng et al., 2017). This amounted to 88 fewer overdose deaths per 100,000 person-years. Furthermore, in Sydney, Australia, calls for ambulance services diminished by 68% during periods in which SCS were open (Salmon et al., 2010). In a systematic review conducted by Potier et. al. (2014), it was discovered that in 75 peer-reviewed journal articles examining SCS, not a single overdose death occurred at any of the consumption sites. In fact, of the hundreds of overdoses that occur at SCS, no overdose deaths have been reported in any academic article studying SCS which is a defining feature of these services which are staffed by health professionals trained in preventing and reversing overdoses.

SCS reduce drug death overdoses in two fundamental ways. First, SCS proactively serve to circumvent the likelihood of overdoses due to substance use. This occurs in three important ways: (1) SCS are strategically placed in neighbourhoods generally experiencing higher overdose deaths, thereby increasing accessibility, convenience, and probability of use, (2) personnel at SCS possess the ability to assess vital markers (e.g., oxygen saturation levels, respiration levels, heart rate) of PWUS and instigate overdose protocols earlier, which can substantially minimize overdose deaths, and (3) in interacting with PWUS and remaining as vigilant members of the community, SCS staff can spot upticks in overdoses and provide timely warnings about potentially dangerous and tainted drugs being sold in the community. Second, if an overdose does occur, SCS employ trained staff and nurses who can reverse the overdose by providing life-saving drugs such as Naloxone.

One aspect of care that is being explored in SCS across the world is the possibility of adding drug-checking to the battery of services (Lysyshyn et al., 2017). These technologies are in place to a range of degrees already, ranging from low specificity and non-quantitative test strips (that identify only the presence of fentanyl, the drug responsible for a significant portion of fatal overdoses worldwide, but not the amount) to more advanced and costly gas chromatography/mass spectroscopy (British Columbia Centre on Substance Use, 2017a, 2019a, 2019c; Harper et al., 2017). There has been discussion about implementing these services within SCS or at the drug

dealer level (Bardwell et al., 2019). Some SCS use a mail-in service; however, results take several days to come back.

SCS Reduce the Spread of Infections

Acquiring a blood-borne infection (BBI) can be a consequence of illicit substance use. BBI include Hepatitis C and HIV (Bayoumi et al., 2012; MacArthur et al., 2014), which can spread when drug paraphernalia (such as used needles and cookers) are shared by PWUS.

SCS have been found to significantly reduce the spread of BBI by providing clean syringes and clean equipment within a hygienic and safe place to use, and by trained staff providing teaching and health care (Kinnard et al., 2014; Potier et al., 2014). A systemic review by Portier et. al. (2014) highlighted that SCS decrease rates of syringe sharing, syringe reuse and public injection. These findings echo a 2009 study by Milloy and Wood (2009) asserting that SCS reduce the likelihood of syringe sharing by 69% (Milloy & Wood, 2009). Similarly, a study by Kinnard et. al. (2014) in Denmark found that over 75% of SCS clients reported diminished risky behavior, such as the sharing of needles. The study also found that 65.9% of participants injected in a less frantic, more controlled manner while public injections also reduced by 53.7%.

SCS can also help PWUS prevent soft tissue injuries. Injection drug use can lead to soft tissue infections, scarring, bruising and swelling (Jawa et al., 2021; National Harm Reduction Coalition, 2020). These complications can lead to abscesses and even life threating infections such as septicaemia and endocarditis (Keeshin & Feinberg, 2016; Rudasill et al., 2019).

SCS Provide Cost Effective Care and Good Value for Investment

SCS are cost effective and reduce health care spending in two ways. In the short term, SCS significantly reduce both the economic and social costs of overdoses and the need for urgent care. Individuals regularly using illicit drugs visit the emergency room more frequently compared to the general population (Kendall et al., 2017). SCS avert these costs by treating overdoses on site, thereby avoiding ambulance, emergency room and hospital costs. In a Calgary, Alberta study exploring the cost savings provided by an overdose management site found that over 98% of overdoses were treated directly at the facility, providing a cost savings of $1,600 CAD *per overdose*. This would amount to public health care savings of $2.3 million over the life of the SCS (Jackson, 2020).

In the long-term, SCS also reduce the costs associated with HIV infections. Based on conservative odds-ratio and mathematical modeling, Bayoumi and Zaric (2008) found that a SCS both saved money and improved life expectancy due to averted HIV infections. Andresen and Boyd (2010) estimated savings between $2.85 and $8.55 million from averted HIV infections, benefit-cost ratios ranging from 1.94 to 5.80, and cost-effectiveness ranging from $26,000 to $79,000. Consequently, SCS provide a good return on investment. Pinkerton (2010) suggests that if Vancouver's SCS and needle exchange programs closed their doors, the annual number of new HIV infections among injection drug users would increase by 83.5 infections per year. These infections are associated with $17.6 million in life-time HIV-related medical care cost (Andresen and Boyd (2010). Vancouver's supervised injection facility, Insite averts nearly 40 HIV cases and

3 deaths per year, thereby providing a societal benefit in excess of $6 million per year, translating into an average benefit-cost ratio of 5.12:1, indicating positive net benefits (the cost of running the SCS is financially worth the investment) (Andresen and Boyd (2010). Effectiveness ratios are significantly less than the lifetime medical cost of a new HIV infection.

SCS can also provide an entry point into treatment, which also can result in significant health care savings, as prolonged and costly hospital stays can be averted (Lloyd-Smith et al., 2010).

SCS Reduce Public Disorder and Public Substance Use

People who use substances often use in public streets, alleys, and public washrooms (Harm Reduction Coalition, 2016; KPMG & NSW Health, 2010; Wolfson-Stofko et al., 2017). These circumstances can result in loitering and violence. SCS reduce the likelihood of such occurrences by offering a safe environment that is free from interference and in which substance use behaviour is decriminalized (DeBeck, Wood, et al., 2012; Jozaghi & Andresen, 2013; KPMG & NSW Health, 2010; Petrar et al., 2007; Potier et al., 2014; Rapid Response Service, 2014; Salmon et al., 2007). Visitors surveyed at a Vancouver SCS indicated that there was a 71% decrease of public/outdoors injections after the SCS became available (Petrar et al., 2007).

Although critics worry loitering will not disappear but only move closer to SCS, and that drug trafficking will also increase near these areas (Watson et al., 2012) there is no scholarly evidence to support these claims (Milloy & Wood, 2009; Potier et al., 2014). Researchers measured drug trafficking, assaults, and robbery in regions before and after SCS were deployed; no changes across these variables were observed (Wood et al., 2004; Wood, Tyndall, et al., 2006). A Vancouver study found that robbery and theft both decreased in the area around the SCS (Wood, Tyndall, et al., 2006), while other reports did not document any change (Fitzgerald et al., 2010; Freeman et al., 2005).

SCS Provide a Low-Barrier Entry Point for Health Services

People who regularly consume illicit drugs often face challenges in accessing mainstream acute and chronic health care and social services (Gardner, 2017; Woods, 2014). Some people are not able to recognize the severity of their condition without insight from a facility nurse (R. McNeil et al., 2014). Some people also have a hard time getting care for chronic problems because they can't find the time to get help for their medical needs, have difficulty keeping appointments, or need to prioritize their drug consumption. Additionally, when PWUS access health care services, they often have negative experiences due to the stigma of substance use and high levels of distrust in the health care system (McCradden et al., 2019; Muncan et al., 2020; Rodrigues et al., 2013). Consequently, visits to emergency rooms and urgent care centers become the dominant form of health care for these individuals (Milloy et al., 2010; Small et al., 2009) at a significant cost to the public. By staffing the SCS with trained health professionals, people who use substances can get the health care they need in a timely fashion.

SCS provide opportunities for people to access health care services (DeBeck, Kerr, et al., 2012). Early and timely interventions can help prevent severe illness, which lowers overall health care costs (Wang et al., 2016). Low-barrier settings such as SCS are characterized by staff that establish

trust, social acceptance and freedom from judgment which all foster a safe haven for PWUS (Kappel et al., 2016; Rance & Fraser, 2011; Vishloff, 2015). SCS staff are committed to creating the relational and therapeutic foundation upon which prevention, treatment and referrals are implemented (Kappel et al., 2016).

Staff at SCS also provide referrals to addiction treatment centers, detoxification regimens and opioid agonist therapy (such as methadone) (Kennedy et al., 2017; Potier et al., 2014; Small et al., 2009; Wood et al., 2007; Wood, Tyndall , et al., 2006). Small et al. (2009) found that Vancouver's SCS (Insite) facilitated access to health care services by providing non-judgmental treatment during service provision, access to integrated services in a single location, availability to on-site care for abscesses and other injection-related infections, and referrals for external services. The study also found that Insite connected participants with valuable counselling services. An Australian study found that PWUS increasingly accessed detoxification services within a 12-month period (OR = 1.32, 95% CI = 1.11 – 1.58) after the site opened (Wood et al., 2007). Additionally, SCS can offer immunizations during outbreaks and pandemics (Government of Canada, 2008).

SCS provide nursing services, with nurses on site to provide wound care, injection-site care, referral to services, and psychosocial support (Dolan et al., 2000; Lloyd-Smith et al., 2009; R. McNeil et al., 2014; Rapid Response Service, 2014; Salmon, Dwyer, et al., 2009; Small et al., 2009; Small et al., 2008; Wood et al., 2007). Lloyd-Smith et al. (2009) reported that 65% of visitors to Insite sought out nursing services specifically for injection-related skin infections. If not for Insite, these individuals would likely not seek care at all until they are very sick and require costly acute care services and hospitalization. Due to SCS nurses' non-judgmental engagement in patient health, early interventions for complications related to injection drug use can be detected and treated without hospital treatment (Lloyd-Smith et al., 2009; Lloyd-Smith et al., 2010; Small et al., 2008). Other reasons for seeking nursing care included psychosocial support (7%), foot care (6%), respiratory care (3%), pregnancy test (2%), and other needs (Lloyd-Smith et al., 2009). SCS clients appreciate being able to get health care without their substance use being the main topic during a visit (Salmon et al., 2010). Another advantage for PWUS accessing health care services at SCS is that it can prevent a trip to the hospital. PWUS often feel stigmatized by health care staff for their substance use problems and dislike seeking medical care from hospital settings. As well, hospital stays usually result in withdrawal symptoms (which can be severe) and greater instability in their personal lives and housing, ultimately escalating stress and even disrupting HIV medication regimens (Salmon, van Beek, et al., 2009).

SCS Provide Education and Reduce Harm

SCS have a strong patient education component, aimed at reducing HIV and HCV transmission as well as minimizing other complications from drug use (Bravo et al., 2009; Kerr et al., 2005; Stoltz et al., 2007; Woods, 2014). PWUS often experience injury, scarring, difficulty finding veins, swelling, infections, thrombosis, bruising, septicaemia, and endocarditis, conditions that can be mitigated through health teaching (Lloyd-Smith et al., 2009). In efforts to reduce the harm associated with poor injection techniques, nurses provide teaching on safer injection techniques to minimize infections and injuries (Jozaghi & Reid, 2014; Small et al., 2011). Studies have found that PWUS use these learned techniques even away from the SCS, where this knowledge is shared

and practiced with others (Salmon, van Beek, et al., 2009). Over 75% of study participants in Vancouver who used a SCS indicated that they had positively altered their injecting behavior, 37% reused syringes less often, 49% cleaned the injection site more often, and 60% found it easier to get a vein on the first attempt (Petrar et al., 2007).

Models of Supervised Consumption Services

There are several models of SCS; these models reflect the specific needs and the available resources of the community. Government support and funding can greatly influence the number of resources offered and the number of individuals served by these facilities. In Canada, to establish and operate an SCS, an organization must apply to Health Canada for a Section 56 exemption to the federal Controlled Drugs and Substances Act.

While SCS that are sanctioned (i.e., permitted by local and federal authorities) are the ideal model, sometimes community advocates respond to local needs by operating an *un*sanctioned site, which lacks the Health Canada exemption. Unsanctioned sites are sometimes implemented in response to either paused or withdrawn funding for a sanctioned SCS or in response to the need to augment existing sanctioned SCS. For example, the Toronto Overdose Prevention Society erected pop-up tents in 2018 to handle the defunding of sanctioned SCS by the provincial government (Jones, 2018). Similarly, an unsanctioned pop-up tent was offered to PWUS in Lethbridge, Alberta in 2020 in response to the sudden cutting of funding to the sanctioned site by the Alberta government (Labby, 2020). This facility, as with many other unsanctioned SCS, was fined by local law enforcement and asked to dismantle the tent.

Unsanctioned sites may lack some of the services available at sanctioned sites. Unsanctioned SCS are often temporary and ad hoc in nature and are often operated in pop-up tents, mobile vans or even traditional street-side locations. It is significant to note that nurses and other health care professionals who assist in the operation of an unsanctioned site are in danger of losing their licenses to practice because they are participating in an illegal activity without the Section 56 exemption.

The following models for sanctioned SCS were summarized from the Supervised Consumption Services Operational Guidance published by the British Columbia Centre on Substance Use (2017b).

Fixed Stand-Alone Model

Fixed stand-alone SCS are located in a street-side building, often located in areas where PWUS frequent. Showers, refreshments, meals, primary care services, counselling, and temporary housing (i.e., shelter) are other services often provided by fixed stand-alone facilities. These sites may also be closely connected to other local service organizations for PWUS via established referral pathways. Consequently, it has been suggested that a stand-alone SCS may better reach clients who actively avoid or do not seek health care services, if they perceive the facility as a place to safely inject their drugs, rather than as a health care facility per se. Accordingly, this form of SCS is best utilized in settings with large and more concentrated populations of PWUS.

Integrated Model

The integrated model SCS is the most common type of SCS and these are often part of larger facilities offering a wide array of services. As such, integrated facilities aim to provide holistic health and medical care in addition to social services for both harm reduction and health care services. This integration allows clients to access several different services without having to travel outside of the facility premises, thereby enhancing client retention, decreasing systemic barriers to care, and ensuring continuity of care.

Embedded Model

SCS may be embedded within other health and social services that traditionally do not permit the use of illicit substances (such as supportive housing and hospitals). SCS embedded in other health services and housing programs can be highly effective as PWUS would otherwise need to leave the setting to use substances. For example, most hospitals operate under an abstinence-based policy and forbid non-prescribed drug use or drug paraphernalia on their premises. This policy has resulted in PWUS engaging in high-risk drug use on hospital premises (such as using drugs alone in a locked bathroom), avoiding accessing hospitals when needed, and leaving the hospital against medical advice (Ryan McNeil et al., 2014). Using principles of harm reduction and providing SCS within acute care settings may mitigate the risk related to drug use among PWUS in these settings.

Mobile Outreach Model

Since drug use is often spread throughout large geographical locations and traditional SCS may be inaccessible to some PWUS, the mobile outreach model brings the SCS to the PWUS via a bus or van and is deemed more favorable to local stakeholders compared to traditional street-side SCS. The trade off to mobility, however, is that mobile facilities serve fewer people, due to space limitations and time constraints for services at each location. Additionally, mobile facilities may require the same number of staff, thereby inflating the cost per client. These mobile facilities can be partnered with larger, fixed facilities to provide an increased array of services.

Women-only Model

Women who use substances encounter a unique set of barriers, challenges, and risks that inherent gendered power relations and violence. Consumption of drugs in public or unsafe settings can expose women to potential violence, requiring women to hastily consume their drug of choice, consequently interfering with their ability to use safer practices. Further, women are more likely than men to need assistance when injecting, which puts them at an increased risk for HIV, viral hepatitis, overdose, and other drug-related harms (O'Connell et al., 2005; Wood et al., 2003). SCS can decrease the experiences of violence by women who inject drugs. A women's only facility can provide women a protected space in which to inject their drugs, free from concerns about physical, sexual, or intimate partner violence. Moreover, women who use SCS have also reported that SCS offer a safe haven from the harassment by men, thus allowing them to develop the competency to inject themselves (Fairbairn et al., 2008).

Indigenous Model

An Indigenous approach to harm reduction is inherently decolonizing and shaped by Indigenous cultural wisdom and practice. While non-Indigenous interventions narrowly address substance use, such as through naloxone programs and SCS focused exclusively on substance use, an Indigenous approach is holistic and addresses the intersecting harms of colonization, racism, substance use, poverty, homelessness, and violence (Interagency Coalition on AIDS and Development & Canadian Aboriginal AIDS Network, 2019). An Indigenous approach to supervised consumption services must be Indigenous-led, peer-engaged, and inclusive.

Acute Care Model

Acute care (i.e. hospitals) could benefit from enhanced harm reduction programming as well. People who inject substances often experience soft-tissue infections and problems directly related to drug use (i.e., overdose). These issues are common causes for emergency department visits (Rachlis et al., 2009). In many settings, people who use substances tend to use emergency departments as their primary point of care due to a variety of factors such as stigma, mistreatment, inconsistent care, provider-patient mistrust, or a lack of access that leads to health conditions going untreated. Conditions such as endocarditis are often debilitating and may progress to being life-threatening. In these cases, extended antibiotic treatments require prolonged hospital stays but due to the hospital's zero tolerance policies patients are forced to leave against medical advice (Hyshka et al., 2019; Merrill et al., 2002; Rachlis et al., 2009). Patients that leave prematurely are 12 times more likely to be readmitted, given a similar clinical diagnosis within 14 days, and twice as likely to die than those who have completed their acute treatment. Repeated admissions for incomplete treatment are costly for the patient, hospitals, health care systems and the public taxpayer.

Hospitals are increasingly caring for patients that are experiencing substance abuse problems. These patients have had many negative hospital experiences (Hyshka et al., 2019; McNeil et al., 2016; Pauly et al., 2015). To resolve some conflicts, hospitals may benefit from education related to substance use and harm reduction as well as formal organizational policy changes.

Reports Indicating the Need for More Harm Reduction Services in Manitoba

In this section we highlight the various position statements and reports that have been developed primarily over the past five years in response to a growing awareness for increased harm reduction services for people experiencing problematic substance use. These documents are as follows:

Position statements on Manitoba's commitment to harm reduction:

1. Manitoba Health Position Statement(Manitoba Health, 2016)

Documents demonstrating the Winnipeg Regional Health Authority's commitment to harm reduction:

2. Winnipeg Regional Health Authority's Position Statement (Winnipeg Regional Health Authority, 2016)

Reports commissioned to explore potential solutions to social problems associated with substance use in Winnipeg and Manitoba:

3. Manitoba Policy Analysis Case Report (Anderson-Baron et al., 2017)
4. Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans (VIRGO Planning and Evaluation Consultants, 2018)
5. Transformed Approach to the Treatment of Chronic and Acute Substance Abuse: Business Plan (MNP & Community Wellness and Public Safety Alliance, 2018)
6. Winnipeg Health Region Community Health Assessment 2019 (Cui et al., 2019)
7. Winnipeg Safer Consumption Spaces Consultation and Needs Assessment (Marshall et al., 2019)
8. Managed Alcohol Programs in Manitoba: Feasibility Report (Bryans, 2019)
9. Recommendations to Reduce the Use and Effects of Illicit Drugs within Manitoba's Communities (Illicit Drug Task Force, 2019)
10. Winnipeg Downtown Safety Study Initial Report (Manitoba Police Commission, 2019)
11. Methamphetamine Use in Manitoba: A Linked Administrative Data Study (Nickel et al., 2020)
12. State of the Inner City Report 2019. Forest for the Trees: Reducing Drug and Mental Health Harms in the Inner City (Smirl, 2020)
13. Manitoba Sexually Transmitted and Blood-Borne Infections Strategy 2015-2019 (Government of Manitoba, 2020)
14. Tracks Survey (PHAC) (Tarasuk et al., 2021; Tarasuk et al., 2020)
15. West Broadway Methamphetamine Strategy (Charron & Canfield, 2021)
16. Projected Cost Analysis for Supervised Consumption Services in Winnipeg (St. George, 2021)
17. [Updated] Winnipeg Safer Consumption Spaces Consultation and Needs Assessment (TBA)

Data from Winnipeg

18. Coroner's Reports (Chief Medical Examiner's Office, 2020)
19. EMS Reports (City of Winnipeg Fire Paramedic Service, 2021)

20. City of Winnipeg Open Data: Fire Paramedic Calls for Substance Use (City of Winnipeg, 2021c) and Naloxone Administration (City of Winnipeg, 2021b)

Manitoba Health's Position Statement on Harm Reduction (Manitoba Health, 2016)

Manitoba Health supports a harm reduction approach for people experiencing problematic substance use. The Chief Provincial Public Health Officer's Position Statement affirms that harm reduction is "a proven public health approach that reduces the adverse health, social and economic outcomes" related to substance use and other activities. The document is clear that harm reduction measures recognize that drug use is going to occur, and that making it safer for people experiencing problematic substance use can help people avoid serious injury and illness, both of which are costly to individuals but also taxing on the health care system. The writers of this statement readily acknowledge that **harm reduction measures are both evidence-informed and cost effective**.

The document supports harm reduction as a "come as you are" pragmatic approach to care that preserves human dignity. It also recognizes that harm reduction is one of several measures best taken together; in other words, harm reduction works best when it is part of "an integrated, cross-sectoral approach to ensure a continuum of care and support for individuals, their families, and their communities." Some of the benefits identified in this document are the **reduction in overdose deaths and lowering the rates of blood-borne pathogen transmission (infections like HIV and Hepatitis C). Harm reduction programs can also promote entry into addiction treatment**.

Harm reduction also addresses health inequity by supporting "marginalized clients that have traditionally been difficult to reach through conventional health care programming." The document also points out that people who have a history of systemic inequalities tend to experience more substance use due to the need to cope with severe emotional and physical pain; they also experience more of the harms associated with substance use. By working with community services and striving for policy change, we can better help people who right now have trouble accessing health care. **This document supports policies that reduce unintended harms and rejects a punitive approach to substance use.**

Winnipeg Regional Health Authority's Position Statement (Winnipeg Regional Health Authority, 2016)

In 2016, the Winnipeg Regional Health Authority (WRHA) endorsed the principles of harm reduction for people who use substances, expanding their previous position statement from 2008.

This Position Statement acknowledges additional harms caused by stigma and by the criminalization of illicit drugs. In particular, it acknowledges that the **harms of criminalization are borne disproportionally by Indigenous peoples in Canada**. The Statement recognizes that while people make their own health decisions, these decisions are only one factor influencing health outcomes. It also confirms harm reduction as an effective and viable approach throughout the organization.

The Statement highlights the steep costs of the "war on drugs," which has fueled epidemics of HIV and stigma and has worsened the drug problem. The "war on drugs" has had a disproportionately

negative impact on Indigenous people due to "historical legacies of colonialism, displacement, and residential schools, and present-day factors, including racism and economic marginalization."

Concerning substance use, this Position Statement recommends advocating for policy, legal, environmental, and structural interventions to that reduce the harms identified by people who use substances. They recommend the introduction of **new initiatives such as supervised consumption spaces, overdose monitoring and response systems, heroin-assisted treatment programs, and managed alcohol programs**. They also emphasize that harm reduction approaches for Indigenous people must be context-specific, locally-informed, Indigenous-led, and culturally safe.

Manitoba Policy Analysis Case Report (Anderson-Baron et al., 2017)

The Canadian Harm Reduction Policy Project (CHARPP), funded by the Canadian Institutes of Health Research, explored provincial policies governing harm reduction services across the 13 Canadian provinces and territories. Drawing on policy documents, key informant interviews, media portrayals, and a national public opinion survey, the researchers explored the state of Manitoba's provincial harm reduction policies.

While the study covered the years between 2000 and 2015, they found that support for harm reduction is stronger at the regional level (i.e., Winnipeg) than the provincial level, a trend we continue to see today. Overall, they found a concerted failure to meaningfully address substance use in their provincial policies, with a dearth of detailed policies addressing substance use (also reported in Wild et al., 2017). This lack is significant, because drug use rates are high in Manitoba, with 41.1% of Manitobans reporting lifetime use of one or more illicit drugs. That same study (Canadian Alcohol and Drug Use Monitoring Survey, 2012, as cited in the CHARPP study), found that 3.1% of Manitobans reported experiencing harm from substance use over the preceding year. During the writing of the Manitoba report, the opioid death rate was steadily rising across Manitoba, with increasing overdoses deaths from fentanyl and these numbers continue to rise today.

The document highlights the work of methadone clinics and Street Connections in Winnipeg, a part of the WRHA. Street Connections is a mobile public health service in Winnipeg that focuses on reducing the spread of bloodborne infections sexually transmitted and blood-borne infections (STBBIs) and reducing drug-related harms.

Of note, Anderson-Baron et al. (2017) examined a previous version of Manitoba Health's Position Statement on Harm Reduction (2008), describing it as "a comprehensive explanation of harm reduction that aligns with internationally recognized principles." The Statement contained "**interventions for various modes of use and substance types, including needle exchange, supervised injection and inhalation, safer crack use kits, heroin prescription and street drug testing**." The researchers referred to this 2008 Position Statement a "very useful visionary document that frames harm reduction as an effective, evidence-based approach, and clearly demonstrates the WRHA's support for harm reduction moving forward."

Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans (VIRGO Planning and Evaluation Consultants, 2018)

The Government of Manitoba commissioned VIRGO Planning and Evaluation Consultants (2018) to explore ways to improve access and coordination of services for people experiencing substance use and/or mental health issues. This report is comprehensive, highlighting the many gaps in care for people who use substances in Manitoba, and delivers strong recommendations to the Government of Manitoba.

In this report, the consultants describe the need as "extremely high" on all substance use need indicators. They describe that these high needs are causing a "huge financial drain" on Manitoba as well as exacting a "tragic physical and emotional drain on communities, families and individual Manitobans" (p. 43). The report describes the needs—and the failure to act—as costly, and that addressing the many unmet needs related to problematic substance use will result in significant cost savings to the province.

The report also notes that the needs are evolving and increasing in complexity at both the individual and community levels. The authors noted in particular the "**heavy toll that alcohol continues to take on almost all segments of Manitoban society**" (p. 255), with rates of abusing or being dependent on alcohol constantly much higher than the Canadian average.

Taken together, the consultants concluded that the overall level of need clearly signals a call to action. They make many strong recommendations, of which we will highlight but a few.

- There is a need to **re-visit substance use and mental health funding, of which the health component falls below the national benchmark for health investment**.
- The health system for addictions and mental health is fragmented and siloed, and often characterized by a separation of the mental health and substance use services in the province.
- Community-based supports and agencies play a very important role in substance use care in Manitoba.
- **Indigenous people** are disproportionately experiencing higher needs than other Manitobans.
- Many addictions services have significant barriers to accessing them, resulting in people not being able to get help for the substance use disorder.
- There is a lack of services to address the diversity, severity and complexity of people's needs.
- Current service levels do not meet the demand.

The authors of this report explored the values that are important to Manitobans regarding substance use services, including harm reduction as a "fundamental strategy". Overall, this report highlights the need for more harm reduction-oriented services in the treatment of substance use disorders. They also recommended, based on public consultation, **greater availability of and access to harm reduction supplies, managed alcohol programs, a supervised consumption service, and increased access to addiction services**. The recommendation to introduce supervised consumption services was clearly stated in the report (p. 39) as a cost-saving and life-saving measure. However, the consultants removed the recommendation for this service from the list of final recommendations (p. 226, recommendation 2.18). Since the VIRGO report was released, however, substance use and overdose deaths have greatly increased in Winnipeg.

Additionally, the report highlights the need to recognize the unique strengths and needs of Indigenous people regarding problematic substance use. The report emphasizes the need to focus on enhanced physical, mental, emotional and spiritual health, and encourages services that blend principles and practices of traditional healing with other non-traditional models of care.

Transformed Approach to the Treatment of Chronic and Acute Substance Abuse: Business Plan (MNP & Community Wellness and Public Safety Alliance, 2018)

In 2015, a group of concerned community, business, and public sector leaders in downtown Winnipeg came together to find community-based strategies to help people experiencing problematic substance use in the downtown core. The Community Wellness and Public Safety Alliance conducted a comprehensive assessment of the current system and reviewed the practices in other cities. They found that the current system of service provision provides few options for individuals who are experiencing problematic and chronic substance use. There is a **distinct lack of services "for the humane and effective treatment of intoxicated individuals and those struggling with ongoing mental health and addictions issues"** (MNP & Community Wellness and Public Safety Alliance, 2018, p. 4). The authors note that the level of need is very high, as individuals have very complex health, social, and justice issues that are difficult for individual agencies to address in the present system configuration. The authors also acknowledge that while substance use and mental health services must be available to all citizens, it is important to ensure that Indigenous communities, agencies and people are meaningfully consulted and that Indigenous healing practices are reflected through culturally appropriate design, programming, and services that are Indigenous-led.

The resultant comprehensive business plan is a roadmap for enhanced mental health and substance use care in downtown Winnipeg. This proposed model is "founded on the belief that it must be easier to connect vulnerable and marginalized individuals to the services they need" and focuses on "a holistic treatment facility and an effectively integrated service delivery model that will seamlessly work with government and community service delivery entities to provide trauma informed, evidence-based, outcome focused services" (p. 17). The detailed plan also recommends the addition of **supervised consumption services, managed alcohol consumption, and drug replacement therapy programs**. Harm reduction is a critical component of their comprehensive plan that can also lead to considerable cost savings.

Winnipeg Health Region Community Health Assessment 2019 (Cui et al., 2019)

This broad report explored the health of residents of the Winnipeg Health Region between 2010 and 2015. Of note, the neighborhoods of Point Douglas South and Downtown East had the highest rates of substance use disorders in Winnipeg and a much lower life expectancy than other areas in the city. Between 2007 and 2016, mental and behavioral disorders (including substance use) were among the top five most frequent causes of death in the Region. Point Douglas was also noted to have the highest proportion of Indigenous residents (29%) in the Region in 2016.

Lower income residents were noted to be more likely to experience mental health issues and other chronic debilitating conditions. As well, First Nations people were noted to experience higher rates

of poor mental health, opioid dispensations, and substance use disorder, highlighting the need for a systematic and cultural approach to resolving traumas and inequities.

Winnipeg Safer Consumption Spaces Consultation and Needs Assessment (Marshall et al., 2019)

This report outlines a 2018 study by the Safer Consumption Spaces Working Group that consulted with PWUS in Winnipeg about their perspectives on SCS and recommendations for establishing a SCS here in Winnipeg. This project was funded in part by the Canadian Research Initiative in Substance Misuse (CRISM), a national project funded by the Canadian Institutes of Health Research (CIHR). The study utilized the World Café model to gather these viewpoints through discussions in a focus group format and individual interviews. Many participants acknowledged they would use supervised consumption services if made available.

Participants noted that harm often comes from factors within the social realm of PWUS which include harms from various social institutions, stigma, trauma, lack of resources, drug costs, violence, and the culture within the drug scene. Recommendations for SCS in Winnipeg emphasized several key points which included: **establishing the SCS in central Winnipeg** and away from where children gather and play, the inclusion of PWUS in service planning and delivery, **offering additional health and social services on site that are grounded in culturally safe and trauma-informed practice**, and a place where rules are valued that ensures the safety and security of all service users.

Participants expressed a need for safe spaces to exist without fear of the expulsion that characterizes their experience in public spaces. More than 50% of the participants had no permanent residence and were prohibited or excluded from many public spaces in their neighbourhood. **A supervised consumption service would be a safe space where individuals could not only attend to their substance use needs but also sleep, eat, be high, meet with friends, attend to personal hygiene, and access health and social services**. Participants indicated that they would use supervised consumption services if they were available because these places provide safety and security from the violence and exposure of using drugs in public places, streets, and alleys. Most of the participants in this project identified as Indigenous, and they expressed the need for supervised consumption services alongside access to social and health services in a manner that was culturally safe, trauma-informed, healing centered, and free of judgment.

Participants also cautioned that the rules of SCS needed to reflect common drug use practices, such as assisted injection (which has recently become a standard feature of SCS in Canada) and drug splitting and sharing of substances, to ensure additional barriers to the service are not created.

Managed Alcohol Programs in Manitoba: Feasibility Report (Bryans, 2019)

The authors of this report consulted with over 75 individuals from several organizations and communities across Manitoba and hosted four events to gather community wisdom. People experiencing problematic alcohol use, frontline staff, and policy makers were all supportive of managed alcohol programs. **They recognized that current addiction/substance use services**

were not appropriate for some people and that, for people using alcohol chronically, MAPs can greatly reduce harm. Manitoba stakeholders in this province-wide study believe that MAPs are needed in Manitoba. In this report, people identified the importance of a MAP that is **culturally grounded, Indigenous led and trauma-informed**.

The authors of this report emphasize the need to decolonize harm reduction approaches by basing them on Indigenous ways of doing, knowledge, and science. Harm reduction programs must be meaningful for Indigenous people, by being both led and informed by Indigenous people.

This MAP Working Group has representatives from Sunshine House, Health Sciences Centre Department of Psychiatry, Addictions Foundation of Manitoba, Main Street Project, Winnipeg Regional Health Authority, Health Sciences Centre Emergency Department, Northern Connections Medical Clinic, Manitoba Harm Reduction Network, University of Manitoba Department of Community Health Sciences, and the University of Winnipeg.

Recommendations to Reduce the Use and Effects of Illicit Drugs within Manitoba's Communities (Illicit Drug Task Force, 2019)

The City of Winnipeg's Illicit Drug Task Force involving members from government, police, emergency medical services (EMS), health care, and community agencies. The Task Force collaborated to address the use and impacts of illicit drugs, resulting in a report recommending **improvements to the current harm reduction strategy via centralized funding for harm reduction initiatives and a central harm reduction supply distribution program and needle recovery for Manitoba**. The document highlights several key points for the need for education, outreach, and peer networks utilized to create social change. The Task Force acknowledged the potential effectiveness of SCS for improving quality of life and acting as a beginning point for accessing treatment. They recommend the establishment, enhancement, and expansion of other foundational harm reduction activities. Indigenous populations would benefit from a cultural approach to planning and implementation of prevention strategies that focus on community and wellness.

The mandate of this Task Force was illicit drugs and did not include alcohol. However, they acknowledge that **problematic substance use is strongly associated with problematic alcohol use, mental health disorders, and homelessness**. As such, they urge that any strategies for substance use must also simultaneously address problematic alcohol use, mental health challenges and underlying social determinants of health – such as the need for safe and reliable housing.

Winnipeg Downtown Safety Study Initial Report (Manitoba Police Commission, 2019)

The Manitoba Police Commission (MPC) was asked by the Minister of Justice to consult with the City of Winnipeg, the Winnipeg Police Service (WPS) and private sector stakeholders to "identify and leverage ongoing work and to develop recommendations to make downtown Winnipeg a safer place for Manitoba families" (p. 5). The MPC was clear that this document does not in itself represent a safety strategy and that "ample work on downtown safety has already been undertaken and is currently underway" (p. 5). The report includes observations and recommendations from the general public and downtown stakeholders about what they perceive as issues.

Significantly, the MCP recommends better coordination between the Winnipeg Police Service and groups that seek to help individuals who are "chronic and prolific offenders (consumers of public services)" (p. 34), recognizing that many people are not able to enter recovery. They recommend **a harm reduction model and a commitment to poverty reduction because they recognize that "enforcement alone does not work" and that "chronic offenders need to be treated differently"** (p. 26). They also urge action by the Province of Manitoba to address the social conditions and poverty that drive crime. The report urges the Government of Manitoba to support, prioritize and reallocate **much greater funding resources to health services (particularly to substance use treatment and mental health services) and social services to address issues like homelessness and poverty**.

Methamphetamine Use in Manitoba: A Linked Administrative Data Study (Nickel et al., 2020)

This report is produced and published by the Manitoba Centre for Health Policy. In their study of methamphetamine use across Manitoba, using administrative data from several linked sources, they found that **methamphetamine use increased around 700%** between 2013 and 2018. Furthermore, the data indicated that people who had engaged with the health care system within the first year of documented use tended to use the health care system more frequently than other Manitobans. People who use methamphetamine were also more likely than other Manitobans to have a mental health issue as well and to engage in heavy service usage.

State of the Inner City Report 2019. Forest for the Trees: Reducing Drug and Mental Health Harms in the Inner City (Smirl, 2020)

This peer-reviewed report from the Canadian Centre for Policy Alternatives discusses issues such as substance use inequities, poor responses to drug-related harms, the West Broadway Methamphetamine strategy, the media's impact on the methamphetamine crisis, perspectives from a peer focus group, and recommendations for changes to reduce the drug-related harms in the inner city of Winnipeg. Several recommendations advocate for the need **to create an official harm reduction government policy and more harm reduction services including SCS in Winnipeg, a safe drug supply pilot project, harm reduction housing, access to harm reduction supplies at RAAM clinics, and round-the-clock safe spaces for PWUS**.

The report acknowledges the many benefits of SCS, including that people who use the service have: increased access to health and social services; greater access to substance use treatment services; improved health outcomes; and, decreased need to inject in public. The report readily acknowledges that harm reduction policies are a best practice approach for people experiencing problematic substance use. Indeed, harm reduction policies are widely recognized by local, national, and international experts as being practical, feasible, safe, and cost-effective. The report also cites a poll commissioned by the Winnipeg Free Press, in which two thirds of Winnipeggers were "generally in favour of a safe consumption site."

The report also acknowledges the social crisis resulting from colonialism. They assert that self-determination, cultural safety, hope, belonging, meaning, and purpose are protective factors for Indigenous peoples.

Manitoba Sexually Transmitted and Blood-Borne Infections Strategy 2015-2019 (Government of Manitoba, 2020)

Beginning in 2010, Manitoba Health, Manitoba Healthy Living Youth and Seniors (MHLYS), and other key partners and stakeholders developed the Manitoba Sexually Transmitted and Blood-Borne Infections Strategy for 2015-2019. The report indicates that preventing and managing sexually transmitted and blood-borne infections (STBBI) is a key public health priority in Manitoba. The report notes that socio-demographic determinants contribute to the spread of bloodborne infections including marginalization, substance use, trauma and mental health, and that these determinants affect populations differently, with some populations more vulnerable than others.

The authors of the report recommend a strategic provincial approach that advocates for policies that **remove barriers to healthier lifestyles and promotes harm reduction activities**. The report urges that as a province we recognize that substance use is a part of human behaviour that is unlikely to go away and thus a harm reduction approach, through private and public sector collaborative work, is required to reduce adverse health consequences.

A key strategy in the report is "accessible and quality services," which includes: **increasing access to harm reduction supplies; providing "a comprehensive and integrated continuum of services for persons who use licit or illicit substances through harm reduction, health promotion, illness prevention, early identification and management"** (p. 16); and advocating for legislative and regulatory changes in support of the recommended changes.

Notably, the report also promoted the *Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms* (Strike et al., 2013) to help integrate harm reduction approaches into policies and programs.

Tracks Survey (PHAC) (Tarasuk et al., 2021; Tarasuk et al., 2020)

These two peer-reviewed articles describe the Tracks survey of people who inject drugs (PWID), which was conducted by the Public Health Agency of Canada in collaboration with local public health partners in 14 Canadian cities (2017-2019), including Winnipeg. The purpose of the study was to explore trends in the prevalence of HIV, hepatitis C and associated risk factors in key populations, such as PWUS, and to determine better harm reduction and prevention strategies.

The results indicate the ever-increasing need for evidence-based strategies to address gaps in prevention, testing and linkage to care approaches. **Better access to opioid substitution therapy and supervised consumption services** were recommended as important ways to prevent bloodborne infections (like HIV and hepatitis C) and reduce needle sharing.

In the Winnipeg arm of the study, 83.2 % of survey participants were Indigenous. Higher rates of HIV and hepatitis C was also noted among Indigenous peoples who use intravenous drugs.

A report of the Winnipeg-specific data from the Tracks survey is not yet available.

West Broadway Methamphetamine Strategy (Charron & Canfield, 2021)

This report is from the West Broadway Director Network and the Manitoba Research Alliance. The West Broadway neighbourhood is experiencing high rates of socioeconomic change as well as some of the highest rates of substance use in Winnipeg. While substance use is found in all socioeconomic groups, people living in poverty tend to have more risk factors for substance use and its harms. In this report, the authors explore methamphetamine use in the West Broadway community and identifies gaps for improvement of services. Individual interviews and surveys were conducted with PWUS, local business owners, and community service workers in West Broadway to determine these service gaps.

The West Broadway Methamphetamine Strategy arose from concerns about the increasing use of injection drug use, that was negatively impacting the individuals using drugs and the neighbourhood as whole. With higher rates of injection drug use, community members also experienced an increase in property crimes, an increase in needle debris, and a decrease in feelings of personal safety.

The findings indicate that more diverse treatment approaches that utilize harm reduction principles are desperately needed in this neighbourhood. Other identified gaps included the needs for: **supportive housing in the area, 24/7 safe spaces, trauma-informed supports, reducing the substance use stigma, and more awareness and education on the socioeconomic factors that influence methamphetamine usage.**

Of note, this report is emphatic that all levels of government need to "take responsibility for the ongoing methamphetamine issue and invest in adequately supported, diverse, and tailored substance use support options" (p. 53). The report does not mince words when it says,

> the current provincial government continues to offload responsibility for major systemic social issues onto community based organizations through streams of funding veiled as 'innovative community initiatives.' Meanwhile, community-based workers are paid a fraction of the wage that would be allocated to professionals in the government sector, while services within the community sector are repeatedly recycled and duplicated in order to fill gaps created by these systems. Both municipal and provincial governments must take responsibility for the methamphetamine issue by responding to community recommendations, adopting true harm reduction philosophies to guide their thinking, and diversifying support options to meet the needs of many vulnerable populations. (p. 53)

The authors also urge the Manitoba government to establish a concrete, comprehensive and clear strategy for how and where evidence-based harm reduction philosophies and methodologies will be implemented to impactfully address Winnipeg's worsening substance use issues.

Projected Cost Analysis for Supervised Consumption Services in Winnipeg (St. George, 2021)

This comprehensive report was prepared for the City of Winnipeg and provides a detailed cost analysis for the introduction and operation of a supervised consumption site in Winnipeg. The report discusses the best options for areas in Winnipeg in which to open SCS and provides an overview of the potential capital costs associated with possible site options and models of operation.

This report highlights some troubling statistics regarding overdose deaths and the economic impacts of people getting very sick and dying. The average age of death from an overdose is 33.8 years old (compared with the average life expectancy in Manitoba of 80.2 years), with an estimated $4.67 billion dollar loss to the Canadian economy due to the potential lost employment earnings due to drug overdoses. While overdose deaths are a tragic loss for individuals, partners, friends and families, there are serious economic consequences as well.

The report outlines the cost effectiveness of SCS. **Specifically, a supervised consumption service can: reduce costly emergency medical services, through the provision of onsite nursing and medical care, including life-saving naloxone to reverse overdoses; reduce costly police calls that often accompany a "man down" scenario, freeing up police officers to attend to other calls; and reduce costly emergency department visits by people experiencing acute drug poisoning or overdose.**

The report provides statistics from a nationwide study that indicated the cost effectiveness of between $2.12 and $2.88 per $1.00 investment to a supervised consumption service. These direct cost savings are a result of decreasing the reliance on emergency response services, acute health facilities, and law enforcement.

Indirect cost savings arise from averted bloodborne infections (such as HIV and hepatitis C). For example, the average annual cost for the treatment of hepatitis C (a common infection in people who inject drugs) is $173,840.00 per annum. Thus, the averted costs otherwise borne by the provincial health care system are significant.

Winnipeg Safer Consumption Spaces Consultation and Needs Assessment (TBA)

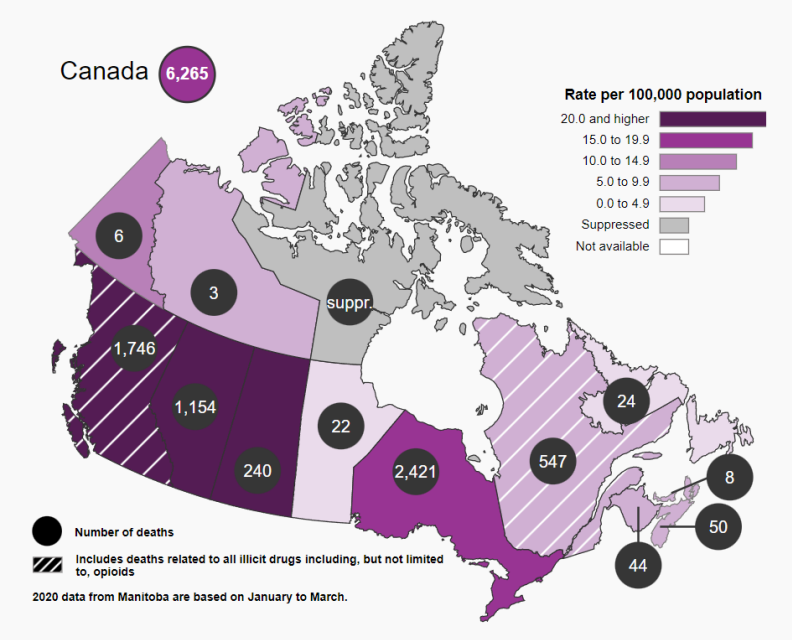
A team from Sunshine House is carrying out a follow-up study to that completed by the Safer Consumption Spaces Working Group. In this study they will again consult with PWUS in Winnipeg about their perspectives on SCS and recommendations for establishing a SCS here in Winnipeg.

The study is in progress and data not yet available at the time of this writing.

Coroner’s Reports (Chief Medical Examiner's Office, 2020)

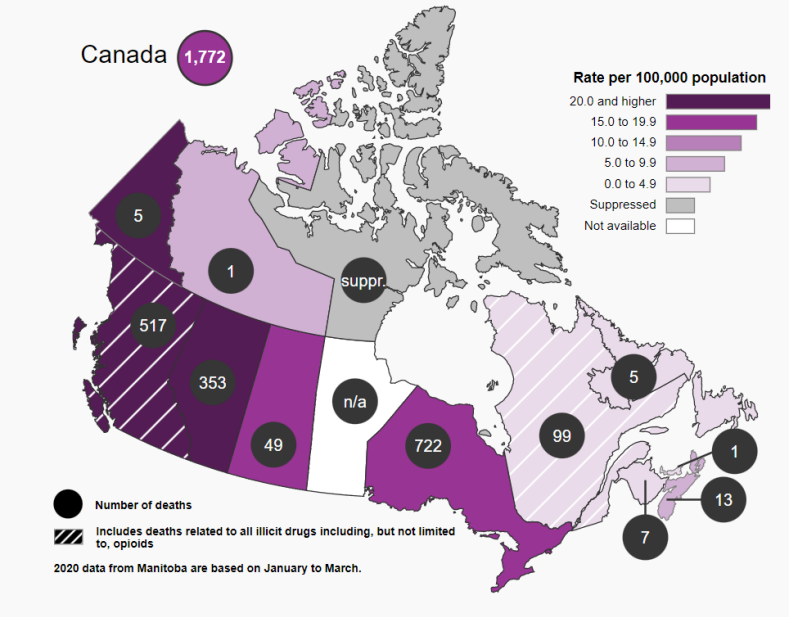
Drug-related deaths in Manitoba increased from 202 deaths in 2018 to 372 in 2020. No other information is available to the public at the time of this writing. According to the Government of Canada, Manitoba had 22 apparent opioid toxicity deaths per 100,000 population in 2020, which is lower than several other provinces (see Figure 1). Opioid toxicity deaths data for 2021 is available in all provinces except Manitoba (see Figure 2). Data on substance use and drug-related deaths seems to be more difficult to acquire in Manitoba than in other Canadian provinces, which have current information publicly posted. Streamlining the timely release of data from the Chief Medical Examiner's Office would bring Manitoba into alignment with other Canadian provinces. It is a level a transparency that Manitobans deserve and that service providers need for planning their services and applying for grants that fund their work.

Figure 1. Number and rates (per 100,000 population) of total apparent opioid toxicity deaths by province or territory in 2020.



Source: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/maps

Figure 2: Number and rates (per 100,000 population) of total apparent opioid toxicity deaths by province or territory in 2021; note the absence of Manitoba data.



Source: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/maps

EMS Reports (City of Winnipeg Fire Paramedic Service, 2021)

Emergency medical services (EMS) data from the City of Winnipeg Fire Paramedic Service (2021) indicate that Winnipeg has a steadily growing substance use problem. Data regarding calls for service that were substance related (alcohol, cocaine, methamphetamine, marijuana, or opioids) are rising (see Table 1 below).

Of note, alcohol is the substance most commonly resulting in calls for service; however, the numbers are declining. While alcohol is decreasing, all other substances are increasing, particularly methamphetamine (234% increase over 5 years) and opioids (336% increase[1]) (see Table 1). So far in 2021, calls for service for methamphetamine and opioid use are on target to surpass 2020's levels.

Table 1. Number of cases where the chief complaint (reason for service call) involved substance use, by substance and year

Year	Alcohol	Cocaine	Methamphetamine	Marijuana	Opioids	Total (Year)
2016	5,715	186	436	189	231	6,747
2017	6,389	192	771	238	298	7,888
2018	5,901	233	1,167	276	198	7,775
2019	5,677	238	1,479	277	398	8,069
2020	4,384	308	1,458	255	1,226	7,631

[1] Calculated by averaging the opioid calls for service between 2016 and 2019 (M=281.25)

Similarly, EMS-administered naloxone (to reverse opioid overdoses) service calls jumped 91.2% from 2019 to 2020, and community-administered naloxone increased 100% over that same period (see Table 2). Manitoba's take-home naloxone program launched in January 2017 (Canadian Agency for Drugs and Technologies in Health [CADTH], 2020), allowing people to have this life-saving, overdose-reversing drug readily available in their homes. The data on take-home naloxone, administered by peers, family, or friends, is more difficult to track because events are not registered at a central location.

Table 2. EMS- and community-administered naloxone, 2016-2020

Year	EMS Administered	Community Administered
2016	1,524	727
2017	1,520	737
2018	1,095	602
2019	1,404	789
2020	2,684	1,579

City of Winnipeg Open Data: Fire Paramedic Calls for Substance Use (City of Winnipeg, 2021c) and Naloxone Administration (City of Winnipeg, 2021b)

The City of Winnipeg has made data publicly available (City of Winnipeg, 2021b, 2021c) for download in CSV format, allowing our team to conduct a spatial analysis of substance use events that resulted in EMS callout and whether or not Naloxone was administered (Wilke et al., 2021). At the University of Manitoba, Ms. Wilke and Dr. Rabbani analyzed the City's Fire and Paramedic Service Substance Use dataset, dating from 2011 to 2021. Neighbourhood boundaries were delineated following the City's census website (City of Winnipeg, 2016) to determine population densities and to group locations of EMS calls. Statistical analyses were performed by Ms. Wilke and Dr. Rabbani using statistical software R (version 4.1). A map of Winnipeg indicating the various neighbourhood clusters is in Appendix A. A map of the four downtown neighbourhoods is in Appendix B. Population counts for each Winnipeg neighbourhood is in Appendix C.

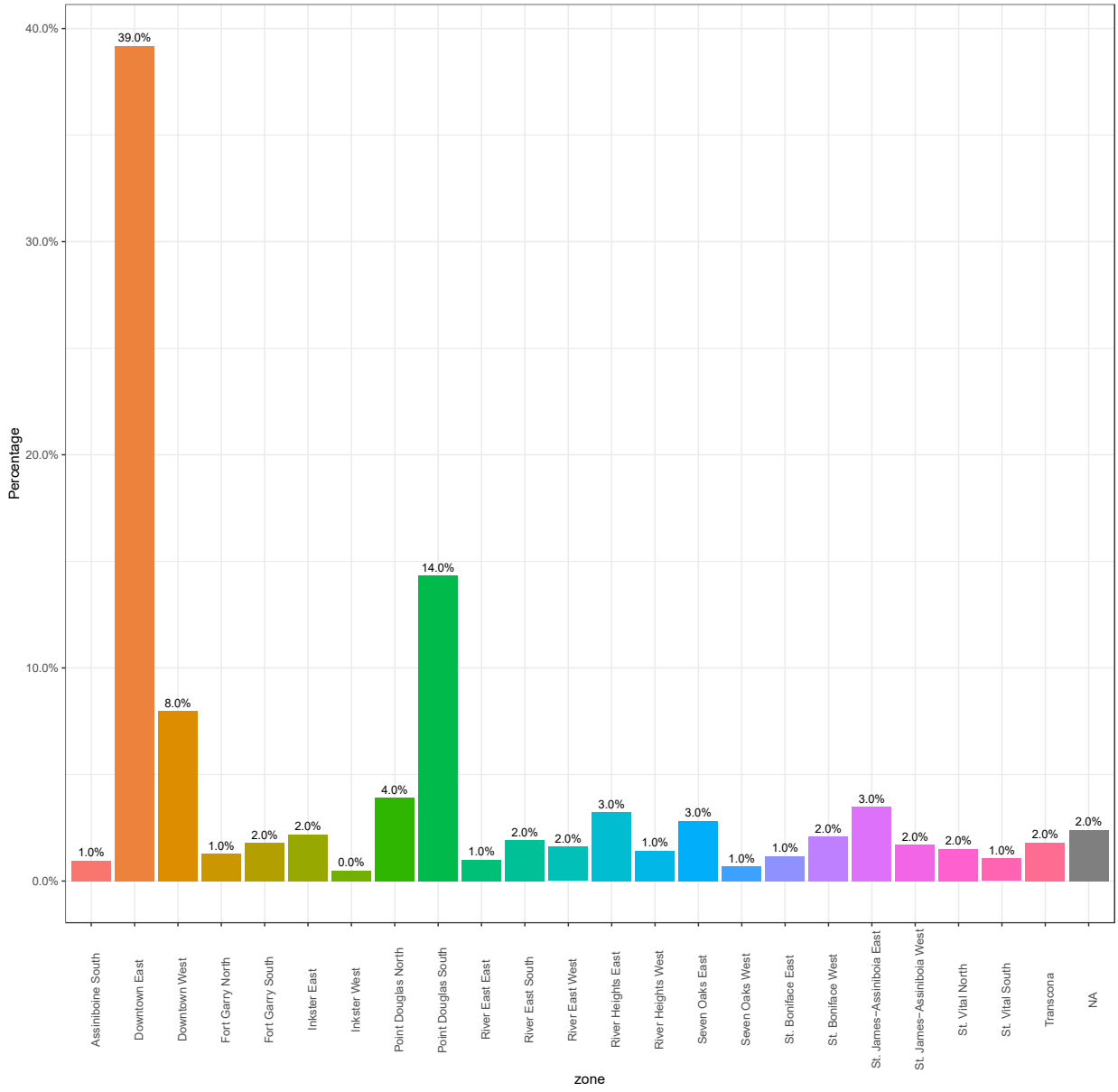
Our goals in conducing this analysis were to:

1. Determine the location of substance use calls, by substance type and by neighbourhood. We hypothesized that while calls are dispersed throughout Winnipeg, there would be a significantly higher density of calls in the downtown core neighbourhoods. The value in identifying "hotspots" is to be able to strategically locate harm reduction services (e.g., needle dropboxes, Naloxone distribution, supervised consumption, overdose prevention, managed alcohol programs) where they are most needed.
2. Determine the location of Naloxone administration by neighbourhood. We hypothesized that the administration of Naloxone (by EMS, not community-administered) would be dispersed throughout Winnipeg with no single areas of density.

Our analysis found that Downtown East (39.0%), Point Douglas South (14.0%), and Downtown West (8.0%) had the highest percentage of substance use calls compared to all other Winnipeg neighbourhoods (see Figure 3). It is important to note that in Figure 3 (below), while the proportions add up to 100% (i.e., the percentage of all EMS substance use calls that are attributable to each Winnipeg neighbourhood), these proportions compare all neighbourhoods across the city

of Winnipeg and do not take into account the population density in each neighbourhood. **It is also imperative to note that these substance use-related calls for EMS service were logged by *location of service*, not *location of the patients' home address*.** As such, the reader should bear in mind that it is not extraordinary that calls for service are more frequent in neighbourhoods that have a higher density of drinking establishments or in areas in which substances are purchased and consumed.

Figure 3. Substance Use-Related EMS Calls Across All Winnipeg Neighbourhoods

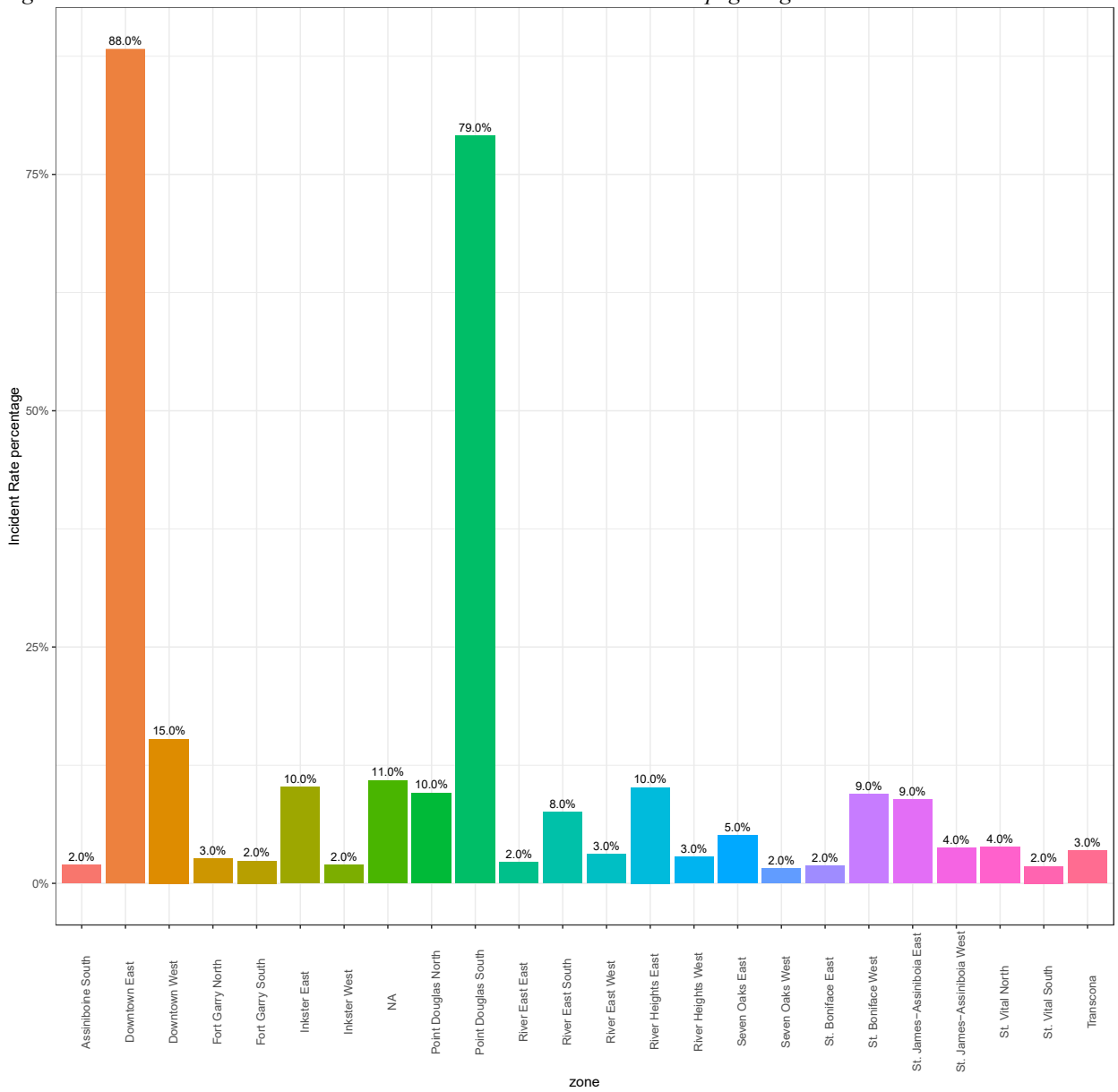


NB: All of the neighbourhood percentages add up to 100%.

The incidence rate for substance use-related EMS calls for service was calculated as the frequency of calls for service, by neighbourhood, using the census count for that neighbourhood (City of Winnipeg, 2016) over the specified time period. The percentage graph in Figure 4 reveals that two (2) downtown areas are the highest in terms of incidence of substance use-related EMS calls:

Downtown East (88%) and Point Douglas South (79.0%). It is important to note that Figure 4 displays the proportion of *substance use-related requests for EMS* in a given neighbourhood by its *population*, not the proportion of the population receiving that service. In other words, it is very likely that some residents are responsible for more calls for EMS than others, and that a large proportion of residents have never requested EMS service for a substance use issue; however, the data was anonymized (i.e. stripped of identifiers) so we were unable to assess those patterns. **As well, as stated above, substance-use related calls for EMS service are logged by *location of service*, not *location of the patients' home address*.** Calls for service are more frequent in neighbourhoods that have a higher density of drinking establishments and in areas in which substances are purchased and consumed.

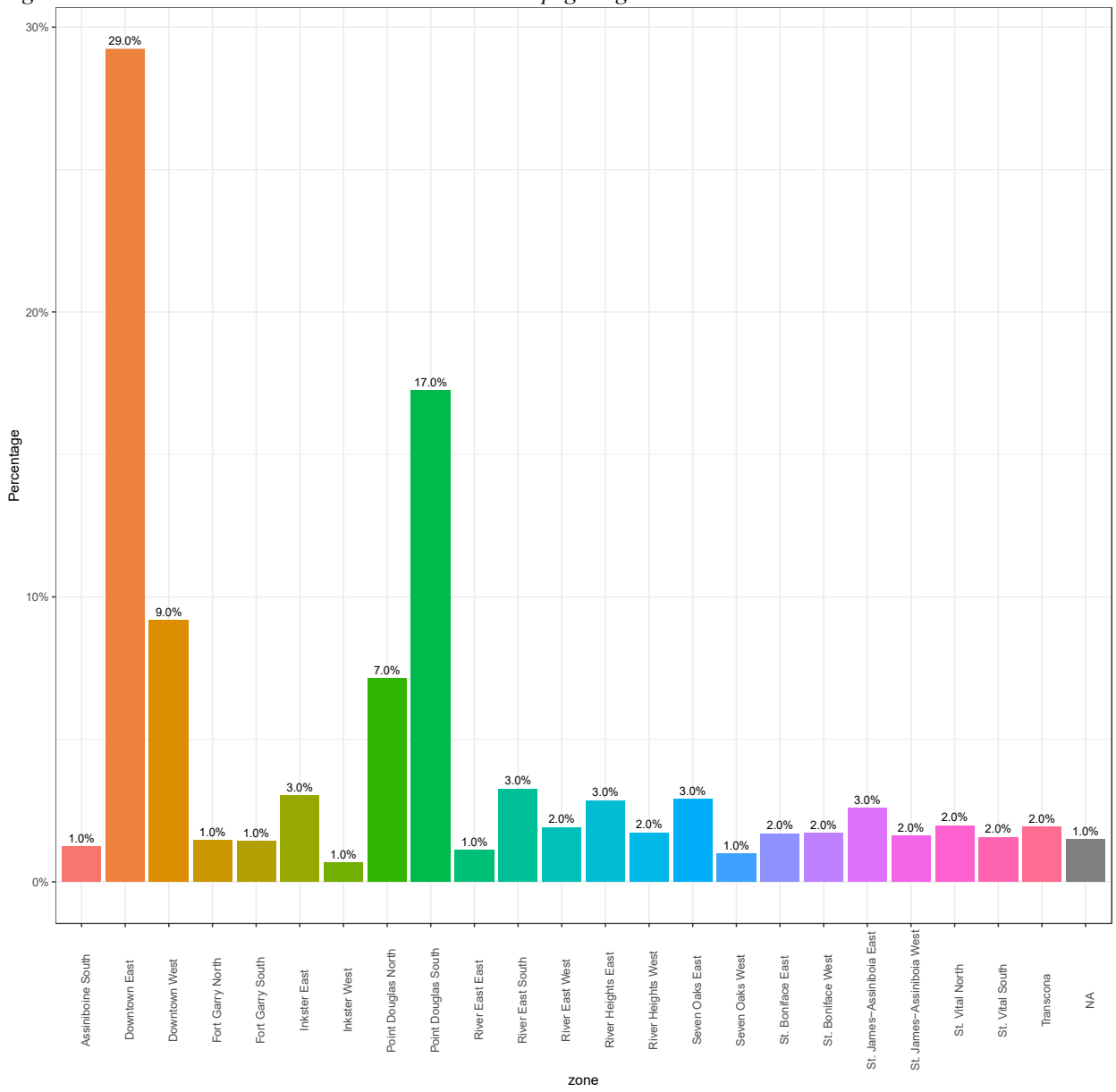
Figure 4. Substance Use-Related EMS Calls - Incidence Across All Winnipeg Neighbourhoods



NB: It is important to note that Figure 4 displays the proportion of *substance use related requests for service* in a given neighbourhood by its *population*, not the proportion of the population receiving that service.

Similarly, EMS-administered Naloxone data was analyzed to assess for hotspots and to see how well these aligned with substance use calls for service. Our analysis found that Downtown East (29%), Point Douglas South (17.0%), Downtown West (9.0%), and Point Douglas North (7.0%) had the highest percentage of EMS-administered Naloxone compared to other Winnipeg neighbourhoods (Figure 5). It is important to note that in Figure 5 (below), while the percentages add up to 100% (i.e., the proportion of calls for EMS-administered Naloxone attributable to each Winnipeg neighbourhood), these proportions do not take into account the population density in each neighbourhood.

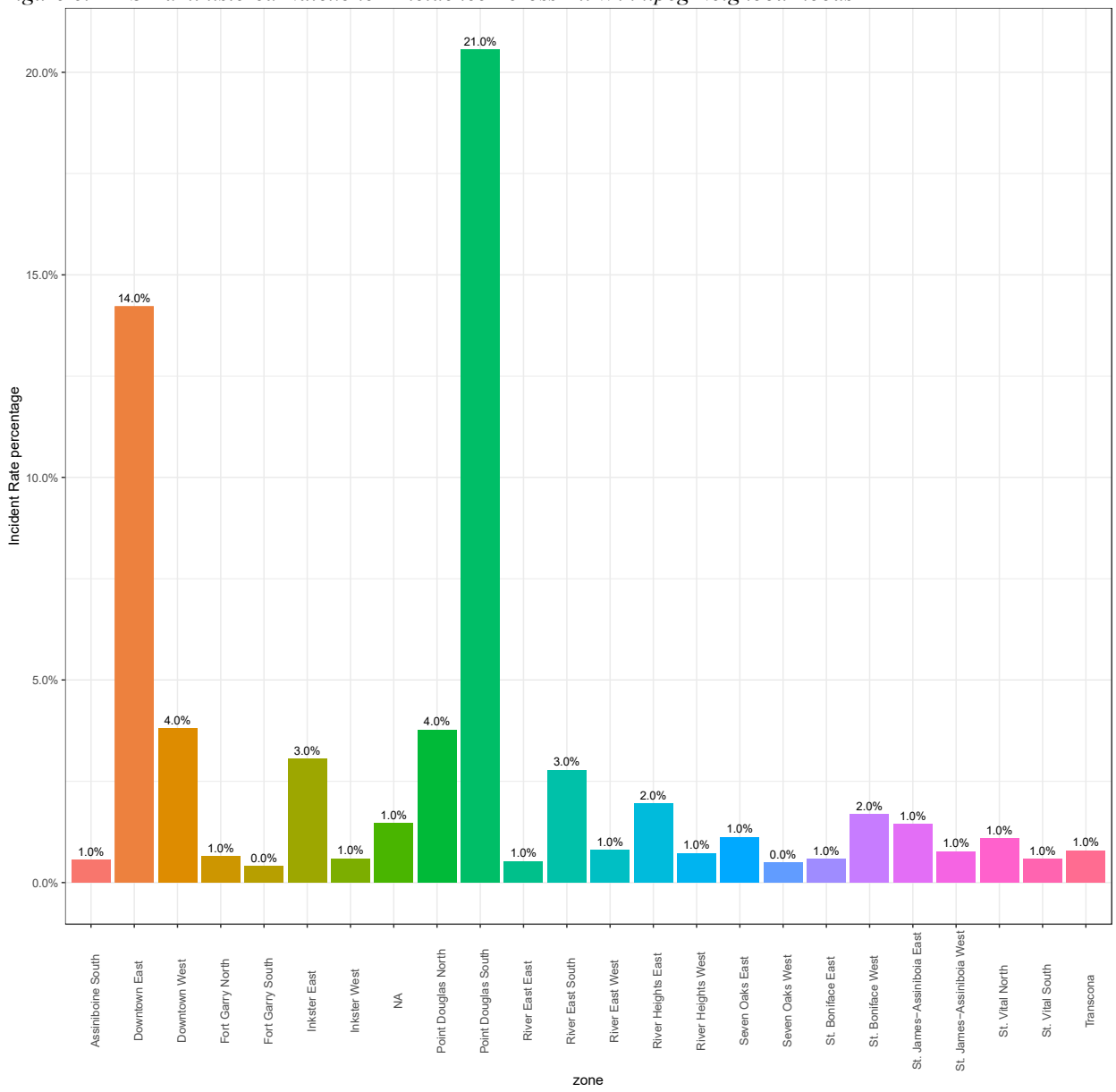
Figure 5. EMS-Administered Naloxone Across All Winnipeg Neighbourhoods



NB: All of the neighbourhood percentages add up to 100%.

The incidence rate for EMS-administered Naloxone was calculated as the frequency of Naloxone, by neighbourhood, using the census count for that neighbourhood (City of Winnipeg, 2016), over the specified time period. The analysis (Figure 6) reveals that two (2) downtown areas are the highest in terms of EMS-administered Naloxone: Point Douglas South (21.0%) and Downtown East (14.0%). It is important to note that Figure 6 displays the proportion of *EMS-administered Naloxone* in a given neighbourhood by its *population*, not the proportion of the population receiving that service. In other words, it is very likely that some neighbourhood residents require Naloxone more frequently than others, and that a large proportion of residents have never required Naloxone.

Figure 6. EMS-Administered Naloxone - Incidence Across All Winnipeg Neighbourhoods



NB: It is important to note that Figure 6 displays the proportion of *EMS-administered Naloxone* in a given neighbourhood by its *population*, not the proportion of the population receiving that service.

The data were then analyzed by type of substance identified in the initial call for EMS. (It should be noted that the reason for the call does not equate to a confirmed diagnosis.) We focused the analysis on the four downtown neighbourhoods identified above: Downtown East, Downtown West, Point Douglas North and Point Douglas South (see area maps in Appendix B). For analysis, these neighbourhoods were scaled to be 100% in their respective substance use percentages, and percentages for each neighbourhood were found using the total count of a specific substance divided by all substance counts and then multiplied by 100.

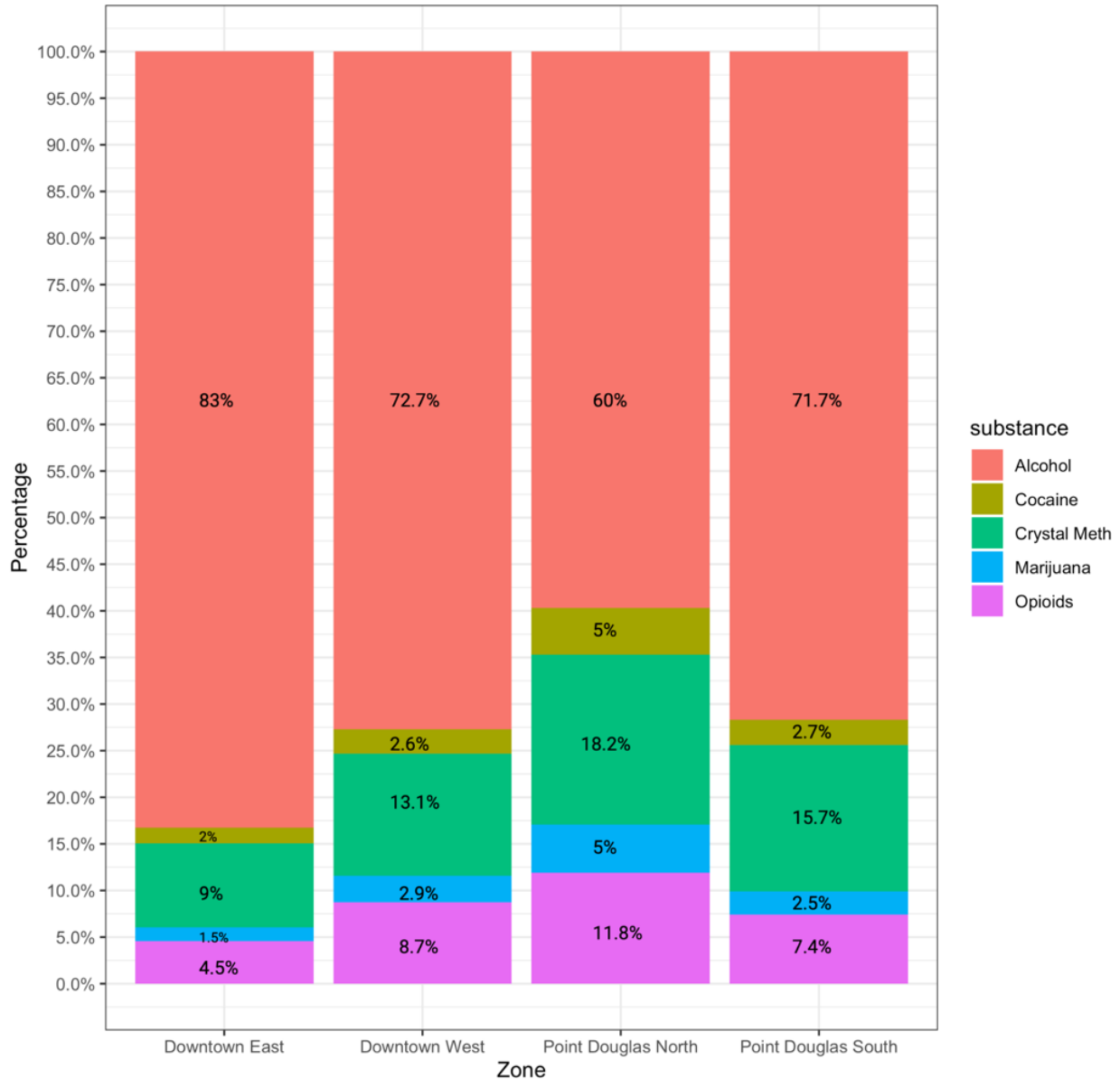
Figure 7 indicates that alcohol was the substance most often responsible for substance use-related calls for EMS in the downtown neighbourhoods. The Downtown East had the highest proportion of substance use-related EMS calls due to alcohol consumption, with 83.0% of calls originating from an event involving alcohol intoxication. Point Douglas North had the lowest proportion (60%) of alcohol-related EMS calls of these four downtown neighbourhoods; however, alcohol-related events accounted for the largest proportion of substance use-related EMS calls across all four downtown neighbourhoods.

The substance responsible for the second highest proportion of substance use-related EMS calls was crystal meth, with the highest number of calls for service in Point Douglas North (18.2%) and the lowest in Downtown East (9%) (of the four downtown neighbourhoods).

The substance responsible for the third highest proportion of substance use-related EMS calls was opioids, with the highest number of calls for service in Point Douglas North (11.8%) and the lowest in Downtown East (4.5%) (of the four downtown neighbourhoods).

As indicated above, it must be restated that in this dataset substance-use related calls for EMS service were logged by *location of service*, not *location of the patients' home address*. Thus, it should not be assumed that substance use-related EMS calls in the downtown are entirely arising from people who live in those neighbourhoods. Downtown neighbourhoods in Winnipeg have **a higher density of drinking establishments than other neighbourhoods in the city, so it is not surprising calls are higher in these areas.**

Figure 7. Calls for Service by Substance Type in the Downtown Neighbourhoods



Next Steps: A Call to Action

Harm reduction measures can foster positive outcomes for communities in Manitoba by enhancing the health and well-being of people who are experiencing problematic substance use. Problematic substance use is a complex issue, and no single approach can solve it in isolation. Long-term solutions to problematic substance use require a public health approach that is multi-pronged and evidence based. Enhancing harm reduction services in Manitoba will require support across several groups and more than one level of government. In this section we outline several recommendations arising from the reports that have been completed in the past five years.

Our recommendations align with the goals, objectives, and policy direction of *OurWinnipeg 2045: Development* Plan (City of Winnipeg, 2020) and *Complete Communities 2.0: An OurWinnipeg Direction Strategy (City of Winnipeg, 2021a)* and we have structured our recommendations accordingly (see Table 3).

Recommendation 1: Renew Manitoba's Provincial Substance Use Strategy

Create a new, official, and coordinated drug strategy that is informed by the best available evidence in public health and rooted in harm reduction principles and practices, in collaboration between the City of Winnipeg and the Province of Manitoba. The Province of Manitoba lacks a stand-alone, provincial-level harm reduction strategy (Hyshka et al., 2017; Smirl, 2020). In 2011, the provincial government published "*Rising to the Challenge: A Strategic Plan for the Mental Health and Well-being of Manitobans*" (Government of Manitoba, 2011), which has a focus on mental health and co-occurring disorders but does not reflect the complexities of the current substance use profile of Manitobans. Most Canadian provincial governments have well-developed drug strategies based on the *Canadian Drugs and Substances Strategy* (Health Canada, 2019).

A provincial drug strategy needs to (1) address inequalities in the social determinants of health, (2) support Indigenous peoples by decolonizing structures, policies, and programs, (3) shift to a health and wellness perspective (instead of a criminalization perspective), (4) involve persons with lived experience, and (5) articulate with regional and municipal strategies. See recommendations in Smirl (2020) and Piscitelli (2017).

In 2015, the Manitoba government created *A Culture of Shared Responsibility: Manitoba's Strategy to Reduce Alcohol-Related Harms.* This strategy mentions harm reduction, but the document unfortunately does not seem to address the needs of people who are experiencing problematic alcohol use, not seeking sobriety, or consuming non-beverage alcohol.

In years past, a "four pillars" approach to substance use was recommended; however, it has recently come under critique. A traditional four pillars drug strategy is comprised of prevention, harm reduction, enforcement, and recovery and rehabilitation. Some models have a fifth pillar of integration, which fosters intersectoral collaboration. The Wellington Guelph (Ontario) Drug Strategy is based on a four pillar approach that includes *community safety* rather than enforcement (Wellington Guelph Drug Strategy, 2017). The community safety pillar works to reduce crime and community harms while also protecting the vulnerable. It encourages a working partnership

between police, justice and social/health service providers and focuses on developing effective pathways to support community members with substance issues.

While prevention, harm reduction and recovery are seeing gains in helping people who are experiencing problematic substance use, enforcement has consistently been counterproductive. Taha et al. (2019) suggest that the "single biggest lesson learned in the enforcement pillar is that arresting individuals who are using drugs will not end the crisis" (p. 5). A shift away from arresting acknowledges that problematic substance use is a chronic health issue rather than a criminal justice issue. To this end, Toronto is developing an alternate model that involves requesting an exemption from Health Canada from the Controlled Drugs and Substances Act for the possession of all drugs for personal use in Toronto (also referred to as decriminalization). This approach resembles Portugal's innovative model that includes decriminalization of illicit drugs for people carrying a personal supply (for up to 10 days). Portugal's strategy also ensures access to a long-term safe supply for chronic opioid users, who can be connected to ongoing treatment and community support. The Portugal model has resulted in lower overdose rates, lower costs of incarceration and health care, and lower rates of property crime (Transform Drug Policy Foundation, 2021).

There is a growing body of evidence that indicates decriminalization is an effective way to help mitigate the harms associated with substance, especially harms associated with criminal justice prosecution for simple possession. Decriminalization is not a single approach, but a range of policies and practices (Canadian Centre on Substance Use and Addiction, 2018).

Indigenous peoples are particularly harmed by not only enforcement but historical and current trauma. It has been suggested that the mainstream four pillar approach to harm reduction will not meet the needs of Indigenous people, particularly those in Northern, rural, and remote communities. The Native Youth Sexual Health Network (NYSHN) advocates for a "Four Fire" model, developed through consultation with youth leaders, young people, Elders, community members, and other Indigenous peoples. This model includes cultural safety, sovereignty, reclamation, and self-determination. NYSHN doesn't advocate for a one-size-fits-all prescriptive approach, but rather suggests that this Four Fire model be applied uniquely in community-specific ways that recognize the diversity of Indigenous peoples. The authors suggest that by "focusing on community well-being and the restoration of various Indigenous knowledge systems, life ways, ceremonies, culture and governance structures, Indigenous peoples of many Nations and cultures can reduce the harm we experience in our lives" (Native Youth Sexual Health Network [NYSHN], 2016). In British Columbia, the First Nations Health Authority proposes a different kind of four-pillar model, with the symbolism of: (1) the wolf (relationships and care); (2) the eagle (knowledge and wisdom); (3) the bear (strength and protection); and (4) the raven (identify and transformation (First Nations Health Authority, n.d.).

Manitoba's distinct lack of a substance use strategy, combined with its lack of services, leaves PWUS vulnerable to stigma, infections, violence, homelessness, illness, injuries, and overdoses. The burden on existing health and police services is significant.

Recommendation 2: Generate Timely Substance Use Death and Overdose Statistics That Are Made Available to the Public

Manitoba would benefit from creating a surveillance system by which up-to-the-minute statistics related to drug-related deaths and overdoses are readily available to the people of Manitoba via an online dashboard. Winnipeg has recently contributed to an open data strategy with their online data for EMS callouts and substance use. A provincial data dashboard could similarly display key indicators and data points about substance use, displaying information in an interactive, intuitive, and visual way for Manitobans. While official reports can be cumbersome, an online dashboard that is kept current would make data readily available to the public. Manitobans and service providers need to know what is happening.

Recommendation 3: Create a Harm Reduction Task Force

Create official community-based and provincially-supported task forces, or expand an existing committee (e.g., STBBI/Problematic Substance Use and Harms, Harm Reduction Expert Task Force) dedicated to expanding harm reduction services in Manitoban communities that need them, including Winnipeg (Smirl, 2020). A dedicated task force could be chaired by a harm reduction position funded by each community and articulate with existing groups, and comprise representatives from the Manitoba Harm Reduction Network, health care, emergency medical services, social work, addictions, law enforcement, Indigenous groups, the Downtown Community Safety Partnership, community agencies that work with PWUS, community development, media/communications, and public policy makers, and include people with lived and living experience.

The purpose of such task forces is to: (1) foster interagency connection, communication and support; (2) reduce duplication while enhancing integration; and (3) strategically align resources to address the harms associated with substance use in Manitoba communities. Local task forces represent a system-level mechanism, supported and developed by local communities, by which agencies and groups that serve people who use substances can engage in interagency meetings to address the fragmentation and "siloed" approach that several reports mentioned. Sample Terms of Reference are in Appendix E.

Recommendation 4: Establish More Low-Barrier Housing

Several reports mentioned the connection between substance use, mental health, and homelessness. Governments must invest in the health and well-being of Manitoba's vulnerable citizens who face barriers to service access and housing and who experience severe health and socioeconomic inequities. This investment includes housing programs that directly impact the lives and wellbeing of vulnerable and Indigenous people. If a person is not housed, there is very little opportunity for them to address their problems. Housing is the first step to a better life. Low-barrier housing means that the person doesn't need to abstain from using substances while living there.

Recommendation 5: Conduct an Environmental Scan and Quantitative Needs Assessment

Commission a formal environmental scan and quantitative needs assessment using a robust sampling method[2] and an established instrument (such as the Edmonton Drug Use and Health Survey) to determine the best course of action for a service delivery model and location(s) for greater harm reduction programming, including the need for supervised consumption services. An environmental scan could be used to gather information such as: the regions with greater density of EMS callouts related to substance use; locations at which needles are being inappropriately discarded; where services are located for PWUS; and locations at which there are heavier concentrations of PWUS. Funding may also be available from CRISM (Canadian Research Initiative in Substance Misuse). Make findings public and base interventions on the data.

Recommendation 6: Implement a Managed Alcohol Program

Many communities in Canada are implementing managed alcohol programs (MAPs) for people experiencing chronic alcohol use and homelessness. Many of these programs are within congregate housing settings such as permanent supportive housing, homeless shelters, and transitional housing. These programs provide regulated and measured doses of alcohol to residents in supportive accommodation to prevent the harms associated with consuming non-beverage alcohol and binge drinking and to provide stable housing. These programs have been shown to reduce the impacts of problematic substance use on the public health systems and reduce contacts with paramedics and law enforcement, particularly when paired with housing (Hammond et al., 2016). For Indigenous people experiencing problematic alcohol use, a reconnection to Indigenous culture along with traditions can help to promote healing (Aboriginal Standing Committee on Housing and Homelessness, 2017).

We believe that a managed alcohol program is essential and must be implemented prior to or at the same time as a supervised consumption service. Methamphetamine is both cheap and readily available, and easier to procure than alcohol. Thus, providing access to alcohol is an important harm reduction measure to prevent people from switching to methamphetamine and to more risky methods of consumption.

Recommendation 7: Introduce Supervised Consumption Services

SCS are a powerful and accessible way to minimize the devastating consequences of the ongoing opioid crisis and substance use at large. Perhaps most importantly, SCS permit PWUS to openly talk about their problems and provide the resources to send them down the path to greater life stability improved mental health, and higher self-efficacy.

We recommend that funding is committed to introduce an interim overdose prevention service as soon as possible, and then by next summer, open two bricks-and-mortar supervised consumption sites and one mobile supervised consumption service in the city. These services must deliver a wide range of services, including but not limited to: drug checking, health care, housing assistance, STBBI testing, safe spaces to consume (inject or smoke) substances, counseling, and culturally appropriate care. Past research shows that SCS and affiliated services operate better as part of a

[2] Such as respondent driven sampling; n=300-400

larger coordinated spectrum of addictions care. An Indigenous approach to supervised consumption services must be Indigenous-led, peer-engaged, and inclusive. (Interagency Coalition on AIDS and Development & Canadian Aboriginal AIDS Network, 2019).

Operational guidance is provided from the British Columbia Centre on Substance Use (2017b) and Toronto Public Health (2017). Additionally, in Winnipeg, MNP and Community Wellness and Public Safety Alliance (2018) created a detailed plan for enhancing care for people experiencing substance use and mental health issues. Effective harm reduction approaches for Indigenous peoples are highlighted by the First Nations Health Authority (n.d.; 2013), the Interagency Coalition on AIDS and Development and Canadian Aboriginal AIDS Network (2019), Aboriginal Standing Committee on Housing and Homelessness (2017) and CATIE (2020).

We recognize that establishing SCSs in Manitoba can make some people feel uncomfortable. For this reason, we recommend a community-wide strategy that brings people along and engages both the public and people who use substances. We recommend careful planning and consideration to determine how to make this service come to fruition in a manner that promotes better health for PWUS and integrates with the community and existing services.

Recommendation 8: Introduce Drug Checking Services

Drug checking services can identify poisoned drugs so that PWUS can know what substances they are consuming, thus reducing overdose deaths. Drug checking can also contribute to provincial surveillance of illicit drugs that are circulating in the province. Within the context of an increasingly poisoned drug supply, which has been contributing to rising morbidity and mortality rates in Manitoba, drug checking services would also be beneficial, using gas chromatography/mass spectroscopy (British Columbia Centre on Substance Use, 2017a, 2019a, 2019b, 2019c; Harper et al., 2017). A drug checking service could extend the reach of harm reduction beyond SCS, as people that live outside of Winnipeg's central core could test their substances prior to consuming them in their homes.

Table 3. Recommendations and Their Alignment to OurWinnipeg Policies and Directions

Recommendation	*OurWinnipeg* Policies and Directions
Recommendation 1: Renew Manitoba's Provincial Substance Use Strategy	*Policy 1.5:* Evidence-Informed Decisions. Invest in data and technology in order to support **objective, evidence-informed decision-making**; support open government and **open data principles for collection and sharing**; help coordinate records and information management; and improve process efficiency and results-based service delivery. Residents are entitled to know, understand and consent to the data collected about them. *Policy1.15:* Community Capacity Development. **Partner with community organizations** to enable community development, leadership and empowerment opportunities, by leveraging municipal programming and service resources … **in particular for systemically disadvantaged groups and for those living in areas of highest need.**

Recommendation	*OurWinnipeg* Policies and Directions
	Policy 4.2: Evidence-Informed Health Action. **Leverage strategic partnerships on community health and development activities that promote resource pooling, data collection, information sharing, and joint action.** *Policy 4.3:* Proactive Health Intervention. Utilize **social determinants of health** to understand and achieve poverty reduction, **crime prevention and harm reduction**. Practice early intervention and engage in **community partnerships that fully leverage wrap-around supports, recreation and resources, and enable opportunities for all, and especially for those who are systemically disadvantaged.**
Recommendation 2: Generate Timely Substance Use Death and Overdose Statistics That Are Made Available to the Public	*Policy 1.5:* Evidence-Informed Decisions. Invest in data and technology in order to support **objective, evidence-informed decision-making**; support open government and **open data principles for collection and sharing**; help coordinate records and information management; and improve process efficiency and results-based service delivery. Residents are entitled to know, understand and consent to the data collected about them.
Recommendation 3: Create a Harm Reduction Task Force	*Policy 1.11:* Representative and Participatory Democracy. Create **meaningful engagement opportunities with impacted residents and stakeholders, ensuring notification and information-sharing on decision-making processes and when public feedback will influence the outcome**. *Policy 4.1:* Health Equity. Provide municipal services through a health equity lens, to fully **leverage desired health and safety outcomes through proactive community development opportunities.** *Policy 4.2:* Evidence-Informed Health Action. **Leverage strategic partnerships on community health and development activities that promote resource pooling, data collection, information sharing, and joint action.**
Recommendation 4: Establish More Low-Barrier Housing with Services	*Policy 1.16:* Equitable Funding Distribution. Decisions on external requests for public funding and resources must be determined using predictable and transparent criteria to prioritize community-led organizations that **respond to the needs of systemically disadvantaged groups**, and demonstrate long-term community benefit through this Plan's goals. *Policy 3.12:* Poverty Reduction. Support poverty reduction through a community economic development approach that **addresses systemic barriers to opportunity and participation, particularly in areas of highest need.**

Recommendation	*OurWinnipeg* Policies and Directions
	Policy 5.4: Reconciliation with Indigenous Peoples. **Prioritize municipal implementation responsibilities** within the United Nations **Declaration on the Rights of Indigenous Peoples,** the Truth and Reconciliation Commission of Canada's Calls to Action and the National Inquiry into Missing and Murdered Indigenous Women and Girls' Calls for Justice. *Policy 5.5:* Indigenous Lens. **Develop an Indigenous lens, which recognizes, respects, and advances multiple and diverse First Nations, Inuit, and Métis rights, knowledge, and perspectives**. Apply the lens throughout municipal leadership and governance processes, policies, programs, and practices to be inclusive and eliminate elements that knowingly or unknowingly enable the exclusion of Indigenous Peoples. *Policy 5.6:* Equitable Service Access. Welcome and support Indigenous Peoples, newcomers, and those who migrate from rural communities, through strategic collaboration and action that expedites **service access and sense of belonging for residents.**
Recommendation 5: Conduct an Environmental Scan and Quantitative Needs Assessment	*Policy 1.4:* Integrated Knowledge and Resources. Coordinate inter-departmental systems, projects and resources, making the best use **of internal and external expertise to better understand service needs**, find the **most appropriate solutions, optimize resources, and maximize community outcomes.** *Policy 1.17:* Neighbourhood Needs Assessment. Invest in neighbourhood revitalization and supportive land uses, without contributing to gentrification or the displacement of systemically disadvantaged people, by layering interdepartmental and **community data to better understand socio-economic needs, gaps and resource pooling required for collaborative action.** *Policy 1.5:* Evidence-Informed Decisions. Invest in data and technology in order to support **objective, evidence-informed decision-making**; support open government and **open data principles for collection and sharing**; help coordinate records and information management; and **improve process efficiency and results-based service delivery**. Residents are entitled to know, understand, and consent to the data collected about them.
Recommendation 6: Implement a Managed Alcohol Program **Recommendation 7: Introduce Supervised Consumption Services**	*Policy 1.7:* Equitable Service Access. Identify and provide access to **a base level of municipal services to everyone, directly or facilitated through partnerships. Remove systemic barriers to participation**, based on race, … physical or mental ability, a conviction for which a pardon has been granted or a record suspended, … socioeconomic status, geographic location…

Recommendation	*OurWinnipeg* Policies and Directions
Recommendation 8: Introduce Drug Checking Services	*Policy 5.1:* Equitable Service Access. Provide municipal services through an age-friendly lens that **promotes equitable access for all,** with a focus on the youngest, oldest, and **systemically disadvantaged members of the community.** *Policy 1.15:* Community Capacity Development. **Partner with community organizations** to enable community development, leadership, and empowerment opportunities, by leveraging municipal programming and service resources … **in particular for systemically disadvantaged groups and for those living in areas of highest need.** *Direction: C1 Downtown – Goal 3:* Ensure inclusive … services Downtown [that] reflect the **diversity of our population**. *Direction: C1 Downtown – Policy 3.4*: Supportive services. Ensure that Downtown is an **inclusive place by facilitating ongoing access to supportive services**.
	Policy 4.3: Proactive Health Intervention. Utilize **social determinants of health** to understand and achieve poverty reduction, **crime prevention and harm reduction**. Practice early intervention and engage in **community partnerships that fully leverage wrap-around supports, recreation and resources, and enable opportunities for all, and especially for those who are systemically disadvantaged.** *Policy 4.6:* Community Safety. Facilitate a culture of **safety and crime prevention** across the City and community, by building trusting relationships to enable collaborative action. *Policy 4.7:* Community Safety. Provide **capacity to prepare, mitigate, assess risk, respond to and recover from** … human or natural emergencies, disasters, and diseases, to promote community resilience within a changing hazard landscape. *Policy 4.9:* Inclusive Public Places. Provide and promote the amenities, and the design and maintenance standards, necessary to ensure accessible, **safe, and sanitary conditions in gathering spaces** frequented by the public. *Policy 4.11:* Equitable Service Access. Prioritize equitable access to … services, and infrastructure, in order to: …create supportive environments; build community capacity; and achieve desired health outcomes… *Direction: C1 Downtown – Policy 5.4:* Ensure Crime Prevention Through Environmental Design (CPTED) principles are integrated into development to increase safety and perceptions of safety.

Recommendation	*OurWinnipeg* Policies and Directions
	Direction: C1 Downtown – Policy 5.4.1: Ensure CPTED interventions incorporate lived experiences and local knowledge to maximize widespread access, usability, safety, and quality of life for all users.

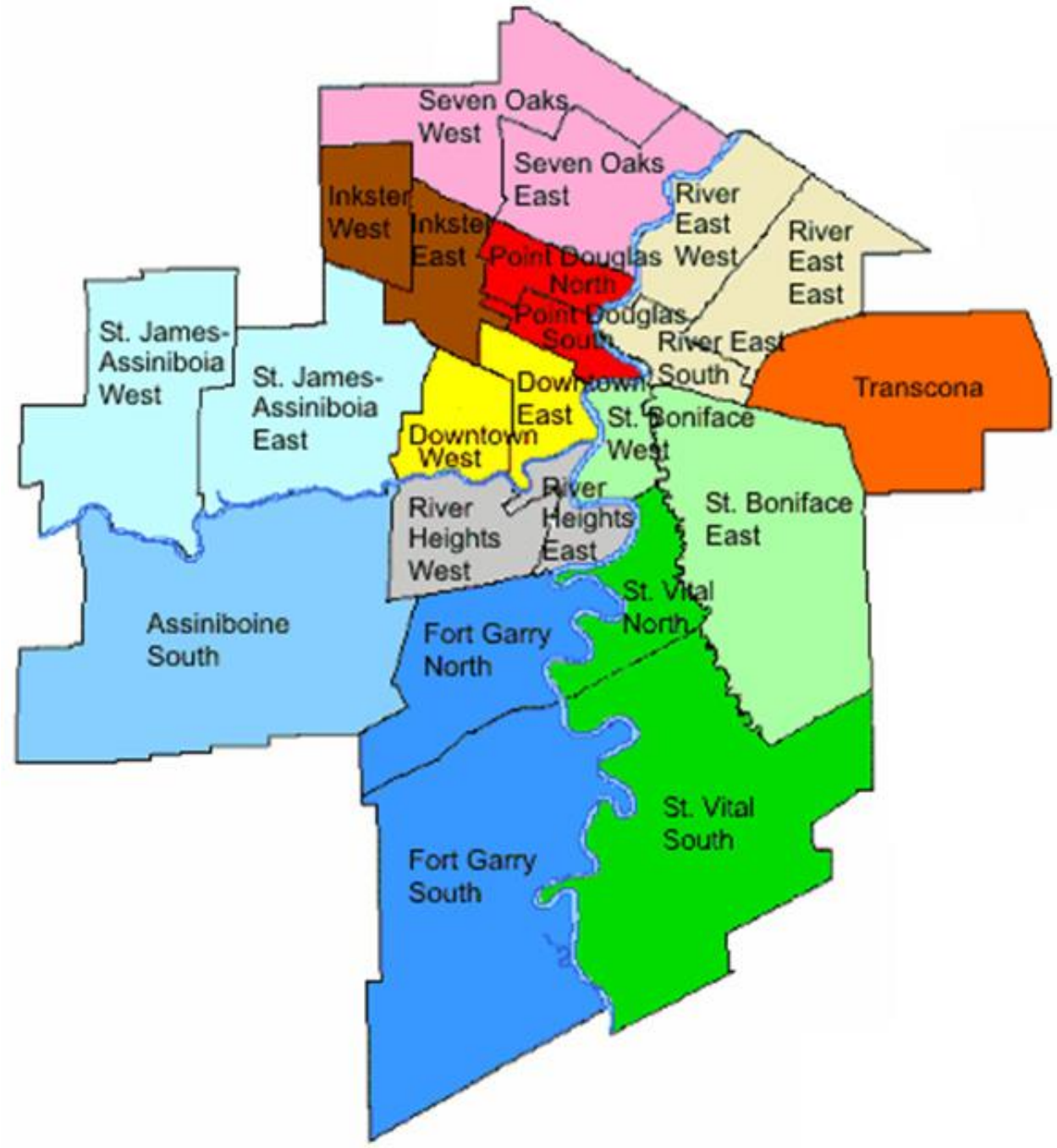
Conclusion

Mental health and addictions care in Manitoba needs to shift towards a progressive strategy that includes services and supports for the most marginalized people in our province – people experiencing problematic substance use. For many years, substance use was viewed as a criminal matter, an issue handled solely by law enforcement, courts, and corrections. This approach, however, failed to address the socioeconomic and mental health-related issues that often lead to substance use problems. This approach also worsened the stigma associated with substance use and most leading experts agree that the "war on drugs" has been a disaster.

Manitoba has many hard-working and committed community-based organizations and activists ready to assist in the development of new harm reduction initiatives in our province. Throughout this report, we have highlighted a breadth of important information, statistics, and resources to help get this process started. We also have a very skilled workforce in Manitoba that is ready to do this very important work: saving lives, promoting better health, and providing a pathway to treatment. Our continued effort to implement managed alcohol programs, low barrier housing, and supervised consumption services relies heavily on the support of municipal and provincial governments to help streamline this process with allocated funding and advocacy. We look forward to continuing to help our government officials understand the efficacy of harm reduction and move towards better health policy changes in Manitoba.

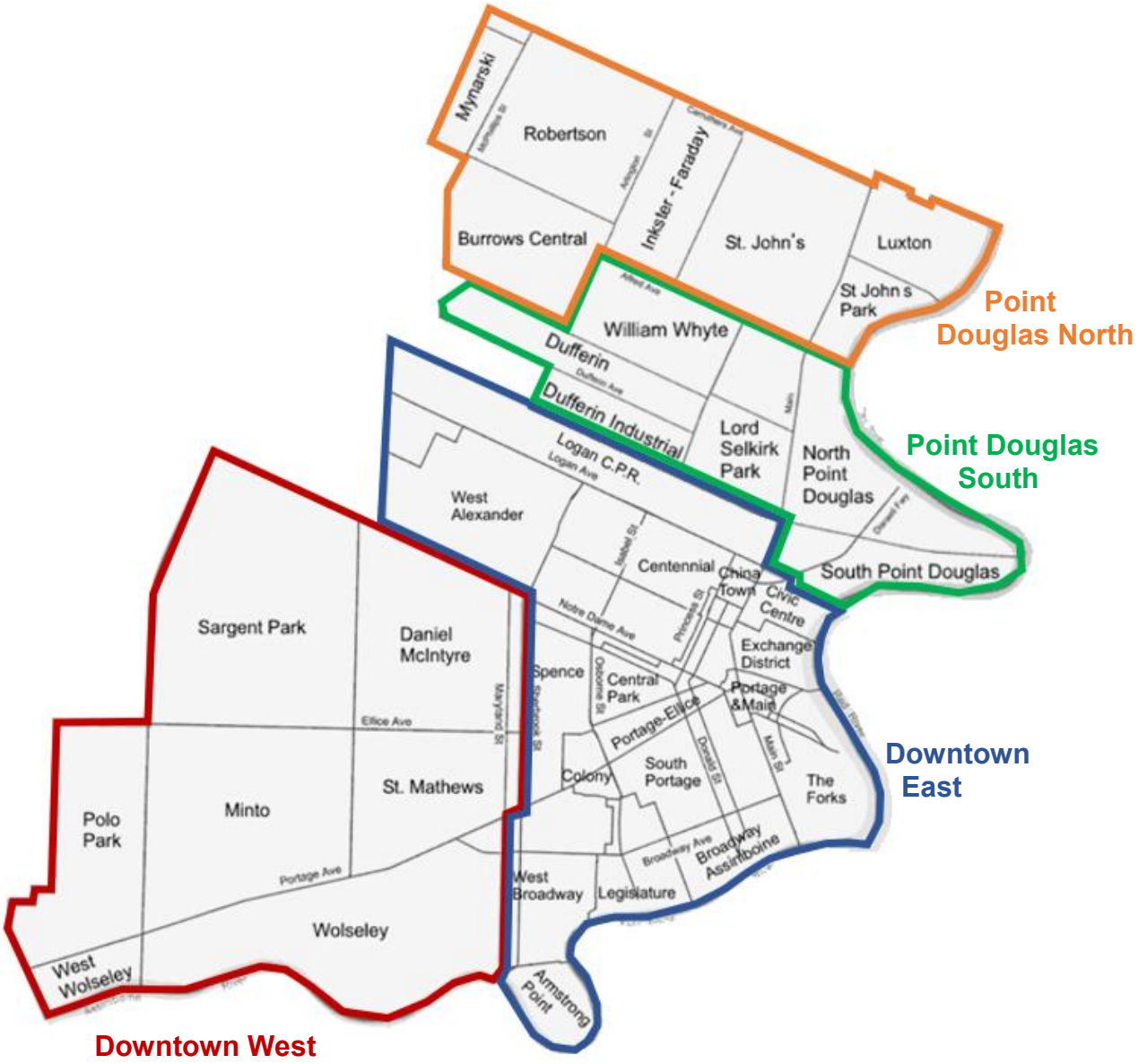
Appendix A: Winnipeg Neighbourhood Clusters (Census, 2016)

An overview of Winnipeg's neighborhoods:



Appendix B: Winnipeg's Downtown Neighbourhoods (Census, 2016)

Winnipeg's downtown neighbourhoods in detail:



Appendix C: Winnipeg Neighbourhood Populations (Census, 2016)

Neighbourhood	Population	Entire Neighbourhood			Populated Areas Only		
		Land Area (km^2)	Population Density (per km^2)	% of City Area	Land Area (km^2)	Population Density (per km^2)	% of City Area
Assiniboine South	33,405	61.2	545.5	12.9%	51.6	647.3	14.0%
Downtown East	30,715	7.6	4,060.8	1.6%	6.5	4,702.0	1.8%
Downtown West	36,135	8.8	4,125.0	1.8%	8.8	4,125.0	2.4%
Fort Garry North	33,680	21.3	1,580.9	4.5%	14.4	2,336.0	3.9%
Fort Garry South	52,095	55.7	934.6	11.7%	24.0	2,172.0	6.5%
Inkster East	14,840	9.1	1,625.0	1.9%	3.8	3,949.9	1.0%
Inkster West	17,145	9.0	1,912.5	1.9%	7.1	2,403.0	1.9%
Point Douglas North	28,260	6.3	4,517.7	1.3%	6.3	4,517.7	1.7%
Point Douglas South	12,535	4.6	2,714.5	1.0%	4.2	3,001.8	1.1%
River East East	31,255	15.7	1,996.7	3.3%	13.7	2,284.2	3.7%
River East South	17,560	6.1	2,859.0	1.3%	4.9	3,614.4	1.3%
River East West	35,790	12.9	2,777.7	2.7%	12.9	2,777.7	3.5%
River Heights East	21,980	5.9	3,732.7	1.2%	5.9	3,732.7	1.6%
River Heights West	35,395	12.2	2,898.1	2.6%	12.2	2,898.1	3.3%
Seven Oaks East	38,555	17.4	2,215.7	3.7%	14.2	2,714.6	3.9%
Seven Oaks West	29,805	22.5	1,326.1	4.7%	22.5	1,326.1	6.1%
St. Boniface East	43,230	41.6	1,038.0	8.8%	29.9	1,447.9	8.1%
St. Boniface West	15,290	6.0	2,545.9	1.3%	6.0	2,545.9	1.6%
St. James-Assin. East	26,995	28.8	938.3	6.1%	20.1	1,340.4	5.5%
St. James-Assin. West	31,490	30.5	1,032.6	6.4%	16.7	1,880.4	4.5%
St. Vital North	27,170	10.8	2,506.1	2.3%	10.8	2,506.1	2.9%
St. Vital South	40,410	52.4	770.6	11.0%	51.0	792.5	13.8%
Transcona	36,285	28.8	1,260.9	6.1%	20.8	1,748.1	5.6%
WINNIPEG	**705,244**	**475.2**			**368.2**		

Appendix D: Letters of Support

Aboriginal Health & Wellness Centre of Winnipeg, Inc.
181 Higgins Avenue, Suite 215 Winnipeg, Manitoba R3B 3G1
Telephone: (204) 925-3700 Fax (204) 925-3709

December 17, 2021

To the Legislative Assembly of Manitoba; Sherri Rollins – City Councillor Fort-Rouge, East Fort Garry

On behalf of Aboriginal Health and Wellness Centre of Winnipeg, Inc. (AHWC), I am writing in support for the establishment of a supervised consumption service in Winnipeg. Over the past several years, overdose deaths continue to rise in Winnipeg, and HIV transmission rates continue to increase due to intravenous drug use. Although this public health crisis continues in our city, currently Winnipeg is the only city west of the Maritime provinces that does not have any supervised consumption services.

We are also deeply concerned that Indigenous people are disproportionately represented among the clients we serve. The ongoing legacy of colonial violence, residential schools, and structural racism has resulted in deep traumatization and ongoing pain. The legacy of residential schools continues into the present day as reflected in the health and social disparities between Indigenous and non-Indigenous Canadians—a heartbreaking reality that we witness every day at AHWC.

The Calls to Action in the Truth and Reconciliation Commission Final Report urges Canadian leaders and governments to recognize and address distinct health needs of First Nations, Metis, Inuit peoples and to provide sustainable funding for existing and new healing centres. Harm reduction services that are Indigenous-created and Indigenous-led are a priority for Winnipeg and Manitoba.

AHWC is an Indigenous-governed, community-based, social service, housing support, and health organization committed to offering a continuum of holistic and contemporary healing services to the Urban Indigenous community of Winnipeg. AHWC provides services and supports to individuals experiencing homelessness or at risk of homelessness through Doorways coordinated intake and assessment, Housing and Housing Support Programs, Social Support Programs and the Primary Care Clinic. AHWC is committed to caring for people experiencing problematic substance use, homelessness/housing insecurity and social marginalization.

We support the recently completed report, *Harm Reduction Services in Winnipeg: A Consolidating Report and Call to Action*, which compiles all the reports in Winnipeg that highlight a dire need for services for people experiencing problematic substance use and social disenfranchisement.

This letter is symbolic of our common goal among other community-based organizations in Winnipeg that stand together in solidarity and commitment for the establishment of greater harm reduction services, including managed alcohol services and supervised consumption services.

We encourage the City of Winnipeg and the Government of Manitoba to commit to creating a safe place to prevent overdose deaths, reduce blood borne infections, and lower heath inequities for people experiencing problematic substance use. Our hope is that governments will consider the action plan for the development of a supervised consumption site and additional harm reduction services in Winnipeg. We appreciate your consideration for this proposal and look forward to your timely response to this initiative.

Sincerely,

Della Herrera

Della Herrera
Executive Director
The Aboriginal Health and Wellness Centre of Winnipeg, Inc.

Klinic COMMUNITY HEALTH

167 Sherbrook Street, Winnipeg Manitoba R3C 2B7 | **phone:** (204) 784-4090
admin. fax: (204) 772-7998 | **medical fax:** (204) 784-4013 | **e-mail:** klinic@klinic.mb.ca

December 22, 2021

To the Legislative Assembly of Manitoba:

On behalf of Klinic Community Health, I am writing in support for the establishment of a supervised consumption service in Winnipeg. Over the past several years, overdose deaths continue to rise in Winnipeg, and HIV transmission rates continue to increase due to intravenous drug use. Although this public health crisis continues in our city, currently Winnipeg is the only city West of the Maritime provinces that does not have any supervised consumption services.

We are also deeply concerned that Indigenous people are disproportionately represented among the clients we serve. The ongoing legacy of colonial violence, residential schools, and structural racism has resulted in deep traumatization and ongoing pain. The legacy of residential schools continues into the present day as reflected in the health and social disparities between Indigenous and non-Indigenous Canadians—a heartbreaking reality that we witness every day at Klinic Community Health.

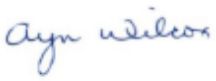
The calls to action in the Truth and Reconciliation Commission Final Report urges Canadian leaders and governments to recognize and address distinct health needs of First Nations, Metis, Inuit peoples and to provide sustainable funding for existing and new healing centres. Harm reduction services that are Indigenous-created and Indigenous-led are a priority for Winnipeg and Manitoba.

Klinic Community Health is committed to caring for people experiencing problematic substance use, homelessness/housing insecurity and social marginalization [and any other populations]. Klinic Community Health is committed to caring for people experiencing problematic substance use, homelessness/housing insecurity and social marginalization [and any other populations]. We continue to witness the impacts of chronic substance use and advocate for supervised consumption services based on our Vision, Mission & Values - Klinic Community Health. All of Klinic's programs and services are grounded in the harm reduction philosophy. We support the Harm Reduction Position Statements of both the Winnipeg Regional Health Authority and Manitoba Health, in recognition that there is a dire need for services for people experiencing problematic substance use and social disenfranchisement. We support the recently completed report, *Harm Reduction Services in Winnipeg: A Consolidating Report and Call to Action,* which compiles all the reports in Winnipeg that highlight a dire need for services for people experiencing problematic substance use and social disenfranchisement.

This letter is symbolic of our common goal among other community-based organizations in Winnipeg that stand together in solidarity and commitment for the establishment of greater harm reduction services, including managed alcohol services and supervised consumption services.

We encourage the City of Winnipeg and the Government of Manitoba to commit to creating a safe place to prevent overdose deaths, reduce blood borne infections, and lower heath inequities for people experiencing problematic substance use. Our hope is that governments will consider the action plan for the development of a supervised consumption site and additional harm reduction services in Winnipeg. We appreciate your consideration for this proposal and look forward to your timely response to this initiative.

Sincerely,



Ayn Wilcox
Executive Director
Klinic Community Health

Just Care. *For Everyone.*
www.klinic.mb.ca

nine circles
COMMUNITY HEALTH CENTRE

705 Broadway
Winnipeg, Manitoba
R3G 0X2

Phone: 204 940-6000
Fax: 204 940-6003
E-mail: ninecircles@ninecircles.ca

MEETING THE MOMENT
HEALTH CLINIC

December 21, 2021

To Sherri Rollins and City of Winnipeg Councillors

On behalf of **Nine Circles Community Health Centre** and the **Meeting the Moment Project** I am writing in support for the establishment of a supervised consumption service in Winnipeg. Over the past several years, overdose deaths continue to rise in Winnipeg, and HIV transmission rates continue to increase due to intravenous drug use. Although this public health crisis continues in our city, currently Winnipeg is the only city West of the Maritime provinces that does not have any supervised consumption services.

We are also deeply concerned that Indigenous people are disproportionately represented among the clients we serve. The ongoing legacy of colonial violence, residential schools, and structural racism has resulted in deep traumatization and ongoing pain. The legacy of residential schools continues into the present day as reflected in the health and social disparities between Indigenous and non-Indigenous Canadians—a heartbreaking reality that we witness every day at [Agency].

The calls to action in the Truth and Reconciliation Commission Final Report urges Canadian leaders and governments to recognize and address distinct health needs of First Nations, Metis, Inuit peoples and to provide sustainable funding for existing and new healing centres. Harm reduction services that are Indigenous-created and Indigenous-led are a priority for Winnipeg and Manitoba.

Nine Circles is committed to caring for people experiencing problematic substance use, homelessness/housing insecurity and social marginalization. We continue to witness the impacts of chronic substance use and advocate for supervised consumption services based on our mandate to work with people who use drugs (PWUD) in Winnipeg, or who are unstably housed, or experience social exclusion/isolation, in Winnipeg's Downtown and Point Douglas neighbourhoods. As an organization we acknowledge our role in the systems of colonization and the work we have to do to dismantle them. We commit to promoting reconciliation in our thinking and actions and using our influence and leadership to promote these values to the communities we serve. We commit to reading and reflecting on the Calls to Action released by the Truth and Reconciliation Commission of Canada, and the Calls for Justice released through the National Inquiry into Missing and Murdered Indigenous Women and Girls, and other Indigenous works. We commit to integrate knowledge of the events of the past and present in an effort to establish respectful relationships among Indigenous and Non-Indigenous people.

We support the recently completed report, *Harm Reduction Services in Winnipeg: A Consolidating Report and Call to Action,* which compiles all the reports in Winnipeg that highlight a dire need for services for people experiencing problematic substance use and social disenfranchisement.

ninecircles
COMMUNITY HEALTH CENTRE

705 Broadway
Winnipeg, Manitoba
R3G 0X2

Phone: 204 940-6000
Fax: 204 940-6003
E-mail: ninecircles@ninecircles.ca

MEETING THE MOMENT
HEALTH CLINIC

This letter is symbolic of our common goal among other community-based organizations in Winnipeg that stand together in solidarity and commitment for the establishment of greater harm reduction services, including managed alcohol services and supervised consumption services.

We encourage the City of Winnipeg and the Government of Manitoba to commit to creating a safe place to prevent overdose deaths, reduce blood borne infections, and lower heath inequities for people experiencing problematic substance use. Our hope is that governments will consider the action plan for the development of a supervised consumption site and additional harm reduction services in Winnipeg. We appreciate your consideration for this proposal and look forward to your timely response to this initiative.

Sincerely,

Sarah Hansen, RPN (she/her)
Project Manager for the Meeting the Moment Project
Nine Circles Community Health Centre
705 Broadway
Winnipeg, MB
R3G 0X2
(204)599-0871

Sunshine House, Inc.
646 Logan Avenue
Winnipeg, MB R3A 0S7
ph. 204.783.8565
fx. 204.772.7237

21 December 2021

To the Legislative Assembly of Manitoba, Mayor Brian Bowman and Winnipeg City Council

On behalf of Sunshine House, I am writing in support for the establishment of a supervised consumption service in Winnipeg. Over the past several years, overdose deaths continue to rise in Winnipeg, and HIV transmission rates continue to increase due to intravenous drug use. Although this public health crisis continues in our city, currently Winnipeg is the only city west of the Maritime provinces that does not have any supervised consumption services.

We are also deeply concerned that Indigenous people are disproportionately represented among the clients we serve. The ongoing legacy of colonial violence, residential schools, and structural racism has resulted in deep traumatization and ongoing pain. The legacy of residential schools continues into the present day as reflected in the health and social disparities between Indigenous people and non-Indigenous Canadians—a reality that we witness every day at Sunshine House.

The calls to action in the Truth and Reconciliation Commission Final Report urges Canadian leaders and governments to recognize and address distinct health needs of First Nations, Metis, Inuit peoples and to provide sustainable funding for existing and new healing centres. Harm reduction services that are Indigenous-created and Indigenous-led are a priority for Winnipeg and Manitoba.

Sunshine House is committed to caring for people experiencing chaotic substance use, homelessness/housing insecurity and social marginalization, including 2SLGBTQ+ folks and newcomers. We continue to witness the impacts of chronic substance use and advocate for supervised consumption services based on our mandate of harm reduction and social inclusion. We support the recently completed report, *Harm Reduction Services in Winnipeg: A Consolidating Report and Call to Action,* which compiles all the reports in Winnipeg that highlight a dire need for services for people experiencing problematic substance use and social disenfranchisement.

We stand with other organizations in solidarity and commitment for the establishment of greater harm reduction services, including managed alcohol services and supervised consumption services. Sunshine House has published two reports calling for the establishment of these — the *Managed Alcohol Programs in Manitoba: Feasibility Report* (2018) and the *Safer Consumption Spaces Winnipeg Consultation & Needs Assessment* (2019). Both can be downloaded here: www.sunshinehousewpg.org/publications.

Sunshine House, Inc.
646 Logan Avenue
Winnipeg, MB R3A 0S7
ph. 204.783.8565
fx. 204.772.7237

We encourage the City of Winnipeg and the Government of Manitoba to commit to creating a safe place to prevent overdose deaths, reduce blood borne infections, and lower heath inequities for people experiencing problematic substance use. Our hope is that governments will consider the action plan for the development of a supervised consumption site and additional harm reduction services in Winnipeg. We appreciate your consideration for this proposal and look forward to your timely response to this initiative.

Sincerely,

Levi A. Foy
Executive Director
Sunshine House, Inc.

NORTH END
women's
centre

P: 204.589.7347
F: 204.586.9476
E: info@newcentre.org

394 Selkirk Ave.
Winnipeg, MB
R2W 2M2

December 17, 2021

To the Legislative Assembly of Manitoba,

On behalf of North End Women's Centre, I am writing in support of the establishment of a supervised consumption service in Winnipeg. Over the past several years, overdose deaths continue to rise in Winnipeg, and HIV transmission rates continue to increase due to intravenous drug use. Although this public health crisis continues in our city, currently Winnipeg is the only city West of the Maritime provinces that does not have any supervised consumption services.

We are also deeply concerned that Indigenous people are disproportionately represented among the participants we serve. The ongoing legacy of colonial violence, residential schools, and structural racism have resulted in deep traumatization and ongoing pain. The legacy of residential schools continues into the present day as reflected in the health and social disparities between Indigenous and non-Indigenous Canadians—a heartbreaking reality that we witness every day at North End Women's Centre.

The calls to action in the Truth and Reconciliation Commission Final Report urges Canadian leaders and governments to recognize and address distinct health needs of First Nations, Metis, and Inuit peoples and to provide sustainable funding for existing and new healing centres. Harm reduction services that are Indigenous-created and Indigenous-led are a priority for Winnipeg and Manitoba.

North End Women's Centre is committed to caring for people experiencing problematic substance use, homelessness/housing insecurity and social marginalization. We continue to witness the impacts of chronic problematic substance use and advocate for supervised consumption services based on our mandate to serve gender-marginalised folks using participant/community-centred, harm reduction-focussed, and anti-oppressive approaches. We support the recently completed report, *Harm Reduction Services in Winnipeg: A Consolidating Report and Call to Action,* which compiles all the reports in Winnipeg that highlight a dire need for services for people experiencing problematic substance use and social disenfranchisement.

This letter is symbolic of our common goal among other community-based organizations in Winnipeg that stand together in solidarity and commitment for the establishment of greater harm reduction services, including managed alcohol services and supervised consumption services.

We encourage the City of Winnipeg and the Government of Manitoba to commit to creating a safe place to prevent overdose deaths, reduce blood borne infections, and lower heath inequities for people experiencing problematic substance use. Our hope is that governments will consider the action plan for the development of a supervised consumption site and additional harm reduction services in Winnipeg. We appreciate your consideration for this proposal and look forward to your timely response to this initiative.

Sincerely,

Cynthia Drebot
Executive Director
North End Women's Centre

cc'd: Bernadette Smith, MLA for Point Douglas; Ross Eadie, Mynarski Ward Councillor

MANITOBA HARM REDUCTION NETWORK

545 Broadway
Winnipeg, MB,R3C 0W3

Ph: 204-783-6184
mhrn.ca

January 28, 2022

Re: Letter of Support for SCS/OPS services in Winnipeg and Manitoba

To: Councillors, City of Winnipeg & Members of the Legislative Assembly of Manitoba:

On behalf of the **Winnipeg Harm Reduction Network**, I am writing in support for the establishment of a supervised consumption service in Winnipeg. Over the past several years, overdose deaths continue to rise in Winnipeg, and HIV transmission rates continue to increase due to intravenous drug use. Although this public health crisis continues in our city, currently Winnipeg is the only city West of the Maritime provinces that does not have any supervised consumption services, despite more than one Manitoban dying daily every year. The tragedy of lost lives is only accelerating with time and the pandemic.

We are also deeply concerned that Indigenous people are disproportionately represented among the clients we serve. The ongoing legacy of colonial violence, residential schools, and structural racism has resulted in ongoing systemic harms and violence resulting in health and social disparities. The legacy of residential schools continues into the present day as reflected in the health and social disparities between Indigenous and non-Indigenous Canadians - a heartbreaking reality that we witness every day at the Manitoba Harm Reduction Netwrk.

The calls to action in the Truth and Reconciliation Commission Final Report urges Canadian leaders and governments to recognize and address distinct health needs of First Nations, Metis, Inuit peoples and to provide sustainable funding for existing and new healing centres. Harm reduction services that are Indigenous-created and Indigenous-led are a priority for Winnipeg and Manitoba.

Furthermore, the COVID-19 pandemic has had a devastating impact on people experiencing problematic substance use. We were in a crisis before the pandemic and since March of 2020, overdose rates have increased not only in Manitoba but across Canada.

The Manitoba Harm Reduction Network is committed to supporting people experiencing problematic substance use, homelessness/housing insecurity and social marginalization. We continue to witness the impacts of chronic substance use and advocate for a wide variety of supervised consumption services. We support the recently completed report, *Harm Reduction Services in Winnipeg: A Consolidating Report and Call to Action,* which compiles all the reports in Winnipeg that highlight a dire need for services for people experiencing problematic substance use and social disenfranchisement.

This letter is symbolic of our common goal among other community-based organizations in Winnipeg that stand together in solidarity and commitment for the establishment of greater harm reduction services, including managed alcohol services and supervised consumption services.

We encourage the City of Winnipeg and the Government of Manitoba to commit to creating a safe place to prevent overdose deaths, reduce blood borne infections, and lower health inequities for people experiencing problematic substance use. Our hope is that governments will consider the action plan for the development of a supervised consumption site and additional harm reduction services in Winnipeg. We appreciate your consideration for this proposal and look forward to your timely response to this initiative.

Sincerely,

Jonny Mexico
Network coordinator - Winnipeg
Manitoba Harm Reduction Network

Appendix E: Sample Terms of Reference (TOR) for Harm Reduction Committee

Example 1: Metro Vancouver Aboriginal Executive Council Urban Indigenous Opioid Task Force: Terms of Reference (2017)

Included here with permission.

MVAEC was founded in 2008 to respond to the community's desire for a more collaborative, strategic, and unified voice. The organization serves 23 Aboriginal not-for-profit members that are appointed by their Board of Directors who are elected by the community.

Background/Context

Metro Vancouver is facing a severe opioid crisis; BC's provincial health officer declared a public health emergency on April 14th, 2016. 2016 saw 325 fentanyl-detected drug overdoses. Fentanyl is 50-100x more toxic than morphine and since its introduction as a street drug, overdose deaths in BC have quadrupled.

- The UIOTF addresses the opioid crisis as a health issue requiring a healing and a trauma-informed approach. Restorative solutions complementary to an *Indigenous Wellness Framework* are to be prioritized and for each downstream intervention there needs to be an upstream solution. The differences between on and off-reserve lived experiences are recognized so strategies will be tailored to individual needs.
- MVAEC hosts roundtables designed to facilitate discussions and create action strategies for Metro Vancouver's urban Indigenous population. The Psychology of Poverty addresses internal and systemic barriers that contribute to the vulnerability of this demographic. Poverty, intergenerational trauma, and discrimination are combined factors that place Indigenous people at higher risk of dependent drug-use and death due to overdose.
- The Opioid Response project will create action initiatives directed by the outcomes of the Action Table discussions. Based on a community assessment, topics to address will include: 1) Emergency Harm-Reduction Response; 2) MVAEC Awareness Campaign; 3) Culture as the Intervention; 4) Intervention, Treatment, & Prevention; and 5) Indigenous Collective Impact Strategy.
- Indigenous Collective Impact (ICI) is a strategical framework endorsed by MVAEC that enables increased efficiency in delivering community programs. Community leaders collaborate to assess readiness, agree on the parameters of a shared vision, and implement shared measurements via objectives and metrics dashboard.
- The opioid crisis is broad, complex, and, despite current initiatives, continues to escalate. The development of a **MVAEC *Urban Indigenous Opioid Task Force (UIOTF)*** will increase the understanding of the interplaying dynamics of the opioid crisis, increase capacity for overdose response, and improve outreach into the community. Long term outcomes will include improved health of Indigenous families and reduce the risk for overdose death through prevention initiatives.

Roles and Functions of the MVAEC *Urban Indigenous Opioid Task Force (UIOTF)*

The **UIOTF** will:

- provide strategic leadership in the development, implementation and sustainability of opioid response projects and strategies
- provide advice, support and assistance in the implementation of the project
- identify and assess developing trends in harm-reduction strategies
- monitor identified and emerging risks and advise on their prevention strategies including long-term awareness efforts to address the impacts of substance use on children, youth, and families
- recognise barriers and enablers to accessing mental health and addiction treatment and assist in developing initiatives to address these
- monitor trends in the opioid crisis and share knowledge with the Indigenous community
- recognise and develop Culture as the Intervention as a healing tool for the Aboriginal community
- assess community readiness and agree on shared vision and measurements through an Indigenous Collective Impact strategy

Role of Individual Group Members

The role of the individual members of the MVAEC **Urban Indigenous Opioid Task Force (UIOTF)** includes:

- attending regular monthly meetings when available
- actively participating in the group's work
- genuinely interested in the initiatives and outcomes being pursued
- be an advocate for the program's outcomes
- share information more broadly as it becomes known
- contribute where possible to developments that increase understanding and proposed interventions

General

Membership

The MVAEC **Urban Indigenous Opioid Task Force (UIOTF)** shall be comprised of:

MVAEC (Kevin Barlow, CEO and Colter Long, Projects Officer)
Vancouver Native Health Society (Lou Demerais)
Aboriginal Front Door Society (Nora Hanuse & Debbie Krull)
Battered Women's Support Services (Terriea Harris)
BC Centre for Disease Control (Margot Kuo)
BC Centre for Substance Use (Cheyenne Johnson, Kenneth Tupper, Lindsay Farrell, Cody Callon & Kanna Hayashi)

BC Ministry of Health (Tara Nault, Michelle Wong, Meg Emslie, Heather Bretschneider, & Eric Berndt)
Canadian Drug Policy Coalition (Donald MacPherson & Scott Bernstein)
City of Vancouver (Chris Van Veen & Zakary Zawaduk)
Circle of Eagles Lodge Society (Barb Ellis & Leslee Montgomery)
Elder Support (Brenda Wesley)
First Nations Health Authority (Ashraf Mohammed, Soha Sabeti, Andrea Derban, Andrea Medley, & Janine Stevenson)
Fraser Health (Erin Gibson & Tracy Steere)
Fraser Region Aboriginal Friendship Centre Association (Rodney Olinek)
Lu'ma Native Housing Society (Marcel Swain)
Native Courtworker and Counselling Association of BC (Arthur Paul& Lynn Power)
Native Education College (Dan Guinan)
Overdose Outreach Team (Roger Tourand)
PHS Community Services Society (Russell Maynard & Patrick Smith)
Provincial Health Services Authority (Cheryl Ward, Danielle Mitchell, Alycia Fridkin, Brianna Stevenson, & Nancy Laliberte)
Providence Health Care (Elise Durante)
Simon Fraser University: Public Health, The Health Officers Council of BC, & REACH Community Centre (Malcolm Steinberg)
Spirit of the Children Society (Alba Banman & Jamie Dexel)
Streetohome (Rob Turnbull & Denise Bradshaw)
University of British Columbia & BC Centre for Disease Control (Mark Tyndall)
Urban Native Youth Association (Jenna Gaines, Fleurie Hunter, & Shaun MacDonald)
Vancouver Coastal Health (Laurel Jebamani & Sarah Levine)

Vancouver Aboriginal Child & Family Services Society (Cole McGillivary)
Vancouver Aboriginal Community Policing Centre (Norm Leech)
Vancouver Aboriginal Friendship Centre (Fawn Adolph & Dorothy Brown)
Western Aboriginal Harm Reduction Society (Delilah Gregg)
WISH Drop-In Centre (Wanda Pelletier)
Other members may be included in the group as required. Open attendance is encouraged

Chair/Convenor

The group will be chaired by Kevin Barlow, CEO and the Health Roundtable Chair. Meetings will be convened by the Chair and supported by the Coordinator Colter Long, Projects Officer, UIOTF.

Agenda Items

All agenda items will be forwarded to the Coordinator by close of ten working business days prior to the next scheduled meeting.

The agenda, with attached meeting papers, will be distributed at least five working days prior to the next scheduled meeting.

Minutes and Meeting Papers

The minutes of each MVAEC UIOTF meeting will be prepared by Colter Long.

Full copies of the minutes, including attachments, will be provided to all MVAEC UIOTF members no later than five working days following each meeting.

By agreement of the group, out-of-session decisions will be deemed acceptable. Where agreed, all out-of-session decisions will be recorded in the minutes of the next scheduled meeting.

Frequency of Meetings

The MVAEC UIOTF will meet monthly, or as agreed upon.

Proxies to Meetings

Members of the MVAEC UIOTF may send a proxy to attend a meeting if the primary member is unable to attend.

The proxy is responsible for relaying relevant comments/feedback about the meeting back to the primary member they are representing.

Quorum Requirements

No quorum is required as the Task Force holds no binding authority on any party or participant.

Review

The effectiveness and membership of the MVAEC *Urban Indigenous Opioid Task Force* will be reviewed after 6 months.

Example 2: Peel Health Region, Opioid Strategy Steering Group (Toronto)

Peel Opioid Strategy Steering Group:
Terms of Reference

Source: https://www.peelregion.ca/opioids/pdf/Peel-opioid-strategy.pdf

Included here with permission.

Purpose

We are currently faced with the challenging and critical public health issue of opioid use. In Peel, the rate of fatal opioid-related overdoses is presently lower than the provincial average, but is also increasing over time. In 2017, there were an estimated 79 deaths in Peel involving opioids, alone or in combination with alcohol, compared to 45 in 2014, 53 in 2015, and 46 in 2016 (*Source: Ontario Agency for Health Protectionand Promotion (Public Health Ontario). Interactive Opioid Tool. Toronto, ON: Queen's Printer for Ontario;2017).*

In the fall of 2016, both the Federal and Ontario governments announced action plans to address the opioid epidemic. Coordinated efforts at the national and provincial levels are critical to preventing opioid-related harms and overdoses; however, this work must be supported by regional and local responses thatreflect the local context.

In Peel, there is currently no coordinated approach/strategy related to opioid/substance use. Various sectors and organizations (e.g., community organizations, public health, LHINs, hospitals, law enforcement)are involved in different aspects related to opioid/substance use in the region.

The Peel Opioid Strategy Steering Group will lead and guide the development an Opioid Strategy for Peelwhich is intended to:

- facilitate cross-sectoral collaboration and coordination of priorities, policies and interventions toprevent and reduce harms related to opioid use for Peel residents; and
- guide long-term local solutions to prevent harmful opioid use, ensure access to effective treatment for opioid use disorders and prevent and reduce harms related to opioid use in Peel.

Objectives

The Steering Group will:

- Provide expertise to inform the development of an Opioid Strategy for Peel;
- Coordinate and link work across the four Strategy pillars (Prevention, Harm Reduction,Treatment, Enforcement and Justice), where appropriate;
- Approve objectives and outcomes for each of the four Strategy pillars;

- Identify and commit, where appropriate, resources, structural supports (e.g., working groups) and partners needed to support Strategy development and work under the four Strategy pillars;
- Discuss strategic issues and provide direction to resolve challenges and advance Strategydevelopment and achievement of Strategy objectives.

Membership

The Peel Opioid Strategy Steering Group will be chaired by the Peel Associate Medical Officer of Healthresponsible for substance use.

The Peel Opioid Strategy Steering Group is comprised of:
- organizations / individuals that have a mandate / role in the provision of services/programsrelated to substance-use prevention, harm reduction, and treatment
- people with lived / living experience of substance use.

Based on available capacity to participate at this time, current members include representatives from the following organizations. [Listed but omitted for inclusion in Appendix.]

The Steering Group may decide to invite additional members to participate, so that the organizations /individuals best suited to support a given topic area can contribute.

Meetings

- It is expected that meetings of the Peel Opioid Strategy Steering Group will be held approximately every 8 weeks for approximately three hours. Additional meetings may be calledat the request of the Chair.

Meeting principles

- Meetings will be an inclusive and safe environment for all members.
- Personal experiences and information shared will remain confidential and will not be sharedoutside of the group without consent.
- Members are encouraged to share authentically, listen actively, and remain open-minded toalternative viewpoints.
- All members have an equal voice at the table; no one opinion will weigh more than another.

Operational support

- The Opioid Strategy Steering Group will be supported by staff from Region of Peel-Public Health.
- Region of Peel-Public Health will provide administrative support for meeting notes.
- Meeting notes will be action-oriented.

- Meeting notes will be approved by the group and made available to other appropriate individualsor groups at the discretion of the Chair.

Accountability

- The Peel Opioid Strategy Steering Group will be responsible to the Advisory Group and willregularly update the Advisory Group on progress.
- Terms of reference will be reviewed on an annual basis.

Meeting Process

- Decision-making will be consensus-based.

History

Date of approval: September 28, 2018
Next date of review: September 2019

Example 2: Executive Leader's Coalition on Opioid Use: A Mayor's Committee (Lethbridge, Alberta, 2018)

Source: https://www.lethbridge.ca/living-here/Our-Community/Documents

Included here with permission.

Terms of Reference

PURPOSE:

The purpose of the Executive Leaders Coalition on Opioid Use (ELCOU) is to save lives, reduce risk, facilitate treatment, and prevent the harm related to opioid use in Lethbridge and surrounding communities. This will be accomplished through policy and advocacy training, and organizational capacity-building.

GUIDING PRINCIPLES:

1. Commit to collaborative and creative solutions.
2. Respect each other and those we serve in the community.
3. Be accountable and transparent.
4. Support a comprehensive, evidence-based approach to caring for those with addictions, which includes prevention, early intervention, harm reduction, treatment, and rehabilitation.
5. Acknowledge that all levels of government must be engaged to successfully address the crisis.

GOALS:

1. Integrate and coordinate existing systems and services to meet the needs of the community related to the use of opioids and other addictive substances
2. Commit to innovation in addressing identified gaps in services in the community
3. Provide timely, coordinated information updates to the community and stakeholders on the work of the Coalition
4. Establish ad hoc working groups as needed to address emerging priorities.

ROLES AND RESPONSIBILITIES OF MEMBERS:

In addition to adhering to the Guiding Principles, the roles and responsibilities of the members of the Coalition are to:

- Represent the sector's interests, concerns and issues
- Respond to the communication and educational needs of service providers, responders and community/neighborhoods
- Provide consistent, accurate information to stakeholders for policy development and decision-making
- Plan and implement sector policy and operational plans regarding prevention, education and awareness, communication, harm reduction and treatment/outreach

- Identify the need for communication and education with internal stakeholders as well as the community at large
- Fully participate in the monthly Coalition meetings and working groups as required. For continuity purposes, regular attendance by one particular organizational designate is expected
- Provide an alternate attendee when necessary

REPORTING & AUTHORITY:

Member organizations are primary stakeholders in dealing with the community opioid crisis, and are therefore accountable unto one another, in order to achieve the agreed-upon goals. Every member organization will share the direction and the outcomes of the Coalition efforts through their organizations and informal networks. The Mayor is invested in the work, and shares with Council on an as-needed basis.

MEMBERSHIP:

- Appointment to the committee is to the organization that can then choose to appoint the appropriate designate. The designate can change with no formal approval from the Coalition, though notice is appreciated
- New appointments will be at the discretion of the Coalition and by consensus
- The appointments of member organizations shall continue until such time that the Coalition is dissolved, though an annual review will take place when the Terms of Reference is reviewed
- Decision making will proceed upon consensus. When a vote is necessary, majority vote will be observed, and executed by a show of hands
- Each member organization has one vote
- A Facilitator(s) will be appointed by the Coalition by consensus, or vote if necessary (the Facilitator will retain an atmosphere of flexibility and openness)
- There are no committee member terms

Coalition membership currently includes, but is not limited to, Senior Executive Leaders or designates from the following organizations:

Coalition membership currently includes, but is not limited to, Senior Executive Leaders or designates from the following organizations:

- Government of Alberta
    - Post-Secondary Institutions
    - Alberta Justice and Solicitor General
    - Children's Services
    - Community and Social Services
    - MLAs (ex-officio) or designate
- AHS South Zone City of Lethbridge (including the Mayor, CSD and SHIA Committees of Council, Corporate Communications, Heart of our City Committee)

- Community based agencies involved in prevention, early intervention, harm reduction, treatment, and rehabilitation
- Emergency First Responders
- School Divisions
- Lethbridge Emergency Shelter & Resource Centre
- Sik Ooh kotoki Friendship Society
- Lethbridge Public Library
- Law Enforcement
- MP, Government of Canada (ex-officio) or designate
- Ad Hoc members when invited by the committee to support various initiatives

WORKING GROUPS:

Working groups will be formed to develop a Strategic Framework in order to fulfill the mandate of the Coalition. The working groups will be populated with at least one Coalition member, and can include participants who are not formal members of the Coalition.

Working Groups may include:
1. Supervised Consumption and Harm Reduction
2. Public Communications
3. Prevention, Education and Awareness
4. Treatment/Outreach
5. Research and Evaluation
6. Worker Care and Resiliency
7. Ad hoc sub-committees or task forces as required

MEETINGS:

- At least monthly and at the call of the Facilitator(s), normally 8-9:30 a.m. at City Hall or via Teleconference. The frequency of the meetings will be altered upon the consensus of the Coalition
- Meeting Minutes will be circulated within 48 hours of the meeting. Additional advisories will be circulated as required
- Regular meetings are called and led by the Coalition Facilitator(s)
- Meetings are not open to the public, nor may the Minutes of a meeting be circulated outside of the Coalition membership
- Guests may attend Coalition meetings upon invitation

RESOURCES AVAILABLE TO THE COMMITTEE:
- In-Kind support from the City of Lethbridge, including:
    - Administrative support through Community Social Development Department
    - A facility in which to meet
- Other?

DECISION MAKING:

Decision making will be through consensus. At the call of the Facilitator(s), a vote may be considered if consensus cannot be reached. When a vote is required, a minimum of 50%+1 of members must be present at the meeting or the vote is null and void. The facilitator(s) is counted in quorum, and has a vote.

REVIEWING THE TERMS OF REFERENCE:

The Coalition will review the Terms of Reference in September on an annual basis.

DISSOLUTION:

The Coalition will be dissolved when no longer relevant. Dissolution will occur by consensus, or by majority vote. Documents or materials related to the work of the Coalition will be housed on the City of Lethbridge server for a period no less than seven years.

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