Winnipeg Regional Health Authority, Population and Public Health

Healthy Sexuality and Harm Reduction

Street Connections/Outreach Services

Program Monitoring and Evaluation Report

For the year October 1, 2013 to September 30, 2014

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Background and overview

Street Connections is a WRHA public health service whose goal is to reduce the spread of sexually-transmitted and blood-borne infections (STBBIs) and reduce other drug-related harms in Winnipeg. It works primarily with people who use illegal drugs, people involved in the sex trade, men who have sex with casual and anonymous male partners, and street-involved persons. The service came to the WRHA's Healthy Sexuality and Harm Reduction (HSHR) team from Mount Carmel Clinic in 2001.

Street Connections is primarily a mobile service: a van circulates Winnipeg streets six nights a week from about 6pm to midnight. Outreach services are also available during the day out of HSHR's office at 496 Hargrave Street, from 8:30am to 4:30pm, Monday to Friday.

The dedicated workforce includes 4.0 EFT Outreach Workers and 1.5 EFT Public Health Nurses (PHNs). But there is overlap between this team and the rest of HSHR. For example, Outreach Workers also assist with communicable disease case and contact investigations, and HSHR PHNs occasionally do street outreach. Importantly, 0.5 EFT of the PHN dedication works during the day, following up on work generated in the evening, liaison with other providers, and performing other tasks that—when they do not entail direct client contact—are not captured in this evaluation.

The service's complete budget—corresponding to the October 1/13 to September 30/14 evaluation period—is appended as Appendix A. Its total annual cost is approximately $592,000.

The goals of *Street Connections* are threefold: a) that services are accessible and effective at preventing, detecting, and treating STBBIs and other drug-related harms; b) that the general health and quality of life of clients are promoted; and c) that client perspectives are respected in program planning. A variety of activities and strategies are employed to achieve these goals. These are outlined in the Program Logic Model (Appendix B).

Process of program monitoring and evaluation planning

The evaluation was structured according to the tool developed by the 'Towards Evidence-Informed Practice' program of the Ontario Public Health Association (2009), hybridized with tools developed by Health in Common.

The process included:

- December 2012: The 'evaluation team' was populated to include, from HSHR, the Program Specialist, Team Manager, Clinical Nurse Specialist, Communicable Disease Coordinator, a PHN, and an Outreach Worker. Outside representatives include the Executive Director of the 595 Prevention Team, the program managers of Mount Carmel Clinic's *Wiisocotatiwin* (Assertive Community Treatment) and *Manito Ikwe Kagiikwe* (Mothering Project) teams, the Team Manager of the WRHA's Tuberculosis team, and a representative from WRHA's Health Outreach and Community Support team. The Special Projects Manager at Sunshine House was also consulted *ad hoc*.
- February 2013: Evaluation team brainstormed content to populate the program logic model.
- April 2013: Program logic model was finalised (Appendix B) and draft evaluation questions were identified.

- June 2013: Evaluation framework (with finalised questions and indicators) was drafted and circulated to the evaluation team.
- July 2013: Evaluation framework was finalised (Appendix C) and data collection tools were developed. Based on available capacity, the framework was split into a two-year evaluation, the first half to be undertaken in 2013/14.
- October 2013 – March 2014: Data collection.
- April 2014 – July 2014: Data cleaning and analysis based on 6 months of data (October-March).
- August – September 2014 – Report drafted and circulated to evaluation team.
- October 2014 – Next 6 months of data received, cleaned, and analysed.
- December 2014 – Final report drafted based on year's worth of data.

Context: Roles of *Street Connections*/outreach staff

Street Connections *van*: In the evening, the van travels a set route with stops at specific times. Home visits can also be arranged for individuals requiring needles (distribution or collection) or nursing services. The van is staffed by two HSHR team members. From Tuesday to Saturday, the pair comprises a PHN and an Outreach Worker; on Mondays both are Outreach Workers. The primary function of the van is to distribute harm reduction supplies, provide education and counselling, and support clients to make healthier choices. Team members also distribute a weekly newsletter and provide advocacy and referral services. When a PHN is in the van, nursing services are available: STBBI testing and treatment, immunisation, screening for tuberculosis and pregnancy, basic prenatal services, and minor wound care.

Daytime services: The services available from the van are available during the day at the HSHR office at 496 Hargrave Street. Two Outreach Workers and one PHN generally work during the day. They are called to the reception area by admin staff to provide services to 'walk-in' clients. Daytime staff also follow up on testing and referrals generated the night before. As indicated above, this work is often not included in *Street Connections* statistics. The report below therefore represents the majority—but not the entirety—of the staff's time and work.

Process

Three broad areas were explored. These evolved into one question each for program monitoring, evaluation, and applied research.

- **Program Monitoring:** Are *Street Connections* activities being undertaken as planned?
- **Evaluation:** How well do Safer Crack Use Kits meaningfully engage and promote the health of marginalized clients?
- **Applied Research:** To what extent are the times/locations/services of Street Connections evidence-based and client-centred?

Program Monitoring and Evaluation are included in the report below. For Applied Research, the identified question (*To what extent are the times/locations/services of* Street Connections *evidence-based and client-centred?*) can only be partially answered, as we await the results of a thorough 'mapping' project (i.e. of locations frequented by *Street Connections'* priority populations) undertaken in collaboration with the Centre for Global Public Health (University of Manitoba) and Sunshine House. Results will be available in the winter of 2014/15.

Program Monitoring

New expanded statistics sheets were implemented in October 2013 (Appendix D). Staff completed these sheets in real time, with one 'line' representing one *individual* encounter (i.e. if two clients were seen, two lines were filled out, etc.). HSHR's Senior Administrative Secretary then entered the data into a MS Excel database. After 6 months (i.e. March 31, 2014), the Program Specialist cleaned, imported, and analysed the database using Epi Info 7. Results were circulated to the evaluation team for feedback. Once refined, the next 6 months of data were incorporated to produce the present report, based on the year October 1, 2013 to September 30, 2014.

For some questions, the data were augmented by other sources, identified in more detail below.

Because of the labour required for this project, some of the data entry was delegated to administrative students working in the HSHR team. Some initial errors emerged that were corrected by the Senior Administrative Secretary, but others emerged only later. Data were then checked against two other sources: supply distribution statistics were compared to the Management Information System (MIS) database (entered from the same sheets but by different staff) for three random months, and testing statistics were compared to the Night Report for one random month. In both instances the overall concurrence was reasonably close (for more information, see Appendix E).

Question – Are *Street Connections* activities being undertaken as planned?

The *Street Connections* program undertakes a large number of activities to achieve a number of goals (see the program Logic Model). A narrow scope was chosen for this report for the sake of simplicity, but the indicators below should not be considered exhaustive. For example, the program produces a public health benefit through its ability to connect with individuals lost to HIV care; this is not explored in the indicators below. The included indicators generally represent quantifiable measures related to the 'core' functions of *Street Connections*.

Indicators examined:

Indicator 1a	**Number of harm reduction supplies distributed and recovered**
Indicator 1b	**Number and types of STBBI tests performed, and results**
Indicator 1c	**'Other Health Care' services provided**
Indicator 1d	**Number of 'Bad Dates' collected**
Indicator 1e	**Number of prenatal contacts**
Indicator 1f	**Number of external presentations**
Indicator 1g	**Number of community distribution sites and supply distribution therein**
Indicator 1h	**State of relationship with the police**

Data source

The primary data source for these indicators was the expanded statistics sheets filled out by *Street Connections* staff, both in-house and in the van.

The final database comprised 18,583 records.

14,327 records represent *evening and weekend* statistics, over 300 days.[1] Evening staff were asked to record stops even when *no* interaction took place. This occurred 106 times.[2] Therefore, the evening and weekend statistics capture 14,221 interactions.

4256 records were collected during the *daytime*, but 171 of these represent out-of-office daytime outreach over only seven days. Because of the small number (compared to the actual amount of daytime outreach that occurs but for which no statistics were apparently submitted), these records were excluded. 4085 records therefore represent daytime statistics, in-house at the HSHR office, over 249 days.

Indicator 1a - Number of harm reduction supplies distributed and recovered

Safer Crack Use Kits (SCUKs)

WRHA SCUKs comprise a glass stem, a pack of 5 screens, a small piece of PVC tube (for use as a mouthpiece), alcohol swabs, an education sheet, and (optionally) a chopstick, all assembled into a small re-sealable plastic storage bag by individuals working at a local agency for people with disabilities.

In the *evening*, 10,795 encounters included the distribution of a SCUK, representing 76% of all evening interactions. 85% of the time, two stems were given out to a client (the official maximum), with only one given 15% of the time. In one instance, three stems were given, and twice four were. The total number of SCUKs distributed totalled 20,028.

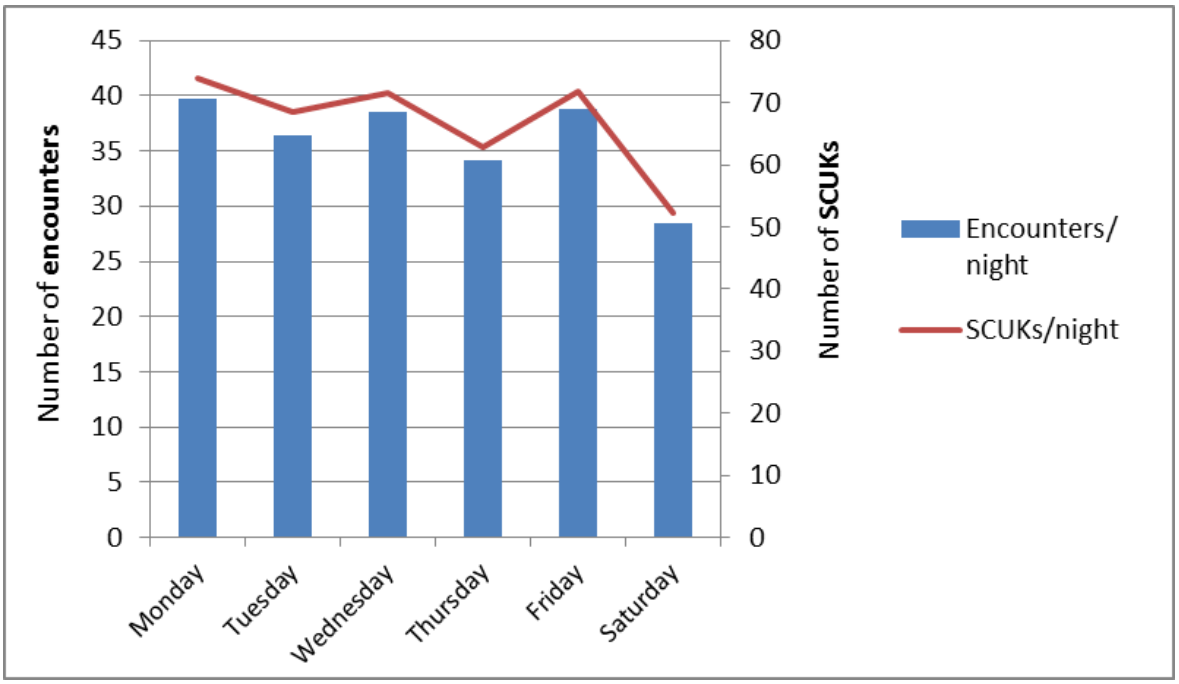
Due to holidays and other closures, there is not an equal number for each day of the week (e.g. there were 52 Saturdays but only 46 Mondays, etc.). For that reason, an average number of SCUK encounters and total SCUKs distributed *per day* were calculated and plotted in Figure 1. Fewer encounters and less distribution occurred on Saturdays. Staff indicated that this was consistent with their experience and that this slowness allowed for more nursing work to be done on Saturdays (see Indicator 1c).

[1] Note that the 300 days represent shift days and not necessarily calendar days. That is, although technically some encounters occurred on a Sunday (i.e. the Saturday shift after midnight), for the purposes of this report post-midnight encounters are included with the previous evening's statistics, meaning that Monday statistics include all encounters from 5pm on Monday to 1am Tuesday, and so on.

[2] The most frequent locations where no clients visited the van were the 705 Broadway stop (32 times), Sargent (18 times), Osborne (17 times), and 185 Smith (16 times).

For all graphs, the number of *encounters* pertaining to the distribution/collection of that particular supply is represented with a bar (following the scale on the left axis) and the number of *supplies* is represented with a line (following the scale on the right axis).

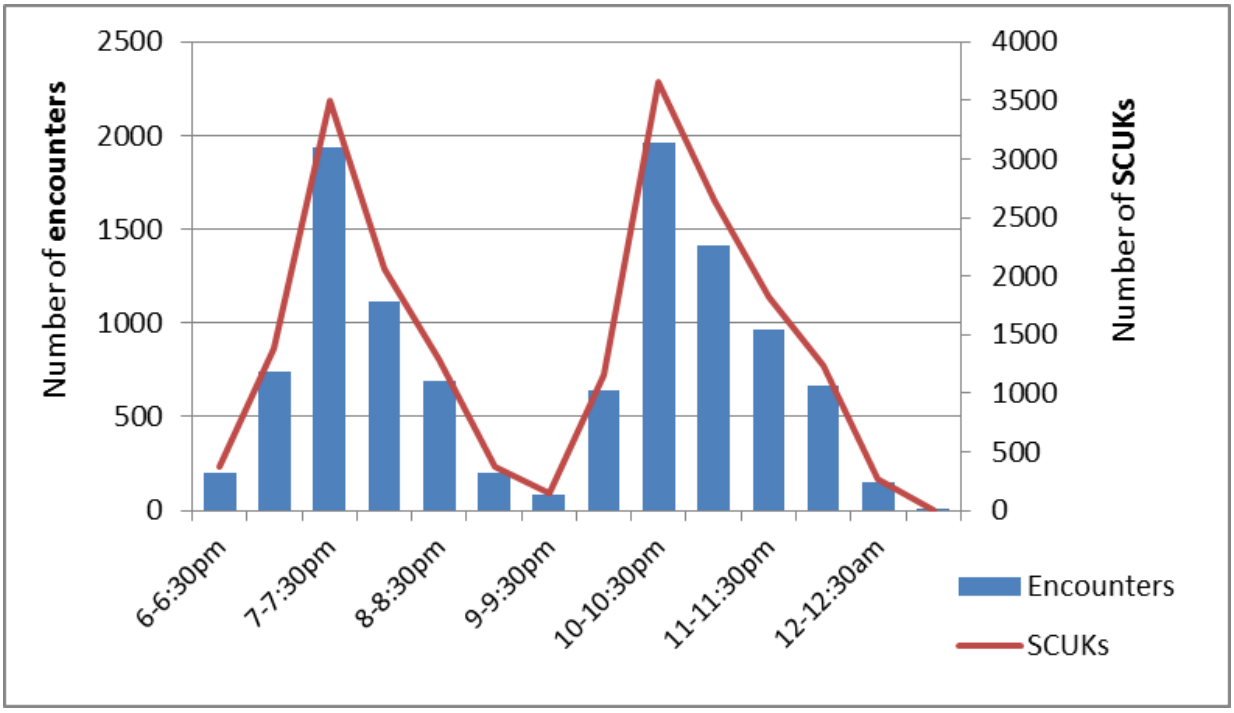
Figure 1: Average per-evening SCUK distribution by day of the week



There was also variety in terms of the hours of the evening. *Street Connections* schedules stops from approximately 6:30 to 7:30pm and again starting at 9:45pm. Home visits (pre-arranged visits to client residences for needle delivery, pick-up, and/or STBBI testing) are often arranged for 7:30 to 8:30pm, while 8:30 to 9:30pm often includes the staff dinnertime. Because home visits generally do not include SCUK delivery—and in light of meal times—the volume of SCUKs distributed not surprisingly dips between 7:30 and 10pm.

Figure 2 represents the *total* number of encounters made and supplies distributed over all days (Monday to Saturday) during the evaluation period. Note that a small number of encounters were recorded between 4 and 6pm; these are included in other analyses but excluded from this graph.

Figure 2: Total evening SCUK distribution by hour, all dates included



Staff were asked to record the street name in the 'Location' field for all encounters. Although in some instances this may be unclear ('Main' could mean either 'Main and Portage' or 'Main and Inkster,' for example), in practice staff were confident that they could predict where an interaction likely took place based on one street name. At the conclusion of the data collection phase, staff were given a list of all the street names recorded and asked to break them into intuitive 'zones.' See Appendix F for more information. Five zones resulted, mostly reflecting the van's regular cruising areas:

A. West End cruise area

B. North End cruise area – NORTH of (and including) Selkirk Ave.

C. North End cruise area – SOUTH of Selkirk

D. ALL other areas

E. Home Visits

A Note on Home Visits

Street Connections does not routinely store the locations of home visits. Therefore, 'Home Visits' are included as a 'Location,' but with no further indication where precisely encounters took place.

To give some sense to the category, two months of locating information was collected for home visits. To protect the anonymity of clients, staff recorded the WRHA neighbourhood cluster of a home visit. This was collected from September 8 to October 31, 2014.

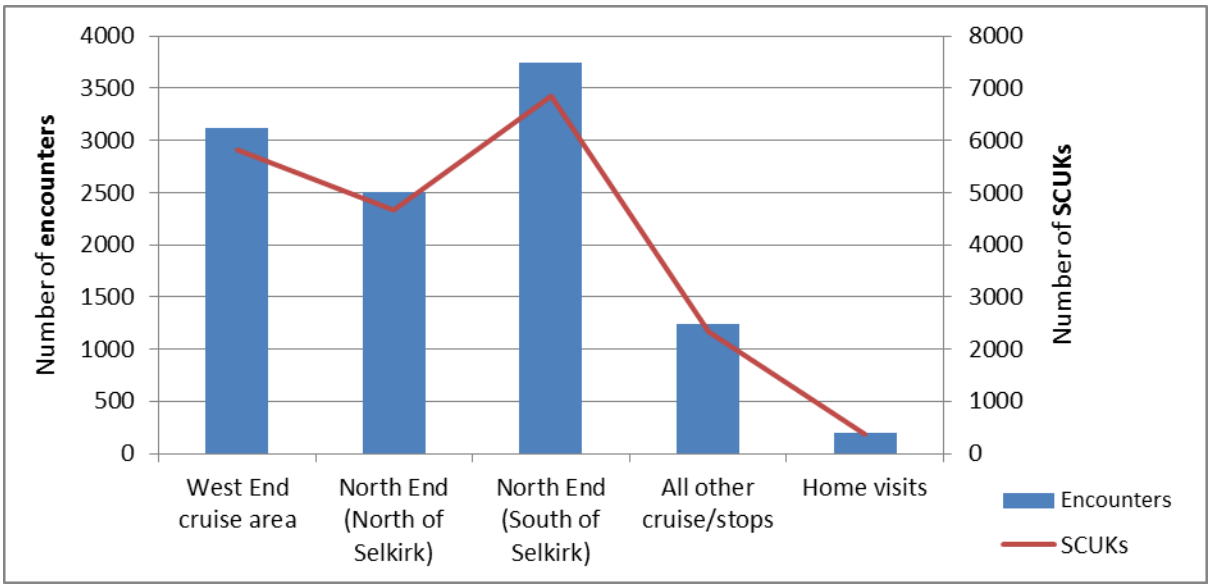
Over an eight week period, locations were recorded for 116 home visits.[3] Somewhat surprisingly, 22 out of 25 neighbourhood clusters received at least one home visit. The characteristics were as follows.

Neighbourhood Cluster	Cluster name	No. of visits	Percentage of home visits/total
01A	St. James-Assiniboia West	**1**	0.86%
01B	St. James-Assiniboia East	**8**	6.90%
002	Assiniboine South	**1**	0.86%
03A	Fort Garry North	**1**	0.86%
03B	Fort Garry South	**0**	0.00%
04A	St. Vital North	**1**	0.86%
04B	St. Vital South	**3**	2.59%
05A	St. Boniface West	**1**	0.86%
05B	St. Boniface East	**6**	5.17%
006	Transcona	**2**	1.72%
07A	River East South (Elmwood)	**5**	4.31%
07B	River East West	**2**	1.72%
07C	River East East	**3**	2.59%
07D	River East North	**0**	0.00%
08A	Seven Oaks West	**3**	2.59%
08B	Seven Oaks East	**5**	4.31%
08C	Seven Oaks North	**1**	0.86%
09A	Inkster West	**0**	0.00%
09B	Inkster East	**5**	4.31%
10A	Point Douglas North	**11**	9.48%
10B	Point Douglas South	**16**	13.79%
11A	Downtown West	**11**	9.48%
11B	Downtown East	**23**	19.83%
12A	River Heights West	**2**	1.72%
12B	River Heights East	**5**	4.31%

[3] This does not necessarily mean an equal number of 'encounters,' as one home visit may comprise encounters with more than one individual. For this analysis only, 'encounters' that seemed to comprise one 'home' (i.e. same time, same place) were combined into one 'home visit.'

The three major zones showed roughly equivalent number of encounters and SCUKs distributed, with the smaller zones collectively accounting for an additional 1236 SCUK encounters.

Figure 3: Total evening SCUK distribution by area, all dates included



One hundred and ninety-eight (198) home visits included SCUK distribution. Home visits are generally not made for SCUKs only, but SCUKs may be distributed during a visit for something else. Indeed, needles were also distributed or collected 144 times and testing of some kind took place 17 times.[4] Twenty-eight (28) times the visit was marked for SCUKs and safer sex supplies only, once for SCUKs and tuberculosis directly observed treatment (TB DOT) only, and 13 times for SCUKs only. Staff indicated that a home visit for SCUKs may be considered if the client lives more than 2 km outside the *Street Connections* cruise areas or has mobility challenges (and in fact, 120 of the 198 visits were during the fall or winter months).[5]

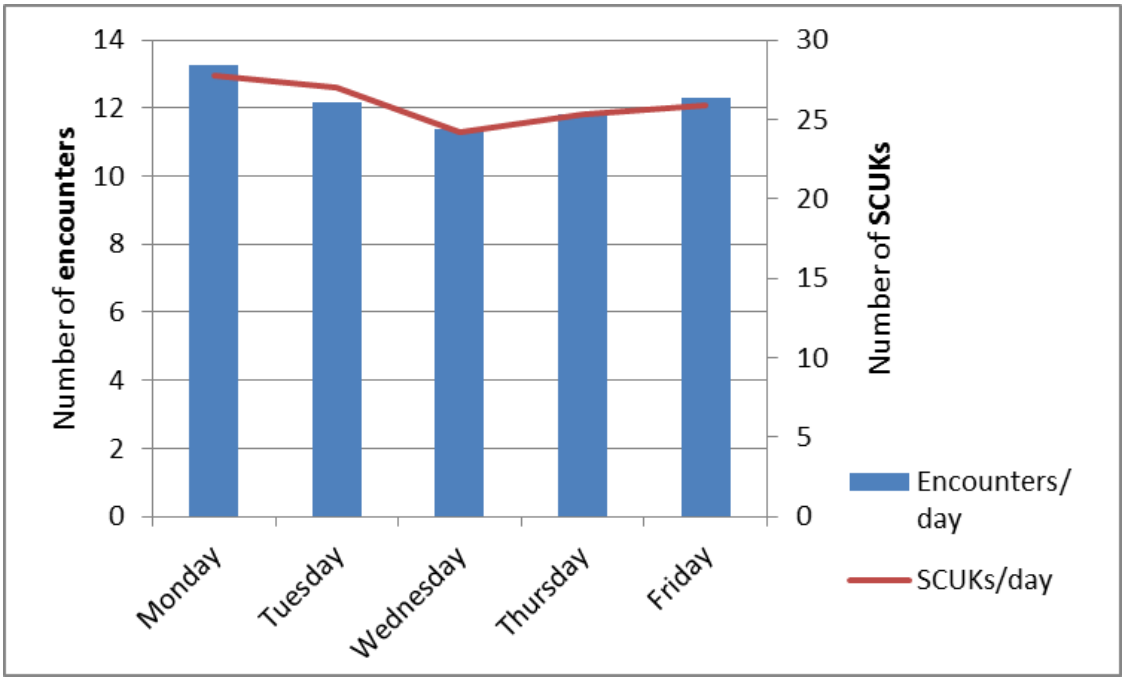
During the *daytime*, 3021 encounters included the distribution of a SCUK, representing 74% of all daytime interactions. 86% of the time, two stems were given out to a client, with only one given 6% of the time. Rarely, between 3 and 20 SCUKs were given, presumably to multiple people presenting together. The total number of SCUKs given out totalled 6461.

There were no major differences observed based on the day of the week, though Mondays were slightly more popular, presumably because no service is available on Sundays.

[4] These are not necessarily mutually-exclusive as visits may encompass multiple services/reasons.

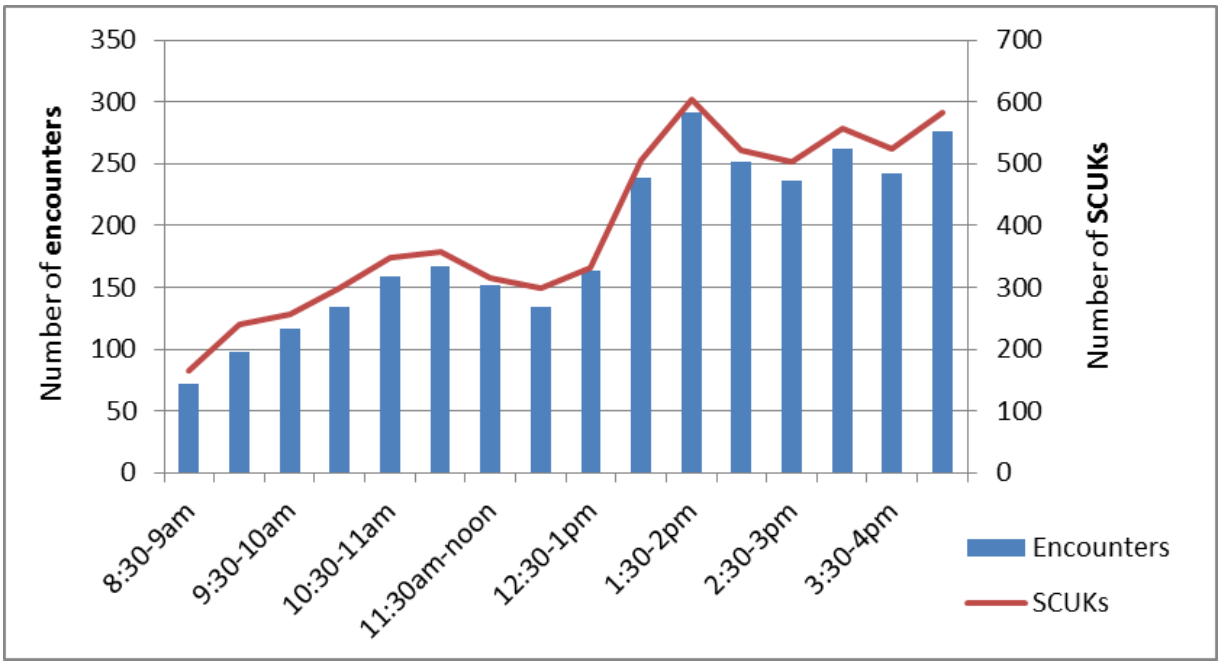
[5] Interestingly, a handful of 'home visits' were recorded where neither safer drug-use supply distribution nor nursing services (including TB DOT) took place: Twenty-seven (27) times a visit was indicated for safer sex supplies only. Twenty-one (21) times no reason was indicated for a home visit;' these may represent errors in the completion of the statistics sheet.

Figure 4: Average per-day daytime SCUK distribution by day of the week



The afternoon was clearly more popular for SCUK distribution than the morning. The noon-hour statistics are fairly high when one considers that only 185 out of 249 days recorded encounters over the lunch-hour. These may be due to closures over lunch—which are not uncommon due to staffing issues—but may also simply be due to no clients visiting over the lunch hour on those particular days.

Figure 5: Total daytime SCUK distribution by hour, all dates included



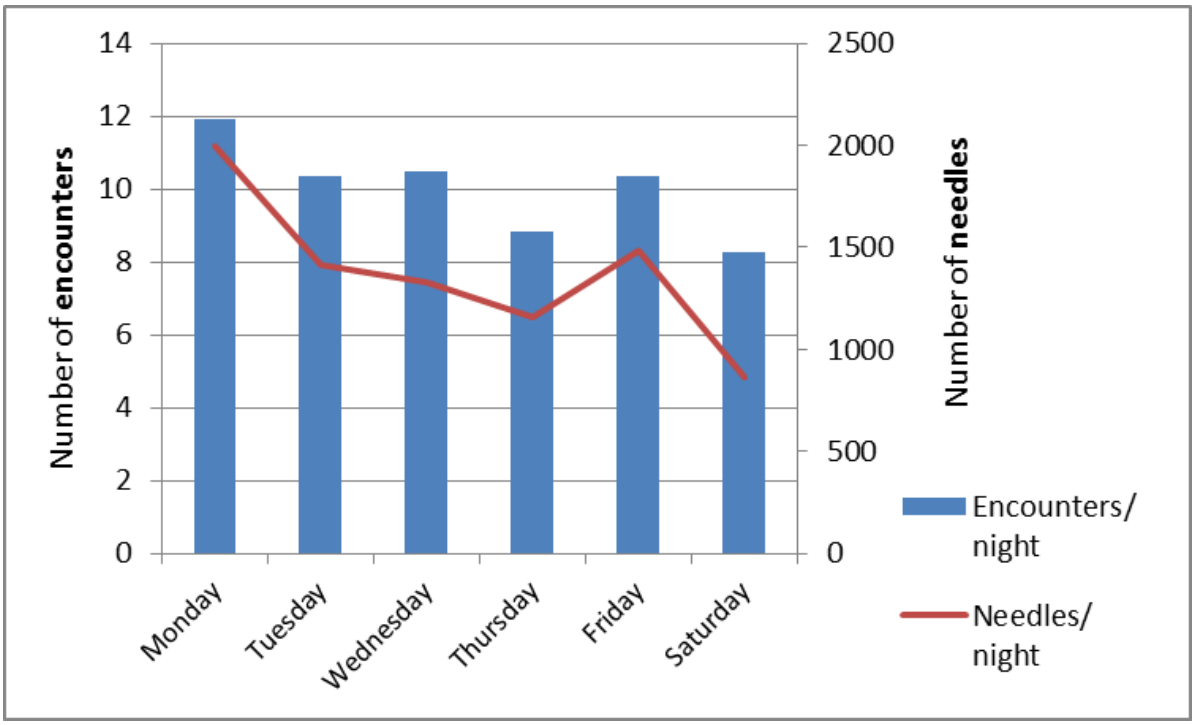
Staff indicated that the popular times were not only consistent with their experience, but also mirrored the busy times of the former *Street Connections* drop-in location on Main St. in the 1990s.

Needle Distribution

In the *evening*, 3003 encounters included needle distribution, representing 21% of all evening interactions. The most common amount distributed during an encounter was 20 (35% of the time). The amounts ranged from 1 needle to 2000, with a median of 40. The total number of needles given out totalled 409,671.

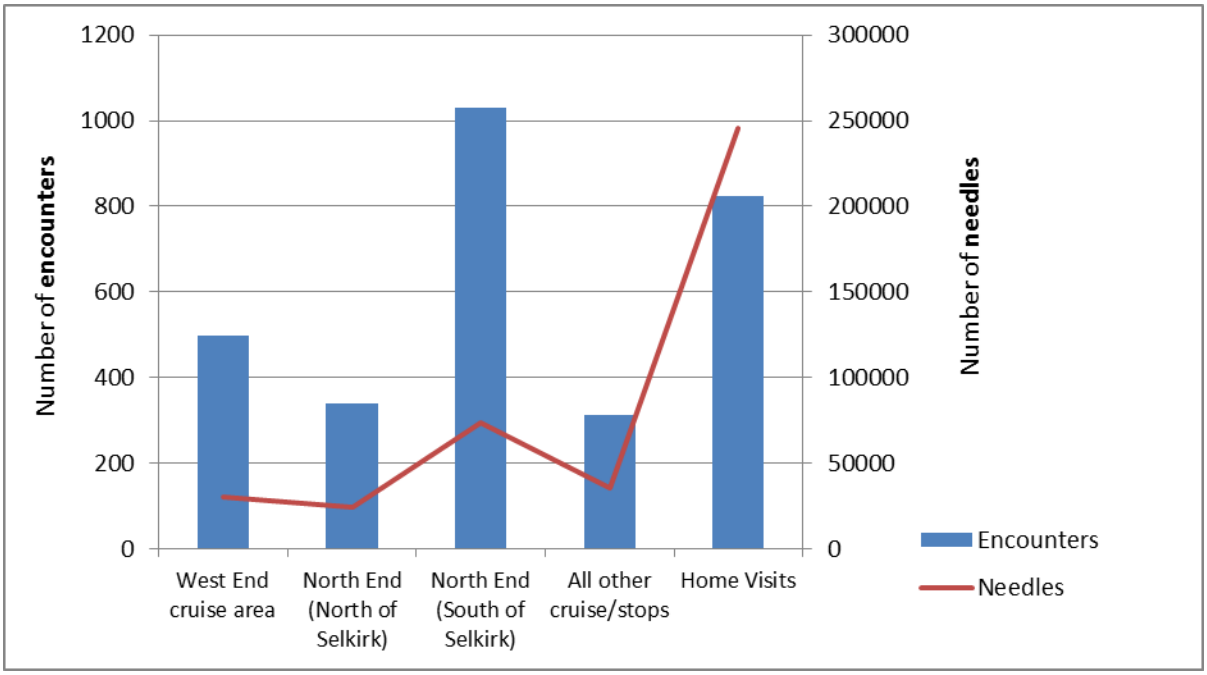
Like SCUKs, less distribution took place between 8 and 10pm. Unlike SCUKs, two differences were observed. First, needle distribution peaked on Mondays and then steadily declined during the week.

Figure 6: Average per-evening needle distribution by day of the week



Differences were also observed in the parts of town where needles were distributed. Namely, home visits and the North End zone south of Selkirk Ave. accounted for the largest number of encounters. Drilling deeper, 934 of the 1064 'North End' encounters took place on Main St. The proportion of needles per encounter in those two areas varied greatly: home visit clients took a median of 200 needles while those at the North End stops took a median of 20.

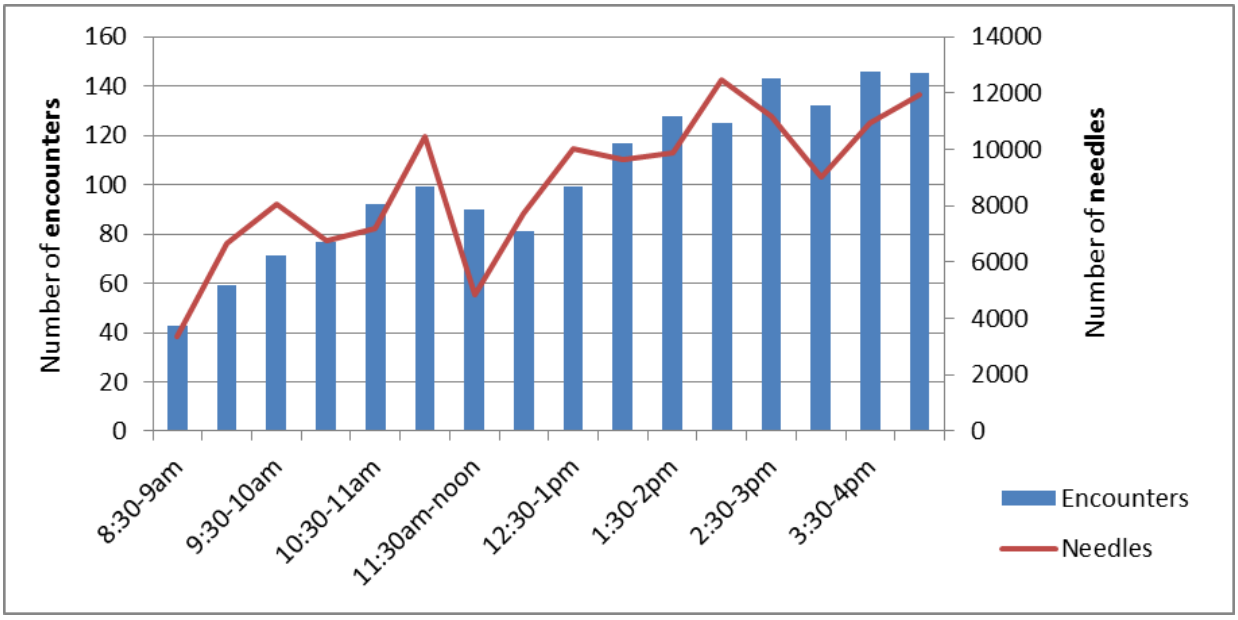
Figure 7: Total evening needle distribution by area, all dates included



During the *daytime*, 1668 encounters included needle distribution, representing 41% of all daytime interactions (a larger proportion than during the evening). The quantities distributed during the day were smaller, ranging from 1 to 1020 needles, with a median of 40. The total number of needles given out totalled 141,512.

Similar to SCUKs, the afternoons were more popular for needle distribution.

Figure 8: Total daytime needle distribution by hour, all dates included



Daytime needle distribution over the course of the week was similar to the evening, peaking on Monday and declining through the week before an uptick on Friday. And in fact, the tendency towards afternoon-heavy distribution was less evident on Mondays, when proportionally more needles were distributed in the morning compared to other days.

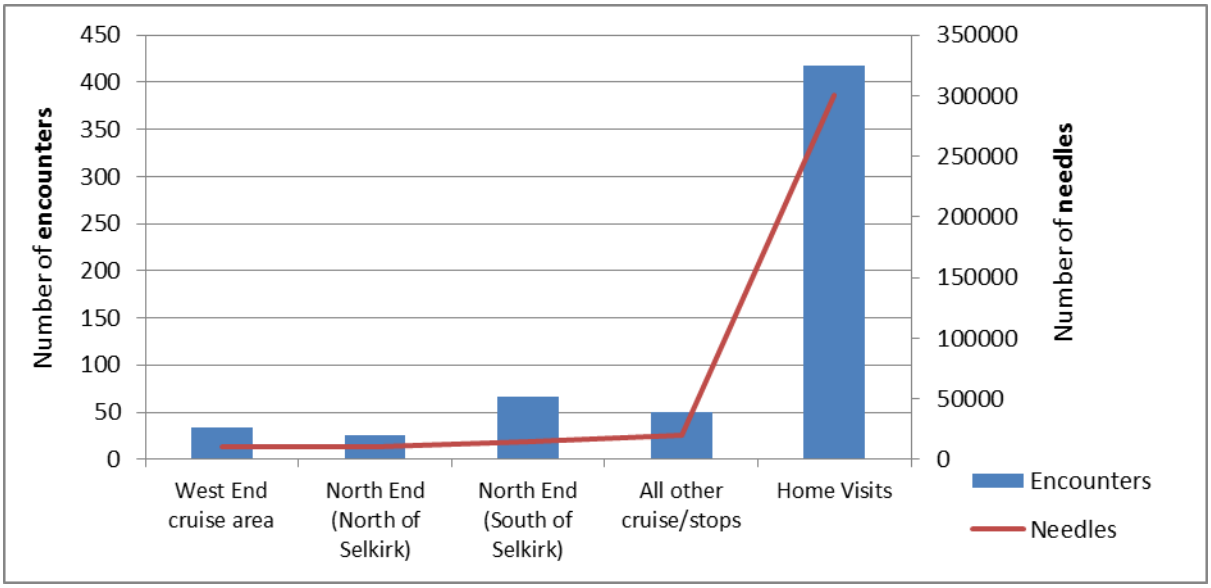
Needle pick-up

Used needles are collected by HSHR; these are then collected and disposed by Stericycle Canada.

In the *evening*, 592 encounters included collecting used needles, representing 4% of all evening interactions. The most common amount collected during an encounter was 500 (19% of the time), but the number varied from 1 needle to 5500. The number of needles collected by the van in the evening totalled 355,791, resulting in a return rate of 87% compared to the amount of needles distributed in the evening (409,671).

Like needle distribution, needles were primarily collected during home visits, and in fact the total distributed on home visits (245,304) is far exceeded by the amount collected on home visits (300,111). Staff suggested that clients often procure their needles from a variety of sources (street stops, home visits, through friends, etc.), but dispose of them *en masse* to *Street Connections* during home visits.

Figure 9: Total evening needle pick-up by area, all dates included



During the *daytime*, 180 encounters included needle-collection, representing 4% of all daytime interactions. Not surprisingly, the quantities brought in during the day were smaller than in the evening, the most common amount being 20 needles (19% of the time), though again there was a broad range from 1 to 5000. The number of needles taken into 496 Hargrave during the day totalled 45,948, resulting

in a return rate of 32% compared to the amount of needles distributed in the daytime. This is not surprising in light of the phenomenon discussed above (i.e. mass needle-disposal via home visit).

Finally, HSHR maintains a network of nine drop-boxes where individuals can dispose of needles 24 hours a day. During this one-year period, 752 needles were collected from drop boxes. Despite relatively low volumes, boxes are often valuable in more residential communities were loose needles are a concern.

For a tally of all SCUKs and needles distributed—and needles collected—by the *Street Connections* van (evening), office (daytime), and distribution partners, see the table on p. 23.

Safer sex supplies

Condoms, dental dams, lube, and safer sex information are distributed to *Street Connections* clients, although the statistics do not identify the kind(s) of supplies distributed, nor the volume, during an encounter. In practice, a checkmark under 'Safer sex supplies' usually indicates that a handful of condoms were given (up to a maximum of 24), but other supplies would be available upon request. These may be referred to as 'condoms' below (for the sake of simplicity), with the understanding that other safer sex supplies may have also been distributed.

In the *evening*, 9450 encounters included safer sex supplies distribution, representing 66% of all evening interactions. Condoms were almost never distributed alone: 68% of SCUK encounters and 56% of needle distribution encounters also included condom distribution. 1379 times, condom distribution was the only recorded purpose for an encounter. This is important because of the Winnipeg Street Health Report's finding that 13% of their street-involved respondents indicated not being able to find a condom when they felt they needed one (Gessler, Maes, & Skelton, 2011).

During the *daytime*, 1269 encounters were marked as including condom distribution (31% of encounters). Condoms, though, may also be procured from baskets and in the HSHR office bathroom during the day (which are not tracked by staff), undoubtedly increasing the total number of supplies taken by clients. It is likely that the proportion of clients taking condoms with their supplies is similar to the nighttime proportion (i.e. ~ 66%).

Indicator 1b - Number and types of STBBI tests performed, and results

Promoting the accessibility of STBBI testing is an important role for *Street Connections*: 21% of Gessler, Maes, and Skelton's (2011) sample of street-involved Winnipeggers had not been tested for STBBIs in over five years.

Evening

According to the statistics sheets, 184 clients were tested for STBBIs through urine and/or blood testing. This translates to about 3 to 4 testing encounters per week. No oral or rectal swab samples were collected during the review period.

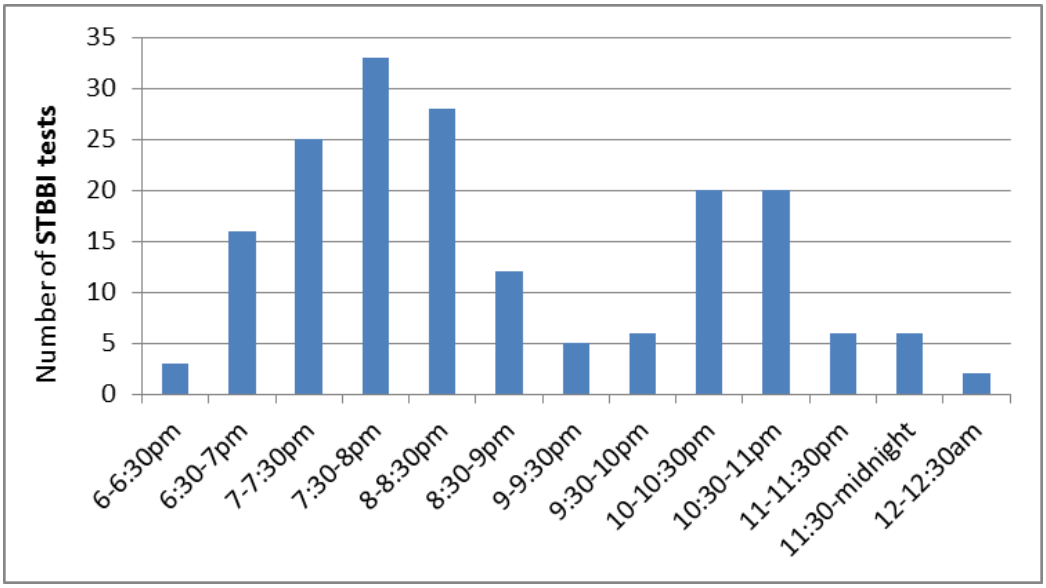
One hundred and six (106) clients submitted urine for testing. The location was seasonally-influenced: over half of urine testing occurred during a home visit in the fall/winter, but this dropped to 30% in the spring/summer. SCUK-takers comprised the majority of testers (47 requested only a SCUK, 13 requested only needles and/or disposal, and 8 requested both a SCUK and needles/disposal). Eighty-five (85) urine testers also had blood testing at the same time, for a concurrence rate of 80%.

One hundred and sixty-three (163) clients underwent some kind of serology test, the vast majority of whom were tested for HIV, syphilis, and hepatitis C at the same time. In 5 instances, serology testing was accompanied by a point-of-care/rapid HIV test. SCUK-takers again comprised more serology testers (73 of 163) than needle-users (36 of 163); of these, 10 requested both a SCUK and needles/disposal.

Overall, although SCUK-takers received more total testing—due to the high number of SCUK distribution encounters—individuals taking needles received proportionately more testing: 1.3% of 3003 needle-distribution encounters included testing, versus only 0.8% of 10,795 SCUK-distribution encounters.

There were no clear differences based on evening of the week. Unlike supply distribution, most testing was done in the first half of the evening.

Figure 10: Total evening STBBI testing by hour, all dates included



Although needle-takers were not the majority of testers, the geographic pattern of evening testing resembles that of needle-distribution (i.e. primarily the North End and home visits). This at least partially reflects the fact that testing is proportionately higher among needle-takers than among others.

Daytime

Fifty-five (55) clients tested for STBBIs during the day, in the HSHR office.

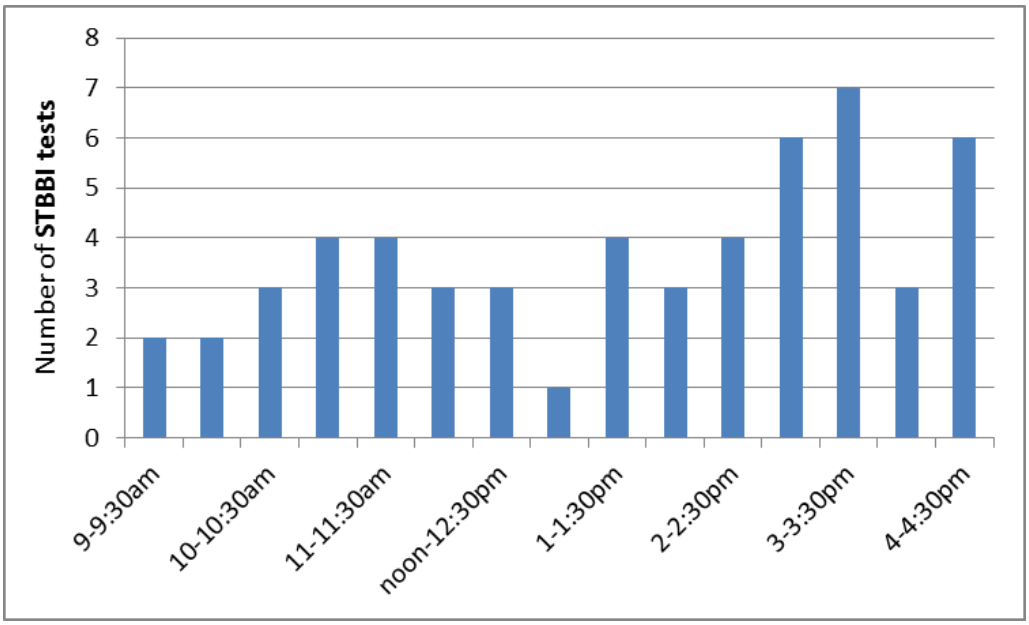
Forty-seven (47) clients submitted urine for testing. Ten (10) of these also took only a SCUK, 3 took or disposed of needles only, and 4 took both a SCUK and needles/disposal. Thirty-four (34) urine testers had blood testing at the same time, for a concurrence rate of 72%.

Forty-two (42) clients underwent some kind of blood testing, the vast majority of whom were tested for HIV, syphilis, and hepatitis C at the same time. Eight (8) point-of-care/rapid HIV tests were recorded, 6 alongside serology testing and twice on their own.

Four (4) clients were tested by swab, all of whom also underwent at least one other kind of test (i.e. blood or urine). All four clients gave an oral swab; one of these also gave a rectal swab.

Although the total number was small, testing was also more common in the afternoon:

Figure 11: Total daytime STBBI testing by hour, all dates included



Across both the evening and daytime, *Street Connections'* overall serology testing concurrence rate—i.e., when a urine test was also accompanied by a blood test—was 78% (119 out of 153). Importantly, serologic testing is not always indicated at the time of bacterial testing, and is sometimes declined. This greatly exceeds the average concurrence rate for all providers in the Winnipeg Health Region, which in 2012 was 40.8% (Bullard et al., 2015).

Results

Determining the percent-positivity of tests is a difficult endeavour, as it depends on two sources of valuable but imperfect data: the denominator is drawn from the statistics sheets (i.e. the checkboxes under 'Serology,' 'Urine,' or 'Swabs') and the numerator from an Access database containing all positive STBBI test results for the entire Winnipeg Health Region. In this database, *Street Connections* clients were considered to be those who were assigned to 'SC' in the 'PHN#' field.

During this evaluation period, there were 31 positive results:

Infection	# of positives
Chlamydia	14
Chlamydia/Gonorrhea co-infection	3
Gonorrhea	4
Hepatitis C	9
HIV	1
Syphilis	0

These results can be compared to the total number of daytime and evening urine tests (153) and blood tests (205),[6] to determine the percent-positivity, which in turn can be compared to the percent-positivity at the Winnipeg Remand Centre and Manitoba Youth Centre in 2012,[7] and the province as a whole in 2013.[8]

	Percent positives, all MB	**Street Connections**	Winnipeg Remand Centre	Manitoba Youth Centre
Chlamydia	5.1%	**11.1%**	14.5%	27%
Gonorrhea	0.4%	**4.6%**	4.7%	7.2%
HIV	0.23%	**0.5%**	0.5%	0
Hepatitis C	4.1%	**4.4%**[9]	3.5%	0

These results demonstrate that *Street Connections* clients demonstrate rates of some STBBIs up to 11.5x higher than in the general population, and on par with HSHR's outreach activities to adults in the Winnipeg Remand Centre.

Importantly, those seeking testing would also be assessed for eligibility for vaccinations against hepatitis A and B, conferring a public health benefit even in the case of a negative STBBI result.

[6] These would not include daytime outreach testing (due to a lack of documentation). Although in practice there is little testing performed during daytime outreach, the denominator (total tests performed) may be slightly underestimated.

[7] Links to both reports can be found at http://www.wrha.mb.ca/extranet/publichealth/services-healthy-sexuality.php.

[8] Personal communication from Dr. Jared Bullard, November 3, 2014.

[9] Note that without a chart audit, it is not known whether the hepatitis C diagnoses would always have been *new* to the client, so this should not be interpreted as incidence.

Indicator 1c – 'Other Health Care' services provided

The expanded statistics sheet includes columns under 'Other Health Care' designed to better reflect the breadth of work done primarily by the *Street Connections* PHNs. Note, though, that these represent primarily services provided directly to clients. The daytime PHN especially frequently works with other health care providers and systems *on behalf* of clients, but not directly with them; this work is not captured in this evaluation.

These columns were checked a total of 197 times, during 169 encounters, across *both* the evening and daytime:

	Occurrence
Results Given	47
Antibiotic Tx	47*
Immunized	44
Wound Care	30
Prenatal (misc. - not testing or serology)	10
TB Sputum	2
OW referral to PHN	1
PHN referral to OW	0
Client Referral	16†

* The number of clients receiving antibiotic treatment exceeds the number of positive cases due to treatments given to sexual contacts (at ~2-3 contacts per case).

† Client Referral included 8 to primary care, 3 to social services, and one each to addictions, urgent/emergency care, prenatal/PIIPC,[10] and a combination addictions/primary care.

'Other Health Care' columns were more often checked on Saturdays and Tuesdays. This supports the claim that nursing services are slightly more available on Saturdays due to lower client volumes, whereas on Tuesdays it likely represents an accumulation of results to be delivered and other work generated since the previous Friday.

Because the counts are so low as to make detailed analyses practically impossible, consideration may be given to excluding them from the statistics form altogether and (if desired) capturing this work in some other medium.

Indicator 1d - Number of 'Bad Dates' collected

People working in the sex trade can report 'bad dates' (i.e. violent or aggressive clients) or 'street hassles' (i.e. general public) to *Street Connections*. These can be put in the weekly newsletter and—if the person wishes—reported to Sage House (for dissemination to their service-users) and/or to the Winnipeg Police Service Sex Crimes Unit. For legal liability reasons, reports appearing in the newsletter include a legal disclaimer and exclude information that could be used to—correctly or incorrectly—

[10] PIIPC stands for Partners in Inner-City Integrated Prenatal Care, a research project aiming to link families to services that support healthy pregnancies and healthy babies.

identify an individual as a 'bad date' or 'hassler.' The completed forms are stored at 496 Hargrave, the archives of which stretch back to the mid-1990s.

From October 2013 to September 2014, three 'Bad Dates' and three 'street hassles' were collected by staff. All were reported by female-identified individuals, appeared in the *Street Connections* newsletter, and were shared with Sage House. Five of six were shared with the WPS. In addition, a 'bad date' report collected by the RCMP was forwarded to HSHR for inclusion in our newsletter.

Unfortunately, because demographic information is not routinely collected from clients, the total number of sex workers who engage with *Street Connections* is not known. Therefore it is impossible to determine the proportion of incidents reported compared to the population size. That said, the reports seem to suggest that violent incidents on the street (especially robberies) are as common as violent or aggressive clients.

Indicator 1e - Number of prenatal contacts

Seventy-seven (77) clients were screened for pregnancy during the report period, 27 during the day and 50 in the evening.

On 30 occasions, the pregnancy test was accompanied by SCUK distribution, and on 19 occasions by either needle distribution or disposal (9 occasions included both supplies). In 57 instances, the client was also screened for STBBIs, usually through both blood and urine testing. One time the client receiving pregnancy testing was also marked as receiving a referral for prenatal care.

Indicator 1f - Number of external presentations

Presentations to groups (on STBBIs, safer sex and/or drug use, etc.) are facilitated by both PHNs and Outreach Workers, and not necessarily limited to the *Street Connections* program. A total of 31 presentations were recorded, with 614 attendees reached:

	Groups	**Participants**
October	3	64
November	4	98
December	0	0
January	2	40
February	2	25
March	2	30
April	6	174
May	3	57
June	5	58
July	1	30
August	0	0
September	3	38

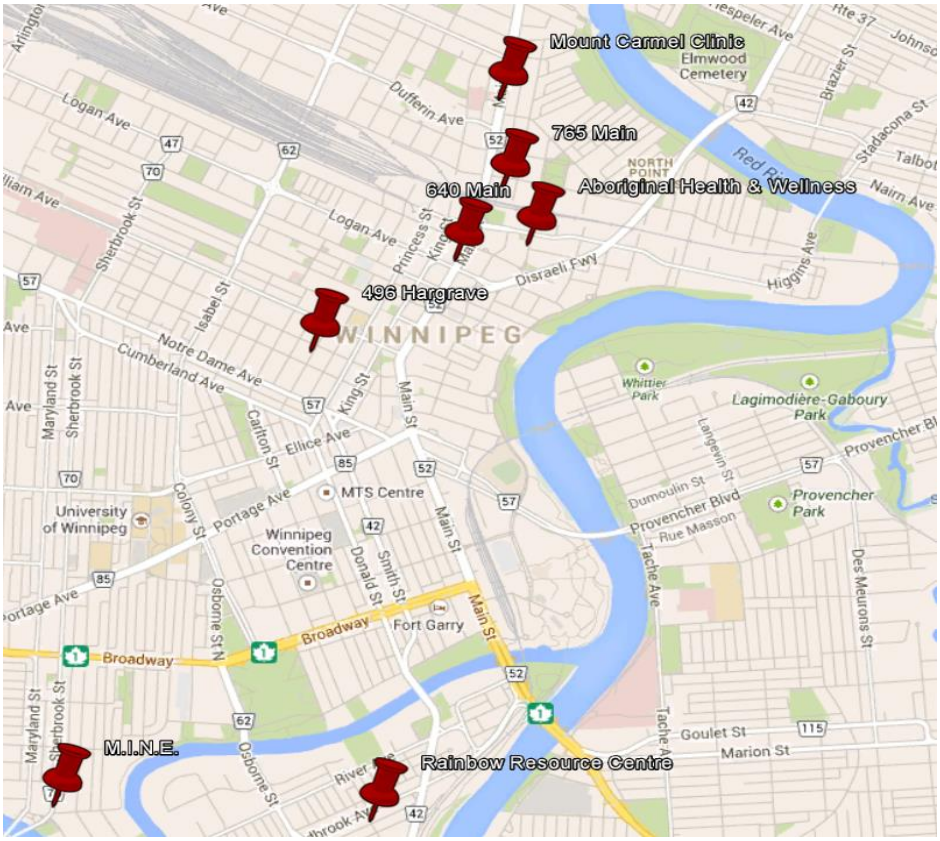
Indicator 1g - Number of community distribution sites and supply distribution therein

Supplies are provided to a number of agencies to distribute on HSHR's behalf in Winnipeg. Namely, supplies are distributed (and/or used needles collected) by:

- Mount Carmel Clinic (including the Sage House and *Wiisocotatiwin*/ACT programs)
- The Transition, Education & Resources for Females (TERF) program (via Klinic CHC)
- The Bell Hotel
- M.I.N.E. (Methadone Intervention and Needle Exchange)
- The 595 Prevention Team
- The North End Community Renewal Corporation
- Health Action Centre/ACCESS Downtown (640 Main St.)
- Nine Circles Community Health Centre
- Aboriginal Health and Wellness Centre

Importantly, only Aboriginal Health and Wellness, Mount Carmel Clinic (including the ACT office at 765 Main St.), M.I.N.E., and ACCESS Downtown provide supplies to the general public. Other sites supply to their client base only and so are not widely advertised. Rainbow Resource Centre will also distribute supplies, though it is rarely accessed. This results in a relatively narrow area in which supplies are available, including no sites in the West End, north of Selkirk Ave., Inkster, or Elmwood:

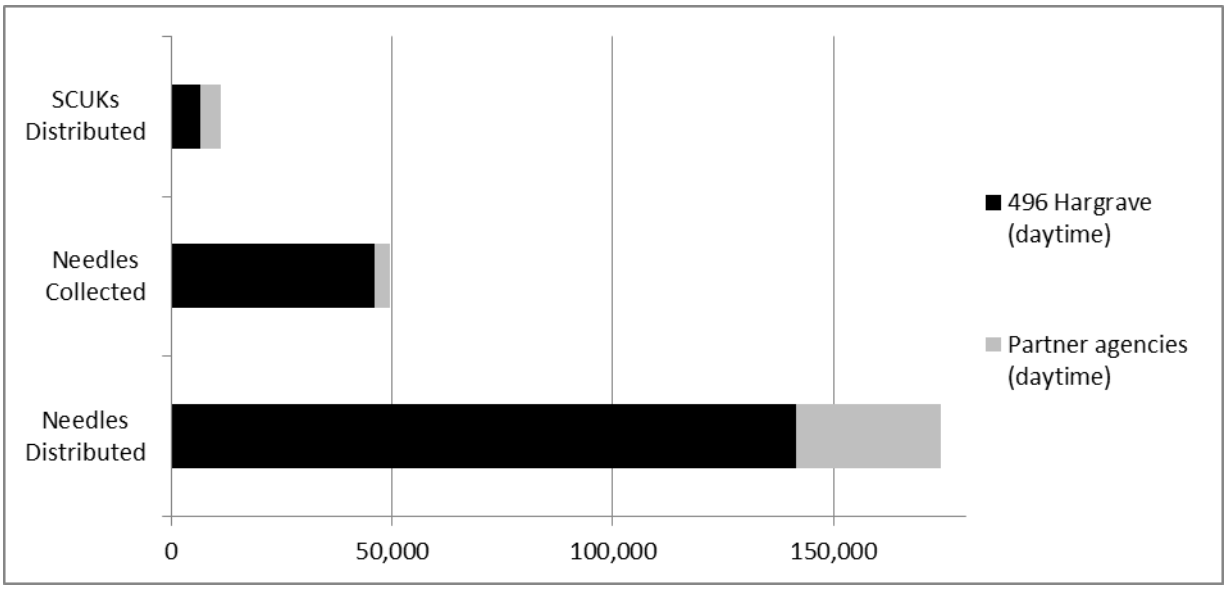
Figure 12: Supply distribution sites accessible to the public



Day and time limitations also exist. Supplies are currently available nowhere a) Monday to Saturday between the end of business hours and the first *Street Connections* van stop (i.e. between 5 and 6:35pm), b) Sundays outside of 1:30 to 4:30pm (Mount Carmel's WISH Clinic), nor c) any day between around 12:30am and 8:30am.

Despite the fact that the HSHR office is not located in a particularly high-traffic area, it distributes and collects the vast majority of supplies during the daytime in Winnipeg. This is especially true with regards to needles, likely due to the fact that more than half of all distribution encounters at the HSHR office entailed large-volume distributions of between 110 and 1000 needles. Even with a strengthened daytime distribution network, these large volumes would likely remain with HSHR.

Figure 13: Daytime needles distribution and pick-up by HSHR or partner agency



As part of their agreements with HSHR, partner agencies report their distribution at regular intervals. Including their statistics gives as close of a complete picture as possible[11] of supply distribution and collection in Winnipeg.

[11] Partner agencies, for example, are likely to mainly dispose of needles in their own regular medical waste, which would not be counted, etc. Also, as per above, clients often 'stockpile' thousands of needles before arranging for a home visit pick-up, somewhat skewing the numbers at any particular point in time.

Site	*Needles Distributed*	*Needles Collected*	*SCUKs Distributed*
Street Connections (evening)	409,671	355,791	20,028
Street Connections (daytime)	141,512	45,948	6461
Partner agencies (daytime)	32,827	3438	4729
Street Connections (day outreach*)	1351	1	232
Needle drop-boxes	0	752	0
TOTAL	**585,361**	**405,930**	**31,450**

*As indicated above, Street Connections daytime outreach statistics were not analysed in this report, but the *total* number of supplies distributed and collected during these shifts were recorded in the MIS database. These may apparently also be incomplete (i.e. underreported), but are nonetheless included.

Indicator 1h - State of relationship with the police

During the evaluation period, representatives from HSHR (Team Manager, Medical Officer of Health, and PHN) met—alongside representatives of partner agencies—with members of the Winnipeg Police Service four times. The meetings were held with both District 3, and the Counter-Exploitation (formerly Vice) unit. The goal of the now-regular meetings is to strengthen our respective understandings of how the health care system and police force work with street-involved populations. This year, a PHN and one of the HSHR Medical Officers of Health also had the opportunity to participate in the District 3 education days. They provided information and education about *Street Connections'* harm reduction philosophy as well as an overview of the program to all officers working in this district. *Street Connections* staff also meet with the WPS Sex Crimes unit on a (at least) bi-annual basis.

Supplemental Analyses and Comparisons

a) Comparison between the North End and Downtown

Although this report is designed to evaluate the current *Street Connections* route (and geographic 'zones' therefore reflect the van's cruise areas), the Evaluation Team pointed out that *clients* undoubtedly separate the city into different zones. Namely, a significant divide is thought to exist between the North End and Downtown, with the Canadian Pacific Railway yard (between Higgins and Sutherland) acting as both a physical and psychological barrier.

For harm reduction supplies distribution specifically, we focused on a comparison between the North End (defined as the area bordered by Redwood to the north, McPhillips to the west, Sutherland to the south, and the Red River to the east) and Downtown (defined as the area bordered by Higgins to the north, Sherbrook to the west, Broadway to the south, and the Red River to the east). Although Downtown contains a larger surface area and a higher number of encounters (4835, versus 3830 in the North End), *proportions* were more important than absolute numbers.

In general, the Downtown was the site of slightly more needle use and STBBI testing, whereas the North End was characterised more by SCUK- and condom-distribution.

Percentage of encounters…	North End	Downtown
Where a SCUK was distributed	83.71%	82.21%
Where a needle was distributed or collected	11.12%	15.93%
Where safer sex supplies were distributed	72.48%	68.98%
Where STBBI testing took place	0.70%	1.08%

Interestingly, although more encounters included needle-distribution Downtown versus the North End, the average amount taken per distribution encounter was about the same: 72.53 needles/encounter in the North End versus 78.79 needles/encounter Downtown. This points to a higher absolute number of needle-using *individuals* in the Downtown.

Note that, as mentioned above, these 'zones' do *not* include Home Visits, and so do not definitively characterise these areas of the city. For example, it could be that more needles are distributed via Home Visit in the North End, making up the (apparent) difference, etc.

b) Seasonal comparison

As expected, seasonal variation was evident in practically all areas.

For the purposes of this analysis, all encounters were assigned a 'Season' based solely on the month in which they took place:

Fall	October, November, December 2013
Winter	January, February, March 2014
Spring	April, May, June 2014
Summer	July, August, September 2014

Evening

Not surprisingly, in terms of encounters, all dipped to their lowest point in the winter months and peaked in the summer.

	Fall	Winter	Spring	Summer
TOTAL ENCOUNTERS	*3097*	*2534*	*3893*	*4697*
Total # of SCUK encounters	2372	1924	3015	3484
Total # of needle distribution/collection encounters	634	622	732	1070
Total # of safer sex supplies encounters	2207	1639	2603	3001

Interestingly, in terms of actual *volumes* of supplies, needle-distribution seems at first to be much less affected by the seasons than SCUK-distribution. In the summer, there were 183% more SCUKs distributed than in the winter. For needles distributed, the difference was only 117%, and for needles collected, 111%.

	Fall	Winter	Spring	Summer
Total # of SCUKs distributed	4414	3552	5572	6490
Total # of needles distributed	94931	96500	105731	112509
Total # of needles collected	83578	88203	85832	98178

The consistency of needle distribution and collection despite the seasons (and despite a dip in the number of needle-related *encounters*) seems to be largely due to the Home Visit system, which allows clients to continue receiving and disposing needles without having to leave their home. The lowest proportion of Home Visits was in the summer, with 5 home visits per hundred street encounters (237:4460); the highest was during the winter, when there were 14 home visits per hundred street encounters (310:2224). Indeed, when needle-distribution is broken down, what appears at first to be a 'flatter' distribution pattern is actually an amalgam of two different trends: a peak of regular-stop needle distribution in the summer (166% more than in the winter, not in fact unlike SCUK distribution), but a peak of Home Visit needle distribution in the winter.

	Fall	Winter	Spring	Summer
Total # of needles distributed	94931	96500	105731	112509
Needles distributed on the street	*38654*	*31530*	*41822*	*52361*
Needles distributed on a Home Visit	*56277*	*64970*	*63909*	*60148*

Daytime

The trends for in-office daytime encounters do not differ from the evening, but *volumes* trend in an opposite way. Namely, needle distribution and collection is heavily affected by the seasons (137% and 245% more in the summer compared to the winter, respectively), while SCUK distribution only experiences 124% higher volumes in the summer compared to the winter.

	Fall	Winter	Spring	Summer
Total # of SCUKs distributed	1538	1395	1795	1733
Total # of needles distributed	24847	35225	33278	48162
Total # of needles collected	11580	6695	11278	16395

Together, evening and daytime trends seem to indicate that, in general, SCUK-takers tend to visit the HSHR office more consistently during the year, accessing the van less in the winter months, whereas needle-takers visit the office less during the winter, opting instead for evening-time home visits. It is still important to note that these differing trends do not 'balance' out supplies distribution: overall, the lowest number of encounters and supplies distributed are in the winter, and the highest are in the summer. This could suggest that drug use activities are less safe in the winter (due to lower accessing of clean supplies), but it is also possible that actual drug use dips in the winter months due to a diminished flow of drugs into Winnipeg, or other factors.

c) Proportion of outreach versus nursing activities

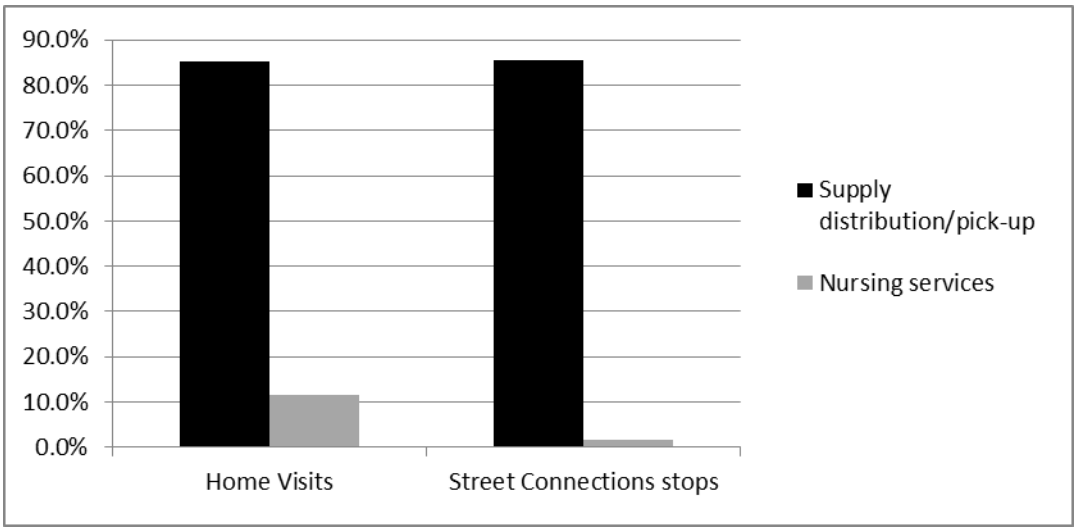
In terms of the amount of time currently being spent on different tasks at different times of the day, two trends emerge:

a) Daytime visits are periodic and therefore pose challenges in terms of scheduling dedicated full-time Outreach Workers for the task. The HSHR office averages 2.1 client visits per hour, from a low of 1.2 first thing in the morning to a high of 2.8 in the hour after lunch. Outreach workers have estimated that the average encounter lasts ~ 3 minutes; even increasing that number to 5 minutes results in 5 to 15 min. of client interaction time per hour.

If SCUKs did not require human resources for daytime distribution, the number of visits per hour (for needle distribution, disposal, and STBBI testing) would average 0.9 visits an hour, peaking at 1.3 visits per hour from 3:30-4:30pm.

b) Evening nursing encounters are periodic. There may be value in incorporating forthcoming research findings (mapping, etc.) in order to maximise nursing resources. Analysis of data for Tuesdays through Saturdays shows that nursing services[12] comprise about 11.5% of all encounters during home visits, and 1.7% of encounters occurring outside of home visits. It is of course important to note that nursing services are considerably more time-intensive than a supply distribution encounter, and so the disparity in encounters does not necessarily reflect a disparity in terms of time spent. In addition, in order for the van to make all its scheduled stops at a predictable time, nursing services may not always be offered if the time does not permit. Finally, direct encounters with clients by mail or phone—as well as work with other professionals and systems—are not reliably recorded in the MIS database.

Figure 14: Evening supply distribution/pick-up versus nursing services, as a percentage of all encounters



In order to gain some perspective, the Urban Public Health STBBI Network was consulted about the staffing models of other evening mobile services. Three other jurisdictions provided information:

[12] 'Nursing services' are defined as all testing or 'Other Health Care' on the statistics sheet.

- Saskatoon Public Health operates the Health Works Van, Monday to Friday from 7pm to midnight. It is currently staffed by an outreach worker and a PHN.
- Hamilton Public Health operates 'the Van,' Monday to Saturday from 8pm to midnight. It is staffed by a nurse only one night/week.
- Peel Public Health operated the NEP Mobile Van, Monday to Friday from 2 to 10pm. It also is staffed by a nurse only one night/week.

d) Popularity of 'stops'

The *Street Connections* route comprises five 'stops' and four 'cruise' times:

6:35 - 6:45 pm	Stop at 705 Broadway (behind Nine Circles)
6:50 - 7:00 pm	Stop at Sargent and McGee St.
7:10 - 7:20 pm	Stop at Main St. and Higgins Ave.
9:45 - 9:50 pm	Stop on Andrews St. near Selkirk Ave.
10:00 - 10:15 pm	Stop on Main St. near Jarvis Ave.
10:40 - 10:45 pm	Cruise Juno St.
11:00 - 11:15 pm	Cruise Assiniboine Ave. & Osborne Village
11:20 - 11:30 pm	Stop near 185 Smith St.
11:35 pm - 12:30 am	Cruise North End, Ellice, Sargent, & Juno

For the sake of simplicity, only the six 'stops' were compared. Staff are only able to record a 'Location' by using one street name, so encounters were identified according to the criteria below (also taking into account some flexibility in terms of time):

Posted Stop Time	*Posted Stop Name*	*Criteria for inclusion*
6:35 - 6:45 pm	Stop at 705 Broadway (behind Nine Circles)	All encounters between 6:25 and 6:55pm with location marked as 'Broadway'
6:50 - 7:00 pm	Stop at Sargent and McGee St.	All encounters between 6:40 and 7:10pm with location marked as 'Sargent' or 'McGee'
7:10 - 7:20 pm	Stop at Main St. and Higgins Ave.	All encounters between 7:00 and 7:30pm with location marked as 'Main or 'Higgins'
9:45 - 9:50 pm	Stop on Andrews St. near Selkirk Ave.	All encounters between 9:35 and 10pm with location marked as 'Andrews' or 'Selkirk'
10:00 - 10:15 pm	Stop on Main St. near Jarvis Ave.	All encounters between 9:50 and 10:25pm with location marked as 'Main' or 'Jarvis'
11:20 - 11:30 pm	Stop near 185 Smith St.	All encounters between 11:10 and 11:40pm with location marked as 'Smith'

Although the 'window period' of inclusion for each stop was about the same, there were clear differences in terms of the 'popularity' of each stop:

Stop	*Total Encounters*	*SCUKs distributed*	*Needles distributed*	*Testing*
Broadway	187	272	2390	3
Sargent/McGee	753	1217	5745	13
Main/Higgins	1770	2303	16730	15
Andrews/Selkirk	376	504	6559	4
Main/Jarvis	1533	2239	37087	18
Smith	93	133	6070	0

These results will need to be considered in light of the findings of the mapping research initiative. Together, they may be used to suggest changes to the *Street Connections* route.

Evaluation of Safer Crack Use Kits (SCUKs)

A number of articles have synthesised the evidence regarding the infection-transmission risks of sharing crack pipes, though the evidence is scant and the causal pathways unclear (see, for example, Backé et al., 2012; Canadian HIV/AIDS Legal Network, 2008; Strike et al., 2013). Regardless, engaging with individuals who use crack remains a priority to Public Health due to their implication in *sexual* networks characterised by STBBIs, as well as their experience of overall health inequities.

WRHA SCUKs comprise a glass stem, a pack of 5 screens, a small piece of PVC tube (for use as a mouthpiece), alcohol swabs, an education sheet, and (optionally) a chopstick, all assembled into a small re-sealable plastic storage bag by individuals working at a local agency for people with disabilities.

The identified evaluation priority for 2013/14 was: How well do Safer Crack Use Kits (SCUKs) meaningfully engage and promote the health of marginalized clients?

Indicators examined:

Indicator 2a	**Number of clients accessing Street Connections for SCUKs**
Indicator 2b	**Client characteristics**
Indicator 2c	**Number of supply sharing episodes in the past 30 days**
Indicator 2d	**Experience of crack use-related harms**
Indicator 2e	**Number of SCUK-takers who also inject drugs**
Indicator 2f	**Staff and clients' expressed satisfaction with the kits and their distribution**

Data source

Four sources of data were used to answer this question:

- The expanded statistics forms, as per 'Program Monitoring' above.
- From October 2013 to March 2014, a survey was offered to Street Connections clients who requested a SCUK. The survey was adapted from the one used by Johnson and Malchy (2008) and took approximately 15 minutes to complete. It is appended as Appendix G. Respondents received a $20 gift card for their time. The survey was offered both during the day and in the evening by HSHR staff, as well as through a number of partner agencies who distribute SCUKs to their clients. Inherent in this methodology are two limitations. First, because surveys were usually verbally administered by staff, responses may have been affected by social desirability bias. Second, because surveys were administered by more than one individual, it cannot be guaranteed that no respondents completed the survey more than once. To mitigate this risk, respondents were asked if they had previously completed the survey but told that they could re-complete it and receive a gift card again; this was done so that there would be no disincentive to identifying a duplicate (one duplicate was eventually flagged and therefore excluded).
    - To determine statistically significant relationships between survey responses, the dataset was sent to *Health In Common* for supplemental analysis, but only a small number of relationships were investigated. The p-value is indicated below where a relationship was found. Any relationships suggested *without* a p-value should be assumed to be non-significant.

- In May and June 2014, an online survey was sent to health care providers and outreach staff in Winnipeg who distribute SCUKs. This was adapted from the interview guide used by Vancouver Coastal Health (2013). It is appended as Appendix H.
- In summer 2014, a volunteer accompanied the *Street Connections* van in order to capture the perspectives of clients. This captures the qualitative/relationship-building aspect of the work, not well represented in quantitative statistics. Excerpts from this project are incorporated throughout this section, with the client feedback as recorded by the volunteer and the time it was recorded.

> ***7:11pm:*** *I've known Street Connections and the staff for many years and they're always there to help us. I think the service should be everywhere in Winnipeg.*

Question - How well do Safer Crack Use Kits meaningfully engage and promote the health of marginalized clients?

One hundred and forty-three (143) surveys were completed by clients. One hundred and thirty-six (136) comprised the final dataset after seven (7) surveys were excluded for various reasons.

Surveys were completed at a number of sites:

- *Street Connections* (evening) 32
- *Street Connections* (daytime / 496 Hargrave) 61
- Mount Carmel Clinic (Sage House/*Manito Ikwe Kagiikwe*) 11
- Mount Carmel Clinic (*Wiisocotatiwin*/ACT) 10
- Nine Circles Community Health Centre 9
- The 595 Prevention Team 7
- The Bell Hotel (a project of Main Street Project) 4
- Klinic Community Health Centre (at the TERF program) 2

There were no gender differences between respondents through the *Street Connections* van, but 496 Hargrave respondents comprised significantly more men, and partner agency respondents comprised significantly more women (both $p < 0.05$).

The online survey of health care providers and outreach staff was completed by 19 individuals. To maintain anonymity, no information was collected about their place of work, position, etc. The complete raw answers are appended as Appendix H.

Indicator 2a - Number of clients accessing Street Connections for SCUKs

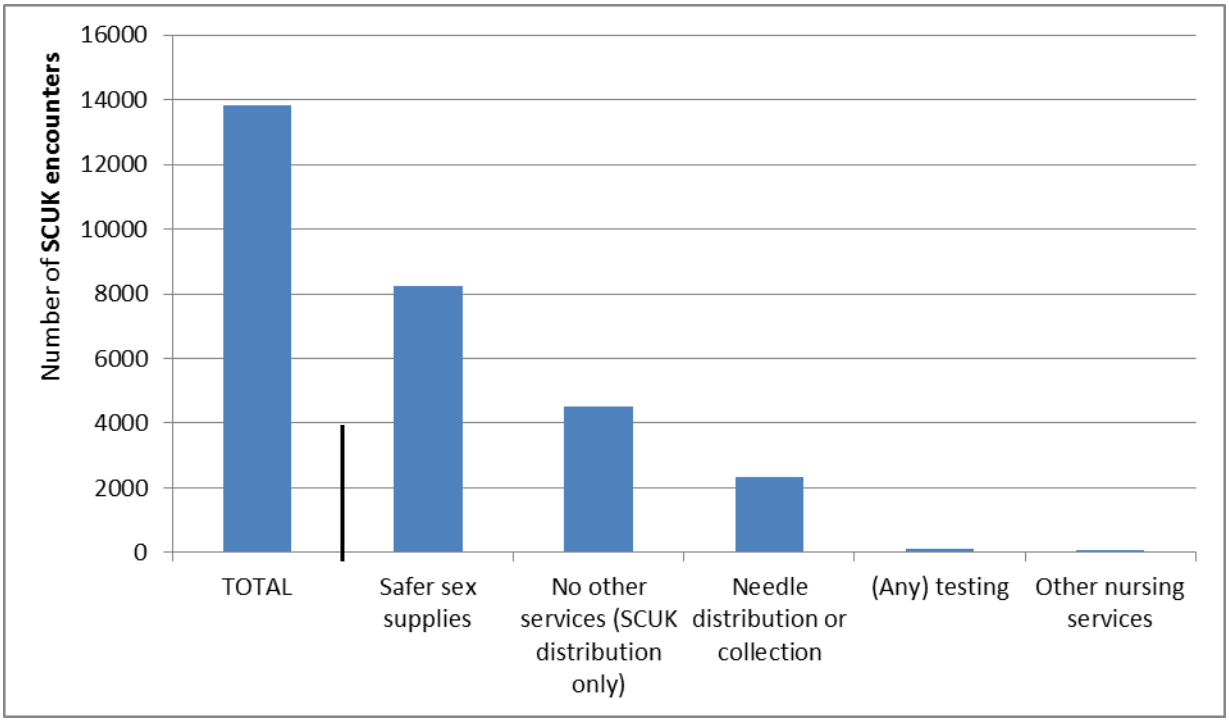
Because identifying information is not collected from clients, the number of unique clients cannot be assessed. In terms of encounters, according to the *Street Connections* statistics over the year October 1, 2013 to September 30, 2014, there were 13,816 SCUK distribution encounters (10,795 in the evening

and 3021 during the day). Forty-eight (48) were marked as being 'New' clients (i.e. not previously known to staff).[13]

During these encounters, other services were also provided (some encounters include more than one):

Safer sex supplies distribution	8249
Needle distribution or collection	2344
STBBI and/or pregnancy testing	117
'Other Health Care'[14] and TB DOT	60
No other services (SCUK distribution only)	4507

Figure 15: Services or supplies accompanying SCUK distribution encounters (*Street Connections* program monitoring statistics)

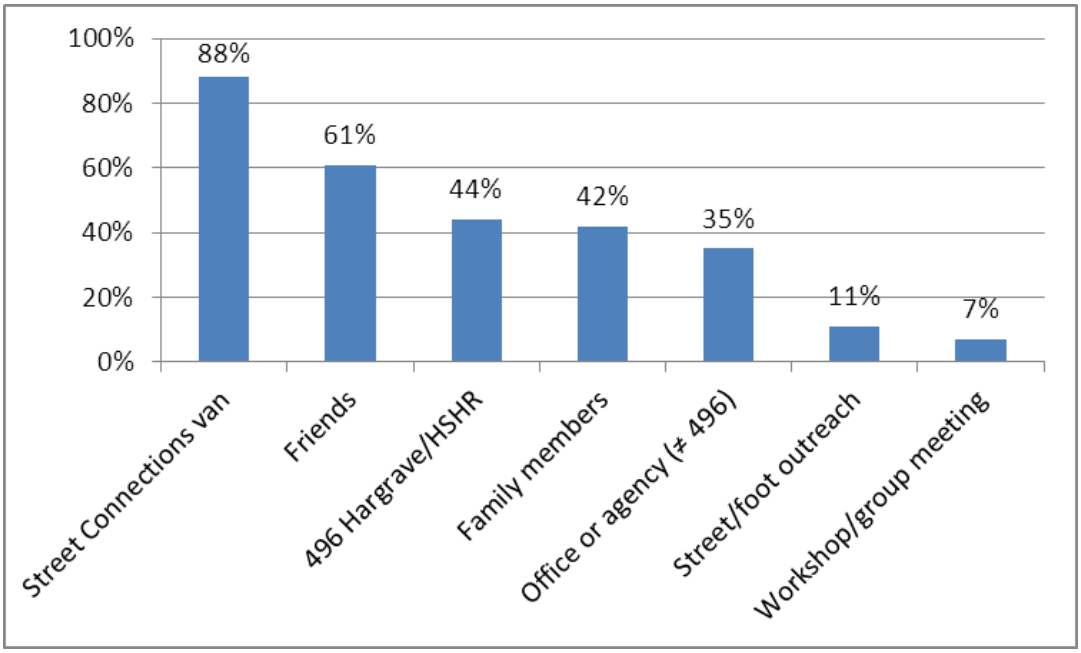


Clients also access SCUKs at other locations. In the survey, although 88% and 44% of SCUK-users accessed their kits from the Street Connections van and daytime office (respectively), many also accessed from other sources. Note that individuals could indicate more than one source.

[13] This designation is inexact because a client may be unknown to a particular Outreach Worker but not necessarily to them all. Because 'new' clients were so infrequent, staff may also have not been in the habit of checking that column consistently.

[14] For a refresher on what was included in 'Other Health Care,' see Indicator 1c in the 'Program Monitoring' report.

Figure 16: Sites accessed for SCUKs



When the 'Friends' and 'Family members' responses were combined, 93 respondents (69%) had procured a SCUK from at least one of these informal distribution sources. Although Leonard (2010, in Strike et al., 2013) argues that clients should be encouraged to access their supplies from formal distribution sites directly—in order to benefit from the supports and services provided therein—the 595 Prevention Team (2013) has shown that informal distribution networks also feature high levels of information-sharing and support between peers.

Among the 48 clients who indicated accessing an agency or office *other than 496 Hargrave,* the most frequently mentioned were Nine Circles (19 times), Sage House (12), and the 595 Prevention Team (11). Mount Carmel Clinic, the *Wiisocotatiwin*/ACT team, the Bell Hotel, the TERF program, Addictions Foundation of Manitoba, and Four Rivers were all mentioned between 1 and 8 times.

Sixteen (16) respondents did not access the *Street Connections* van for their SCUKs, 76 (a majority) did not access 496 Hargrave, and 12 of these accessed neither: six accessed a particular agency exclusively, five procured SCUKs only through informal distribution networks, and one made his own pipe. [15]

Finally, when asked what the *main* source of their SCUKs was (one choice), of those who responded (n=124), 61% said the *Street Connections* van, 31% said an office or agency, 6% through informal distribution, one had previously been making his own, and one was a recent arrival to Winnipeg and had mainly been accessing supplies in Ontario. Even among those who did not complete their survey with the *Street Connections* van, 53% still indicated mainly accessing the van for their supplies. This is consistent with Wylie's (2005) finding that the van is also the primary source of supplies for individuals who use injection drugs in Winnipeg.

[15] This respondent was accessing 496 Hargrave for the very first time when he was surveyed.

> ***7:22pm:*** *This service helps us a lot because we don't have to wait 3 or 4 hours at the hospital.*

Indicator 2b - Client characteristics

Demographics

The survey respondents do not necessarily reflect the characteristics of all SCUK-takers in Winnipeg, let alone all individuals who use crack. That said, they do correspond with the experiences of the *Street Connections* team.

Gender. Respondents primarily identified as male (57%), with 38% identifying as female. Three respondents indicated an 'other' identity, and three identified as trans. Based on street-level dynamics and the organisation of services in Winnipeg, the trans respondents are included with cisgender women whenever gender-based analyses are undertaken below.[16] Due to the small numbers, a statistical comparison was not possible between cisgender women and trans- and 'other'-identified individuals.

Age. The age of respondents varied, from 20 to 62, with a median of 40 years. Female respondents were slightly younger (median of 35 years, compared to 42 for men). For simplicity's sake, ages were also combined into four groups:

20-29	16% of the sample
30-39	31% of the sample
40-49	35% of the sample
50+	18% of the sample

The 20-29 group is the only one where women outnumber men (12 to 10), and the 50+ group is disproportionately male (21, versus only 3 women).

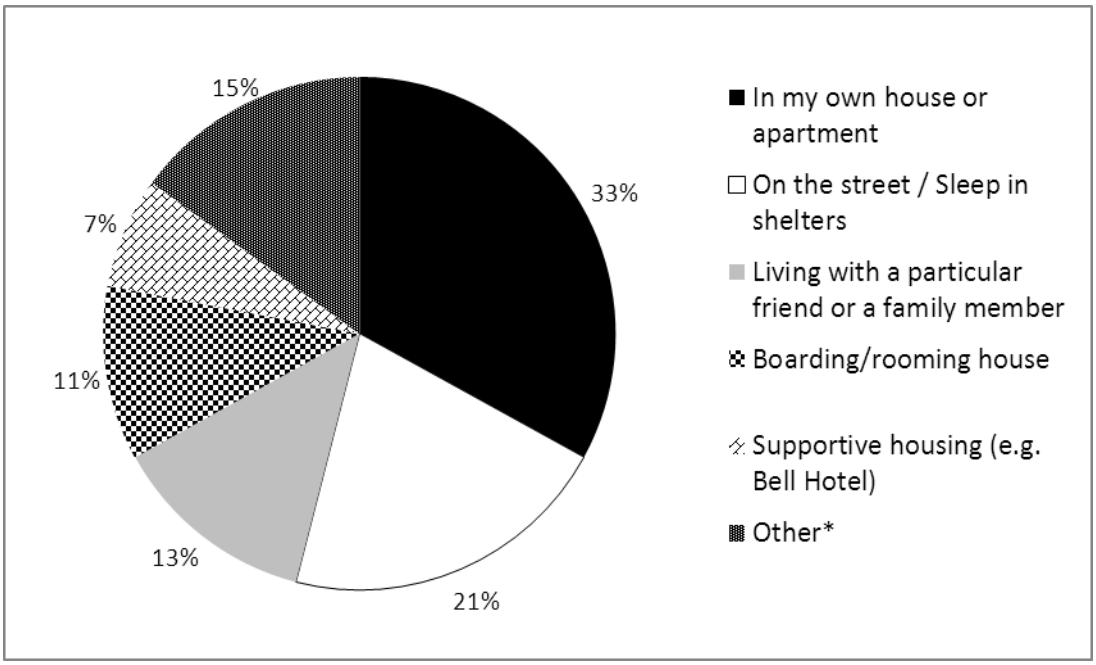
Ethnicity. Respondents were given a broad range of options with which to identify their ethnicity. All but one respondent answered this question (n=135). 65% identified with an Aboriginal identity of some kind, with a fairly even three-way split between those answering 'Métis,' 'Status,' and 'First Nation.' The majority of non-Aboriginal respondents identified as 'Canadian.'

Housing. Respondents were asked 'What part of town would you say that you live in?' Coding these responses proved difficult, as a fair number indicated simply 'Downtown' or 'Central' or 'West End,' etc. Of 129 respondents, the clear majority (73%) indicated residing in the North End, Point Douglas, or Downtown. 14% lived in the West End, 6% in West Broadway, and 7% outside these areas.

The housing status of respondents varied greatly:

[16] This, of course, assumes that the transgender-identified respondents were transgender women, which is an educated assumption but one which cannot be confirmed.

Figure 17: Housing status of survey respondents



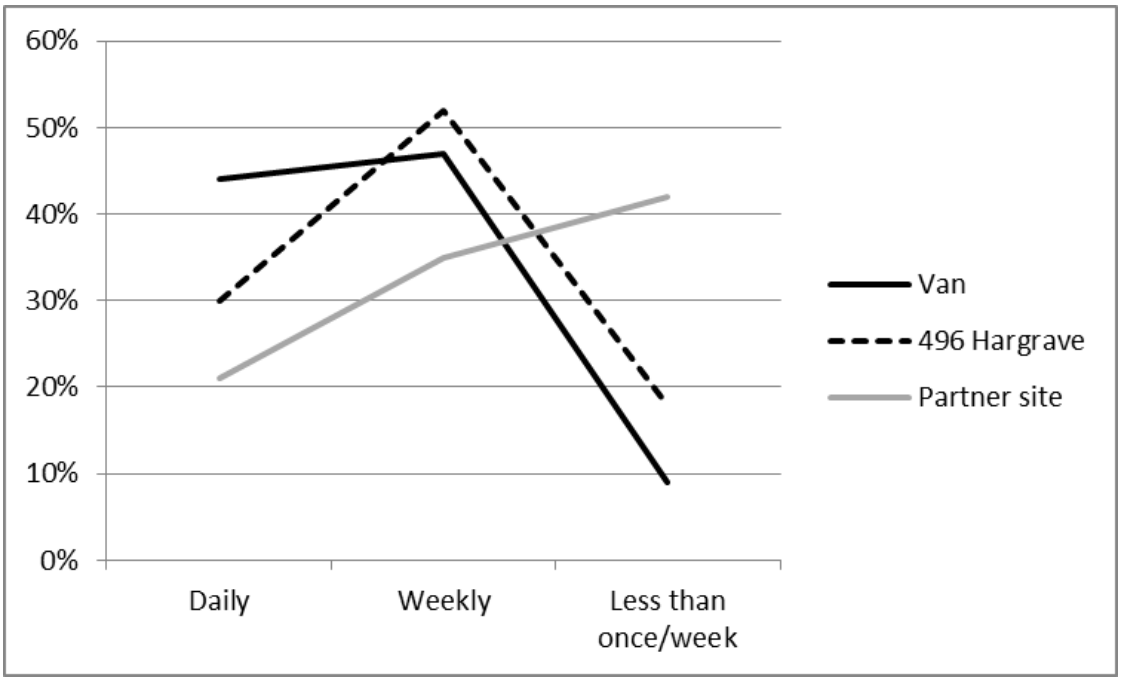
* Other included living with a partner, couch-surfing, living in an SRO, etc.

Crack Use

Frequency of use. The crack use frequency of respondents varied. 30% indicated using crack daily, while 46% used weekly, and 24% less than once/week. Of those indicating daily use, the median number of times used per day was 4, though this ranged from 1 to 100. No gender differences were found.

In terms of site where respondents were interviewed, the highest proportion of individuals reporting daily crack use was among those who completed their survey with the *Street Connections* van (44%), whereas the highest proportion of users reporting use less than once/week was among those who completed their survey at one of the partner sites (42%). Among daytime/496 Hargrave respondents, crack use was primarily weekly (52%). These differences were significant (p=.006), and suggest that evening/van clients more frequently use crack, while those accessing SCUKs at offsite/partner locations are more periodic users (and may take supplies mainly while accessing other services).

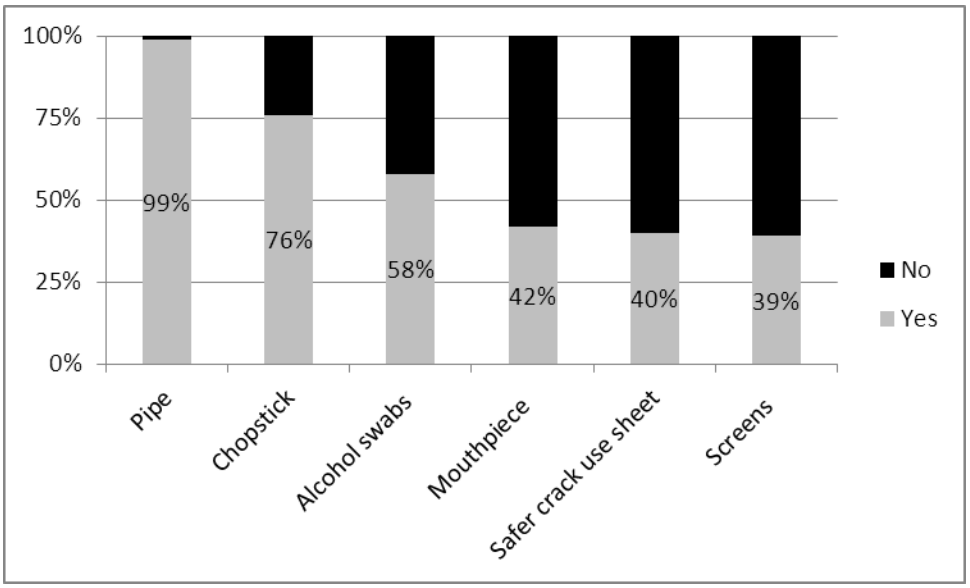
Figure 18: Frequency of crack use, by interview location



In terms of neighbourhood where respondents indicated that they lived, the only major difference observed was that respondents in the West End indicated exclusively using crack daily or weekly (i.e. zero respondents indicated less-than-weekly use). These users may be of particular interest due to their high frequency of use.

Use of supplies. Respondents were asked whether they consistently/regularly used the various supplies included in the SCUK:

Figure 19: Respondents reporting regularly (i.e. on a consistent basis) using items in the SCUK

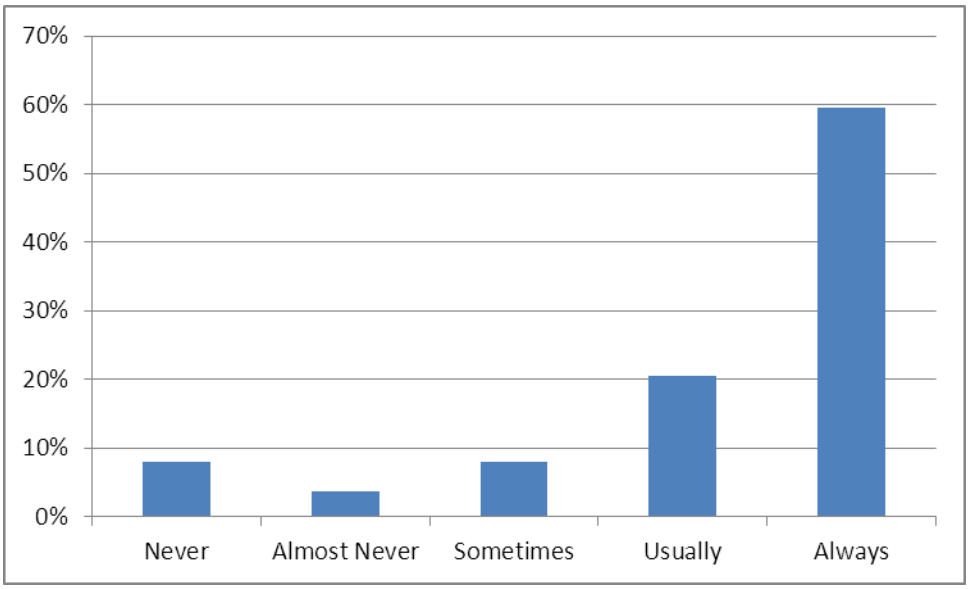


No gender differences were observed. The only glaring difference between site of interview was for the alcohol swabs: 72% of van clients reported using their alcohol swabs, whereas only 55% and 52% of clients at 496 Hargrave and partner sites (respectively) reported using theirs. Interestingly, the reported use of the various supplies mirrored remarkably closely the results of the surveys undertaken by Vancouver Coastal Health's (2013) and—in Ottawa—Johnson & Malchy (2008), with the exception of mouthpiece use, which was 75% in the former and 79% in the latter, but only 42% in our survey.

> ***7:30pm:*** *Sometimes we have to run to catch the van. It would be nice if they had extra time to talk to us, to listen, to get to know us better.*

Two questions were asked concerning specific supplies. First, respondents were asked about their use of Brillo in lieu of screens.[17] The trend was clear: 60% of respondents *always* used Brillo, with an additional 21% using it 'usually.' This is despite the fact that 39% indicated consistently using the screens (see Figure 19); this may be due to clients using both, either at the same time or depending on availability. The phenomenon may also reflect clients' use of screens in marijuana/pot pipes, as the majority of respondents reported also using marijuana in the last month (see p.37). This may merit additional (qualitative) investigation.

Figure 20: "How often do you use Brillo?"



Second, respondents were asked how often they used a mouthpiece. Here too the trend was fairly clear (the reasons for which will be discussed in greater detail below): 43% indicated that they 'never' used a mouthpiece, with another 17% answering 'almost never.'

Neither screen use nor mouthpiece use was associated with the interview location, frequency of crack use, or respondent gender.

[17] For a review of the evidence regarding the harms of Brillo use, see Strike et al. (2013).

Social behaviours. Although respondents overwhelmingly reported preparing their pipe themselves, in general smoking in the presence of others was common. Just over 60% 'always' or 'usually' smoke with other people, with those answering 'sometimes' accounting for another 30%. This helps to support to importance of peer networks as sites of information exchange and supply distribution. Importantly, social smoking behaviours were not associated with the frequency of crack use, interview location, or respondent gender.

Other drugs used. Respondents were asked "In the last month, what other drugs have you used on a regular (i.e. once a week) basis?". Respondents could select more than one:

Pot/marijuana	72.79%
Beverage alcohol	71.32%
Cocaine, other than crack	49.26%
Opioids[1]	44.85%
Benzos/sleeping pills[2]	44.12%
Crystal meth	29.41%
Ecstasy	16.42%
Ritalin[3]	13.24%
Non-beverage alcohol	4.55%
Other[4]	5.19%
Solvents	4.41%

[1] T3s were by far the most common opioid reported (32), followed distantly by Percocet (11), morphine (10), dilaudid (4), 'oxy' and methadone (3 each), fentanyl (2), and heroin (1). Note that respondents could indicate more than one. Two additional respondents answered 'ALL.'
[2] Restoril, Xanax, and valium were the most common, with about equivalent frequencies of mention.
[3] 39% reported using Ritalin with Talwin; 61% used it alone.
[4] Answers: Gabapentin, GHB, barbiturates, Gravol, ketamine (x2), and mushrooms.

These findings were similar to Leonard, DeRubeis, and Burkett's (2006) survey, except that cocaine was more common than beverage alcohol in the Ottawa survey. No gender differences were found, with one exception: only women reported any non-alcohol beverage use ($p < 0.05$).

Marijuana use is not considered an HSHR priority, but its inclusion in our survey captured its popularity. Importantly, Andrade et al. (2011) have suggested that marijuana use could be considered a harm reduction tool for individuals who use crack, as it may "mellow the negative physical and mental agitation experienced … [and] decrease the cravings for more crack" (383). Marijuana use *alone*, though, does not allow an individual to access a SCUK, although individuals who use only marijuana frequently request them.

Beverage alcohol was also included, echoing Kuo et al.'s (2014) suggestion that alcohol be assessed because of the clear role it plays in respiratory depression when combined with opioid use. Forty-seven (47) respondents (35%) reported using both alcohol and opioids.

Excepting marijuana and beverage alcohol, 117 respondents (86%) used at least one other illicit, illegal, or 'off-label' drug, in addition to crack.

Interestingly, weekly users of crack reported significantly higher number of other drugs used (4.0) than either daily (3.4) or less than once-weekly (3.1) users (F=3.73, p=.027). Weekly users were significantly more likely to also use marijuana (p=.054) and especially cocaine (p=.00). It may be that daily users of crack are more committed to their drug of choice, while less frequent users incorporate crack into a more broad polysubstance use. Only ecstasy use was more frequently reported by daily users of crack compared to other users; this difference was significant (p=.030).

Respondents were also asked to estimate how much they spent on drugs for themselves in the last month. Though the range was wide—from $0 up to $25,000—the median reported was $300. This was the same for men only, while women reported a median monthly expense of $245. Some respondents wrote in an answer rather than giving a dollar figure, e.g. "lots," "good question," "hundreds," and "everything."

These are not inconsistent with Long et al.'s (2013) finding of a median expense of $400/month among their sample of people who inject drugs in Vancouver. The authors argued that the need for money to support these habits often necessitated engaging in activities that could put individuals at risk of arrest[18] or violence, pointing to the potential benefit of providing alternative sources of drugs (or, at minimum, drug-use supplies), including (in the Vancouver context) methadone maintenance therapy and prescription heroin.

Indicator 2c - Number of supply sharing episodes in the past 30 days

A cornerstone of the philosophy behind SCUK programs is that they reduce equipment sharing between users. Because we sampled only clients accessing a SCUK distribution program, the sharing habits of those who do not access any of our sites cannot be assessed.

Thirty-two percent (32%) of respondents indicated that they had never used a pipe that had been used by anyone else. Of the remaining 68%, the vast majority had used a pipe shared by someone else either 'almost never' or 'sometimes.' Only 22 respondents (16%) either usually or always used a used pipe. No major gender differences were apparent.

Mouthpiece sharing was slightly more common: among respondents who indicated any mouthpiece use (n=76), half had used a mouthpiece that had already been used by someone else, though again the proportion of those reporting 'usually' or 'always' using a used mouthpiece was low (n=8, 11% of all mouthpiece users).

Evidence suggests that equipment sharing largely mirrors relationship dynamics in general, namely what Shaw et al. (2007) describe as 'comfort networks' and 'convenience networks' (see also Seear et al., 2012). Sharing is often done within these networks, especially between intimate partners. Not dissimilar to the 68% (above) who reported *using* a used pipe at least once, 65% reported having *given* their pipe to another person to use within the last month (n=89). And of these, all but two people (or 98%) gave to a person that they knew; only 27 (30%) had shared with a person they did not know.

[18] The causal link between drug dependence and acquisitive crime is a complicated one, and has been questioned by Hayhurst et al. (2013), who found that behavioural and demographic factors were in fact more associated with acquisitive crime than were drug use expenditures.

Of our 76 mouthpiece-users, only 43% (n=33) had given their mouthpiece to another person in the last month. As with pipes, this is only slightly less than the proportion who had ever used a used mouthpiece (50%). Also like pipes, sharing was primarily confined to intimates: 100% had shared with a person they know; only 9 (27%) had shared with a person they did not know.

Indicator 2d - Experience of crack use-related harms

By and large, respondents were not harmed by their supplies. More than three-quarters (78%) had never or almost never had a pipe either shatter or break apart during use. Split or cracked pipes were more common: 56% had 'never' or 'almost never' used a split or cracked pipe, but 35% answered 'sometimes' and the remaining 9% used them more frequently than that.

> ***9:50pm:*** *It's great, it helps the community to stay safe. I've known Street Connections for at least 22 years and I try to help others too.*

In terms of infection transmission, crack use-related injuries most of interest to public health affect either the lips, mouth, teeth, and/or gums. Seventy-seven (77) respondents—or 57%—reported at least one of these problems:

Have you had any of the following health problems in the past year?	***Yes***	*M*	*F*
Burns on your lips or mouth from smoking crack	**34%**	31%	35%
Lesions such as cracked lips or sores on your lips or mouth from smoking crack	**21%**	24%	15%
Problems with your teeth or gums (e.g., cavities or bleeding gums)	**37%**	32%	42%

These also seemed to cluster: of the 77, 37 (48%) individuals had at least two problems, and 10 (13%) had all three. There were no obvious demographic characteristics of those experiencing multiple harms.

Insomnia or trouble sleeping was the most frequent problem reported by respondents (71%, n=97). Insomnia was significantly associated with housing situation (homelessness or sharing housing with friends or family; p=.041), polysubstance use (p=.007), and specifically use of opioids (p=.018) and—not surprisingly—benzos/sleeping pills (p=.000). A three-variable model incorporating female gender, housing, and drug use resulted in all three being associated with sleep disturbances. Frequency of crack use was not associated with insomnia.

Finally, consistent with increasing calls to consider the harms related to the criminalisation of drug use, Fischer et al. (2006) reported that their sample of people who used crack was more frequently arrested than were users of other street drugs. Indeed, 28 of our respondents reported a run-in with police related to their crack-use equipment in the last 6 months: 13 people had their kit confiscated by police, 11 people were forced to smash their pipe, and in 21 instances the police themselves smashed the client's pipe. Again, problems seemed to cluster: 15 out of the 28 (or 54%) reported at least two of these incidents occurring in the last 6 months. Those who reported kit confiscation were also significantly more likely to have been interviewed by the *Street Connections* van compared to either 496 Hargrave and partner agency respondents (p=.024). Overall, though, our prevalence of police harassment was lower than what has been reported among individuals who use crack in both Ottawa (Johnson & Malchy, 2008) and Vancouver (Vancouver Coastal Health, 2013).

Seven individuals felt that they had actually been prevented from obtaining their supplies when needed, often by police. But other systems also actively worked against our SKUC distribution: five individuals had their SCUK either taken or smashed by staff at an overnight shelter.

> ***9:55pm:*** *My recommendation: make the service available everywhere in Winnipeg and Manitoba. Have some light food in the van, and ask us questions about our lives, because we trust them and they can connect us to other services.*

Indicator 2e - Number of SCUK-takers who also inject drugs

Setting aside its utility as a tool to directly prevent infection transmission, SCUKs are also considered valuable because they may make it easier to inhale drugs, encouraging those who inject their drugs to 'migrate' to inhalation (see, for example, Leonard et al., 2008). When asked whether their drug use had changed in the last year, only two individuals referenced injection drugs, one to say that s/he had stopped injecting, another that s/he had started injecting.

Thirty-two (32) respondents—or 24%—indicated currently injecting drugs. This group was younger than the sample as a whole (59% were aged 39 or younger) and more likely to be men (over two-thirds). Interestingly, analysis of the 'Program Monitoring' statistics seems to corroborate this: 17% of SCUK-distribution encounters also included either needle distribution or pick-up. This number may be slightly (and artificially) lower because a limit is enforced on SCUK distribution but not on needle-distribution, so an individual using both kinds of supplies would have more SCUK visits than they would for needles because the latter are more liberally distributed. The 'Program Monitoring' statistics may also be skewed due to clients taking one kind of supply for personal use but another for a friend or partner.

Importantly, a number of clients who did not currently inject drugs indicated having previously done so. Of 104 non-injectors, 41 (or 39%) had injected drugs at some time in the past. This group did not differ from the sample as a whole on any demographic factor.

Importantly, respondents were not explicitly asked whether they believed that SCUK availability had changed how they consumed drugs. Questions asked whether the respondent's drug use had changed, but only in the past year. Another question asked if SCUKs had changed their use of crack only. It may be worthwhile to explore whether clients feel that SCUKs have affected their injection drug-use specifically, and/or explore other data sources.

Indicator 2f - Staff and clients' expressed satisfaction with the kits and their distribution

SCUK supplies

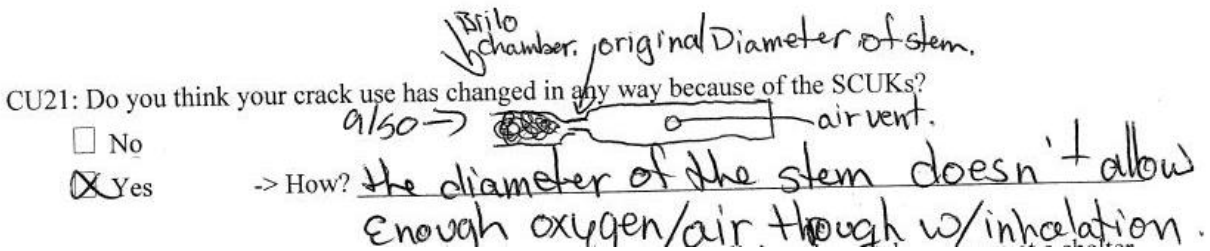
When asked to rate the overall quality of the supplies they received, clients were overwhelmingly pleased, with 84% answering that the SCUKs are 'Good' or 'Excellent.' When asked for feedback on problems they had ever encountered with the SCUK, as suggested above (and consistent with their relatively low use), mouthpieces and screens were most often flagged.

Fifty-three percent (53%) of clients reported trouble getting the mouthpiece on and off their pipe, with almost all indicating that the mouthpiece gets 'glued' to the pipe when it heats up, and many indicating

that they had stopped using the mouthpieces for that reason. Health providers seemed aware of this problem, indicating in their survey the same challenges expressed by clients.

The screens were disliked either because drugs would get stuck in them or would actually melt through them (one respondent said that she was always sucking hot screens into her mouth). This may be exacerbated by a feature of the pipes, illustrated by a respondent (below). She points out that, in the past, pipes both narrowed to prevent the screen from being sucked through and featured an air vent that allowed for an easier flow of air.

Figure 21: Client illustration (from a survey)



One health care provider suggested that we test the screens to get to the bottom of this problem, but seemingly all extant studies of people who use crack report the popularity of Brillo compared to screens, primarily because the former is (simply) easier to use. For this reason, Vancouver Coastal Health (2013) suggests incorporating demonstrations about how to use the screens into programs' education repertoire.

A few clients indicated problems with the chopstick, preferring a metal stick such as a coat hanger because the porous wood soaks up drug resin (although these are known to damage glass stems; see, for example, Boyd, Johnson, and Moffat, 2008).

When asked if they would remove anything from the existing kit, health providers expressed two suggestions. First, that the info sheet should be made somehow optional or separate (or else 'more fun'), as many clients have already read it and most discard it immediately (consistent with Boyd, Johnson, and Moffat, 2008). Second, individual pipes should be more routinely offered on their own (possibly as the default offer) as opposed to the complete SCUK, as the mouthpiece, screen, and info sheet are often discarded.

Finally, when asked what they would *add* to the kit, 79 client respondents offered suggestions. Almost half of these (37 people) would like Brillo. Of the other respondents, 14 asked for some combination of chapstick, gum, and/or candy (often mentioned together). The remaining suggestions varied, and included more screens or swabs, condoms, bleach, gloves, different mouthpieces/sticks, and other suggestions mentioned only once or twice (including crack). Health care providers suggested chapstick and gum, condoms and lube, and gloves. One provider suggested distributing the pipes pre-assembled in order to discourage the use of Brillo.

SCUK distribution

> ***10:40pm:*** *It's been a few years that I've known Street Connections. It's very clean and helps to keep us healthy. And it keeps our community healthy. That's what Street Connections has brought to my life.*

Despite *Street Connections* operating (in some form) about 76 hours a week, clients still had some difficulty accessing SCUKs. When asked how often they can find a pipe when they need one, 65% answered 'usually' or 'always,' with 28% answering 'sometimes' (and the remainder less frequently than that). This is not inconsistent with the findings of Vancouver Coastal Health (2013). There was no relationship found with the interview location, but women were significantly more likely to report problems than men ($p < 0.05$). When asked if they had a problem finding a SCUK *in the last year*, 30% responded that they had, the vast majority of whom indicated that it was after-hours or on Sunday.

Possibly due to their dissatisfaction with the supplied mouthpieces, mouthpiece-users described mostly *not* being able to find a mouthpiece when they needed one (55% saying 'sometimes' or less often).

Few respondents indicated buying their pipe, though 31% 'almost never' or 'sometimes' bought one (65% never did).

Service providers were asked their perspective on supply distribution. Only 3 (17%) reported 'often' pairing education with their supply distribution, with comments indicating that clients have limited time and patience when they usually 'know their stuff' as well (or better) than the person distributing the supplies. Some providers indicated that learning *from* clients was actually more valuable than the reverse: for example, getting a sense of what drugs are commonly being used in the networks served by *Street Connection*s, how clients have used screens in ways that work for them, etc. In fact, feedback from the *Street Connections* staff indicated that they likewise appreciated the survey's ability to engage with clients on a different level than usual (Kuo et al., 2014, had the same experience).

Providers offered a number of other suggestions on how to improve distribution, the main theme being to increase SCUK availability (more distribution sites) and accessibility (not requiring clients to have to talk to a staffperson to get them). Other suggestions included paying closer attention to the staff providing the service (training and 'fit'), better communication to clients about where else they can go for SCUKs, and eliminating the 'maximum' number of SCUKs distributed to a client at one time. One person also suggested improving education to the public about our model, what we do, and why we do it (important considering that more than a quarter of providers indicated 'sometimes' or 'often' fielding complaints from their community or neighbourhood about their SCUK distribution). Interestingly, increasing peer distribution was not raised, although this would undoubtedly improve access to SCUKs.

The value of SCUK distribution

Finally, clients were specifically asked whether they felt that the SCUK distribution services had affected their crack use in any way. While 43% didn't believe that it had, 49% offered examples of how they felt that their drug use had become safer. For example, many indicated either that they no longer shared or detailed how the supplies they used before (including pop cans, etc.) would cause injuries. Few indicated an actual change to the *amount* of crack they used: 4 people indicated that they used less, while one person said that he used more because of SCUKs.

Service providers were likewise asked whether they felt that SCUK distribution was valuable and successful. First and foremost, most providers (79%) felt that SCUK distribution was 'successful' or 'very successful' for building relationships with clients, especially regulars. An even greater proportion (84%) indicated that SCUK distribution was overall a 'valuable' or 'very valuable' use of resources, with several discussing the cost-effectiveness compared to the cost of treating HIV or hepatitis C. Two caveats emerged: First, that SCUK distribution was only truly valuable if it was having the desired effect, i.e. to make crack use safer. If clients continue to share, fail to use the mouthpieces and screens, etc., then the *only* benefit may be the relationship-building one. Second, one respondent felt that s/he was insufficiently expert in the area and so questioned whether the service provided to clients was as valuable as it could be if someone else was providing it.

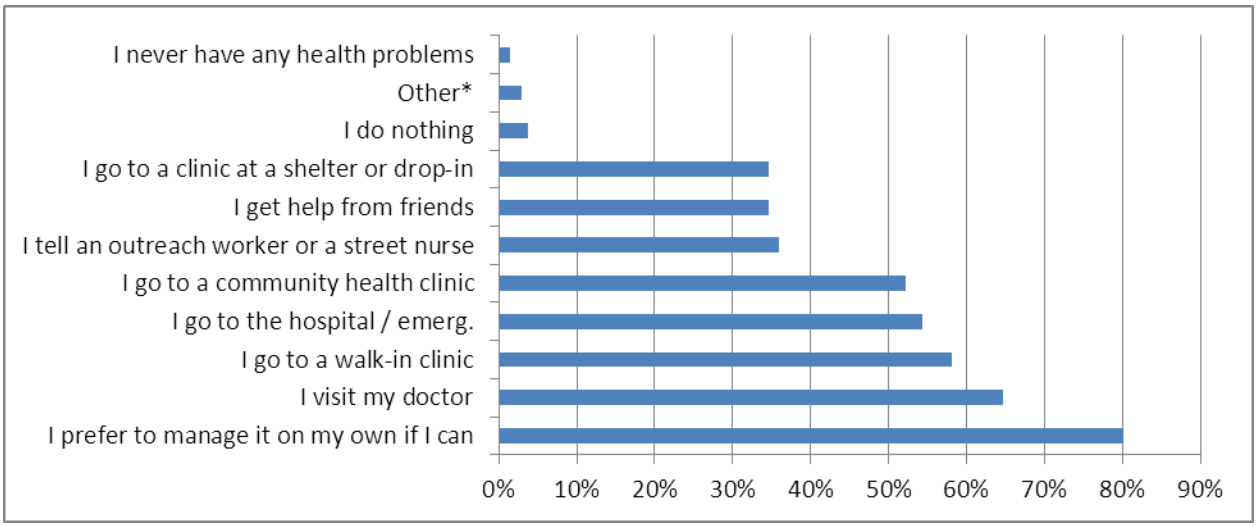
7:30pm: *What impresses me the most is the workers. They're not afraid to help us.*

Indicator 2g - Clients' connection to other health and nursing services

If a primary value of SCUK distribution is its ability to engage with 'marginalised' clients who are otherwise excluded—actively or otherwise—from health services, some assessment of this (dis)connection is important. This especially important in light of Fischer et al.'s (2006) finding that individuals who use crack report more physical health problems than users of other street drugs.

First, respondents were asked what they usually do when they have a health problem. By far, managing 'it on [their] own' was the most common response (respondents could choose more than one).

Figure 22: "What do you usually do if you have a health problem?"



*Other: Aboriginal healer, HealthLinks, ACT team (x2)

Encouragingly, although 109 clients indicated that they would manage it on their own, only 6 of these did not choose another option as well.

Survey respondents were also asked about their access to various providers. Most indicated 'never' having contact with volunteers (60%) and counsellors (62%). Although the frequency of access varied greatly, most respondents indicated seeing *at least monthly* a nurse (59%) and outreach worker (71%). Access to a doctor was less common: 46% reported seeing one a few times a year, 35% saw one monthly, and 7% never did.

As per the Program Monitoring report, the majority of *Street Connections* STBBI and pregnancy testing was sought by clients accessing SCUKs. This may partially be an artifact of the fact that there are simply more people who use crack in Winnipeg than people who inject their drugs: 20% of Gessler, Maes, and Skelton's (2011) sample had used crack in the past year, while only 7% had injected any drug. On the other hand, STBBI testing among SCUK-takers still points to a success at engaging people who use crack into health services.

Limitations

As this report is designed to evaluate the SCUK-distribution system centrally overseen by HSHR (i.e. to *Street Connections* clients and partner agency clients), the survey results obviously represent individuals already connected to some kind of service. This information will therefore need to be compared to the mapping project results, to determine whether there are geographic or demographic gaps not addressed by the program.

It should be noted that this evaluation concerns the ability to 'engage' individuals who use crack into services that are specifically provided by *Street Connections* (i.e. mainly STBBI testing). These results should not be extrapolated to include, for example, primary care sites, where individuals accessing SCUKs would have access to a wide range of important health services. In these settings, SCUKs may be an especially important way of engaging clients who may not need STBBI testing but who would benefit from low-threshold access to a primary care site. These results should especially not be interpreted as reflecting rural contexts, not only because of client characteristics, but because SCUK distribution in rural contexts is much more likely to be done by a primary care/access centre, where other services are provided (e.g. diabetes care, maternal health, mental health services, addiction services, etc.).

Conclusions

First, by comparing survey responses by the location where the participant was interviewed, *Street Connections* van clients emerge as the most marginalised cohort of individuals who use crack. A significant relationship was found when comparing police involvement and frequency of crack use by interview location: van clients reported significantly higher levels than those interviewed at partner agencies or at 496 Hargrave. Although the forthcoming mapping results will shed light on areas of the city possibly having unmet service needs, it is safe to say that *Street Connections* is *reaching* appropriate populations.

The question of *engagement* is more complicated, and here a somewhat lack of coherence is evident. On the one hand, there is no actual engagement precondition in order to access SCUKs: clients are under no obligation to give their name, any information about their substance use (except to screen out

marijuana users), submit to STBBI testing, etc. This is probably entirely appropriate: it would not be cost-effective for an individual accessing SCUKs to submit to testing every single time, as long as their testing frequency aligns with guidelines based on their risk factors. Public health services—unlike community agencies or primary care sites, for example—also offer a relatively narrow menu of services, calling into question what exactly clients are being 'engaged' into. On the other hand, having 'engagement at the ready' seems to be a pillar of *Street Connections'* SCUK distribution design. For example, the daily SCUK distribution limit essentially makes repeated (even daily) contact with program staff mandatory in order for clients to maintain their personal inventory, despite both expending considerable human resources and foreclosing the possibility of distribution through peer networks.[19]

Low-threshold distribution of harm reduction supplies is not *necessarily* (or perhaps even often) compatible with the goal of engagement. Imposing distribution limits or face-to-face encounters with service providers can be justified, provided that this repeated contact is removing barriers to other services, either in-house or via referral partners. When other services (beyond STBBI testing) are not available, clients—and program staffing budgets—likely benefit from distribution that is as low-threshold as possible, without the rituals or rigmarole of an engagement approach.

Returning, then, to HSHR's goal of reducing the spread and transmission of STBBIs and reducing other drug-related harms in the Winnipeg region, what emerges (alongside some overall lessons learned) is the need for a hybrid approach that treats public health services differently than more comprehensive service agencies. Some preliminary ideas about how this may be achieved are included as *Recommendations*.

[19] It should be noted that the stated rationale for the daily per-person SCUK limit is not to encourage engagement *per se*, but rather to curb the expense of 'limitless' distribution. This rationale is somewhat unconvincing, though, in light of findings that the daily limit has undoubtedly led to SCUK distribution amounting to three-quarters of all *Street Connections* encounters, despite handing out only 5% of the number of needles distributed during the same period.

Recommendations

Data Sources – For the Healthy Sexuality and Harm Reduction team

No firm conclusions could be drawn about daytime outreach, due to a lack of documentation.

> *Recommendation 1:* Ensure the completion of statistics forms for daytime outreach.

Continuing to thoroughly monitor the program using paper forms is not feasible.

> *Recommendation 2:* Explore a user-friendly electronic data-keeping tool, with functionality for both GPS (i.e. recording the location of an encounter) and reporting.

In the meantime, data can be drawn from two sources: a scaled-down version of the enhanced statistics sheet (entered into the existing MIS database) and HSHR's Access database.

> *Recommendation 3:* Develop standardised guidelines to ensure more consistent data entry into the Access database. The DR/CLINIC field should only have a handful of acceptable choices for data capture purposes.[20] In addition, postal code information should be updated whenever a file is closed (i.e. after it has been confirmed).

Outcomes – Health Status

Recognising that *Street Connections* services ultimately aim to impact health outcomes, care must be taken to avoid focusing simply on 'proxy' indicators (the volumes of supplies distributed, testing, etc.). At minimum, the incidence of STBBIs within populations of interest should be monitored (i.e., HCV/HIV rates among people who use crack, people who inject drugs, etc.).

> *Recommendation 4:* Explore with PPH Surveillance and Applied Public Health Research innovative projects that might better monitor the intended long-term outcomes of *Street Connections*. These could include a retrospective review (e.g., previous encounters with *Street Connections* by those testing positive for an STBBI), a longitudinal cohort study, etc.

Program Monitoring

While the *Street Connections* van is certainly meeting its supply-distribution objectives, there is less evidence to support anchoring nursing services to the same routes.

> *Recommendation 5*: Discuss and reimagine the ideal 'street' Public Health Nursing role. Report findings (along with forthcoming mapping results) can be used to inform a role that balances access for van clients with greater accessibility of nursing services to other locations, times, networks, and/or populations. Creating opportunities for more upstream work (including strengthening linkages with other services) should also be prioritised.

[20] Currently, entries are marked as DR PLOURDE SC, SC, SC CONNECTIONS, SC/STD UNIT, STREET CONNECTIONS, WRHA – SC, WRHA SC, WRHA- SC, WRHA STREET CONNECTIONS, WRHA-SC, and WRHA-STREET CONNECTIONS.

Recommendation 6: As other HSHR staff engage in outreach activities (bath house outreach, newcomer outreach, corrections nursing, etc.) consider an integrated 'Outreach Team' so that staff can share lessons learned and promote consistency, respecting the uniqueness of each program. This may be especially interesting considering that overlap may exist between populations (e.g. corrections and Street Connections).

Although walk-in clients at 496 Hargrave can disrupt the work of staff whose roles are not dedicated to serving them, daytime visits are rarely frequent enough to justify full-time dedicated staff.

Recommendation 7: Discuss and reimagine daytime in-house outreach services and staffing. These will be influenced by the SCUK evaluation findings (below) and forthcoming mapping results. During the day, visits requiring *only* needle distribution/disposal or nursing services could be handled by nursing staff, as the number of these visits would average 1/hour. This would free up outreach resources for other activities and also ensure consistent services at all hours of the day (including the noon hour).

Some clear short-term recommendations are indicated:

Recommendation 8: Broaden the number of supply-distribution partners in Winnipeg. The mapping results will inform not only where drug use is occurring, but also specific locations where population members access health and social services. These trusted agencies—especially where little distribution is available (e.g. West End) and/or those open on Sundays—would be ideal distribution sites. WRHA offices and sites would also be appropriate. Finally, opportunities to augment peer distribution through social networks should be explored.

Recommendation 9: Due to fewer clients accessing *Street Connections* in the winter, prioritise augmenting the number of drop-in centres distributing supplies, and scale up advertising of all supply distribution locations in the winter months.

Recommendation 10: Scale up provision of rapid/point-of-care HIV testing into the *Street Connections* van and other outreach settings. Testing is within the scope of outreach staff, some of whom may be especially well-placed to undertake it due to existing relationships with clients.

Safer Crack Use Kit Distribution

HSHR's needle distribution program has undoubtedly contributed to the low rates of HIV and hepatitis C among individuals who inject drugs. Despite evidence supporting the benefits of SCUK distribution in other jurisdictions, there is a need to continue to evaluate how best this should be done in the Winnipeg context.

Recommendation 11: Explore initiatives that would contribute to the local evidence base around crack use and SCUKs. For example, undertake a longitudinal study on the health outcomes of people who use crack in Winnipeg, the prevalence of BBIs, etc. Consult with nationwide partners on their experiences distributing SCUKs. Based on the findings of these endeavours, continue to refine a SCUK distribution strategy whose resource needs are appropriate to its benefits.

Regardless of these findings, short-term adjustments can be made to the design of SCUK distribution schemes both by *Street Connections* and via partner agencies. When distribution locations offer a relatively narrow offering of ancillary services, supplies should be distributed with as few barriers and preconditions as possible. In these settings, the goal of engaging clients (into limited services) should be secondary to the goal of low-barrier access, and SCUKs could be made available without mandatory staff interaction. In a fixed location, SCUKs (or only stems) can be provided alongside condoms in a basket or vending machine, or by reception staff. A spike in distribution is to be expected when limits are eased, but this would likely eventually level out and in any event would cost less than dedicating human resources for distribution. Johnson and Malchy (2008) noted that limits on crack kit distribution led to commodification, which in turn led to aggression towards staff and a black market of SCUKs. Their recommendations call for the provision of "unlimited safer crack use supplies […] integrated into existing harm reduction services" (58).

On the other hand, in a rural, primary care, and/or community agency setting, including an encounter with an outreach worker or staff person can be justified, as the individual accessing SCUKs could conceivably be given access to the comprehensive services offered therein.

> *Recommendation 12:* Implement a two-track SCUK distribution system: a) an 'engagement' approach for comprehensive service agencies, distributed by staffpersons, and b) a 'hassle-free distribution' approach for limited-service distribution sites (including mobile services, to peers or natural helpers for informal distribution, perhaps pharmacies, etc.). If free distribution of SCUKs is cost-prohibitive, consider a minimal cost-recovery scheme (for example, charging 25¢ in a vending machine), or maintain distribution limits for SCUKs but have stems freely available without limit.
>
> *Recommendation 13:* Recognising that, even when 'engagement' is prioritised in community agencies, partners will occasionally ease distribution limits on SCUKs based on their knowledge of particular clients or situations. HSHR should either develop criteria for this (already-occurring) reality—e.g. relaxing limits before the weekend, distribution to natural helpers or peers for informal distribution networks, etc.—or leave this to sites to manage. In the latter case, HSHR reserves the right to cap its distribution to sites.

Some clear short-term recommendations are indicated:

> *Recommendation 14:* Continue to work with police, aiming to eliminate instances of SCUKs being confiscated or smashed. Implement periodic 'check-ins' with clients to assess.
>
> *Recommendation 15:* Although staff will distribute individual items from the SCUK upon request, the option is not routinely given to clients. Based on feedback about the use of various kit items, individual items—at minimum, pipes—should be offered to all clients.
>
> *Recommendation 16:* Working with partner agencies and clients, the SCUK mouthpieces should be replaced with a more acceptable alternative.
>
> *Recommendation 17:* Although challenging, it may be worthwhile to entertain a conversation about a 'harm reduction' approach to (widespread) Brillo use—for example, if Brillo is currently being procured through criminal activity.

Recommendation 18: Commit to including drug-related, non-STBBI harms into HSHR's programming with priority populations, for example sleep deprivation, overdoses, criminalisation, etc. For example, a significant association was found between particular kinds of polysubstance use and *weekly* (but not daily) crack-use; this population may have special needs meriting more attention. The association between housing, female gender, and polysubstance use and sleep disturbances may likewise warrant some kind of programming or 'next steps.'

Recommendation 19: HSHR should review all education materials handed out with supplies. These should be revamped, diversified, and complemented by visual materials. Materials developed by and for individuals who use drugs should be prioritised. New technologies should also be incorporated, including the *Street Connections* website, along with more interactive approaches to education: videos, demonstrations, and soliciting information *from* clients—who are experts in safer drug use—to share with others. One potential priority would be demonstrating the proper use of screens.

Ongoing and Long-Term

Recommendation 20: Incorporate the forthcoming mapping project results (and other research and evaluation projects) and—in line with *Recommendations 5* and *7*—work with staff to incorporate these into a model and/or plan for HSHR's outreach services. If any actions result in a reduction of human resources into the van, partnerships should be sought with other agencies—for example, primary care or other health services—to boost the mobile services offered to clients.

Recommendation 21: HSHR outreach and *Street Connections* should be continually monitored and elements should be evaluated. Consider dedicating resources or forming partnerships to integrate more robust or complementary evaluation components (cost-effectiveness, for example).

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Appendices

Appendix A

HSHR Annual Expenses for *Street Connections*

October 1, 2013 to September 30, 2014

These expenses include a combination of actual expenses (e.g. supplies distributed), budgeted expenses, and approximations (e.g. staff salaries, to avoid intrusion into individual staffpersons' salaries). That said, they represent as accurately as practical the total annual expenses of the *Street Connections* service.

As this evaluation did not include a cost-effectiveness analysis, no attempt was made to estimate the financial *benefits* generated by the program. Several studies, though, have described the financial benefits of harm reduction programs, referring for example to the extremely high cost of treating just one new case of hepatitis C or HIV (see Gold et al., 1997; Health Outcomes International Pty Ltd, 2002).

Item	**Cost**	**Notes**
Safer crack kits	$18,556	Using actual evaluation period expenses: 31450 at $.59/kit (for a breakdown of the costs per kit, see Backé et al. (2012))
Condoms	$7,322	Using actual evaluation period expenses: 2/3 of all encounters (18,306), at ~6 condoms per encounter, at $.10/condom
Needles	$58,536	Using actual evaluation period expenses: 585,361 needles distributed at $.10/needle
Needle disposal (Stericycle Canada)	$1,500	Using actual evaluation period expenses
Street Connections van	$12,000	$60,000 amortised over 5 years
Van gas	$5,500	Using actual evaluation period expenses
Van maintenance	$1,200	At 10% of amortised van cost
Van insurance	$1,246	
4.0 FTE outreach workers	$261,522	Using 2nd top of scale, 22% MERCS
1.5 FTE PHNs	$161,135	Using 2nd top of scale, 22% MERCS
Administration	$63,422	Management support, IT, communications: at 12% of total expenses
TOTAL	**$591,939**	

Appendix B

HSHR Corrections Logic Model – FINAL

April 2013

Program: **HSHR Outreach and Street Connections Logic Model -- FINAL**

Situation:

- STBBIs are an equity issue: all STBBIs except for chlamydia driven by social inequity.
- IDU accounts for about 6% of new HIV+ (also 54% HCV+). Primarily concentrated in a relatively small number of hotels.
- Practically no data on sex work in Wpg (including STBBI risk), though women disproportionately Aboriginal (87%) and trans (18%).
- 43% of street-involved people had never used a condom and 21% hadn't had an STI test in >5 yrs. Unknown STBBI prevalence.
- Street youth: STBBI prevalence: 12% CT, 2% GC, .6% HIV.

Intended Audience: Individual-directed Activities

Activities

Outreach	*Education*	*Supply Distribution*	*Immunisations*	*STBBI testing / tx / f-u*	*Linkages to care*
Ensure that all services are low-threshold and meet wherever clients are at: van, home visits, Bell Hotel, in-office, etc. Maintain up-to-date guidelines on best practices.	Promote safer injecting practices, safer sex, info about community resources, and other relevant information. Disseminate social marketing campaign materials.	Distribute and monitor safer inhalation kits; rags and ziplock bags for solvent-users; safer injecting kits; and safer sex supplies. Collect used supplies for disposal.	Assess for need and offer flu; Hep A, B, and A/B; pneumo; and Gardasil. Run flu clinics.	Blood and urine testing, with POCT coming soon. Deliver results and administer tx or link with tx. Perform contact tracing and partner notification.	Refer and facilitate linkages with primary care, mental health, addictions, etc. Periodic sharing of information with Sex Crimes.

Short-term Outcome Objectives

Services are evidence-based. Outreach times /locations appropriate.	Educational info and materials available and accessible.	HS & HR supplies are available and accessible.	Needs assessed and appropriate immunisations offered.	Clients can access screening and tx and/or referral to tx.	Care and information transferred to appropriate services.

Intermediate Outcome Objectives

Clients are comfortable and able to access services.	Clients access and use information, supplies, etc. to keep themselves safer. Decreased incidence of infection and sequelae, and/or increase of client engagement (relationship-building).			Clients detect STBBIs and receive appropriate tx and follow-up.	Clients receive continuity of care.

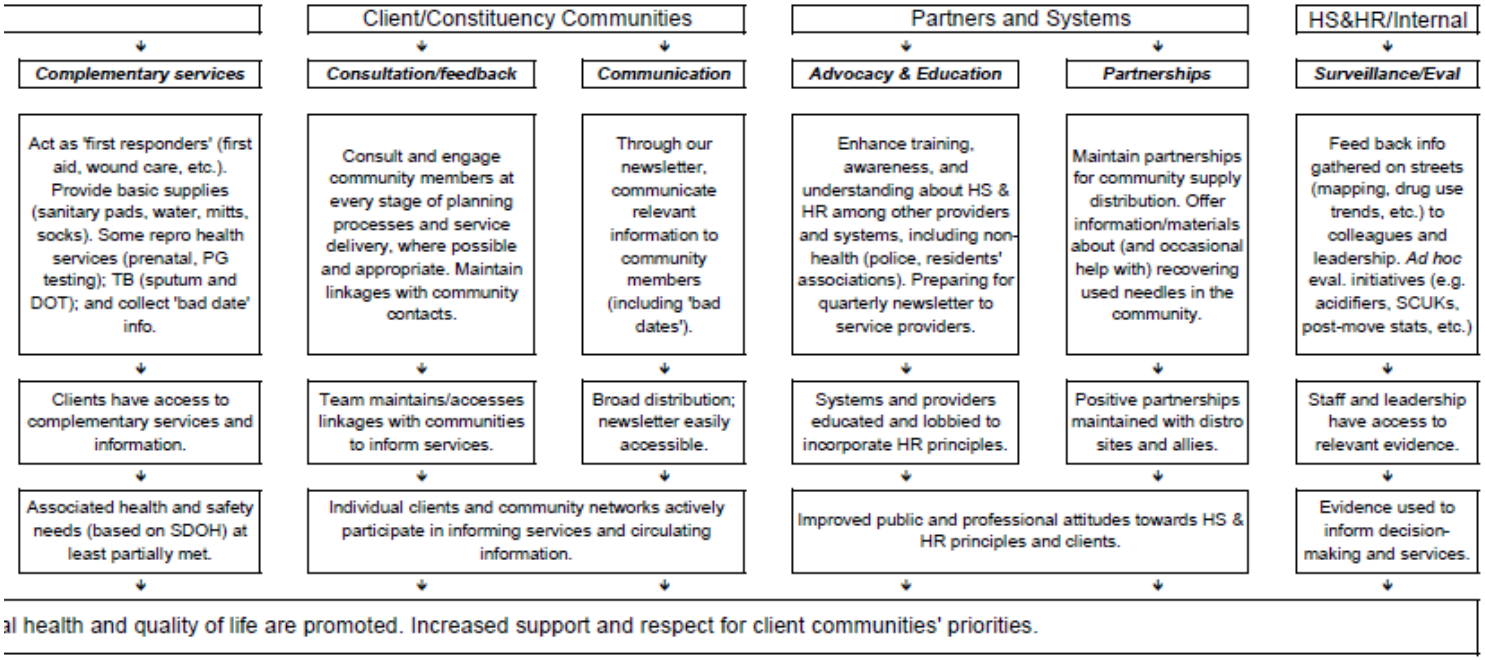
Long-term Outcome Objectives

Services are accessible to priority populations, and STBBIs prevented, detected, and treated. Genera

Theory/evidence base undergirding interventions (to various degrees):

- We have adequate information about client populations (T&R, solvent-users, sex workers, polysubstance-users, etc.)
- Programming and communication reflects appreciation of drug-use and sex harms AND benefits
- Some client priorities are congruent with our priorities; some less so
- Education and supply distribution influence risk reduction
- ↑ outreach = ↑ access
- Nursing priorities are generally compatible or complementary with outreach worker priorities; some less so.
- Services are designed to target/reach those most 'at risk'
- Education and supply distribution ≠ 'enable' drug use, risk-taking
- Ppl who use drugs experts in their own lives
- Risk-taking is natural and healthy
- Drugs use not inherently harmful; harm largely the product of contexts in which drug use takes place. Our services informed by those 'harms'
- People who use drugs have a right to equitable access to health care

Page 2



External Factors

- SDOH (housing, poverty gender, violence, culture, etc.)
- Environment (physical location of our services, extreme weather)
- Client characteristics: Winnipeggers different (more families of clients), trauma and mental health hx, heterogeneity (different drugs = different lifestyles)
- Legal/policy contexts in general
- Quality of client care and information by other agencies (shelters, faith-based)
- General lack of public and partner knowledge about CD transmission
- Public support always ? (-ve media perception, WRHA risk-averse)
- Organisational/Professional factors: PHIA, nursing duties to respond, 'Working Alone' policy, professional priorities/roles (nursing + OW)
- Staff characteristics (personal values, stigma of workers, van staffing)
- Barriers to testing (other sites not testing routinely, etc.)
- Stigma of STBBIs
- Drug market factors

Appendix C

Evaluation Framework – Indicator Review

Question	Indicator(s)
1. Are activities being undertaken as planned? (sentinel process indicators)	**a. Number of harm reduction supplies distributed and recovered**
	b. Number and types of STBBI tests performed, and results
	c. 'Other Health Care' services provided[21]
	d. Number of 'Bad Dates' collected
	e. Number of prenatal contacts
	f. Number of external presentations
	g. Number of community distribution sites and supply distribution therein
	h. State of relationship with the police
2. How well do Safer Crack Use Kits meaningfully engage and promote the health of marginalized clients?	**a. Number of clients accessing Street Connections for SCUKs**
	b. Client characteristics
	c. Number of supply sharing episodes in the past 30 days
	d. Experience of crack use-related harms[22]
	e. Number of SCUK-takers who also inject drugs[23]
	f. Qualitative: Staff and clients' expressed satisfaction with the kits and their distribution
	g. Qualitative: Clients' connection to other health and nursing services
3. To what extent are the times/locations/services of Street Connections evidence-based and client-centred?	**a. Policies and practices are consistent with 'best' outreach and harm reduction practices**
	b. Number of contacts based on location and time
	c. Current availability of HR supplies distribution, STBBI testing, and general outreach services from HS&HR or partners
	d. Qualitative: Appropriateness of locations in c) based on clients' lives and preferences

[21] This indicator was originally limited to 'Number of immunizations administered' but this was expanded.
[22] This indicator was originally limited to cracks, lesions, and sores, but this was expanded.
[23] This indicator originally concerned IV drug use in the past 30 days, but this was expanded.

Appendix D

Street Connections

Enhanced Statistics Forms

Winnipeg Regional Health Authority Office régional de la santé de Winnipeg
Caring for Health À l'écoute de notre santé

MONTHLY REPORT OF STREET CONNECTIONS ACTIVITY OFFICE (Walk-In)

Month: ___________________________

			MIS - Stats												HSHR – Internal Use Only																		
Office Information			Supplies						TB	HSHR Contact					Serology						Urine		Swabs		Other Health Care								
Date	Time	Initial	**HR** - #	New	Stems Out (number)	Needles In (number)	Needles Out (number)	Safer Sex Supplies	TB DOT/DOPT	Letter	Indirect Contact	Hep C	STI	Agency Contact	HIV	Syphilis	Hep C	Prenatal	POCT	Other	NAAT	Pregnancy	Oral	Rectal	Results Given	Antibiotic Tx	Immunized	Wound Care	Prenatal	TB Sputum	OW referral to PHN	PHN referral to OW	Client Referral Enter Code*
☒	**TOTALS**																																

Each page has 20 rows.

Client Referral Codes: **A** - Addictions **PC** - primary care **SS** - social services **ER** - urgent/emergent care **PN** - prenatal/PiiPC

Stems out, Needles In and Needles Out - indicate with numbers. **All other columns** indicated with tick mark.

S:\PUBLIC_HEALTH\HEALTHY_SEXUALITY_&_HARM_REDUCTION\MIS- Stats\FORM- SC Extended Stats OFFICE.doc

Winnipeg Regional Health Authority — Caring for Health | Office régional de la santé de Winnipeg — À l'écoute de notre santé

DAILY REPORT OF STREET CONNECTIONS

Circle Site: *VAN (Evening)* *VAN (Days)* *OFFICE (Walk-in)*

Date: _____ Outreach end/return to office time: _____ Names: _____

		MIS - Stats												HSHR – Internal Use Only																		
Stop Information		Supplies						TB	HSHR Contact					Serology						Urine		Swabs		Other Health Care								
Time	Location	HR	New	Stems Out (number)	Needles In (number)	Needles Out (number)	Safer Sex Supplies	TB DOT/DOPT	Letter	Indirect Contact	Hep C	STI	Agency Contact	HIV	Syphilis	Hep C	Prenatal	POCT	Other	NAAT	Pregnancy	Oral	Rectal	Results Given	Antibiotic Tx	Immunized	Wound Care	Prenatal	TB Sputum	OW referral to PHN	PHN referral to OW	Client Referral Enter Code*
	TOTALS																															

Each page has 20 rows.

Client Referral Codes: **A** - Addictions **PC** - primary care **SS** - social services **ER** - urgent/emergent care **PN** - prenatal/PiiPC

Stems out, Needles In and Needles Out - indicate with numbers. **All other columns** indicated with tick mark.

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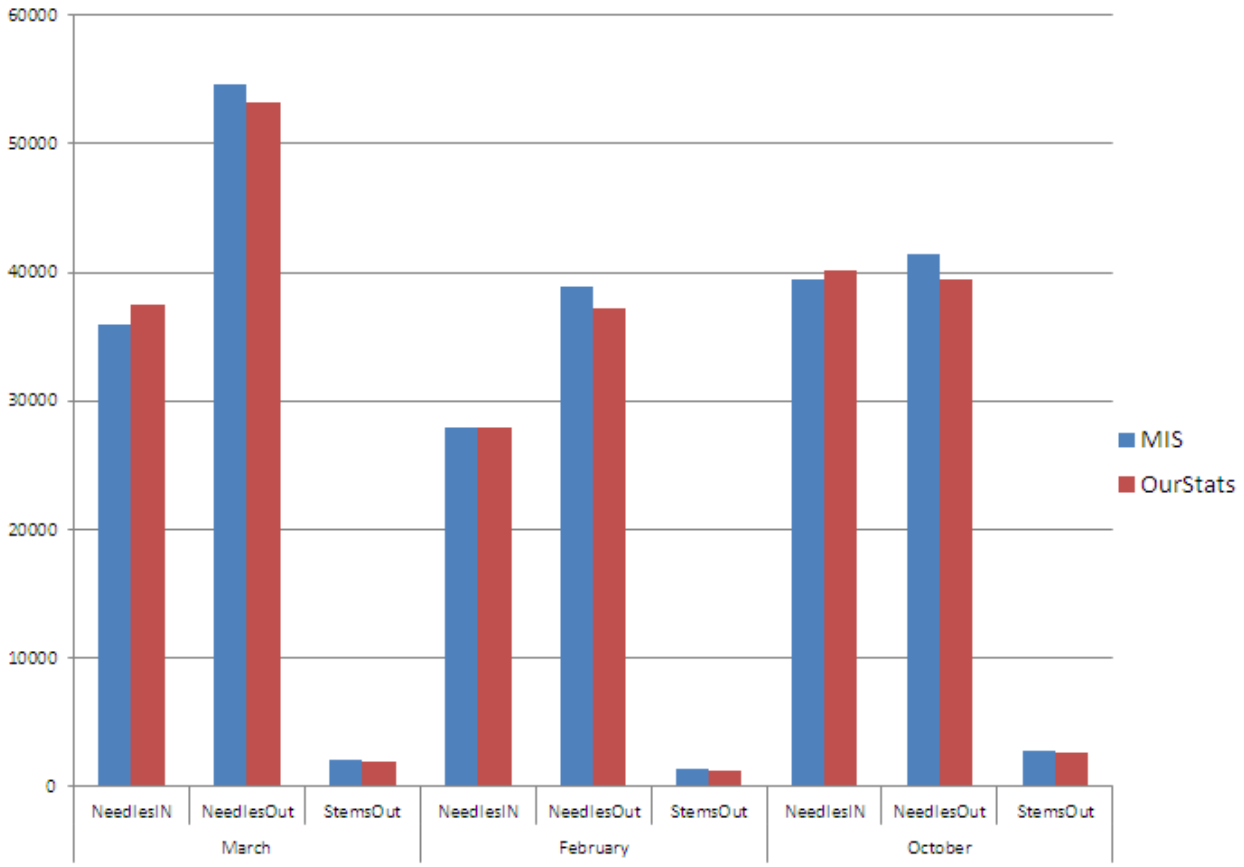
Appendix E

Quality Check of Data

Supply distribution data from the statistics sheets ('OurData') were compared against data pulled from the same sheets but entered by different staff for the purpose of reporting to Manitoba Health ('MIS'). These analyses demonstrate that the data presented in this report are within 5% of what was recorded in the MIS database:

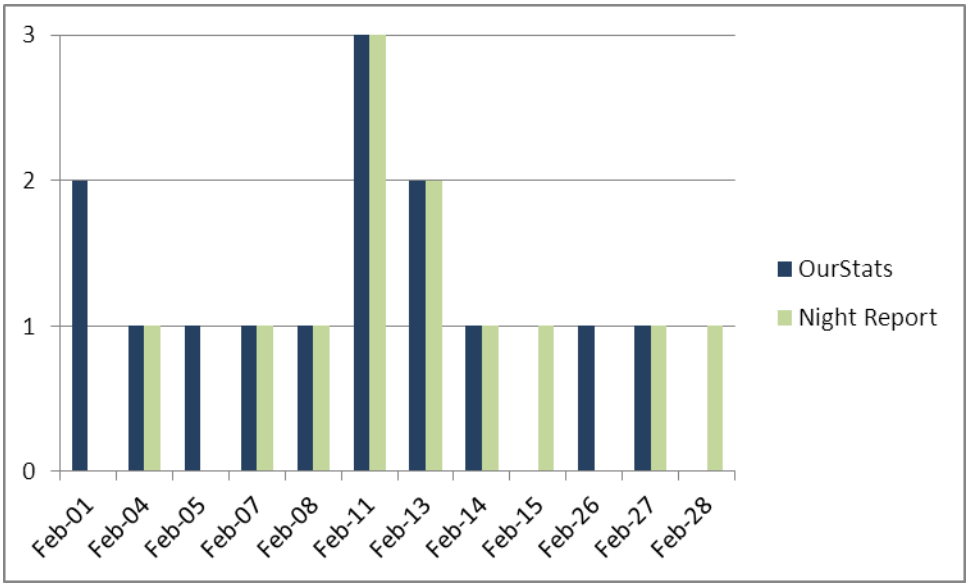
Month	Supply	MIS	OurStats	Variance
March	NeedlesIN	35915	37469	104.33%
	NeedlesOut	54688	53257	97.38%
	StemsOut	2056	1987	96.64%
February	NeedlesIN	27951	27990	100.14%
	NeedlesOut	38944	37240	95.62%
	StemsOut	1316	1298	98.63%
October	NeedlesIN	39504	40093	101.49%
	NeedlesOut	41379	39529	95.53%
	StemsOut	2798	2592	92.64%

Overall concordance		
NeedlesIN	NeedlesOut	StemsOut
101.99%	96.18%	95.97%



Testing data from the (original, hard-copy) statistics sheets ('OurData') were compared against Night Reports logged by staff after every night shift and circulated to the team via email for communications/continuity of care purposes. Data were found to vary significantly, though if anything the Night Reports undercount testing encounters (i.e. the statistics sheets may be a more accurate representation):

February	OurStats	Night Report
Feb-01	2	0
Feb-04	1	1
Feb-05	1	0
Feb-07	1	1
Feb-08	1	1
Feb-11	3	3
Feb-13	2	2
Feb-14	1	1
Feb-15	0	1
Feb-26	1	0
Feb-27	1	1
Feb-28	0	1
TOTAL	**14**	**12**



Appendix F

Breakdown of *Street Connections*

statistics into 'Zones'

Initial grouping of *Street Connections* statistic 'Locations' into zones:

1. West End cruise area: Agnes, Arlington, Balmoral, Ellice, Furby, Home, Isabel, Langside, Maryland, McGee, Sargent, Sherbrook, Spence, Young
2. West End – outside of cruise area: Edmonton, Sara, St. Matthew's, Valour, Wellington, Westminster, Wolseley
3. North End cruise area – NORTH of (and including) Selkirk: Aikins, Andrews, Burrows, Charles, College, Magnus, Manitoba, McKenzie, Parr, Powers, Pritchard, Redwood, Selkirk
4. North End cruise area – SOUTH of Selkirk: Dufferin, Henry, Higgins, Jarvis, King, Logan, Main, McGregor, Salter, Sutherland
5. North End – outside of cruise area: Aberdeen, Alfred, Boyd, Martha, Mountain, Sinclair, Stella
6. Osborne cruise area: Blake, Osborne, River, Scott, Stradbrook
7. William/Juno cruise area: Bannatyne, Juno, Kate, McDermot, Notre Dame, William
8. 185 Smith stop
9. Outside regular cruise areas: Alexander, Austin, Belmont, Carlton, Colony, Concordia, Corydon, Cumberland, Disraeli, Donald, Dowling, Elgin, Ellen, Fort, Fountain, Gallagher, Garry, Gertie, Graham, Hargrave, James, Jefferson, Kennedy, Kingston Row, Lock, McMillan, McPhillips, Nassau, Pacific, Pandora, Portage, Princess, Provencher, Qu'apelle, Roslyn, Ross, St. James, St. Mary, St. Mary's, Talbot, Tuxedo, Vaughan, Walker, Watt
10. Broadway
11. Assiniboine
12. Home visits

Subsequent grouping of zones based on low numbers in zones 2, and 5-11:

A. West End cruise area
B. North End cruise area – NORTH of (and including) Selkirk
C. North End cruise area – SOUTH of Selkirk
D. ALL other van stops
E. Home visits

Appendix G

“Safer Crack Use Kit Survey”

Questionnaire

Safer Crack Use Kit Survey

DATE OF INTERVIEW (mm/dd): _____

LOCATION OF INTERVIEW (nearest intersection): _____

OW'S INITIALS: _____

We are doing a short survey to help us in our evaluation of our crack kits – to make sure it meets its goals and meets your needs. The questions are about your background, health, and crack use. The results will be put together into a report that will mainly be used by our team to make changes to the program. All of your answers are confidential and your identity will remain anonymous. You do not have to participate in the survey if you don't want to. It is completely voluntary – it will have no impact on your ability to connect with *Street Connections* or get supplies. Do you want to continue?

YES? >> Thank you. This survey should take about 15 minutes. I will be asking some personal questions, so if you do not feel comfortable answering some of them just tell me and I can move on to the next one.

Part 1. Crack Use

CU1. In the last month, how often have you ***usually*** smoked crack?
DO NOT READ RESPONSES: **TICK CLOSEST RESPONSE**.

- ☐ Daily: If daily how many times a day? _____
- ☐ Weekly
- ☐ Less than once a week

GIVE THEM THE CARD TO LOOK AT, REVIEW WHAT EACH NUMBER MEANS AND THEN READ EACH QUESTION AND CIRCLE THEIR RESPONSE

When you smoke crack:

	Never	Almost Never	Sometimes	Usually	Always
CU2. How often do you use Brillo?	1	2	3	4	5
CU3. How often do you use pipes with splits or cracks?	1	2	3	4	5
CU4. How often do you use a mouthpiece?	1	2	3	4	5
CU5. How often do you use a *mouthpiece* that has already been used by someone else?	1	2	3	4	5
CU6. How often do you use a *pipe* that has already been used by someone else?	1	2	3	4	5
CU7. How often have you had a pipe overheat and explode or break apart?	1	2	3	4	5
CU8. How often can you find a pipe when you need one?	1	2	3	4	5
CU9. How often do you buy a pipe?	1	2	3	4	5
CU10. How often can you find a	1	2	3	4	5

mouthpiece when you need one?

	Never	Almost Never	Sometimes	Usually	Always
CU11. How often do you prepare your pipe yourself?	1	2	3	4	5
CU12. How often do you smoke with other people?	1	2	3	4	5

CU12. In the last month, have you shared a mouthpiece with?

READ OUT THE LIST AND TICK APPROPRIATE RESPONSE

	YES	NO
People you know?		
People you don't know?		

CU13. In the last month, have you ever shared a pipe with?

READ OUT THE LIST AND TICK APPROPRIATE RESPONSE

	YES	NO
People you know?		
People you don't know?		

CU14:Where have you gotten a safer crack kit in the past?

READ THE LIST OUT AND TICK APPROPRIATE RESPONSES

	YES	NO
From the Street Connections van		
People doing foot outreach	Where?	
At an office or agency	Which ones?	
Family members including a boyfriend or girlfriend		
Friends		
At a workshop or group meeting	Which one?	
Other (please describe):		

CU15: And which of these is the *main* place or person you get your SCUK from?

_____

CU16: Do you use each of the following items in the SCUK regularly (i.e. on a consistent basis)?
READ LIST AND TICK RESPONSE

	Yes	No		Yes	No
Pipe	1	2	Mouthpiece	1	2
Chopstick	1	2	Alcohol swabs	1	2
Screens	1	2	Safer crack use sheet	1	2

CU17: Have you ever had trouble getting mouthpieces on and off the pipe?

☐ No ☐ Yes -> Comments:

_____

CU18: Have you had any other problems with the supplies in the SCUK?

CU19: Is there anything you think we should *add* to the SCUKs we give out?

☐ No ☐ Yes -> Specify:

_____

CU20: Overall, how would you rate the *quality* of the supplies in the SCUK?	Very poor	Poor	Ok	Good	Excellent
	1	2	3	4	5

CU21: Over the past year have you had any trouble getting a safer crack kit when you needed one?

☐ No

☐ Yes -> Could you tell me what the problem was?

_____

CU21: Do you think your crack use has changed in any way because of the SCUKs?

☐ No

☐ Yes -> How?

_____

CU23. In the last ***6 months***, have police, someone working for a clinic or hospital, someone at a shelter, or anyone else in the social services ever:

a. Taken your kit

☐ Yes -> Could you tell me where that happened?

_____

☐ No

b. Smashed your pipe

☐ Yes -> Could you tell me where that happened?

_____

☐ No

c. Made you smash your pipe

☐ Yes -> Could you tell me where that happened?

_____

☐ No

CU24. Have police or security guards ever stopped you or tried to stop you getting help or supplies?

PROMPT: "for example, a drop-in centre, the hospital"

☐ Yes -> Could you tell me where that happened?

_____

☐ No

Part 2. Substance Use

People who smoke crack sometimes use other drugs as well. I'm going to read you a list of other drugs that people use and I just want you to answer yes or no, whether or not you use those drugs. So,

SU1. In the last month, what other drugs have you used regularly (i.e. once a week) basis?

READ THE LIST OUT AND CHECK ALL THAT APPLY

	Yes	**No**	
a. Pot / Marijuana	1	2	
b. Non-beverage alcohol (listerine, rubbing alcohol, hand sanitizer, etc.)	1	2	
c. Beverage alcohol	1	2	
d. Ritalin	1	2	(if yes, with Talwin? Y N)
e. Crystal meth	1	2	
f. Solvents / Sniff	1	2	
g. Cocaine, **other than crack**	1	2	
h. Ecstasy	1	2	
i. Opioids: (methadone, fentanyl, morphine dilaudid, oxycodone, percs, T3s)? Specify: What kind? Anything else? _____	1	2	
j. Benzos/sleeping pills: (valium, ativan, xanax, restoril)? Specify: What kind? Anything else? _____	1	2	
k. Other: e.g. ketamine, GHB, barbiturates (What are they?) Anything else? _____	1	2	

SU2. Overall, how much would you say you spent on drugs for yourself in the last month?
$_____

SU3. Do you currently inject (shoot up) any of these substances?

☐ Yes

☐ No

↳ If no, did you ever inject drugs in the past?

☐ No ☐ Yes

SU4. Has your drug use changed at all in the past year?

☐ No ☐ Yes: How has it changed?

_____

Part 4. Health Experiences and Services

H1. Have you had any of the following health problems in the past year?

	Yes	No
a. Burns on your lips or mouth from smoking crack		
b. Lesions such as cracked lips or sores on your lips or mouth from smoking crack		
c. Problems with your teeth or gums (e.g., cavities or bleeding gums)		
d. Insomnia or trouble sleeping		

H2. What do you usually do if you have a health problem?

READ: TICK ALL THAT APPLY

- ☐ I prefer to manage it on my own if I can
- ☐ I get help from friends
- ☐ I go to the hospital / emerg.
- ☐ I go to a community health clinic – like Mount Carmel or Aboriginal Health & Wellness
- ☐ I go to a walk-in clinic
- ☐ I tell an outreach worker or a street nurse and they help me figure out what to do
- ☐ I go to a clinic at a shelter or drop-in centre – like Sage House or Siloam
- ☐ I visit my doctor
- ☐ I never have any health problems
- ☐ Other (Specify): _____
- ☐ I do nothing

H3. How often do you usually have contact with the following people?

GIVE THEM THE CARD AND THEN READ OUT EACH PERSON IN THE LIST.

	Daily	2 -3 x Per week	Weekly	Monthly	Only a Few Times a Year	Never
a. Nurse						
b. Outreach Worker						
c. Volunteer						
d. Counsellor						
e. Doctor						

Part 6. General Information

In this last section I am going to ask you some general questions about yourself such as your age and that type of thing. Once we finish this section we will be finished the survey.

D1. What is your current type of sleeping arrangements?

DO NOT READ: TICK THE MOST APPROPRIATE ANSWER. PLEASE TICK ONLY ONE ANSWER

- ☐ In my own house or apartment
- ☐ In a partner's house or apartment
- ☐ Single room occupancy (SRO)/Hotel (e.g. Yale, McLaren, Mount Royal, etc.)
- ☐ Boarding/rooming house
- ☐ Supportive housing (Staff available; e.g. Bell Hotel)
- ☐ On the street / Sleep in shelters
- ☐ Rehabilitation/detox
- ☐ Abandoned building
- ☐ Living with a particular friend or a family member
- ☐ Couch-surfing (with various friends/family/acquaintances)
- ☐ Other : Specify _____

D2. What part of town would you say that you live in?

IF A LARGE NEIGHBOURHOOD (NORTH END, ETC.) WRITE THE CLOSEST MAJOR INTERSECTION.

_____

D3. What is your age? _____

D4. What ethnic group or family background do you most identify with?

DO NOT READ OUT LIST BUT MAY PROMPT: REFER TO LIST EXPLAINING CATEGORIES IF NEEDED, CHECK ONE ONLY

- ❑ Eastern European
- ❑ Southern European
- ❑ Other European
- ❑ Oceanic (e.g. Australian, Pacific Islander)
- ❑ Caribbean (Specify: _____)
- ❑ Central, Latin and Southern American
- ❑ East and South East Asia
- ❑ South Asian
- ❑ Middle Eastern
- ❑ North African
- ❑ Sub Saharan African
- ❑ Aboriginal (Indicate subgroup)
  - ❑ Metis
  - ❑ Inuit
  - ❑ First Nation, specify: _____
    - ❑ Status ❑ Non-status
- ❑ Canadian
- ❑ American (U.S.)
- ❑ Other (Specify: _____)
- ❑ Don't know

I'm going to ask you now about your gender…

D5. Do you identify as……

READ LIST AND TICK THEIR RESPONSE

- ❑ Female
- ❑ Male
- ❑ Transgender
- ❑ Another identity

Thank you!

Appendix H

Raw survey responses from health care providers

and outreach workers

Service Providers' Feedback about SCUK Distribution

Q1 Do you have specific feedback about the supplies in the SCUK? (quality, size, durability, compatibility with other materials, number /kit)

Answered: 10 Skipped: 9

Answer Choices	Responses
Pipe	20.00%
Chopstick	30.00%
Screens	30.00%
Mouthpiece	60.00%
Alcohol swabs	30.00%
Safer crack use info sheet	50.00%

#	Pipe
1	no
2	no
#	**Chopstick**
1	no
2	no
3	no
#	**Screens**
1	no
2	Some people say that they burn through screens very quickly
3	no
#	**Mouthpiece**
1	no
2	Gets stuck on the stem so two people can not share a stem with 2 mouth pieces if needed
3	Fit too tight and folks often don't take them
4	no
5	no
6	too small, get fixed to the pipe when heated.
#	**Alcohol swabs**
1	no
2	Not sure if well smoking crack, people actual take time to use the swabs
3	no
#	**Safer crack use info sheet**
1	no
2	could be more fun!
3	no
4	A lot of folks say they do not need this, as they have reviewed it before
5	I leave it in the package but quite a few clients take it out and throw it away.

Q2 Is there anything you would REMOVE from the kits (or that your agency already removes from them)? Why?

Answered: 12 Skipped: 7

#	Responses
1	no
2	no
3	no
4	no
5	no
6	no
7	Some people only want a pipe and mouthpiece, others want only the stem. I remove these when the client requests this. Some clients say they don't want to be caught with the information sheet, others say they already have the information and only use the stem. I should mention that this does not happen often.
8	no
9	I would suggest keeping the info sheet separate so that folks seeking SCUKs could be asked if they would like one. A lot of folks say they do not need them because they have reviewed them before.
10	Mostly interested in the glass pipe. I have a lot of clients that take just the glass and leave everything behind. A lot take the mouthpiece. I have had clients ask for the "cheap" kit. We leave the kit as is!
11	not to my knowledge
12	No.

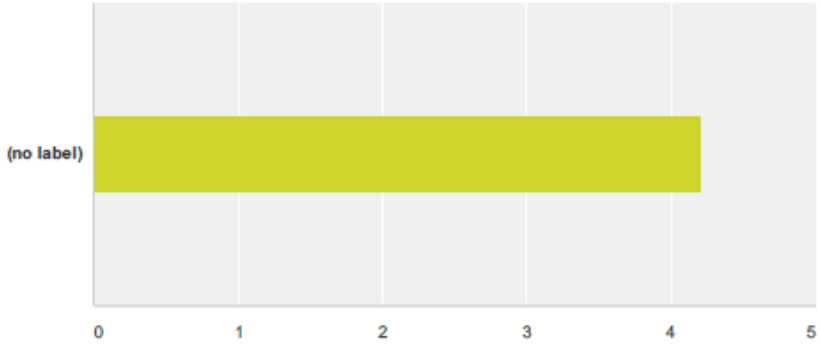
Q3 Is there anything you would ADD to the kits (or that your agency already adds to them)? Why?

Answered: 13 Skipped: 6

#	Responses
1	no
2	Pre assembed pipes. Pre assembling the pipes with screens already in them would avoid people using brilo and or putting the pipe together improperly.
3	gloves
4	no
5	no
6	no
7	chapstick, for lip protection
8	no
9	do not know
10	I would add condoms and lube. I would also add vaseline for lip care(with a sticker that indicates that it is for lip care and not lube for sex). We used to provide gum but it was taken out I think r/t to funding. I would add it back it as crack can cause dry mouth which can increase the risk for tooth decay. Crack can also cause bruxism (teeth grinding).
11	I am not sure what we could add to the kit.
12	unaware
13	Well, we have and pass out Vitamin C, tourniquets, spoons, small tubed water, tiny cotton balls, condoms, 1 cc needles and material to go with these items.

Q4 Do you think that SCUKs are successful at building relationships that lead to more in-depth interactions between your program and the population(s) you serve?

Answered: 19 Skipped: 0

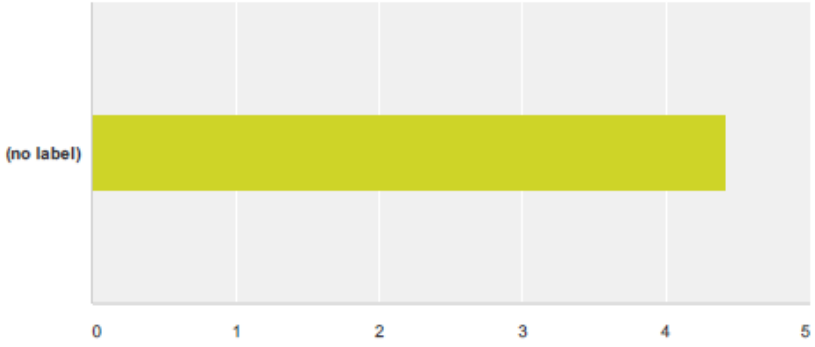


	Not at all successful	(no label)	Neither yes or no / Unsure	(no label)	Very successful
(no label)	0.00% 0	0.00% 0	21.05% 4	36.84% 7	42.11% 8

#	Explain:
1	The SCUK do bring people to the van although because of our schedule there is not always time to have more in-depth interactions.
2	I have connected with clients when they educate me regarding their safe drug use practices
3	people are more comfortable in asking for them because they feel they are able to ask without us judging them.
4	distributing the kits allows for staff to be aware of who is using and that they are using in a safer manner.
5	Opportunity to acknowledge user's greater knowledge of the equipment-offers user a chance to talk about frequency of use-opening for "how's it going" at a different level; opportunity to establish trust and openness with user.
6	incentive for folks to come in and chat
7	Most of the people who come to are I) people I already have a relationship 2) strangers who are in a hurry and not interested in chatting
8	Once the person in need is provided with the supplies they tend to feel more accepted and understood, and less judged.
9	Sometimes when folks are getting SCUKs, we start talking about how they are doing and end up identifying ways that my agency can help/support them w/ various issues in their lives. As well, providing SCUKs builds trust w/ our clients in that they know where to go to get what they need and not feel judged about their substance use.
10	Most of the interactions for crack kits are quite short in duration, however it does encourage clients to engage with public health services.
11	They feel safe coming to the building. Majority of clients are regulars.
12	We have people in the committee that are not even in our program coming in to ask for SCUKS. They have been told by our participants in our program that we have them.

Q5 Do you think that SCUK distribution is a valuable use of resources (cost of supplies, staff hours, etc.)?

Answered: 19 Skipped: 0

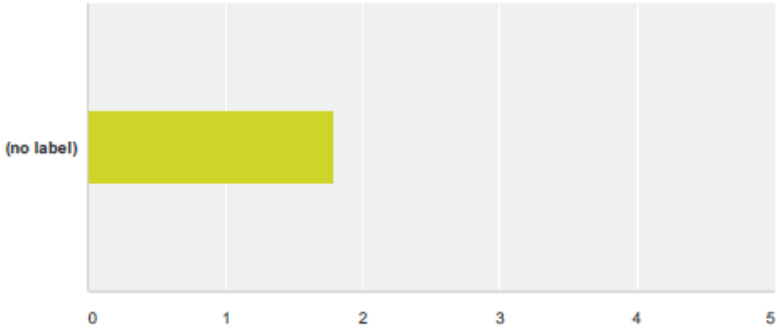


	Not at all valuable	(no label)	Neither yes or no / Unsure	(no label)	Very valuable
(no label)	**0.00%** 0	**0.00%** 0	**15.79%** 3	**26.32%** 5	**57.89%** 11

#	Explain:
1	If people are not sharing the pipes than yes. Although I beleive more sharing of the pipes occurs than we would like to think and this seriously defeats the purpose.
2	For staff - depends on the staff as I find it challenging as it is not my area of expertise and yet I work the harm reduction drop in time - not the best resource for the clients and not sure best use of my skills
3	Without this service people would be careless when using drugs by sharing. if they are to share and end up with hiv or hep c the cost of treatment is greater than the cost of supplying the kits. this is a very important services and needs to remain a service we provide.
4	does not take much time; puts use in the open and offers opportunity for conversation
5	effective at building relationships, reducing transmission of STBBI, encouraging less risky ways of using (as opposed to injecting)
6	I think it keeps people connected to services. It is valuable to the people who use the service or they wouldn't come.
7	People need ways to access SCUK and other harm reduction supplies so that they can use safely, and build relationship w/ community supports.
8	the crack kits are made available to clients in a way that is open to them-they are not requested, but placed within the facility for easy access, as required by clients.
9	I get a lot of traffic coming for Harm Reduction supplies. I think they feel safe coming here. Their needs are being met.
10	There are less people passing on dirty needles and spreading disease or infections. It saves cost on them winding up in hospitals and holding up time up that is needed for higher emergencies.

Q6 How often are you or your colleagues able to pair education with SCUK distribution?

Answered: 18 Skipped: 1



	Rarely - clients generally just take the kits	Sometimes	Often - we frequently discuss safer smoking with clients who take SCUKs
(no label)	38.89% 7	44.44% 8	16.67% 3

#	Comments?	Date
1	Many people when taking the pipes do not want to talk long cause they want dates.	6/7/201
2	Most people just want the items and then leave. We don't push them and they keep coming back. Ones that are willing to listen, do and then were able to talk to them more on being safe.	6/5/201
3	education is often offered, but lots of regular know thier stuff and it would be a barrier if they had to listen to it every time	6/2/201
4	Sometimes folks have time to listen or to ask questions, while other times they want the supplies and that is it (Possibly because they are already well informed).	6/2/201
5	Usually they come ask for a kit and leave.	5/30/20

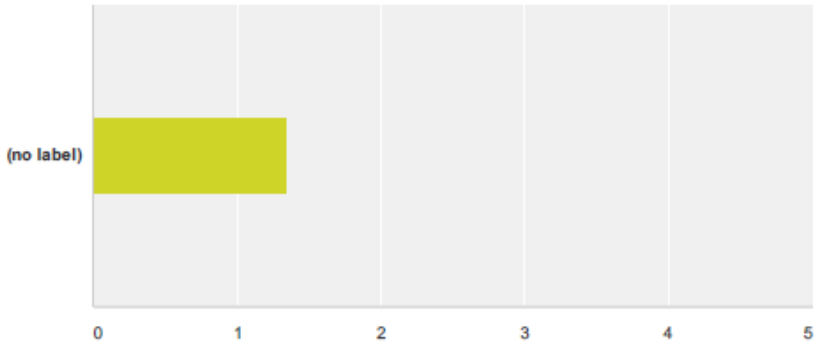
Q7 How do you feel safer smoking education could be improved? Describe any insights you've gained about education strategies, messaging, and/or topics that work well or less well.

Answered: 5 Skipped: 14

#	Responses
1	Often talk about the dangers of brilo and not sharing. This is often done in a quick sentance when they are taking the pipe and trying to leave. It is difficult to know if people do use the screens and not share.
2	I feel that as long as we continue to educate people and get through to 1/2 of the people it's better then nothing. You can't force or control someone to do something they aren't ready to do or don't want to do. When and if the time ever comes, they will know and will do something about their habits. Some you can never help and this will go on and has been going on for Centuries. It's part of our society!
3	different methods for using screens (clients have suggest several ways they like better than the standard way), making screen use more appealing, maybe offering some kits that already have the screens packed and see if folks want them
4	Speaking with client that currently using to keep up to date to current practices to tailor the education unique to winnipeg population.
5	This is a poor and very ambiguous question.

Q8 How often do you or your colleagues field complaints from your community/neighbourhood about your distribution of SCUKs?

Answered: 17 Skipped: 2



	Rarely	Sometimes	Often	Total	Avera
(no label)	**70.59%** 12	**23.53%** 4	**5.88%** 1	17	

#	From whom? / Comments:
1	I have had complients about kits in the backlanes.
2	dont know
3	collegues-inopportune times community-waste of time and resources
4	Our participants in our program and people in the community.
5	never
6	Sometimes from other agencies that do not follow our harm reduction model
7	never
8	Other clients, they feel we are wrong in handing out supplies. They think we are encouraging them to use by supplying them with the tools.

Q9 Overall, how do you feel that SCUK distribution could be improved? (at your agency or in general)

Answered: 11 Skipped: 8

#	Responses
1	further education for those providing the service - and / or choosing staff with this expertise to provide the service
2	I guess to make the SCUK distribution more available at other places where the people of the community feel comfortable in going to.
3	we seem to run out of kits very fast. A larger supply would be appreciated
4	Weather resistant posters with locations and schedule posted and also included with supplies.
5	more availible, offered in a way where folks dont have to talk to staff if they dont want to
6	i think it's a great thing for the clients
7	Educate thegeneral public about the need for harm reduction in terms that they can relate to
8	Increase distribution sites
9	make access easier, if you are going to do this at all.
10	not sure- sometimes I am not sure whether clients use the kits or distribute them
11	Have more information in the community about where to get SCUK and to not have limits on how many a client can receive at one time.

Q10 Is there any other information you think we should know about SCUK distribution? (service provider, agency, or client issues)

Answered: 5 Skipped: 14

#	Responses
1	Screens should be tested to see if they do burn through. Clients have stated that people take the stems out and throw away the rest. Use brilo and share with others, especially if there is only one rock. Not sure if this is the case.
2	No.
3	I am sometimes asked for just the pipe. Perhaps some could be provided individually.
4	mouthpieces are not used. need a better size (bigger) to fit around pipe easier.
5	no