Program Evaluation for Mainline Needle Exchange: Contributing to a Harm Reduction Landscape in Nova Scotia

Halifax, Nova Scotia

Prepared for:
Mainline Needle Exchange

Prepared by:
The Atlantic Interdisciplinary Research Network
For Social and Behavioural Issues in Hepatitis C and HIV

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March 2016
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The authors would like to thank all members of the Steering Committee of key stakeholders who provided invaluable guidance throughout the various phases of the evaluation process. Your expertise and dedication to the health of Nova Scotians and to the province’s harm reduction landscape is remarkable.

We would also like to acknowledge the contributions of Mainline’s clients, partners, stakeholders, and staff. Your input and insight provided through the interviews was critical to the process, and is greatly appreciated.

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ASO</td>
<td>AIDS Service Organization</td>
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<tr>
<td>CBO</td>
<td>Community-based Organization</td>
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<td>DHA</td>
<td>District Health Authority</td>
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<td>DHW</td>
<td>Nova Scotia Department of Health and Wellness</td>
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<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>HCV</td>
<td>Hepatitis C Virus</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HRM</td>
<td>Halifax Regional Municipality</td>
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<td>MOSH</td>
<td>Mobile Outreach Street Health</td>
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<td>MNFC</td>
<td>Mi’kmaw Native Friendship Centre</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NEP</td>
<td>Needle exchange program</td>
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<td>NSACA</td>
<td>Nova Scotia Advisory Commission on AIDS</td>
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<td>NSHA</td>
<td>Nova Scotia Health Authority</td>
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<td>NSP</td>
<td>Needle and syringe program</td>
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<td>PHAC</td>
<td>Public Health Agency of Canada</td>
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<td>PWID</td>
<td>People who inject drugs</td>
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<td>PWUD</td>
<td>People who use drugs</td>
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<td>STBBI</td>
<td>Sexually transmitted and blood borne infections</td>
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1.0 Introduction and Background

Here we present the rationale for the evaluation, as well as the intended purpose and plan of action with regards to the findings. The proposed methodology is described and briefly explained.

1.1 Purpose of the Evaluation

This report presents the findings of an evaluation of Mainline Needle Exchange Program, a program of the Mi’kmaw Native Friendship Centre in Halifax, Nova Scotia. The evaluation, which was undertaken and completed by the Atlantic Interdisciplinary Research Network (AIRN) for Social and Behavioural Issues in Hepatitis C and HIV/AIDS in the fall of 2015, was commissioned by Mainline in order to:

a) Provide a comprehensive picture of Mainline’s services, programming, and involvement with the community;
b) Have an outside perspective on the operation of the programs in terms of effectiveness and impacts to date, as well as current and emerging needs;
c) Generate considerations and recommendations to increase the efficiency and positive impacts and outcomes of programming; and
d) Enhance sustainability efforts with funders and other interested parties.

1.2 Methodology

1.2.1 Key sources of information

Information to inform the evaluation was collected and compiled from three key sources:

Review of key documents: A review of pertinent documents was undertaken to give context to the environment in which Mainline is operating. Key documents were selected to provide regional, provincial, and federal information regarding the current climate of HIV, HCV, and harm reduction initiatives. A list of the documents reviewed can be found in the reference section.

Analysis of Mainline’s database: De-identified quantitative information on client characteristics, supplies distributed (e.g. needles, condoms), and financial resources was accessed using Mainline’s electronic record system to track program operations and service use, including trends over time.

Key informant interviews: In-person interviews were conducted with staff (3), clients (3), and key partners (4) to provide supporting evidence of Mainline’s impact on clients and communities, including their role within the broader system of harm reduction services in Nova Scotia. The interview guides can be found in Appendix A. All quotes used in this report were reviewed and approved by interviewees, and all interviewees were given the option of how they wanted to be identified in the report.
The Steering Committee of key stakeholders guided the evaluation throughout the process, from establishing the objectives, methodology, data collection, analysis and synthesis processes, through to the development of the final report.

1.2.2 About AIRN

AIRN was commissioned by Mainline to complete this evaluation as a result of its history and credibility in supporting community-based research to address the social and behavioural issues in the HIV and HCV epidemics and the lives of people affected. Active since 2005, AIRN is a network of over 250 individuals and organizations from academia, community, and government working in the areas of Hepatitis C (HCV) and HIV/AIDS in the Atlantic region. The goal of AIRN is to coordinate research efforts to support evidence-based decision-making to influence policy, programs, and practice to prevent the transmission of HIV and HCV, and to improve the quality of life of those affected by HIV and HCV. AIRN is also a partner with the national CIHR Centre for Research Evidence into Action for Community Health (REACH) in HIV/AIDS and the CIHR CBR Collaborative: A Program of REACH.

1.2.3 Limitations of the evaluation

This evaluation was intentionally limited in scope to focus mainly on Mainline’s operations, impacts, and challenges. We did not focus heavily on Mainline’s governance structure, attempt to cover all harm reduction services in the province, or review other needle exchange programs. Given budgetary constraints, it was not possible to interview all of Mainline’s partners and stakeholders. In choosing to interview those partners most closely affiliated with Mainline, we may have received a more positive picture than had we interviewed partners with less involvement with Mainline. We were also unable to interview all of Mainline’s clients. One notable omission is that we were unable to interview a provincial outreach client.

1.3 Setting the Stage for the Evaluation

Mainline Needle Exchange is, from a governance perspective, a program of the Mi’kmaw Native Friendship Centre (MNFC), though it appears to function as an independent community-based organization. The Director of Mainline is accountable to the Executive Director of the MNFC who, in turn, reports to a board of directors through monthly meetings.

Mainline was first established in 1992 in response to an identified need in the community, and has been in continuous operation since, as the only needle exchange program in mainland Nova Scotia. The program is deeply rooted in the philosophy of harm reduction, aimed at reducing the negative consequences associated with drug use and respecting the dignity and rights of people who use drugs. Drug use is considered a health concern rather than a moral or criminal issue. The values of personal empowerment, respect, and non-judgement are at the core of all that Mainline does.

**Mainline’s Vision**

To reduce the acquisition and transmission of HIV, Hepatitis B and C among people who use illicit drugs and to increase awareness and knowledge of HIV/AIDS, Hepatitis B and C and social issues affecting people who use illicit drugs.
Mainline’s Mission

Mainline is dedicated to supporting people who currently use or previously used drugs to focus on their well-being through raising awareness of the risks, education, and empowerment.

To meet its vision and mission of reducing the harms associated with drug use, Mainline engages in a number of services including: the provision of needles, syringes, other drug use supplies, and condoms; the collection and appropriate disposal of needles; awareness and education on harm reduction practices related to safer injection and sexual practices and general health; and the provision of peer support. These services are provided by people with lived experience who are in recovery.

The Director of Mainline feels that the organization is currently operating at its fiscal limits in order to provide basic services to its clients, who are often marginalized and face multiple challenges such as geographic isolation and distance from services, lack of stable housing, illness, legal involvement, and mental health issues. The organization recognizes that there is a need for further service provision to populations not receiving adequate harm reduction services, and that barriers exist that prevent people from accessing services. Mainline has been expanding its scope of services to address some of these urgent challenges in order to promote and facilitate health and wellness for their clients and the broader community of at-risk individuals.

Mainline Needle Exchange commissioned AIRN to conduct an external evaluation of their programs and services for the purposes of documenting and conveying their impact and efficiency to the public, stakeholders and partners, and future funders. Mainline is confident in its ability to help the various communities of clients accessing its services, however, without adequate and stable funding, it consistently faces challenges in providing these services. Mainline wished to document program operations and impacts, as well as current and emerging needs. It also sought considerations and recommendations to increase the efficiency, positive impacts and outcomes of programming.

1.4 Injection Drug Use, HIV and Hepatitis C in Nova Scotia

This section provides an overview of the environmental context in which Mainline operates. Informed by key documents, trends of HIV, HCV, STBBIs and injection drug use over time in the province are presented.

1.4.1 Historical context

Needle exchange was first introduced in Nova Scotia in 1989, as an unofficial program of the Nova Scotia Persons with AIDS Coalition (NSPWAC). In its first year of operation, 5,000 needles were dispensed.

HIV due to injection drug use was first acknowledged as a public health reality in Nova Scotia in the early 1990s when the Nova Scotia provincial health department revealed that an injection drug user had contracted HIV, and was potentially spreading it to others. In response, the Health Minister announced that the province would fund a needle exchange program and, in collaboration with a number of community agencies, worked to develop it over a two-year period. The agencies involved included the Mi’kmaw Native Friendship Centre, the North
End Community Health Centre, the Stepping Stone Association, the Persons with AIDS Coalition, as well as a branch of the Correctional Service of Canada. Mainline Needle Exchange officially opened its doors in May 1992. The province’s second official needle exchange (SHARP Advice) opened in 1994 on Cape Breton Island in Sydney, Nova Scotia.

The creation of Mainline took place against a backdrop of other important national and provincial initiatives related to HIV and Hepatitis C. In 1990, the first National AIDS Strategy was released by the federal government. In 1991, the Atlantic First Nations AIDS Task Force (AFNATF)—now known as Healing Our Nations—was formed to educate First Nations communities about HIV/AIDS. In 1993, the Nova Scotia Department of Health launched its first provincial AIDS strategy. That same year, the National AIDS Strategy was renewed for five years, and the Krever Inquiry began to investigate how thousands of Canadians had become infected with HIV and Hepatitis C from the supply of blood and blood products in the public health care system. In 1998, the Canadian Strategy on HIV/AIDS was launched replacing the national AIDS Strategy.

Throughout the 1980s, the HIV epidemic in Canada was largely concentrated among men who have sex with men (MSM). The 1990s saw a significant increase in the proportion of new HIV infections related to injection drug use in Canada and, by 1999, 34% of all new HIV infections were found among injection drug users.¹

In 1997, *HIV/AIDS and Injection Drug Use: A National Action Plan* was produced by the National AIDS Strategy in collaboration with Canada’s Drug Strategy. ² Highlighting the dramatic increase of HIV among injection drug users and the public health crisis concerning HIV/AIDS and injection drug use, it was an urgent call to action. Key among the recommendations was the need to address the discrimination against drug users with HIV/AIDS, and to improve a number of services, including the exchange and disposal of needles and access to methadone treatment.

Nova Scotia’s second *Strategy on HIV/AIDS* was launched in 2003, and included 19 recommendations under four strategic directions.³ Of particular relevance to Mainline were the recommendations listed under the “Build a Coordinated Approach to Prevention and Harm Reduction” strategic direction. This strategic direction explicitly recommended the development and implementation of a network of anonymous testing services, access to barrier prevention methods, needle exchange programs, and methadone maintenance treatment services in the community as well as in correctional facilities.

In 2004, the Nova Scotia Department of Health launched the *Standards for Blood Borne Pathogens Prevention* aimed at guiding long-term improvement in HBV, HCV, and HIV prevention efforts. The goals of these standards are to prevent or reduce harms associated with the risk behaviours leading to blood borne pathogens, as well as to increase access to services

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that reduce harms, and reduce vulnerability to blood borne pathogens. On the national scene, the Canadian Strategy on HIV/AIDS (1998) was replaced by the Federal Initiative to Address HIV/AIDS in Canada in 2004. The Federal Initiative outlined three main policy directions: (1) Partnerships and engagement; (2) Integration; and (3) Accountability. Leading Together: Canada Takes Action on HIV/AIDS (2005-2010) was released shortly thereafter in 2005 to guide a strategic and coordinated pan-Canadian approach to HIV/AIDS.

In recent years there has been increasing focus on integration, a holistic approach to communicable diseases prevention, testing, treatment and care services and service delivery that has been proposed and promoted as a way to provide better continuity of care, create efficiencies, and enhance collaboration across sectors. Tied to this conceptual shift is a proposed change in funding structures. Under the Federal Initiative to Address HIV/AIDS in Canada and the Hepatitis C Prevention, Support and Research Program, the Public Health Agency of Canada provided separate funding programs to support the community response to HIV and Hepatitis C. As of April 1, 2017, HIV/AIDS and Hepatitis C Grants and Contributions funding, at both the regional and national levels, will be integrated into a proposed new Community Action Fund. The call for Letters of Intent (LOI), the first stage of a two-part solicitation process was just released (mid-February, 2016), and community based organizations are preparing for greater service integration and collaborative partnerships across organizations.

1.4.2 Current rates of HIV/AIDS and HCV

Since HIV reporting began in Canada in 1985, a total of 80,469 cases of HIV infection have been reported to the Public Health Agency of Canada (PHAC) to the end of 2014. The national rate of HIV in 2014 was 5.8/100,000 population, and varied from a high of 10.8/100,000 in Saskatchewan to a low of 0.4/100,000 in New Brunswick. According to the most recent provincial surveillance report, there have been 811 cases of HIV infection reported in Nova Scotia since 1985. Of these, 171 cases have been reported since 2005, and represent an overall rate of 1.8/100,000 population. There were 10 newly diagnosed cases of HIV in Nova

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Scotia in 2014 (1.1/100,000), the majority (>90%) of which were reported among MSM. This rate is lower than the 16 and 17 new cases reported in 2013 and 2012 (rates of 1.7–1.8/100,000).

The reported number of Hepatitis C diagnoses for 2013 in Canada was 10,379 cases, or 29.5/100,000 population.\(^\text{11}\) Hepatitis C is currently the fourth most frequently reported notifiable disease in Nova Scotia.\(^\text{12}\) There have been a total of 2642 cases of HCV reported in Nova Scotia since 2005, representing an overall rate of 28.2/100,000 population. There were 323 new cases of HCV diagnosed in Nova Scotia in 2014 (34.4/100,000). This rate is up from 250 cases (26.4/100,000) in 2012 and 288 (30.6/100,000) in 2013, and is the highest since 2005. Injection drug use continues to be the most common risk factor for HCV. Of the 44% of HCV cases in 2010 in Nova Scotia who reported a known risk factor for infection, 77% reported Injection drug use (IDU). This is higher than the proportion reported Canada wide. Among newly acquired HCV cases with risk factor information in the Enhanced Hepatitis Strain Surveillance System (EHSSS), 61% reported a history of injection drug use.\(^\text{13}\) The national surveillance system I-Track, which monitors HIV, HCV, and associated risk behaviours among people who inject drugs in Canada, found lifetime exposure to Hepatitis C as measured by the presence of HCV antibody from a dried blood spot specimen, to be 68%.\(^\text{14}\)

It is important to note that surveillance reports vastly under report HIV and HCV infections because they neither include individuals who have not been tested nor those who were diagnosed outside of a particular jurisdiction. PHAC estimates that 75,500 individuals were living with HIV/AIDS at the end of 2014, 21% of whom (16,020 people) were unaware of their status because they had not been tested and diagnosed. This represents an increase of 9.7% since the 2011 estimates.\(^\text{15}\) Given its higher prevalence and its much more infectious nature, rates of undiagnosed HCV infection are even higher than those of HIV infection. PHAC estimates that more than 332,400 were living with chronic HCV infection in Canada in 2011, 44% of whom were likely undiagnosed.\(^\text{16}\)

### 1.4.3 Prevalent drugs

Nova Scotia has a history of prescription drug addiction, and Halifax has been referred to as always having been a “pill city.” While heroin is occasionally found in the city, particularly among transient groups, it has not taken hold as a common drug among people who inject drugs in Nova Scotia. This may be, in large part, the result of its lack of consistent availability. Opioids prescribed as pain medications—including hydromorphone (Dilaudid), oxycodone (OxyContin) and morphine—have been most prevalent.” It is estimated that 12,000 people in Nova Scotia are dependent on opioids and that fewer than 2000 are on methadone. The

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\(^{13}\) Public Health Agency of Canada, Hep C & STI, surveillance and epi section (2009). Epidemiology of acute Hepatitis C infection in Canada: results from the enhanced Hepatitis strain surveillance system (EHSSS).


extent of the problem is highlighted in reports from the province’s medical examiner, in that there were 342 fatal prescription overdoses reported in Nova Scotia between 2007 and 2014 from hydromorphone, methadone, oxycodone, morphine, codeine and fentanyl. These findings are consistent with data indicating that the use of non-medical prescription opioids is one of the most common forms of substance use in Canada. Only tobacco, alcohol and marijuana are more common.

While opiate addiction alone was seen in Nova Scotia in the past, dual addiction with cocaine has become much more common in recent years. Mainline estimates that 90% of its clients are dual opioid and crack/cocaine users. Moreover, as prescription medications change, so do the risks associated with their use, and often results in unintended consequences for the drug using population. Making one drug harder to get results in users seeking out new drugs, often more potent and resulting in an increased risk of overdose. In 2012, for example, OxyContin was taken off the market and replaced with OxyNEO, a tamper-resistant form of the drug with tighter restrictions on prescribing. The void left by the discontinuation of OxyContin resulted in an increased use of the stronger opioid, fentanyl.

Between 2009 and 2014, there were more than 1000 fentanyl-detected deaths in Canada, more than half of which (525) occurred in 2013–2014. While the numbers in Nova Scotia remain relatively low compared to those in Canada’s larger provinces—there were 13 documented deaths in Nova Scotia between 2009 and 2014—the number of fentanyl-implicated deaths also increased between 2012 and 2014. Worries about increasing fentanyl use in the province have prompted warnings from law enforcement and health professionals.

The most recent data on drug use in Halifax come from the 2012 Halifax Regional Municipality Drug Use Report, conducted by the Canadian Community Epidemiology Network on Drug Use (CCENDU). Information was gathered by surveying 82 individuals who were either involved in or recovering from drug use, or had front-line interactions with drug using populations in the last 12 months. Participants were asked to rate the seriousness of various prescription opioids in the Halifax Regional Municipality (HRM). Hydromorphone (88%), oxycodone (86%), and morphine (76%) were rated as being a problem by the largest proportion of respondents. Codeine was identified as serious by 51%, while fentanyl (26%) and meperidine—e.g. Demerol (21%)—were seen as problematic by relatively fewer respondents. Other findings from this survey are listed below:

- The most commonly reported drugs being injected in HRM were prescription opioids (67%) and cocaine/crack (63%); heroin (4%) was the least reported.

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• 39% of respondents identified prescription opioids as being responsible for an increase in deaths in HRM within the past year. Reasons cited for increased mortality included difficulty accessing treatment, decreasing health and wellness, and poor public health policies.

• Prescription opioids (48%) and cocaine/crack (42%) were most commonly associated with an increase in drug trafficking. Factors believed to be accountable for increased trafficking included poverty, unemployment, and lack of affordable housing; lack/difficulty accessing treatment services; demand from consumers and availability from suppliers; and ineffective health policies.

1.4.4 Social determinants of health

The social determinants of health are the social and economic conditions that interact to influence individual and group differences in health. These are conditions of everyday life and are reflected in the circumstances in which people are born, grow up, live, work, and age. These include, but are not limited to, income and social status, social support networks, education, employment/working conditions, social environments, physical environments, healthy child development, gender, and culture.22

There is widespread consensus that income and social status are the leading determinants of health. Higher incomes and social status are linked to better health; conversely, lower incomes and social status are linked to poorer health. We also know that the greater the gap between the richest and poorest people, the greater the differences in health, and that the healthiest populations are those with the most equitable distribution of wealth.23

Atlantic Canada has more inequities than the rest of the country, and experiences relatively higher rates of adverse economic and social conditions such as unemployment and poverty. Adverse economic and social conditions are related to an increased prevalence of many communicable and non-communicable diseases, as well as mental illness. Not surprisingly, the rates of many chronic diseases are higher in the Atlantic Region than in other parts of Canada.24

There is a strong link between social and economic inequalities in Nova Scotia and injection drug use. Many individuals who begin to inject drugs are already marginalized in some way through conditions such as poverty, homelessness, a history of abuse, trauma, and mental illness. The ongoing use of injection drugs further marginalizes them.

An environmental scan on injection drug use in Atlantic Canada identified the following life circumstances as most commonly impacting the health of people who inject drugs (PWID): lack of housing; difficulty securing and maintaining employment; poverty; inadequate social support networks; family history of abuse and violence; stigma and discrimination; lack of access to appropriate health services; lack of formal education; and mental illness.25

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1.5 Harm reduction

Harm reduction theory is explained; context is given as to how NEPs incorporate harm reduction practices into their operations, and how this viewpoint is beneficial to clients’ well-being, as informed by relevant literature. NEP best practices are reviewed, and overview of harm reduction initiatives in Nova Scotia is given.

1.5.1 Philosophy/approach

Harm reduction has as its first priority a decrease in the negative consequences of drug use. The Canadian Harm Reduction Network defines harm reduction as referring to:

...policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use. Its cornerstones are public health, human rights and social justice. It benefits people who use drugs, families and communities.26

While the harm reduction approach can be applied to the use of all drugs, including nicotine and alcohol, as well as to other risky behaviours such as unsafe sexual activity, it has most commonly been applied to injection drug use in response to the transmission of HIV/AIDS. Harm reduction can be contrasted with abstentionism, a common North American policy or strategy aimed exclusively at decreasing and eliminating the use of drugs. Harm reduction recognizes that abstinence may not be a realistic or desirable outcome for some individuals, particularly in the short term. Acknowledging that abstinence is not the only acceptable or important goal, harm reduction is a practical and pragmatic approach.27 This is in stark contrast to the prohibitionist and “tough-on-crime” stance taken by Canada’s federal conservative government led by Stephen Harper between 2006 and 2015.28

Harm reduction is founded on humanistic values and respects the dignity and rights of persons who use drugs. Most programs emphasize a hierarchy of goals, prioritizing the most pressing needs, and ensuring that substance-related problems and issues are addressed systemically.

Another key feature of harm reduction philosophy is the involvement of persons who use drugs in the creation or delivery of services designed to serve them. It recognizes the various social inequities and their interactions on people’s vulnerability to and capacity for dealing with addiction and risk-taking behaviours—e.g. poverty, homelessness, racism, homophobia, social exclusion, a history of trauma.29

Needle and syringe distribution programs are considered the cornerstone of harm reduction programs for PWID. Other more current examples of harm reduction initiatives for drug users include the distribution of safer crack kits, supervised injection and smoking sites, methadone

27 Ibid.
maintenance, and other opioid replacement therapies. They also include educational approaches and outreach interventions that seek to educate clients to reduce drug-related risks and harms.

1.5.2 Overview of harm reduction in Nova Scotia

There are various organizations and programs working within a harm reduction framework in Nova Scotia. While some provide outreach services across the province, the majority are based in Halifax. Central among the harm reduction organizations that serve people who use drugs in Halifax are Mainline Needle Exchange, Direction 180, and Mobile Outreach Street Health (MOSH). These organizations work very closely together and with others to help Halifax’s most vulnerable populations. Cape Breton’s population is served by the Ally Centre, which includes Sharp Advice Needle Exchange (S.A.N.E), as well as various other harm reduction services. A description of these programs is included below under section 2.9.1.

Atlantic Canada’s harm reduction services have been described as more constrained than elsewhere. A number of harm reduction initiatives available in Canada’s larger centres are not available in Nova Scotia. There are no supervised injection or smoking sites in the province, for example, or access to heroin prescription for those who do not respond to more traditional opioid replacements such as methadone or Suboxone. Nonetheless, Nova Scotia’s harm reduction organizations take many steps to enhance the health and well-being of their clients and reduce risk behaviours. These include the provision of clean injection and smoking equipment and safe disposal services, methadone maintenance, safer sex supplies, as well as various other support and referral services.

The importance of harm reduction has long been recognized in Nova Scotia. Many of the recommendations initially made in the province’s 2003 HIV/AIDS Strategy underscored the need for a range of comprehensive harm reduction efforts for different populations within a variety of service settings across the province. Central to this strategy was the need to address the various social determinants of health, including: the availability of safe and secure housing; employment; adequate income support; access to health, social, and addiction services; and homophobia. The strategy also outlined the need for peer-based prevention and education programming, outreach for the most vulnerable populations, ongoing training on harm reduction, ongoing program evaluation, and collaboration among service providers and with members of the community.

The 2014 review of the province’s HIV/AIDS Strategy acknowledges the progress made in Nova Scotia over the years, pointing to a reduction of HIV-related stigma, especially within healthcare settings, and the establishment and/or expansion of important collaborative programs and health services—e.g. Mobile Outreach Street Health, methadone maintenance treatment programs, anonymous HIV testing, needle exchange. However, the review also highlights the ongoing efforts needed to increase access to harm reduction services, especially beyond the Halifax Regional Municipality and in rural areas.

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1.5.3 Best practices

The Public Health Agency of Canada defines best practices as interventions, program/services, strategies, or policies which have demonstrated desired changes through the use of appropriate well documented research or evaluation methodologies. Best practice recommendations are based on empirical evidence of effective service provision strategies identified by front-line service workers and research initiatives.

**Recommended best practices for Canadian harm reduction programs**

The most recent guidelines were published in 2013 by the Working Group on Best Practice for Harm Reduction Programs in Canada. The working group included representation from across Canada, including researchers, service providers, policy makers, and people with lived experience using drugs.

Intended for service providers, managers and policy makers, these guidelines include a comprehensive series of recommendations aimed at improving the effectiveness of harm reduction programs for people who use drugs, and are at risk for HIV, HCV, HBV, and other related harms. These national best practice recommendations are based on the best available and most recent evidence about the distribution of injection and smoking equipment, safer drug use education, and overdose prevention. While the ideal harm reduction program would include all recommended components, the guidelines acknowledge the financial and other constraints experienced by most programs. An inability to provide all components should not be used to discourage the delivery to the best of a service's ability.

The guidelines underscore that policies limiting the number of needles distributed limit the effectiveness of needle and syringe programs (NSPs) to prevent HIV and HCV transmission, and that restricting clients to one new needle for each used needle returned is an unsatisfactory practice. The recommended ideal is to distribute sufficient needles to provide a new sterile needle for each injection (i.e. 100% coverage). Acknowledging that 100% coverage may not always be feasible, however, the guidelines highlight the importance of moving away from exchange policies to distribution policies allowing access to more needles as the goal. The terminology used in these most recent guidelines is consistent with this recommendation, in that what has traditionally been called needle exchange programs is referred to as needle and syringe programs.

An outline of all key recommendations is included as Appendix B. As shown, recommended best practice policies are provided to facilitate use and reduce the harms of various injection and crack smoking equipment, including: needles and syringes, cookers, filters, ascorbic acid and other acidifiers, water, alcohol swabs, tourniquets, and crack cocaine smoking equipment. It is recommended to place no limit on the number of needles provided per client, per visit.

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While encouraging clients to return and/or properly dispose of used needles and syringes is recommended, requiring clients to return used needles is not, and is not considered a best practice. With each needle, the guidelines recommend offering a sterile cooker, filter, vial of water, and alcohol swab, along with a clean tourniquet, ascorbic acid and other acidifiers if needed. Offering a variety of needles, syringes, and cookers is also recommended in meeting the client’s needs. As with needles, it is recommended that no limits be placed on the quantities of all other injection equipment provided. The quantity of condoms, lubricant, and materials for safer crack smoking is similarly to be determined by the client.

Overlap can be found in a number of recommendations. For instance, regardless of the equipment to which the guidelines refer, all include:

- Providing pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently;
- Educating clients about the risks (e.g. of using unsterile needles, cookers, filters, alcohol swabs; of using unclean tourniquets and non-injection-grade sterile water; of improperly using ascorbic acid to dissolve drugs, unsafe smoking, unsafe sex);
- Educating clients about the proper disposal of all used injection and smoking equipment;
- Providing multiple, convenient locations for safe disposal of used equipment; and
- Disposing of all used injection and smoking equipment in accordance with the applicable local, provincial/territorial and/or federal regulations for biomedical waste and to prevent needlestick and/or sharps-related injuries.

In addition to recommending best practice policies to reduce or eliminate the risk of HIV, HCV, and other communicable and non-communicable diseases and infections, these guidelines seek to reduce other potential harms (e.g. overdosing, soft tissue injuries, injuries to the lips and mouth) through tailored safer drug use education using a variety of formats and methods, including peer education. It is recommended that clients be integrally involved in the design and evaluation of services.

The final set of harm reduction recommendations is related to increasing knowledge and application of opioid overdose prevention, as well as how to respond in the event of an overdose. It is recommended that clients be educated about such issues such as prevention, symptoms, first aid, and 911. Where naloxone is available, it is recommended that clients be properly trained, and that kits be widely available. Where it is not available, harm reduction programs are encouraged to assess the feasibility and acceptability of a naloxone distribution program.
2.0 Mainline Needle Exchange Operations

In this section we present the services and programs that Mainline offers. In order to provide a complete picture of Mainline’s operations, we present everyday practices and how services are provided. Mainline’s current funding is broken down and past budget trends discussed.

2.1 Mainline: A Snapshot

Mainline is located in the heart of the North End of Halifax, in close physical proximity to a number of other services that clients access, including the Mi’kmaw Native Friendship Centre, Direction 180, and the North End Community Health Centre. Despite the fact that Mainline is sandwiched between two adjoining buildings on either side, its bright blue front makes it easily visible. In warm weather the door is always open. The interior of the building is old and in need of repairs. It is not unusual to find a yellow sharps disposal bucket catching the run off from a leak when it is raining. There is a small reception area right inside the front door where clients interact with staff, a room that holds supplies, and a small office space that serves multiple purposes.

2.2 A History of Community Development

Mainline has a rich history in the community, which has been extensively detailed in a document put together for the organization’s 20th anniversary in 2012.34 Under the leadership of Director Diane Bailey, who has been with Mainline since its inception, the organization has worked consistently to improve the lives of vulnerable people in the province through policy development, research involvement, key partnerships, culturally conscious programming and an unending compassion for their clients.

Mainline has repeatedly been the driver of community development initiatives in Halifax and beyond. Examples include:

- Mainline identified a need for their services to be more accessible to those who were not centrally located in the province. This led to the provision of outreach needle exchange upon request between 1993–1998, first to the South Shore and then to other areas of Mainland Nova Scotia. The development and implementation of an official outreach needle exchange program began in Amherst in 1998, followed by the Pictou, Truro and Greater Halifax areas in 1999, and then to other key areas of the province.

Mainline advocated for, piloted, and administered the first community based methadone program in the province, which subsequently developed into an integral partner organization, Direction 180.

In 2009, Diane Bailey of Mainline, and Patti Melanson, previously of Phoenix Youth Programs, came together when there was a need identified for better access to primary health care among people who use drugs and people who are street involved, which led to the creation of Mobile Outreach Street Health (MOSH).

In 2012, a Halifax Metro Transit strike left many without access to harm reduction services. Mainline responded by assisting Direction 180 to take their services mobile in the Mainline van to reach clients who were unable to get downtown to receive their methadone treatment. After the strike, Diane Bailey and the Director of Direction 180, Cindy MacIsaac, came together to develop and source an outreach program for mobile methadone services.

The outreach methadone program delivered on Direction 180’s BAILEY Bus (an acronym for Broadening Access, Improving Lives, Engaging You, and no doubt acknowledging Mainline’s Executive Director) has been operating since 2012 as an interim, wait-list management program aimed at reducing the harms associated with ongoing opioid use among those waiting to get into a comprehensive methadone maintenance program. The bus and its staff currently travel daily to meet clients in four Halifax-area neighborhoods, and has reduced wait-times for methadone dramatically.

More recently, Mainline and Direction180 again joined forces to address the problem of drug overdose. Their funding request to the Nova Scotia Department of Health and Wellness (DHW) for a one-year pilot project—the “Take Home Naloxone Program”—was accepted and was launched during this writing. This overdose prevention initiative aims to train front-line staff and opioid users in the distribution of approximately 200 life-saving naloxone kits in the municipality of Halifax. A similar demonstration project has been funded in Cape Breton.

### 2.3 A Value-Based, Client-Centred Approach

Mainline’s work is grounded in social justice and the pursuit of health equity. Mainline’s approach is client-centred, and this is reflected in all of their programs and services.

Mainline believes that:

- Each client is unique, valuable and vital in contributing to its program. Through the commitment, respect and dedication of its clients, Mainline is able to maintain its mission and uphold its values.
- Clients deserve Mainline’s respect. By helping clients, staff help themselves. Owning one’s past directs the future relationships with clients and among staff.
- Clients should be supported even if they make choices staff wouldn’t make personally.
- “No questions asked” creates a comfortable, safe and friendly environment for staff and clients. This promotes an atmosphere of trust. Through this process, staff contribute to meaningful and trusting relationships.
- People who use drugs or engage in other forms of risk-taking behaviours are capable of change. Mainline supports its community members in those efforts to make that change.
- Support and education is very important for people engaging in and affected by risky behaviours.\(^{35}\)

As was evident in the review of key documents and stakeholder interviews, Mainline stays abreast of the latest best practice recommendations in harm reduction, and applies them directly to their service provision model. Mainline’s commitment to clients is one of respect and understanding; they strive to meet clients “where they’re at” without judgement, in order to gain trust and build rapport to facilitate the best helping processes. As with all needle exchange programs, Mainline’s effectiveness is influenced by their ability to attract and retain individuals, and their ability to encourage safer practices and facilitate behavior change.

> “…When I need sort of an interaction and I don’t want to annoy everyone else who’s here, I walk up the block and I pop into Mainline and we can…they’re just so embedded in the reality of the work that we can have you know, pretty honest, open conversations about where folks are at, and come up with some pretty creative ways of trying to meet their needs. So I just really appreciate how with folks they are, and how far they’re willing to go, and how many chances folks get.” – EJ Davis, Community Partner

### 2.4 Mainline’s Services

#### 2.4.1 Fixed site

Mainline’s storefront office, known as its “fixed site” is open Monday to Thursdays from 9am to 3pm, and 9am to 12pm on Fridays, weekends and holidays. A minimum of two staff members are always on site. Snacks for clients are delivered on a daily basis in the morning by Feed Nova Scotia.

The distribution of supplies is based on best practices for needle exchange programs, including no limit on the number of needles provided. While clients are encouraged to return or appropriately dispose of used needles, there is no requirement of exchange. The proportion of needles returned to Mainline in 2014–2015 was estimated to be 68%. Mainline operates according to what is termed “circulation theory”, in that they strive to decrease the amount of time that contaminated needles are in circulation. In addition to regular pickup of used needles, sweeps are routinely made of high use areas. Supplies have expanded over time to include paraphernalia for the safer use of cocaine via snorting and smoking, with the distribution of crack pipes beginning in 2005.

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\(^{35}\) All six value statements were adapted from the Mainline website at [http://mainlineneedleexchange.ca/](http://mainlineneedleexchange.ca/)
Supplies available to clients include:

- Sterile needles and syringes in unlimited quantities and a variety of needle and syringe types by gauge and size
- Sterile cookers (stericups) and filters
- Alcohol prep-pads/sterile water/ascorbic acid
- Crack pipe stems, mouth pieces, screens, matches and push sticks
- Sharps containers (small, medium, large)
- Tourniquets (ties)
- Condoms and lubricant

Supplies are made available individually or as pre-packaged kits. Despite the best practice that all supplies be provided in unlimited quantities, lack of resources currently limits the distribution of some supplies. Spoons/stericups, rubber ties, filters and sterile water, for instance, are limited to two per client per day at the fixed site, while glass stems for smoking crack are limited to one per client per day.

Mainline distributed close to a million (917,687) needles and 25,286 condoms over the course of 2014–2015. As shown in the table below, they also distributed various quantities of other supplies.

<table>
<thead>
<tr>
<th>Supplies</th>
<th>Qty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needles</td>
<td>917,687</td>
</tr>
<tr>
<td>Sterile Water</td>
<td>6963</td>
</tr>
<tr>
<td>Screens</td>
<td>55,049</td>
</tr>
<tr>
<td>Filters</td>
<td>4127</td>
</tr>
<tr>
<td>Condoms</td>
<td>25,286</td>
</tr>
<tr>
<td>Rubber Ties</td>
<td>3949</td>
</tr>
<tr>
<td>Cookers/stericups</td>
<td>9384</td>
</tr>
<tr>
<td>Vitamin C</td>
<td>2700</td>
</tr>
<tr>
<td>Glass stems</td>
<td>9294</td>
</tr>
<tr>
<td>Matches</td>
<td>2699</td>
</tr>
<tr>
<td>Rubber Tips</td>
<td>8922</td>
</tr>
</tbody>
</table>

### 2.4.2 Information sharing and education

A key role of Mainline is to share information with clients, and provide education. This is often done informally on a one-to-one basis as staff interact with clients and “meet them where they are at.” More formal education sessions are also held, but they are done on an ad hoc basis, depending on available programs and resources, as well as client need. Staff provide information on harm reduction practices to reduce the risk of HIV, Hepatitis B and C, and sexually transmitted infections, and the risks of unsafe practices. They educate clients as needed and/or as requested on the proper use of supplies, and ways to prevent common health complications associated with injection drug use such as abscesses, deep vein thrombosis and bacterial infections. Topics such as wound care, and dealing with crisis situations such as overdose are addressed.
Over the course of 2014–2015, Mainline provided information and support to 4114 client contacts[^36] on the prevention of HIV/HCV and other drug-related harms, as well as on the various treatment services available (e.g. MOSH, detox/treatment, and methadone). This information excludes referrals, and is presented in Table 2.

<table>
<thead>
<tr>
<th>Topic</th>
<th># Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/HCV/BBP</td>
<td>1369</td>
</tr>
<tr>
<td>MOSH</td>
<td>1041</td>
</tr>
<tr>
<td>Methadone</td>
<td>940</td>
</tr>
<tr>
<td>Detox/Treatment</td>
<td>764</td>
</tr>
</tbody>
</table>

In addition to sharing information with clients, Mainline also provides education to partner organizations (e.g. HepNS). Staff also attend relevant health fairs and awareness raising events such as activities around World Hepatitis Day and World AIDS Day. Mainline has a presence at federal prison-based health fairs at Nova and Westmorland Institution that are attended by inmates, as well as correctional officers, nursing and institutional support staff. Mainline has not attended such events at Dorchester Penitentiary and Springhill Institution (the other two federal prisons in Atlantic Canada) in many years due to funding cuts within the correctional healthcare system. A direct line is available for inmates from the provincial Burnside facility to call Mainline.

### 2.4.3 Support and social determinants of health

Equally important to the sharing of information and the provision of education is the emphasis Mainline places on the social determinants of health. Many clients seek the non-judgemental environment of Mainline, and come for social contact in a safe environment. Assumptions are not made about the reasons for a client visit; staff deal with whatever the client identifies as their issue for coming in. This could range from coming for a snack to needing housing support to dealing with an immediate health crisis.

> “[It helps] with housing, supplies, even just, you know, moral support. It’s pretty refreshing to have somewhere where you—what I like about it is that they don’t judge. They don’t make people feel alienated, like maybe a lot of other, you know, businesses or what have you. Because I would carry around a 140 pound backpack before, and sleeping outside you’re just not—you know, you just don’t look so welcoming for people to want to speak to you…” – Mickey, Mainline Client

> “‘Because they’re just keep constantly on ya. Talking to ya, and drop in—they’re just ‘Hey, come in. If you’re having a bad day, just come in. Need something, we’re there for you.’ You know, like—if I’m hungry, and I’m out of money, she won’t give me the money, she’ll just tell me “Go over there—call over there at the restaurant,” and they got some kind of account or something, and just, “they’ll get you something to eat.” They’ll never let you down, no matter who you are.” – Denny, Mainline Client

[^36]: Client contacts refer to individual visits with clients. For example, a client who comes to Mainline once a day, five times a week would be counted as five contacts.
In 2014-2015, Mainline provided information, referrals and support related to various social determinants of health, including income, housing, and education/employment (see Table 3). A total of 6985 client contacts were related to Community Services; 1094 contacts involved housing; and 240 contacts related to education and employment. Food was provided over the course of 9556 contacts.

### Table 3. Information, Referrals and Support Provided (2014–2015)

<table>
<thead>
<tr>
<th>Topic</th>
<th># Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>9556</td>
</tr>
<tr>
<td>Community Services</td>
<td>6985</td>
</tr>
<tr>
<td>Housing</td>
<td>1094</td>
</tr>
<tr>
<td>Legal Issues</td>
<td>814</td>
</tr>
<tr>
<td>Education and Employment</td>
<td>240</td>
</tr>
</tbody>
</table>

#### 2.4.4 Referrals

Mainline works to keep close relationships with other harm reduction service providers so that they are able to refer clients to other organizations or agencies if they are unable to provide support themselves. In this way, Mainline contributes to creating a seamless network of highly accessible services to promote a barrier-free experience for clients. In many cases, Mainline will also ease the transition to the referred service by making calls and advocating for their clients, informing the clients about how to navigate the referral service, and following up with both the client and the referral service staff.

> “Oh I just come down sometimes just to pick up a pipe or something or to see Diane or Kary or one of them just to talk to them, if I’m having a problem, if I want to get in to detox, they’re there to help you how to get in faster, right, than just going over to detox and going through all the bullshit to get in there, right? They’re there for you to make it work faster.” – Denny, Mainline Client

The numbers of referrals provided by Mainline over the course of 2014–2015 are depicted in Table 4. As shown, while the most common referrals were to MOSH, methadone and detox/treatment, referrals were also provided to services addressing other socioeconomic and mental health needs.

### Table 4. Referrals Provided (2014–2015)

<table>
<thead>
<tr>
<th>Program/Service</th>
<th># Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOSH</td>
<td>295</td>
</tr>
<tr>
<td>Methadone</td>
<td>75</td>
</tr>
<tr>
<td>Detox/Treatment</td>
<td>61</td>
</tr>
<tr>
<td>Housing</td>
<td>57</td>
</tr>
<tr>
<td>Community Services</td>
<td>40</td>
</tr>
<tr>
<td>HIV/HCV/BBP</td>
<td>23</td>
</tr>
<tr>
<td>Mental Health</td>
<td>11</td>
</tr>
</tbody>
</table>
2.5 Outreach

A mobile van is used to provide outreach needle exchange services. Staff make mobile runs in the van five days a week, covering both central locations in the Halifax Regional Municipality (HRM), and locations throughout the province. The current schedule of outreach is provided below.

Central outreach
- Tuesday 2pm to 8pm – Dartmouth areas
  - 2 Mainline staff
- Wednesday 2pm to 8pm – Bedford/Sackville/Fairview/Spryfield areas
  - 1 Mainline staff with MOSH nurse
- Thursday 2pm to 8pm – South end Halifax and Dartmouth areas
  - 1 Mainline staff with MOSH nurse
- Friday 12pm to 4pm – Halifax areas
  - 2 Mainline staff

Provincial outreach
- 2 Mondays per month – Pictou/Truro/Millbrook/Indian Brook areas
- 2 Mondays per month – Windsor/Kentville/Berwick areas
- 1 Wednesday per month – Oxford/Springhill/Amherst areas
- 1 Wednesday per month – Hubbards/Lunenburg/Bridgewater areas
- 1 Wednesday per month – Liverpool/Shelburne/Yarmouth/Digby areas

Central outreach runs begin with a search for and removal of discarded needles in high drug use areas. Clients are contacted either through a call or text along the route by staff in the van and asked if they need any supplies; if so, staff will go to them to provide supplies. In buildings with many clients, staff will go inside with a supply backpack and go directly to clients’ apartments. In houses or buildings with fewer clients, staff will park and wait for clients to come and get supplies from the van. Staff are respectful of clients’ surroundings, and strive to maintain their privacy.

“Even there was a time when my phone was down, and he would go around the back and just honk so I knew he was there, and you know, come out. Like they’re really good at making sure that you’re able to access them.” – Jill, Mainline Client

Clients on provincial outreach runs are contacted the day before the visit; this prevents staff from wasting time going to areas where they are not needed. The same practices for the delivery of supplies to clients take place on provincial runs as on central outreach. In case a client is missed or needs supplies between provincial runs, Mainline leaves supplies with some addiction service programs and its peer helpers in various rural communities. When these options are not available or accessible, Mainline uses the postal service to mail supplies to clients in need.
On outreach, staff not only provide clean supplies to clients; they try to get a sense of how each client is doing, and whether Mainline could help them with anything in addition to supplies. Because outreach clients (especially provincial clients) are not seen as often as clients who come to the site, Mainline keeps a record of each client interaction. In this way they are able to continue to connect with clients and stay informed on their issues and progress, visit after visit. Mainline’s outreach also involves visiting community pharmacies, community organizations and women’s shelters asking them to distribute “Don’t Share” cards which include information, Mainline’s toll free number and contact information for public health nurses across the province.

2.6 Mainline’s Programs

A number of additional services are delivered via programs. Although the distinction is sometimes blurred between programs and services, we refer here to programs as those entities funded through additional independent sources to Mainline. These programs are usually implemented as a result of applying for funds to a granting agency. As such, they are often time and resource limited. The challenge for Mainline is to maintain the programs once funding ends. We report here on current programs.

2.6.1 Wellness Navigator

The Wellness Navigator program is funded by the Mental Health Foundation of Nova Scotia via a Community Grant. The program was first implemented in March 2014. In the first year of the program, funding for one Wellness Navigator was supported on a full time basis. There has since been a drop in funding, which does not allow for a full time dedicated person in this role, and makes sustainability of such labour intensive activities a challenge.

Objective

The objective of the program is to empower and enable Mainline clients to make decisions about and participate in their own health care, thereby supporting the development of strong mental, emotional, and physical health.

Goals

- Better attendance at medical appointments
- Increased understanding of and adherence to medical advice
- Better ability to maintain behaviours for good health
- Clients feeling empowered and able to navigate the system in the future

The program serves individuals who are most marginalized and stigmatized. It is tailored to help clients on an individual basis with tasks and processes they are either unfamiliar with, incapable of, or uncomfortable tackling on their own. Some of the services provided by the Wellness Navigator include:

- Escorting clients to appointments
  - Medical, dental, Liver Clinic, physiotherapy, etc.
- Waiting to take people home from the hospital
- Getting IDs, birth certificates and health cards for clients by helping them with Access Nova Scotia
- Helping clients register for bank accounts
- Filing tax returns
- Paying bills, overdue fines
- Advocating for clients
  - Justice system
  - Clients with mental health issues who need medication
  - Community Service
- Helping with housing
  - Partnering closely with landlords

### 2.6.2 Community Based Legal Support & Education

The Community Based Legal Support & Education program started in 2005, and has been funded ever since by the Law Foundation of Nova Scotia as a result of Mainline’s successful annual proposal submissions. The benefits of peer support programs are well documented as an effective strategy and approach in working with populations who are involved with the justice system and at risk of being incarcerated. The program, with its emphasis on advocacy, legal support and education, offers court support to clients and families involved with the criminal justice system.

**Objectives**
- Provide individuals (offenders/clients) with access to legal information and education
- Provide a continuity of care and support for individuals who are involved with the criminal and civil justice system
- Help individuals to make lifestyle choices leading to improved well-being
- Provide support for individuals to secure safe and affordable housing and/or income assistance and/or addiction treatment
- Provide support for individuals to achieve success in the community and to reduce recidivism

**Goals**
- Provide community education within the justice system, and within the provincial and federal correctional system
- Help to improve public access to the law
- Act as a liaison between individuals and the courts
- Contribute to the administration of justice in the province

Two Mainline staff members work on site and in court to help clients. They will assist clients in talking to parole and probation officers, and help clients shift to the Mental Health Court. They also work with families of youth involved in the justice system. In addition to going to court with clients, they attend Halifax provincial courts three times a week, and Dartmouth provincial court upon request.
2.6.3 Hep C and Me

‘Hep C and Me’ is a program funded by a grant from the Public Health Agency of Canada (PHAC). First initiated in 2012, the project was designed to assess and address the needs, attitudes, behaviours, knowledge gaps, and learning preferences of people living at risk of HCV in an urban environment. The grant was renewed for one year in 2013 to expand the project to rural Nova Scotia, and renewed for three years in 2014 to increase the scope of the program to target urban and rural youth, as well as mobile methadone clients. Mainline estimates, through client self-identification, that 85% of clients are HCV positive.

Objectives

- To increase organizational knowledge (within Mainline as well as other community institutions and organizations) of the factors and circumstances putting individuals at risk of contracting HCV
- To increase knowledge and skills among drug-using individuals to reduce the transmission of HCV
- To improve overall service delivery (within Mainline and in the wider community) and effectiveness of HCV prevention initiatives

Goal

To understand how to better provide for clients who are living with or at risk of contracting Hepatitis C.

The Hep C and Me program enhances understanding of, and responsiveness to, the health and social determinants and other factors that put individuals who access needle exchange services at risk of HIV and HCV. One of the many outputs from the project is Don’t Share cards and posters that were distributed to key community organizations throughout HRM and mainland Nova Scotia.
2.7 Staff

The basic administrative framework, including position titles and responsibilities is put forth. Emphasis is placed on Mainline’s hiring criteria, and the unique skill sets that staff possess from their own lived experiences with drug use and street involvement. The implication of these skill sets on the clients is discussed to promote further understanding of the benefits of harm reduction practices. This section is informed by interviews with staff, clients, and partners.

2.7.1 Staff complement and lived experience

In addition to the Director, there are two other full-time staff, and four part-time staff. One full-time staff member serves as the ‘Hep C and Me’ project coordinator, as well as outreach worker; the other full-time staff member takes on the role of Wellness Navigator project coordinator and provides court support for the Law Foundation project. The four part-time positions include Outreach Coordinator; Law Foundation project coordinator; and two Outreach workers.

Key informant interviews with clients and partners repeatedly underscored the wealth of strengths and qualities that Mainline staff bring to their clients and the community. Staff are approachable, knowledgeable, and experienced with street life. In addition to being friendly and non-judgemental, they have built strong, trusting relationships with individuals who use illicit drugs and/or are street involved. Peer staff provide one-on-one assistance and peer support based on their knowledge of drugs, drug use, and the drug scene.

“...people that work here, they’re really friendly, very helpful very, in-depth with their knowledge of addiction, and just the level of humanity that they show people, it’s pretty great.” – Mickey, Mainline Client

Having lived experience is the cornerstone of Mainline’s approach, and is reflected in the organization’s hiring policy. All staff at Mainline have lived experience, providing a unique skill set that is essential in addressing front-line client needs. Their lived experience gives them credibility in drug-using communities, and renders them important models for risk reduction.

“And I think because you know that they’ve all had the same life experience, their opinion seems to hold a little more weight, you know.” – Jill, Mainline Client

“[it’s not like anybody’s looking] down on you, or looking at you strange, exactly, they’ve all been there, you know.” – Jill, Mainline Client

“...they’re [the staff] just all so dependable, they’re all so committed, they’re all so loyal.” – Diane Bailey, Mainline Director
2.7.2 Code of Conduct

Mainline’s Code of Conduct outlines expectations of behaviour based on Mainline’s mission and values. Central to this code is the right of clients to be respected by staff and to have their confidentiality protected by staff members at all times and under all circumstances. Mainline recognizes that staff may have previous relationships with clients and that staff may be working with two clients at the same time who have a relationship to one another. In order to maintain the integrity of the program and the respect of all staff, employees must adhere to the pledge of confidentiality at all times. The code identifies the behaviour expected of staff working at Mainline and establishes expectations of staff as they relate to clients and members of the community.

Code of Conduct:

- No staff member will violate the legal rights of the clients or the program.
- Staff members will not accept any personal gift or accept money for services from a client.
- No staff member will sell to or purchase any item from a client.
- Staff members will not promote personally held views about religion or type of therapy.
- All staff members will respect the confidential nature of their work.
- Staff members will act as role models to clients.
- Staff members must receive permission from the Program Director to conduct interviews or speak to the media.
- Under no circumstances will staff carry out their jobs at the office or on outreach under the influence of alcohol or illicit drugs.
- Staff members must always provide an explanation to a client when they refuse a client’s request.
- Staff members will demonstrate respect to clients and to each other at all times.

2.8 Clients

Unique characteristics of Mainline’s client base are noted; specific emphasis is placed on understanding the various situations leading clients to access Mainline’s services. Both staff and client interviews inform this area. General demographic information, as found in Mainline’s database, is presented.

Mainline provides services to a variety of people from all walks of life: youth, middle-aged and seniors; male, female and trans-gendered; employed, underemployed and unemployed; as well as casual, moderate and hard users of drugs across various ethno-racial identities. The majority of those served by Mainline are Nova Scotia’s most disadvantaged and marginalized populations. People who use drugs face layers of intersecting disadvantages. Thus, the target population is broad, and includes those who use illicit drugs, are poly-drug addicted, use injectable steroids, are street involved, are homeless and/or live in less than adequate housing, are unemployed and/or have less than adequate income, have complex health, social and mental health issues, do not access mental health services, are involved with the criminal justice system and/or are incarcerated in provincial and federal institutions, are exposed to violence, trauma and abuse, are HIV and/or HCV-infected or at risk of becoming infected.
The majority of clients who inject drugs are also crack/cocaine users, many of whom use makeshift implements. Crack users experience a high burden of infectious disease, including HIV and HCV. People who use crack are also among the most vulnerable and socially marginalized, experiencing some of the highest rates of poverty, homelessness and criminal engagement.

A number of characteristics and/or trends have been noted with respect to drug use in Nova Scotia. The first is that “pockets” of drug using communities exist across the province. In rural areas especially, there are inter-generational families of drug users. Secondly, those who work on the front lines have noticed a marked increase in the number of youth (under 19) accessing their services over time, particularly in recent years.

Mainline maintains a database on the characteristics of each of their client contacts—i.e. new or returning client, sex and/or gender, age group, race and ethnicity, and drugs of choice. Data pertaining to the services provided by Mainline are also included—e.g. number and nature of supplies, education and referrals provided. While contacts refer to individual visits and therefore cannot be substituted for number of clients, this gives a reasonably accurate picture of who is using the services. Limitations in this data are important to note, however, in that staff do not ask clients directly to specify their sex/gender, race/ethnicity or age. Until a client proactively self discloses, the data is based on speculation. As outlined in Section 2.3, this “no questions asked” approach is vital to Mainline’s client-centred value of creating a comfortable, safe and friendly environment for building trust and meaningful relationships.

As will be discussed in more detail in section 2.11, client contact information has been gathered since 1992, and the number of contacts has increased significantly from 2276 contacts in the first year to 26,342 contacts in 2014–2015. Figures 1–3 depict the demographic characteristics of all contacts over the past five years. As shown, the majority of contacts over the years were white males, aged 30 years or over. Data for 2014–2015, for instance, indicate that the largest proportion of contacts were male (65%), white (79%), and 30 years or age or older (77%). Almost three-quarters (74%) were returning clients.

Mainline has noticed an increase in the number of female contacts over the years, as well as an increasing number of younger individuals accessing services. More specifically, the number of contacts with females has increased by 40% since 2010–2011, and the number of contacts with individuals younger than 19 has more than tripled in the past five years, from 127 to 455. Mainline has not noticed any significant trends in terms of race/ethnicity. That is, the proportion of contacts with white clients has ranged from 79% to 82% over the past five years. The proportion of contact with black clients has ranged from 9% to 14%, while that with First Nations has ranged from 7% to 10%.

Drugs used by contacts in 2014–2015 are presented in Figure 4 and give a sense of the prevalence of certain drugs among Mainline’s clients. As shown, approximately one-half of all 26,342 contacts were with individuals using opiates (51%) or crack/cocaine (50%). Almost one-third of all contacts used methadone (31%). The use of amphetamines and steroids was relatively low (less than 2%), while almost all (95%) were using one or more drugs not listed in the database categories. The “other drug” category is very broad, most commonly including alcohol and cannabis.
Sex/Gender of Contacts*

*Note: The data does not capture contacts who identify as transgendered.

*Figure 1*

Contact Age Groups

*Figure 2*
Figure 3

Race/Ethnicity

<table>
<thead>
<tr>
<th>Year</th>
<th>White</th>
<th>Black</th>
<th>First Nations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-10</td>
<td>16330</td>
<td>2718</td>
<td>1634</td>
<td>33</td>
</tr>
<tr>
<td>2010-11</td>
<td>15789</td>
<td>2751</td>
<td>1494</td>
<td>35</td>
</tr>
<tr>
<td>2011-12</td>
<td>17178</td>
<td>2570</td>
<td>1475</td>
<td>75</td>
</tr>
<tr>
<td>2012-13</td>
<td>20937</td>
<td>2418</td>
<td>1955</td>
<td>184</td>
</tr>
<tr>
<td>2013-14</td>
<td>19943</td>
<td>2765</td>
<td>2386</td>
<td>214</td>
</tr>
<tr>
<td>2014-15</td>
<td>20323</td>
<td>2449</td>
<td>2490</td>
<td>297</td>
</tr>
</tbody>
</table>

*Note: The methadone category includes those on MMT and those not on treatment.

Figure 4

Drugs Used (2014-15)*

<table>
<thead>
<tr>
<th>Drug</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>13,381</td>
</tr>
<tr>
<td>Crack/Cocaine</td>
<td>13,118</td>
</tr>
<tr>
<td>Methadone</td>
<td>8,360</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>406</td>
</tr>
<tr>
<td>Steroids</td>
<td>157</td>
</tr>
<tr>
<td>Other Drugs</td>
<td>25,067</td>
</tr>
</tbody>
</table>

*Note: The methadone category includes those on MMT and those not on treatment.
2.9 Partners

Collaborative efforts and initiatives are discussed. The contribution of CBOs and government agencies to the harm reduction system are noted; specific emphasis is put on how Mainline makes connections in the community to help their clients gain access to other wellness services. Unique connections with relevant government agencies are outlined. This section is informed by staff interviews and correspondence with key informants.

Partnerships and collaboration are fundamental to the work of Mainline. The fostering of strong relationships and partnerships with other programs and services of benefit to vulnerable populations has and continues to be a key pillar of their approach. Mainline partners with government department and agencies, as well as other stakeholders, particularly those working in the field of HIV/AIDS, Hepatitis B, and Hepatitis C. It collaborates with health organizations, researchers, and others to enhance access to services, decrease stigma and reduce barriers to prevention and treatment for marginalized populations. Serving HRM and mainland Nova Scotia, Mainline continues to seek partnerships in diverse communities to facilitate locally tailored and culturally appropriate services.

2.9.1 Community-based organizations

Mainline partners with a myriad of community-based organizations, including but not limited to: Direction 180, MOSH, Hepatitis Outreach Society, Stepping Stone, AIDS Coalition of Nova Scotia, ARK, Grace Mission, Halifax Housing Help, Adsum House, Barry House, and Metro Turning Point. These relationships vary in nature and intensity. Some collaborations involve specific labour-intensive initiatives (e.g. Direction 180, MOSH, and Hepatitis C Society), while others are related primarily to the sharing of information and needle exchange supplies and/or the mutual provision of referrals—e.g. ARK, Halifax Housing Help, and Metro Turning Point. Nonetheless, all partnerships serve to address the complex needs of marginalized populations, including people who use drugs.

The list below is intended to give a general impression of some of Mainline’s community partners in mainland Nova Scotia. It also commonly collaborates with its Cape Breton counterpart, the Ally Centre’s Sharp Advice Needle Exchange (S.A.N.E.).

- **Direction 180**: A community-based low threshold methadone maintenance program established in 2001. It is located just around the corner from Mainline in Halifax’s North End.
- **Mobile Outreach Street Health (MOSH)**: Delivers front-line primary health care services to people who are homeless, insecurely housed, street-involved and underserved in Halifax.
- **Hepatitis Outreach Society (HepNS)**: Dedicated to supporting people who are at risk for and people with hepatitis through information and education.
- **Stepping Stone**: Provides health, safety, and social support to women, men, and transpersons working in the sex trade.
- **AIDS Coalition of Nova Scotia (ACNS)**: Working to support those living with HIV/AIDS and provide information and education to those at risk of becoming infected with HIV.
• **ARK**: A drop-in for street-involved and homeless youth, ages 16–24. It offers daily meals, showers, laundry facilities, and access to other basics like clothing and socks.

• **Grace Mission**: A Christian community-based organization helping people who are marginalized through friendship, service, and worship.

• **Halifax Housing Help**: An organization that aims to provide support and housing placement for service users who have many needs.

• **Adsum House**: A community-based shelter for women, children, and adolescents experiencing homelessness.

• **Barry House**: A 20-bed client-centred shelter for women and their children who are experiencing homelessness.

• **Metro Turning Point**: An emergency shelter that provides temporary housing to men experiencing homelessness.

**Closest Collaborators**

Of the various community-based organizations with which Mainline partners, the most profound collaborations are those with Direction 180 and MOSH.

Mainline and Direction 180 work in close collaboration to provide a client-centred, non-judgmental, community-based and holistic approach to harm reduction services. In December 2015, Direction 180 had a total of 523 clients receiving methadone treatment at their Gottingen Street site or via the mobile bus. Mainline is a key point of access to Direction 180 by providing referrals to clients needing access to methadone. The collaboration between Mainline and Direction 180 has resulted in a number of innovations in Nova Scotia’s harm reduction landscape, including the recently launched Naloxone pilot project.

Having played a pivotal role in the creation of MOSH, Mainline continues to work in close partnership with them. The most tangible aspect of their collaboration is Mainline’s outreach program. Two days a week, a staff member from Mainline and a nurse from MOSH provide mobile harm reduction and primary healthcare services throughout HRM. Mainline also plays a role in the recently launched MOSH Housing First initiative, which prioritizes Halifax’s most vulnerable homeless individuals. Each participant works with a case manager to secure appropriate housing; and then works collaboratively to develop individual goals to ensure housing stability and develop independence. Through their knowledge of clients, Mainline assists by ensuring that Housing First is accessing the most vulnerable people in the community, not just the first people who want to take part.

2.9.2 **Government departments and university researchers**

Mainline collaborates on various fronts with municipal, provincial and national government departments and agencies, particularly those related to health, community services and justice. Their work with these groups is related primarily to the sharing of harm reduction-related information and knowledge, the provision of referrals, and advocating for their clients.
On the federal level, Mainline collaborates most commonly with the Public Health Agency of Canada and the Correctional Service of Canada. Provincialy, it works most closely with the Department of Health and Wellness and the Nova Scotia Health Authority, including the Liver Clinic, Infectious Disease Clinic and Addiction Services. Mainline also collaborates very closely with the Department of Community Services, the Department of Justice, and the Nova Scotia Advisory Commission on AIDS. It works with the municipal government in various capacities including, for example, the Halifax Regional Police to advocate for their clients, and to make the streets of Halifax safer.

As will be discussed in Section 3.2, Mainline plays an important role in various areas of academic research. The staff’s lived experience and front-line expertise has contributed to the evidence-base related to the needs of people who use drugs and other marginalized populations locally and nationally. Although Mainline has worked with academic researchers from across Canada, it has collaborated most closely with those in the Atlantic Region, particularly researchers affiliated with Dalhousie University. Through its collaboration with the Atlantic Interdisciplinary Research Network (AIRN), however, it has partnered with other academics, including those from Cape Breton University, the University of Prince Edward Island, the University of New Brunswick, and Memorial University of Newfoundland. Through its affiliation with AIRN it also engages with academic and community-based researchers across the country.

2.10 Funding

Mainline’s primary source of funding comes from the Nova Scotia Department of Health and Wellness (DHW). As shown in Figure 5, Mainline’s budget has increased since 1992, with annual funding ranging from $74,000 in 1992–1993 to $380,000 in 2014–2015. Between 2005 and 2012, it received $250,000 annually from DHW, and in 2012–2013, its funding increased to $280,000. In 2013–2014, the $280,000 was supplemented with a one-time grant of $50,000. In 2014–2015, Mainline received $380,000 in operational funding from DHW, but its funding dropped back to $280,000 in 2015–2016. By the end of December 2015, however, Mainline was over budget by approximately $55,000 and was faced with the prospect of substantially reducing services. Additional discussions with DHW resulted in the provision of $60,000 in supplemental funding in January 2016, and demonstrated the government department’s ongoing commitment to the value of needle exchange.

It is important to note that the amounts in the table and figure below represent only the funds received from DHW, and not those received from other granting agencies (e.g. PHAC, Mental Health Foundation, and the Law Foundation of Nova Scotia). These funds are received not for Mainline’s operations, but rather for specific time-limited projects or programs.

It should also be noted that the amounts below do not include funding received by the former district health authorities or the current Nova Scotia Health Authority (NSHA). In 2014–2015, for instance, Mainline received $30,000 in funding and a quantity of needles valued at $15,000 from the various district health authorities. In 2015–2016, NSHA provided $60,000 to supplement the initial $280,000 provided by DHW.
Table 6. Annual Department of Health and Wellness Funding (1992–Present)

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992–1993</td>
<td>$74,000</td>
</tr>
<tr>
<td>1993–1994</td>
<td>$86,000</td>
</tr>
<tr>
<td>1994–1995</td>
<td>$100,000</td>
</tr>
<tr>
<td>1995–1996</td>
<td>$114,000</td>
</tr>
<tr>
<td>1996–1998</td>
<td>$100,000</td>
</tr>
<tr>
<td>1998–1999</td>
<td>$136,000</td>
</tr>
<tr>
<td>1999–2002</td>
<td>$161,000</td>
</tr>
<tr>
<td>2002–2005</td>
<td>$178,000</td>
</tr>
<tr>
<td>2005–2012</td>
<td>$250,000</td>
</tr>
<tr>
<td>2012–2013</td>
<td>$280,000</td>
</tr>
<tr>
<td>2013–2014</td>
<td>$320,000</td>
</tr>
<tr>
<td>2014–2015</td>
<td>$380,000</td>
</tr>
<tr>
<td>2015–2016</td>
<td>$340,000</td>
</tr>
</tbody>
</table>
2.11 Growth

This section discusses the implications of expanding PWID populations on community-based harm reduction programming, and more specifically increased use of Mainline’s services. Information to inform this section comes from Mainline’s database and relevant information on their programming.

Mainline has experienced significant growth over the years, with an increased demand for services and supplies. As shown in Figure 6, the number of contacts has increased substantially and steadily over the past 23 years, from 2276 contacts in 1992–1993 to 26,342 in 2014–2015. Not surprisingly, the increased number of contacts corresponds with an increased distribution of safer drug use and safer sex supplies. In 2000–2001, for instance, Mainline recorded a total of 10,770 client contacts and 96,933 needles distributed (see Figure 7). Ten years later, they recorded 20,283 client contacts and more than 501,327 needles distributed. These figures continued to grow over the next five years and, by the end of 2015, reached an all-time high, with 26,342 client contacts and the distribution of almost one million (917,687) needles. In short, the number of client contacts and needles distributed since 2001 has increased by almost 10-fold.

Additional information specific to Mainline’s growth in the past five years is presented in Table 7. While the number of needles and condoms distributed has grown significantly, representing increases of 83% and 151% respectively, the distribution of glass stems, otherwise known as crack pipes, has remained relatively constant since 2010–2011. This has less to do with need, which has been documented to be on the increase, and more to do with limitations put on the distribution of these supplies given funding challenges.
Table 7. Summary of Mainline Growth and Distribution of Supplies (2010–2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>DHW Funding</th>
<th>Client Contacts</th>
<th># Needles</th>
<th># Condoms</th>
<th># Crack Pipes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010–2011</td>
<td>$250,000</td>
<td>20,283</td>
<td>501,327</td>
<td>10,057</td>
<td>9131</td>
</tr>
<tr>
<td>2011–2012</td>
<td>$250,000</td>
<td>21,445</td>
<td>553,633</td>
<td>10,400</td>
<td>8965</td>
</tr>
<tr>
<td>2012–2013</td>
<td>$280,000</td>
<td>25,797</td>
<td>736,636</td>
<td>13,417</td>
<td>10,157</td>
</tr>
<tr>
<td>2013–2014</td>
<td>$320,000</td>
<td>25,682</td>
<td>844,209</td>
<td>14,590</td>
<td>9377</td>
</tr>
<tr>
<td>2014–2015</td>
<td>$380,000</td>
<td>26,342</td>
<td>917,687</td>
<td>25,286</td>
<td>9294</td>
</tr>
</tbody>
</table>

*Note: The number of needles distributed in 2000-01 was lower than in any other year since 1994 and corresponded with the opening of Direction 180.

Figure 7
3.0 Mainline Needle Exchange Impacts and Challenges

Various impacts of Mainline are discussed: impacts on the PWID community, the city, and the province at large in the areas of wellness, social integration, safety, addictions education and surveillance of an often-unexplored landscape. This section uses interviews and past trends data to demonstrate the impacts of harm reduction programming.

3.1 Personal impacts

3.1.1 Overall health and wellness

Mainline has a demonstrable impact on improving the health and well-being of Nova Scotia’s most vulnerable populations. With the values of respect and non-judgement at the core of all their work, they support people who currently use or previously used drugs to focus on their health and well-being through raising awareness, education and personal empowerment. Mainline commonly serves as a point-of-entry and access to critical health and social services for a population that is often isolated from family and friends, and stigmatized by the traditional healthcare system.

Research indicates that harm reduction programs such as Mainline have been highly successful in reducing risks of communicable disease exposure and infection, and in creating safe environments for people who use drugs (PWUD) to access safe equipment as well as health and social services.\textsuperscript{37} Through health promotion education and support, and the provision of clean drug use and safer sex supplies, Mainline decreases the risks of HIV, HCV and other STBBI transmission and the incidence of infections such as abscesses, cellulitis, and endocarditis. Topics such as vein care, wound care, and the prevention of overdoses are covered, as is crisis intervention in the event of an adverse drug reaction or overdose. If needed and/or requested, information is shared on the options of methadone maintenance therapy, detoxification, and counselling. Clients are also provided with ancillary support related to addressing a range of other complex health and social needs.

\textit{“...Everybody’s on an individual basis, so that’s the thing, and one of the things we tell staff is “the answer is never no.” If we can’t help you, we’ll find somebody that can.”}  

\textemdash Diane Bailey, Mainline Director

Mainline continually seeks to decrease the number and severity of negative health and social outcomes associated with drug use, street involvement, and homelessness. Through their various primary, secondary and tertiary prevention initiatives, the personal impacts on the mental, emotional and physical health and wellness are far-reaching and life-saving.

\textsuperscript{37} Patten (2006). Supra note 1.
As explained by another client, Mainline staff play a proactive role when someone new to the drug scene comes to the area. Through their vigilance and outreach, they seek to minimize the risks of street involvement by reaching out to provide information and support.

“I mean, there’s been times when I’ve came in, and friends have come in and they’ve [staff] actually just said like, “You need to go to the hospital”, like drove us there themselves, you know, otherwise we could have probably not been here.”

– Jill, Mainline Client

3.1.2 Facilitating access, stabilization and social integration

People who use drugs commonly face difficulties accessing health care services and frequently report negative interactions that lead them to stop care against medical advice or avoid seeking care proactively. In drug using communities, especially rural areas, there are limited community supports, and an understanding of the risk and risk environments remains low among allied health and community services. This serves to reinforce and entrench fear and stigma, and potentially leads to less safe practices.

Key informant interviews emphasized how much Mainline is connected to the needs and circumstances of their clients. Through their extensive network of partnerships with other organizations in Halifax and beyond, Mainline facilitates access to a myriad of other health and social services, including those related to food, housing, legal aid, education and employment, mental health, and primary healthcare. When unable to assist clients directly, they provide referrals, often seeking to ease the transition by serving as a connector.

Through their close collaboration with Direction 180 and MOSH, for instance, Mainline contributes to seamless access to low-threshold methadone maintenance and primary healthcare. Mainline is often the first point of contact with mainland Nova Scotia’s harm reduction system, and plays a key role in the stabilization and social integration of individuals seeking guidance and support.
The Wellness Navigator program is a prime example of an initiative designed to stabilize and socially integrate individuals, and has its greatest impact on those who are most marginalized and stigmatized. While the program has been reported to be highly beneficial to clients, it also impacts the broader community. Clients report finding it less intimidating to access certain services when accompanied by Mainline staff. In addition, other organizations within the health care system acknowledge that medical appointments are better attended when Mainline staff accompany clients. This program also enables Mainline to develop and maintain closer working relationships with other CBOs and government agencies, by increasing capacity for connection and collaboration.

While the level of support provided by the Wellness Navigator is labour intensive, the demonstrable impact on individuals’ lives is high. For example, many clients do not possess the necessary identification to open a bank account. This is important because beginning in 2016 the federal government will only deposit income tax returns, GST, or other federal cheques via direct deposit to a bank. The Wellness Navigator escorts clients to Access Nova Scotia to obtain birth certificates and other forms of identification. This program also helps clients to file income tax returns (a requirement for continued income assistance), apply to income assistance for increased allowances for bus passes and/or security deposits, as well as for special diets for those with medical conditions. Prior to the Wellness Navigator program, if a client required help with housing, Mainline could provide information on housing supports in the community and a referral. With the Wellness Navigator program, they were able to assist in all aspects of the process, including obtaining social assistance if required, searching for suitable accommodations, viewing and securing an apartment, and assistance with furnishings.
Key informants also pointed to the various barriers to service Mainline seeks to mitigate through its partnerships, collaboration and referral services.

"I think it's easier to access them [other community and government services] through Mainline, you know, if there's calls to be made that they have the connections in the community with, the nurses, the staff, so they can call ahead, and they let them know what the situation is, who's going to be coming, you know, they're going to be there, it cuts travel time, its cuts—they kind of let us know everything before we get there so there's no surprises....It makes people feel a little more comfortable too, because some people don't just go to a service not knowing what to expect right, or they feel strange about it. Whereas they'll let you know, okay, “No, it's okay, you can go there, and this is what'll happen, and…” So I think it actually urges people to get the help they need, because a lot of people just don't go.” – Jill, Mainline Client

“Yeah, yeah it is [easier to go through Mainline to get to services], yeah, because they got better pull, you know, with the people over there and that, right?”

– Denny, Mainline Client

3.1.3 **Hope, self-esteem and empowerment**

Mainline’s impact on client hope, self-esteem and empowerment was highlighted repeatedly throughout the key informant interviews. In addition to respect and non-judgement, the value of personal empowerment is at the heart of Mainline’s existence. The objective of the Wellness Navigator Program, for instance, is not simply to “do” or take the necessary steps for the client, but guide and support them in achieving new skills and independence.

The fact that staff have the lived-experience of drug use and street life lends itself not only to their own credibility but also to clients’ hope for the future. Peer staff can be important role models for risk reduction and recovery.

“A lot of the clients....I know from—I used with them, I hung with them, I lived with them, and they see me doing so well today and it kinda inspires them and it gives them hope that they can get clean to and they can live a different way…”

– Kary Hannan, Mainline Staff

Whenever possible, Mainline strives to engage clients in opportunities to contribute to and connect with the community through, for example, participation in peer education and support programs, or assisting in the delivery of needle disposal buckets. Mainline works closely with Direction 180 in this regard, in that clients of Direction 180 are commonly asked and, if interested, are financially compensated to help when needles and/or sharps containers are delivered. As explained by the Director of Direction 180:
3.2 Community Impacts

3.2.1 Overview

Mainline has been at the forefront of Nova Scotia’s harm reduction landscape since its inception. On a fundamental level, it contributes to community health and safety by promoting the safe disposal of used needles, distributing sharps containers, and ensuring that discarded needles in high drug use areas are removed regularly. These practices not only reduce the prevalence of blood borne pathogens such as HIV and HCV among people who inject drugs, but also decrease the risk of exposure among the broader community. Its community impacts extend much beyond, however.

As outlined in Section 2.2, the organization has an extensive history of community development, and has been persistently involved in advocacy, partnership development, policy development, research, as well as in the development and implement of evidence-based best practices. Their first of many reports contributing to the harm reduction evidence-base dates back to a 1995 needs assessment of people who inject drugs.\(^\text{38}\)

The depth of knowledge and peer-based expertise that Mainline brings to Nova Scotia’s harm reduction efforts is clearly recognized by stakeholders.

> “What we do get from Mainline is—and this is I think the strength of the community connection—is a very good understanding of what’s happening and where the trends are in drug use…Diane and Cindy, they know very well what’s going on, where things are happening.” – Dr. Robert Strang, Chief Medical Officer of Health

> “What I appreciate most is how they’re one of the few, if not the only, peer-run peer support organizations, and they do that really well. And it’s a model that doesn’t get replicated very much in our city… they know folks in such a—sometimes a different way—and sometimes, you know, like it’s just a different relationship with folks that’s very valuable.” – EJ Davis, Community Partner

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Mainline has worked diligently over the years to increase the awareness of and capacity for addressing the issue of drug use in rural communities. To this end, they have developed and managed a number of projects, including:

- **Barriers to HIV Testing in Rural Communities** – Aimed at increasing the capacity of rural drug users to opt for HIV testing, increasing knowledge and skills of safer practices among drug users, and increasing partnerships among stakeholders in rural Nova Scotia.

- **DHA Injection Drug Users Project (DIDUP)** – Aimed at increasing organizational knowledge of the contexts and situations in which risk-taking behaviours occur among injection drug use populations in the former District Health Authorities 1, 2, and 3.

- **Mainline Needle Exchange Provincial Needs Assessment** – Aimed at researching and assessing the need for needle exchange services in the northern, western and southern regions of Nova Scotia.

While based in Halifax, Mainline’s services extend across mainland Nova Scotia, and its outreach services have an impact in rural and small communities. In 2013, its rural outreach program was selected for inclusion as an outstanding program in a CIHR initiative documenting promising and proven HIV prevention projects or interventions with a rural catchment or focus.39

Mainline’s work has been officially recognized through various other channels. In October 2015, for instance, the Public Health Association of Nova Scotia awarded Mainline its Public Health Champion Award for “Innovation, Commitment and Leadership.”

3.2.2 Knowledge, advocacy and community mobilization

Since its inception, Mainline has played a key role in advocating for the necessity of relevant, stable harm reduction initiatives in Halifax and provincially. While operating mainly as a fixed site in central Halifax when it first opened, services were expanded beyond the downtown core to other areas in Mainland Nova Scotia one year later in 1993. In 2004, Mainline further expanded its scope to include a walking outreach component along with its mobile (van) outreach to specific areas of Halifax known for high drug use, focusing especially on people who use crack and/or cocaine. Through its provincial outreach program, Mainline currently provides monthly or twice-monthly access to individuals in almost all counties in mainland Nova Scotia.

Beyond developing and implementing a still-growing needle exchange outreach program, Mainline has had significant impact in mobilizing action for harm reduction. Through their work with other community-based, government and research-based organizations, they have spearheaded and contributed to the ongoing success of several other essential harm reduction services in Nova Scotia. These include community-based and mobile methadone treatment, and increased access to primary health care for Halifax’s most vulnerable populations. Mainline’s ongoing impact in terms of innovation is evidenced through the recently launched Naloxone pilot project conducted in partnership with Direction 180.

• **Community-based and mobile low threshold methadone maintenance treatment (MMT)**
Mainline piloted and administered the first community-based methadone program in the province in 2000. Recognizing the need to offer treatment regardless of whether a client discontinues the use of opioids or other drugs, they advocated for and received federal funding for Direction 180 which began in 2001 and continues to this day as a separate program of the Mi’kmaw Native Friendship Centre. In 2012, Mainline and Direction 180 collaborated to develop, fund and implement an outreach program for mobile MMT.

• **Primary health care access for persons who use drugs and are street involved**
Mainline’s Director and a community colleague identified the need for better access to primary health care among persons who use drugs and are street involved. This collaboration resulted in the creation of Mobile Outreach Street Health (MOSH) in 2009, which continues to this day providing essential services to Halifax’s most vulnerable populations.

• **Community-based opioid overdose prevention**
As a result of a successful proposal submitted in collaboration with Direction 180, Mainline launched a one-year Naloxone pilot project in early 2016. Not previously available anywhere in Atlantic Canada—except through paramedics and emergency rooms—Naloxone is an antidote that will likely reduce the incidence of death, disability, and injury from opioid overdoses among Nova Scotia’s drug using community. Additional information is included in Section 2.2.

In addition to spearheading the above innovative harm reduction services, Mainline has worked tirelessly to reduce stigma and discrimination around addiction, homelessness and street involvement by sharing information, knowledge and advocating. Some of this work has resulted in concrete policy and structural changes that have resulted in the establishment or expansion of new services and supports (e.g. low threshold MMT, Suboxone coverage, the “Housing First” approach, community-based Naloxone distribution).

Mainline also has a significant impact in facilitating the multi-directional and meaningful exchange of knowledge between experts, service providers, service users and the public. As noted by the Director of Direction 180 and the team lead of MOSH’s Housing First Program:

> “Mainline is our eyes and ears on the ground, letting us know who’s doing well and who needs help.” – Cindy MacIsaac, Community Partner

> “So there’s that piece, like the individual work piece, but there’s also the “informing our work” piece, so as we’re setting this up…I go over and talk to Diane and we talk to folks as much as possible to try to get input and collaborate and you know, when we get our advisory going, hopefully someone from Mainline will be involved…they have such a wealth of knowledge just as being folks who have come through the struggle themselves, and able to meet folks in that way, in a much different way than I can meet folks…if we don’t have that informing our work, it’s a real loss, and it leads to a lot of different power playing out and privilege playing out, it leads to a lot of blind spots in how we deliver service to folks.” – EJ Davis, Community Partner
3.2.3 Surveillance and Research

Mainline has played an important role in various areas of research locally, provincially and nationally. It has engaged in and lead research projects to improve service delivery, ensure evidence-based practices, better understand the needs of drug users and other vulnerable populations, and establish priorities for advocacy.

Mainline engages continually in academic research, contributing to the knowledge and evidence base on substance use, addictions, marginalization, harm reduction and service delivery. Their personal and front-line expertise in these issues has been and continues to be an invaluable resource. While their involvement dates back further, examples of projects in which they have been involved since 2010 include:

- **I-Track:** Enhanced Surveillance of Risk Behaviors among People Who Inject Drugs in Canada (Phase 3)\(^{40}\)
- Exploring the Current and Future Landscape of Communicable Diseases in Atlantic Canada\(^{41}\)
- Supporting and Maintaining Natural Helper Models for Needle Exchange in Atlantic Canada: Building a Pan-Atlantic Collaborative\(^{42}\)
- Harm reduction within mainstream services (HaRMS): What are the challenges and opportunities to reducing the harms for people who use illicit drugs?\(^{43}\)
- Bridging community and provider perceptions on improving adherence for injection drug users living with HIV/AIDS\(^{44}\)
- Opioid-dependent Users on Methadone: A Knowledge Synthesis of Formal Interventions Aimed at Methadone Retention and Improved Health\(^{45}\)
- Health Canada Monitoring of Alcohol and Drug Use among High-Risk Populations\(^{46}\)
- The Canadian Community Epidemiology Network on Drug Use (CCENDU)\(^{47}\)

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\(^{47}\) CCENDU is network of community partners that informs Canadians about emerging drug use trends and associated issues.
3.3 Government Impacts

The economic burden of HIV/AIDS, hepatitis C, and other blood-borne infections on society is staggering. It has been estimated, for instance, that the direct and indirect lifetime economic loss attributed to individuals infected with HIV in 2009 was $1.3 million per person. This estimate included the then-current costs of treatment ($250,000), economic loss related to lost labour productivity ($670,000), and costs associated with quality of life losses ($380,000).48 The financial burden of Hepatitis C in Canada is also high. The direct and indirect costs of Hepatitis C in Canada was estimated at $500 million per year in 2000, and projected to double to $1 billion in 2010.49

Research documents the cost-effectiveness of needle exchange programs (NEPs) in terms of preventing the significant health care costs incurred for the care and treatment of hepatitis C, HIV/AIDS, and other injection drug use-related health harms.50 It also indicates that the availability of NEPs increases the likelihood that persons who inject drugs will become involved in treatment and prevention interventions.

As a key point of entry into Direction 180 and other treatment services, Mainline also likely plays a role in reducing crime. In addition to improving physical and mental health, social functioning, and employment rates, MMT also reduces the use of opioids and other illegal substances as well as illegal activity and crime.51 Although a crime impact assessment was beyond the scope of the current evaluation, research from other jurisdictions has documented the relationship between MMT and crime reduction. An Australian study, for instance, found that for every 100 individuals on MMT in New South Wales for one year, there were 12 fewer robberies, 57 fewer break-and-enters, and 56 fewer motor-vehicle thefts.52

The cost-effectiveness and governmental impact of Mainline was highlighted by a number of key informants, particularly government and CBO stakeholders.

“If we didn’t have these programs, how much more would we be spending in policing, in health services, all those kind of pieces right. So we’re getting huge cost-benefit from the investment, as modest as it is.” – Dr. Robert Strang, Chief Medical Officer of Health

3.4 Allocative and Implementation Efficiency

According to the World Bank, allocative efficiency is defined as the distribution of resources among a combination of programs, which are projected to achieve the largest possible effect with available resources and set objectives. Allocative efficiency of health or HIV specific interventions is about the right intervention being provided to the right people at the right place in the correct way to ensure that health outcomes are maximized.53

Implementation efficiency describes a set of measures to ensure that programs are implemented to achieve target outputs using the smallest input of resources. In practical terms, improving implementation efficiency means identifying better delivery solutions. This requires improved planning and design of service delivery models, as well as assessing and addressing service delivery obstructions that prevent clients from moving smoothly through the service delivery process, and reducing the waste of resources.

A thorough analysis of Mainline’s allocative and implementation efficiency is beyond the scope of this evaluation. However, support can be found in the research indicating that the return-on-investment for needle and syringe programs (NSPs) is huge for government departments. A number of areas in which efficiencies are noted include the provision of supplies to partner organizations for distribution to their clients, and the use of referrals to partner organizations for seamless care. Areas in which efficiencies can be examined include the bulk purchasing for supplies and the incorporation of volunteers. The unfolding landscape with respect to integration also provides an opportunity to address efficiencies with partner organizations. These opportunities are discussed in section 4.2.

A report by Australia’s Department of Health calculated the net savings and cost-effectiveness of NSPs in terms of HIV and HCV infections averted.54 They estimated that NSPs resulted in the averion of 32,050 new HIV infections and 96,667 HCV infections over the course of a decade, resulting in a cost-saving of over $1.03 billion between 2000 and 2009. For every dollar invested in a NSP, more than four dollars in direct healthcare costs were returned in addition to the investment (i.e. five times the investment). When including patient and productivity costs in the analysis the return was $27 for every dollar invested. They point to the conservative nature of


"It costs a lot of money to keep someone homeless and on the street, and using, or drinking. It costs—you know, I know Patti has—and many cities have done analysis of cost to just cells, emergency services, ERs, the legal system...to keep someone is, you know, $70,000–$120,000 a year. So it's a huge cost. I think folks are so—government folks, community folks, non-profits—are so accustomed to having Mainline in existence that if it wasn't there...it's just beyond. It's really hard to actually imagine what would happen.”

— EJ Davis, Community Partner
their estimates in that their analysis did not consider primary health care costs, and did not include many of the other benefits of NSP’s, such as avoided mental health crisis and injecting related injuries.

The Australian report concluded that NSPs are more cost-effective than other common public health interventions, such as vaccinations, in-patient interventions or drug dependence programs. Their results suggested that increasing funding levels by 150% to 200% would yield the maximum return on investment, by averting additional HCV and HIV infections, and an additional 150%–200% in government healthcare cost savings (e.g. testing, medications, other treatments, hospital admissions).

Referring to the inadequacy of government funding in terms of the return on investment of harm reduction programs, one key informant noted:

“It’s not smart. It’s not smart at all…they’re not being accountable in their decision making about where resources need to be infused that will mitigate or prevent further damage…Well the cost of Hep C and HIV— I mean just look at it. To treat two people on Hepatitis C treatment, right, $150,000 say. Two people. So, okay, what about four people, Hep C treatment, or HIV for a million over the lifespan. So let’s just say okay, government, commit to treat or prevent yourselves from having to pay for treatment for five people, that’s almost $400,000 you could be investing in the needle exchange.”

– Cindy MacIsaac, Community Partner

A review of Mainline’s budget indicates that close to one-third of the operating costs (32%) are related to the purchasing of safer drug use and safer sex supplies. In 2014–2015, they gave out close to a million (917,687) needles and 25,286 condoms. These supplies, along with the others in line with best practices recommendations, cost $120,000.

Interviews with key informants from the Department of Health and Wellness pointed to some suggestions for enhancing Mainline’s implementation efficiency by, for example, reducing the costs of purchasing supplies and incinerating used sharps containers.

“The majority of their costs relate to their supplies, and is there a way that we can do bulk purchasing and find ways to do that? Maybe either purchasing through the Nova Scotia Health Authority or even as an Atlantic group, or nationally down the road, just that vision around what is the most effective way…they were buying buckets for example, and for the return of needles, and they were paying for each single bucket to be incinerated, and the Nova Scotia Health Authority already owns an incinerator…..”

– Government Partner

It is important to note that, while not their most significant expense, Mainline has been able to reduce their costs for needles by 50% since 2012 by purchasing needles/syringes at the same price as the provincial government [$100 per 1000].
3.5 Program Challenges

It is no secret that Mainline, as well as other community-based harm reduction service providers, face many challenges when attempting to make their services as accessible as possible. These challenges are presented and discussed as they pertain to the larger picture of STBBIs and injection drug use in the province. Recommendations are made for ways in which some of the problems could be alleviated. Collected data from interviews and correspondence with key informants contribute to further understanding of the gaps in services available to PWID and those who are street involved; suggestions are made regarding how best to fill the existing gaps.

3.5.1 Funding

As outlined in Section 2.11, Mainline has experienced significant growth over the years, with an increased demand for services and supplies. The increased demand for services, however, has not been matched by corresponding increases in operating budgets. In 2015–2016, Mainline received $340,000 from DHW, representing a 36% increase over the $250,000 in 2005–2006. The inadequacy of this funding is evident when considering the increased cost of living, and that Mainline has faced a steadily increasing client load and demand for supplies. The number of client contacts, for instance, increased by 72% between 2005 and 2015, from 15,323 to 26,342. During this period, its distribution of needles more than tripled—from 296,096 to 917,687 (210% increase). The increasing trend is continuing in that Mainline had already distributed more than 300,000 needles in the first three months of fiscal year 2015–2016. In short, while its funding has increased by 36% over the past 10 years, it has not kept pace with the need.

In 2014–2015, Mainline received an additional $100,000 from DHW, bringing their annual budget to $380,000. They also received $10,000 from each of the Colchester, Cumberland and Pictou County district health authorities, and a donation of needles from the Annapolis, South Shore and South West district health authorities valued at $15,000. The total funding of $425,000 from DHW and the district health authorities enabled them to increase the number of outreach days, number of supplies allotted to each client, as well as to enhance the resources available through their Wellness Navigator program (e.g. providing sneakers, covering rent deposits).

For the 2015–2016 fiscal year, Mainline received $280,000 from DHW and $60,000 from the Nova Scotia Health Authority, formed in April 2015 with the amalgamation of the former nine district health authorities. An additional $60,000 from DHW was granted in January 2016 when it was evident that Mainline was over budget and would have to cut services. Despite this supplement, Mainline is operating with $25,000 less than in the previous year. This reduction in funding has significant implications on organizational capacity and programming.

Mainline is a front-line community-based organization, developed and run by individuals with lived experience. For such a small organization, the ongoing challenge of not having stable funding and constantly having to seek out and apply for additional resources through grants is labour intensive and time consuming. Responsible for generating funds, Mainline’s Director is diverted from important programming and management functions to constantly searching for funding. It is an ongoing struggle. This is not only frustrating and exhausting, but also impacts on the organization’s ability to follow best practice recommendations.
According to Mainline’s Director, the reduction in funding necessarily translates to a scaling back of services. For instance, in addition to limiting the number of supplies given to clients, Mainline reduced its Friday office hours and eliminated its Saturday outreach run in the fall of 2015. Most of the $60,000 supplement received from DHW has been used to pay their debt, and they must continue operating on a shoestring budget to the end of the fiscal year. This has serious implications not only on the services provided to existing clients, but also on the ability to reach new clients in need of services.

The lack of funding sustainability is not unique to Mainline, and is putting harm reduction initiatives throughout Atlantic Canada at risk. As outlined in the report on the landscape of communicable diseases in Atlantic Canada, resources for HIV and HCV from the federal government are based on funding formulas that are more heavily weighted on reported incidence. Access to testing, particularly anonymous testing, is a huge barrier in the Atlantic region and undoubtedly deters some individuals from being tested. Moreover, project funding is primarily allocated for new and “innovative” programs, and there are very few funding sources that support the continuation of programs that have shown to be effective.55 This makes it difficult, if not impossible, for programs such as Mainline to access federal funding for its ongoing programming.

55 Kirkland et al. (2014). Supra note 39.
The Nova Scotia Advisory Commission on AIDS (NSACA) also underscores the lack of resources in its 2014 review of the province’s HIV/AIDS Strategy. The review revealed that lack of resources was the biggest challenge identified by the vast majority of stakeholders. The Strategy is viewed as underfunded, with inadequate resources and supports for implementation, including stable and sufficient funding for community-based AIDS services and other organizations. Among their recommendations was the need to increase funding and support to front-line service providers who assist those most vulnerable (e.g. street-involved and/or living with concurrent mental health issues and addictions). \(^{56}\)

### 3.5.2 Systemic Barriers

The barriers identified by key informants are consistent with those highlighted in previous research. As noted by NSACA, for instance, the availability of services and resources is lacking outside of HRM; culturally competent harm reduction services are not available and/or accessible equitably across Nova Scotia, and rural access to services is particularly challenging. \(^{57}\)

Limited resources prevent Mainline from delivering a much more comprehensive and accessible service in Halifax and beyond. The small staff is working at capacity. At the fixed-site, there is a need for more space, longer hours and availability seven days a week. As stated by staff and clients alike, “Addicts are addicts every day, all the time, not just 9–5.” Its outreach services beyond HRM are also restricted by resources, and are only available once or twice a month, thereby limiting access to persons who use drugs in more rural areas. As stated by key informants:

> “It’s so small and they only have maybe four or five workers...they’re taking a lot on theirself, you know, once they shut down [for the day], then they jump in the van and they go out, you know, to the working girls and other people around and drive all over, right, that’s a lot of work for these people. They’re doing a great job.”
> 
> – Denny, Mainline Client

> “[It would help] for them to be open more days, you know, and to be able to do the outreach, and still be open here in the afternoons and stuff would be key and ideal, you know. So that way, if somebody’s getting off work and they need to stop by here after work or whatnot because they weren’t able to make it here during the day or in the morning, then there would be somebody here to be able to do that while they’re out doing the outreach and that. So ultimately, you know, unfortunately it comes down to funding once again, you know.”
> 
> – Mickey, Mainline Client

> “Further outside the city I would say there’s definitely a need for something similar.”
> 
> – Jill, Mainline Client

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\(^{57}\) Ibid.
Mainline works within an environment that is generally uneducated about drug use, addiction and street involvement. As noted by key informants, drug use is often seen by society as a criminal justice problem rather than a public health issue. Consequently, there is a high level of stigma, a lack of understanding about harm reduction, and the misconception that Mainline merely distributes needles and promotes drug use.

“It’s the term marginalized right. And we are able to just…dismiss it and for many people it’s…about blame, right, and not understanding the roots of addiction and all those kind of…” – Dr. Robert Strang, Chief Medical Officer of Health

“Well there is people out there that really don’t understand Mainline. They think it’s just a needle place, “Here, give these people their needles and let them off.” They got to stop and look. Maybe…there should be something in the paper about this place, you know, let the community know. I know there’s probably people there that don’t know about it, and think negative of it just because it’s a needle exchange. First thing they think “Needles! That’s all they’re giving them is needles needles!” – Denny, Mainline Client

“I think it’s a very important service, I think it’s an essential service. I think that they need to let people know that it’s not promoting drugs...People are going to use regardless, you know, and I think they need to let people know that that’s not what they’re trying to do, they’re not promoting drug use, and they’re not making it something that’s more accessible, they’re just trying to promote people actually using in a safe manner. It’s going to happen anyways, you know what I mean, it’s...harm reduction, right?” – Jill, Mainline Client

Stigma and discrimination around drug use is prevalent not only in the general population, but also among individuals working within the addictions and community services sector. The government approach to drug use is generally based on an abstinence rather than harm reduction model, and there continues to be a lot of misunderstanding around drug use, the root causes, and best practices.

As discussed earlier, the harm reduction environment in Nova Scotia is conservative compared to that in Canada’s larger centres, such as Toronto, Vancouver, and Montreal. There are no supervised injection or smoking sites in the province, for example, or access to heroin prescription for those who do not respond to more traditional opioid replacements. While needle distribution services are highly effective, this places barriers on the potential effectiveness of Mainline and Nova Scotia’s harm reduction efforts. These views are systemic and entrenched and will undoubtedly take time to change.

58 Kirkland et al. (2014). Supra note 41.
As noted by Nova Scotia’s Chief Medical Officer of Health:

“…It’s kind of like this whack-a-mole phenomenon, as opposed to saying well let’s look at the root cause issues and do some things around where we can actually make progress… in prescription heroin and safe injection sites and all those kind of things that actually help bring people into treatment in a much more—treating it as a medical public health issue, and not a criminal justice issue, and then you can start to actually deal with even some of the upstream issues like housing and the housing first model and all those kind of pieces. Those are the things that are actually going to, over time, make a difference, not that we shouldn’t be working at some of the things we’re doing around opioids, but we are just dealing with one problem and potentially creating even a worse problem, which we’ve seen with the fentanyl and the overdose pieces, right.”

“I think there’s still a huge amount of stigma…around what would really help in terms of being able to, as I said earlier… around prescription heroine, around safe injection sites, all those kind of things which need to be part of a suite of harm reduction. I think we have a long way to go to really accept that there’s always going to be some part of society that is—for a lot of reasons is going to get involved in using illegal drugs, injection drugs. How do we manage that and help those people as a health and a social problem and not just the criminal problem…. we’re still entrenched around “these are bad people that need to be punished” kind of approach.”

– Dr. Robert Strang, Chief Medical Officer of Health

Other key informants within government also acknowledged the systemic issues preventing the adoption of best practices.

“I think it remains a conflict in our whole culture, because we have NA and AA that see addiction as a disease, and many people also see addiction as a chronic illness, versus just a disease and something that you can recover from. I think there are some systematic issues that unfortunately mean that people aren’t necessarily following the most and best of promising practices.” – Government Partner

Comments made by Mainline staff and community partners commonly underscored the challenges of working within a broader health and community services system that fails to provide comprehensive, seamless and client-centred care for society’s most vulnerable populations. From a systems perspective, there is no provincial leadership for harm reduction and a lack of integration and collaboration for adequately addressing drug use and STBBIs. Examples provided included: The government’s elimination in 2015 of the income assistance special diet allowance for many of Mainline’s clients; delays between the detox intake interview, follow-up appointment and treatment process; and mental health and addiction service holiday closures.
3.6 Consequences

Using data collected from Mainline’s database and client and partner/stakeholder interviews, this section assesses the possible consequences that the provincial government, the PWID community and the population at large could face if services such as Mainline and affiliated harm reduction initiatives did not exist.

3.6.1 Increased marginalization and vulnerability

While not a panacea for drug use, Mainline and its affiliated harm reduction initiatives (e.g. Direction 180, MOSH) provide an essential service to the most marginalized and vulnerable populations in HRM and, to a lesser extent, other communities across mainland Nova Scotia. In addition to drug use, Mainline’s clients face multiple challenges, including poverty, unemployment, lack of stable housing, legal issues, poor physical health, and mental illness. Many are infected with or at risk for HIV, HCV, HBV and other STBBI’s. They are discriminated against and stigmatized, and tend to avoid access to traditional prevention and treatment health services.

As documented over the course of this evaluation, Mainline provides a safe place for persons who use drugs to access prevention and treatment information and referrals, risk reduction equipment, as well other services to meet their various complex needs. Further reduction or discontinuation of this harm reduction service would lead to increased marginalization and vulnerability among Nova Scotia’s already most disadvantaged individuals.

Mainline provides access to more than 900,000 clean needles/syringes, 25,000 condoms, and 9000 safer crack pipes annually. The elimination of the service would result in less access to information, education and safer sex/drug use supplies. The direct impacts on physical health would be far-reaching, potentially resulting in the following as well as other consequences:

- Increased transmission of HIV/AIDS, Hepatitis C, and other STBBI’s
- Increased health complications related to drug use (e.g. abscesses, cellulitis, endocarditis, deep vein thrombosis, and injuries to the lips and mouth)
- Increased death, disability and injury from opioid overdose; greater risk of adverse drug reactions and overdose from other drugs
Mainline staff can be important role models in risk reduction and recovery. Through the establishment of trusting relationships, they are able to empower and provide hope to their clients. They facilitate access to a multitude of other essential health and social services, including those related to housing, food, legal aid, education and employment, mental health, and primary healthcare. Mainline plays a key role in the stabilization and social integration of their clients. The loss of Mainline would likely result in a host of psychosocial and legal issues, including but not limited to:

- More income, housing and social problems
- Fewer education and employment opportunities
- More physical, emotional and mental health problems
- Reduced access to methadone maintenance therapy
- Ongoing use of illegal substances
- More involvement in the criminal justice system

### 3.6.2 Broader community effects

As demonstrated in sections 3.2 and 3.3, Mainline is a force within Nova Scotia’s harm reduction environment. Through its emphasis on best practices, advocacy, partnership development, as well as its involvement in policy development and research initiatives, Mainline has been a key pillar in harm reduction innovation since 1992. The eradication of Mainline would have a significant impact on the broader community. Examples of potential consequences are provided below:

- Increased needle/syringe debris
- Reduced community health and safety
- Increased street involvement
- Increased crime and incarceration
- Less informed health and social service providers
- Less informed community partners (“eyes and ears to the ground”)
- Less lived-experience involvement in surveillance and best practices research
- Less informed policy and decision makers
- Increased government costs, particularly in the areas of health, public safety, and corrections

As documented by the research presented earlier in section 3.0, needle and syringe programs are effective at preventing HIV and HCV and have a myriad of other cost-saving impacts. The potential consequences of losing Mainline service were corroborated by key informants:

> “I think there would be a horrific boom in the HIV epidemic, for sure, that’s probably—also with Hep C, even more so, with the sharing of needles. I think...more people in jail...more people hurt. Because you’re desperate out there, you really are desperate.”
> 
> – Diane Bailey, Mainline Director

> “If we didn’t have these programs, how much more would we be spending in policing, in health services, all those kind of pieces right.” – Dr. Robert Strang, Chief Medical Officer of Health
3.7 Moving Forward and Sustainability

This section explores the likely plans for the future of the harm reduction system in Nova Scotia, specifically Mainline, with regard to factors such as funding, programming and capacity building, as suggested by key informants.

The key to Mainline’s sustainability is sufficient and stable funding. Mainline is currently operating at its fiscal limit in providing basic harm reduction services to clients and to the broader community of at-risk individuals. As previously discussed, its operating budget has not kept up with the demand or need for services and supplies, which has increased markedly over the years, and continues to rise steadily. As a small front-line service run by individuals with lived experience, the ongoing need to seek out and apply for additional funds has significant implications on organizational capacity and programming. Insufficient financial resources necessitates limiting the supply of safer drug use/sex materials available to clients, and hinders the ability to follow best practice recommendations, thereby increasing the risk of various infections and disease.

The lack of sufficient and stable funding has resulted in Mainline’s inability to maintain the services at a level provided in 2013–2014 when they received an additional $100,000 from DHW, bringing their operating budget to $380,000. In addition to limiting the number of supplies to clients, Mainline has had to scale back its Friday office hours, and eliminate an outreach run on Saturday. It has also had to decrease some of the relevant services provided through the Wellness Navigator initiative. Thanks to the $60,000 received from DHW in January 2016, Mainline will not need to scale back further this fiscal year by closing on weekends and further reducing outreach services. Nonetheless, continually operating with insufficient resources clearly jeopardizes the health and wellness of their clients and other vulnerable populations, and certainly runs counter to the NSACA’s recommendation to increase access to harm reduction services, especially beyond the Halifax Regional Municipality and in rural areas.

Rather than reducing or eliminating services, Mainline strives to enhance its programming. Acknowledging that its provincial outreach program is insufficient to adequately meet the needs of vulnerable populations across mainland Nova Scotia, funding restricts Mainline to travelling only once or twice a month to the various outlying areas. There are also some areas in Nova Scotia (e.g. the Counties of Guysborough and Antigonish) that Mainline is not able to visit at all. Sufficient and stable funding would enable Mainline to deliver a more comprehensive suite of harm reduction services.

It will be important for Mainline to determine how it can best align itself with other organizations in the interest of further service integration, collaborative partnerships, and maximizing the use of limited resources in the long term. Mainline works within a broader provincial system, including government and community stakeholders that are also vested in STBBI prevention. In moving forward, it will be important for all parties to consider how to build stronger leadership and accountability for equitable access to health promotion and disease prevention within an integrated population health/harm reduction approach.
Another important consideration in moving forward is succession planning. Having been involved since the program's inception in 1992, the Director of Mainline has been a pillar in the harm reduction community, having worked tirelessly as educator, supporter, leader, mentor, and advocate. The sustainability of any organization is related to the ability to effectively transition for the eventuality of when a long-time leader or other key people leave an organization. A succession plan is essential for service continuity and on-going effectiveness.

The growth and sustainability of Mainline may also be impacted by the conceptual shift for greater service integration and collaboration across organizations and sectors. As mentioned at the onset of this document, PHAC’s funding structure will be shifting in April 2017 so that resources currently allocated separately to the community response to HIV and Hepatitis C will be integrated into the new Community Action Fund (CAF). As highlighted throughout this document, Mainline already collaborates very closely with various partners such as Direction 180 and MOSH. While direct health service delivery activities falling under municipal or provincial/territorial jurisdiction will not be eligible for funding, there are many activities that Mainline and its partners perform that may well fit within the new CAF structure (e.g. capacity and skills building for people who use drugs).
4.0 Summary and Recommendations

The evaluation finishes with some key findings resulting from the data collection, as well as with some recommendations and considerations informed by the findings.

4.1 Summary

Injection drug use remains a public health issue in the province of Nova Scotia. Mainline provides an essential service that not only supports the health and wellness of people who inject drugs, but also saves lives. The benefits to the broader community are also clear. In addition to reducing the risk of exposure to HIV, HCV and other STBBIs among the population at large, harm reduction services have been shown to enhance community health and safety, reduce rates of crime and incarceration and, among other benefits, reduce government costs.

There was unanimous support among those interviewed for the harm reduction work that Mainline does in the community. The organization has a multitude of key strengths including, but not limited to: the lived experience of staff; the effective delivery of peer-based knowledge and support; an in-depth knowledge of drug use, drug culture, and harm reduction best practices; strong relationships with key community, government and research stakeholders; exceptional dedication, passion and compassion; innovation and creativity; and multiple successes in enhancing Nova Scotia’s harm reduction landscape.

Mainline is recognized as an innovator and at the forefront of virtually every harm reduction initiative introduced in Nova Scotia. Clients and partners alike praised the dedication and relentless work of Mainline’s staff to meet the needs of people who use injection drugs in Nova Scotia. The focus on non-judgemental support provided by people with lived experience and “meeting clients where they are at” means that Mainline stays grounded in serving those most marginalized and those most in need.

Despite Mainline’s work, the need for harm reduction services continues to increase. This is evident by the steady increase in the number of contacts, referrals, and supplies distributed by Mainline every year. Mainline’s strengths, such as being independent from the formal health care system, their street credibility, and their ability to advocate without restraint, are also often what makes them vulnerable in terms of sustainability.

The lack of consistent stable funding has placed Mainline in a position of constantly adding and taking away services and programs as funding dictates, and they lack the institutional supports that many organizations take for granted. The continual need to apply for funding also detracts from what they do best, which is providing front-line service to their clients. As evidenced by their budgetary shortfall in FY 2015-2016, a total of $400,000 in funding from DHW and the NSHA is insufficient to operate as effectively and efficiently as possible. A more realistic budget, aligned with Mainline’s experience, as well as the previously cited recommendations from Australian research on cost effectiveness of NSPs, is presented in Appendix C.
In moving forward, it will be important for Mainline to work closely with its community and government partners to maximize the efficient use of resources in order to reduce the transmission of HIV, Hepatitis C, and other sexually transmitted and blood borne infections throughout Nova Scotia, including the less serviced rural areas. In particular, greater involvement with the health system (i.e. DHW, NSHA) and other government partners could lead to the generation of a stable funding model; greater involvement with community partners could lead to better integration of services and more seamless care for clients.

The recent change in the federal government gives new hope to those who work in harm reduction. As mentioned earlier, the previous “Harper Government” was known for its prohibitionist approach to drug policy and its stance against harm reduction. In contrast, the new Liberal Government campaigned on a promise of “evidence-based decision-making,” and its leader has spoken in support of Vancouver’s Insite supervised injection facility. It is hoped that this shift from ideology-based to evidence-based policy development will reach and serve to strengthen front-line organizations such as Mainline and Direction 180.

4.2 Points for Consideration, Recommendations

In this final section we respectfully offer points for consideration. These points and associated recommendations arose from the evaluation itself, and have been both discussed and endorsed by the Steering Committee.

The following points are recommended for consideration by Mainline, and are listed under four categories: (1) General Internal Considerations; (2) Internal Considerations for Increasing Efficiencies; (3) External Considerations for Increasing Efficiencies; and (4) Broader Systemic Considerations.

General Internal Considerations

- While governance was not a main focus of this evaluation, Mainline’s vision and mission statements should be revisited to be sure that they are relevant, succinct, and on point. While doing so, the broader aspects of its governance model could be examined to ensure optimal effectiveness in moving forward and sustainability.

- Mainline’s data collection system is an essential reporting tool, however there are deficiencies in terms of being able to interpret the data. As previous mentioned, the “no questions asked” approach results in much of the data being based on speculation until a client self-discloses. This approach is valuable, however, and central to Mainline’s ability to create a safe environment for building trust and meaningful relationships.

Other aspects of Mainline’s data collection merit closer consideration. For instance, it is not possible to differentiate the number of individual clients from the number of client contacts;

the gender/sex category does not capture transpersons; and some of the categories listed under “drugs of choice” are ambiguous—e.g. “methadone” includes clients on MMT, as well as those who obtain the drug on the street; the “other drug” category is very broad and captures virtually all (95%) contacts. As such, it may be helpful for Mainline to revisit some of the categories used in the collection of demographic and drug use data. When considering the options, it is important to keep in mind that Mainline is a small client-centred organization, and that any data collected should serve to enhance capacity, rather than hinder front-line work.

• Lived-experience is the cornerstone and greatest strength of Mainline — trust and credibility are paramount. For this reason, Mainline does not have volunteers. It pays its clients to help out when resources permit. In addition to facilitating trust and street credibility, this model provides much-needed, albeit sporadic, employment and income for those who need it most. However, it also limits a potential pool of people without lived-experience who would be willing to volunteer (e.g. students).

Although Mainline has previously involved students, it may be worthwhile to consider doing so more regularly to assist in the background. Examples of tasks which may be appropriate include, but are not limited to: administration, purchasing supplies, bookkeeping, as well as proposal and report writing.\(^6^0\) The regular involvement of student volunteers should be considered only if resulting in a win-win situation for both Mainline and students. Volunteer management can be challenging and time consuming, and would likely best be accomplished with a larger staff complement, including a research assistant, as recommended in the budget presented in Appendix C.

• Advocacy cannot be put on the back burner, yet this requires resources, skills, and incredible fortitude. Education is the foundation from which to increase awareness and reduce stigma, and Mainline has played a key role. The health system, the education system, and the justice system are the key foci for this work. Education and awareness raising can get put aside when there are competing urgent issues, crises, and funding challenges. As a small step, it is suggested that a “fact sheet” or “myth busting” link be included on Mainline’s webpage for access by the general public and journalists.

• The call for letters of intent (LOIs) under PHAC’s new HIV and Hepatitis C Community Action Fund is currently underway.\(^6^1\) An overview of the funding priorities indicates that Mainline may well be positioned to apply under the new funding structure which lists persons using drugs as a priority population, and front-line activities — including interventions to prevent new infections and promote health as well as capacity and skills building—as key areas of action. Further discussion is warranted as to how Mainline could best be supported with PHAC funding.

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\(^6^0\) Students have previously been involved in conducting an economic evaluation and developing a logic model for Mainline. In moving forward, one member of the Steering Committee indicated that tasks such as proposal and report writing could be carried out by her third year students in a class titled “Drugs, health and society.”

• Labour-intensive programs such as the Wellness Navigator were hailed as highly successful by staff and clients. The success of this program in particular was related to not just the provision of services, but the transfer of essential life skills to clients. These programs also had the greatest impact in moving clients forward in terms of recovery. Mainline has had to eliminate some of the support provided through this successful initiative due to a reduction in funding. The adequate provision of funding must be reconsidered, as there are no short-cuts to these programs, which are founded on the building of relationships and establishing trust. The eligibility of the capacity building elements of this program under various government programs, especially PHAC’s Community Action Fund, should be explored.

• As mentioned in section 3.7, the sustainability of any organization is related to the ability to effectively transition for the eventuality of when a long-time leader or other key people leave an organization. This is a function of effectiveness governance. To this end, Mainline and MNFC should ensure that a strong succession plan is in place for service continuity and on-going effectiveness.

Internal Considerations for Increasing Efficiencies

• From an allocative efficiency standpoint, it is recommended that Mainline negotiate with NSHA to have all harm reduction materials be supplied directly from NSHA. Mainline currently purchases some of its needles from NSHA. However, there are some sizes not stocked by NSHA which they must purchase from a more expensive supplier. Similarly, while Mainline is able to purchase smaller needle disposal buckets from NSHA, they currently rely on a third party for the larger buckets. The disposal of materials in accordance with the appropriate biomedical waste standards is another cost which could be more efficiently be covered through the use of NSHA’s incinerator, thereby saving thousands of dollars annually.

• Mainline does an outstanding job of collaborating with community partners who are involved directly with vulnerable and marginalized populations, especially Direction 180 and MOSH. While Mainline has excellent relationships with AIDS Service Organizations (ASOs) in New Brunswick, there is less evidence of effective partnerships with ASOs elsewhere in Atlantic Canada. Ways to strengthen these relationships, particularly in Nova Scotia, should be explored.

• More formal collaboration with the Ally Centre and SHARP Advice would lead to greater coverage across the province, greater opportunity for introducing best practices, and less competition for funds. Integration provides an opportunity for Mainline to engage more fully in the provision of seamless care to clients. They should be a central player because they serve the most vulnerable populations, and those at greatest risk of HIV, HCV, and other STBBIs. Yet they are on the periphery, mainly because the bulk of their funding does not come from PHAC, traditionally held by ASOs.

62 NSHA does not regularly stock 1 cc syringes.
External Considerations for Increasing Efficiencies

- Despite the outreach services to multiple sites in the province, much of rural Nova Scotia remains under and unserviced for needle exchange and ancillary services. Additional funding could solve this shortfall, by enabling Mainline to increase its outreach efforts through collaboration and increased partnerships with stakeholders in rural areas (e.g. pharmacies, CBOs, natural helpers).

- Mainline’s budget should optimally be more than doubled to an estimated $970,000 (Appendix C). This would ensure adequate staffing levels, adherence to the best practices recommendations, and increased outreach beyond the Halifax downtown core and in rural areas across mainland Nova Scotia. It would also lead to the amplification of the various personal, community and government benefits underscored throughout section 3 of this report.

Broader Systemic Considerations

- Less conservative harm reduction initiatives available in other Canadian cities (e.g. safe injection sites, community detox) should be added to the option of services in the Atlantic Region.

- Best practices are difficult to maintain in the face of funding constraints. A commitment to maintain an acceptable standard should be agreed upon with the Department of Health and Wellness. To this end, it is recommended that the Standards for Blood Borne Pathogens Prevention developed by the Nova Scotia government in 2004 be revisited and, if appropriate, enhanced and revived to achieve its original intent of guiding long-term improvement in HBV, HCV and HIV prevention efforts.

- It was surprising, given the interviewers’ perspectives and corroborated in the literature that mental health is such an important issue among people who inject drugs, that there were so few referrals to mental health services. According to some of the stakeholders interviewed, many clients are uncomfortable accessing government-based mental health services and, even if willing, face a multitude of other barriers (e.g. they have been exposed to bedbugs). A more thorough picture of mental health issues and challenges among people who inject drugs is warranted.

- Strong leadership, integration and collaboration for addressing STBBIs from a systems perspective will be necessary for maximizing the use of limited resources in the long term. Mainline works within a broader health and community service system, including government and community stakeholders. In moving forward, it will be important for all stakeholders to work together to ensure equitable access to health promotion and disease prevention, with an integrated population health/harm reduction approach.
References


Patterson, B. et al. (2013). Promising Practices in the Engagement of People Living With or At-Risk for HIV/AIDS in Rural Canada.


Appendices

Appendix A. Key Stakeholder Interview Guides

A. Client Interview Guide

1) How long have you been coming to Mainline?

2) How did you first hear about Mainline?

3) What did you think or know about Mainline when you started using their services?

4) How often do you come to Mainline? Can you describe to me what happens on a typical visit to Mainline?

5) Do you refer your friends to Mainline? Why or why not?

6) Has Mainline helped you personally? If so, and if you feel comfortable, can you talk about some ways the services and the staff have helped you in the past or are currently helping you?

7) Do you think Mainline is doing a good job of reaching the people that need their services? If not, how could they do better?

8) Do you think Mainline is helping the community as a whole? How so?

9) What do you feel like Mainline has done, if anything, in terms of increasing education and awareness around addiction and street-involvement?

10) What would you say, if anything, is unique about Mainline?

11) Is there anything different about Mainline compared to other organizations and agencies you go to or know about?

12) What do you think would happen if Mainline didn’t exist?

13) If Mainline had the resources to do/ offer more, what would you suggest to them?

14) Is there anything you would like to add?
B. **Outreach Client Interview Guide**

1) How long have you been using Mainline’s services?

2) How did you first hear about Mainline?

3) What did you think or know about Mainline when you started using their services?

4) How often does Mainline come to see you? Can you describe to me what happens in a typical interaction with Mainline?

5) Do you refer your friends to Mainline? Why or why not?

6) Has Mainline helped you personally? If so, and if you feel comfortable, can you talk about some ways the services and the staff have helped you in the past or are currently helping you?

7) Do you think Mainline is doing a good job of reaching the people that need their services? If not, how could they do better? (Do you think it would be beneficial if they could visit more often?)

8) Do you think Mainline is helping your community as a whole? How so?

9) What do you feel like Mainline has done, if anything, in terms of increasing education and awareness around addiction?

10) What would you say, if anything, is unique about Mainline?

11) Is there anything different about Mainline compared to other organizations and agencies you go to or know about? (What do you find difficult about accessing local health services?)

12) What do you think would happen if Mainline didn’t exist?

13) If Mainline had the resources to do/ offer more, what would you suggest to them?

14) Is there anything you would like to add?
C. **Staff Interview Guide**

1) How long have you been working at Mainline?

2) What is your position at Mainline?

3) What does your position entail?

4) How did you become involved with Mainline?

5) What do you particularly enjoy about your job?

6) What are some challenges you face when trying to do your job effectively?

7) What do you find rewarding about your job?

8) Is there anything you find taxing about your job?

9) Do you work often/closely with other organizations or agencies? How do you find that?

10) How well would you say the Mainline staff work together?

11) Is there anything else that you think that Mainline could be doing to meet the needs of clients? Why do you think it isn’t currently being done?

12) What would it be like if Mainline didn’t exist?

13) Is there anything you would like to add?
D. **Partner Interview Guide**

1) What is the mandate of your organization/agency?

2) Describe the client base that you normally serve.

3) Please describe how your organization works with people with addictions or who are street involved.

4) Have you noticed any changes or trends over time with respect to people with addictions or who are street involved (things like demographics, drugs of choice, disease (HIV, Hep C), etc.)?

5) How does your organization/agency work with or interact with Mainline?

6) What does your partnership with Mainline entail? How do you work together to benefit clients?

7) Have you worked with Mainline staff directly? If so, in what ways?

8) Are you aware of the programs and services that Mainline offers?

9) Is there anything that you think is unique about Mainline?

10) What does Mainline do well?

11) What could Mainline be doing better or more efficiently?

12) If resources weren’t an issue, what types of services/programs do you think they could be doing?

13) If Mainline did not exist, how would it impact the community?

14) Thinking about harm reduction in Nova Scotia, how do you feel the system could be improved upon to better serve target populations?

15) Is there anything that we haven’t asked you about that you would like to add?
E. **Stakeholder Interview Guide**

1) What is the mandate of your organization/agency/Department?

2) Please describe how your organization/agency/Department supports organizations that work with people with addictions or who are street involved.

3) Have you noticed any changes or trends over time with respect to people with addictions or who are street involved (things like demographics, drugs of choice, disease (HIV, Hep C), etc.)?

4) Are you aware of the programs and services that Mainline offers? How do you think they are impacting the community?

5) Is there anything that you think is unique about Mainline?

6) If resources weren’t an issue, what types of services/programs do you think they could be providing?

7) If Mainline did not exist, how do you think would it impact the community?

8) Thinking about harm reduction in Nova Scotia, how do you feel the system could be improved upon to better serve target populations?

9) How is your organization/agency/Department working to improve the harm reduction system in Nova Scotia?

10) In regards to harm reduction, what have the funding trends looked like over time?

11) How have attitudes towards harm reduction changed over time? How and by what mechanisms are they continuing to evolve?

12) Is there anything that we haven’t asked you about that you would like to add?
Appendix B. Outline of Best Practices Recommendations for Canadian Harm Reduction Programs

1. Needle and syringe distribution

**RECOMMENDED BEST PRACTICE POLICIES** To facilitate use of a sterile needle and syringe for each injection and reduce transmission of human immunodeficiency virus (HIV), hepatitis C (HCV), hepatitis B (HBV), and other pathogens:

- Provide sterile needles in the quantities requested by clients without requiring clients to return used needles
- Place no limit on the number of needles provided per client, per visit (one-for-one exchange is not recommended)
- Encourage clients to return and/or properly dispose of used needles and syringes
- Offer a variety of needle and syringe types by gauge, size, and brand that meet the needs of clients and educate clients about the proper use of different syringes
- Educate clients about the risks of using non-sterile needles
- Provide pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently

2. Cooker distribution

**RECOMMENDED BEST PRACTICE POLICIES** To facilitate use of a sterile cooker for each injection and reduce transmission of human immunodeficiency virus (HIV), hepatitis C (HCV), and other pathogens:

- Provide individually pre-packaged, sterile cookers with flat bottoms for even heat distribution and heat-resistant handles in the quantities requested by clients with no limit on the number of cookers provided per client, per visit
- Offer a sterile cooker with each needle provided
- Offer a variety of cookers that meet the needs of clients
- Provide pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently
- Dispose of used cookers and other injection equipment in accordance with local regulations for biomedical waste
- Educate clients about the risks associated with sharing and reuse of cookers and the correct single-person use of cookers
- Educate clients about the proper disposal of used cookers
- Provide multiple, convenient locations for safe disposal of used equipment

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3. Filter distribution

RECOMMENDED BEST PRACTICE POLICIES to facilitate use of a sterile filter for each injection and reduce transmission of human immunodeficiency virus (HIV), hepatitis C (HCV), hepatitis B (HBV), and other pathogens, and to prevent other health complications, such as deep vein thrombosis (DVT), from the non-use and/or reuse of filters:

- Provide pre-packaged, sterile .22 μm filters that retain as little drug solution as possible in the quantities requested by clients with no limit on the number of filters provided per client, per visit
- Offer a filter with each needle provided
- Provide pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently
- Dispose of used filters and other injection equipment in accordance with local regulations for biomedical waste
- Educate clients about the risks associated with not using filters, sharing filters, making ‘washes’ from filters, the risks of bacterial contamination and DVT if a new filter is not used, and the correct single-person use of filters
- Educate clients about the proper disposal of used filters
- Provide multiple, convenient locations for safe disposal of used equipment

4. Ascorbic acid distribution

RECOMMENDED BEST PRACTICE POLICIES to facilitate use of ascorbic acid to dissolve drugs (e.g., crack cocaine, some forms of heroin) and to reduce the risk of vein damage and bacterial and fungal infections associated with use of other types of acidifiers:

- Ask clients if ascorbic acid is required to dissolve the drug(s) to be injected
- If needed, provide single-use sachets of ascorbic acid in the quantities requested by clients with no limit on the number of sachets provided per client, per visit
- If needed, offer acidifiers with each needle provided
- Provide pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently
- Educate clients about the potential HIV- and HCV-related risks associated with sharing acidifiers, the risks of fungal infections associated with using spore-contaminated lemon juice and other acids like acetic acid, and the correct single-person use of acidifiers including instruction on how to determine the amount of acid that is needed to dissolve the drug of choice
- Educate clients about the proper disposal of used acidifiers
- Provide multiple, convenient locations for safe disposal of used equipment
5. Sterile water distribution

**RECOMMENDED BEST PRACTICE POLICIES** to facilitate use of injection-grade sterile water for each injection and reduce transmission of human immunodeficiency virus (HIV), hepatitis C (HCV), hepatitis B (HBV), and other pathogens, and to prevent bacterial infection from the use of non-sterile water and other fluids:

- Provide single-use, 2 mL plastic vials with twist-off caps of sterile water for injection in the quantities requested by clients with no limit on the number of vials provided per client, per visit. If 2 mL vials of sterile water for injection are not available, distribute the smallest size of vial available.
- Offer a sterile water vial with each needle provided.
- Provide pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently.
- Dispose of empty water vials in accordance with local regulations for biomedical waste.
- Educate clients about the HIV- and HCV-related risks associated with sharing mixing and rinse waters, the risks of using non-sterile water (such as tap, bottled, rain, puddle, and urinal water) and other fluids (such as saliva and urine), and the correct single-person use of mixing and rinse water.
- Educate clients about the proper disposal of used water.
- Provide multiple, convenient locations for safe disposal of used equipment.

6. Alcohol swab distribution

**RECOMMENDED BEST PRACTICE POLICIES** to facilitate use of sterile alcohol swabs for each injection to reduce transmission of human immunodeficiency virus (HIV), hepatitis C (HCV), and other pathogens, and to prevent bacterial infection from the reuse or non-use of swabs:

- Provide single-use, individually pre-packaged, and sterile alcohol swabs in the quantities requested by clients with no limit on the number of swabs provided per client, per visit. If clients request large quantities of alcohol swabs, make efforts to ensure that the swabs are being used for injection and not for the consumption of the non-beverage alcohol in the swabs.
- Offer sterile alcohol swabs with each needle provided.
- Provide pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently.
- Dispose of used alcohol swabs and other injection equipment in accordance with local regulations for biomedical waste.
- Educate clients about the HIV- and HCV-related risks associated with sharing swabs, the risks of bacterial infection if the injection site is not cleaned with an alcohol swab prior to injection, and the correct single-person use of swabs.
- Educate clients about the proper disposal of used swabs.
- Provide multiple, convenient locations for safe disposal of used equipment.
7. **Tourniquet distribution**

**RECOMMENDED BEST PRACTICE POLICIES** to facilitate use of a clean tourniquet for each injection and reduce the potential for contamination of tourniquets with bacteria that can cause illness and abscesses (e.g., MRSA), and to reduce trauma to veins and blood circulation impairment:

- A tourniquet is considered unclean and needs to be replaced when: there is visible blood and/or dirt; it has ever been used by someone else; there is a loss of elasticity
- Provide thin, pliable, easy-to-release, non-latex tourniquets with non-porous surfaces in the quantities requested by clients with no limit on the number of tourniquets provided per client, per visit
- Offer tourniquets with each needle provided
- Provide pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently
- Dispose of used tourniquets and other injection equipment in accordance with local regulations for biomedical waste
- Educate clients about the risks of bacterial contamination and HIV- and HCV-related risks associated with the reuse and sharing of tourniquets, the risks of tissue and vein damage and blood circulation impairment if a clean, quick-release tourniquet is not used, and the correct single-person use of tourniquets
- Educate clients about the proper disposal of used tourniquets
- Provide multiple, convenient locations for safe disposal of used equipment

8. **Safer crack cocaine smoking equipment distribution**

**RECOMMENDED BEST PRACTICE POLICIES** to facilitate smoking with a pipe—stem, mouthpiece, and screen—which is made from materials that are non-hazardous to health and have never been shared.

- Provide safer smoking equipment - stems, mouthpieces, screens, and push sticks - in the quantities requested by clients without requiring clients to return used equipment
- Make available both pre-packaged kits and individual pieces of equipment
- Integrate distribution of safer smoking equipment into existing harm reduction programs and services, including within needle and syringe programs (NSPs)
- Provide safe disposal options, including personal sharps containers, and encourage clients to return and/or properly dispose of used or broken pipes
- Provide other harm reduction supplies, such as condoms and lubricant, in the quantities requested by clients with no limit on the number provided
- Educate clients about safer use of equipment, safer smoking practices, the risks of sharing smoking supplies, and safer sex
- Educate clients about the proper disposal of used safer smoking equipment
- Provide multiple, convenient locations for safe disposal of used equipment
9. Disposal and handling of used drug use equipment

**RECOMMENDED BEST PRACTICE POLICIES** to facilitate disposal of all used injection equipment (i.e., needles/syringes, cookers, filters, swabs, tourniquets) and non-injection equipment (i.e., stems, mouthpieces, screens, other smoking and inhalation devices) in accordance with local, provincial/territorial, and federal regulations regarding disposal of biomedical waste and to prevent needlestick and/or sharps-related injuries to staff members, clients and others:

- Regular review and assessment of compliance with local, provincial/territorial and federal regulations regarding collection, storage, transportation, security and disposal of biomedical waste
- Educate clients and staff members on how to properly handle, secure and dispose of used injection and non-injection equipment
- Encourage clients to return and/or properly dispose of used injection and non-injection equipment
- Provide clients with tamper resistant sharps containers in a variety of sizes
- Provide multiple, convenient locations for safe disposal of used equipment in rural and urban settings. Do not penalize or refuse to provide new equipment to clients who fail to return used drug equipment.
- Visually estimate the amount of returned equipment; staff should not touch used equipment and neither staff nor clients should manually count used equipment
- Encourage staff and clients to be vaccinated against hepatitis B (HBV)
- Provide access to safety devices for staff and procedures for first aid and post-exposure prophylaxis (PEP)

10. Safer drug use education

**RECOMMENDED BEST PRACTICE POLICIES** to facilitate knowledge and application of drug consumption practices that reduce or eliminate the risk of transmission of human immunodeficiency virus (HIV), hepatitis C (HCV), hepatitis B (HBV), and other pathogens; drug overdose; soft tissue injuries; and other drug consumption related harms.

- Provide educational interventions targeted toward reduction of injection-related risk behaviours (e.g., needle and other injection equipment reuse and sharing) associated with HIV and HCV transmission, drug overdose, soft tissue injuries, and other drug consumption related harms
- Provide educational interventions targeted toward reduction of crack cocaine smoking risk behaviours (e.g., pipe reuse and sharing) to reduce smoking-related harms, such as injuries to the mouth and lips, associated with HIV and HCV transmission
- Provide safer drug use education in a variety of formats including one-on-one education, workshops and group education, skills-building sessions, information pamphlets, instructional videos, demonstrations, and other formats as necessary
- Provide peer-delivered, brief interventions, and longer interventions to reach a broad range and diversity of clients
• Develop and evaluate programs to train peers to deliver safer drug use education.
• Involve clients in the design and evaluation of educational materials and interventions to ensure message acceptability, relevance, and comprehension. Tailor education for the populations and contexts served by the program.
• Integrate evaluation of educational interventions into programming to ensure desired impact and to build evidence

11. Opioid overdose prevention: education and naloxone distribution

RECOMMENDED BEST PRACTICE POLICIES to facilitate knowledge and application of opioid overdose prevention strategies, and how to appropriately respond in the event of an overdose (including the use of naloxone if available)

• Educate clients about opioid overdose prevention techniques
• Educate clients about the signs and symptoms of opioid overdose
• Provide first aid and CPR training to clients
• Educate clients about how to respond to an opioid overdose including calling 911
• Assess feasibility and acceptability of a naloxone distribution program
• Partner with multiple community stakeholders to prevent mortality from opioid overdose
• Where naloxone is available, ensure eligible and at risk clients are trained on appropriate use of naloxone and offer kits and training in a variety of locations. Evaluate opioid overdose prevention and response interventions to ensure desired impact and to build evidence
## Appendix C. Optimal Mainline Budget

<table>
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<th>Expense Item</th>
<th>Cost</th>
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<td><strong>Staffing</strong></td>
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<td>Director (1 FT)</td>
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<td>Administrative Assistant (1FT)</td>
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<td>Project Coordinators (3 FT)</td>
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<td>- Hep C and Me</td>
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<td>- Wellness Navigator</td>
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<td>- Mental Health</td>
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<tr>
<td>Outreach Workers (7 PT)</td>
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<td>- $25/hr x 25 hrs/wk (approx..) x 52 wks x 7</td>
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<tr>
<td>Research Assistant</td>
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<td>- Grant writing, report writing, etc. (Not necessary to have lived-experience)</td>
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<tr>
<td><strong>Harm Reduction Materials</strong></td>
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<td>- Needles, condoms, buckets, pipes/stems, disposal costs, etc. (fulfilling best practice recommendations for Canadian harm reduction programs)</td>
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<tr>
<td>- Safety gear (boots), first aid kits</td>
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<td><strong>Outreach Transportation</strong></td>
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<td>- New van</td>
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<td>- Maintenance, safety inspection, insurance, gas, etc.</td>
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<td><strong>Supplies and Services</strong></td>
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<td>- Rent &amp; utilities</td>
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<td>- Office equipment (computers, photocopier, cellphones, etc.)</td>
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<td>- Office supplies (toner, paper, software, etc.)</td>
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<tr>
<td>- Housing support for clients (security deposit, furnishings, etc.)</td>
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<td>- Health promotion fund (healthy food, vitamins, blankets, warm clothing, transportation, etc.)</td>
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