International Journal of Drug Policy 45 (2017) 9–17

Contents lists available at ScienceDirect

International Journal of Drug Policy

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

Editor's Choice

Canadian harm reduction policies: A comparative content analysis of provincial and territorial documents, 2000–2015

T. Cameron Wild[a,*], Bernie Pauly[b], Lynne Belle-Isle[c], Walter Cavalieri[d], Richard Elliott[e], Carol Strike[f], Kenneth Tupper[g], Andrew Hathaway[h], Colleen Dell[i], Donald MacPherson[j], Caitlin Sinclair[a], Kamagaju Karekezi[a], Benjamin Tan[a], Elaine Hyshka[a,k]

[a] School of Public Health, University of Alberta, Canada
[b] School of Nursing and Centre for Addictions Research of BC, University of Victoria, Canada
[c] Canadian AIDS Society and Centre for Addictions Research of BC, University of Victoria, Canada
[d] Canadian Harm Reduction Network, Canada
[e] Canadian HIV/AIDS Legal Network, Canada
[f] University of Toronto, Canada
[g] School of Population and Public Health, University of British Columbia, Canada
[h] University of Guelph, Canada
[i] University of Saskatchewan, Canada
[j] Canadian Drug Policy Coalition, Canada
[k] Inner City Health and Wellness Program, Royal Alexandra Hospital, Edmonton, Canada

ARTICLE INFO

Article history:
Received 20 October 2016
Received in revised form 8 February 2017
Accepted 22 March 2017

Keywords:
Harm reduction
Policy
Content analysis

ABSTRACT

Background: Access to harm reduction interventions among substance users across Canada is highly variable, and largely within the policy jurisdiction of the provinces and territories. This study systematically described variation in policy frameworks guiding harm reduction services among Canadian provinces and territories as part of the first national multimethod case study of harm reduction policy.

Methods: Systematic and purposive searches identified publicly-accessible policy texts guiding planning and organization of one or more of seven targeted harm reduction services: needle distribution, naloxone, supervised injection/consumption, low-threshold opioid substitution (or maintenance) treatment, buprenorphine/naloxone (suboxone), drug checking, and safer inhalation kits. A corpus of 101 documents written or commissioned by provincial/territorial governments or their regional health authorities from 2000 to 2015 were identified and verified for relevance by a National Reference Committee. Texts were content analyzed using an a priori governance framework assessing managerial roles and functions, structures, interventions endorsed, client characteristics, and environmental variables.

Results: Nationally, few (12%) of the documents were written to expressly guide harm reduction services or resources as their primary named purpose; most documents included harm reduction as a component of broader addiction and/or mental health strategies (43%) or blood-borne pathogen strategies (43%). Most documents (72%) identified roles and responsibilities of health service providers, but fewer declared how services would be funded (56%), specified a policy timeline (38%), referenced supporting legislation (26%), or received endorsement from elected members of government (16%). Nonspecific references to 'harm reduction' appeared an average of 12.8 times per document—far more frequently than references to specific harm reduction interventions (needle distribution = 4.6 times/document; supervised injection service = 1.4 times/document). Low-threshold opioid substitution, safer inhalation kits, drug checking, and buprenorphine/naloxone were virtually unmentioned. Two cases (Quebec and BC) produced about half of all policy documents, while 6 cases – covering parts of Atlantic and Northern Canada – each produced three or fewer.

Conclusion: Canada exhibited wide regional variation in policies guiding the planning and organization of Canadian harm reduction services, with some areas of the country producing few or no policies. Despite a wealth of effectiveness and health economic research demonstrating the value of specific harm reduction

* Corresponding author at: School of Public Health, University of Alberta, Edmonton, AB T6G 2T4, Canada.
E-mail address: cam.wild@ualberta.ca (T. C. Wild).

http://dx.doi.org/10.1016/j.drugpo.2017.03.014

interventions, policies guiding Canada from 2000 to 2015 did not stake out harm reduction interventions as a distinct, legitimate health service domain.

Contents

Introduction

Health system decision making increasingly relies on instrumental-rational arguments to inform policies designed to allocate scarce resources to services. In these deliberations, principles and tools of evidence-based medicine, including results from randomized controlled trials, systematic reviews and meta-analyses, and health-economic evaluations of services are prioritized (Donaldson, Mugford, & Vale, 2002; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1995). On the surface, the substantial evidence base supporting the positive population impact and cost-effectiveness of harm reduction interventions (Kimber et al., 2010; Rhodes & Hedrich, 2010; Strang et al., 2012; Ritter & Cameron, 2006) should translate into relatively straightforward policy support for the uptake of harm reduction as a routine component of health systems and services. However, when decisions regarding harm reduction services for people who use drugs are at issue, evidence-based considerations are often less influential than political issues regarding implementation (Hathaway & Tousaw, 2008; Hathaway, 2001). This is particularly true in Canada and other North American jurisdictions, where harm reduction services continue to be highly contentious in many contexts and access to them is at best variable (e.g. Cooper et al., 2012; Dias & Betteridge, 2007; MacNeil & Pauly, 2010; Parker, Jackson, Dykeman, Gahagan, & Karabanow, 2012; Tempalski et al., 2007; Tempalski & McQuie, 2009).

It is widely acknowledged that health policy recommendations for services are influenced by attitudes, values, and sociopolitical dynamics in addition to quality of the scientific evidence (Pettiti, 2012; Steinberg & Luce, 2005). However, harm reduction researchers and advocates typically construe these factors narrowly, as barriers to effective uptake of evidence, rather than objects of enquiry (DeBeck & Kerr, 2010; Fafard, 2012). In contrast, we propose that research on attitudes, values and sociopolitical factors per se can enhance understanding of policymaking decisions. In this context, the contested nature of harm reduction services suggests that they form a prototypical example of *morality policy* in the health arena, i.e., policymaking that involves clashes of core values about the legitimacy of providing certain kinds of services to a target population (Bowen, 2012; Euchner, Heichl, Nebel, & Raschzok, 2013; Heichel, Knill, & Schmitt, 2013; Strike, Myers, & Millson, 2004). From this perspective, policymaking that guides harm reduction services is highly resistant to instrumental-rational arguments that rest on evidence related to effectiveness and health economics. This may contribute to haphazard endorsement and implementation of harm reduction services in many jurisdictions. Understanding the sources of such variable implementation requires data informing how a range of policy stakeholders construe highly contested moral, value-laden discourses about people who use drugs and their right to access health services.

The present research is a component of the Canadian Harm Reduction Policy Project (CHARPP), a mixed-method, multiple-case study drawing on four data sources (policy documents, key informant interviews, media portrayals, and a national public opinion survey) to describe how policies governing harm reduction services are positioned within and across Canadian provinces and territories. As part of CHARPP, we undertook a systematic review of Canadian policy frameworks used for the planning and delivery of harm reduction services. Instead of a review of front-line practices, our focus was to describe and compare Canadian governance for harm reduction services, where *governance* refers to " . . . regimes of laws, rules, judicial decisions, and administrative practices that constrain, prescribe, and enable the provision of publicly supported goods and services" (Lynn, Heinrich, & Hill, 2001, p. 7).

Methods

A comprehensive search of Canadian provincial and territorial government and health authority harm reduction policy documents was performed, followed by a comparative content analysis of policy texts across jurisdictions.

Cases and scope

A multiple case study design was used to address the research objective. This approach is appropriate because we are studying