

Alberta Policy Analysis Case Report

Canadian Harm Reduction Policy Project
July 2017

This research was conducted as part 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 the 13 Canadian provinces and territories.

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Table of Contents

- 1.0 Overview 4
 - 1.1 Contextual Background 4
 - 1.2 Health Care Governance..... 5
 - 1.3 Substance Use Trends..... 6
 - 1.4 Harm Reduction Services in Alberta 6
- 2.0 Methods..... 7
- 3.0 Documents Retrieved 10
- 4.0 Results: Inductive Analysis of Documents 10
 - 4.1 Harm reduction is inconsistently defined and understood within current provincial policy documents 10
 - 4.1.2 Definitions in STBBI Policy 12
 - 4.1.3 Definitions in Addiction and Mental Health Policy..... 14
 - 4.1.4 Summary..... 15
 - 4.2 The provincial approach to addressing STBBI prevention has shifted in recent years to include less direct consideration of Aboriginal issues..... 15
 - 4.2.1 Aboriginal Populations and Harm Reduction 15
 - 4.2.2 Summary..... 17
 - 4.3 Provincial policy documents reflect a less comprehensive acknowledgement of harm reduction in recent years, compared to historical policy documents 17
 - 4.3.1 Summary..... 19
 - 4.4 Policy documents reflect a low level of commitment to and follow-through of harm reduction initiatives 19
 - 4.4.1 Follow-Up Reports 20
 - 4.4.2 Roles and Responsibilities 20
 - 4.4.3 Summary..... 21
- 5.0 Results: Deductive Analysis of Current Documents (Policy Report Card)..... 22
- 6.0 Conclusion..... 26
- Appendix A: Geographical Service Zones..... 27
- Appendix B: Systematic search strategy flow diagram..... 28
- Appendix C: Standard methodology for generating provincial/territorial case report 29
- Appendix D: Descriptive summary of current policy documents 32
- References 33

1.0 Overview

This document provides a descriptive and analytical account of Alberta's provincial harm reduction policy documents produced between 2000 and 2015. This account is part of the Canadian Harm Reduction Policy Project (CHARPP), a multimethod case study comparing provincial/territorial harm reduction policies across Canada. Alberta results reported in this document will be summarized and integrated into a national-level report that outlines key features of each set of provincial/territorial policies and compares the strength of each case's policy commitment to harm reduction services.

This document begins with an overview of Alberta's harm reduction policy context including: governance, healthcare delivery structures, substance use trends and harm reduction programming. A brief overview of the methodology is provided, followed by a descriptive table of the policy documents retrieved through a systematic search. The remainder of the document summarizes findings obtained from an inductive and deductive analysis of Alberta's harm reduction policy documents.

In the inductive analysis, historical policy changes are reflected upon to highlight shifts, gaps, and the evolution of harm reduction policies in the province. **Four key findings are highlighted:** 1) Harm reduction is inconsistently defined and understood within provincial policy documents; 2) the provincial approach to addressing sexually transmitted and blood-borne infections (STBBI) prevention has shifted in recent years to include less direct consideration of Aboriginal issues; 3) provincial policy documents reflect a less comprehensive acknowledgement of harm reduction in recent years, compared to historical policy documents; and 4) policy documents reflect a low level of commitment to and follow-through of harm reduction initiatives. In the deductive analysis, a set of criteria were applied to Alberta policy documents. Results are presented in a standardized policy report card.

1.1 Contextual Background¹

Alberta is one of three Prairie Provinces in Canada, spanning 661 185 square kilometers (Government of Alberta, 2016a). It has a population of 4.2 million (Statistics Canada, 2015), with two major cities: Edmonton (population 900 000) and Calgary (population 1.4 million) (Government of Alberta, 2016a). Historically, Alberta has been governed by conservative political parties. However, the 2015 provincial election resulted in the New Democratic Party, led by Premier Rachel Notley, forming a majority government. This ended 44 years of successive Progressive Conservative governments in Alberta. While conservative politicians in Alberta have traditionally shied away from public endorsement of a harm reduction approach

¹ Contextual information in sections 1.1 to 1.4 is current up to the end of 2016.

to illicit drugs, Alberta's current Health Minister (2015 – present), Sarah Hoffman, has repeatedly expressed support for the approach and called for increased access to harm reduction services in the province (Henton & Varcoe, 2016). Whether or not this enthusiasm for harm reduction translates into formal policy documents (many related policies and strategies end in 2016), remains to be seen.

1.2 Health Care Governance

Currently, there are two major institutions that influence healthcare policy and delivery in Alberta; Alberta Health² (AH) and Alberta Health Services (AHS). Alberta Health is a Government of Alberta ministry that sets the provincial direction, policy, legislation, and standards for the delivery of healthcare in the province. Prior to 2008, healthcare was delivered by nine regional health authorities³, two provincial health boards⁴ and the Alberta Alcohol and Drug Abuse Commission (AADAC), all three of which were arms-length bodies independent of government. In 2008, all of these authorities and boards were merged into a single provincial health authority, AHS.

AHS is responsible for the delivery of health care services throughout the province, which it divides into five geographical service zones; North Zone, Edmonton, Central, Calgary Zone and South Zone (see Appendix A for further information). AHS further divides these service zones into 132 Local Geographical Areas (LGAs), in which AHS employs over 108 000 employees, 99,900 of whom are direct employees. Within 106 acute care hospitals, five psychiatric facilities, and 42 primary care networks, AHS has 8,471 acute care beds, 23,742 continuing care beds, 208 community palliative and hospice beds and 2,439 addiction and mental health beds (Alberta Health Services, 2016a). While AH sets policy at the provincial level, AHS also provides a policy function insofar that it sets strategic direction for healthcare delivery (in line with AH direction), responding to emerging trends through collaboration with stakeholders in each of the five healthcare delivery zones. The Minister of Health, Sarah Hoffman, and the Alberta Health Services Board oversee the operation of AHS, which has been led by President and CEO Dr. Verna Yiu since January 2016 (Alberta Health Services, 2016b).

Of note, in October 2015, Hoffman introduced new members of the AHS board, which included Marliss Taylor (Government of Alberta, 2015a). Taylor is the Program Manager at Streetworks, a needle exchange and outreach program in Edmonton's Inner City; her inclusion on the AHS

² Alberta Health (AH) was formerly named Alberta Health and Wellness (AHW); AH will be used throughout the document.

³ Chinook Health Region, Palliser Health Region, Calgary Health Region, David Thompson Health Region, East Central Health Region, Capital Health Region, Aspen Health Region, Peace Country Health Region, Northern Lights Health Region

⁴ Alberta Mental Health Board; Alberta Cancer Board

board is significant, suggesting commitment from the Minister to harm reduction. Further to this, in November 2015, Sarah Hoffman discussed Taylor's board position and her important work in harm reduction in the Legislative Assembly of Alberta (Government of Alberta, 2015b, p. 423).

1.3 Substance Use Trends

According to data drawn from the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS, 2012), 46.4% of Albertans reported lifetime use of one or more illicit drugs. Over their lifetime, 7.3% of Albertans reported using cocaine/crack, 14.9% reported using hallucinogens, and 4.8% reported using ecstasy. From CADUMS, Albertans also reported on drug use in the past 12 months; 12.1% reported using at least one illicit drug in the past year, while 11.6% reported using one of the following illicit drugs: cannabis, cocaine/crack, speed, ecstasy, hallucinogens or heroin (Health Canada, 2012). In 2010, 2.2% of Albertans reported experiencing harm from their own drug use; this involves experiencing one or more types of harms (e.g. physical, emotional, financial, etc.) related to substance use over the past 12 months. While these numbers are generally consistent with national trends (e.g. 43.2% of Canadians have used at least one illicit drug in their lifetime; 11.3% of Canadians have used at least one illicit drug in the past 12 months; 2.0% of Canadians report experiencing harm related to drug use) (Health Canada, 2012), Alberta has recently experienced an increase in overdose deaths, specifically related to the use of fentanyl. In 2016, 343 people died from an overdose linked to fentanyl, a 33% increase from the year prior, in which 272 people died (Logan, 2017). This compares to 120 deaths in 2014, 66 in 2013, 29 in 2012 and 6 in 2011 (Southwick, 2016).

1.4 Harm Reduction Services in Alberta

The Alberta Community Council on HIV (ACCH) is a non-profit, provincial network of organizations that work to prevent the spread of HIV and other STBBIs. In 2012, they began a bulk harm reduction supplies purchasing and distribution program, through which they supply harm reduction equipment to select agencies and service providers in the province. In 2013-14, they distributed 1,988,100 needle and syringes, 6,563 sharps containers, 733,000 sterile waters, 360,000 cookers, 7,251,000 alcohol swabs, 422,850 filters, 735,396 condoms, and 105,168 lubricants (Alberta Community Council on HIV, 2014).

AH funds seven harm reduction programs in the province which operate in eight cities and various satellite locations: Safeworks (Calgary), Streetworks (Edmonton), Turning Point (Red Deer), HIV North Society (Grande Prairie and Fort McMurray), ARCHES (Lethbridge), HIV West Yellowhead (Edson) and the HIV Community Link (Medicine Hat) (Government of Alberta, 2016b). These programs provide a range of services, including distribution of harm reduction supplies, outreach and counselling, health services and housing. In particular, Streetworks was

the first organization in Canada to initiate a take home naloxone program (introduced in 2005), in which naloxone is prescribed by a physician and clients receive overdose prevention training.

Methadone maintenance treatment (MMT) is delivered in various ways in Alberta. There are eight MMT clinics in Alberta, two of which are provincially funded and operated through AHS (Edmonton and Calgary opioid dependence programs) and six of which are private group practices. MMT is also delivered through private practice in primary care settings, and in provincial prisons. There were over 2000 patients in MMT in Alberta in 2009, with approximately 80 physicians with exemptions to stabilize patients on methadone (only 20 physicians, however, have an exemption to initiate patients on MMT) (Luce & Strike, 2011).

In 2016, the Alberta government promised almost \$750,000 to several advocacy groups across the province to fund preliminary work on developing supervised consumption sites, including locations in Edmonton and Calgary (Zabjek, 2016). The funding is intended to help cover costs of necessary community consultation and preparing formal applications to the federal government.

2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. Documents produced for Alberta during this period were (a) analyzed and synthesized inductively to describe historical and current policy developments guiding harm reduction services in the province over this time period, and (b) reviewed collectively and evaluated using a deductive coding framework comprised of 17 indicators, assessing the quality of harm reduction policies in order to facilitate cross-case comparison.

2.1 Search Process

A separate paper provides complete methodological details regarding the National search process (Wild et al., 2017). Systematic and purposive search strategies identified and verified publicly-available policy documents produced from 2000 – 2015. We defined relevant documents as harm reduction policy texts that (1) were issued by and representing a provincial or territorial government or (2) issued by and representing a regional, provincial, or territorial delegated health authority; (3) that mandated future action; and (4) that addressed one of seven targeted harm reduction interventions⁵ or (5) were produced as either a stand-alone

⁵ The seven harm reduction interventions of interest to this research are 1) syringe distribution, 2) Naloxone, 3) supervised consumption, 4) low threshold opioid substitution, 5) outreach, 6) drug checking, 7) safer inhalation kits.

harm reduction policy or as part of a strategy document guiding services for substance use, addiction, mental health, and/or prevention of blood-borne or sexually transmitted infections. We excluded documents that described services at the municipal level, in prisons, and on First Nation reserves (where health services are the responsibility of the federal government). Additionally, given our focus on provincial and territorial policy frameworks, and not harm reduction practice, we excluded government or health authority authored documents exclusively focused on best practice guidelines for frontline service providers.

Four current⁶ and five historical⁷ documents were identified and analyzed using a two-step (inductive and deductive) process described below (Appendix B provides the Alberta -specific search strategy).

2.2 Inductive Analysis

Each of the nine documents was analyzed using a three-step process (Appendix C provides analytic details). First, relevant text⁸ was extracted from each policy document and analyzed, resulting in a set of analytic notes. The focus of the analytic notes was primarily descriptive and instrumental (i.e., generating a deeper understanding of the intent and purpose of the policy document and the relevant stakeholders and their roles). Next, each document's analytic notes and a set of accompanying quantitative data (see Appendix C) were synthesized and compiled into a narrative document description. Finally, all narrative document descriptions for the case were synthesized and compiled into a single document. This resulted in a descriptive summary, describing the main themes and trends in Alberta's set of harm reduction policy documents over the 15-year study period.

2.3 Deductive Analysis

We developed the CHARPP framework, a set of 17 indicators, to assess the quality of policy documents based on how well they described key *population characteristics* and *program features* of a harm reduction approach. To develop the CHARPP framework, a list of indicators was generated based on key harm reduction principles outlined by the International Harm Reduction Association (2010) and the World Health Organization (WHO, 2014). These indicators were refined through consultation with a working group of harm reduction experts from across Canada to ensure they reflected quality indicators of harm reduction policy in Canada.

⁶ A document was considered current when (1) the policy was in effect in 2015 (2) the document was the most recent version retrieved for the case and had not been replaced by a newer document of the same focus, and/or (3) the document had no stated end date.

⁷ A document was considered historical when (1) the years the policy applied to had passed, (2) the document was replaced by a newer document, or (3) the document was no longer available online.

⁸ "Relevant text" refers to text that directly or indirectly relates to the provision of harm reduction services, including any mention of harm reduction or the seven interventions of interest.

Current Alberta policy documents were content analyzed using this framework. Each document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria not met) of each quality indicator. Dichotomous scores for each indicator were justified with an accompanying written rationale. Scores and rationales were then compiled into a standardized *policy report card* for each provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions

3.0 Documents Retrieved

We retrieved seven unique policy documents in our provincial search and two corresponding update reports. Of the seven, four were considered current policy documents and three were historical. See Table 1 below for further information on each document. Additional descriptive summaries of each policy document are included in Appendix D.

Table 1: Descriptive Details of Alberta Policy Documents

Current	Document	Authors	Year Published	Years Active
	1 Creating Connections: Alberta’s Addiction and Mental Health Strategy <i>and</i> Action Plan [2 documents]	Alberta Health and Wellness; Alberta Health Services	2011	2011-2016
	2 Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan	Alberta Health and Wellness, Alberta Health Services	2011	2011-2016
	3 Harm Reduction for Psychoactive Substance Use	Alberta Health Services	2013	2013-2016
	4 North Zone Addiction and Mental Health Strategic Plan	Alberta Health Services	2013	2013-2016
Historical	5 Stronger Together: A Provincial Framework for Action on Alcohol and Other Drug Use	Alberta Alcohol and Drug Abuse Commission	2005	2005-2009
	6 Alberta Aboriginal HIV Strategy	Alberta Health and Wellness, Health Canada	2001	2001-2004
	7 Blood Borne Pathogens and Sexually Transmitted Infections Action Plan	Alberta Health and Wellness	2008	NA
Historical Update	8 Alberta Drug Strategy – Stronger Together: A co-ordinated Alberta response to Methamphetamine	Alberta Alcohol and Drug Abuse Commission	2006	2005-2010
	9 Creating Connections: Alberta’s Addiction and Mental Health Strategy Implementation Interim Report	Alberta Health and Wellness; Alberta Health Services	2015	2011-2013

4.0 Results: Inductive Analysis of Documents

4.1 Harm reduction is inconsistently defined and understood within current provincial policy documents

To better understand the provincial commitment to harm reduction, we analyzed how current

policy documents define and understand 'harm reduction' and related concepts. In this section, the definitions and understanding of harm reduction embedded within the four current policy documents are discussed and compared. Our analysis reveals major inconsistencies in how harm reduction is defined between documents, from a comprehensive evidence-informed understanding - to documents that mention the approach only once or not at all. The conceptualization of harm reduction is generally in line with the aim of the document. For example, in the policy which focuses on STBBI transmission [2], harm reduction is conceptualized as a way to reduce the spread of disease from injection drug use and sex. While this is not necessarily a surprising finding, it is notable that no province-wide understanding of harm reduction exists, particularly as all four policy documents are authored or co-authored by Alberta Health Services and share many stated outcomes, such as improving the health and wellness of Albertans.

4.1.1 Definitions in Harm Reduction Policy

Harm Reduction for Psychoactive Substance Use [3], published in 2013 by Alberta Health Services (AHS), is the only named harm reduction policy in the province. This policy outlines the mandate and goals that AHS considers fundamental to its substance use response. The authors define harm reduction as:

“...policies, programs and practices that aim primarily to reduce the adverse health, social or economic consequences of the use of legal and illegal psychoactive substances without necessarily reducing consumption. Initiatives include but are not limited to outreach and needle exchange programs, supervised injection sites, safer inhalation kits, drug substitution therapies (such as methadone maintenance), health and drug education, and safe housing options. A harm reduction approach to substance use accepts that abstinence may not be a realistic goal for some people.” (p. 3)

This definition conceptualizes harm reduction as an approach to reduce the adverse effects of substance use without the expectation of abstinence. Within this definition, AHS provides a list of harm reduction services, including “outreach and needle exchange programs, supervised injection sites, safer inhalation kits, drug substitution therapies (such as methadone maintenance), health and drug education and safe housing options” (p. 3). This list encompasses four of the seven harm reduction interventions of interest to this analysis (syringe distribution, supervised consumption, outreach, safer inhalation kits) missing ‘drug checking’, ‘low threshold opioid substitution’ and “Naloxone”.

The policy also provides a definition of the term “psychoactive substance”:

“...a substance that, when ingested affects mental processes (e.g. cognition or affect). This term and its equivalent, psychotropic drug, are the most neutral and descriptive terms for the whole class of substances, licit and illicit (including controlled drugs like alcohol, tobacco and prescription drugs). This term does not necessarily imply abuse or dependence.” (p. 3)

This definition acknowledges that both licit and illicit substances can affect mental processes, and positions substance use on a spectrum in which not all use implies dependence. However, the definition does not acknowledge that when used with care many psychoactive substances can have positive health, social or spiritual effects, and are not inherently harmful (Health Officers Council of BC, 2005).

Harm Reduction for Psychoactive Substance Use [3] also positions harm reduction on a continuum of care, acknowledging that it is “an important component in the continuum of care required to effectively serve individuals that use psychoactive substances” (p. 1). The “continuum of care” is identified as one of five key policy elements of the document, reinforcing AHS’ perspective of harm reduction as a strategy that can be applied across the spectrum of health services, rather than an approach contained to the prevention of blood borne pathogens. According to this policy, harm reduction interventions can be used beyond addiction and mental health services, in areas such as primary care and acute care.

In addition to these comprehensive definitions, *Harm Reduction for Psychoactive Substance Use [3]* asserts the broad reach of its policy, stating: “Compliance with this policy is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary)” (p. 1). An effort is made to include physicians and other services providers who are not AHS employees, but who work in AHS and AHS-contracted facilities. Taken together, the comprehensive list of harm reduction services and definition of psychoactive substances described above, as well as the application of the policy across health services and health care providers, suggests that AHS recognizes harm reduction as important for a variety of psychoactive substances and modes of administration. This extends the scope of harm reduction beyond just the provision of sterile injection equipment to prevent blood borne pathogens (BBP), and promotes its integration throughout the health care system.

4.1.2 Definitions in STBBI Policy

The *Alberta Sexually Transmitted Disease and Blood Borne Pathogens Strategy and Action Plan [2]*, published in 2011, is the current provincial strategy to address the prevention of STBBI. The strategy positions harm reduction as one of nine guiding principles of the document (p. 19),

embedding related strategies and philosophy throughout the document. Harm reduction is defined as follows:

Harm reduction—recognizes there will always be a portion of the population who will engage in higher risk behaviours, such as the use of unprescribed injection drugs and/or have unprotected sex with more than one sex partner. Harm reduction focuses upon reducing or minimizing the harms associated with higher-risk behaviours. Harm reduction helps protect individuals from the most harmful health consequences of addiction behaviours for themselves, their families/partners and their communities, while facilitating referrals to treatment and rehabilitation services (p. 19).

This definition accepts that abstinence and the elimination of substances is not always possible for people, but does not comment on specific harm reduction approaches or clarify whether harm reduction can apply to modes of substance use administration other than injection drug use (e.g. smoking, snorting, ingesting) or sex. Under Strategic Goal 1.0, the document does provide a list of harm reduction programs, including “condom distribution, needle exchange programs, distribution of drug paraphernalia, methadone maintenance programs, education and outreach programs, law enforcement policies and tolerance areas/safe injection facilities” (p. 36). However, this list does not explicitly include harm reduction services for those who do not inject substances (e.g. safer inhalation services), suggesting that strategy is focused on preventing the spread of disease via injection drug use and sex.

While *Harm Reduction for Psychoactive Substance Use* [3] positions harm reduction as applicable across the healthcare continuum, the *Alberta Sexually Transmitted Disease and Blood Borne Pathogens Strategy and Action Plan* [2] presents harm reduction through the lens of disease prevention. This is clear from the definitions discussed above, and is further reflected in the action plan’s [2] goals that aim to reduce, prevent or control STI/BBP, especially within marginalized populations (p.31). In meeting these goals, the action plan [2] calls for stakeholders to increase harm reduction collaboration, “Increase and support the efforts of harm reduction groups, such as needle exchange programs, to arrange disease testing and serology and to work in concert to develop mechanisms for testing, treatment and follow-up” (p.31). Although the action plan’s [2] focus on marginalized populations is appropriate, it fails to recognize that infections can result from multiple modes of drug use other than injection (i.e. smoking, snorting). It also fails to acknowledge the importance of other approaches to reducing disease transmission, such as developing relationships with clients to support health promotion and treatment uptake. These omissions are significant as this plan represents one of only four policies in the province that addresses harm reduction, and is the only strategy that focuses on preventing STBI transmission.

4.1.3 Definitions in Addiction and Mental Health Policy

Two mental health and addiction strategies exist in the province, *Creating Connections: Alberta's Addiction and Mental Health Strategy and Action Plan (2011)* [1] and *North Zone Addiction and Mental Health Strategic Plan (2013)* [4]. *Creating Connections* [1] defines harm reduction as follows: "Any program or policy designed to reduce harm of substance use without requiring the cessation of substance use. Interventions may be targeted at the individual, the family, community or society" (p. 46). While this definition contains the basic principles of harm reduction, it does not provide details on the types of programs, policies or interventions included in this approach, nor does it acknowledge the various types of harms that can be reduced (e.g. overdose, disease transmission, unstable housing, lack of social support).

Harm reduction is only discussed once within the strategy (other than when it is defined), under the strategic direction to "address complex needs". The document states, "people with complex needs will have ready access to secondary preventative and treatment services to mitigate harm, including harm reduction services" (p. 28). Positioning harm reduction within the strategic direction to 'address complex needs' for 'people with complex needs' suggests that it is only relevant to a specialized target population. This is reinforced by the document's description of this population as "individuals with complex mental health and health problems and/or severe behavioural problems related to addiction, mental health and mental illness" (p. 27). In addition, the document refers to harm reduction services as "secondary preventative and treatment services" (p.28), directing these services to people who are exposed to risk factors or engaged in risk behaviors. Harm reduction is contextualized as an interim approach to addressing 'complex needs', rather than a universal approach for promoting health and reducing harm amongst people who use psychoactive substances.

One follow-up report exists for the document, *Creating Connections Interim Report 2011-2014* [9]. The update highlights several initiatives, but provides no update or mention of harm reduction services. It focuses primarily on people living with developmental disabilities, with some discussion of people living with persistent mental illness.

The *North Zone Addiction and Mental Health Strategic Plan* [4] does not mention harm reduction at all, and therefore has no definition of this approach. The plan was included in our analysis because it is a policy that directs action to address addiction and mental health issues at the provincial level. The policy asserts a goal that "evidence-informed practice(s) are applied and continuous evaluation of all service delivery approaches occurs to ensure and demonstrate value" (p. 5). Despite the plan's emphasis on evidence-informed practice, there is no mention of harm reduction - an evidence-informed response to substance use. Furthermore, not one of

the seven harm reduction interventions of interest are mentioned, even though ample scientific evidence exists to compel support for them. These omissions run counter to the plan's goals to be evidence-informed (p. 5) and decrease stigma and discrimination (p. 5).

4.1.4 Summary

The inconsistent understanding of harm reduction evident within Alberta policy documents suggests that AHS' support for comprehensive harm reduction does not extend to the ministry of health (Alberta Health) or individual health zones. While there is a named harm reduction policy from the provincial health authority (AHS), there is no equivalent policy from the ministry of health. Policy from the ministry of health positions harm reduction as a disease prevention strategy rather than an approach to care for people who use psychoactive substances. While AHS' stand-alone policy on harm reduction contains a broad understanding of the approach, the two mental health and addiction strategies, as well as the provincial STBBI strategy, focus narrowly on disease prevention. Although AHS' stand-alone harm reduction policy exists, the other three documents are equally important pieces of the policy context and dictate action surrounding the response to substance use, STBBI transmission, and addiction and mental health concerns across the province. Overall, these policy documents reflect little continuity in conceptions of harm reduction and commitment to relevant initiatives.

4.2 The provincial approach to addressing STBBI prevention has shifted in recent years to include less direct consideration of Aboriginal issues

Two documents can be considered precursors to the current *Alberta Sexually Transmitted Disease and Blood Borne Pathogens Strategy and Action Plan (2011)* [2]; the *Blood Borne Pathogens and Sexually Transmitted Infections Action Plan (2008)* [7] and the *Alberta Aboriginal HIV/AIDS Strategy (2001)* [6]. In-depth analysis of these documents reveals that the provincial approach to STBBI prevention has changed considerably over the past 15 years. Current policy reflects a limited consideration of Aboriginal-specific populations, particularly when compared to historical documents. This is notable as Aboriginal peoples face significant challenges related to STBBI, including disproportionately high rates of new HIV cases in Canada compared to people of other ethnicities (Challacombe, 2016).

4.2.1 Aboriginal Populations and Harm Reduction

A comparison of current policy documents to the historical *Alberta Aboriginal HIV Strategy (2001)* [6] reveals changes in how the unique needs of Aboriginal populations are addressed. The *Alberta Aboriginal HIV Strategy* [6] was written to address the needs of Aboriginal people

living in Alberta, and reflected an understanding of the complex health and social issues facing Aboriginal communities. Importantly, it also included consultation with various Aboriginal stakeholders. The document focused on injection drug use and unsafe sex as the key areas for intervention and represented an explicit focus on Aboriginal communities that is missing from the current set of policy documents.

The *Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan (2011)* [2] very briefly touches on challenges facing Aboriginal peoples, including disproportionately high rates of HIV and hepatitis C. Aboriginal people are also identified as “persons at increased risk” within the document, alongside a list of target populations including other ethnic groups, men having sex with men, and injection drug users (p.34). Despite this recognition, the 2011 strategy does not consider the unique needs of Aboriginal peoples to the extent reflected in the 2001 *Alberta Aboriginal HIV Strategy* [6].

A population health approach is outlined as a guiding principle of the *Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan* [2]. This approach encourages stakeholders to identify challenges to STBBI prevention that affect the general public, as well as high-risk populations, including social norms, stigma, religious beliefs, gender role norms, marginalization, sexism, racism and homophobia (p. 16). The document also highlights five key factors that present challenges to STBBI prevention; these include disease factors, psychological factors, socio-demographic factors, behavioural factors and environmental factors (p. 16). In discussion of Aboriginal communities, however, the document shifts towards using personal responsibility language. For example “Injection drug use is one of the most prevalent risk factors exposing Aboriginal people to HIV and HCV. Underlying injection drug use may be histories of multiple abuses, addictions, poverty and overall, low self-esteem, all of these leading to *poor choices and decision making*” (p. 36, emphasis added). This language is different from the systemic language used when the authors discuss injection drug use among the general population.

The *Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan* [2] briefly touches on cultural aspects of harm reduction and addiction that may influence services in Aboriginal communities. For example, the strategy asserts: “The harm reduction approach continues to be misunderstood or rejected in some Aboriginal communities in favour of more abstinence-based approaches” (p. 36). No additional context or information is provided as to why, however, this appears to indicate that some communities are actively opposing harm reduction approaches. Other challenges are mentioned in the document, but not addressed to any further degree, including “Confidentiality fears, particularly in small reserve communities, Metis settlements and other ethnic minority communities” (p.38) as a barrier to STBBI testing.

Finally, it is striking that there is no mention of collaboration or consultation with Aboriginal communities in the development of the *Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan [2]*, or as members of the advisory committee or working groups.

The remaining three Alberta policy documents fail to discuss Aboriginal communities in the context of harm reduction. The *Creating Connections [1]* strategy and action plan does specifically address First Nations, Metis and Inuit peoples (FNMI) (strategy, p. 32), and notes the inclusion of an FNMI sub-task group in the strategy development. The main focus is on increasing support and access to general mental health and addiction services. Although the action plan mentions unique challenges, such as “systemic barriers” and promotes customizing services to “meet the needs of FNMI people and communities” (action plan, p. 31), there are no specific actions provided. It is evident that more recent policy documents do not consider the unique context and challenges of Aboriginal communities to the same degree as historical policy documents.

4.2.2 Summary

As demonstrated in this analysis, approaches to addressing STBBI have shifted significantly since 2000. While the current STBBI strategy embeds harm reduction throughout and articulates specific action items around harm reduction, it represents a shift in terms of policy related to Aboriginal communities. Historical policy documents featured a more direct recognition of the unique needs of Aboriginal communities, which were addressed through an Aboriginal-specific policy document. It should be noted that the motive for this shift was not made clear in policy documents. It is possible that Aboriginal groups requested there be one integrated provincial approach, rather than addressing special populations with a unique strategy. Without evidence of consultation with any Aboriginal groups or communities, the reason is not clear; however the absence of consultation from the current strategy remains problematic.

4.3 Provincial policy documents reflect a less comprehensive acknowledgement of harm reduction in recent years, compared to historical policy documents

Although *Creating Connections (2011) [1]* marks the first addiction and mental health strategy in Alberta, the province previously endorsed a provincial drug strategy, *Stronger Together: A Provincial Framework for Action on Alcohol and Other Drug Use (2005) [5]*. This document was written in 2005 and is no longer available online. A comparison of *Stronger Together* and *Creating Connections* reveals shifts in policy around substance use and harm reduction, and suggests that harm reduction is no longer a central component of the provincial policy landscape.

It is significant that a stand-alone substance use strategy existed in Alberta, and it is important to recognize the implications of replacing it with a more general mental health and addiction strategy. The former stand-alone strategy embraced harm reduction as a core philosophy and discussed this approach in-depth in the context of addressing substance use. In contrast, *Creating Connections [1]* - the mental health and addiction strategy, frames substance use as a mental health issue – consistently using the term ‘addiction’. Addiction is not addressed independently from mental health problems or mental illness in the document. For example, the more recent strategy [1] refers to the “continuum of addiction and mental health services and supports” (p.9), and notes a goal to “...reduce risk factors that contribute to addiction, mental health problems and mental illness” (p.16). The strategy [1] also fails to consider that substance use exists on a spectrum, in which there is both problematic use and beneficial use. Within the strategy [1], substance use is only discussed in the context of “substance abuse”, “substance use disorders” or “dependence”. This shift represents a significant change in the way substance use is framed by the ministry of health.

As mentioned previously, *Creating Connections [1]* positions harm reduction as a supplemental treatment option to be used only in ‘complex’ and ‘extraordinary’ circumstances. *Stronger Together [5]*, alternatively, positioned harm reduction as one of four key pillars for addressing substance use. *Stronger Together [5]* defined harm reduction as follows:

Harm reduction recognizes that it is impossible to completely eliminate substance use, and that there is a need to minimize the harms caused by alcohol and other drug use. Harm reduction aims to improve health, social, and economic outcomes for individuals and society through a range of pragmatic treatment and public health approaches. Harm reduction respects personal autonomy and supports practical interventions that assist people to address their most pressing health challenges and concerns” (p. 11).

This definition highlights the importance of respecting personal autonomy and assisting individuals with their self-identified needs. This is an aspect of harm reduction that is not included in contemporary policy documents.

Stronger Together [5] centered its objectives on reducing and decreasing alcohol and drug use and the harms associated with this use, rather than on abstinence. Four of the six objectives exemplify this language; “delay the onset of alcohol and other drug use”, “decrease alcohol and other drug problems in at-risk groups”, “reduce alcohol and other drug-related morbidity and mortality” and “reduce the harms associated with alcohol and other drug use” (p. 9-10). The document did not contain objectives that aimed to eliminate or prevent all drug use; rather,

they were pragmatic and reflected harm reduction philosophy. The fourth objective of the strategy exemplifies how harm reduction was contextualized throughout the document:

Not all individuals who use alcohol and other drugs will experience harm, and of those that do, not all will seek to change their behavior. Providing effective treatment to those who seek treatment is important, but a focus on reducing harm is critical, irrespective of a reduction in drug use. This can be accomplished through implementation of a range of pragmatic strategies and public health interventions (p. 10).

This explanation recognized that reducing immediate harm is often more critical than preventing or deterring all substance use. It also implied a spectrum of use ranging from positive to negative, but did not acknowledge that some people have positive experiences with substance use. It also recognized that not everyone who uses alcohol or other drugs will experience harm.

4.3.1 Summary

As demonstrated through this analysis, the framing of substance use in provincial policy documents has shifted from 2000 to 2015. Through the elimination of their four tiered approach and movement away from a comprehensive understanding of harm reduction that was present in *Stronger Together* [5], the ministry of health currently endorses an approach to mental health and addiction that positions harm reduction as relevant to certain populations under certain conditions, rather than an approach that can benefit all Albertans. Harm reduction is no longer a central component of the policy landscape, and substance use is presented through the narrow lens of ‘addiction’ as a mental health concern.

4.4 Policy documents reflect a low level of commitment to and follow-through of harm reduction initiatives

We considered the ways in which policy documents conceptualized roles and responsibilities of key stakeholders and leaders, as well as how they articulated their support for building partnerships between and across ministries and agencies. Responding to substance use is a complex task that requires input and collaboration from various levels of community and government. Specifically, implementing harm reduction services requires investment and commitment from health service providers, the community, and government in order to deliver the best possible services. Our findings suggest a low-level of commitment to harm reduction policy aims in practice. This is demonstrated by a lack of action on proposed policy initiatives, a weakened commitment to harm reduction in more recent follow-up documents, and a lack of

clarity around who is responsible for implementing policy strategies.

4.4.1 Follow-Up Reports

Follow-up reports provide a record of a jurisdiction's commitment and progress toward goals and objectives outlined in a policy. Only two follow-up reports exist for all harm reduction documents in Alberta; *Stronger Together: A co-ordinated Alberta response to methamphetamine (2006)* [8]; and *Creating Connections: Alberta's Addiction and Mental Health Strategy Implementation Interim Report (2015)* [9].

Although *Stronger Together* [5] had the potential to guide implementation of harm reduction services in a meaningful way, our analysis of its sole follow-up report, *Stronger Together: Coordinated Alberta Response to Methamphetamine* [8] suggests that action items were not realized. While this update report claims to be informed by the original document, it does not uphold the same harm reduction philosophy. The historical *Stronger Together* [5] positions harm reduction as one of four core elements, and embeds harm reduction throughout its framework, while the update report mentions harm reduction only twice. Within a 'continuum of services', the update report acknowledges harm reduction as part of that continuum, though no initiatives listed under this priority mention harm reduction. Instead, there is a focus on health education, training of first responders, and increased availability of detox and treatment services. Overall, this follow-up report primarily highlights ongoing or past initiatives, without a clear plan for moving forward. Also of note, the update report is focused solely on methamphetamine, and does not consider other illicit substances.

One follow-up report exists for *Creating Connections* [1], the *Creating Connections- Interim Report 2011-2014 (2015)* [9]. This follow-up report does not mention harm reduction activities originally discussed in the 2011 action plan [1]. The original action plan briefly discussed the provision of harm reduction to individuals with "complex needs" (p.28). However, in the follow-up report, the only discussion around complex needs relates to people living with developmental disabilities and people living with persistent mental illness.

4.4.2 Roles and Responsibilities

Throughout the Alberta documents, varying levels of commitment are evident in terms of policy implementation and partnership facilitation. In general, the policies call for increased collaboration and partnerships between community and government agencies, but largely do not provide concrete expectations around support, action and timelines for these collaborations. The one exception to this is *Creating Connections* [1]. It is the only document with a specific "action plan" for each strategic direction, including details such as performance measures and targets, action roles and responsibilities, and an action schedule with specific

timelines. Although this is promising to see, particularly that responsibility for each action is assigned, there is no way to track the progress of these specific actions and determine if responsible parties followed through. The Interim Report [9] only reports on key achievements, and is far less detailed than the original action plan.

In *Harm Reduction for Psychoactive Substance Use* [3], AHS emphasizes the importance of collaboration and partnership. This is reflected in the document's purpose; "To encourage and facilitate joint harm reduction strategies and partnerships between AHS and community agencies" (p. 1), and its policy statement; "AHS may directly, or in partnership with community agencies, provide a range of harm reduction programs and services that assist individuals, families and communities" (p. 1). In addition, "collaboration" is one of five policy elements. AHS calls for collaboration with individuals, families and community to address determinants of health ("such as socio-economic status, early childhood development, housing and safety" (p.3)). Despite its inclusion as a key policy element, the policy does not contain any action items related to collaboration, nor does it list any concrete responsibilities for AHS or other key partners for implementation.

The *Alberta Sexually Transmitted Disease and Blood Borne Pathogens Strategy and Action Plan* [2] similarly promotes partnerships and collaborations throughout the document. However, the plan shifts responsibility away from the provincial government and health authority, towards local providers and organizations. The plan asserts that it depends on the commitment of partners to fulfill their roles and responsibilities, as outlined in the plan. For example, in the Introduction, the plan asserts: "The success of this plan is dependent on the commitment of multiple partners to fulfilling their roles and responsibilities. Partners are expected to incorporate the STI and BBP strategies into their organizations' plans in accordance with their identified roles and responsibilities" (p. 4). There is no discussion of whether partners had a role in developing the plan or if additional resources or funding were provided to implement the priorities.

4.4.3 Summary

Although contemporary policy documents highlight the importance of collaboration and identifying roles and responsibilities for key players, there is a lack of commitment to these goals. Without any follow-up reports, it is difficult to assess whether these collaborative roles were realized. In terms of the two follow-up documents that were published, harm reduction is addressed significantly less in both and previously promoted initiatives are not acknowledged, reflecting a weakened commitment to the harm reduction philosophy in more recent policy.

5.0 Results: Deductive Analysis of Current Documents (Policy Report Card)

All current documents were content analyzed using a deductive coding framework comprised of 17 indicators. These assessed the quality of policies relative to how well they described key *population* aspects (nine indicators) and *program* aspects (eight indicators) of a harm reduction approach. Each document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria not met) of each quality indicator. Results are displayed in the following three tables.

Table 1: Presence of key population indicators in current policy documents

	Creating Connections: Alberta's Addiction and Mental Health Strategy and Action Plan	Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan	Harm Reduction for Psychoactive Substance Use	North Zone Addiction and Mental Health Strategic Plan	Total (out of 4)
[1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or have drug problems?	1	0	0	0	1
[2] Does the document affirm that people who use substances need to be involved in policy development or implementation?	1	0	0	0	1
[3] Does the document acknowledge that not all substance use is problematic?	0	0	1	0	1
[4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community?	1	1	1	0	3
[5] Does the document acknowledge that	0	0	0	0	0

harm reduction can be applied to the general population?					
[6] Does the document target women in the context of harm reduction?	0	0	0	0	0
[7] Does the document target youth in the context of harm reduction?	0	0	0	0	0
[8] Does the document target indigenous populations in the context of harm reduction?	0	1	0	0	1
[9] Does the document target LGBTQI populations in the context of harm reduction?	0	0	0	0	0
TOTAL (out of 9 indicators)	3	2	2	0	(7 of 36)

Table 2: Presence of key program indicators in current policy documents

	Creating Connections: Alberta's Addiction and Mental Health Strategy and Action Plan	Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan	Harm Reduction for Psychoactive Substance Use	North Zone Addiction and Mental Health Strategic Plan	Total (out of 4)
[10] Does the document acknowledge the need for evidence-informed policies and/or programming?	1	1	1	0	3
[11] Does the document acknowledge the importance of preventing drug related harm, rather than just preventing drug use or blood borne or sexually	1	1	1	0	3

transmitted infections?					
[12] Does the document discuss low threshold approaches to service provision?	0	1	0	0	1
[13] Does the document specifically address overdose?	0	0	0	0	0
[14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach?	1	1	1	0	3
[15] Does the document consider harm reduction approaches for a variety of drugs and modes of use?	0	0	1	0	1
[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	0	1	0	0	1
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	0	1	1	0	2
TOTAL (out of 8)	3	6	5	0	(14 of 32)

Table 3: Proportion of policy quality indicators endorsed for all documents within cases

Case	Target population quality (out of 9 indicators)	Service quality (out of 8 indicators)
British Columbia (10)	38/90 (42%)	52/80 (65%)
Alberta (4)	7/36 (19%)	14/32 (44%)
Saskatchewan (3)	9/27 (33%)	13/24 (54%)
Manitoba (7)	10/63 (16%)	19/56 (34%)
Ontario (7)	3/63 (5%)	9/56 (16%)
Quebec (11)	24/99 (24%)	26/88 (30%)
New Brunswick (1)	0/9 (0%)	1/8 (13%)
Nova Scotia (4)	12/36 (33%)	11/32 (34%)
Prince Edward Island (1)	0/9 (0%)	1/8 (13%)
Newfoundland (2)	1/18 (6%)	1/16 (6%)
Yukon (0)	n/a	n/a
North West Territories (2)	2/18 (11%)	1/16 (6%)
Nunavut (2)	3/18 (17%)	5/16 (31%)
Canada (54)	109/486 (22%)	153/432 (35%)

6.0 Conclusion

The formal harm reduction policy landscape in Alberta is sparse. Only four current policy documents direct services and resources related to harm reduction. While the provincial health authority does have a stand-alone harm reduction policy that applies to staff in health care settings across Alberta, the same does not apply to the provincial government or the ministry of health. Furthermore, this policy provides high level direction, and does not offer specific guidelines on implementation. At the provincial level, although a harm reduction philosophy is endorsed throughout the provincial STBBI strategy, it is absent from both addictions/mental health strategies.

In the document considered a predecessor to the current mental health and addiction strategy, *Stronger Together* [5], substance use was addressed through the evidence-informed four-pillar approach (prevention, harm reduction, treatment, enforcement). The dissolution of AADAC, a government agency dedicated to addressing substance use in the province, coupled with the release of an updated addiction and mental health strategy [1], suggests a move away from harm reduction as a central pillar to the provincial approach to substance use.

Without a provincial-level harm reduction policy or statement, and a narrow focus on disease prevention within existing policy, Alberta is not supporting harm reduction interventions and resources in a comprehensive way. With all four current policies set to expire in 2016, combined with a shift in provincial government, we are hopeful that this policy landscape will change in the coming years.

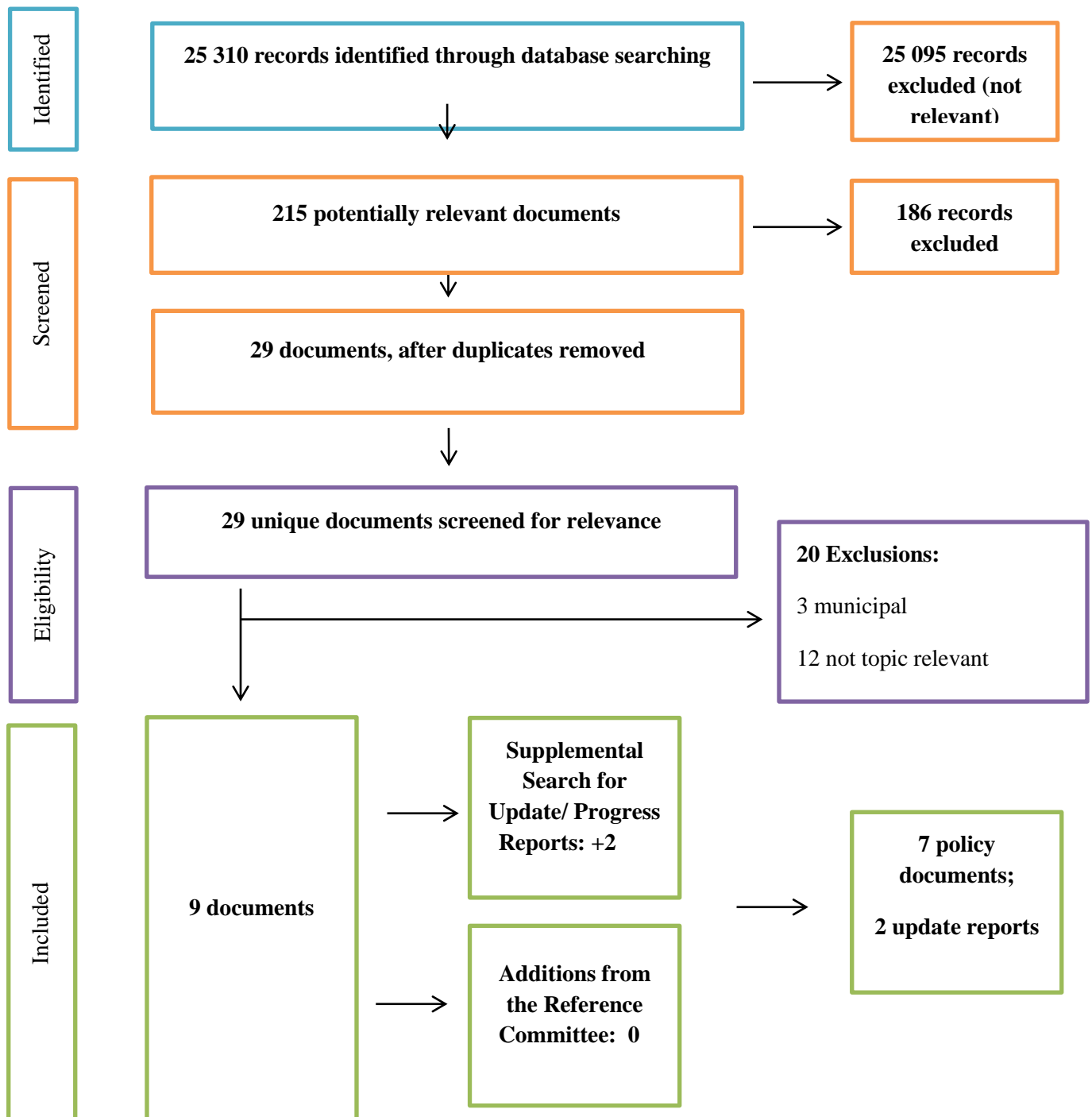
Appendix A: Geographical Service Zones

Geographical Services Zones	Area (km²)⁹	Population¹⁰
North Zone	448 500	478 979
Edmonton Zone	11 800	1 295 164
Central Zone	95 000	470 490
Calgary Zone	39 300	1 544 495
South Zone	65 500	298 169

⁹ Alberta Health Status Update (2011) - <http://www.albertahealthservices.ca/poph/hi-poph-surv-hsa-update-2011-alberta.pdf>

¹⁰ Alberta Health Services Zone Map (2014) - <http://www.albertahealthservices.ca/ahs-map-ahs-zones.pdf>

Appendix B: Systematic search strategy flow diagram¹¹



¹¹ Adapted from PRISMA 2009 Flow Chart (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009).

Appendix C: Standard methodology for generating provincial/territorial case report

Overview

A separate paper (Wild et al., 2017) describes the search and verification strategies used to assemble a corpus of harm reduction policy texts for each case. All policy documents meeting inclusion criteria were coded into one of three categories: (1) primary documents (i.e., policy texts that direct harm reduction services or resources as their main named purpose), (2) secondary documents (i.e., policy texts that direct services and resources that relate to harm reduction, and for which harm reduction is embedded throughout the document [e.g., as part of an addiction strategy or as part of an HIV/AIDS policy framework]), and (3) tertiary documents (i.e., policy texts that direct services and resources that relate to harm reduction but do not mention harm reduction explicitly).

Documents were analyzed in a two-step process, involving inductive and deductive methods. The inductive analysis was designed to provide a synthesis of *current and historical* developments in harm reduction policy for the case. The deductive analysis was designed to facilitate cross-case comparisons, and involved evaluating *current* policy documents for each case in relation to the CHARPP framework – a set of 17 indicators assessing the quality of harm reduction policies.

Inductive analysis

The qualitative analysis proceeded in three phases for each relevant policy document. First, each document was reviewed for relevant text (i.e. text directly or indirectly relating to the provision of harm reduction services in the given provincial/territorial jurisdiction). Relevant sections were then excerpted into word processing software. Each excerpt was then analyzed using a modified version of Mayan's (2009) latent content analysis procedure and analytic notes were generated. The focus of the analytic notes was primarily descriptive and instrumental (i.e., generating a deeper understanding of the intent and purpose of the policy document and the relevant stakeholders and their roles).

Next, each document's analytic notes and accompanying quantitative data (see next page) were synthesized and compiled into a narrative document description. Combining the quantitative and qualitative data at this stage was useful for two reasons; (1) quantitative data presented at the start of each document description provided a quick means to compare across documents in each case; and 2) presenting the quantitative data at the start of the synthesis facilitated review of the analytic notes to ensure that they contained adequate qualitative information to contextualize each quantitative data point. For example, if the quantitative data indicated that there is mention of funding mechanisms in the report, then the analyst reviewed their analytic notes and ensured this funding commitment is adequately described in the narrative synthesis. This narrative description provided an overview of current and historical developments in provincial/territorial harm reduction policymaking. The length of the narrative descriptions vary considerably depending on whether a given document is primary, secondary or tertiary, as well as whether it is shorter or longer and simple or complex.

Finally, the narrative document descriptions were synthesized and compiled. Descriptive comments summarized the overall scale and scope of the documents contained in each case, and described the main features of the set of policy documents. Particular attention was paid to identifying points of convergence and divergence within and between policy documents.

Deductive analysis

To facilitate cross-case comparison between the policy documents of each province and territory, we developed the CHARPP framework – a set of 17 indicators that assessed the quality of policies based on how well they described key *population characteristics* and *program features* of a harm reduction approach. The indicators were guided by principles outlined by the International Harm Reduction Association (2010) and the World Health Organization (2014), and developed in consultation with a working group of harm reduction experts from across Canada.

Nine *population* indicators were specified, based on the premise that high-quality harm reduction policies characterize service populations accurately when they: (1) recognize that stigma and discrimination are issues faced by people who use illegal drugs; (2) affirm that people who use drugs need to be involved in policy development or implementation; (3) acknowledge that not all substance use is problematic; (4) recognize that harm reduction has benefits for both people who use drugs and the broader community; (5) acknowledge that a harm reduction approach can be applied to the general population; and affirm that (6) women; (7) youth; (8) indigenous peoples; and (9) LGBTQI (lesbian, gay, bisexual, trans, queer and questioning, and intersex) people are key populations for harm reduction.

Eight *program* indicators were specified based on the premise that high-quality harm reduction policies should (10) acknowledge the need for evidence-informed policies and/or programs; (11) recognize the importance of preventing drug-related harm (rather than just preventing drug use, or blood-borne or sexually-transmitted infections); (12) discuss low-threshold [49] approaches to service provision; (13) specifically address overdose; (14) recognize that reducing or abstaining from substance use is not required; (15) consider harm reduction approaches for a variety of drugs and modes of use; (16) discuss harm reduction's human rights (e.g. dignity, autonomy) dimensions; and (17) consider social determinants (including income, housing, education) that influence drug-related harm.

Each document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria not met) of each quality indicator. Dichotomous scores for each indicator were justified with an accompanying written rationale. Scores and rationales were then compiled into a standardized *policy report card* for each provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions. Formal policies that score highly on CHARPP indicators are high-quality because they conceptualize and describe a harm reduction approach in close accordance with its internationally-recognized attributes and principles. Conversely, poor-quality harm reduction policies score low on CHARPP indicators because they refer to the approach only sparingly, and/or do not elucidate its key attribute and principles.

Accompanying Quantitative Data

- Author(s);
- Year published;
- Number of years the policy covers;
- Page length of the document;
- Triage level (primary, secondary, tertiary);
- Number of distinct mentions of the term 'harm reduction' as well as each of the 7 specific harm reduction services described earlier;
- Language used (i.e. 'harm reduction', 'reducing harm', 'risk reduction');
- Policy level (provincial or regional health authority);
- Scope/target population (entire population, specific target population);
 - Specify target population: (i.e. Aboriginal communities, rural communities, health region);
- Population size of target population;
- Timeline for the policy provided? (yes/no);
 - Specify timeline: (i.e. 3-year plan, 5-year plan)
- Evidence of endorsement from Premier or other member of Cabinet? (yes/no);
- Any reference to legislation enacted to support policy implementation? (yes, no);
 - Specify name of Act or Statute
- Does the document assign specific roles and responsibilities to relevant actors? (yes/no);
- Does the document mention funding mechanisms and/or commitments? (yes/no)
- Does the document have regular progress reporting or updates? (yes/no)
 - Names and date of progress reports or updates
- Does the document have any progress reporting or updates?
- Reference to consultations with target population during policy development?

Appendix D: Descriptive summary of current policy documents

Creating Connections: Alberta's Addiction and Mental Health Strategy and Action Plan [1] is the current provincial mental health and addiction strategy. It was produced jointly by AHS and AH in 2011, and was proposed as a five-year plan (2011-2016), with its goal to reduce the prevalence of addiction and mental health illness in Alberta. This document marks the first provincial strategy to address mental health and addiction together, but only mentions harm reduction twice. This document is accompanied by one interim report, published in 2015.

The *Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan [2]* is the current strategy to address the prevention of STBBI transmission. It was jointly produced by AHS and AHW in 2011, and was proposed as a five-year plan. The goal of the plan is to prevent and reduce the impact of STBBI on the health of Albertans. The plan addresses health at a population level and positions harm reduction as one of nine guiding principles.

Harm Reduction for Psychoactive Substance Use [3] is a Level 1 Policy implemented by AHS in 2013, and set for review in 2016. AHS defines Level 1 Policy as “the highest level of AHS policy that sets out requirements fundamental or significant to the mandate of AHS and the overall clinical and / or corporate goals of AHS.” The overarching purpose of the policy is to provide direction for program and service planning based on the principles of harm reduction, and to facilitate partnerships and joint strategies between AHS and community agencies to support harm reduction initiatives. By classifying harm reduction policy as a Level 1 Policy, AHS positions harm reduction within its organizational mandate.

The *North Zone Addiction and Mental Health Strategic Plan [4]* is a regional document produced within the AHS Addiction and Mental Health portfolio of the North Zone in 2013. The North Zone encompasses over 450 communities (including Metis Settlements and First Nations) in the northern half of the province, a total population of 466 135¹. This strategy aims to address growing concerns around addiction and mental health in the North Zone of the province, and aligns itself with the provincial addiction and mental health strategy (*Creating Connections [1]*) and AHS' vision, mission, values and strategic directions. This strategy does not include harm reduction philosophy in its approach to addressing addiction, but focuses more on prevention, abstinence and increasing efficiency within the health care system. No addiction and mental health strategies were found for any of the other four zones.

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