

British Columbia Policy Analysis Case Report

Canadian Harm Reduction Policy Project (CHARPP)

August 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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1.0 Overview

This document provides a descriptive and analytical account of British Columbia's (B.C.) provincial harm reduction policy context. This account is part of the Canadian Harm Reduction Policy Project (CHARPP), a multimethod multiple case study comparing provincial/territorial harm reduction policies across Canada. B.C.'s 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 B.C.'s harm reduction policy context including: governance, healthcare delivery structures, substance use trends and harm reduction programming. Next, a description of study methodology is provided, including information about the policy documents retrieved during a systematic search. Finally, we detail the results of our inductive and deductive policy analysis.

1.1 Contextual Background¹

Bordering the Pacific Ocean, B.C. is Canada's westernmost province. It is the third largest province in Canada, spanning 944,735 square kilometers (Statistics Canada). It has a population of 4,751,612 (Statistics Canada, 2015), and includes four major cities: Abbotsford- Mission (population 183,500), Kelowna (population 197,300), Victoria (population 365,300) and Vancouver (the third most densely populated city in Canada, with a population of 2,504,300). Welcoming 44,000 immigrants annually, B.C. may well be the most culturally diverse province in Canada (Government of British Columbia, 2016a). In fact, almost 30% of the population of B.C. have immigrated from another country (Government of British Columbia, 2016b).

The B.C. Liberal Party has led the provincial government since 2001. With respect to harm reduction policies, political leadership has been relatively progressive, particularly when compared to other Canadian provinces. B.C. has led several ground-breaking initiatives (Globe and Mail, 2016). For example, the first safe injection site in Canada opened in Vancouver in 1998, and B.C. remained the only province to offer this service up until the end of 2016 (Wiant, 2016). After the federal Conservative's (under the leadership of Stephen Harper) were elected in 2006, this site became an arena of political struggle between Federal Government and Provincial powers, with the Harper government attempting to close the site down (MacLean's,

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

2015). In 2011, the Supreme Court of Canada sided with the provincial government allowing the site to continue its operation, and it remains open to this day.

1.2 Healthcare Governance

The B.C. Ministry of Health is responsible for setting health care policy, guidelines, and legislation for the province as well as being directly responsible for managing PharmaCare (prescription drug coverage), The Medical Services Plan (physician services), HealthLink B.C. (health website that provides citizens with health information and resources), and the B.C. Vital Statistics Agency (registers events such as deaths, marriages, and birth certificates) (Government of British Columbia, 2016c). Health care services are delivered by five regional health authorities within the province: Fraser Health Authority, Interior Health Authority, Northern Health Authority, Vancouver Coastal Health Authority, and Vancouver Island Health Authority. These regional authorities are responsible for identifying the population health needs, planning and ensuring sufficient funding for various programs and services, and complying with the goals and guidelines mandated by the Ministry of Health (Institute of Public Administration of Canada, 2013). A sixth authority, B.C.'s First Nations Health Authority (FNHA), was introduced in 2013 and represents the first province wide health authority of its kind in Canada (Government of British Columbia, 2016d). It is a health authority that works to address health disparities confronting B.C. First Nations and Aboriginal peoples, and is responsible for the planning, management, service delivery and funding of health programs in partnership with First Nations communities (First Nations Health Authority, 2016).

One last authority, the Provincial Health Services Authority (PHSA) is responsible for overseeing and co-ordinating the delivery of provincial programs (such as the Provincial Blood Coordinating Office and the Provincial Infection Control Network of B.C.) and health care services that are highly specialized, such as transplants, cancer treatment, and heart surgery (Government of British Columbia, 2016d). There are ten agencies operated by PHSA providing province wide specialized health services including: B.C. Cancer Agency, B.C. Centre for Disease Control, B.C. Children's Hospital & Sunny Hill Health Centre for Children, B.C. Mental Health & Substance Use Services, B.C. Provincial Renal Agency, B.C. Transplant, B.C. Women's Hospital & Health Centre, Perinatal Services B.C., Cardiac Services and B.C. Emergency Health Services (PHSA, 2015).

1.3 Substance Use Trends

According to data collected from the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS, 2012), 50.6 % of the population of B.C. reported lifetime use of one or more illicit drugs. Over their lifetime, 9.9 % of British Columbians reported using cocaine/crack, 3.7% reported using speed, 6.3% reported using ecstasy, and 17.4% reported using hallucinogens.

British Columbians also reported on drug use in the past 12 months; 14.9 % reported using at least one illicit drug in the past year, while 13.9% reported using one of the following illicit drugs: cannabis, cocaine/crack, speed, ecstasy, hallucinogens or heroin. In the same survey, 2.1% of British Columbians reported experiencing harm (including physical, emotional, social, financial) from their own drug use over the past twelve months related to substance use. Both in terms of lifetime and past year drug use, B.C. had greater illicit drug consumption than any other province. However, the numbers were still fairly close to national trends (11.3% of Canadians vs. 14.9% of British Columbians have used at least one illicit drug in the past 12 months; 43.2% of Canadians vs. 50.6% of British Columbians have used at least one illicit drug in their lifetime). Despite the fact that B.C. has greater drug consumption than any other province, the percentage of British Columbians experiencing harm related to drug use in the last year is essentially on par with the national average (2.1% in B.C. compared to the national average of 2.0%).

Increases in illicit drug overdose were fairly stable from 2012-2014, with a slight spike in 2015: 274 reported cases in 2012; 331 in 2013; 366 in 2014; and 480 in 2015 (CKNW, 2016). Statistics from the B.C. coroner's office demonstrate the recent increase in drug overdoses related to fentanyl: 5% in 2012; 15% in 2013; 25% in 2014 and 35% from January to August 31st in 2015 (Globe and Mail, 2015). A 2015 report examining Fentanyl related deaths in Canada and its provinces, cautioned that, although fentanyl related overdoses had increased steadily and significantly in B.C. between 2012 and 2014, it was unclear what role fentanyl had contributed to overall illicit drug use overdose (Canadian Center in Substance Abuse, 2015). However, in 2016, a staggering 978 people are reported to have died due to illicit drug overdoses in the province. Preliminary data released by the B.C. Coroners Service suggested that fentanyl was detected in 67% of these cases (BC Coroners Service, 2017).

1.4 Harm Reduction Services in British Columbia

The B.C. Harm Reduction Strategies and Services (HRSS) committee, managed by B.C. Center for Disease Control (BCCDC), is responsible for guiding provincial policies related to harm reduction and for coordinating activities between the Ministry of Health, the First Nations Health Authority, the five regional health authorities and other key stakeholders (BCCDC, 2016). Each health authority, with financial support from the Ministry of Health and the Provincial Health Services Authority, is responsible for coordinating efforts with community partners to provide a wide range of harm reduction services in accordance with HRSS policy (Buxton et al., 2009). HRSS policy dictates that harm reduction products, such as condoms, needles and syringes, alcohol swabs and sterile water, should be provided to all citizens who request them, regardless

of choice of drug and where they live (Buxton et al., 2009). There are more than 20 harm reduction supplies available at over 300 sites in the province (BCCD, 2015). With the approval from the regional health authorities, local health units and community agencies order the supplies, which are tracked and distributed by the BCCDC (Kuo et al, 2014). In 2015, 11, 832, 750 needles and 3, 784, 200 condoms were distributed province wide (Center for Addictions Research of BC, 2015).

In 2014, 14,662 patients were enrolled in methadone maintenance programs (Greer et al, 2014). In B.C, these programs are managed by the College of Physicians and Surgeons of British Columbia, who sets the guidelines and regulations for methadone treatment in the province. Methadone is prescribed by primary care physicians and prescriptions are filled by community pharmacists (British Columbia Center for Excellence in AIDS/HIV, 2015). In order to prescribe and dispense methadone, physicians and pharmacists must receive special training in accordance with their respective colleges (BCCDC, 2012). Patients do not need to discontinue drug use in order to receive methadone treatment and although the College of Physicians and Surgeons recommends urine screening for patients receiving at home dosages of methadone, the decision ultimately rests with the prescribing physician (Open Society Institute, 2010). As with other prescription drugs, methadone is largely covered by the province's PharmaCare program. For those on income assistance, the treatment is covered in full (Government of British Columbia, 2011). As of 2015, opioid substitution drugs, such as Suboxone (buprenorphine & Naloxone) were added to the B.C. public drug coverage plan, PharmaCare, making them more accessible to people with opioid addiction. The changes have removed barriers that previously required patients to have special approval in addition to proof that they had tried methadone unsuccessfully first (Government of British Columbia, 2015).

A number of noteworthy harm reduction initiatives have emerged within the province during the last couple decades. As noted above, B.C. is the only province in Canada to have successfully implemented a supervised injection site (as of 2016). There are two locations: Insite and Dr. Peter Center, both of which are located in Vancouver. The province is also home to some of the most innovative outreach programs for harm reduction in pregnant women, including Sheway and Firsquare (Cavaliere, 2012). In 2012, B.C. began its take-home naloxone program, distributing Naloxone to individuals at risk of experiencing an opioid overdose (BCCDC, 2016). According to Jane Buxton, head of the BCCDC's harm reduction office, in 2015, about 5000 people had been trained to administer naloxone, 4,000 kits were provided and over 325 overdoses were reported to have been successfully treated with the new initiative (Globe and Mail, 2015). In 2014, Vancouver became the first city in the country to install a crack-pipe vending machine (which dispenses safer crack kits), with the aim of preventing communicable diseases such as HIV and HEP C (CTV News, 2014). While this does represent an important development in safer smoking for crack users, some critics have suggested that outreach to

individuals using crack has been underdeveloped in the province (Cavalieri, 2012). Specifically, while the HRSS does distribute many of the safer smoking supplies outlined in their best practices for supply distribution report (HRRS, 2008), including vinyl mouthpieces, crack pipe screens, and push-sticks, they have been unable to sufficiently fund the distribution of Pyrex pipe stems (Vancouver Coastal Health, 2013). There are also significant regional differences in the province, with some supply distribution sites not providing safer smoking supplies (BCCD, 2015).

2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. Documents produced for B.C. during this period were meant to be (a) analyzed and synthesized inductively to describe historical² and current³ policy developments guiding harm reduction services in the territory 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 interventions⁴ or (5) were produced as either a stand-alone 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

² 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.

³ 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.

⁴ 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.

reduction practice, we excluded government or health authority authored documents exclusively focused on best practice guidelines for frontline service providers.

In the search, ten current and 19 historical documents were found. Appendix B provides the B.C. search strategy.

2.2 Inductive Analysis

Each of the 29 documents was analyzed using a three-step process (Appendix C provides analytic details). First, relevant text⁵ 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 B.C.'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 (HRI, 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.

Current B.C. 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

⁵ "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.

3.0 Documents Retrieved

The study sought to identify provincial and regional health authority level harm reduction documents produced between 2000 and 2015 in B.C. A total of 64 policy texts were retrieved in the search. Following the exclusion of documents that did not meet the project’s inclusion criteria, the B.C. corpus included 29 policy texts written or commissioned by a provincial ministry, or regional health authority. Twenty policy documents were provincial, and nine were regional. In addition, ten were considered current policy, while 19 were historical policy documents. See Table 1 for further information on each document. Descriptive summaries of each policy document are included in Appendix D.

Table 1: Descriptive Details of British Columbia’s Policy Documents

Current Provincial Level	Document	Authors	Year Published	Years Active
1	BC Harm Reduction Strategies and Services Policy and Guidelines 2014	BC Harm Reduction Strategies and Services Committee	2014	2014 – no stated end
2	Crystal Meth and Other Amphetamines: An Integrated BC Strategy	British Columbia Ministry of Health Services	2004	2004 – no stated end
3	Every Door is the Right Door: A BC Planning Framework to Address Problematic Substance Use and Addiction	British Columbia Ministry of Health Services	2004	2004 – no stated end
4	From Hope to Health: Towards an AIDS-free Generation	British Columbia Ministry of Health Services	2012	2012-2016
5	Healthy Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in BC	British Columbia Ministry of Health Services	2007	2007-2017
6	Healthy Pathways Forward: Progress Report 2011	Clinical Prevention Services BC Centre for Disease Control & Population and Public Health Ministry of Health	2007	2007-2017
7	Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia	Ministry of Health Services; Ministry of Child and Family Development	2010	2010-2020
8	A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - 10 year Plan	First Nations Health Authority; BC Ministry of Health; Health Canada	2013	2013-2023
9	Collaborating for Action: Provincial Health Services Authority HIV/AIDS Framework	Provincial Health Services Authority	2006	2006 – no stated end

Current Regional Level	10	Position on the Prevention of Problematic Substance Use: With a focus on alcohol. An integrated population health approach	Northern Health Authority	2012	2012 – no stated end
Historical Provincial	11	BC Harm Reduction Strategies and Services Policy and Guidelines 2009	BC Harm Reduction Strategies and Services Committee	2009	2009-2014
	12	BC Harm Reduction Strategies and Services Committee Policy Indicators Report (2013)	BC Harm Reduction Strategies and Services Committee	2011	2011
	13	BC Harm Reduction Strategies and Services Committee Policy Indicators Report (2014)	BC Harm Reduction Strategies and Services Committee	2012	2012
	14	Crystal Meth and Other Amphetamines: 6 Month Progress Report	British Columbia Ministry of Health Services	2004	2004-2005
	15	From Hope to Health: Progress Report 2013-14	British Columbia Ministry of Health Services	2013	2013-2014
	16	From Hope to Health Progress Report Source Data and Technical Information	British Columbia Ministry of Health Services	2013	2013-2014
	17	Healthy minds, Healthy People: Monitoring Progress: 2012 Annual Report	Ministry of Health; Ministry of Child and Family Development	2011	2011
	18	Healthy Minds, Healthy People - First Annual Report 2011	Ministry of Health; Ministry of Child and Family Development	2010	2010
	19	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007	BC Ministry of Health Planning; Ministry of Health Services	2003	2003-2007
	20	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007: 2004 Annual Progress Report	BC Ministry of Health	2003	2004-2004
	21	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007: 2005 Annual Progress Report	BC Ministry of Health	2005	2005
	22	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007: 2006 Annual Progress Report	BC Ministry of Health	2006	2006
	23	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007: 2007 Annual Progress Report	BC Ministry of Health	2007	2007
Historical Regional	24	Interior Health's Action Plan for Blood-Borne Pathogens	Interior Health Authority	2006	2006-2009

25	Meeting the Challenge: A Blood-borne disease strategy for Northern Health	Northern Health Authority	2005	2005-2009
26	Meeting the Challenge: A 2007 Blood Borne Disease Update for the Northern Communities	Northern Health Authority	2007	2005-2006
27	Meeting the Challenge: A Blood Borne Disease Update for the Northern Communities, December 2008	Northern Health Authority	2008	2007-2008
28	Mental Health and Addiction Services: Strategic Plan Fraser Health	Fraser Health Authority	2007	2007-2012
29	Closing the Gap: Integrated HIV/AIDS and Hepatitis C Strategic Directions for Vancouver Island Health Authority	Vancouver Island Health Authority	2006	2006-2009

4.0 Results

4.1 In B.C. policy documents, substance use is presented on a spectrum, and harm reduction is framed as an intervention targeting problematic substance use

4.1.1. Defining problematic substance use

Provincial and regional-level current documents conceptualize psychoactive substance use as a behaviour that falls along a spectrum of use, ranging from beneficial to problematic, with harm reduction targeting problematic use.

A shared understanding of this spectrum is demonstrated across four policy documents, including, *Every Door is the Right Door* [3] (p.8), *Healthy Minds, Healthy People* [7] (p.16), *A Path Forward* [8] (p.20), and *Position on the Prevention of Problematic Substance Use* [10] (p. 3).

These four documents illustrate this concept in a figure titled “Spectrum of Psychoactive Substance Use”. The spectrum describes types of use that result in a variety of outcomes in the following order: (i) beneficial use, (ii) non-problematic use, (iii) problematic use, and (iv) chronic dependent use. Definitions of each type of substance use are provided. Beneficial use is defined as “use that has positive health, spiritual or social impact”, and non-problematic use is defined as, “recreational, casual or other use that has negligible health or social effects”.

Problematic use is presented in two ways within the spectrum of psychoactive substance use. *Every Door is the Right Door* [3] differentiates between degrees of problematic use, i.e. “potentially harmful use” and “substance use disorder”. Potentially harmful use is defined as “use that begins to have negative consequences for individuals, friends/family, or society (p. 8), while, “substance use disorder” is defined as “clinical disorders as per DSM IV criteria” (p. 8).

Healthy Minds, Healthy People [7], *A Path Forward* [8], and *Position on the Prevention of Problematic Substance Use* [10] present a similar understanding. These documents conceptualize “problematic use” as separate from “chronic dependent use”. In this case, problematic use is defined as “use at an early age, or use that begins to have negative impacts for individuals, family/friends or society”. While, chronic dependent use is defined as “use that has become habitual and compulsive despite negative health and social effects”.

The conceptualization of psychoactive substance use as a behaviour with a variety of outcomes, including beneficial outcomes is an important finding. It suggests policymakers acknowledge that substance use itself is not problematic, but rather, it is the methods, patterns of use, and the resulting health and social outcomes on the individual and those around them that differentiate beneficial from problematic use. This underlies the framing of harm reduction as an intervention targeting problematic use in both regional and provincial documents in the B.C. corpus.

4.1.2 Harm reduction targets problematic substance use

A sub-set of documents identify harm reduction as an evidence-based approach to reducing harms associated with *problematic substance use specifically*, differentiating from non-problematic use.

Six current documents specifically target problematic substance use. They are *BC Harm Reduction Strategies and Services Policies and Guidelines* [1], *Crystal Meth and Other Amphetamines* [2], *Every Door is the Right Door* [3], *Healthy Minds, Healthy People* [7], *A Path Forward* [8], and *Position on the Prevention of Problematic Substance Use* [10]. These documents focus on methamphetamine use, specifically [2]; problematic substance use in general [1, 3, 7, 10]; and problematic substance use among Aboriginal populations, only [8].

Four current provincial and regional-level policy documents present a framework of service delivery that seeks to prevent or reduce problematic substance use: *Crystal Meth and Other Amphetamines* [2], *Every Door is the Right Door* [3], *Healthy Minds, Healthy People* [7], and *Position on the Prevention of Problematic Substance Use* [10]. The framework of service delivery is typically presented as a spectrum of services, or as a stepped model of care, which ranges from primary to tertiary prevention interventions. Harm reduction services are

positioned as secondary and tertiary prevention interventions within this service delivery model.

For example, *Position on the Prevention of Problematic Substance Use* [10] describes secondary prevention and activities as,

“...indicated prevention, which targets individuals who’s [sic] biological or sociological markers indicate a predisposition to problematic substance use but who show minimal signs of substance use problems...Some examples of secondary prevention initiatives and resources include...culturally-sensitive harm reduction training...” (Appendix A, p.1).

This document also describes tertiary interventions and their relation to harm reduction,

“Tertiary prevention lessens the disability resulting from problematic substance use and mental disorders, reduces co-morbidity and restores effective functioning. It aims to reduce further damage or impact of long-term disease and disability to people with substance use disorders....Some examples of tertiary prevention initiatives include...harm reduction programs...” (Appendix A, p.2).

Historical provincial and regional texts also frame harm reduction as an intervention to address problematic substance use. These texts include the 2009 edition of the *BC HRSS Policy and Guidelines* [11]; the 2013 and 2014 editions of the *BC Harm Reduction Strategies and Services Committee Policy Indicator Report* [12, 13]; *Healthy Minds, Healthy People: First Annual Report* [17]; *Priorities for Action Progress Report 2004* [20]; *Mental Health and Addiction Services: Strategic Plan Fraser Health, 2007* [28]; and, *Closing the Gap: Integrated HIV/AIDS and Hepatitis C Strategic Directions for VIHA, 2006* [29].

4.1.3 Summary

Current provincial and regional-level policy documents that address substance misuse focus on problematic use and position harm reduction as a secondary and tertiary prevention intervention to address problematic use. This suggests a shared approach to the issue at both provincial and regional levels of health care governance, and an understanding of the applicability of harm reduction within a stepped care approach to populations at risk of substance use related harms.

4.2 Harm reduction is positioned as an integral piece of the continuum of services that address problematic substance use

4.2.1 Responses to problematic substance use are grounded in a population health approach

The B.C. health system’s response to problematic substance use is centered on a population health approach. Five current provincial and regional policy texts explicitly describe a response

based on a population health approach; *Crystal Meth and Other Amphetamines* [2], *Every Door is the Right Door* [3], *Healthy Minds, Healthy People* [7], *A Path Forward* [8], and *Position on the Prevention of Problematic Substance Use* [10]. These documents endorse a framework that addresses the health needs of groups of people, rather than those of an individual. Furthermore, this approach is used by the health system to deliver prevention or care services that target populations along the continuum of substance use.

4.2.2 Continuum of problematic substance use services

4.2.2.1 Current policy

A continuum of health promotion, prevention, harm reduction, treatment and care to address problematic substance use - that is based on a population health approach - is described in most current policy documents. The exceptions to this are *A Path Forward* [8] and *Collaborating for Action* [9].

Two current policy documents, *Crystal Meth and Other Amphetamines* [2] and *Every Door is the Right Door* [3], present a stepped care approach to problematic substance use. This stepped care approach begins with broad-based prevention interventions that target the entire B.C. population, and end with highly-specialized interventions that target populations most at risk. Harm reduction interventions are identified as examples of a “low threshold response system” in these two documents (p.5 and p.13, respectively). In *Every Door is the Right Door* [3], the low threshold response system is described as “frontline services” (p. 44), that target people who “may be engaging in problematic substance use, but who are not ready to engage with the treatment system. Low threshold services help to prevent harms such as infection, blood-borne pathogen and other health problems...” (p. 44). This description reflects a harm reduction approach and further illuminates how harm reduction is positioned within the range of services that address problematic substance use.

An adapted stepped care approach is presented in *Healthy Minds, Healthy People* [7]. Here intervention approaches are described as targeting specific populations. For example, “Mental Health Promotion Strategies” target all British Columbians, “Targeted Prevention and Risk/Harm Reduction Strategies” target people vulnerable to mental health and/or substance use problems, and “Therapeutic Interventions” target people with substance use problems/dependence (p.12). This stepped care approach positions harm reduction as a secondary prevention approach, which targets people at risk of harms associated with substance use (p.12).

An alternative to a stepped care approach is presented in *Position on the Prevention of Problematic Substance use* [10]. Founded on a population health approach, this model presents a continuum of services for problematic substance use (Appendix A, p.1). The continuum

identifies strategies that promote primary, secondary, and tertiary prevention to populations along the continuum of substance use. Harm reduction is identified as both an intervention relevant to the secondary and tertiary prevention of problematic substance use, targeting “people with early signs of problematic substance use” (Appendix A, p.1), and people experiencing disability resulting from problematic substance use and mental disorders (Appendix A, p.2).

4.2.2.2 Historical policy

Historical provincial and regional policy documents which address substance use related harms also depict a “continuum of services” approach to addressing problematic substance use. *Priorities for Action* [19], *Meeting the Challenge* [25], and *Mental Health and Addiction Services* [28] base their approach on a population health approach and continuum of care model. These historical documents conceptualize harm reduction as a secondary and tertiary intervention, targeting individuals experiencing, or at risk of experiencing, harms associated with substance use.

One historical regional policy document proposed an alternative conceptualization of the continuum of care framework. Rather than categorizing the continuum by levels of prevention i.e. primary, secondary or tertiary, *Closing the Gap* [29] describes its approach as segmented into universal interventions, selective interventions, indicated interventions, and targeted interventions (p. 22-23). These interventions are based on the level of risk of disorder in various groups, and harm reduction is described as a targeted intervention, which focuses on population groups with increased average risk of experiencing harms and those with early emerging problems associated with substance use or sexual activity (p.23).

4.2.3 Summary

An analysis of provincial and regional health systems approaches to addressing problematic substance use suggests their methods are grounded in a population health approach and structured along a continuum of health promotion, prevention, harm reduction, treatment, and care. Harm reduction is clearly identified as a core element of this continuum, and conceptualized as a secondary and tertiary prevention intervention, or as a targeting intervention. Despite differences in the terminology used to describe harm reduction’s position within the continuum, the intervention’s target population is consistent. Harm reduction is conceptualized as a prevention intervention that targets individuals at risk of, and those experiencing, harms associated with substance use or sexual activity.

4.3 Although harm reduction is generally framed as an intervention for preventing infectious disease, policy documents also consider broader concerns around health, social, and economic harms

4.3.1 Health harms

Healthy Pathways Forward [6] and *Collaborating for Action* [9] are current policy documents that primarily seek to reduce the incidence and prevalence of sexually transmitted infections and blood borne pathogens (STBBP). These documents frame harm reduction as an approach whose primary objective is the prevention of health harms, i.e. HIV and Hepatitis C (HCV).

For example, Healthy Pathways Forward [6] frames harm reduction as “an initiative needed to reduce ongoing transmission” of HCV (p.8). It identifies harm reduction as a principle of the strategy, describing the approach as, “... policies and programs that mitigate the adverse health impacts of drug use without requiring cessation.” (p. 17). Sanctioned interventions include, “needle exchange programs, safe needle disposal, low threshold approaches to addictions treatment, supervised injection facilities, and medical prescription of heroin” (p.21). Specific actions to address social or economic harms associated with substance use are not discussed in the document, although the document’s definition of harm reduction does describe harm reduction as “policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use” (p. 43).

Crystal Meth and Other Amphetamines [2] is a current provincial level policy focused on reducing the incidence and prevalence of, and harms associated with methamphetamine use. It frames the reduction of health, social and economic harms associated with methamphetamine use as one of the strategy’s five areas of focus. In relation to this, the strategy calls for “increased public education on the health, social and economic impacts of methamphetamine” (p.18). However, although the document considers health, social and economic impacts of methamphetamine use, harm reduction-specific interventions only focus on health harms, and promote needle exchange (p. 18)

4.3.2 Health, social, economic harms

Eleven current and historical policy documents position harm reduction as a response to substance use related health, social and economic harms. While the reduction of health harms is the main focus of harm reduction interventions in these documents, most documents also propose strategies to address social harms such as substance use related stigma.

4.3.2.1 Current Policy

Three current policy texts, *From Hope to Health* [4], *Healthy Minds, Healthy People* [7], and *Position on the Prevention of Problematic Substance Use* [10], target health and social harms associated with substance use.

BC HRSS Policy and Guidelines [1] positions harm reduction as a response to health, social and economic harms related to substance use and sexual health (p.2). Harm reduction is described as a “client-centered approach to improve health outcomes and reduce stigma and discrimination” (p.2). The authors also acknowledge the impact of the criminalization of illegal drug use on stigma and associated health harms (p. 2). Interventions of interest that target health harms are promoted in the “Guidelines”, including needle distribution, naloxone, safer injection facilities, and safer inhalation. The authors also propose interventions to address social harms including using harm reduction service providers as points of referral to social and economic services like housing, income support, food, and legal services, in addition to other primary health services (p.9); and promoting activities to reduce stigma and discrimination of people who use drugs by increasing understanding of harm reduction principles, policies and programs among professionals in health, social, and criminal justice systems (p.3).

From Hope to Health [4] acknowledges harm reduction’s applicability to both health and social harms, including HIV infection and stigma. The reduction of health harms are the primary focus of the document’s harm reduction interventions, and sanctioned interventions include low threshold opioid substitution therapy, needle distribution and recovery, and the integration of low barrier harm reduction program into HIV screening (p. 8). However, the document also promotes the use of public education and health promotion to reduce stigma associated with high risk behaviours such substance use (p. 8).

Healthy Minds, Healthy People [7] frames harm reduction as policies and programs that seek to reduce adverse health, social and economic consequences of psychoactive substance use (p.15). Proposed interventions to address health harms include safe injection facilities, and sterile syringe distribution and recovery (p.23). In relation to social and economic harms, the document proposes interventions to address stigma and discrimination (p. 18), and more generally, “the expansion of harm reduction serves that prevent and reduce health, social, and fiscal impacts of illegal drug use” (p.23).

Position on the Prevention of Problematic Substance Use [10] also describes harm reduction as an approach to reduce health, social and economic harms associate with psychoactive substance use (p.7). It promotes the uptake of a harm reduction philosophy in the development of public policy; community actions on problematic substance use; and the reorientation of health services (p.10-13). Needle and syringe distribution, as well as supervised consumption, are promoted to address health harms associated with problematic substance use (p.13). The

policy document also proposes interventions to address social harms. Interventions include the development of partnerships between community stakeholders to reduce stigma and discrimination towards people who use substances (p.11), and tasking policymakers with the development of healthy public policy which considers the harms associated with legislation or enforcement policies that target substance use (p. 10).

4.3.2.2 Historical Policy

The identification of harm reduction policy or programs as a method to reduce health, social and economic harm also occurs in historical provincial and regional documents. *BC HRSS Policy and Guidelines* [11], *BC HRSS Committee Indicator Reports* [12, 13], *Priorities for Action* [19], *Mental Health and Addiction Services* [28]; and *Closing the Gap* [29] frame harm reduction as interventions to address health, social and economic harms. However, in a similar trend to that observed in current policy, interventions primarily focus on health harms associated with problematic substance use, while stigma and discrimination of people who use substances are the most frequently addressed social harm.

4.3.2 Summary

Based on current and historical documents in the corpus, it is evident that provincial and regional policymakers have conceptualized harm reduction as an approach for broadly addressing health, social, and economic harms associated with substance since 2003. This longstanding approach to harm reduction across provincial and regional documents suggests a common understanding of harm reduction. Despite the acknowledgement of harm reduction's applicability to health, social and economic harms, sanctioned interventions primarily focus on health harms. However, the corpus does propose activities to address social harms such as stigma and discrimination, and two current policy texts consider the harms associated with drug policy and regulation, including the criminalization of illicit psychoactive substance use.

4.4. A consistent definition of harm reduction is used across the B.C policy set

Of the 29 policy texts in the B.C. corpus, a total of 15 documents (eight current and seven historical) include a formal definition of harm reduction. An analysis of these harm reduction definitions suggests that there is a common understanding of harm reduction across documents and jurisdictions, and the quality of definitions is high. These definitions strongly align with the characteristics of harm reduction outlined by Harm Reduction International (HRI, 2010).

Core characteristics of the HRI harm reduction definition include an acknowledgement that harm reduction includes (i) policies, programs and practices; (ii) is focused on the reduction of

health, social, and economic harms; (iii) does not require abstinence; and (iv) can apply to the entire population or specific sub-populations (HRI, 2010).

4.4.1 Consistency of definitions in current documents

Five of the eight current provincial and regional policy documents that include a formal definition of harm reduction consistently address three or more of the core characteristics of harm reduction as defined by HRI. These are *BC HRSS Policy and Guidelines* [1], *Every Door is the Right Door* [3], *Healthy Minds, Healthy People* [7], *A Path Forward* [8], and *Position on the Prevention of Problematic Substance Use* [10]. The five definitions share the following characteristics: the conceptualization of harm reduction as policies, programs and practices; its focus on reducing harms; its non-requirement for abstinence; and its applicability to the entire population or specific sub-populations.

The definition of harm reduction in *BC HRSS 2014 Policy and Guidelines* [1], *Healthy Minds, Healthy People* [6], and *Position on the Prevention of Problematic Substance Use* [10] are the most comprehensive. These definitions include four characteristics of the HRI definition. While, *A Path Forward* [8] and *Every Door is the Right Door* [3] include three HRI harm reduction definition characteristics.

Across all eight current documents that include a formal definition, harm reduction is most often described as focused on reducing harms, followed by the conceptualization of harm reduction as policies, programs and practices, and its non-requirement for abstinence. An acknowledgement of harm reduction's applicability to the entire population and specific sub-populations is emphasized least across the eight documents.

4.4.2 Consistency of definitions in historical documents

A shared understanding of harm reduction exists among most current documents, and a similar trend is observed within historical policy documents. Of the 19 historical provincial and regional policy texts, seven formally define harm reduction. Of these seven, *The BC HRSS 2009 Policy and Guidelines* [11], two *BC HRSS Committee Indicator Reports* [12, 13], the *Fraser Health Mental Health and Addiction Services Strategic Plan* [28], and *Closing the Gap* [29] offer the most comprehensive definitions of harm reduction within the corpus of historical documents.

Across these seven historical documents, the conceptualization of harm reduction as policies, programs and practices, as well harm reduction's focus on reducing harms are most emphasized.

4.4.3 Summary

The BC corpus presents a relatively consistent definition of harm reduction across documents, which closely align with the HRI definition. The majority of current provincial level texts include a formal definition of harm reduction, which share at least one characteristic of the HRI

definition, i.e. harm reduction's focus on the reduction of harms. The conceptualization of harm reduction as policies, programs and practices, and its non-requirement for abstinence in over half of current policy documents further demonstrates the consistent definition of harm reduction across documents, and the high quality of these definitions. While harm reduction is more frequently defined in current policy texts, a smaller proportion of historical provincial and regional documents define harm reduction. Definitions in historical documents present high quality definitions with at least three historical provincial documents meeting all HRI definition characteristics.

The inclusion of a formal definition of harm reduction in over half of the B.C. corpus suggests a concerted effort by policymakers to conceptualize the issue within documents that address mental health and addiction, problematic substance use, and BBP transmission. The frequent inclusion of definitions is alone an important finding. Furthermore, the definitions' alignment with many of the HRI definition characteristics, particularly the promotion of harm reduction as an approach to reduce harms through policy, programs and practices, and the non-requirement of abstinence, speaks to the high quality of definitions in policy. This suggests BC policymakers have sought to align local conceptualizations of harm reduction with international standards and principles, most prominently at the provincial level.

4.5 Leadership in harm reduction is provided by the provincial government and regional health authorities

4.5.1 Presence of harm reduction across the corpus

The term "harm reduction" is mentioned in all 29 B.C. provincial and regional documents, and each of the seven interventions of interest⁶ are mentioned at least once, with needle exchange mentioned most often. The promotion of harm reduction and explicit sanctioning of interventions of interest in these policy texts suggests that provincial and regional health authorities are taking deliberate action to support the institutionalization of harm reduction within the health system.

4.5.2 Regional leadership on harm reduction

The B.C. corpus includes seven regional policy documents published by four of the five regional health authorities (RHAs). Documents from Interior Health Authority (IH) [24], Northern Health Authority (NH) [10, 25, 26, and 27], Fraser Health Authority [28], and Vancouver Island Health Authority (VIHA) [29] are included in the B.C. corpus. These regional documents direct harm reduction policies, programs, and practices within their jurisdictions in relation to problematic substance use [10], BBPs [24, 25 and 29], and mental health and addiction [28].

⁶ Interventions of interest include: (i) needle/syringe distribution; (ii) Naloxone; (iii) supervised injection; (iv) low threshold opioid substitution; (v) drug checking; (vi) safer inhalation kits; (vii) outreach.

Relevant policy documents from Vancouver Coastal Health (VCH) were not retrieved in the search. This is a surprising finding since VCH is situated within a highly populated region of the province, and has a high concentration of harm reduction services within its catchment area, including Canada's first supervised injection facility (Vancouver Coastal Health, 2017).

Of the seven regional policy documents, six are historical and one current. *Position on the Prevention of Problematic Substance Use* [10] is the only current regional document within the corpus.

4.5.2.1 Regional leadership in current policy

Position on the Prevention of Problematic Substance Use [10], published by NH, focuses specifically on problematic substance use and presents an outline of NH's approach to preventing problematic substance use and its related harms. Harm reduction is identified as an essential part of a comprehensive response to individual, system, and social harms associated with alcohol and other illicit substances (p.7). The document calls for stakeholders to employ a harm reduction philosophy in all aspects of policymaking, and to base regulation of substance use in a public health approach (p.10). Named strategies to reduce harms associated with problematic substance use include expanded access to needle/syringe distribution, and supervised consumption sites (p. 13).

By naming harm reduction as an essential component of the health system's response to problematic substance use, and promoting harm reduction strategies and philosophy, *Position on the Prevention of Problematic Substance Use* [10] provides leadership to stakeholders by directing them to take up harm reduction strategies and philosophy. The authors present a clear and concise description of regional priorities and suggest strategies that will support the reduction of harms associated with problematic substance use. However, while the document does outline regional priorities and name sanctioned strategies, a number of governance components are excluded from the strategy. They include details on funding allocation, roles and responsibilities, and a monitoring and evaluation framework, which would further direct actions of stakeholders.

4.5.2.2 Regional leadership in historical policy

With only one current regional document retrieved, it is important to assess harm reduction leadership in historical regional policy to gain a better understanding of regional approaches to this issue over the years. Historical regional policy addresses BBPs, and mental health and addiction. NH and IH published BBP specific documents in 2006 and 2005, respectively. These policy texts reflect a sense of urgency in the region's approach to the HIV epidemic occurring at the time, and both documents call for the enhancement of regional harm reduction visions, policies and mandates [24, 25].

IH's BBP action plan [24] positions harm reduction as a targeted prevention service and calls on the health authority to provide leadership on the region's harm reduction vision, policy and mandate, and develop a plan to *"establish accessible needle exchange"* (p.12). Policymakers also call for IH to *"investigate means of establishing low-barrier, low threshold access to mental health, addictions and support services"* (p.12) and *"further develop the harm reduction strategy for the Methadone Maintenance Programs"* (p.15), suggesting a call for low threshold methadone maintenance treatment (MMT).

NH's BBP strategy, *Meeting the Challenge* [25] positions harm reduction as one of three components of its action plan on HIV and HCV (p.18-24). Actions surrounding the enhancement of harm reduction strategies are similar to those published in the IH BBP action plan [24]. Similarities include NH's development of a plan to establish accessible needle exchange services, and a call for NH to provide leadership by developing a *"harm reduction vision, policy, and mandate that outlines values and beliefs, and indicates commitment to the principles of harm reduction"* (p. 19). The policy document directs specific harm reduction related roles and responsibilities to stakeholders. These include directing NH to establish mobile harm reduction services and calling on Health Service Delivery Areas (HSDAs) within NH's jurisdiction to establish needle exchanges and expand access to a low threshold methadone program (p. 22-23). This BBP strategy is followed up with two annual progress reports [26,27] which monitor and evaluate progress on the implementation of specific harm reduction action, such as the establishment of mobile harm reduction services in Prince George, and harm reduction education and knowledge exchange activities conducted within the region to increase stakeholder understanding of harm reduction and facilitate the sharing of expertise among community members.

VIHA's *Closing the Gap* [29] is a historical strategic plan to addresses HIV/AIDS and HCV, published in 2006. Harm reduction is proposed as a Key Concept of the strategy (p.23) and a core component of the service delivery continuum (p.1). Harm reduction interventions are promoted and the health authority is tasked with the responsibility to increase accessibility of these services to target populations. Interventions include comprehensive needle exchange, street nurse outreach, the research and developments of supervised consumption environments, and low threshold services, including MMT (p. 20).

4.5.2.3 Summary: Regional leadership

Retrieved current and historical regional policies direct harm reduction activities within their respective jurisdictions. Historical regional policy explicitly name stakeholders' roles and responsibilities, and monitor and evaluate strategy implementation. Current regional policy appears to be less robust. While current regional policy does promote the implementation or expansion of interventions of interest, it excludes an explicit outline of specific stakeholder

roles and responsibilities, funding allocation, and evidence of monitoring and evaluation of policy implementation.

4.5.3 Provincial leadership on harm reduction

The B.C. corpus largely consists of provincial level policy, which includes nine current and 13 historical documents. The term “harm reduction” is mentioned in each document, and 19 provincial texts mention at least one intervention of interest.

Provincial policy provides leadership on harm reduction to stakeholders, and supports the institutionalization of harm reduction through identification of stakeholder roles and responsibilities. Stakeholders include regional health authorities, the Provincial Health Services Authority (PHSA), departments within the Ministry of Health, and community partners. Furthermore, provincial leadership is exhibited by government’s commitment to achieving stated goals, which in many cases is demonstrated through efforts to monitor and evaluate progress on the implementation of a strategy.

4.5.3.1 Roles and Responsibilities in provincial policy

Five current provincial policies explicitly outline harm reduction related roles and responsibilities including, *BC HRSS Policy and Guidelines* [1], *Crystal Meth and Other Amphetamines* [2], *Every Door is the Right Door* [3], *Healthy Minds, Health People* [7], and *Collaborating for Action* [9].

The *BC HRSS Services and Strategies* [1] document presents eight policy objectives and clearly identifies stakeholder responsibilities in relation to each policy objective (p.6). For example, health authorities are tasked with developing and maintaining collaborations with community agencies, people who access and those who deliver harm reduction services and supplies to the public (p.6). The document also identifies roles and responsibilities of contracted agencies and community partners. Together, these three stakeholder groups are tasked with the responsibility to maximize the reach of HRSS, address the recovery of needles, syringes and other drug paraphernalia that is inappropriately discarded, eliminate syringe sharing and promote syringe exchange, disseminate harm reduction information including harm reduction policy and best practices, consider the implementation of supervised consumption and overdose prevention response training, and train service providers on harm reduction best practices (p. 6).

Crystal Meth and Other Amphetamines [2], and *From Hope to Health* [4] present health authority roles and responsibilities, only. *Crystal Meth and Other Amphetamines* [2] directs health authorities to deliver harm reduction services such as needle exchange and outreach (p.37). While, *From Hope to Health* [4] directs health authorities to work with municipalities, governments, law enforcement and corrections to expand the delivery of needle exchange

services (p.8). This document also tasks health authorities with the responsibility of health education and health promotion to reduce stigma, and the integration of low-barrier harm reduction programs in HIV screening and care (p. 8)

Every Door is the Right Door [3] outlines community and Ministry of Health harm reduction related roles and responsibilities (p. 47-51). The community is tasked with fostering an environment where people and community groups can be active participants in an effort to address problematic substance use, and the Vancouver Area Network of Drug Users (VANDU) is identified as a community organization that works to advocate for drug users (p.47-48). Though this role does not call for the delivery of harm reduction services per se, it does promote a principle of harm reduction that prioritizes the participation of people who use drugs in decision making processes that affect them (HRI, 2010). Furthermore, while health authorities' responsibilities are described in broad terms not specific to harm reduction, i.e. the planning, delivery, evaluation of prevention and health services, the Ministry of Health's role as a developer of harm reduction guidelines is acknowledged (p. 49).

Collaborating for Action [9] describes the roles and responsibilities of PHSA agencies, including BC Centre for Disease Control (BCCDC) Division of STI/HIV Prevention and Control. This division is tasked with reducing transmission of STIs and HIV, and activities include the delivery of a Street Nurse Program that provides STI/HIV outreach services to marginalized populations (p.12). The role of BCCDC's Division of STI/HIV Prevention and Control and corresponding activities suggests the delivery of harm reduction services falls within its purview.

Two current policies allude to harm reduction actions and/or roles and responsibilities by either referencing other provincial strategies identified within the B.C corpus, or presenting actions without assigning responsibilities for these roles to particular stakeholders. *Healthy Pathways Forward* [6] lists roles and responsibilities that are not explicitly related to harm reduction, and instead directs the reader to refer to *Every Door is the Right Door* [3] for a detailed discussion of harm reduction (p.19). In addition, *Healthy Minds, Healthy People* [7] outlines harm reduction actions to be taken over the course of the strategy's implementation, however, it is unclear which stakeholders are responsible for the implementation of these actions (p.17, p.23).

Two historical policy texts, the *BC HRSS Policy and Guidelines* [11] (published in 2009) and *Priorities for Action* [19] (published in 2003), present stakeholder harm reduction related roles and responsibilities. The inclusion of harm reduction specific roles and responsibilities in historical documents suggests that provincial policy has attempted to make clear which stakeholders are responsible for the delivery of harm reduction since at least 2003.

In the case of the 2009 edition of the *BC HRSS Policy and Guidelines*, roles and responsibilities are shared by health authorities, contracted agencies and community partners. These roles and

responsibilities are presented in a list of seven policy objectives (p.4), which are very similar to those presented in the 2014 edition of the *BC HRSS Policy and Guidelines* [1]. However, the 2009 edition's roles and responsibilities exhibit one difference from those presented in the 2014 edition; the 2009 edition does not direct health authorities, contracted agencies and community partners to ensure adequate training of service providers on harm reduction best practices, as was done in the 2014 edition.

Priorities for Action [19] presents health authority roles and responsibilities in relation to harm reduction (p. 31). It tasks health authorities with ensuring effective service delivery that engages vulnerable populations in an effort to address the HIV epidemic in B.C. at the time. Policymakers cite harm reduction as one approach health authorities should use to support this mandate (p.31).

4.5.3.1.1 Summary: Roles and responsibilities

Harm reduction stakeholder roles and responsibilities are articulated in most current and historical provincial documents. Current policy largely directs harm reduction related roles and responsibilities towards health authorities, who are tasked with leading the planning and delivery of harm reduction services. While the roles and responsibilities of community partners and community based organizations are also presented, these documents suggest the responsibility of delivering harm reduction services has been formally decentralized to health authorities, and the provincial Ministry of Health is tasked with setting higher level policy that guides health authority activities.

4.5.3.2 Monitoring and evaluation in provincial policy

Policymakers demonstrate a commitment to achieving goals and objectives set out in policy texts through either the inclusion of a monitoring and evaluation plan in the policy document, and/or the publication of update or progress reports during the course of the policy's tenure.

At the provincial level, four policy texts describe plans to monitor and evaluate progress towards the implementation of harm reduction related activities over the course of the policy's implementation timeline. These documents include *From Hope to Health* [4], *Healthy Minds, Health People* [7], and *Priorities for Action* [19].

Of the 14 update/progress reports in the corpus, 11 provincial level reports included updates on harm reduction related activities. They are: *Healthy Pathways Forward: Progress Report 2011* [6], *BC HRSS Committee Policy Indicator Report 2013* [12], *BC HRSS Committee Policy Indicator Reports 2014* [13], *Crystal Meth and Other Amphetamines: Six Month Progress Report* [14], *From Hope to Health Progress Report: 2013-14* [15], *Healthy Minds, Health People: First Annual Report 2011* [18], *Healthy Minds, Health People: Monitoring progress 2012 Annual*

Report [17], and the four *Priorities for Action in Managing Epidemics* progress reports [20, 21, 22, 23].

Healthy Pathways Forward: Progress Report 2011 [6] reported on the first three years of the policy's tenure. Harm reduction related activities included the expansion of harm reduction distribution sites among people who inject drugs (p.6). The authors also acknowledged the impact of supervised injection facilities on HCV transmission (p. 6).

The two *BC HRSS Policy and Guideline* reports [12, 13] present updates of progress on the implementation of four goals outlined in the 2011 edition of the *BC HRSS Policy and Guideline*. Our search for relevant policy did not retrieve the 2011 edition of the BC HRSS Policy and Guideline; however, content in the 2013 and 2014 indicator reports [12,13] show that the 2011 edition of the guidelines share many similarities with the 2014 edition of the guidelines [1]. The 2013 and 2014 indicator reports [12,13] describe activities implemented by stakeholders to (i) support the reduction of drug related health and social harms; (ii) promote and facilitate referral to primary health care, addiction, mental health services, and social services; (iii) reduce barriers to health and social services; and (iv) ensure full and equitable delivery of harm reduction programs to people who use drugs, provide education about health promotion and illness prevention to inform decision making.

Crystal Meth and Other Amphetamines: 6 Month Report [14] describes harm reduction related activities that train people who deliver services with appropriate skills and knowledge that are based on harm reduction philosophy (p.4). The report also describes harm reduction education activities that reduce individual harms, including activities targeting men who have sex with men and clients of the Vancouver Area Network of Drug User (VANDU) who use amphetamines (p.6).

From Hope to Health Progress Report 2013-14 [15] provides an update on harm reduction specific activities, which relate to ensuring equitable access of needle exchange and condoms across B.C. (p.4), and health authority community engagement activities (p.22). To measure progress on the equitable availability of sterile needles and condoms in each health region, the report provides surveillance data on trends of health authority sterile needle and condom orders from the BCCDC's Harm Reduction Supply Program. In relation to sterile needles, specifically, trends indicate an increase in sterile needle orders in all health authorities between 2013 and 2014 (p. 7). In relation to community engagement activities, VIHA provided a report on outreach activities to clients of harm reduction sites and methadone clinics (p.22).

Healthy Minds, Healthy People: First Annual Report 2011 [18] provides a report on progress towards the implementation of harm reduction specific activities. Activities that specifically focus on the reduction of harms associated with illicit drugs are framed in relation to

populations with substance dependence, only (p.28). The report cites legislative changes surrounding the Supreme Court of Canada's decision on Insite as a success for the province, and an opportunity for future expansion of SIF in other regions of the province (p.28).

While the 2011 report [18] only reported on illicit drug harm reduction activities in relation to people with substance dependence, *Healthy Minds, Healthy People: Monitoring Progress: 2012 Annual Report* [17] reports on activities that target both people who are vulnerable to substance use problems, and those with substance dependence. Reports relating to populations vulnerable to substance use problems cite the 2012 launch of *Towards the Heart*, and the increased availability of social media resources to facilitate access to "knowledge exchange between the BCCDC harm reduction programs and others in the health care system" as examples of activities supporting the reduction of substance use problems (p.20). In relation to reports on activities targeting people with substance dependence, the authors describe the development of standards and guidelines for working with hard to reach programs, of which one component is an outreach program that is integrated into primary care (p. 29).

Four *Priorities for Action in Managing Epidemics* annual progress reports [20, 21, 22, 23] were published in 2004, 2005, 2006 and 2007. They include reports on harm reduction activities that address HIV/AIDS prevention activities (Goal 1); care, treatment and support for people living with HIV/AIDS (Goal 2); stakeholder capacity building (Goal 3); and coordination and cooperation activities to address HIV/AIDS (Goal 4).

The 2004 and 2005 *Priorities for Action* progress reports [20, 21] describe the expansion of low threshold harm reduction services such as exchange and safe disposal of needles, syringes, and other supplies, and supervised injection. The reports also address the opening of Insite, and continued implementation of the North American Opiate Medication Initiative (NAOMI).

The 2006 report [22] reviews the Federal government's deferral of VCH's request to renew Insite's exemption, and outlines anticipated negative impacts if the federal exemption is not granted to VCH (p.20). This report also discusses harm reduction activities in relation to HIV prevention among speciality populations including people who inject drugs, Aboriginal people, youth, inmates of correctional facilities, sex trade workers, gay men and men who have sex with men, people with multiple sex partners, homeless people, people with disabilities, HIV-positive men and women, new immigrants, and the South Asian Community (p.16). The final report, published in 2007 [23] provides an update on the (i) delivery of harm reduction supplies (needles, syringes, needle recovery) (p.16); (ii) the development of the *Healthy Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in BC* policy document, which is viewed as complimentary BBP provincial policy (p.25); and (iii) the provision of supervised injection services through Insite (p.15).

4.5.3.2.1 Summary: Monitoring and evaluation

The large number of provincial level progress reports suggests a commitment by provincial policymakers to monitor and evaluate efforts to address problematic substance use and BBPs. In most cases, reports provide a summary of activities conducted to date; however in more robust reports, progress is measured against objectives outlined in the original policy text, theoretically enabling policymakers to evaluate how well reported activities are meeting policy objectives.

Across all provincial reports, reviews of harm reduction related activities are frequent, and provide a glimpse into how policy priorities and actions were implemented in practice. Furthermore, findings suggest that harm reduction service delivery improvements were observed, and major harm reduction milestones took place between 2003 and 2014. Milestones include (i) the introduction of supervised injection facilities, (ii) the Supreme Court of Canada's challenge and decision to uphold Charter rights of Insite patients, which enabled the continuation of SIF service provision at Insite; (iii) the expansion of needle exchange services; sanctioning and support for the implementation of prescription heroin programs, including the NAOMI project; (iv) establishment of mobile harm reduction outreach services; (v) development of new harm reduction education and training programs for service providers; and (vi) the creation and launch of *Towards the Heart*, a centralized harm reduction resource for service providers, people who use drugs, and the wider community.

4.5.4 Major changes over time

Provincial and regional leadership on the promotion of prescription heroin appears to have reduced over time.

Prescription heroin was promoted as a low threshold opioid substitution therapy (OST) in documents published during the early to mid-2000s. This intervention is mentioned in one current provincial document, *Healthy Pathways Forward* [7] published in 2007, and three historical provincial texts, which are *Priorities for Action* [19] published in 2003, *Priorities for Action Progress Report* published in 2004 [20], and *Closing the Gap* [29] published in 2006. However, after 2007, mentions of this form of OST are not observed in policy texts or progress reports.

It appears that the promotion of prescription heroin in policy texts coincided with the initiation of the North American Opiate Medication Initiative (NAOMI). This was a randomized control trial that measured the efficacy of providing pharmaceutical grade injectable heroin to people who use opiates. The NAOMI Project ran from 2005 and 2008 in B.C. and Quebec, while a separate heroin prescription clinical trial, the Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) ran from 2011 to 2015 in BC (Oviedo-Joekes et al., 2008; Providence Health Care, 2016).

4.5.5 Interventions less frequently endorsed

While the term “outreach” or “outreach services” or “street nurse outreach” are used to describe interventions to address problematic substance use (Fraser Health Strategic Plan for Mental Health and Addiction Services, 2007; BC HRSS indicator report, 2012; Crystal Meth and Other Amphetamines, 2004; Closing the Gap, 2006 etc.), it is unclear if these services specifically meet the definition used in this analysis; i.e. services delivered beyond a fixed site that distribute substance use related harm reduction services⁷

4.5.6 Summary

Provincial and regional levels of government demonstrate leadership in the promotion and delivery of harm reduction. Regional and provincial policies direct harm reduction specific policies, programs, and practices to harms associated with problematic substance use and BBP transmission. Through these documents, policymakers sanction all interventions of interest, outline stakeholder harm reduction roles and responsibilities, monitor progress on policy objectives, and evaluate the extent to which implementation is meeting policy objectives. Furthermore, the B.C. corpus of policy texts suggests that B.C. takes a progressive stance on harm reduction. Documents promote and outline support for the implementation of SIFs and prescription heroin. While the B.C. corpus has a number of merits, it does include one key weakness. Outreach services are often mentioned within the corpus, particularly in relation to HIV/BBP programming; however, it is unclear if these services consistently meet the definition used in this analysis, making the mention of outreach services ambiguous and difficult to assess their applicability to this analysis.

4.6 It is unclear how overarching provincial-level harm reduction policy influences regional level policy documents

An alignment of provincial and regional policy would suggest policymakers are seeking to develop an integrated and cohesive approach to harm reduction across the province. One

⁷ Outreach: An intervention designed to engage people experiencing marginalization, disconnection or alienation from mainstream and/or targeted services and supports, in which education, supplies and care are delivered outside of a fixed site (i.e. mobile). The scope of outreach is very broad, and can refer to many practices beyond harm reduction. For the purposes of this research, an intervention is considered outreach if the following two criteria are met:

- 1) It occurs beyond a fixed site. Example of this include a mobile van, or outreach workers visiting people in private homes, street corners or other living spaces.
- 2) A harm reduction service is extended. This refers to one of the six remaining interventions of interest outlined in this document.

method to demonstrate this alignment is through the use of existing policy to direct new regional or provincial policy.

Position on the Prevention of Problematic Substance Use [10] is the only current regional policy document in the corpus, however, the document contains minimal mention of current provincial policy. Published in 2012 by IH, it focuses on problematic use of alcohol and other drugs. Though harm reduction is a core element of this document, neither *BC HRSS Policy and Guidelines 2009* [10] nor *BC HRSS Policy and Guidelines 2011* (not retrieved in search) are referenced in *Position on the Prevention of Problematic Substance Use* [10]. This is somewhat surprising since the *BC HRSS Policy and Guidelines* is the only standalone harm reduction policy in the corpus, and it seeks to direct actions of regional health authorities and other stakeholders. The exclusion of the 2009 and 2011 edition of *BC HRSS Policy and Guidelines* make it unclear if and how objectives outlined in these standalone provincial-level harm reduction policies are taken up within IH's *Position on the Prevention of Problematic Substance Use* [10].

It should be noted that while *Position on the Prevention of Problematic Substance Use* [10] does not explicitly reference *BC HRSS Policy and Guidelines 2009* or *2011*, it does reference two current mental health and addiction policy texts, i.e. *Every Door is the Right Door* [3] published in 2004, and *Healthy Minds, Healthy People* [7] published in 2010. Both *Every Door is the Right Door* [3] and *Healthy Minds, Healthy People* [7] are categorized as "Planning Documents" within a list of resources provided for the reader to review; however, they are not cited as texts that inform sanctioned harm reduction related activities (p.15).

While current regional policy makes minimal mention of current provincial policy, it appears that provincial level documents make an effort to align with existing, complimentary provincial policy. *From Hope to Health* [4] cites *Healthy Minds, Healthy People's* [7] low threshold substitution policy objectives when describing harm reduction methods to prevention HIV transmission (p. 7-8). While, *BC HRSS Policy and Guidelines* [1] lists *Healthy Minds, Healthy People* [7], and *From Hope to Health* [4] as two policy documents that may increase demand for harm reduction services in coming years (p.20).

4.6.1 Summary

Provincial-level policy is not cited in current regional policy as a rationale for promoting harm reduction policy objectives and actions. Interestingly, provincial level policy does acknowledge complimentary provincial policy. *Healthy Minds, Health People* [7] is most often referenced in policy texts as a rationale for the promotion of harm reduction interventions such as low threshold OST, or as a core resource for stakeholders, suggesting that this mental health and addiction policy plays a central role in the mental health and addiction field. While *Healthy Minds, Healthy People* [7] is cited in regional and provincial texts, neither the 2014 nor 2009

editions of the *BC HRSS Policy and Guidelines* [1,11] receive any mention in current policy, bringing into question how these seemingly central standalone harm reduction policy documents direct the actions of policymakers, particularly at the regional level.

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

	BC Harm Reduction Strategies and Services Policy and Guidelines 2014	Crystal Meth and Other Amphetamines: An Integrated BC Strategy	Every Door is the Right Door: A BC Planning Framework to Address Problematic Substance Use and Addiction	From Hope to Health: Towards an AIDS-free Generation	Healthy Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in BC	Healthy Pathways Forward: Progress Report 2011	Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia	A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - 10 Year Plan	Collaborating for Action: Provincial Health Services Authority HIV/AIDS Framework	Position on the Prevention of Problematic Substance Use: With a focus on alcohol. An integrated population health approach	Total (out of 10)
[1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or have drug problems?	1	0	1	1	0	0	1	1	0	1	6
[2] Does the document affirm that people who use substances need to be involved in policy development or implementation?	1	1	1	0	1	1	0	1	0	1	7
[3] Does the document acknowledge that not	1	1	1	0	0	0	1	1	0	1	6

all substance use is problematic?											
[4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community?	1	0	0	0	0	0	0	1	0	1	3
[5] Does the document acknowledge that harm reduction can be applied to the general population?	1	0	0	0	0	0	1	1	0	1	4
[6] Does the document target women in the context of harm reduction?	1	0	0	0	0	0	0	0	0	1	2
[7] Does the document target youth in the context of harm reduction?	1	0	1	0	0	0	1	0	0	1	4
[8] Does the document target indigenous populations in the context of harm reduction?	1	0	1	1	0	0	0	1	0	1	5
[9] Does the document target LGBTQI populations in the context of harm reduction?	1	0	0	0	0	0	0	0	0	0	1

TOTAL (out of 9)	9	2	5	2	1	1	4	6	0	8	38/90
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Table 2: Presence of key program indicators in current policy documents

	BC Harm Reduction Strategies and Services Policy and Guidelines 2014	Crystal Meth and Other Amphetamines: An Integrated BC Strategy	Every Door is the Right Door: A BC Planning Framework to Address Problematic Substance Use and Addiction	From Hope to Health: Towards an AIDS-free Generation	Healthy Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in BC	Healthy Pathways Forward: Progress Report 2011	Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia	A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - 10 year Plan	Collaborating for Action: Provincial Health Services Authority HIV/AIDS Framework	Position on the Prevention of Problematic Substance Use: With a focus on alcohol. An integrated population health approach	Total (out of 10)
[10] Does the document acknowledge the need for evidence-informed policies and/or programming?	1	1	1	1	1	1	1	1	1	1	10
[11] Does the document acknowledge the importance of preventing drug related harm, rather than just preventing drug use or blood borne or sexually transmitted infections?	1	1	1	0	0	0	1	1	0	1	6
[12] Does the document discuss low threshold approaches to service provision?	1	1	1	1	1	1	1	1	0	1	9

[13] Does the document specifically address overdose?	1	1	1	0	0	1	1	0	0	1	6
[14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach?	1	1	1	0	1	0	1	0	0	1	6
[15] Does the document consider harm reduction approaches for a variety of drugs and modes of use?	1	0	1	0	0	0	1	1	0	1	5
[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	1	0	1	0	0	1	1	1	0	1	6
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	1	0	1	0	0	0	1	1	0	0	4
TOTAL (out of 8)	8	5	8	2	3	4	8	6	1	7	52/80

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)	2/9 (11%)	1/16 (6%)
Nunavut (2)	3/18 (17%)	5/16 (31%)
Canada (54)	109/486 (22%)	153/432 (35%)

6.0 Conclusion

Harm reduction policy, programs, and practices are supported by provincial and regional STBBI, problematic substance use, and mental health and addiction policy in B.C. A common definition of harm reduction is observed across the corpus, and definitions closely align with the HRI definition (HRI, 2010). Harm reduction is framed as essential to the health system's approach to preventing and reducing harms associated with psychoactive substance use. This approach is based on a population health approach and harm reduction interventions are conceptualized as secondary and tertiary interventions that target people at risk of experiencing, or those currently experiencing harms, associated with problematic substance use.

The corpus promotes all seven intervention of interest, with needle exchange most frequently cited as a sanctioned harm reduction intervention. Progressive interventions such as supervised injection facilities, as well as prescription heroin are also promoted in policy texts; however, policy published after 2007 excludes any mention of prescription heroin, suggesting a change in provincial support during this time.

One policy text outpaces all others. *BC HRSS Policy and Guidelines 2014* [1] is the only standalone harm reduction policy document. It presents an exemplary definition of harm reduction, and reflects all principles of harm reduction as presented by HRI (2010). Despite its seemingly exemplary status, neither the 2014 edition nor earlier editions of the BC HRSS Policy and Guidelines are referenced in other provincial or regional level policy texts. Instead, the provincial-wide mental health and addictions strategy [7] is frequently referenced in provincial and regional texts, and cited as a planning resource for stakeholders to review.

Finally, the integration of harm reduction into health systems that seek to respond to problematic substance use, STIBBPs, and mental and addiction, and the monitoring and evaluation of progress on the implementation of harm reduction through progress reports, suggests that harm reduction is institutionalized at the provincial and regional level, and these level of government are committed to implementation of harm reduction policies, programs and practices within their jurisdictions.

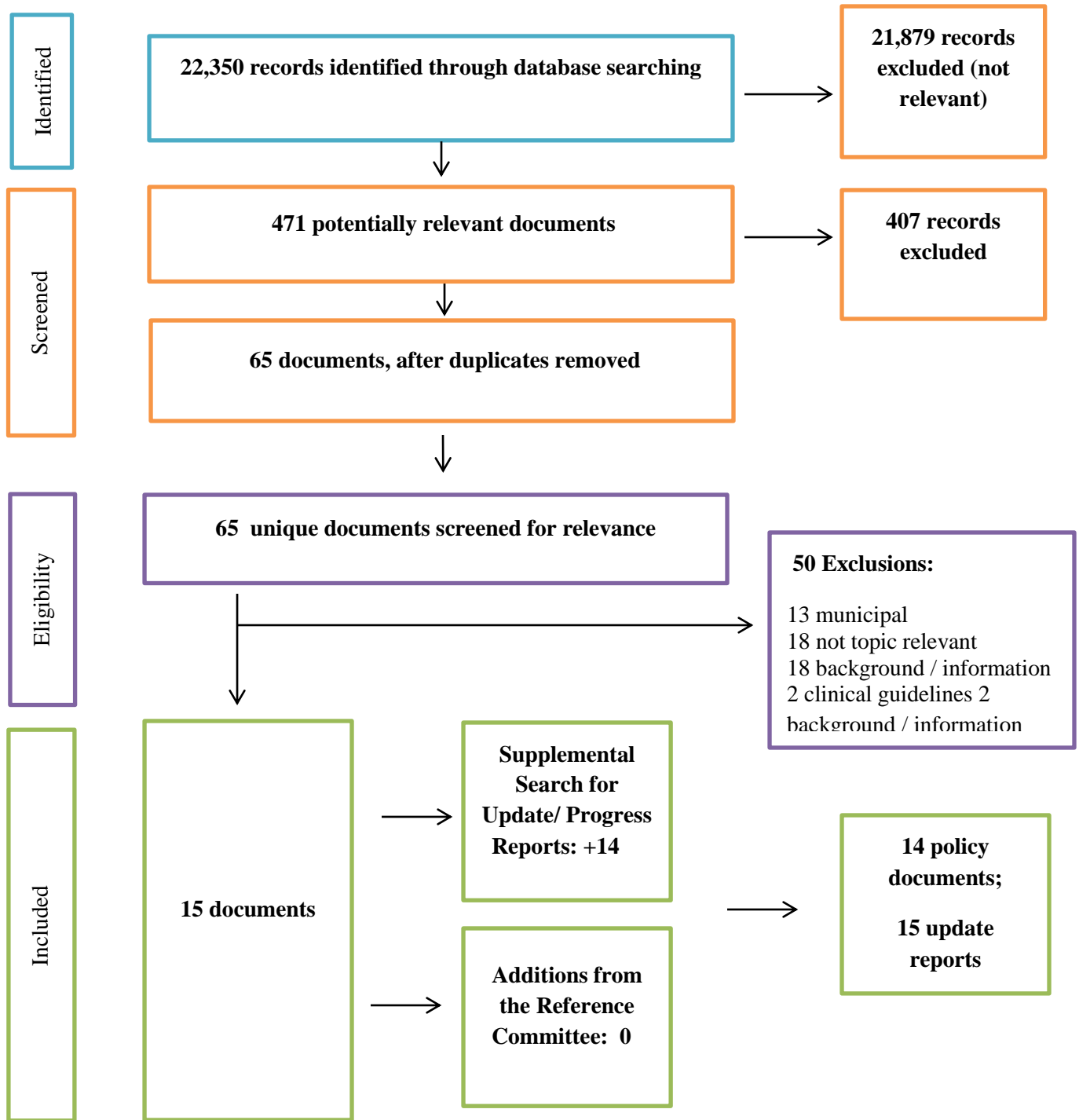
Appendix A: Regional & First Nations Health Authorities

Health Authorities		Population	Notes
Regional Health Authorities⁸	Fraser Health Authority	1,770,000	
	Interior Health	740,000	
	Vancouver Island Health	280,000	
	Northern Health	280,000	
	Vancouver Coastal Health	1,000,000	
First Nations Health Authority⁹	Fraser Salish	7,580	On-reserve population unavailable, total First Nations population reported
	Interior	27,321	On-reserve population
	Northern	12,313	On-reserve population
	Vancouver Coastal	12,287	On-reserve population
	Vancouver Island	15,754	On-reserve population

⁸ 2011/2012 data on population numbers in each regional health authority. Source: Office of the Auditor General of British Columbia. (2018). *Health authority overview*. Retrieved from <http://www.bcauditor.com/online/pubs/775/782>

⁹ 2011 Canadian Census data on BC First Nation populations within each region of the First Nations Health Authority. Source: First National Health Authority. (2018). *Regions*. Retrieved from <http://www.fnha.ca/about/regions>

Appendix B: Systematic search strategy flow diagram¹⁰



¹⁰ 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, than 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 documents

BC Harm Reduction Strategies and Services Policy and Guidelines was published in 2014 by BC Harm Reduction Strategies and Services (BCHRSS). The Committee consists of representatives from the British Columbia Centre for Disease Control (BCCDC), Health Authorities, Ministry of Health, and the Health Officers Council of BC. This provincial-level document is the province's main guideline on harm reduction strategies and services that address substance use related harms and sexual health. The 2014 version is an update of the 2009 edition of the *BC Harm Reduction Strategies and Services Policy and Guidelines*. The 2014 document outlines the BCHRSS harm reduction policy framework, policy goals, monitoring and evaluation plan, and identifies harm reduction interventions service providers can integrate into their service delivery.

Crystal Meth and Other Amphetamines: An Integrated BC Strategy is a provincial level policy document, which was published by the Ministry of Health Services in 2004. The strategy aims to guide BC's response to methamphetamine use and its associated harms. The document is BC's first methamphetamine strategy, and outlines five priorities for action. Priorities include: informing the public; building safer communities; identifying high-risk populations; increasing the skills of service providers; and reducing harm to individuals.

Every Door is the Right Door: A BC Planning Framework to Address Problematic Substance Use and Addiction was jointly published in 2014 by the BC Ministry of Health Services, Mental Health and Addictions. The document was co-authored on behalf of the province by a group of experts from the substance use field, and was developed in consultation with an advisory committee. This provincial-level planning framework aims to guide the responses of regional health authorities and their partners to populations experiencing problematic substance use within their jurisdiction. Furthermore, through the framework the authors sought to ensure a standard continuum of services across the province, by providing RHAs with a guide to deliver evidence-based services that address problematic substance use, addictions and mental health, and foster coordinated prevention and treatment services.

From Hope to Health: Towards an AIDS-free Generation was published by the British Columbia Ministry of Health in 2012. This document is a provincial level policy that aims to direct regional health authority approaches to HIV/AIDS prevention and care services. The document outlines five goals for achievement. The five goals focus on reducing HIV infections, improving the progression through prevention and early diagnoses, improving support services, and increasing treatment rates.

Healthy Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in BC is a provincial-level strategy that aims to direct the actions of decision makers, planners and health-care providers in response to the prevalence of viral hepatitis (HAV, HBV, and HCV). Published

in May 2007, this disease-specific strategy was produced by the BC Ministry of Health and covers a ten year period from 2007 to 2017. The document provides stakeholders with a strategic framework on which to base their viral hepatitis related health promotion, prevention and treatment activities. A large portion of this document focuses on the prevention and control of HCV due to the high prevalence of HCV among vulnerable populations.

Healthy Pathways Forward: Progress Report 2011 reviews activities conducted between 2007 and 2010 in relation to the four goals identified in *Health Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in British Columbia*, and identifies new opportunities for action. The progress report was published in 2011 and prepared by the Clinical Prevention Services BC Centre for Disease Control and the Ministry of Health's Population and Public Health department.

Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia was developed by the British Columbia (BC) Ministry of Health Services and the BC Ministry of Children and Family Development in 2010. This provincial substance use and mental health plan describes the province's planned activities and desired outcomes to improve the state of mental health and substance use in BC over a ten year period, ending in 2020.

A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - 10 year Plan is a policy document jointly published in 2013 by the recently established First Nations Health Authority (FNHA), the British Columbia (BC) Ministry of Health, and Health Canada. The plan presents a roadmap and vision for First Nations and Aboriginal people's mental health and substance use, and creates a framework to facilitate regional and local planning and action. This First Nations and Aboriginal population specific mental health and substance use plan is the first of its kinds in BC, and grounds its approach to improve mental health and substance use in respect and acknowledgement of First Nations and Aboriginal cultural values.

Collaborating for Action: Provincial Health Services Authority HIV/AIDS Framework is a policy document written in 2006 by the Provincial Health Services Authority (PHSA). This high-level document presents a framework to guide the PHSA's response to HIV/AIDS in BC and describes broad concepts in relation to HIV/AIDS prevention and treatment.

Position on the Prevention of Problematic Substance Use: With a focus on alcohol. An integrated population health approach was published by the Northern Health Authority (NHA) in June, 2012. This position statement provides an overview of the NHA's approach to preventing problematic substance use and its related harms in the region. The position

statement seeks to clarify NHA approach to problematic substance use, and introduce evidence informed strategies that address problematic substance use.

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