Northwest Territories 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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Table of Contents

1.0 Overview 4

1.2 Contextual Background 4

1.2 Healthcare Governance 5

1.3 Substance Use Trends 6

1.4 Harm Reduction Services in Northwest Territories 7

2.0 Methods 8

2.1 Search Process 9

2.2 Inductive Analysis 9

2.3 Deductive Analysis 10

3.0 Documents Retrieved 11

Table 1: Descriptive details of Northwest Territories' policy documents 11

4.0 Results: Inductive Analysis of Documents 12

4.1 There is no commitment to harm reduction in current territorial policy, despite endorsement of harm reduction in research and consultation conducted in NWT 12

4.1.1 Summary 12

4.2 The territorial commitment to harm reduction has weakened over time 13

4.2.1 Harm reduction in mental health and addicitions policies 13

4.2.2 Harm reduction in STBBI policy 13

4.3 Current policy is aligned with broader features of a harm reduction approach, despite not endorsing this specifically in name 14

4.3.1 Summary 14

5.0 Results: Deductive Analysis of Current Documents (Northwest Territories Policy Report Card) 16

Table 1: Presence of key population indicators in current policy documents 16

Table 2: Presence of key program indicators in current policy documents 17

Table 3: Proportion of policy quality indicators endorsed for all documents within cases 18

6.0 Conclusion 19

Appendix A: Systematic search strategy flow diagram 20

Appendix B: Standard methodology for generating provincial/territorial case report 21

Appendix C: Descriptive summary of current policy documents 24

References 25

1.0 Overview

This document provides a descriptive and analytical account of Northwest Territories' territorial harm reduction policy documents produced between 2000 and 2015. 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. Results for the Northwest Territories 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 Northwest Territories' 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.

Three key findings are highlighted from the inductive analysis*:* 1) There is no commitment to harm reduction in current territorial policy, despite endorsement of harm reduction in research and consultation conducted in NWT; 2) The territorial commitment to harm reduction has weakened over time; 3) Current policy is aligned with broader features of a harm reduction approach, despite not endorsing this specifically in name. In the deductive analysis, a set of criteria were applied to current policy documents. Results are presented in a standardized Policy Report Card.

1.2 Contextual Background[1]

Northwest Territories (NWT) is one of three northern territories in Canada, spanning 1,143,793 square kilometers. It has a population of around 41,462 - Yellowknife is the only major city (area of 105.44 km; population of 19,234) (Statistics Canada, 2012).

The political process in the Northwest Territories is distinct from the rest of Canada in that it operates under a consensus government model; a modified Westminster style of governance comprised of independent members of the legislative assembly (MLA). Unlike the rest of Canada, MLAs in NWT run as independents from the 19 electoral districts of NWT and are not members of a political party. Once all 19 MLA's are elected from the general election, a speaker is first elected followed by the cabinet consisting of six ministers and a premier. The eleven

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

remaining members are appointed as regular members and are seen as an unofficial opposition (White, 2005). This system of governance has existed in NWT since the 1970s (Mercer, 2010). The current premier, Bob McLeod, has held office since 2011 (CBC News, 2015). Bob McLeod has not made any official statements on harm reduction or related interventions.

As of 2015, the Minister of Health and Social Services, Glen Abernethy (2011-current, up to end of 2016), had not yet publicly endorsed harm reduction. One health authority incorporated harm reduction as part of their health strategy. The Yellowknife Health and Social Services Authority (YHSSA) included harm reduction in their regional strategic plan, published in 2013 (YHSSA, 2013). However, as of August 2016, this health authority had been dissolved.

1.2 Healthcare Governance

The NWT Health and Social Services System works with several partners to meet the health and wellbeing needs of NWT residents. The Department of Health and Social Services is responsible for ministry functions, including setting standards, policies, and priorities; strategic and business planning; and resource allocation and monitoring. Furthermore, the Department administers the NWT Health Care Plan, provides vital statistics services, and provides funding for the largest health authority in the territory (Government of the Northwest Territories, no year; Northwest Territories Health and Social Services Authority, 2016).

In August of 2016, the NWT healthcare system underwent a major transformation. Prior to this, eight regional health authorities operated in the territory, working under the guidance of the Department of Health and Social Services (Government of Northwest Territories, 2016). However, as part of a major health system overhaul, six of these (Beaufort Delta, Sahtu, Dehcho, Fort Smith, Yellowknife, and Stanton Territorial Hospital) were amalgamated into one health authority – the NWT health and Social Services Authority (NTHSSA). The NTHSSA was designed to have a governance model that provides a voice for regional concerns and a territorial board of management that can use this regional knowledge to improve care and outcomes for clients throughout the Northwest Territories. Decision making is informed in part by Regional Wellness Councils from various geographic regions of the NWT, which serve in an advisory capacity.

Alongside the NTHSSA, two additional authorities operate in the NWT. The Hay River Health and Social Services Authority provides services to the community of Hay River, and maintains its own Board of Management. The Tlicho Community Services Agency is also independent and was implemented as a result of the Tlicho Self Government Agreement. The Agency delivers health and social services in Tlicho Communities (Government of the Northwest Territories, no year).

Collectively, the three health authorities are responsible for the design and delivery of territorial health and social services across NWT. They are responsible for the administration and management of services such as mental health and addiction services, diagnostic and curative services, rehabilitation services, child and family services, continuing care services, and promotion and prevention services (Institute of Public Administration of Canada, 2013). Indigenous communities and non-governmental organizations (NGOs) are also important stakeholders in delivering and promoting community wellness activities and services as well as prevention.

1.3 Substance Use Trends

Data drawn from the Northwest Territories Addiction Surveys indicate that lifetime illicit drug use has increased among NWT residents. *The Northwest Territories Addiction Report* indicates that lifetime consumption of either cocaine/crack, hallucinogens, speed, ecstasy, or heroin increased from 16% in 2002 to 24% in 2009 (Department of Health and Social Services, 2010). More recently, the *2012 Northwest Territories Addictions Survey* found that 22% of NWT respondents indicated trying at least one of the aforementioned illicit substances in their lifetime. Hallucinogens and cocaine/crack were consistently the most commonly used illicit substances in NWT in the past decade, followed by ecstasy and speed. Only 1% of NWT residents used pain relievers with codeine or morphine such as Demerol, Percodan, or Tylenol 3 to get high in 2012 (Department of Health and Social Services, 2015). Regarding rates of past year use of the aforementioned illicit drugs, use increased between 2002(2%) and 2009(4%) and can be attributed to the increase in use of ecstasy and hallucinogens such as PCP, magic mushrooms, or LSD (Department of Health and Social Services, 2010). While data regarding illicit drug use among NWT youth is limited, the *Health and Health-Related Behaviors among Young People in the Northwest Territories* report found that NWT youth, in grades 9 and 10, view ecstasy, hallucinogen, PCP, and LSD use as posing slight or no risk to health as compared with the rest of Canadian youth (Freeman et al, 2012).

NWT residents were asked if their illicit drug use has had any harmful effects on their work/studies, social networks of friends and family, their physical health, or their home life such as their marriage. Between 2004 and 2012 there was a general increase in harms from illegal drug use, from 21% to 40% of respondents reporting harm. In 2006, over 53% of NWT residents, who used illicit drugs, indicated that they suffered some harm due to their drugs abuse (Department of Health and Social Services, 2010). Overdoses have also been prevalent in NWT. A coroner's report, *Review of Non-intentional Poisonings by Narcotics*, found that there were 27 drug toxicity accidental deaths between 2009 and 2014. Females accounted for two

thirds of those drug deaths and visited the emergency room more frequently than men. Additionally, there were 18 calls made, between 2011 and 2014, to the Poison and Drug Information Service (PADIS) regarding poisonings due to cocaine, methamphetamine, codeine, or OxyContin use (Department of Health and Social Services, 2016).

Additional data, drawn from the *Northwest Territories Hospitalization Report*, found that 430 individuals were sent to the hospital 615 times between 2008 and 2011 with drug or alcohol related issues. In total, 9% of those patients were due to crack/cocaine issues, while opiates such as heroin accounted for less than 3%. Of those patients who were hospitalized due to an alcohol or drug diagnosis, 28% suffered injuries as a result of assaults, 24% as a result of falls, and 23% a result from self-harm (Department of Health and Social Services, 2013).

Like in other provinces, fentanyl has reached NWT. Between 2009 and 2014, there were four fentanyl related deaths, where fentanyl was the main cause of death in two cases (Canadian Center on Substance Abuse, 2013, Misuse of Opioids in Canadian Communities). From 2011 to 2015, there were five fentanyl related deaths in total, averaging one per year. As of 2016, this represented the highest rate of fentanyl-related deaths per capita in Canada (Bird, 2016).

1.4 Harm Reduction Services in Northwest Territories

While there is growing support among the public and the health system on the effectiveness of harm reduction, harm reduction services are currently difficult to come by in the NWT. Prior to 2016, the ministry of Health and Social Services provided each health authority a lump sum budget in which a portion could be incorporated towards needle exchange programs, as the regional health authorities are responsible for the provision of harm reduction services (Klein, 2007). The YHSSA had taken the lead among health authorities in terms of harm reduction. The YHSSA was the only health authority to incorporate harm reduction in its strategic plan. In addition, the YHSSA created a Harm Reduction Committee for the purposes of creating a Harm Reduction Strategy and Action Plan. In the 2015/16 fiscal year, the committee developed key messages about the YHSSA Harm Reduction Framework and guided discussions related to the YHSSA Harm Reduction Framework (Yellowknife Health and Social Services Authority, 2016).

Other programs that incorporated harm reduction philosophies include the Matrix program, which was piloted by the Fort Smith Health and Social Authority. This program is a 12-week outpatient addictions program that incorporates various perspectives including harm reduction for the residents living in Fort Smith (Department of Health and Social Services, 2014). The status of the program is unknown since 2011 (Thompson, 2011). Despite progress, there remains very little in regards to harm reduction interventions. Within NWT, sterile syringes can only be obtained in pharmacies, health clinics, and the offices of the regional public health

authorities, otherwise known as public health units. Since the majority of these offices can be accessed in urban centers, it is difficult for individuals who live in rural communities to access them (Klein, 2007). Free needle-exchange programs do exist in NWT, however, they suffer from a lack of awareness (Letts, 2014). While needle exchange programs have been in place since 1991, both an MLA and mayor of Yellowknife were unaware of their existence (Edwards, 2009). To date it is unknown if public health units in other health authorities offer needle-exchange programs.

Other limited harm reduction services include methadone and buprenorphine. One report found that methadone treatment is not possible in rural areas of NWT due to a lack of medical supervision. However, it argued that methadone treatment is available in Yellowknife (Crowe Mackay, 2014). A 2011 report found that Methadone Maintenance Treatment (MMT) is not available anywhere in the region (Luce, 2011). Since there are currently no residential treatment centers available, it is likely that methadone treatment can only be accessed outside of the territory in either Alberta or British Columbia. In 2013, the territorial government cut funding to the Nats'ejee K'eh Treatment Centre, the only addictions treatment center in the territory (CBC News, 2013). There are no supervised injection sites, drug checking, safer inhalation kit distribution, or street outreach available in the NWT. In December of 2016, the Government of NWT made take home intra-nasal naloxone available for free at all retail pharmacies across the territory, without a prescription. They stated this was an interim measure until injection naloxone kits could be made available through all NWT retail pharmacies, health centres, clinics, hospitals and health cabins (Scott, 2016).

Few organizations in the territory are incorporating harm reduction practices in their programs. Since alcohol is the most common and problematic substance in the territory, alcohol maintenance programs are being considered by the territory (Anselmi, 2014). The Salvation Army in Yellowknife recently changed the guidelines by accepting clients whether or not the client is intoxicated (Koenig, 2015). Other than the Matrix program, it is unknown whether there are organizations involved in providing harm reduction services for illicit drug use in the NWT.

2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. Documents produced for Northwest Territories during

this period were (a) analyzed and synthesized inductively to describe historical[2] and current[3] policy developments guiding harm reduction services in the province over this time period, and (b) reviewed collectively and evaluated using a deductive coding framework comprised of 17 indicators, assessing the quality of harm reduction policies in order to facilitate cross-case comparison.

2.1 Search Process

A separate paper provides complete methodological details regarding the National search process (Wild et al., 2017). Systematic and purposive search strategies identified and verified publicly-available policy documents produced from 2000 – 2015. We defined relevant documents as harm reduction policy texts that (1) were issued by and representing a provincial or territorial government or (2) issued by and representing a regional, provincial, or territorial delegated health authority; (3) that mandated future action; and (4) that addressed one of seven targeted harm reduction interventions[4] 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 reduction practice, we excluded government or health authority authored documents exclusively focused on best practice guidelines for frontline service providers.

Four documents were identified and analyzed using a two-step (inductive and deductive) process described below (Appendix A provides the NWT -specific search strategy).

2.2 Inductive Analysis

Both NWT documents were analyzed using a three-step process (Appendix B provides analytic details). First, relevant text[5] 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

[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.
[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.

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 B) 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 Northwest Territories' set of harm reduction policy documents over the 15-year study period.

2.3 Deductive Analysis

We developed the CHARPP framework, a set of 17 indicators, to assess the quality of policy documents based on how well they described key *population characteristics* and *program features* of a harm reduction approach. To develop the CHARPP framework, a list of indicators was generated based on key harm reduction principles outlined by the International Harm Reduction Association (2010) and the World Health Organization (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.

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

3.0 Documents Retrieved

We retrieved three policy documents in our territorial search and one corresponding update report. All documents were produced at the territorial level. Of these documents, two were considered current - an original document and associated update report. See Table 1 below for further information on the two documents. An additional descriptive summary of the current policy document is included in Appendix C.

Table 1: Descriptive Details of Northwest Territories' Policy Documents

Current Territorial		Document	Authors	Year Published	Years Active
	1	A shared path towards wellness: Mental health and addictions action plan	Northwest Territories: Health and Social Services	2012	2012-2015
	2	Pathways to Wellness: An Updated Action Plan for Addictions and Mental Health 2014-2016	Northwest Territories: Health and Social Services	2014	2014-2016
Historic Territorial	*3*	Framework for Action - Mental health and addiction services	Northwest Territories: Health and Social Services	2004	Not stated
	4	Sexually transmitted infections. The naked truth: A strategic directions document	Northwest Territories: Health and Social Services	2005	2005-2010

4.0 Results: Inductive Analysis of Documents

4.1 There is no commitment to harm reduction in current territorial policy, despite endorsement of harm reduction in research and consultation conducted in NWT.

In the policy set for NWT, two of the four documents are considered current - *A Shared Path Towards Wellness: Mental health and addictions action plan[1],* and its associated update report, *Pathways to Wellness: An Updated Action Plan for Addictions and Mental Health 2014-2016[2].* Within these documents, there are no mentions of harm reduction or the seven interventions of interest. In the original action plan[1], addiction and several types of substance use are discussed in detail, including cocaine, heroin, prescription drugs and solvent abuse (p. 14). The document recognizes harm caused by addiction to families and communities, and promotes programs to teach children and teenagers the risks of certain types of substance use. However, action to mitigate these risks is limited to education, treatment and prevention. There is no recognition that harm or risk can be reduced or minimized through other types of interventions. Although the document does acknowledge a distinction between problematic and non-problematic substance use (p.7), the focus remains on preventing or stopping substance use, rather than working to mitigate harms. The update document reports on progress for action items outlined in the original action plan. Although this update provides some new recommendations based on additional consultation, the general approach remains the same.

Given the lengthy consideration of addiction and substance use in the original plan, the absence of any reference to harm reduction or related interventions is notable. This is underscored by the fact that it appears a conscious decision was made by policy makers to exclude harm reduction from the present policy document, despite commissioned research promoting this approach in the specific context of NWT. In a background section of *A Shared Path Towards Wellness[1]*, the authors refer to a study commissioned in 2010[6] "on future directions and promising practices for mental health and addictions programs" (p.10). This study appears to have informed the present document significantly as many recommendations were taken up. Importantly, harm reduction is incorporated throughout this commissioned study and endorsed as one of four foundational principles. This suggests that harm reduction was selectively excluded from the present document, despite research specifically recommending otherwise.

4.1.1 Summary

The pair of current policy documents in NWT provide no direction regarding harm reduction or any related interventions. This absence is notable considering that commissioned research specifically recommended a harm reduction approach for the region. This context suggests that harm reduction was deliberately withdrawn from formal territorial policy, despite supporting evidence. It is unclear why this

[6] Transformational Process for Mental Health & Addictions: Future Directions and Promising Practices in the Northwest Territories (NWT), McDermott Consulting, 2011.

would occur, but draws attention to the highly politicized nature of the policy process and resistance to instrumental-rational arguments in the realm of harm reduction policymaking.

4.2 The territorial commitment to harm reduction has weakened over time.

4.2.1 Harm reduction in mental health and addictions policies

As the previous point outlined, current policy in NWT does not endorse or promote harm reduction. The current mental health and addictions plan (*A shared path towards wellness: Mental health and addictions action plan[1])* replaced an older version, the *Framework for Action - Mental health and addiction services[3]*, published in 2004. This older (now historic) document, did in fact endorse harm reduction, albeit to a limited degree. Harm reduction was mentioned three times and was listed as a "core service", described as "the basic services that should comprise the foundation of the system of addictions, mental health and family violence services" (p.11). This same point asserted, "core services need to include … harm reduction".

A formal definition of harm reduction was also included in the document as follows:

> "*Harm Reduction- Addictions services in the NWT mostly aim for total abstinence from alcohol and drugs. Many people have not been able to achieve or maintain total abstinence, and experience a sense of failure when relapse occurs. The harm-reduction approach aims to reduce harmful behaviors as much as possible rather than to eliminate them completely*" (pg.12)

Importantly, the definition challenges the traditional focus on abstinence based treatments in the territory, noting that they may be demoralizing and counterproductive for those who are unable or unwilling to discontinue drug use entirely. Harm reduction is not operationalized in the document in any meaningful way, and none of the interventions of interest are noted. Despite this, a harm reduction approach is clearly endorsed, and attention is drawn to the shortcomings of an abstinence-based approach. This starkly contrasts the current guiding policy for addictions and mental health in the region, and indicates a move away from recognising harm reduction as a legitimate feature of mental health and addictions services over time.

4.2.2 Harm reduction in STBBI policy

Within the region, there was a designated STBBI policy in place in the past (*Sexually transmitted infections. The naked truth: A strategic directions document[4]*). This document expired in 2010. Although it did not address harm reduction at all – or any risks associated with substance use other than sexual activity, it is notable that a more recent version has not been published. Substance use, particularly injection drug use, is a known risk factor for the transmission of STBBIs, and the absence of any current guiding policy on STBBI transmission is notable.

4.3 Current policy is aligned with broader features of a harm reduction approach, despite not endorsing this specifically in name.

The current policy set for NWT does not endorse harm reduction by name, or any of the interventions of interest. Despite this, the document promotes several principles that align well with key features of a harm reduction approach and enable policy implementation.

In *A shared path towards wellness: Mental health and addictions action plan[1]*, the marginalization of those experiencing mental illness, including addictions, is addressed. One of the document's key goals is to "promote understanding, awareness, and acceptance" of mental health and addictions problems, and reducing stigma is a recurring theme. This aligns well with HRI's (2010) principles of dignity and compassion, adopting a non-judgmental approach, and opposing the stigmatization of people who use drugs.

Within *A Shared Path Towards Wellness[1]*, collaboration with various stakeholders is endorsed, including various departments and programs operating in the region (p.16). Furthermore, the document notes that feedback from service providers and clients of mental health and addictions programs informed knowledge around service gaps (p.13). The authors emphasize that programming should be guided by communities, and supported by governments, rather than the other way around. This aligns with HRI's (2010) principle of transparency and involving a range of stakeholders meaningfully, including affected communities.

A harm reduction approach prioritizes low-cost, high-impact interventions, and emphasizes a commitment to basing policy and practice on the strongest evidence available (HRI, 2010). These principles are also endorsed in the original action plan; "… distributes available resources in the most effective manner possible, while at the same time ensuring the sustainability of services" (p.10). Additionally, the document recognizes the importance of evidence, noting a goal of providing "evidence-based best practice that is culturally relevant to the people of the Northwest Territories" (p.21).

In line with the above, *A Shared Path Towards Wellness[1]* incorporates several features of governance that support policy implementation, accountability and evaluation. Legislation is recognized as an important consideration as part of a mental health and addictions system (p.21), and the plan is explicitly endorsed by the Minister of Health and Social Services. Additionally, the plan emphasizes the importance of accountability in policy implementation, outlining steps that will be taken to evaluate this – and respond to findings in a meaningful way. Given that a progress report was published within two years, which does just this, the *Framework for Action[3]* demonstrates a commitment to following through with policy promises.

4.3.1 Summary

Although harm reduction or related interventions are not specifically endorsed, the policy environment appears friendly to the implementation of this approach in the future. Many foundational principles of

harm reduction practice have already been implemented in the NWT. As such, adopting a stronger commitment to the approach would not require a great shift in the broader policy environment.

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

One current document was 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. The 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

	Pathways to wellness: An updated action plan for adiction and mental health	**A shared path towards wellness: Mental health and addictions action plan**	**Total (out of 2)**
[1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or have drug problems?	**0**	**1**	**1**
[2] Does the document affirm that people who use substances need to be involved in policy development or implementation?	**0**	**0**	**0**
[3] Does the document acknowledge that not all substance use is problematic?	**0**	**1**	**1**
[4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community?	**0**	**0**	**0**
[5] Does the document acknowledge that harm reduction can be applied to the general population?	**0**	**0**	**0**
[6] Does the document target women in the context of harm reduction?	**0**	**0**	**0**
[7] Does the document target youth in the context of harm reduction?	**0**	**0**	**0**
[8] Does the document target indigenous populations in the context of harm reduction?	**0**	**0**	**0**
[9] Does the document target LGBTQI populations in the context of harm reduction?	**0**	**0**	**0**
TOTAL (out of 9)	**0**	**2**	**2 of 18**

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

	Pathways to wellness: An updated action plan for adiction and mental health	A shared path towards wellness: Mental health and addictions action plan	Total (out of 2)
[10] Does the document acknowledge the need for evidence-informed policies and/or programming?	**0**	**1**	**1**
[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?	**0**	**0**	**0**
[12] Does the document discuss low threshold approaches to service provision?	**0**	**0**	**0**
[13] Does the document specifically address overdose?	**0**	**0**	**0**
[14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach?	**0**	**0**	**0**
[15] Does the document consider harm reduction approaches for a variety of drugs and modes of use?	**0**	**0**	**0**
[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	**0**	**0**	**0**
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	**0**	**0**	**0**
TOTAL (out of 8)	**0**	**1**	**1 of 16**

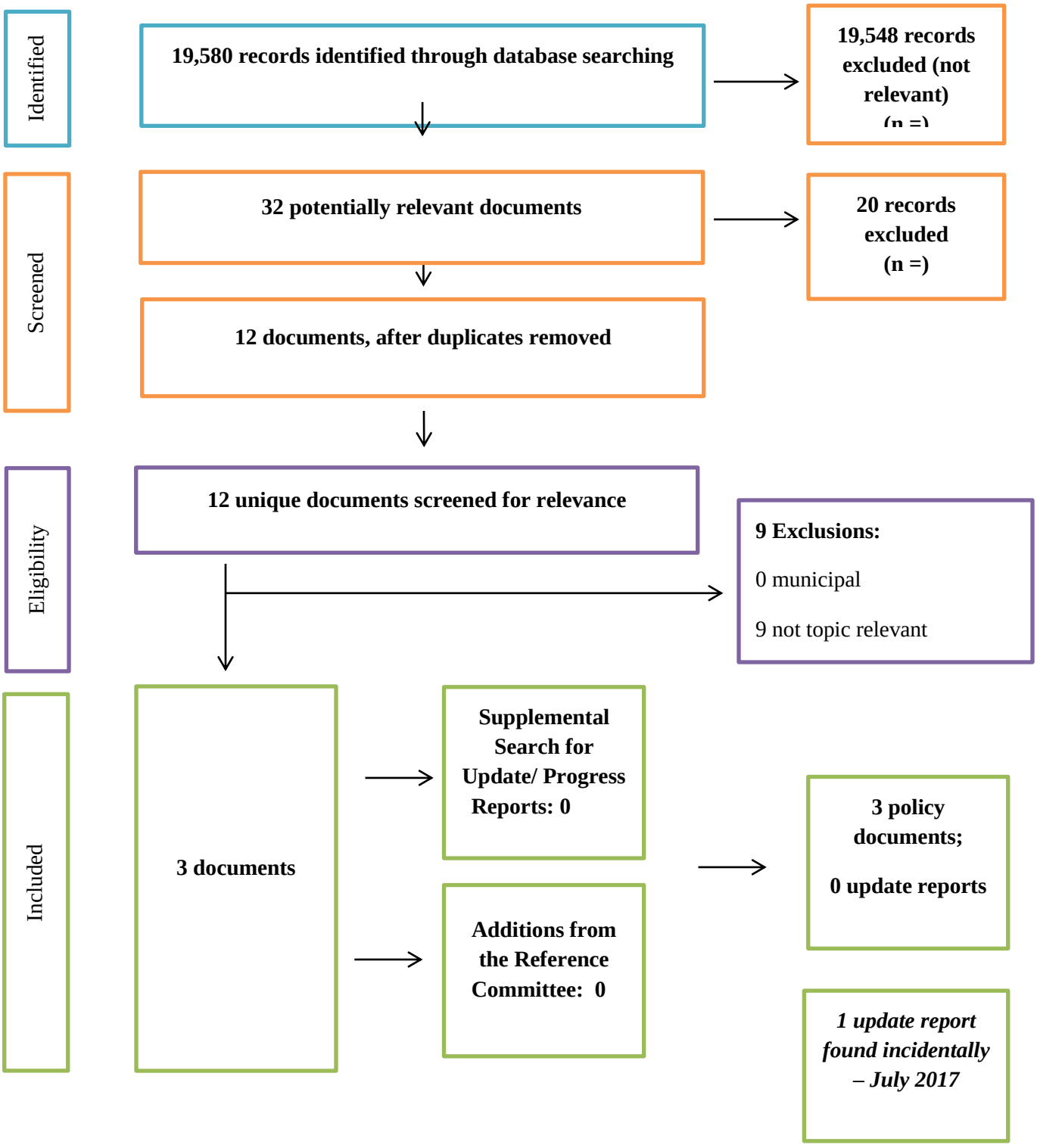
Table 3: Proportion of policy quality indicators endorsed for all documents within cases

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

6.0 Conclusion

The policy set for NWT provides no current direction around the implementation of harm reduction programs, services or interventions, and can be considered weak at best. While this is not unique for provincial or territorial-level policy in Canada, several key features of the policy environment stand out, making the absence particularly notable. At the territorial level, there is clearly an awareness of harm reduction, its principles, and the potential for positive outcomes, based on third party research conducted as part of the policy development process. Furthermore, historical documents do endorse a harm reduction approach (albeit vaguely), indicating that commitments to harm reduction have actually weakened over time, despite compelling and increasing evidence for them – and support – elsewhere in the region. It is not clear why harm reduction has been omitted from current policy, although it is likely this was not a simple oversight. This omission draws attention to the politicized nature of policy development, and the resistance of harm reduction policy to instrumental-rational arguments that rest on evidence. In looking towards the future, the policy environment of NWT is highly amenable to adopting an explicit commitment to harm reduction, given that several features of harm reduction practice are already exemplified in current policy.

Appendix A: Systematic search strategy flow diagram[7]



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

Appendix B: 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 complied 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 C: Descriptive summary of current policy documents

A Shared Path Towards Wellness- Mental Health and Addictions Action Plan

A Shared Path Towards Wellness- Mental Health and Addictions Action Plan was published by the Department of Health and Social Services in 2012. The purpose of the document was to provide a framework and action plan to guide the development and delivery of mental health and addictions services in the territory over a three year period. The document is well made, and provides an in-depth discussion of addiction and substance use – distinct from mental illness. Harm reduction or the seven interventions are not mentioned throughout the document. One update report exists – published in 2014, *Pathways to Wellness.*

Pathways to Wellness: An Updated Action Plan for Addictions and Mental Health 2014-2016

Pathways to Wellness: An Updated Action Plan for Addictions and Mental Health 2014-2016, was published in 2014 by the Department of Health and Social Services. It is an update report to *A Shared Path Towards Wellness- Mental Health and Addictions Action Plan*. The update report contains actions contained in the original *Action Plan*, with recommendations from *Healing Voices* – a report of the Minister's Forum on Addictions and Community Wellness. This forum was originally proposed as an action item in the *Action Plan*. As part of the forum, the Minister travelled to all six regions of the NWT to consult with residents about community needs/ concerns. The document reports on the same goals outlined in the original plan – providing an update on specific action items. It includes additional recommendations based on *Healing Voices* that focus on addictions and community wellness, specifically. Action items promote a recovery-based approach, with a focus on treatment options, and appear to promote abstinence as the end goal. There is no mention of harm reduction, or any interventions of interest. This document is a progress report, and does not add anything new in terms of harm reduction, however it does report on new recommendations based on consultation suggested in the original plan.

References

Anselmi, E. (2014). Harm reduction hones home in Yellowknife. Retrieved November 22, 2016, from http://www.nnsl.com/frames/newspapers/2014-11/nov28_14drgs.html

Bird, Hilary. (12 July, 2016). N.W.T. averaging 1 fentanyl related death per year, study finds. CBC News. Retrieved from http://www.cbc.ca/news/canada/north/fentanyl-deaths-nwt-1.3676257

Canadian Center on Substance Abuse. (2013). Misuse of Opioids in Canadian Communities. [Bulletin]. Toronto, ON. Retrieved November 2, 2016 from http://www.ccsa.ca/Resource%20Library/ccsa-CCENDU-Opioid-Bulletin-2013-en.pdf

CBC News. (2013). Contract axed for N.W.T.'s only addictions treatment center. Retrieved November 22, 2016, from http://www.cbc.ca/news/canada/north/contract-axed-for-n-w-t-s-only-addictions-treatment-centre-1.1301893

CBC News. (2014). Harm reduction set to become big focus in Yellowknife. Retrieved November 22, 2016, from http://www.cbc.ca/news/canada/north/harm-reduction-set-to-become-big-focus-in-yellowknife-1.2751053

CBC News. (2015). Bob McLeod re-elected N.W.T. premier. Retrieved November 23, 2016, from http://www.cbc.ca/news/canada/north/nwt-new-premier-and-cabinet-1.3367621

Crowe Mackay. (2014). Government of Northwest Territories Department of Health and Social Services Assessment and Review of Withdrawal Management Services: Final Report. Retrieved from www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/review-withdrawal-management-services.pdf.

Department of Health and Social Services. (2016). Review of Non-intentional Poisonings by Narcotics. Retrieved from http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/resources/non-intentional-poisonings.pdf.

Department of Health and Social Services. (2015). The 2012 NWT Report on Substance Use and Addiction. Retrieved from http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/report-on-substance-use-and-addiction-2012.pdf.

Department of Health and Social Services. (2014). Addictions Where to get help in the NWT. Retrieved from http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/addictions-where-get-help.pdf.

Department of Health and Social Services. (2013). Northwest Territories Hospitalization Report. Retrieved from http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/nwt-hospitalization-report.pdf. Accessed from November 22, 2016.

Department of Health and Social Services. (2010). NWT Addictions Report: Prevalence of alcohol, illicit drug, tobacco use and gambling in the Northwest Territories. Retrieved from http://docplayer.net/13020402-Nwt-addictions-report-prevalence-of-alcohol-illicit-drug-tobacco-use-and-gambling-in-the-northwest-territories.html

Department of Health and Social Services. (u.d.). The 2006 NWT Addictions Report. Retrieved from http://pubs.aina.ucalgary.ca/health/66658.pdf

Edwards, T. (2009). CN NT: Clean Needles Available For Drug Addicts. Retrieved November 22, 2016, from http://www.mapinc.org/drugnews/v09/n422/a04.html

Freeman, J., King, M., Briand, P., and Pickett, W. (2012). Health and Health-Related Behaviours Among Young People in the Northwest Territories. Kingston, ON: Queen's University.

Government of Northwest Territories. (2016). Establishment of the Northwest Territories Health and Social Services Authority. Retrieved from http://www.gov.nt.ca/newsroom/news/establishment-northwest-territories-health-and-social-services-authority

Government of Northwest Territories. (no year). NWT Health and Social Services Delivery. Retrieved from http://www.practicenorth.ca/index.php?page=nwt-health-social-services-delivery

Institute of Public Administration of Canada. (2013). Healthcare Governance Models in Canada A Provincial Perspective Pre-Summit Discussion Paper. Retrieved November 2, 2016 from The Institute of Public Administration of Canada website: www.ipac.ca/documents/ALL-COMBINED.pdf

International Harm Reduction Association (HRI). (2010). What is harm reduction? A position statement from Harm Reduction International. London, UK: International Harm Reduction Association

Klein A (2007). Sticking Points: Barriers to Access to Needle and Syringe Programs in Canada. Toronto: Canadian HIV/AIDS Legal Network. Retrieved from http://librarypdf.catie.ca/PDF/P48/stickingpoints.pdf

Koenig, S. (2015). Yellowknife's Salvation Army loosens rules on sheltering the intoxicated. Retrieved November 23, 2016, from http://www.cbc.ca/news/canada/north/yellowknife-s-salvation-army-loosens-rules-on-sheltering-the-intoxicated-1.3232601

Letts, D. (2014). Free bannock and condoms. Retrieved November 22, 2016, from http://www.nnsl.com/frames/newspapers/2014-07/jul30_14hep.html

Luce, J. (2011). A Cross-Canada Scan of Methadone Maintenance Treatment Policy Developments: A Report Prepared for the Canadian Executive Council on Addictions. Canadian Executive Council on Addictions. Retrieved November 03, 2016 from http://www.ceca-cect.ca/pdf/CECA%20MMT%20Policy%20Scan%20April%202011.pdf

Mayan, M. (2009). Essentials of qualitative research. Walnut Creek. CA: Left Coast Press.

Mercer, T. (2010). Consensus Government in the Northwest Territories: A Parliamentary Panacea?. Parliamentarian, 91(3), 234-239

Northwest Territories Health and Social Services Authority. (2016). About Us. Retrieved November 23, 2016, from http://nthssa.ca/en/about-us.

Scott, Mackenzie. (20 December, 2016). Opioid antidote naloxone now available free at all N.W.T. pharmacies. CBC News. Retreived from http://www.cbc.ca/news/canada/north/naloxone-available-free-nwt-pharmacies-1.3905748

Statistics Canada. 2012. Northwest Territories (Code 61) and Canada (Code 01) (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Ottawa. Released October 24, 2012. Retrieved from http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E (accessed November 23, 2016).

Thompson, R. (2011). New addiction treatment option. Retrieved November 23, 2016, from http://www.nnsl.com/frames/newspapers/2011-08/aug18_11ADD.html

White, G. (2005). Cabinets and First Ministers. Vancouver, B.C: UBC Press.

Wild, T. C., Pauly, B., Belle-Isle, L., Cavalieri, W., Elliott, R., Strike, C., ... & Hyshka, E. (2017). Canadian harm reduction policies: A comparative content analysis of provincial and territorial documents, 2000–2015. International Journal of Drug Policy, 45, 9-17.

World Health Organization (WH0). Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key 28 populations. Geneva, Switzerland. 2014.

YHSSA. (2013). Yellowknife Health and Social Services Authority Strategic Plan 2013-2018.

Retrieved from http://www.yhssa.hss.gov.nt.ca/sites/default/files/yhssa_strategic_plan_2013-2018.pdf

Yellowknife Health and Social Services Authority. (2016). A Culture of Quality and Safety: The 2015-2016 YHSSA Annual Report. Retrieved from http://www.yhssa.hss.gov.nt.ca/sites/default/files/2016yhssa_ar-en.pdf_v0_0_1.pdf. Accessed from November 22, 2016