# New Brunswick Policy Analysis Case Report

**Canadian Harm Reduction Policy Project (CHARPP)**

*September 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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## *Related citations:*

*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.*

## Table of Contents

## 1.0 Overview

This document provides a descriptive and analytical account of New Brunswick's provincial harm reduction policy documents produced between 2000 and 2015. This account is part of the Canadian Harm Reduction Policy Project (CHARPP), a multimethod multiple case study comparing provincial/territorial harm reduction policies across Canada. New Brunswick 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 New Brunswick'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.

**Three key findings are highlighted from the inductive analysis:** 1) There is no commitment to harm reduction in New Brunswick policy, and guidance around addictions or substance use more generally is very limited; 2) New Brunswick policy, while limited in scope, does generally align with several principles of a harm reduction approach; 3) The limited policy that exists for New Brunswick is high quality, despite the absence of harm reduction. For the deductive analysis, a set of criteria were applied to current policy documents. Results are presented in a standardized policy report card.

## 1.1 Contextual Background[1]

New Brunswick is the largest of Canada's three maritime provinces, spanning 73,440 square kilometers. Located under Quebec's Gaspé Peninsula, it is bounded by the State of Maine on its western border. The eastern border is largely coastal, bordering the Bay of Fundy and the Gulf of St. Lawrence. However, it is also partly bounded by Nova Scotia. It has a population of 754,300 (Statistics Canada, 2016), and includes three major cities: St John (population: 70,063), Moncton (population: 69,074 people) and Fredericton (population: 56,724) (Government of New Brunswick, 2011). New Brunswick is the only officially bilingual province in Canada, with

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

about 33% of the population fluent in French.

Since 2014, the Liberal Party has led the provincial government in New Brunswick under the leadership of Brian Gallant. Prior to this, the Progressive Conservative Party held office from 2010 until 2014. Provincial leadership has alternated fairly regularly between the Liberal and Conservative parties over the past several decades (Conservatives: 1970-1987; 1999-2006. Liberals: 1987-1999; 2006-2010). The current and former Premiers have not voiced any public opinions on harm reduction, and there are otherwise no formal statements from the government to shed light on this.

### 1.2 Healthcare Governance

In New Brunswick, health care legislation, funding and strategy are established by the Department of Health (The Institute of Public Administration of Canada, 2013). Two regional health authorities are tasked with delivering healthcare services, including addiction and mental health services, hospital services, community health center services, and most public health services (Government of New Brunswick, 2016). Horizon Health Network, serves the southern two thirds of the province including St. John, Fredericton, Upper River Valley and Miramichi areas, while Vitalité Health Network serves the northern portion of the province, including Edmundston, Campbellton, and Bathurst areas (Horizon Health Network, 2016; Vitalité Health Network, 2016). The southeastern Moncton area is served by both regional authorities. The Vitalité Health Network is the only francophone managed organization of its kind in Canada, offering health care services in the patient's language of choice (Vitalité Health Network, 2016). In 2008, eight regional health authorities were merged into two, in an effort to provide greater uniformity and efficiency in the delivery of health care services (Government of New Brunswick, 2016).

FacilicorpNB is a public sector company, established in 2008 by the provincial government to provide support services to the regional health authorities (The Institute of Public Administration of Canada, 2013). The organization manages non-clinical services, including supply chain, clinical engineering, information technology and telecommunications, and laundry and linen services. (The Institute of Public Administration of Canada, 2013; Government of New Brunswick, 2016). In October 2015, FacilicorpNB was merged with the new Service New Brunswick corporation along with the Department of Government Services, the New Brunswick Internal Services Agency, and Service New Brunswick.

In accordance with the New Brunswick Health Council Act, the New Brunswick Health Council was established in 2008 in an effort to foster transparency, citizen engagement, and accountability with respect to health care services (The Institute of Public Administration of Canada, 2013). It functions to monitor the quality of health care services, inform citizens of performance in service delivery, engaging citizens in dialogues about health care, and providing recommendations for policy reform to the Minister of Health (New Brunswick Health Council,

2016).

### 1.3 Substance Use Trends

According to data drawn from the most recent Canadian Alcohol and Drug Use Monitoring Survey (CADUMS, 2012), 38.7% of the population of New Brunswick reported lifetime use of one or more illicit drugs. Over their lifetime, 3.4% of New Brunswickers reported using cocaine/crack, 2.7% reported using speed, 2.2% reported using ecstasy, and 6.9% reported using hallucinogens. From this survey, New Brunswickers also reported on drug use in the past 12 months; 9.2 % reported using at least one illicit drug in the past year, while 8.6% reported using one of the following illicit drugs: cannabis, cocaine/crack, speed, ecstasy, hallucinogens or heroin. Both in terms of lifetime and past year illicit drug use, New Brunswick has the lowest rate of illicit drug consumption of all the provinces. However, the numbers are fairly close to national trends: 11.3% of Canadians vs. 9.2% of New Brunswickers have used at least one illicit drug in the past 12 months.

According to provincial coroner's services data, there were 178 opioid-related deaths between 2007 and 2012 (roughly 30 deaths per year). Between 2009 and 2014, there were 5 fentanyl related deaths (roughly 1 per year). During this period, the rate of fentanyl related deaths was 0.1 per 100, 000 residents, which is smaller than the national average of 0.3 per 100, 000 (Government of New Brunswick, 2016). In 2016, 23 people died from accidental drug overdoses involving opioids (Donkin, 2017).

### 1.4 Harm Reduction Services in New Brunswick

There are three AIDS service organizations offering needle exchange programs in New Brunswick: AIDS New Brunswick (ANB), SIDA-AIDS Moncton (SAM), and AIDS St. John (ASJ) (Kirkland et al., 2006). ANB offers needle exchange services in two locations in New Brunswick; Fredericton and Miramichi. SAM and ASJ provide needle exchange programs in Moncton and St. John, respectively. In 2015, SAM distributed 101, 000 sterile needles. For the past couple of years, AIDS Moncton has also been supplying safer smoking crack kits, including screens, a small glass tube, mouthpiece, and chop sticks (Weldon, 2016).

In New Brunswick there are currently eleven methadone maintenance programs funded by Horizon Health Network (Opiate Addiction and Treatment Resource, 2104).Treatment is limited to the southern two-thirds of the province, with no methadone clinics available in the northern areas of Campbellton, Edmunston, and Bathurst. One clinic in St. John (St. Joseph's Health Center) offers low threshold methadone maintenance treatment, an approach in which barriers typical to methadone programs, such as mandatory patient counselling and regular urine tests,

are removed (CBC, 2012). Patients are not punished for using other drugs, and referrals may come from any source, including self-referral (Christie at al., 2103). The one-year treatment retention rate at the clinic was 95%; higher than any other in the country and double the rate other clinics (CBC, 2012). In addition, the number of patients using illicit opiates decreased by 66% (Christie et al., 2013). While methadone prescription is covered by the New Brunswick Drug Plan, which provides drug coverage for New Brunswickers without insurance, Buprenorphine is not (Government of New Brunswick, 2016).

## 2.0 Methods

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

[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.

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.

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

### 2.2 Inductive Analysis

Both New Brunswick 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 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 New Brunswick'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.

The single current New Brunswick policy document was content analyzed using this framework. The document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria

[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.

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 one unique policy document in our provincial search and one corresponding update report. Of these two, one was considered current, and was produced at the provincial level. 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 New Brunswick's Policy Documents

| | | Document | Authors | Year Published | Years Active |
|---|---|---|---|---|---|
| Current Provincial | *1* | The Action Plan for Mental Health in New Brunswick 2011-18 | Province of New Brunswick | 2011 | 2011-2018 |
| *Update documents* | *2* | Progress Report: The Action Plan for Mental Health in New Brunswick | Province of New Brunswick | 2013 | 2011-2013 |

## 4.0 Results: Inductive Analysis of Documents

### 4.1 There is no commitment to harm reduction in New Brunswick policy, and guidance around addictions or substance use more generally is very limited.

Only one formal policy document was found for this case, the *Action Plan for Mental Health in New Brunswick* (2011), and one associated progress report, published to update on the first two years of implementation (in 2013). Collectively, these two documents make up the policy framework for the province that could potentially direct action around harm reduction. However, neither document mentions harm reduction or any of the seven interventions of interest. The *Action Plan* focuses primarily on mental health, discussing addiction sparingly throughout the document and not as a distinct concern. Substance use or illicit drug use more specifically are not addressed.

The approach to dealing with addictions is quite vague in the document, but can be described as generally contrasting to harm reduction. Examples of services currently offered or endorsed as part of the strategy include detoxification, out-patient services, community prevention services, short and long-term residential services (p.3), counselling and case management (p.9). In discussing details of the proposed approach to addressing mental health and addictions issues, the document states, "… promoting a collaborative model of care focused on recovery" which "addresses mental disorders and substance use disorders as chronic diseases" (p.9). The focus is on "recovery", and while there is recognition that the recovery model is "not a treatment imposed on an individual" (p.9), there is nothing which appears to address the harms of substance use, only preventing or stopping the behavior itself.

The *Progress Report* does not contain any new recommendations for moving forward, reporting only on goals addressed in the original strategy. As such, the discussion around addictions is largely the same, and no new direction is provided on this or related areas of substance use.

#### 4.1.1 Summary

In terms of harm reduction, there is nothing in formal provincial policy to guide the implementation of services or programs. Furthermore, although "addiction" is broadly recognized as something relevant to mental health concerns, there is nothing to guide specific action around this or substance use more generally in the policy set.

### 4.2 New Brunswick policy, while limited in scope, does generally align with several principles of a harm reduction approach.

Despite the absence of harm reduction in policy specifically, and the promotion of a "recovery-based approach" for mental health and addictions, the *Action Plan for Mental Health* incorporates several key principles that align well with a harm reduction approach, as outlined by Harm Reduction International (2010).

The action plan recognizes the importance of addressing the social determinants of health, and the "web of factors" (p.7) that influence mental health and vulnerability to mental-health problems. These include education, employment, income, housing and aspects of the justice system, such as "the criminalization of mental illness" (p.7). The document cites the necessity of structural change and a transformed system of service delivery in order to appropriately address these factors. While harm reduction or substance use are not specifically noted in this context, the identification of factors that influence vulnerability, as well as challenging policies that maximize harm – such as the criminalization of mental illness - align well with a harm reduction approach more broadly.

Throughout the document, the importance of eliminating stigma and discrimination is emphasized. Stigma is mentioned in several contexts, including anti-stigma campaigns aimed at the "public and health-care sector" (p.7), "educational, workplace and community settings" (p.7), and "landlords and the housing private sector" (p.8). Furthermore, one of seven goals outlined in the action plan is to "reduce stigma by enhancing awareness". Although discussions center around mental illness, and not substance use, it is positive to see this issue acknowledged. Closely related to this concept is the acknowledgement that people with mental illness deserve equality, dignity and respect. A foundational principle of the document is "dignity", described further as, "people are recognized, valued and respected; they are treated in a manner consistent with their inherent human rights" (p.5). Equality, respect and dignity are also mentioned in discussions around reducing stigma, further linking these two concepts together. Although this applies narrowly to people experiencing mental illness, it aligns well with Harm Reduction International's (2010) fundamental endorsement of dignity and compassion for people who use drugs, opposing the stigmatization of people who drugs, and avoiding judgement.

Just as harm reduction has a commitment to basing policy and practice on the strongest evidence available (HRI, 2010), the action plan also endorses this principle. One of seven foundational principles of the plan is "excellence", described as "effective, high-quality mental-health care services are based on promising and proven practices" (p.6). The document also endorses following a collaborative model of response that endorses evidence-based practice as a key principle (p.10).

Another foundational principle of the action plan is "partnership". The document states that "partnership and collaboration among the individual, family, community, business and government are critical in promoting mental health and well-being" (p.6). Throughout the document, other examples of this principle are evident, including calls for coordination between various government departments and community partners. Furthermore, the document refers to contributions from various stakeholders including people with mental illness and their families (p.22), and promotes the inclusion of people with lived experience in various phases of service delivery and evaluation. This parallels HRI's (2010) endorsement of transparency and accountability, and including a wide range of stakeholders in policy development and implementation, including people who use drugs. Once again, the action plan does not endorse this in the context of harm reduction or substance use, but the foundational ideas are quite similar.

Finally, the action plan is sensitive to gender and diversity, and identifies several populations in need of

special attention including Aboriginal peoples, those in rural communities, youth, seniors, newcomers and women. The plan outlines specific action items for each of these groups, as part of the stated goal, "responding to diversity" (p.11).

#### 4.2.1 Summary

The principles outlined in the action plan reflect a progressive, inclusive policy framework that aligns closely with many key features of a harm reduction approach. Although harm reduction specifically is not incorporated into this document, there is clear support for many foundational principles, including recognition of the social determinants of health, the need to eliminate stigma and discrimination, the importance of evidence-based policy and practice, transparency and accountability, and sensitivity to diverse population needs. This indicates that direct recognition of harm reduction could be incorporated into the policy framework in the future.

### 4.3 The limited policy that exists for New Brunswick is high quality, despite the absence of harm reduction.

The *Action Plan for Mental Health in New Brunswick* does not address several key issues related to mental health, including addictions, substance use or harm reduction. Despite this, the small policy set reflects features of high-quality policy more generally, which support governance and indicate a commitment to policy implementation, follow-through and evaluation.

The document is endorsed by the provincial Health Minister, outlined in a page-long letter of support for the plan and its key initiatives. The endorsement from policy by a key member of the provincial government indicates a commitment to health system planning, rather than just rhetorical support for policy initiatives (Wild et al., 2017). To further support this claim, each goal is accompanied by a series of specific action items. Each action item assigns responsibility to one or more actors, lists a specific objective, and includes a stated timeline.

In terms of evidence to support follow-through and commitment to policy implementation, the original *Action Plan* includes a "progress monitoring framework", developed to track progress of the action plan over its implementation period. The *Progress Report* builds on this, reporting on which specific goals were achieved at two years into the plan, and listing remaining action items.

Finally, the document situates itself well in the broader policy context of the province, providing an in-depth discussion of relevant studies, strategic initiatives, and other policy documents that exist for the province, and how these fit together. This demonstrates thoughtfully developed policy, intended to fill a specific void, rather than provide redundant direction in the province.

#### 4.3.1 Summary

Overall, the policy set for New Brunswick is sparse, and does not provide direction in terms of harm reduction or substance use. Despite this, the limited policy corpus appears to support governance,

policy implementation and system planning, rather than acting just as a visionary document which only provides rhetorical support for policy initiatives. While this does not support the implementation of harm reduction, specifically, it sets the stage for future policy in this realm to be effectively implemented at the provincial level.

## 5.0 Results: Deductive Analysis of Current Documents (New Brunswick 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

| | *The Action Plan for Mental Health in New Brunswick* | Total (out of 1) |
|---|---|---|
| [1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or have drug problems? | **0** | **0** |
| [2] Does the document affirm that people who use substances need to be involved in policy development or implementation? | **0** | **0** |
| [3] Does the document acknowledge that not all substance use is problematic? | **0** | **0** |
| [4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community? | **0** | **0** |
| [5] Does the document acknowledge that harm reduction can be applied to the general population? | **0** | **0** |
| [6] Does the document target women in the context of harm reduction? | **0** | **0** |
| [7] Does the document target youth in the context of harm reduction? | **0** | **0** |

| | | |
|---|---|---|
| [8] Does the document target indigenous populations in the context of harm reduction? | **0** | **0** |
| [9] Does the document target LGBTQI populations in the context of harm reduction? | **0** | **0** |
| **TOTAL (out of 9)** | **0** | **0 of 9** |

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

| | *The Action Plan for Mental Health in New Brunswick* | **Total (out of 1)** |
|---|---|---|
| [10] Does the document acknowledge the need for evidence-informed policies and/or programming? | **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** |
| [12] Does the document discuss low threshold approaches to service provision? | **0** | **0** |
| [13] Does the document specifically address overdose? | **0** | **0** |
| [14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach? | **0** | **0** |
| [15] Does the document consider harm reduction approaches for a variety of drugs and modes of use? | **0** | **0** |

| | | |
|---|---|---|
| [16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction? | **0** | **0** |
| [17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm? | **0** | **0** |
| **TOTAL (out of 8)** | **1** | **1 of 8** |

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

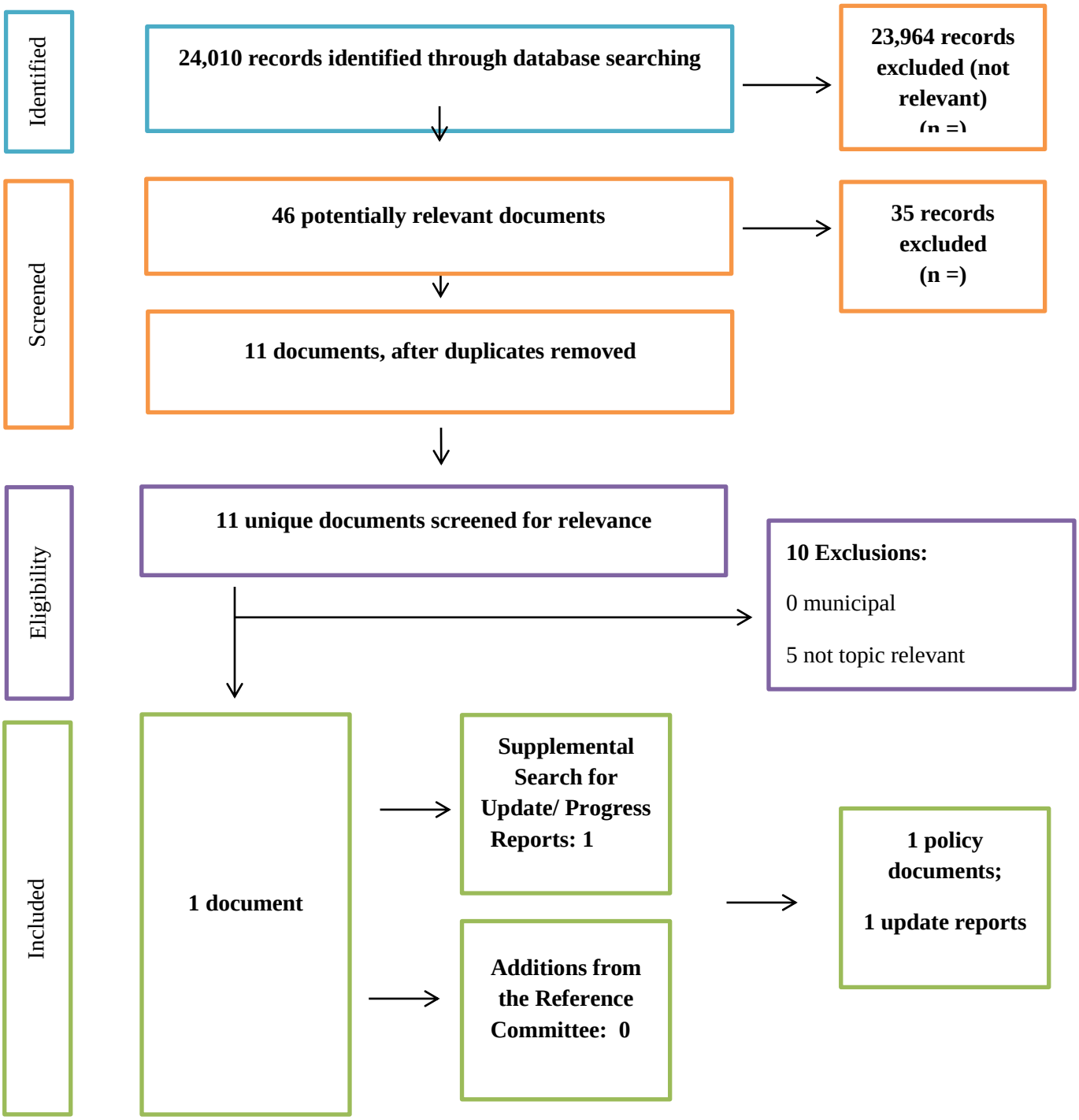
| Case | **Target population quality (out of 9 indicators)** | **Service quality (out of 8 indicators)** |
|---|---|---|
| British Columbia (10) | 38/90 (42%) | 52/80 (65%) |
| Alberta (4) | 7/36 (19%) | 14/32 (44%) |
| Saskatchewan (3) | 9/27 (33%) | 13/24 (54%) |
| Manitoba (7) | 10/63 (16%) | 19/56 (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 New Brunswick is very limited, consisting of only one current document, and one associated update report. The current document, *The Action Plan for Mental Health in New Brunswick*, has a stated focus on mental health. Addiction is discussed sparingly, as a mental health concern and not as an independent issue. There is no acknowledgement of harm reduction or substance use more broadly. In terms of harm reduction and substance use, the policy set provides no direction whatsoever.

Despite this shortcoming, the *Action Plan* itself exemplifies many features of quality policy, and demonstrates a commitment to follow-through, implementation and monitoring progress. In looking to the future, the policy set for New Brunswick could be easily adapted to incorporate harm reduction. Many foundational features of the approach are already in place and endorsed at the provincial level, reflecting a policy environment that appears friendly towards adopting explicit commitments to harm reduction.

## Appendix A: Systematic search strategy flow diagram[6]




[6] 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

***The Action Plan for Mental Health in New Brunswick***

*The Action Plan for Mental Health in New Brunswick* was published by the province of New Brunswick in 2011. The document is intended to serve as a framework and action plan for guiding the development and delivery of mental health care services in the province over a seven year period. Unlike many of the other policy documents included for policy analysis, this document focuses on mental health as opposed to mental health and addictions. While addictions are very briefly mentioned, they seem to be considered to be a separate, but related issue. Harm reduction is not addressed in this document, nor are any of the seven interventions of interest. This document has one update report, published in 2013.

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