

# Ontario Policy Analysis Case Report

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*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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## 1.0 Overview

This document provides a descriptive and analytical account of Ontario's provincial harm reduction policy documents produced between 2000 and 2015. This account is part of the Canadian Harm Reduction Policy Project (CHARPP), a multimethod case study comparing provincial/territorial harm reduction policies across Canada. Ontario 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 Ontario's harm reduction policy context including: governance, healthcare delivery structures, substance use trends and harm reduction programming. A brief overview of the methodology is provided, followed by a descriptive table of the policy documents retrieved through a systematic search. The remainder of the document summarizes findings obtained from an inductive and deductive analysis of Ontario's harm reduction policy documents.

**Five key findings are highlighted from our inductive analysis:** 1) harm reduction receives limited attention in policy documents; 2) policy documents reflect variable understandings of mental illness, addiction and substance use; 3) policy documents are fragmented and do not reflect a cohesive "policy framework"; 4) the need for evidence-based policy is widely acknowledged in policy documents; and 5) policy documents reflect a weak commitment to harm reduction initiatives, and exhibit little follow-through of policy directives. In 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<sup>1</sup>

Ontario is Canada's second largest province, spanning over 1 million square kilometres. It is bounded by Quebec (to the east) and Manitoba (to the west). Ontario is the most populated province in Canada, with 13,792,100 residents in 2015 (Statistics Canada, 2015), meaning that 2 in every 5 Canadians lives in Ontario (Government of Ontario, 2016). Ontario is home to the City of Toronto (population 3 million (City of Toronto, 2016)) and the City of Ottawa (population 870,250). Toronto is Canada's most populated city and also one of its most diverse, welcoming 55,000 immigrants annually between 2001 and 2006, which represents one quarter of all

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

immigrants to Canada during this period (City of Toronto, 2016). Ottawa is the capital city of Canada and is home to the Parliament of Canada.

The Liberals have led the Ontario provincial government since 2003. Previously, the Progressive Conservatives led the province from 1995 to 2003, with the New Democrats in power from 1990 to 1995. The current premier, Kathleen Wynne, is the first woman to lead the province and is also Canada's first openly gay premier. Recently, Wynne stated that harm reduction policies save lives and make communities safer. However, she stopped short of confirming her support for setting up supervised injection sites (The Canadian Press, 2016).

## **1.2 Health Care Governance**

In Ontario, the Ministry of Health and Long Term Care (MOHLTC) is responsible for providing direction and leadership for health care services. Ontario is divided into 14 Local Health Integration Networks (LHIN) (see Appendix A for further details). Prior to 2006 when the LHINs were established, health care services were centrally delivered by the MOHLTC (The Institute of Public Administration of Canada, 2013).

Dr. Eric Hoskins is currently serving as Minister of Health and Long Term Care. The MOHLTC has recently shifted towards embracing more of a stewardship role, which means that the ministry provides leadership and guidance and is less involved in the actual delivery of health care. The provincial government is responsible for planning and funding of public health, ambulances, physicians and laboratories.

The LHINs are responsible for providing funding to many health services providers, including hospitals, psychiatric facilities, long term homes, community care providers, and community mental health and addiction agencies, but do not directly provide health care services. Each LHIN is led by a CEO and governed by a Board of Directors, which is made up of 9 members of the local community who are appointed by the province (Hamilton Niagara Haldiman Brant LHIN, no year). Each year, the LHINs produce an Integrated Health Service Plan (IHSP), on which the ministry bases funding provision (Canadian Mental Health Association Ontario, 2016).

## **1.3 Substance Use Trends**

According to data drawn from the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS, 2012), 41.1% of Ontarians reported lifetime use of one or more illicit drugs. Over their lifetimes, 7.5% of Ontarians reported using cocaine/crack, 4.3% reported using speed, 4.4% reported using ecstasy, and 12.8% reported using hallucinogens. From this survey, Ontarians also reported on drug use in the past 12 months; 10.0% reported using at least one illicit drug in the

past year, while 9.6% reported using one of the following illicit drugs: cannabis, cocaine/crack, speed, ecstasy, hallucinogens or heroin. In the same survey, 2.5% of Ontarians reported experiencing harm from their own drug use; this involves experiencing one or more types of harms (e.g. physical, emotional, financial, etc) related to substance use over the past 12 months. These numbers are consistent with national trends; 43.2% of Canadians have used at least one illicit drug in the past 12 months and 2.0% of Canadians report experiencing harms related to drug use (CADUMS, 2012).

In Ontario, the number of opioid-related overdose deaths rose 463% between 2000 and 2013. Coroner data for 2014 indicates 674 opioid-related deaths, which translated to one death every 13 hours in the province (MDSCNO, 2015). This rate has continued to increase every year, with over 850 deaths reported in 2016 from opioid-related causes (Public Health Ontario, 2017). Of these, over 40% of were linked to Fentanyl. Fentanyl is now the leading cause of opioid deaths in Ontario (Howlett & Woo, 2016).

#### **1.4 Harm Reduction Services in Ontario**

The Ontario Harm Reduction Distribution Program (OHRDP) was established in 2006; it is a not-for-profit organization which is provincially funded by the MOHLTC. The OHRDP provides harm reduction materials to Needle Syringe Programs in Ontario; these materials include alcohol swabs, filters, cookers, sterile water, tourniquets, ascorbic acid, stems, screens, mouthpieces and push sticks. The OHRDP does not distribute syringes or condoms; programs are responsible for purchasing their own syringes which is supported through the public health population branch. These Needle Syringe Programs are located within 36 Public Health Units and 180 satellite locations across the province. These programs are encouraged to follow “Best practice recommendations for harm reduction programs: needle and syringe distribution, other injecting equipment distribution, safer crack kit distribution” (Strike et al., 2012).

The year that the OHRDP was established, 31 of the 36 public health units were operating needle distribution programs. In 2008, the Ontario Public Health Standards mandated that the Public Health Units were responsible for ensuring access to harm reduction resources and services, including distribution of needles and other evidence-based harm reduction strategies.

## **2.0 Methods**

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

were (a) analyzed and synthesized inductively to describe historical<sup>2</sup> and current<sup>3</sup> 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<sup>4</sup> 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.

Six policy reports and one update report were identified and analyzed using a two-step (inductive and deductive) process described below (Appendix B provides the Ontario-specific search strategy).

## 2.2 Inductive Analysis

Each of the seven Ontario documents was analyzed using a three-step process (Appendix C provides analytic details). First, relevant text<sup>5</sup> was extracted from each policy document and analyzed, resulting in a set of analytic notes. The focus of the analytic notes was primarily

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<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> 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.

<sup>5</sup> “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.

descriptive and instrumental (i.e., generating a deeper understanding of the intent and purpose of the policy document and the relevant stakeholders and their roles). Next, each document's analytic notes and a set of accompanying quantitative data (see Appendix C) were synthesized and compiled into a narrative document description. Finally, all narrative document descriptions for the case were synthesized and compiled into a single document. This resulted in a descriptive summary, describing the main themes and trends in Ontario's set of harm reduction policy documents over the 15-year study period.

### 2.3 Deductive Analysis

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

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



### 3.0 Documents Retrieved

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

Table 1: Descriptive Details of Ontario’s Policy Documents

Current – Provincial Level	Document	Authors	Year Published	Years Active
	1 Ontario Public Health Standards	Ministry of Health and Long-Term Care	2008 (revised 2015)	NA
	2 Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addiction Strategy	Government of Ontario	2011	10 years (expected)
	3 A Shared Responsibility - - Ontario’s Policy Framework for Child and Youth Mental Health	Ministry of Children and Youth	2006	NA
	4 Ontario’s Narcotics Strategy	Government of Ontario	2010	NA
Current – LHIN Level	5 Tomorrow... An Adult Mental Health Strategic Plan for Erie St. Clair 2012-2016	Shaw Consulting/The Agora Group	2012	2012-2016
	6 North East LHIN Aboriginal/First Nation and Metis Mental Health and Addictions Framework	North East LHIN	2011	NA
Update	7 Expanded Mental Health and Addiction Strategy: Open Minds, Healthy Minds – Ontario’s Comprehensive Mental Health and Addiction Strategy	Government of Ontario	2014	NA

## 4.0 Results: Inductive Analysis of Documents

### 4.1 Harm reduction receives limited attention in policy documents

The most significant finding of this analysis is that harm reduction is addressed minimally in the set of policy documents for Ontario. There is no stand-alone policy, and harm reduction is not incorporated throughout any of the documents, including those that specifically address mental health and addictions. Only three of the seven documents note harm reduction at all.

*Ontario Public Health Standards [1]* offers the most comprehensive acknowledgement and is the only document to provide a definition, describing “harm reduction strategies” as “any program or policy designed to help reduce substance-related harm without requiring the cessation of substance use” (p. 32). Later in the document, examples of harm reduction strategies are noted to include clean and sterile drug-using equipment, condoms, client-centered counselling, skill-building and education and referral to addictions treatment, health services and other social services (p.53). Although there is no designated section on harm reduction, the document frames harm reduction as an approach to addressing substance misuse related harms and reducing the transmission of STI/BBPs in Ontario. Furthermore, the document mandates boards of health across Ontario to consider a harm reduction approach in the provision of public health services. Specifically, it states “the board of health shall ensure access to a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance (p.51). In this context, harm reduction is promoted as a key piece of the public health response in Ontario.

The remaining two documents that mention harm reduction are the *North East LHIN Aboriginal/First Nation Framework [6]*, and the *Ontario Narcotics Strategy [4]*. In both cases, harm reduction is only mentioned once and in a narrow context. In the *North East LHIN Framework [6]*, the document identifies “methadone treatment, linkages, supports and after care” (p.55) as a gap in the Aboriginal Mental Health and Addiction Service System. Under this heading, the document states “The percentage of Aboriginal clients receiving methadone clinic and harm reduction services is alarmingly high. It is critically important to link these services with multiple supports, aftercare and traditional healing services” (p.55). There is no further discussion or recommendations regarding harm reduction or why it is alarming that Aboriginal clients are accessing such services at a high rate. In the *Ontario Narcotics Strategy [4]*, it states that information gathered through a narcotics monitoring system will be used to “develop harm reduction strategies”. No additional context or information is provided. Both of these examples

reflect a limited understanding of the harm reduction philosophy, and do not offer any relevant policy directives.

The remaining three documents make no mention of harm reduction at all. This omission is particularly notable in *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addiction Strategy* [2], which includes discussions on prevention, treatment, and support for people experiencing addictions, and makes various references to substance use and related issues.

#### 4.1.1 Summary

Within provincial and LHIN-level policy documents, distinct variations exist in the degree to which harm reduction is acknowledged. *The Ontario Public Health Standards* [1] reflects a comprehensive understanding of the principles of harm reduction, and promotes incorporating harm reduction into the operational standards of public health delivery across the province. In contrast, the *Ontario Narcotics Strategy* and the *North East LHIN Framework* [6] offer little more than harm reduction buzz words and contain no policy directives related to harm reduction. The remaining documents omit harm reduction entirely. Overall, harm reduction is acknowledged minimally and is not an integral component of the provincial policy response.

## 4.2 Policy documents reflects variable understandings of mental illness, addiction and substance use

In order to gain a deeper understanding of the provincial commitment to harm reduction, we analyzed how current policy documents frame relevant concepts – such as substance use, addiction, and mental illness - and to what degree these are acknowledged as part of the provincial policy response. Analysis reveals that documents reflect highly variable understandings and levels of acknowledgement of mental illness, addiction and substance use. There is no common thread linking how the issues are framed or how the relationship between addiction and mental health is considered. Although each of the four provincial-level documents has a different focus, they share a common goal of improving the health and wellbeing of Ontarians, and have many shared outcomes in this regard. It is notable that there is no consistency in how mental illness, addictions and substance use are conceptualised, or in the language and terms used to describe these concepts.

#### 4.2.1 Provincially-authored policy documents

In *Ontario Public Health Standards [1]*, substance misuse is acknowledged as a pressing public health concern, defined as “the harmful use of any substance, such as alcohol, a street drug, an over-the-counter drug, or a prescribed drug” (p.29). Substance use is never considered in relation to mental health or mental illness, and addiction is only referenced once - “referral to addictions treatment” is noted as an example of a potential harm reduction strategy. In this document, substance use is framed as a public health issue, falling under the category of “Chronic Diseases and Injuries”, with no discussion of the social or cultural context of substance use.

*Open Minds, Healthy Minds [2]* frames mental illness and addictions as essentially the same issue. There are no instances in the document where mental health or addictions are discussed separately from another, and all recommendations apply to both. Furthermore, all substance use is considered problematic, and there is no acknowledgement that substance use may occur in contexts outside of mental illness and/or addictions. This document frames addiction as a mental health issue that can be prevented or treated with appropriate supports and services.

*A Shared Responsibility – Ontario’s Policy Framework for Child and Youth Mental Health [3]*, addresses “the mental health problems of Ontario’s children and youth” (pg. i). Addiction is not acknowledged anywhere in the body of the document, and substance use is only noted once as a “potential consequence” of mental health problems (p.2). Given that youth aged 15 to 24 are more likely to experience mental illness/and or substance use disorders than any other any age group (Pearson, Janz & Ali, 2013), the explicit omission of any discussion around substance use or addictions is notable.

The *Ontario Narcotics Strategy [4]* is concerned narrowly with “the abuse and misuse of prescription narcotics and other controlled substance medications”. Mental health or mental illness are not discussed anywhere on the Ontario Mental Health and Long-Term Care website where the document is described. Substance use is considered a major public health concern, and addictions treatment is offered as a strategy for dealing with the improper use of prescription drugs. Substance use is framed as a problematic behaviour, and there is no consideration for the potential of non-problematic substance use.

#### 4.2.2 Health authority-authored policy documents

The remaining two documents are health authority-level policies. Although they were not authored at the provincial level, one would expect some degree of consistency with

overarching provincial plans, such as the *Ontario Public Health Standards [1]* or *Open Minds, Healthy Minds [2]*. However, like the section above, these plans also reflect vastly differing ideas around mental illness, addictions and substance use.

In *Tomorrow...An Adult Mental Health Strategic Plan for Erie St. Clair[5]*, there is no acknowledgement of substance use as part of the plan, problematic or otherwise, and discussion around addiction is very limited. The only mention is when “people with addictions” are identified as one of 14 unique population groups “needing special attention” (p.4). In an attached appendix, the “desired outcome” for people with addictions is described as an integrated mental health and addictions service system that serves people with an addiction and/or mental illness equally (p. 171). Although this document has a clear focus on mental health, and not mental health and addiction, there is no addiction strategy for the region. As such, it is notable that addiction and substance use are not addressed in more detail as part of the strategy.

The final document, the *North East LHIN Aboriginal/First Nation and Metis Mental Health and Addictions Framework [6]*, provides a comprehensive discussion of addictions, substance use and mental illness. The document acknowledges that addictions and mental health are separate issues with distinct service gaps, while also considering the connections between these areas and the benefits of integrating services and support. The social and cultural context in which addictions and mental health issues emerge is also discussed, including considerations of colonization, marginalization and poverty. Throughout the document, substance use is characterized as problematic in all forms.

#### **4.3 Policy documents are fragmented and do not reflect a cohesive “policy framework”**

As was described in sections 4.1 and 4.2 above, understandings of harm reduction and what this entails are not shared between individual ministries, the province, or LHINs. The same can be said about conceptions around mental illness, addictions, and substance use. Despite their shared areas of concern and overlapping outcomes, the policy documents rarely acknowledge the existence of other documents. It is clear from this analysis that an overarching policy framework was not considered, and the various plans were not intended to work in collaboration with the others. This has resulted in a fragmented set of policy documents that demonstrate little cohesion or consideration of the broader policy response.

For example, *Open Minds, Healthy Minds [2]* is the most recently published provincial

document and is the overarching mental health and addictions policy, as it applies to the provincial system as a whole. The authors note the importance of “coordination across ministries and sectors”, and the need for leadership at the provincial and local levels (p.25). Despite this, the document does not acknowledge any of the previously released provincial documents included in this set of policy documents. Given this and the document’s focus on “mental health and addictions”, it is notable that neither *Ontario’s Narcotics Strategy [4]* or *Public Health Standards [1]* are referenced at all. Additionally, the first three years of the plan focus on children and youth, with an extensive discussion around the provision of a child and youth mental health strategy, including specific objectives. However, *Ontario’s Policy Framework for Child and Youth Mental Health [3]* is not mentioned anywhere in this discussion. It is unclear whether *Open Minds, Healthy Minds [2]* was intended to replace the child and youth framework, or if the two documents are distinct from one another, as many of the issues and objectives discussed in the documents overlap. With the exception of the *North East LHIN Framework [6]*, which states it was designed to “ensure alignment, where possible, with Ontario policy and programming directions in mental health and addictions” (p.59), none of the policy documents reference one another or include directives to align with other policies.

#### **4.4 The need for evidence-based policy is widely acknowledged in policy documents**

With the exception of *Ontario’s Narcotics Strategy [4]*, all of the documents acknowledge the importance of evidence-informed policy, programs or decision-making. However, only one of these is in the context of harm reduction. Other examples are discussed in the broader context of healthcare provision or policy, or addictions and mental health programming.

In *Open Minds, Healthy Minds [2]*, the importance of evidence-based policy is frequently noted. For example, under the key principle of “Accountability” the document states, “Ontario will build on effective mental health and addictions programs and services with the best available evidence from lived experience, practice and research” (p.9). In the *North East LHIN Framework [6]*, a specific objective in the development of the framework is to “provide culturally appropriate, evidence-based sustainable options for enhanced service delivery structures that will improve access and quality of Mental Health and Addictions care...” (p.59). A key principle outlined in *A Shared Responsibility [3]* is to remain “evidence-based and accountable” (p.ii). Similarly, a strategic direction listed in *Tomorrow... [5]* is to “build an evidence-based and experience-driven service continuum” (p.3).

It is notable that the need for evidence-based policy and initiatives is acknowledged so widely, yet harm reduction is not included as part of this response, particularly as a large body of scientific evidence demonstrates the effectiveness of harm reduction services targeting illicit

drug use. The only document that reflects this is the *Ontario Public Health Standards [1]*. In a footnote the author's state, "the board of health shall ensure access to a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance".

#### **4.5 Policy documents reflect a minimal commitment to harm reduction initiatives, and exhibit little follow through of policy directives**

First and foremost, the set of policy documents analysed for this research reflects a minimal commitment to harm reduction. As was discussed in section 4.1, only one of the six documents, *Ontario Public Health Standards [1]*, includes any objectives or directives relating to harm reduction. Requirements set forth in this document apply only to public health programs and services provided by boards of health.

Outside of harm reduction, the policy documents exhibit a low level of commitment to and follow-through of general policy directives. Of the six documents, only one has a follow-up report that could potentially be used to assess whether key goals and outcomes were realized. This report, the *Open Minds, Healthy Minds Phase 2 Expansion [7]*, provides an update on the first three years of the strategy - which focused on children and youth. It also outlined strategic goals for the next phase. The document reports on initiatives implemented and investments made during this time, but it does not offer any insight as to whether the needs of children and youth were being met, whether clients were satisfied, or whether the strategy was making progress towards its goals of reducing and preventing mental illness and addictions. For the remaining five documents, it is difficult to determine what (if any) parts of the policy were implemented and there are no formal standards in place to ensure accountability.

Timelines are another useful measure by which to enforce accountability in policy. Only two of the seven documents have any sort of timeline by which outcomes should be achieved.

*Tomorrow... An Adult Mental Health Strategic Plan for Erie St. Clair [5]* has a stated start and end date (2012 to 2016) and a formal implementation timeline. *Open Minds, Healthy Minds [2]* is a 10-year plan (2011 to 2021) and lays out a general guideline for the first three years of implementation, but nothing more specific past this point.

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

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

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

	Ontario Public Health Standards	Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy	Expanded Mental Health and Addiction Strategy: Open Minds, Healthy Minds - Ontario's Comprehensive Mental Health and Addictions Strategy	A Shared Responsibility – Ontario's Policy Framework for Child and Youth Mental Health	Ontario's Narcotics Strategy	North East LHIN Aboriginal/ First Nation and Metis Mental Health and Addictions Framework	Tomorrow... An Adult Mental Health Strategic Plan for Erie St. Clair 2012-2016	<b>Total (out of 7)</b>
[1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or have drug problems?	0	1	0	0	0	0	1	<b>2</b>
[2] Does the document affirm that people who use substances need to be involved in policy development or implementation?	0	1	0	0	0	0	0	<b>1</b>
[3] Does the document acknowledge that not all substance use is problematic?	0	0	0	0	0	0	0	<b>0</b>
[4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community?	0	0	0	0	0	0	0	<b>0</b>



[5] Does the document acknowledge that harm reduction can be applied to the general population?	0	0	0	0	0	0	0	0
[6] Does the document target women in the context of harm reduction?	0	0	0	0	0	0	0	0
[7] Does the document target youth in the context of harm reduction?	0	0	0	0	0	0	0	0
[8] Does the document target indigenous populations in the context of harm reduction?	0	0	0	0	0	0	0	0
[9] Does the document target LGBTQI populations in the context of harm reduction?	0	0	0	0	0	0	0	0
<b>TOTAL (out of 9)</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>3 of 63</b>

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

	Ontario Public Health Standards	Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy	Expanded Mental Health and Addictions Strategy	A Shared Responsibility – Ontario's Policy Framework for Child and Youth Mental Health	Ontario's Narcotics Strategy	North East LHIN Aboriginal/ First Nation and Metis Mental Health and Addictions Framework	Tomorrow... An Adult Mental Health Strategic Plan for Erie St. Clair 2012-2016	<b>Total (out of 7)</b>
[10] Does the document acknowledge the need for evidence-informed policies and/or programming?	1	1	0	1	0	1	1	<b>5</b>
[11] Does the document acknowledge the importance of preventing drug	1	0	0	0	0	0	0	<b>1</b>

related harm, rather than just preventing drug use or blood borne or sexually transmitted infections?								
[12] Does the document discuss low threshold approaches to service provision?	0	0	0	1	0	0	1	2
[13] Does the document specifically address overdose?	0	0	0	0	0	0	0	0
[14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach?	1	0	0	0	0	0	0	1
[15] Does the document consider harm reduction approaches for a variety of drugs and modes of use?	0	0	0	0	0	0	0	0
[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	0	0	0	0	0	0	0	0
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	0	0	0	0	0	0	0	0
<b>TOTAL (out of 8)</b>	<b>3</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>9 of 56</b>

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%)
<b>Ontario (7)</b>	<b>3/63 (5%)</b>	<b>9/56 (16%)</b>
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%)
<b>Canada (54)</b>	<b>109/486 (22%)</b>	<b>153/432 (35%)</b>

## 6.0 Conclusion

Overall, the formal harm reduction policy landscape in Ontario is limited. There is no stand-alone harm reduction policy or STI/BBP policy at the provincial level, and harm reduction is not incorporated throughout any of the plans. Although a provincial policy on addictions and mental health does exist, harm reduction is never mentioned in this document. Policy documents do not align with one another and they reflect very different ideas about harm reduction, addictions, substance use, and mental health. The set of provincial policy documents does little to support a harm reduction philosophy or promote the adoption of harm reduction initiatives in practice.

The low commitment to harm reduction in policy presents an interesting contrast to the widespread availability of harm reduction materials and Needle Syringe Programs across Ontario, operating through regional Public Health Units (OHRDP, 2016). It is possible that the influence of *Ontario Public Health Standards* - the sole provincial document to include harm reduction policy directives - is considerable in promoting harm reduction at the provincial level. Although it discusses harm reduction only a few times and does not direct harm reduction services/resources as its main purpose, the document does mandate boards of health to ensure access to harm reduction program delivery models and strategies.

## Appendix A: Local Health Integration Networks

LHIN	Area (km <sup>2</sup> )	Population
Erie St. Clair <sup>6</sup>	~7,234	640,000
South West <sup>7</sup>	21,639	962,539
Waterloo Wellington <sup>8</sup>	~4,800	~775,000
Hamilton Niagara Haldimand Brant <sup>9</sup>	6,600	1.4 million
Central West	~2,590 <sup>10</sup>	~840,000 <sup>11</sup>
Mississauga Halton	~900 <sup>12</sup>	~1.2 million <sup>13</sup>
Toronto Central	unknown	~1.2 million <sup>14</sup>
Central <sup>15</sup>	2,730	~1.8 million
Central East <sup>16</sup>	16,673	1.4 million
Champlain <sup>17</sup>	17,714	1.2 million
North Simcoe Muskoka	unknown	453,710 <sup>18</sup>
North East <sup>19</sup>	~400,000	~565,000
North West	~458,010 <sup>20</sup>	231,120 <sup>21</sup>

<sup>6</sup> <http://www.eriesclairlhin.on.ca/About%20Us/OurAreaProfile.aspx>

<sup>7</sup> <http://www.southwestlhin.on.ca/aboutus/facts.aspx>

<sup>8</sup> <http://www.waterloowellingtonlhin.on.ca/aboutus.aspx>

<sup>9</sup> <http://www.hnhblhin.on.ca/aboutus/geographyanddemographics/HealthAtlas/KeyFindings.aspx>

<sup>10</sup> <http://centralwestlhin.on.ca/Page.aspx?id=3298>

<sup>11</sup> <http://www.centralwestlhin.on.ca/About%20Us/The%20Landscape/Population%20Profile.aspx>

<sup>12</sup> <http://www.mississaugahaltonlhin.on.ca/aboutus/subregions.aspx>

<sup>13</sup> <http://www.mississaugahaltonlhin.on.ca/aboutus/demographics.aspx>

<sup>14</sup> <http://www.torontocentrallhin.on.ca/>

<sup>15</sup> [file:///C:/Users/jtanders/Downloads/ENG-Central\\_LHIN-IHSP-13-16\\_web.pdf](file:///C:/Users/jtanders/Downloads/ENG-Central_LHIN-IHSP-13-16_web.pdf)

<sup>16</sup> <http://www.centraleastlhin.on.ca/aboutus.aspx>

<sup>17</sup> <file:///C:/Users/jtanders/Downloads/201410ChHLAsPopCharEN.pdf>

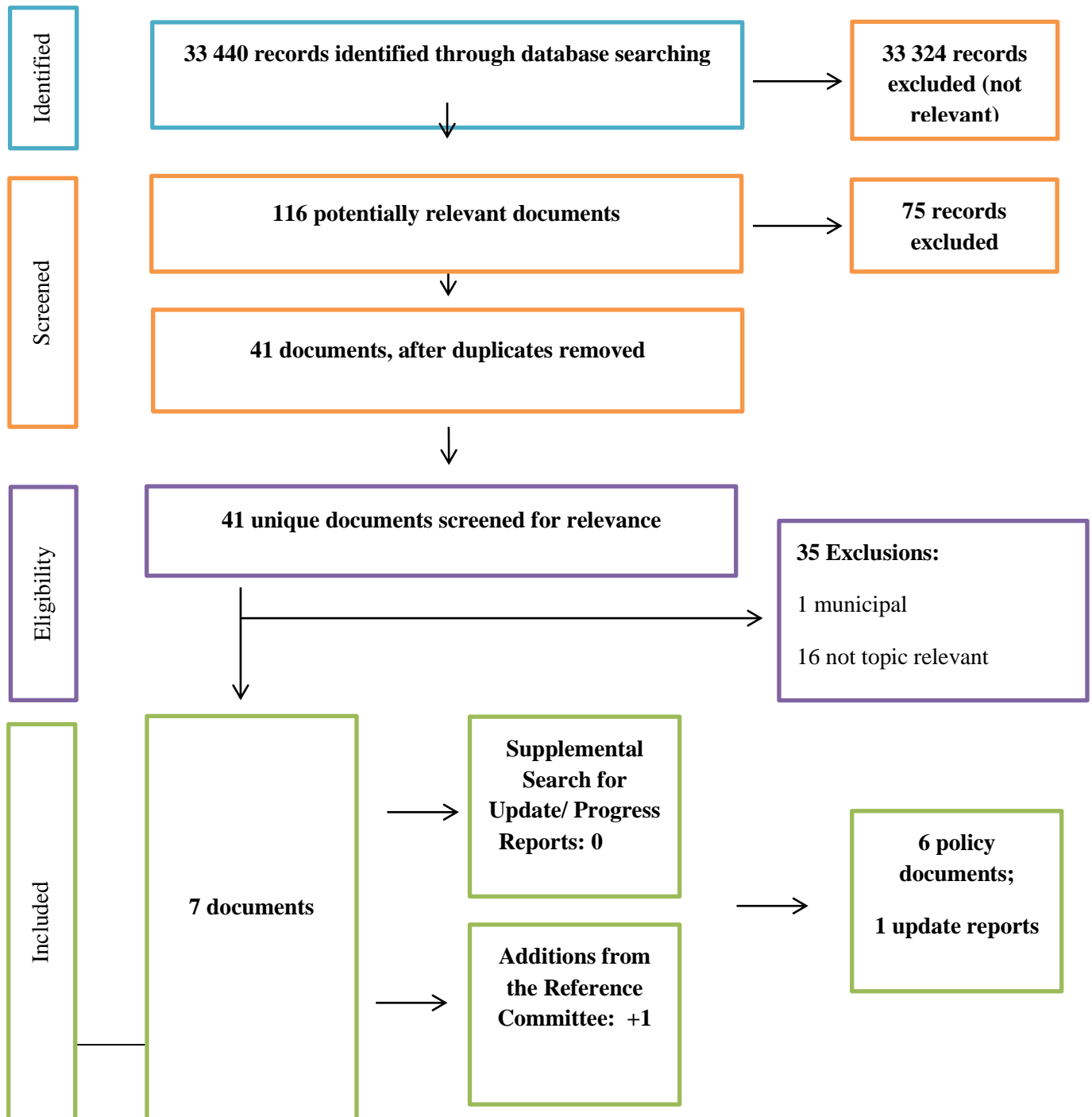
<sup>18</sup> <http://www.nsmllhin.on.ca/aboutus/nsmllhin.aspx>

<sup>19</sup> <http://www.nelhin.on.ca/>

<sup>20</sup> <http://www.northwestlhin.on.ca/AboutOurLHIN.aspx>

<sup>21</sup> [file:///C:/Users/jtanders/Downloads/Population\\_Profile\\_December-2015.pdf](file:///C:/Users/jtanders/Downloads/Population_Profile_December-2015.pdf)

## Appendix B: Systematic search strategy flow diagram<sup>22</sup>



<sup>22</sup> Adapted from PRISMA 2009 Flow Chart (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009).

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

### Overview

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

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

### Inductive analysis

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

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

descriptions vary considerably depending on whether a given document is primary, secondary or tertiary, as well as whether it is shorter or longer and simple or complex.

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

### **Deductive analysis**

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

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

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

Each document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria not met) of each quality indicator. Dichotomous scores for each indicator were justified with an accompanying written rationale. Scores and rationales were then compiled into a standardized *policy report card* for each provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions. Formal policies that score highly on CHARPP



indicators are high-quality because they conceptualize and describe a harm reduction approach in close accordance with its internationally-recognized attributes and principles. Conversely, poor-quality harm reduction policies score low on CHARPP indicators because they refer to the approach only sparingly, and/or do not elucidate its key attribute and principles.

## **Accompanying Quantitative Data**

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

## Appendix D: Descriptive summary of policy documents

The *Ontario Public Health Standards [1]* was published by the Government of Ontario in 2008, and updated in 2015. It is a provincial level document which outlines public health program standards for boards of health in Ontario. This document notes harm reduction in relation to injury prevention and substance misuse, and STI / BBP prevention. It also mandates boards of health to ensure access to harm reduction program models and strategies.

*Open Minds, Healthy Minds [2]* is Ontario's mental health and addiction strategy, which was produced by the Government of Ontario. This is a 10-year plan, which spans the years from 2011 to 2021. The goal of the strategy is improved mental health and well-being of all Ontarians, with an emphasis on recovery and participation in communities. *Open Minds, Healthy Minds* makes no mention of harm reduction or the seven interventions of interest. It is accompanied by one follow-up report which provides an update on the first three years of implementation and outlines the next five-year goals.

*A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health [3]* is a provincial level document, published by the Ministry of Children and Youth in 2006. This high-level policy presents a rationale for the creation of a child and youth mental health framework, and the vision, guiding principles and strategies to address priority areas of action. The document makes no mention of harm reduction, substance use related harms or strategies to address these issues.

*Ontario's Narcotics Strategy [4]* was published by the Ontario Ministry of Health and Long Term Care and is available online. The focus of the strategy is on promoting 'proper' use of prescription narcotics, while reducing drug use and addiction. While there is one mention of harm reduction, the focus of the strategy is on the development of a narcotics monitoring system.

The *North East LHIN Aboriginal / First Nation and Metis Mental Health and Addiction Framework [5]* is a health-authority level strategy which directs action within the North East LHIN. It was published in 2011 with its goal to provide direction to improve access to and quality of mental health and addiction care for Aboriginal, First Nation and Metis people living in Ontario. This document mentions harm reduction only once.

*Tomorrow...An Adult Mental Health Strategic Plan for Erie St. Clair [6]* is a health-authority level strategy which directs mental health care within the Erie St. Clair LHIN. It was published in 2012, spanning four years, with its vision of a fully integrated continuum of mental health services for adults and their families. The document contains no mention of harm reduction of any of the seven interventions of interest.

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