

# Prince Edward Island Policy Analysis Case Report

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*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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### **Report Authored by:**

*Jalene Anderson-Baron, School of Public Health, University of Alberta*

*Kamagaju Karekezi, School of Public Health, University of Alberta*

*Jakob Koziel, School of Public Health, University of Alberta*

*Ashley McCurdy, School of Public Health, University of Alberta*

### **CHARPP Project Leads**

*T. Cameron Wild, Professor, School of Public Health, University of Alberta (Co-Principal Investigator)*

*Elaine Hyshka, Assistant Professor, School of Public Health, University of Alberta (Co-Principal Investigator)*

*Donald MacPherson, Executive Director, Canadian Drug Policy Coalition (Principal Knowledge User)*

### **CHARPP Co-Investigators**

*Mark Asbridge, Associate Professor, Faculty of Medicine, Dalhousie University*

*Lynne Bell-Isle, National Programs Consultant, Canadian AIDS Society*

*Walter Cavalieri, Director, Canadian Harm Reduction Network*

*Carol Strike, Associate Professor, Dalla Lana School of Public Health, University of Toronto*

*Colleen Dell, Professor, School of Public Health, University of Saskatchewan*

*Richard Elliott, Executive Director, Canadian HIV/AIDS Legal Network*

*Andrew Hathaway, Professor, Department of Sociology and Anthropology, University of Guelph*

*Keely McBride, Project Lead, Public Health and Wellness Branch, Alberta Health*

*Bernie Pauly, Scientist, Centre for Addiction Research of BC*

*Kenneth Tupper, Director, Implementation & Partnerships, British Columbia Centre on Substance Use*

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## 1.0 Overview

This document provides a descriptive and analytical account of Prince Edward Island's (PEI) 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. PEI's results reported in this document will be summarized and integrated into a national-level report that outlines key features of each set of provincial/territorial policies, and compares the strength of each case's policy commitment to harm reduction services.

This document begins with an overview of PEI'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.

**Two key findings are highlighted from the inductive analysis:** 1) Harm reduction is unclearly defined and does not align with internationally recognized principles; 2) the PEI policy framework reflects a weak commitment to follow-through and policy implementation. 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>

Prince Edward Island (PEI) is one of three Maritime Provinces in Canada, spanning 5,685 km<sup>2</sup>. It has a population of 140,204 with two major cities: Charlottetown (area of 798 km<sup>2</sup>; population of 64,487) and Summerside (area of 91 km<sup>2</sup>; population of 16,488) (Statistics Canada, 2012a).

The Liberal and Conservative parties have dominated PEI's provincial and federal political landscape over the past century. The Progressive Conservative Party governed from 1996 to 2007, until their defeat in the 2007 general election (Elections PEI, year unknown). Since this time, the Liberal party has remained in power, most recently being elected to a third consecutive majority government in 2015 (Yarr, 2015). Green Party Leader Peter Bevan-Baker was elected as PEI's first Green Member of the Legislative assembly (MLA) in the 2015 provincial election. The current premier of PEI is Wade MacLauchlan who was elected in 2015 (CBC News, 2015). To date, Wade MacLauchlan has not made an official stance on harm reduction. Doug Currie served as Minister of Health and Wellness from 2007 to 2015. As minister of health and wellness, Doug Currie supported needle exchange programs as "good public health practice" (CBC News, 2014) and part of the department's "...provincial harm

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

reduction program strategy” (Government of Prince Edward Island, 2011). Since 2015, Robert Henderson has served as Minister of Health and Wellness (Legislative Assembly of PEI, 2016). He has not publicly commented on harm reduction, but did support the recently published Mental Health and Addiction Strategy for PEI, which vaguely endorses a harm reduction approach (Government of Prince Edward Island, 2016a).

## **1.2 Healthcare Governance**

PEI was the first Canadian province to establish health boards by creating five regional health boards that were responsible for community and health services in 1993. The health system remained relatively unchanged until 2005, when PEI disbanded all regional health boards and the provincial government took over the health and social services of the province. While there are no longer regional boards in the PEI health system, five community hospitals have maintained advisory boards (Philippon & Braithwaite, 2008). In 2010, the government transferred operational authority from the Department of Health and Wellness to Health PEI, a Crown Corporation responsible for the operation and delivery of all publicly funded health services (Institute of Public Administration of Canada, 2013).

Currently, Health PEI is the single health authority of PEI and is responsible for the delivery of the province’s healthcare (Pirie et al, 2016). Health PEI employs approximately 3,900 employees including staff and physicians (Health PEI, 2015). The Health PEI board oversees the financial operations and overlooks the work of the chief executive office (Health PEI, 2016). The board is also responsible for various safety, quality, audit, monitoring, compliance, and public engagement committees. Lastly, the Health PEI CEO is responsible for the operational functioning of Health PEI. The CEO of Health PEI in 2015 was Dr. Richard Wedge (Health PEI, 2015).

The department of Health and Wellness retains responsibility for overseeing PEI’s health system and its services and provides strategic planning and policy development (Pirie et al, 2016). The department provides standards for health services, accountability frameworks, and performance targets. It is chiefly responsible for approving budgets and business plans and establishes guidelines or policies for the management of delivery of services and operations (Government of Prince Edward Island, 2016b).

## **1.3 Substance Use Trends**

According to data drawn from the *Canadian Alcohol and Other Drug Use Monitoring Survey* (CADUMS), lifetime use of illicit drugs among PEI residents, including cannabis, increased from

36.7% in 2011 to 41.8% in 2012 while lifetime use of illicit drugs, excluding cannabis, also increased from 10.1% in 2011 to 12.3% in 2012. Despite the increase, lifetime intake of illicit drugs including, Cocaine/crack, Speed, Ecstasy, Hallucinogens, and Heroin, was lower among PEI respondents than those from other Canadian provinces in both 2011 (14.5%) and 2012 (15.4%) (Statistics Canada 2012b; 2014). The *2013 Canadian Student Tobacco, Alcohol, and Drugs Survey* (CSTADS) found that in 2012, 6% of PEI youth reported using MDMA, Heroin, Cocaine, amphetamines, or hallucinogens to get high as compared with the national average of 5%. A further 3% of students used glue, Salvia, gasoline or other solvents to get high as compared with the national average of 2% (Propel Centre for Population Health Impact, 2014). Findings from the 2004-2013 Student Drug Use Report found that 10.1% of students in grades 7-12 used illicit substances in 2012 and 2013; 62.9% of those students reported using only one illicit substance and 13.6% used at least two substances (Department of Health and Wellness, 2015). Between 2005 and 2014, there were 32 drug-related deaths in PEI (Pitt, 2016). In 2015, 11 islanders died from an overdose, almost doubling the six recorded in 2015 (Pitt, 2017). Five of the 11 overdoses involved opiates, and one involved fentanyl (Pitt, 2017).

### **Opioids**

According to the *PEI student drug report*, 1.8% of students reported lifetime use of heroin. Over the years, heroin use among students in grade 7-12 has remained consistent with less than one percent (0.9%) of students indicating that they used heroin in 2012 and 2013. For 2008 and 2009, 1.1% of students reported using heroin (Department of Health and Wellness, 2015). According to the *National Treatment Indicators 2013-2014 Data*, 63 individuals in 2013 and 2014 accessed opioid substitution treatment in PEI (Pirie et al., 2016). As in other provinces, the opioid crisis in Canada has reached PEI. Of the 32 drug related overdose deaths between 2005 and 2014, 15 deaths were the result of at least one opiate such as morphine, fentanyl, oxycodone, methadone, or hydromorphone (Pitt, 2016). Between 2008 and 2014, two overdoses were the result of fentanyl (Canadian Center on Substance Abuse, 2013).

## **1.4 Harm Reduction Services in PEI**

PEI has developed a harm reduction policy positioned towards needle exchange (Patten, 2006). The Department of Health and Wellness, particularly the Chief Public health office, is responsible for administering and managing the provincial needle exchange program (Department of Health and Wellness, 2013a). Prior to the department of health and wellness taking over harm reduction services, they were primarily operated and funded by non-for profit

community services. The first syringe exchange center opened in Charlottetown in 2002 and was operated by AIDS PEI (McCutcheon & Morrison, 2014). Prior to 2009, needle exchange programs were funded solely on private donations and if donations ran out there were no needles to distribute. The government began contributing to the needle exchange programs in 2006 (Klein, 2007). In 2009, the department of health and wellness took over and began to provide needle exchange programs in Charlottetown and Summerside.

Currently, there are seven syringe exchange centers<sup>2</sup> in PEI (Health PEI, 2015). Despite the availability of harm reduction services, there are a number of issues with needle exchange programs in the province. For instance, other supplies (such as safer crack kits) are limited, despite high demand (Cavalieri & Riley, 2012). In a study on individuals who inject drugs in PEI, McCutcheon & Morrison (2014) found structural and practitioner issues present in various needle exchange centers. People who inject drugs reported harm reduction services had inadequate or unavailable services including limited access to sterile syringes and lengthy wait times for treatment. Additionally, there were issues with program staff being insufficiently trained, and people experiencing stigmatization by health care practitioners. Other studies found a significant geographical distance between where individuals live and the location of the nearest needle exchange program in PEI and other Atlantic provinces (Parker et al, 2012). Despite issues related to needle exchange programs, there is evidence of its effectiveness. A 2008 evaluation report found decreased opioid use and overall improvements in metrics measuring harm reduction, including lower levels of blood borne diseases, after needle exchange programs were implemented (One Island Health System, 2008).

Health PEI operates a Methadone Maintenance Treatment (MMT) Program in two clinics located in Charlottetown and Summerside. The Methadone maintenance treatment program was established in 2004 with harm reduction as one of its main goals (One Island Health System, 2008). In 2013, the government of PEI announced that it would open a low-threshold methadone clinic in Charlottetown (Department of Health and Wellness, 2013b). The Prince Edward Island Pharmacy Board, The Controlled Drugs and Substances Act and Narcotic Control Regulations, The Prince Edward Island Pharmacy Board, and the College of Physicians and Surgeons of Prince Edward Island regulate Methadone dispensing (Ontario College of Pharmacists, 2005). Physicians wishing to prescribe methadone have to travel to Toronto, as PEI does not offer MMT training to physicians (Luce, 2011). In regards to buprenorphine, physicians need to maintain a license to practice, review the buprenorphine treatment for opioid dependency practice, complete courses related to prescribing buprenorphine, and review “the

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<sup>2</sup> Charlottetown Boardwalk Professional Center, Montague Public Health Nursing, Souris Public Health Souris Hospital, Summerside Harbourside Medical Center, O’Leary Community Hospital, Alberton Western Hospital, Tignish Medical Center

Centre for Addiction and Mental Health Buprenorphine Guideline for Treatment of Opioid Dependence”. However, physicians do not need to obtain a methadone exemption in order to prescribe either naloxone or buprenorphine for opioid use disorder (College of Physicians and Surgeons of Prince Edward Island, 2014; CRISM 2016). In PEI there are currently no drug checking interventions and no distribution of safer inhalation kits through any harm reduction services. Additionally, there are no safe injection sites in the province.

AIDS PEI is currently the only provincial organization that supports the well-being of individuals affected by HIV/AIDS through education and health promotion (AIDS PEI, 2016a). Harm reduction is one of the main philosophies of this organization. They provide a variety of needle exchange supplies, including needles, sterilized water, condoms, alcohol swabs, filters, and cookers (AIDS PEI, 2016b).

## 2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. The single document produced for PEI during this period was (a) analyzed and synthesized inductively to describe historical<sup>3</sup> and current<sup>4</sup> policy developments guiding harm reduction services in the province over this time period, and (b) reviewed 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>5</sup> or (5) were produced as either a stand-alone

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<sup>3</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>4</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>5</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.



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.

One current document was identified and analyzed using a two-step (inductive and deductive) process described below (Appendix A provides the PEI-specific search strategy).

## 2.2 Inductive Analysis

The single PEI document was analyzed using a three-step process (Appendix B provides analytic details). First, relevant text<sup>6</sup> was extracted 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, the document's analytic notes and a set of accompanying quantitative data (see Appendix B) were synthesized and compiled into a narrative document description. This resulted in a descriptive summary, describing the main themes and trends in PEI's harm reduction policy document 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.

The current PEI document was content analyzed using this framework. It 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

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<sup>6</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.

provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions

### 3.0 Documents Retrieved

We retrieved one unique policy documents in our provincial search and no corresponding update reports. This document was deemed to be current. See Table 1 below for further information. An additional descriptive summary is included in Appendix C.

Table 1: Descriptive Details of PEI’s Policy Documents

		DOCUMENT TITLE	AUTHORS	YEAR PUBLISHED	YEARS ACTIVE
<b>CURRENT POLICY DOCUMENTS</b>					
<b>Provincial Level</b>	<i>1</i>	A PEI Youth Substance Use and Addiction Strategy	Department of Health, Primary Care Division	2007	Not specified

## 4.0 Results

### 4.1 Harm reduction is unclearly defined and does not align with internationally recognized principles

PEI's policy framework consists of only one formal document, with a stated focus on substance use and addiction for youth – *A P.E.I. Youth Substance Use and Addiction Strategy*. Although the term harm reduction is used six times in the document, no definition is explicitly provided nor can one be implicitly discerned from the contexts in which it is used. Furthermore, none of the seven interventions of interest are noted, and there are no examples of harm reduction in practice.

The term first appears as one of twelve evidence-based principles intended to guide the framework. No definition or context is provided, or details regarding how harm reduction may be applied in practice. The term appears again briefly in a list of approaches toward youth treatment. Here, a reference to Health Canada's *"Best Practices Treatment and Rehabilitation for Youth with Substance Use Problems"* is cited (p.9). The referenced document also provides no formal definition of harm reduction, however, it does acknowledge that abstinence is not required as part of a harm reduction approach. Despite this, the *PEI Strategy* document does not make this principle clear at any point. The third appearance of the term is particularly confusing given the context in which it is used. A pilot program, the 120 Program, is referenced as a crime prevention and "harm reduction" approach (p.12). However, it is unclear what harm reduction values align with the project. The project is described as follows: "When under-aged youth are found in possession of alcohol, rather than receive a fine of \$120, they will be given the choice of participating in the new "120 Program" which will provide education on the dangers of drug and alcohol abuse and its impact on the communities in which they live" (Government of Prince Edward Island, 2007). It is unclear how this aligns with the harm reduction principles that were previously cited in the best practices document, or with any internationally recognized principles of harm reduction (HRI, 2010). The application of the term in this context raises uncertainty regarding the authors understanding of the term.

#### 4.1.1 Summary

Given the lack of clarity surrounding what exactly harm reduction is in this document, it is perhaps not surprising that the concept of harm reduction is not operationalized in any meaningful way. There is no mention of how a harm reduction approach may be applied in treatment or counselling services, nor is there any mention of the seven interventions of interest to this study. Despite it being listed as one of the twelve major principles guiding the document's framework, harm reduction approaches and services do not appear to be an

integral focus of the document, nor is a clear understanding of the approach communicated. In contrast, discussions around the approach implicitly imply endorsement of an abstinence based model – such as the “120 Program” that educates youth on “the dangers of drugs and alcohol abuse” (Government of Prince Edward Island, 2007). Given that this is the only document guiding harm reduction services in the province of PEI, it is notable that there is no clear directive on what harm reduction is or how it can be implemented in practice.

## **4.2 The PEI policy framework reflects a weak commitment to follow-through and policy implementation**

The primary aim of *A P.E.I. Youth Substance Use and Addiction Strategy* was to develop a framework to ensure that island youth “[would] have access to a full continuum of appropriate, integrated services to prevent and treat substance abuse problems/treatment.” This document was intended to outline the first of three phases towards that end, acting as a guiding framework for future action. Phase one, outlined in the present document, involved gathering information, consultations with relevant stakeholders, and information on approaches taken by other Atlantic provinces. This was intended to guide phases two and three, which included the creation of a detailed implementation plan.

Our search found no evidence of an implementation plan being developed since this time, and other update documents do not exist to track the progress of the *Strategy*, despite being published eight years ago. As such, the original strategy appears to be the only guiding document at this time, and is missing key features for translating policy into action. The document outlines seven vague goals, none of which include references to funding or specific timelines. In terms of these goals, or elsewhere in the document, responsibility for actions is not assigned to specific actors. There is no endorsement from the Premier or Minister of Health, and no reference to legislation enacted to guide policy implementation.

### **4.2.1 Summary**

Overall, the document acts as a visionary framework, but provides very little in regards to implementation. In terms of harm reduction more specifically, there are no action items to direct work around this approach. Furthermore, as has been stated previously, no specific interventions are endorsed, leaving many questions around how harm reduction could be implemented in practice. As no update documents have been published, it is not possible to track progress of this plan, and it is unclear why an implementation plan never came to fruition.

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

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

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

	A.P.E.I. Youth Substance Use and Addiction Strategy	Total (out of)
[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
<b>TOTAL (out of 9)</b>	<b>0</b>	<b>0 of 9</b>

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

	<i>A.P.E.I. Youth Substance Use and Addiction Strategy</i>	<b>Total (out of )</b>
[10] Does the document acknowledge the need for evidence-informed policies and/or programming?	1	<b>1</b>
[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	<b>0</b>
[12] Does the document discuss low threshold approaches to service provision?	0	<b>0</b>
[13] Does the document specifically address overdose?	0	<b>0</b>
[14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach?	0	<b>0</b>
[15] Does the document consider harm reduction approaches for a variety of drugs and modes of use?	0	<b>0</b>
[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	0	<b>0</b>
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	0	<b>0</b>
<b>TOTAL (out of 8)</b>	<b>1</b>	<b>1 of 8</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%)
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%)
<b>Canada (54)</b>	<b>109/486 (22%)</b>	<b>153/432 (35%)</b>

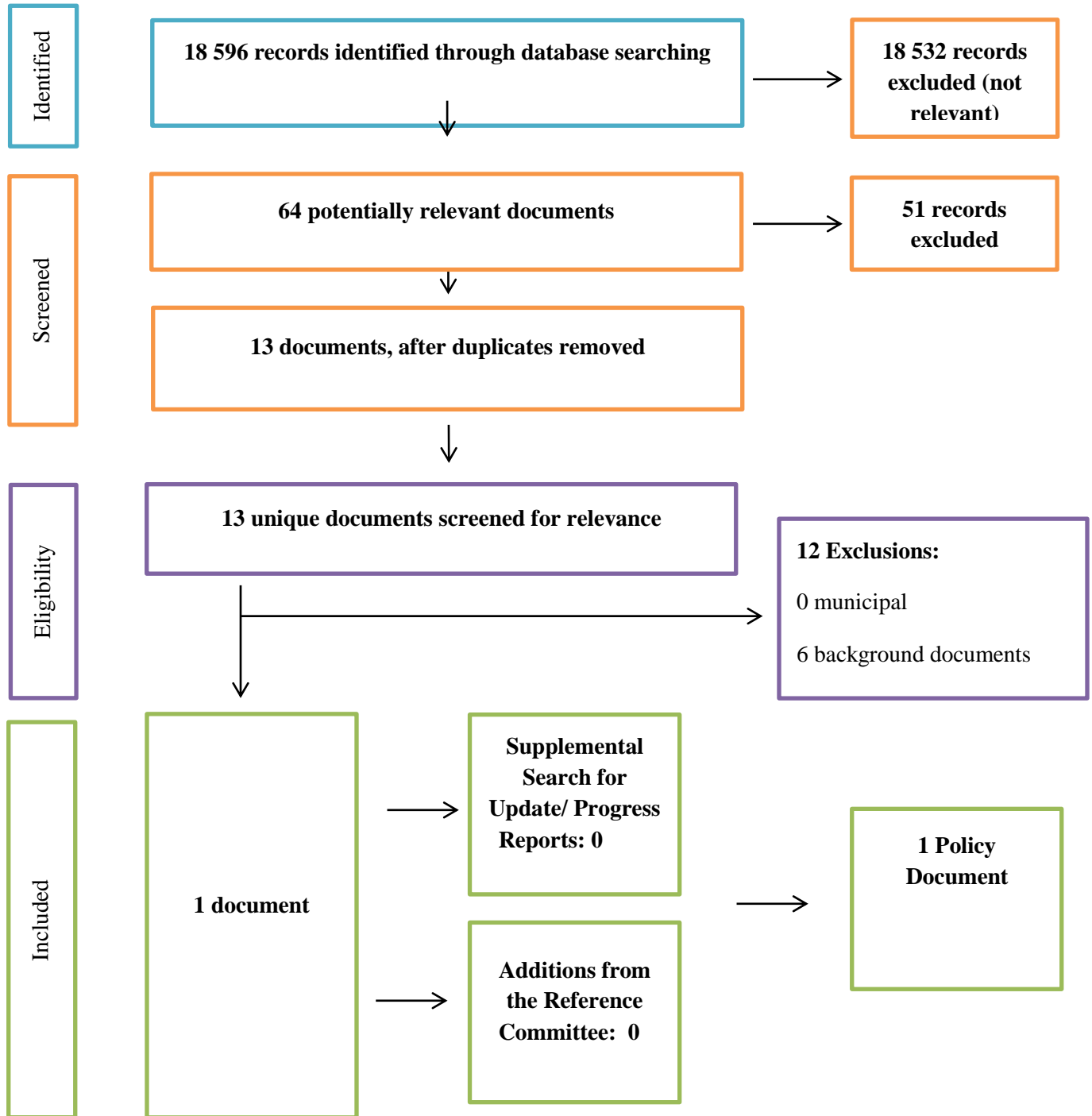


## 6.0 Conclusion

The formal harm reduction policy framework for PEI consists of only one document, published in 2007. The stated focus of this document is addiction and mental health for youth, meaning that policy narrowly focuses on a subset of the general population to begin with, leaving adults and key population groups, such as women and Indigenous peoples, with no policy direction whatsoever.

There is ultimately no guidance around harm reduction in the province. The concept is not clearly defined or understood on paper, and there are few examples provided to indicate how harm reduction could be implemented in practice. None of the seven interventions of interest are noted, and contradictory models – such as fear-based education around substance use, are promoted. Harm reduction aside – the policy document itself is lacking mechanisms to translate policy into action, including an implementation plan, timelines or consideration of funding. Ultimately, the policy context around harm reduction is non-existent in PEI.

## Appendix A: Systematic search strategy flow diagram<sup>7</sup>



<sup>7</sup> 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 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 accord 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 P.E.I. Youth Substance Use and Addiction Strategy* was published in 2007 by the province's Department of Health. The primary aim of the document was to develop a framework to ensure that island youth "[would] have access to a full continuum of appropriate, integrated services to prevent and treat substance abuse problems/treatment." This document was supposed to outline the first step in a three step process toward that end. Phase one involved gathering information from research based best practices based, consultations with relevant stakeholders, and information on approaches taken by other Atlantic provinces and integrating this information into a framework. This framework is intended to guide phases two and three, which will further refine the information gathered in phase one and guide the formation of an implementation plan. This document is considered current, as no timeline is set forth in the document and no update reports have been provided since its publication a decade ago. Harm reduction is mentioned six times in the document, but not clearly defined or described. None of the seven interventions of interest are noted anywhere.

## References

AIDS PEI. (2016a). Prevention. Retrieved November 22, 2016, from <http://www.aidspei.com/prevention.php>

AIDS PEI. (2016b). Needle Exchange Services. Retrieved November 22, 2016, from [http://www.aidspei.com/needle\\_exchange.php](http://www.aidspei.com/needle_exchange.php)

Canadian Center on Substance Abuse. (2013). *Deaths Involving Fentanyl in Canada, 2009-2014*. [Bulletin]. Toronto, ON. Retrieved November 2, 2016 from <http://www.ccsa.ca/Resource%20Library/CCSA-CCENDU-Fentanyl-Deaths-Canada-Bulletin-2015-en.pdf>

Cavaliere, W & Riley, D. (2012). "Harm Reduction in Canada: The Many Faces of Regression". In R. Pates & D. Riley (Eds.), *Harm Reduction in Substance Use and High-Risk Behaviour: International Policy and Practice*. Oxford, UK: Wiley-Blackwell.

CBC News. (2014). Provincial needle exchange program expands to Souris - Prince Edward Island - CBC News. Retrieved November 22, 2016, from <http://www.cbc.ca/news/canada/prince-edward-island/provincial-needle-exchange-program-expands-to-souris-1.2648565>

CBC News. (2015). Liberals win majority in P.E.I. election - CBC News | Elections PEI. Retrieved November 21, 2016, from <http://www.cbc.ca/news/elections/prince-edward-island-votes/liberals-win-majority-in-p-e-i-election-1.305966>

College of Physicians and Surgeons of Prince Edward Island. (2014). Introductory Statement on Prescribing Methadone and Buprenorphine. Retrieved from <http://cpspei.ca/wp-content/uploads/2014/02/BUPRENORPHINE-Treatment-for-Opioid-Dependency-Jan-2714.pdf>

Canadian Research Initiative on Substance Misuse. (2016). Moving Towards Improved Access for Evidence-Based Opioid Addiction Care in British Columbia. Retrieved from <http://www.cfenet.ubc.ca/sites/default/files/uploads/news/releases/improved-access-opioid-addiction-care-bc-final-jun1.pdf>. Accessed November 22, 2016.

Department of Health and Wellness. (2013a). Annual Report 2011-2012. Retrieved from the Government of PEI website: [http://www.gov.pe.ca/photos/original/AR\\_HealthWell12.pdf](http://www.gov.pe.ca/photos/original/AR_HealthWell12.pdf)

Department of Health and Wellness. (2013b). Better Access for Islanders to Mental Health and Addictions Services and Supports. [Bulletin]. Retrieved from [https://www.princeedwardisland.ca/sites/default/files/publications/better\\_access\\_for\\_islanders\\_to\\_mhass-2013.pdf](https://www.princeedwardisland.ca/sites/default/files/publications/better_access_for_islanders_to_mhass-2013.pdf)

Department of Health and Wellness. (2015). Prince Edward Island Student Drug Use 2004-2013. Retrieved from the department of health and wellness from [https://www.princeedwardisland.ca/sites/default/files/publications/student\\_drug\\_use\\_report\\_2004\\_2013.pdf](https://www.princeedwardisland.ca/sites/default/files/publications/student_drug_use_report_2004_2013.pdf)

Elections PEI. (Year Unknown). *Historical Election Dates*. Retrieved from <http://www.electionspei.ca/provincial/historical/results/electiondates.php>

Government of Prince Edward Island. (2007). Young Alcohol and Drug Awareness Program Launched in Kings County. Retrieved from <http://www.gov.pe.ca/index.php3/index.php3?number=news&lang=E&newsnumber=4998>

Government of Prince Edward Island. (2011). "Provincial Needle Exchange Program coming to Montague." [Press Release]. Retrieved from November 21, 2016 from <http://www.gov.pe.ca/infopei/index.php3?number=news&newsnumber=7728&dept=&lang=E>

Government of Prince Edward Island. (2016a). *Prince Edward Island 2016-2026 Mental Health and Addiction Strategy*. Retrieved from [www.princeedwardisland.ca/sites/default/files/publications/peimentalhealthaddictionsstrategy\\_moving\\_forward.pdf](http://www.princeedwardisland.ca/sites/default/files/publications/peimentalhealthaddictionsstrategy_moving_forward.pdf)

Government of Prince Edward Island. (2016b). *Health and Wellness- About Us*. Retrieved from the government of Prince Edward Island website from <https://www.princeedwardisland.ca/en/topic/health-and-wellness>

Health PEI. (2015). Annual Report: 2014-2015. Retrieved from the Health PEI Website from [http://www.gov.pe.ca/photos/original/hpei\\_ar1415\\_eng.pdf?\\_ga=1.125862542.2029848933.1476912652](http://www.gov.pe.ca/photos/original/hpei_ar1415_eng.pdf?_ga=1.125862542.2029848933.1476912652)

Government of PEI. (2013). Annual 2010-2011. Retrieved from the Government of PEI from [http://www.gov.pe.ca/photos/original/AR\\_HealthWell11.pdf](http://www.gov.pe.ca/photos/original/AR_HealthWell11.pdf)

Health PEI. (2016). Health PEI Board. Retrieved from the Health PEI website from <http://www.healthpei.ca/board>

Health PEI. (2015). Provincial Needle Exchange Program Poster. (Poster). Retrieved from [http://www.gov.pe.ca/photos/original/hpei\\_needleexch.pdf?\\_ga=1.130673292.2029848933.1476912652](http://www.gov.pe.ca/photos/original/hpei_needleexch.pdf?_ga=1.130673292.2029848933.1476912652)

Institute of Public Administration of Canada. Healthcare Governance Models in Canada A Provincial Perspective Pre-Summit Discussion Paper. (2013). Retrieved November 2, 2016 from



The Institute of Public Administration of Canada website: [www.ipac.ca/documents/ALL-COMBINED.pdf](http://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>

Legislative Assembly of PEI. (2016). *Hon. Robert. Henderson*. Retrieved from <http://www.assembly.pe.ca/roberthenderson>

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-cept.ca/pdf/CECA%20MMT%20Policy%20Scan%20April%202011.pdf>

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

McCutcheon, J., & Morrison, M. (2014). Injecting on the Island: a qualitative exploration of the service needs of persons who inject drugs in Prince Edward Island, Canada. *Harm Reduction Journal*, 11 (1). doi: 10.1186/1477-7517-11-10.

One Island Health System. (2008). *Prince Edward Island Methadone Maintenance Treatment Program Evaluation Report*. Department of Health and Wellness. Retrieved from [http://www.gov.pe.ca/photos/original/doh\\_mmtpeval.pdf](http://www.gov.pe.ca/photos/original/doh_mmtpeval.pdf)

Ontario College of Pharmacists. (2005). Methadone Distribution Guidelines For a Methadone Maintenance Program. Retrieved from [http://napra.ca/Content\\_Files/Files/PEI/StandardsGuidelines/methadone\\_revision\\_november2006b.pdf](http://napra.ca/Content_Files/Files/PEI/StandardsGuidelines/methadone_revision_november2006b.pdf)

Parker, J., Jackson, L., Dykeman, M., Gahagan, J., & Karabanow, J. (2012). Access to harm reduction services in Atlantic Canada: Implications for non-urban residents who inject drugs. *Health & Place*, 18 (2), 152-162.

Patten, S. (2006). Environmental Scan of Injection Drug Use, Related Infectious Diseases, High-risk Behaviours, and Relevant Programming in Atlantic Canada. The Public Health Agency of Canada, Atlantic Regional Office. Retrieved from [http://www.catie.ca/sites/default/files/\\_sites\\_webphac\\_htdocs\\_archives\\_es-Injection\\_Drug\\_Use\\_e.pdf](http://www.catie.ca/sites/default/files/_sites_webphac_htdocs_archives_es-Injection_Drug_Use_e.pdf)

Philippon, D. J., & Braithwaite, J. (2008). Health system organization and governance in Canada and Australia: a comparison of historical developments, recent policy changes and future implications. *Healthcare Policy*, 4(1): e168-86.

Pirie, T., Wallingford, S.C., Di Gioacchino, L.A., McQuaid, R.J., & National Treatment Indicators Working Group. (2016). National Treatment Indicators Report: 2013–2014 Data. Ottawa, Ont.: Canadian Centre on Substance Abuse.

Pitt, Sally. "Opiates Involved in Nearly Half of P.E.I. Drug Overdose Deaths - Prince Edward Island - CBC News." CBCnews. CBC/Radio Canada, Sept. 2016. Web. 21 Nov. 2016. Retrieved from <http://www.cbc.ca/news/canada/prince-edward-island/pei-drug-overdoses-fentanyl-opiate-methadone-accidental-death-2016-1.3761517>.

Pitt, Sally. (Feb 6, 2017). P.E.I. fatal drug overdoses at highest level in decade. CBC News. Retrieved from <http://www.cbc.ca/news/canada/prince-edward-island/pei-fatal-drug-overdoses-2015-1.3965484>

Propel Centre for Population Health Impact. (2014). 2012/2013 Youth Smoking Survey: Results Profile for Prince Edward Island. Waterloo (ON): University of Waterloo, 1-18.

Statistics Canada. (2012a). Focus on Geography Series, 2011 Census. Statistics Canada Catalogue no. 98-310-XWE2011004. Ottawa, Ontario. Analytical products, 2011 Census. Last updated October 24, 2012. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-pr-eng.cfm?Lang=Eng&GK=PR&GC=11>

Statistics Canada. (2012b). Canadian Alcohol and Drug Use Monitoring Survey. Table 2: Main 2011 CADUMS indicators by province – Drugs. Retrieved from [http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/\\_2011/tables-tableaux-eng.php#t2](http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/tables-tableaux-eng.php#t2)

Statistics Canada. (2014). Canadian Alcohol and Drug Use Monitoring Survey. Table 2: Main 2012 CADUMS indicators by province – Drugs. Retrieved from [http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/\\_2012/tables-tableaux-eng.php#t2](http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2012/tables-tableaux-eng.php#t2).

Yarr, K. (2015). Federal election 2015: Liberals renew dominance of federal politics on P.E.I. - Prince Edward Island - CBC News. Retrieved November 21, 2016, from <http://www.cbc.ca/news/canada/prince-edward-island/federal-election-2015-liberals-renew-dominance-of-federal-politics-on-p-e-i-1.3279332>

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. (2014). *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. Geneva, Switzerland.