

Quebec Policy Analysis Case Report

Canadian Harm Reduction Policy Project (CHARPP)

August 2017

This research was conducted as part of the Canadian Harm Reduction Policy Project (CHARPP), a mixed-method, multiple-case study drawing on four data sources (policy documents, key informant interviews, media portrayals, and a national public opinion survey) to describe how policies governing harm reduction services are positioned within and across the 13 Canadian provinces and territories.

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1.0 Overview

This document provides a descriptive and analytical account of Quebec'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. Quebec 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 Quebec'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.

Five key findings are highlighted from the inductive analysis:

1) *Policy documents are well coordinated at the provincial level:*

The documents adhere to a cohesive approach on harm reduction. Documents cross-reference each other. Less frequently, regional documents refer to relevant provincial documents and state what they add to them.

2) *Policy documents integrate the values and principles of harm reduction:*

The provincial policy documents tend not to provide a definition of harm reduction. Rather, they integrate the values and principles of harm reduction throughout: harm reduction does not require reduction of or abstinence from substance use; harm reduction applies broadly to strategies, policies and programs; harm reduction acknowledges that not all substance use is problematic; harm reduction has benefits for people who use drugs, families and society; harm reduction targets drug-related risks and harms, including overdose; harm reduction is evidence-based; harm reduction is based on social justice and human rights; harm reduction considers the social determinants of health; and harm reduction addresses stigma and discrimination.

3) *Quebec has policy documents that specifically address three of the seven interventions of interest:*

Specific documents exist on street outreach, low-threshold opioid substitution, and supervised injection services. Many documents refer to syringe distribution, which they name 'injection material access centres', while only two documents refer to drug checking. No documents mention naloxone or safer inhalation kits.

4) *Policy documents report a harm reduction approach to drug treatment, including low-threshold access:*

The documents reveal a struggle, however, with the interpretation of a harm reduction approach. They imply that the goal of treatment and social reintegration efforts is to foster a motivation for change in people who use drugs. This aim belies the harm reduction approach, which is meant to meet people where they are at, and reveals that despite integration of the harm reduction approach, there are still residuals of wanting to fix people and change them.

- 5) *Policy documents acknowledge that harm reduction can be applied to the general population as well as specific populations, including women, youth, Indigenous communities, and men who have sex with men.*

In the deductive analysis, a set of criteria were applied to current policy documents. Results are presented in a standardized Policy Report Card below.

1.1 Contextual Background¹

Quebec is the largest province in Canada, spanning 1.667 million square kilometers, although the territory of Nunavut is larger by area. Quebec is the second-most populous province in Canada, with 8,259,500 habitants in 2015 (Statistics Canada, 2016a), second only to Ontario. The largest city in the province of Quebec is Montreal, with a population of 4,060,7000 in 2015. Quebec's capital, Quebec City, had a population of 806,400 in 2015 (Statistics Canada, 2016b).

Quebec is the only province to have a predominantly French-speaking population. On November 27th, 2006, the House of Commons adopted a motion recognizing Quebec as “a nation within a united Canada” as a symbolic political gesture of no constitutional entrenchment or legal consequence (Secrétariat aux affaires intergouvernementales canadiennes, 2015). To the Government of Quebec, the Quebec nation includes all residents of Quebec and is not limited to French-speaking residents. Recognition of the Quebec nation reflects “Quebec’s distinct legal traditions and social values” (Supreme Court of Canada, 2014).

The winds of national sovereignty for Quebec emerged in the late 1960s and in 1968, the Parti Québécois, a national sovereignty political party was formed, led by René Lévesque (Assemblée nationale du Québec, 2014a). The Parti Québécois was in power in 2000 when the period of interest for this report began, under the leadership of Lucien Bouchard until 2001, followed by Bernard Landry (Assemblée nationale du Québec, 2014b). In 2003, the Quebec Liberal Party took power, with former federal Progressive Conservative Party of Canada Jean Charest at the helm. The Quebec Liberal Party remained in power until 2012, when the Parti Québécois, under Pauline Marois, briefly governed the Assemblée nationale du Québec (Quebec National Assembly) until 2014. The Quebec Liberal Party returned to power in 2015, led by Philippe Couillard, and remains in power today (Assemblée nationale du Québec, 2014b).

1.2 Health Care Governance

In Quebec, the Ministry of Health and Social Services aims to maintain, improve and restore health and well-being of Quebec's population by providing access to an array of integrated and quality health and

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

social services, thereby contributing to the social and economic development of Quebec (Gouvernement du Québec, 2016a).

Since April 1st, 2015, with the enactment of the *Loi modifiant l'organisation et la gouvernance du réseau de la santé et des services sociaux notamment par l'abolition des agences régionales* [Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies], Quebec's network of health and social services includes 22 Health and Social Services Integrated Centres, which are responsible for ensuring the development and efficiency of the local networks of health and social services, four university hospitals, three universities, and five institutions that serve northern and indigenous communities (Gouvernement du Québec, 2016b).

The province of Quebec is divided into 18 health regions : Bas-Saint-Laurent, Saguenay-Lac-Saint-Jean, Capitale-Nationale, Mauricie et Centre-du-Québec, Estrie, Montréal, Outaouais, Abitibi-Témiscamingue, Côte-Nord, Nord-du-Québec, Gaspésie-Îles-de-la-Madeleine, Chaudière-Appalaches, Laval, Lanaudière, Laurentides, Montérégie, Nunavik, and Terres-Cries-de-la-Baie-James (Gouvernement du Québec, 2016c). More than 60% of Quebec's population resides in the Montréal, Laval, Lanaudière and Montérégie regions.

Quebec had a Comité permanent de lutte à la toxicomania (CPLT) [Standing Committee on Addictions], with a primary mandate to advise the Minister of Health and Social Services and the Deputy Minister on strategic directions, priority actions or interventions that should be adopted to address drug addiction. Documents from the CPLT were not included in this analysis since they were not official provincial policy but rather recommendations to the government. The CPLT has been prolific, however, in producing knowledge translation documents on the research it commissions, and in conducting consultations and analyses on issues related to substance use. As early as December 1996, the CPLT recommended the implementation of harm reduction programs. In December 1997, the CPLT released a foundational document on *L'approche de réduction des méfaits: sources, situation, pratiques* [The Harm Reduction Approach: Sources, Situation, and Practices] (CPLT, 1997). In October 1999, the CPLT released a document that described the necessary elements for a better understanding of the harm reduction approach (CPLT, 1999).

Quebec also has a National Institute of Public Health (Institut national de santé publique, INSPQ) that supports the Minister of Health and Social Services, the regional public health authorities, and the institutions in their responsibilities by providing expertise and specialized laboratory and screening services.

1.3 Substance Use Trends

According to data drawn from the Canadian Alcohol and Drug Use Monitoring Survey (Health Canada, 2014), 41.9% of Quebecois reported lifetime use of one or more illicit drugs. Over their lifetime, 6.3% of Quebecois reported using cocaine/crack, 5.2% reported using amphetamines, and 8.9% reported using hallucinogens. Quebecois also reported on drug use in the past 12 months; 10% reported using at least

one illicit drug in the past year, while 9.5% reported using one of the following illicit drugs: cocaine/crack, speed, methamphetamine/crystal meth, hallucinogens, ecstasy or heroin (Health Canada, 2014).

Health Canada (2014) reports that in 2012, 2.0% of Canadians experienced harms related to drug use, including harms to physical health, friendships and social life, financial position, home life or marriage, work, studies, or employment opportunities, legal problems, difficulty learning, and housing problems. Estimates for Quebec, however, were suppressed due to high sampling variability.

Like other parts of Canada, Quebec has experienced an increase of opioid-related overdose deaths in recent years. Between 2010 and 2014, there were 194 opioid-related deaths in Quebec, 16 of which were attributable to fentanyl (INSPQ, 2017). The opioid-related death rate has been steadily increasing since 2000. Preliminary data for 2015 and 2016 reveal that the death rate from opioid overdoses continues to climb.

1.4 Harm Reduction Services in Quebec

This section provides an overview of the state of the seven interventions of interest for this report: 1) syringe distribution, 2) Naloxone, 3) supervised consumption, 4) low threshold opioid substitution, 5) outreach, 6) drug checking, 7) safer inhalation kits.

Syringe distribution: Quebec has **Injection Material Access Centres** throughout the province. In 2015, a total of 1,138 sites were identified where Quebecois could access injection material across the province in Health and Social Services Centres situated in community services, hospitals, medical clinics and rehab centres, in pharmacies, and in various community organizations (INSPQ, 2016). The list of Injection Material Access Centres is readily available online (Gouvernement du Québec, 2016d). The number of distributed needles has steadily increased over the years, from 1,997,330 in 2008-2009 to 2,252,450 in 2012-2013 (INSPQ, 2014). Injection Material Access Centres have had 130,213 visits in 2012-2013, 29% of which were women and 71% were men (INSPQ, 2014). Injection Material Access Centres are part of the integrated STBBI services recommended in Quebec's National Public Health Program (MSSSQ, 2015).

Naloxone: **Naloxone** is available in Quebec through a medical directive by a regional public health director, which allows a pharmacist to dispense take-home naloxone kits to individuals who have been trained through a certified training program (CCSA, 2016). Ambulance attendants also carry naloxone. In Montreal, a take-home naloxone program has been operating since 2015, at which time there were two training sites. Training was offered by peers with the support of a registered nurse, by public health registered nurses and by the public health agent. Training was available for people who use opioids illicitly, their family and friends, and community workers (CCSA, 2016).

Supervised consumption: While Quebec does not currently have sanctioned **supervised injection/consumption** facilities or services (up to the end of 2016), the Ministère de la santé et des services sociaux du Québec [Quebec Ministry of Health and Social Services] developed a framework with indicators for health and social services institutions and community organizations interested in offering supervised injection to people who use injection drugs (MSSSQ, 2013).

Low threshold opioid substitution: With regard to **opiate substitution**, in 1999, the Quebec College of Physicians and the Quebec Order of Pharmacists developed guidelines on the use of methadone in the treatment of opiate addiction (Collège des médecins du Québec & L'Ordre des pharmaciens du Québec, 1999), which were slightly modified in 2004 (L'Ordre des pharmaciens du Québec & Collège des médecins du Québec, 2004). A framework and recommendations for best practices on the treatment of opioid dependence with substitution medication was released in 2006 by Quebec's Ministry of Health and Social Services (MSSSQ, 2006a). Mention of **low-threshold opiate substitution** programs surfaces in the policy documents included in this analysis, including two provincial and one regional document (MSSSQ, 2001,2013; Agence de la santé et des services sociaux de la Gaspésie-Îles-de-la-Madeleine, 2011). One historical document from the Lanaudière region describes 'low requirements programs' as programs where methadone is prescribed without requirement of abstinence, without confirmatory urine tests nor systematic psychosocial support (Agence de développement de réseaux locaux de services de santé et de services sociaux Lanaudière, 2005). Such low-threshold programs aim to reach as many opiate users as possible, who are often in precarious situations, in order to reduce risks and harms related to the use of opioid by favouring repeated contacts with the health care system.

Although none of the current policy documents refers to policies related to **buprenorphine (Suboxone)**, Quebec's College of Physicians and Quebec's Order of Pharmacists developed guidelines for the use of buprenorphine in the treatment of opioid dependence (Collège des médecins du Québec & L'Ordre des pharmaciens du Québec, 2009). Buprenorphine was mentioned in the 1999 guidelines on the use of methadone in the treatment of opiate addiction (Collège des médecins du Québec & L'Ordre des pharmaciens du Québec, 1999) as another substitution treatment, though at the time this was not officially available in Canada. In a 2006 framework and best practices guide on the treatment of opioid dependence with substitution treatment (MSSSQ, 2006a), the document states that there is resistance to the use of buprenorphine as a substitution treatment despite evidence of its efficacy.

Outreach: **Street outreach** as a practice in Quebec dates back to the late 1960s in Montreal. Its history is documented in the *Cadre de pratique pour le travail de rue en Montérégie* [Practice framework for street outreach in Monteregie] (ASSS Montérégie, 2013), and is summarized here. The goal of street outreach at the time was to address problematic psychedelic substance use in a Quebec society that had been shaken by the emergence of social, cultural and counter-cultural trends in youth. The first street outreach initiatives served as a launching pad for a growing number of street outreach workers in addictions. In 1969, Youth Consultation Bureaus in Montreal and Laval widened the scope of street outreach to address problems of delinquency, sexuality, employment, housing and sex work among youth.

In the 1980s, the emergence of HIV and AIDS upset established health and social interventions and favoured the resurgence of street outreach, in the context of harm reduction. Research had shown the efficiency of harm reduction in reducing the prevalence of STIs, HCV and HIV by reaching a clientele that was otherwise not accessible. The first training sessions were offered for street outreach. Street outreach programs and organizations were implemented between 1988 and 1992. A provincial association of street outreach workers was established in December 1993, the *Association des travailleurs et travailleuses de rue du Québec* [Quebec Street Outreach Workers Association], known as ATTRueQ. It adopted a first code of ethics to guide and govern street outreach practice in Quebec.

Drug checking: **Drug checking** was mentioned as early as 2001 in Quebec's provincial strategic directions and actions document on addictions (MSSSQ, 2001). As part of its second strategic direction on preventing the risk of negative consequences or worsening of problems associated with the inappropriate use of psychoactive substances, the document mentions drug checking and reporting results back to people who use drugs. The document describes that drug checking should be done in collaboration with competent authorities to analyze the composition of illicit substances in circulation and inform people who use drugs of the results of these analyses and of the particular risks associated with the use of these drugs.

A 2006 document, *Plan d'intervention sur la méthamphétamine (crystal meth) et les autres drogues de synthèse* (MSSSQ, 2006b), describes the province's intervention plan on methamphetamine (crystal meth) and other synthetic drugs. Although the scaling up of harm reduction programs is identified as one of the actions to reach the plan's objective for Axis 3 on Treatment and Social Reintegration, the document does not provide details as to specific programs or interventions that would relate to the use of synthetic drugs. In Appendix 2 on the state of the situation in Canada, there is a section that highlights a BC document on *Methamphetamine and other amphetamines: An Integrated Strategy for BC*. This text points to reducing harms of synthetic drugs at the individual level by direct information and intervention, by providing water and other drinks at festivals, and by distributing safer drug use material, for example through needle exchange service, without referring to drug checking.

Safer inhalation kits: As for **safer inhalation kits**, one report by the Institut national de santé publique du Québec (Quebec's Public Health Institute) states that safer inhalation kits were distributed through the Injection Material Access Centres in five regions (INSPQ, 2016). These kits are not distributed in every region nor is their distribution monitored in any systematic way. A total of 85,890 mouth pieces, 49,822 glass pipes, 50,445 stems, and 670,691 filters were distributed in the five reporting regions in 2013-2014 (INSPQ, 2016). In 2015-2016, 117,500 mouth pieces, 124,685 glass pipes, 813,215 filters and 47,580 push sticks were distributed to the Injection Material Access Centres². There was no specific mention of safer inhalation kits, however, in any of the current policy documents.

² Information from personal communication with author, April 3, 2017. Name withheld for confidentiality.

2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. Documents produced for Quebec during this period were (a) analyzed and synthesized inductively to describe historical³ and current⁴ 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 interventions⁵ 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.

Eleven current and eight historical documents were identified and analyzed using a two-step (inductive and deductive) process described below (Appendix A provides the Quebec-specific search strategy).

2.2 Inductive Analysis

Each of the 19 Quebec documents was analyzed using a three-step process (Appendix B provides analytic details). First, relevant text⁶ was extracted from each policy document and analyzed, resulting in a set of analytic notes. The focus of the analytic notes was primarily descriptive and instrumental (i.e., generating a deeper understanding of the intent and purpose of the policy document and the relevant

³ 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.

⁴ 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.

⁵ 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.

⁶ “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.

stakeholders and their roles). Next, each document’s analytic notes and a set of accompanying quantitative data (see Appendix B) were synthesized and compiled into a narrative document description. Finally, all narrative document descriptions for the case were synthesized and compiled into a single document. This resulted in a descriptive summary, describing the main themes and trends in Quebec’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 (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 Quebec 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 17 unique policy documents in our provincial search and two corresponding update reports. Of the 19, 11 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 C.

Table 1: Descriptive Details of Quebec’s Policy Documents

Current – Provincial Level	Document	Authors	Year Published	Years Active
1	Pour une approche pragmatique de prévention en toxicomanie : Orientations, Axes d’intervention, Actions (For a pragmatic approach to prevention in addictions: Strategic Directions, Areas of Intervention, Actions.)	Ministère de la Santé et des Services Sociaux (Quebec Ministry of Health and Social Services)	2001	NA
2	Prévenir et enrayer... Les infections transmissibles sexuellement à déclaration obligatoire : situation et orientations. (Preventing and Curbing... Notifiable Sexually	Ministère de la Santé et des Services Sociaux (Quebec Ministry of Health and Social Services)	2003	NA

Transmitted Infections: Situation and Strategic Directions.)					
	3	Plan d'intervention sur la méthamphétamine (crystal meth) et les autres drogues de synthèse. (Intervention plan on methamphetamine (crystal meth) and other synthetic drugs.)	Ministère de la Santé et des Services Sociaux (Quebec Ministry of Health and Social Services)	2006	NA
	4	Balises pour les établissements de santé et de services sociaux et les organismes - communautaires désirant offrir des services d'injection supervisée aux personnes qui font usage de drogues par injection. Cadre de référence. (Indicators for health and social services institutions and community organizations interested in offering supervised injection for people who use injection drugs. Reference framework.)	Ministère de la Santé et des Services Sociaux (Quebec Ministry of Health and Social Services)	2013	NA
Current – Regional Level	5	Le travail de rue dans Lanaudière : Vers une vision régionale. (Street Outreach in Lanaudiere: Towards a Regional Vision.)	Régie régionale de la santé et des services sociaux de Lanaudière (Regional Health and Social Services Directorate of Lanaudiere)	2002	NA
	6	Cadre de référence pour le travail de proximité au Saguenay-Lac-Saint-Jean. (Reference Framework for proximity outreach work in the Saguenay-Lac-Saint-Jean Region.)	Agence de la Santé et des Services Sociaux du Saguenay-Lac-Saint-Jean (Saguenay-Lac-Saint-Jean Agency of Health and Social Services)	2009	NA
	7	Orientations régionales : Programme-services Dépendances 2010-2015. (Regional Strategic Directions – Program-Services on Dependence 2010-2015.)	Agence de la Santé et des Services Sociaux de la Côte-Nord (North Coast Agency of Health and Social Services)	2010	2010-2015
	8	Les services de traitement de la dépendance aux opioïdes avec une médication de substitution en Gaspésie et aux Îles-de-la-Madeleine - ORIENTATIONS RÉGIONALES. (Treatment Services for Opioid Dependence with Substitution Medication in Gaspésie and Iles-de-la-Madeleine. Regional Strategic Directions.)	Agence de la Santé et des Services Sociaux de la Gaspésie et aux Îles-de-la-Madeleine (Gaspésie and Iles-de-la-Madeleine Agency of Health and Social Services)	2011	NA
	9	Plan d'action intersectoriel pour la promotion d'une sexualité saine et responsable et la prévention des infections transmissibles	Agence de la Santé et des Services Sociaux de Laval (Laval Agency of Health and Social Services)	2013	2013-2016

		sexuellement et par le sang à Laval. 2013-2016. (Intersectorial Action Plan for the Promotion of Healthy and Responsible Sexuality and the Prevention of STBBIs in Laval. 2013-2016.)			
	10	Cadre de pratique pour le travail de rue en Montérégie. (Practice framework for street outreach in the region of Monteregie.)	Agence de la Santé et des Services Sociaux de la Montérégie (Monteregie Agency of Health and Social Services)	2013	NA
	11	Se développer ensemble. Plan d'organisation – programme de santé mentale. (Developing together: Organization plan – mental health program.)	Agence de la Santé et des Services Sociaux des Laurentides (Laurentians Agency of Health and Social Services.)	2013	NA
Historical - Provincial Level	12	Stratégie québécoise de lutte contre les maladies transmissibles sexuellement – Orientations 2000-2002. (Quebec strategy for the prevention of sexually transmittable diseases: Directions for 2000-2002. – Updated in 2004 – see doc #3)	Ministère de la Santé et des Services Sociaux du Québec (Quebec Ministry of Health and Social Services)	2000	2000-2002
	13	Stratégie québécoise de lutte contre l'infection par le VIH et le sida, l'infection par le VHC et les infections transmissibles sexuellement : Orientations 2003-2009. (Quebec Strategy on HIV/AIDS, HCV and STIs: Strategic Directions 2003-2009.)	Ministère de la Santé et des Services Sociaux du Québec (Quebec Ministry of Health and Social Services)	2004	2003-2009
	14	Plan d'action interministériel en toxicomanie 2006-2011. Unis dans l'action. (Interdepartmental action plan on addictions 2006-2011. United in Action.)	Quebec ministries of health and social services, public safety, education, leisure and sport, employment and social solidarity, executive council, transportation, justice, family, elderly and women, and immigration and cultural communities.	2006	2006-2011
	15	Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience. Programme-services dépendances. Offre de service 2007-2012. (Strategic Directions related to Access Standards, Continuity, Quality, Efficacy and Effectiveness. Programmes and services on dependence. Service offer 2007-2012.)	Ministère de la Santé et des Services Sociaux (Quebec Ministry of Health and Social Services)	2007	2007-2012

Historical – Regional Level	16	Plan régional d'organisation des services en toxicomanie de la région de la Chaudière-Appalaches 2000-2003. (Regional Plan for the Organization of Addictions Services in the Chaudière-Appalaches Region 2000-2003.)	Régie régionale de la santé et des services sociaux de la Chaudière-Appalaches (Regional Health and Social Services Directorate of Chaudiere-Appalaches)	2000	2000-2003
	17	Cadre de référence pour le travail de proximité en Montérégie. (Reference Framework for Proximity Outreach in Monteregie. Updated in 2013 – see document #9)	Régie régionale de la santé et des services sociaux de la Montérégie (Regional Health and Social Services Directorate of Monteregie)	2001	NA
	18	Orientations régionales en toxicomanie 2005-2010.	Agence de la Santé et des Services Sociaux de Lanaudière (Lanaudiere Agency of Health and Social Services)	2005	2005-2010
	19	Orientations régionales en dépendances – Mauricie et Centre-du-Québec – 2008-2012. (Regional Strategic Directions on Dependence – Mauricie and Centre-of-Quebec – 2008-2012.)	Agence de la Santé et des Services Sociaux de la Mauricie et Centre-du-Québec (Mauricie and Centre-of-Quebec Agency of Health and Social Services)	2008	2008-2012

4.0 Results: Inductive Analysis of Documents

4.1 Policy documents are well coordinated at the provincial level.

Four current, provincial-level policy documents were identified (see Table 1):

- (1) *Pour une approche pragmatique de prévention en toxicomanie : Orientations, Axes d'intervention, Actions* (MSSSQ, 2001) : pertains to strategic directions and actions on addictions
- (2) *Prévenir et enrayer... Les infections transmissibles sexuellement à déclaration obligatoire : situation et orientations* (MSSSQ, 2003a) : pertains to the state of the situation and strategic directions to prevent and curb notifiable sexually transmitted infections
- (3) *Plan d'intervention sur la méthamphétamine (crystal meth) et les autres drogues de synthèse* (MSSSQ, 2006d) : intervention plan on methamphetamine (crystal meth) and other synthetic drugs
- (4) *Balises pour les établissements de santé et de services sociaux et les organismes - communautaires désirant offrir des services d'injection supervisée aux personnes qui font usage de drogues par injection. Cadre de référence* (MSSSQ, 2013) : provides a reference framework on indicators for health and social services institutions and community organizations interested in offering supervised injection for people who use injection drugs

Four historical provincial documents (have either been replaced by updated versions or for which the time frame has elapsed) were also included in the corpus of documents for this analysis:

- (12) *Stratégie québécoise de lutte contre les maladies transmissibles sexuellement – Orientations 2000-2002* (MSSSQ, 2000) : provincial strategy for STBBI prevention and control
- (13) *Stratégie québécoise de lutte contre l'infection par le VIH et le sida, l'infection par le VHC et les infections transmissibles sexuellement : Orientations 2003-2009* (MSSSQ, 2004) : provincial strategy for STBBI prevention and control
- (14) *Plan d'action interministériel en toxicomanie 2006-2011. Unis dans l'action* (MSSSQ, 2006c) : interdepartmental action plan on addictions for 2006-2011
- (15) *Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience. Programme-services dépendances. Offre de service 2007-2012* (MSSSQ, 2007) : provincial strategic directions related to standards of access, continuity, quality, efficiency, and effectiveness of addictions programs and services

In addition, two foundational provincial documents existed prior to 2000, which focused specifically on harm reduction. These were not considered relevant for our analysis as they were published prior to 2000. However, they are important in the context of Quebec for understanding the policy process over time.

- (F1) *L'approche de réduction des méfaits: sources, situation, pratiques* (CPLT, 1997)
- (F2) *Toxicomanie et réduction des méfaits* (CPLT, 1999).

Quebec also has a national public health program, with three relevant documents (MSSSQ, 2003b, 2008, 2015). Harm reduction was mentioned in these documents as part of public health interventions. However, these documents were excluded from the analysis since the inclusion criteria focused on strategy documents which *mandated future action*, guiding services for addiction, mental health and/or sexually-transmitted and/or blood-borne infections (STBBIs) (see Wild, et al., 2017 for full inclusion and exclusion criteria). These excluded documents only mentioned harm reduction in passing, whereby the included documents provided details as to the strategic directions of the Quebec government. No information was lost by excluding these documents.

Coordination in provincial-level documents

Through our analysis, the coordination and cross-referencing between provincial documents was very apparent, demonstrating that throughout the policy making process in Quebec, the broader policy context is always considered. Policy documents tend to present a cohesive approach to harm reduction and addictions, rather than the patchwork of policies seen in many other Canadian provinces.

The 2001 document, which presents a pragmatic approach to prevention in addictions [1], refers to the foundational document from 1997 [F1] and adopts its same definition of harm reduction. This addictions document [1] subsequently fed into the interdepartmental action plan on addictions [14], which guided policy in this area from 2006 to 2011. Building on this document, the provincial strategic directions document [15] was produced: it was in place from 2007 to 2012, and was an extension of this interdepartmental action plan [14]. In Quebec's historical Strategy on HIV and AIDS, HCV and STIs [13], this cohesive approach to policy making is described in detail:

...is built around...other ministerial policies, in such a way that the strategic directions and actions assume the collaboration of other sectors (for example, addictions, youth in difficulty), in order to increase intersectoral coordination. [translation] (p. 12)

This same document later references the addictions document [1], which was published two years prior. Another provincial document published in 2003, which assesses and provides direction on sexually transmitted infections [2], refers to the Quebec strategy on sexually transmitted infections [12] that had been released two years prior and covered a similar area of concern. In another example, the intervention plan on methamphetamine and other synthetic drugs [3] discusses the importance of adopting the interdepartmental action plan on addictions 2006-2011 [14]. The 2013 framework that looks at indicators for offering supervised injection [4] contains a "context" section (p. 2) where it describes how the document links to ministerial strategic directions. It specifically states that the *Quebec Ministry of Health and Social Services* strategic directions documents describe the role that supervised injection services can play in a global public health response to problematic substance use, as described in the latest provincial strategy for STBBI prevention and control [14].

Coordination in regional-level documents

This alignment with provincial policy documents is less obvious in current *regional* policy documents (see Table 1), though there is evidence of links to key relevant documents that are included in this analysis. All three current, regional, street outreach documents [5, 6, 10] build on the historical and inaugural 2001 document produced for the Montérégie region [17]. The regional document on strategic directions for addictions programs and services in the Côte-Nord region, published in 2010 [7], also refers to the current provincial document on addictions prevention [1] as well as two historical provincial documents [14,15].

The regional document for Gaspésie and Îles-de-la-Madeleine [8] refers to two historical provincial documents [13,15]. It also builds on the guidelines from Quebec's College of Physicians and Order of Pharmacists regarding methadone and buprenorphine (Collège des médecins du Québec & L'Ordre des pharmaciens du Québec, 2009). Notably, two current regional documents do not refer to any of the policy documents included in this analysis [9,11].

4.1.3 Summary

Overall, provincial documents are very well coordinated, and present a cohesive policy framework. Documents are produced in consideration of the broader policy context, building on previous work in similar areas, and demonstrating an effort to cover areas in need of new policy, rather than producing redundant policy documents. Notably, all provincial-level documents over time were authored by the same government body – the Quebec Ministry of Health and Social Services. In one case, all ministries (including Health and Social Services) authored a document.

Documents produced for the regional level are less cohesive – perhaps as a result of the wider range of authors and greater variability in regional governments. Although some regional documents show consideration for previously released policy at the regional and provincial levels, two are exempt from this.

4.2 Policy documents integrate the values and principles of harm reduction

All but two provincial and two regional policy documents refer to harm reduction at some point. However, documents tend not to provide a formal definition of harm reduction. Rather, they integrate the values and principles of harm reduction into the broader approaches they endorse. The following principles are exemplified in various policy documents: harm reduction does not require reduction of or abstinence from substance use; harm reduction applies broadly to strategies, policies and programs; acknowledgement that not all substance use is problematic; harm reduction has benefits for people who use drugs, families and society; harm reduction targets drug-related risks and harms, including overdose; endorsement of evidence-based interventions or policy; harm reduction is based on social

justice and human rights; harm reduction considers the social determinants of health; and harm reduction addresses stigma and discrimination.

4.2.1 Harm reduction does not require reduction of or abstinence from substance use

The foundational 1997 reference document [F1] defines harm reduction as follows:

Harm reduction is a collective health approach aimed at, rather than the elimination of the use of psychoactive substances (or other risky behaviours), enabling those affected to develop ways to reduce the negative consequences of their behaviours and of the perverse controls on these behaviours, for themselves, their entourage and society, at the health, economic and social level. (CPLT, 1997, p. 9) [translation]

The current provincial document on a pragmatic approach to prevention in addictions [1] refers to the foundational definition above. The document also offers this excerpt, which could be considered a definition of harm reduction:

It is impossible to eliminate the use of illegal drugs or the problematic use of alcohol as much as it is to think we can eliminate heart disease or cancer. It is possible, however, to limit or reduce the health and well-being problems as well as the harms that result from the inappropriate use of psychoactive substances. This means that in addition to health promotion and prevention measures, services must be offered to people who use drugs that, without aiming for abstinence or non-use, aim to reduce the harms associated with inappropriate use. (MSSSQ, 2001, p. 24) [translation]

Both these examples recognize that reducing or abstaining from substance use is not required. There is consistency in this view across policy documents. The 2001 pragmatic approach to addictions [1] fed into the interdepartmental action plan on addictions [14], which implies that it also adhered to the same conceptualization of harm reduction as described above.

The current provincial document on supervised injection services [14] adopts a harm reduction approach and is focused on supervised injection services, thereby recognizing that people use drugs. The document does not refer to abstinence or reduction of drug use, rather it focuses on the reduction of drug-related harms, implying that abstinence is not required through the intervention it promotes. As for regional documents, two documents on street outreach provide insight into their approach to harm reduction. One states that harm reduction is founded on pragmatism, not insisting on abstinence and meeting people where they are at [10] (p. 35). The other describes harm reduction as a valuable strategy in a context where it is preferable to reduce the impacts of risky behaviours, which cannot be prevented, by reinforcing safer practices [6] (p. 9). Neither of these documents promotes abstinence or a reduction of substance use.

4.2.2 Harm reduction applies broadly to strategies, policies and programs

Provincial policy documents make clear statements about harms caused by drug policy and legislation. The provincial strategy on prevention in addictions [1] includes harms caused by the impact of policy and legislation and acknowledges that most harms to people who use drugs result from prohibition (p. 18). In the guiding principles (pp. 27-28), the document acknowledges both individual and societal responsibility in prevention of harms related to addictions. The plan elaborates on intervention and actions to be taken (in Chapter 5), which include taking action upstream to create healthier environments and prevent or address challenging life situations that may lead to inappropriate substance use. The actions include addressing problems of social adaptation, preventing the risk of negative consequences or the worsening of problems associated with the inappropriate use of psychoactive substances, and promoting the adoption of coherent public policy on psychoactive substances (MSSSQ, 2001).

The interdepartmental action plan on addictions [14] refers to and complements the document mentioned above [1], as well as the provincial document on strategic directions related to standards of access, continuity, quality, efficiency, and effectiveness of addictions programs and services [15], which is an extension of the interdepartmental action plan. In that sense, all three provincial policy documents on addictions in this analysis are aligned in terms of recognizing that harms reduction can be applied to strategies, policies and programs.

The STBBI strategy of 2004 [13] situates risk and vulnerability to harms within a greater context than simply individual behaviour. It describes the role of the greater social context. It identified the risk environment as well as the social dimensions in the context of drug-related harms and vulnerability to STBBIs. The document alludes to the importance of both behaviour modification and social and structural interventions to address STBBIs - implicitly endorsing harm reduction through strategies, policies and programs.

The current provincial intervention plan on methamphetamine and other synthetic drugs document [13] states that the harm reduction approach, along with prevention, is increasingly used to foster healthy lifestyles and to improve the quality of life of people living with addictions, as well as the security of communities. The document includes harm reduction in its strategies, policies and program recommendations.

As for the indicators document on supervised injections services [4]), since the purpose is to guide the implementation of a harm reduction intervention, namely supervised injection services, it is implicit that it recognizes that harm reduction can be applied broadly through strategies, policies and programs.

Only one of the regional documents, the strategic directions document on opioid substitution treatment in the Gaspésie and Îles-de-la-Madeleine region [8] situates itself within the provincial policy documents included in this analysis. In that sense, it recognizes that harm reduction can be applied broadly through strategies, policies and programs.

4.2.3 Acknowledgement that not all substance use is problematic

The provincial policy documents acknowledge that not all substance use is problematic. The provincial strategy on prevention in addictions document [1] introduces the notion of inappropriate use (p. 9). It refers to the spectrum of use and the fact that not all substance use leads to negative consequences. It also clarifies that harms from substance use are not unique to those who are dependent on them. The document strives for balance between harms associated with psychoactive substances and safer, appropriate or responsible use. Page 11 adds that recognizing that some types of use are not problematic has important implications for prevention objectives and actions. The ministerial strategic directions of this document therefore aim to promote population health and well-being and to reduce human and social problems associated with inappropriate use of psychoactive substances. The document states it is possible to limit or reduce the health and well-being problems as well as the harms that result from the inappropriate use of psychoactive substances. The document therefore implies that appropriate use can occur.

The 2004 STBBI strategy [13] goes one step further and states that preventive actions target behaviours that are motivated by pleasure, namely sexuality and drug use. It elaborates on the idea of creating social norms around prevention of drug related harms. The provincial indicators document on supervised injection services [4] refers to varied, intensive and continued actions aimed at, on one hand, enabling people to make responsible choices with regard to their use and, on the other hand, reducing the consequences or worsening of problems linked to use (p. 15). Both documents implicitly acknowledge that not all substance use is problematic.

None of the regional policy documents acknowledge that not all substance use is problematic.

4.2.4 Harm reduction has benefits for people who use drugs, families and society

Several provincial policy documents acknowledge that harm reduction has benefits for people who use drugs, families and society. In the provincial document on a pragmatic approach to prevention in addictions [1], there is a letter from the Minister of Health, Social Services and Youth Protection (p. 5) which sets the state for the remainder of the document. This letter recognizes that substance use sometimes becomes unrestrained, which leads to problems for the individual, their immediate entourage and society in general.

In the provincial intervention plan on methamphetamine and other synthetic drugs [3], a statement reads (p.15), "a prevention approach aimed at raising awareness about risks and consequences of synthetic drugs in relevant settings and the harm reduction approach are increasingly used to foster healthy lifestyles and to improve the quality of life of people living with addictions and the security of communities". This touches on benefits to people who use drugs, their families and society in general.

In the provincial indicators document for supervised injection services [4], the document includes public disorder and public safety as being negatively affected by public injection use and focuses on supervised injection services as an approach that can reduce these harms. It also speaks of benefits to public health.

One regional policy report on strategic directions related to addictions in Lanaudière [18] refers to the harm reduction principle of pragmatism, which they identify as a health-related value linked to universal access to health care and services, collective and individual protection of health and safety, and collective and individual health promotion. These statements thereby recognize individual and collective benefits from harm reduction efforts.

4.2.5 Harm reduction targets drug-related risks and harms, including overdose

The provincial documents state that harm reduction targets drug-related risks and harms, including overdose. The provincial strategy on prevention in addictions [1] refers to the importance of considering the link between harms and some modes of drug use, namely alcohol intoxication and injection drug use. Prevention targets all people who use drugs in order to reduce risky modes of drug use and the harms associated with them. The document describes the various social and health problems that may be associated with the use of substances in addition to the transmission of hepatitis and HIV (p. 9): overdoses, criminal activity (theft, trafficking, sex work), dropping out of school prematurely, delinquent behaviour, and early pregnancy.

In this document's second strategic direction on "Preventing the Risk of Negative Consequences or Worsening of Problems Associated with the Inappropriate Use of Psychoactive Substances" (MSSSQ, 2001, pp. 39-46), the strategy proposes developing individual capacity to make informed choices related to psychoactive substances and to manage the risks. To achieve this, one proposed action is to plan, implement and evaluate prevention programs that reduce risks associated with inappropriate use of illicit drugs (namely transition to injection and overdoses) and encourage less risky modes of use. The document also includes proposed actions to ensure that hospitals register all overdose cases related to illegal drugs and that, starting from a threshold, people who use drugs be informed of this. For people who overdosed on heroin, actions are proposed to ensure quick access to appropriate treatment by health professionals, namely by nurses and ambulance attendants. Actions also include ensuring training of nurses and ambulance attendants on how to intervene in an overdose of illegal substances.

The interdepartmental action plan on addictions [14] cites the same harms (same paragraph) as the provincial strategy on prevention in addictions cited above. In describing the rationale for an interdepartmental action plan on addictions, the text describes consequences for people struggling with addictions, their family and loved ones (p.21), including devastating health effects such as cirrhosis, fetal alcohol syndrome, overdoses or transmission of viral hepatitis and HIV.

While the provincial STBBI strategy of 2004 [13] focuses on HIV and HCV as drug-related harms, it nonetheless situates these harms within a broader context. It describes vulnerability to HIV and HCV as

critical to the potential of these infections and the ability of individuals and groups to protect themselves and to exercise more control over their health. Poverty, homelessness, addictions, mental illness, violence and discrimination play a role in people's capacity to choose safer behaviours, to consult, to seek treatment for STBBIs and to live with chronic infections such as HIV and HCV. These factors can lead to faster progression of diseases. They also contribute to socially and economically marginalizing people and often deprive them of access to important social support. Investing in health promotion is essential. The document does not, however, refer to overdoses.

The provincial intervention plan on synthetic drugs [3] focuses on the prevention and reduction of harms related to the use of crystal meth and other synthetic drugs, although it does not explicitly identify those harms. The only mention of overdose is found in Appendix 2, where they reference a document from British Columbia.

Finally, the provincial indicators document on supervised injection services [4] mentions the prevention and reduction of injection drug-related harms, specifically overdose deaths, HIV and HCV, and public disorder (public injections, discarded needles). It states that supervised injection services are designed to reduce overdoses and their consequences, including risks of death (p. 1).

As for regional policy documents, one document on strategic directions for addictions programs and services in the Côte-Nord region [7] describes that the goal of the program is to prevent, reduce and treat problems related to drug use and drug dependence, though it does not identify what those problems are. The practice framework for street outreach in the Montérégie region [10], mentions that one of the outcomes of street outreach is the prevention of overdoses.

4.2.6 Recognition of the importance of an evidence based approach

The provincial STBBI strategy 2004 [13] mentions that findings were based on current and rapidly evolving evidence related to HIV, HCV, and STIs. This evidence provided the foundation for identifying the main issues related to prevention, and the actions that are needed to meet the strategic directions and the needs of targeted groups (p. 12). Similarly, the interdepartmental action plan on addictions [14] clearly states that the proposed actions are informed both by evidence and experience.

[The action plan] is founded on an objective analysis of the risks and consequences of addictions. The choice of actions and means offered in the plan take into account the most recent scientific knowledge as well as the evolution of needs in the field of addictions. These actions build on the experience of recent years and incorporate recognized or promising practices. [translation] [14] (MSSSQ, 2006c, p. 24)

Although the provincial strategy on prevention in addictions [1] does not explicitly acknowledge the need for evidence informed policy making, the document clearly cites research, with references, on which it has based its strategy. The provincial intervention plan on synthetic drugs [3] states that to better understand substance use requires a better understanding of ways to prevent it, to reduce its

harms, to follow its evolution through epidemiological data, and to better estimates its risks and consequences (p. 18). The results of research can then be used to improve policies, programs and interventions. Finally, the provincial indicators document for supervised injection services [4] is founded on best practices and evidence drawn from the implementation of supervised injection services around the world, as stated on page 4.

As for regional policy documents, the practice framework for street outreach in the Montérégie region [10] mentions that street outreach has been shown to be an effective measure to reduce the prevalence of STBBIs. The regional strategic directions document for addictions programs and services from the Côte-Nord region [7] is based on evidence and includes indicators for program and service management and data on the use of services. The regional intersectoral action plan for the promotion of health and responsible sexuality and the prevention of STBBIs in the Laval region [9] is also based on evidence and includes the need for more evidence in its action plan. Finally, the regional mental health plan from the Laurentides region [11] is based on evidence and states that evidence allows to anticipate the demand for services in the health care system and specifically for mental health programs.

Policy documents were clearly quite consistent with stating the importance of evidence.

4.2.7 Harm reduction is based on social justice and human rights

The provincial strategy on prevention in addictions [1], in its *Guiding Principles* (pp. 27-28), states that health promotion and prevention related to the inappropriate use of psychoactive substances must:

- Be respectful of the person
- Be respectful of vulnerable groups
- Include people from the targeted populations in every step
- Be realistic and pragmatic.

Human rights and social justice seem implicit to the approach used to develop the document. Respect for the person, for vulnerable groups and the inclusion of people from targeted population reflect these values. More explicitly, in another strategic direction, the document promotes organizing community groups that work on human rights and support for people with addictions (p. 39-46). The conclusion of this document (p. 58) reiterates the role of a human rights approach and states that the document is founded on health promotion, prevention related to psychoactive substances and harm reduction linked to an inappropriate use of psychoactive substances. Through varied actions and the integration of related problems, and from a holistic human rights approach, the reach of this strategy will be wider to address addictions.

The provincial STBBI strategy of 2004 [13] in the Introduction, states that this strategy aims to:

- reduce the incidence of STBBIs;
- make quality care and services accessible; and
- create a social environment that fosters the prevention of STBBIs while respecting human rights.

The document states (p.23) that given the exclusion experienced by vulnerable groups, it is important to work with communities to strengthen their capacity to adapt and transform, i.e. their autonomy. It is also important to intervene in the social environment with regard to human rights, equity and social justice. STBBIs are not just medical problems, they are also social problems.

The provincial indicators document for supervised injection services [4] cites the Supreme Court of Canada decision regarding Insite. Specifically they refer to the government's discretion to decide whether to grant an exemption, which must be in accordance with the Charter's section on the right to life, liberty, and security of the person (p. 3). Based on this principle, Quebec's Minister of Health has been supportive of SIS in Quebec.

Notably, the interdepartmental action plan on addictions [14] does not refer to either human rights or social justice explicitly. Furthermore, only one regional policy document on street outreach in the Lanaudière region [5] refers to human rights advocacy, specifically for youth, as one of the roles of outreach workers.

4.2.8 Harm reduction considers the social determinants of health

Policy documents varied as to whether they considered determinants of health as part of harm reduction and how much detail they provided. In the provincial strategy on prevention in addictions document [1], the first strategic direction involves “taking action upstream of social adaptation problems” (pp. 29-38), which means recognizing risk factors and aiming to reduce or modify them, rendering people capable of adopting healthy lifestyles and making responsible choices, and ensuring acceptable living conditions for everyone. It includes actions to create favourable environments for the mobilization and support in living environments. As part of improving life conditions, it is well recognized that social inequities influence health and well-being, especially socioeconomic status. All actions aimed at remediating the consequences of poverty can foster a sense of belonging, social recognition and, consequently, help to prevent the inappropriate use of psychoactive substances.

While the interdepartmental action plan on addictions [14] does not explicitly refer to social determinants of health, it includes ‘collective responsibility’ in its principles. This principle reflects one of the fundamental strategic directions of Quebec’s Health and Well-being Policy (Politique de la santé et du bien-être), which states that the maintenance and improvement of health and well-being rests on a balanced sharing of responsibilities between individuals, families, living environments, public powers and the range of activity sectors of collective life. The responsibility to prevent addictions and reduce addictions-related consequences is both an individual and collective one. Housing as a determinant of health is alluded to in the identification of homeless people as people with specific needs. There is also reference to improving living environments to foster healthy lifestyles.

In the provincial STBBI strategy of 2004 [13], a section on risk and vulnerability (p. 22) describes how it is justified and even imperative to take all reasonable precautions to reduce risk to a minimum. It describes how some people are not only at greater risk of STBBIs because of particular behaviours but

also because of the environments they find themselves in. Preventive action aimed to modify risky behaviours can be effective. However, focusing on behaviour modification efforts gives the impression that STBBI transmission is only the result of personal negligence. Vulnerability to STBBIs involves psychoindividual and sociocultural factors, beyond individual factors. This vulnerability to STBBIs is critical to the transmission of these infections and the ability of individuals and groups to protect themselves and exercise more control over their health. Poverty, homelessness, addictions, mental illness, violence and discrimination play a role in people's capacity to choose safer behaviours, to consult and seek treatment for STBBIs, and to live with chronic infections such as HIV and HCV. These factors can also lead to faster progression of diseases. They also contribute to socially and economically marginalizing people and often deprive them of access to important social support. Investing in health promotion is essential.

In terms of regional documents, the street outreach policy document for the Lanaudière region [5] describes that street outreach workers intervene in various areas, including problems of social integration, isolation, poverty, school problems, and limited access to the job market. In that sense, it integrates social determinants of health. The regional policy document on opioid substitution treatment in the Gaspésie and Îles-de-la-Madeleine region [8], in the context of opioid substitution services, includes psychosocial intervention, which involves the promotion of the individual's social needs (basic needs and housing, enrollment in social programs such as social assistance, employment insurance, etc. (p. 8). The document thus considers the social determinants of health in the context of harm reduction. Finally, the outreach document in the Saguenay-Lac-Saint-Jean region [6] mentions that street outreach helps individuals with housing and employment.

4.2.9 Recognition of stigma and discrimination

In the provincial strategy on prevention in addictions document [1], a proposed action is to plan and implement information and educational programs regarding psychoactive substances targeted at youth 15 to 24 with accurate, non-stigmatizing information to increase knowledge about psychoactive substances, addictions and known risk factors and to modify attitudes and behaviours related to psychoactive substance use. This strategic direction also aims to create environments favourable to healthy management of use and reduction of the harms associated with inappropriate use of psychoactive substances. To achieve that, proposed actions include integrating activities and media campaigns, the promotion of non-stigmatizing attitudes toward people who use psychoactive substances by focusing on information for a better understanding of addictions and of people living with addictions rather than on the drugs themselves, and promoting, in various settings, the implementation of policies that advocate non-stigmatizing interventions and favour social inclusion of people who use psychoactive drugs. Clearly, addressing stigma is integrated into these strategic directions and actions.

The interdepartmental action plan on addictions [14] brings the issue of addictions to one that concerns everyone. It acknowledges that people with addictions need help and support without discrimination and exclusion. The document acknowledges that injection drug use is associated with several physical and social problems, including marginalization and exclusion. Rather than providing strategic directions

and actions to address stigma and exclusion, however, the document seems to focus on actions to foster a desire for change and motivate change, which is contrary to the harm reduction principle of meeting people where they are at. For example, the text mentions harm reduction as an alternative approach to the traditional biopsychological approach and traditional therapeutic approaches (p.53-54). According to the document, the harm reduction approach is used to improve access to services adapted to the needs of people living with addictions. Unlike traditional approaches, this approach does not require abstinence. Rather, it aims to reduce the negative consequences of alcohol and drug use. Such an approach is able to reach people who are less motivated to cease use. It values the link with people who use drugs and encourages their participation to foster a desire for change. It reveals itself as particularly well adapted to some clientele, namely people who use injection drugs and people who are disaffiliated.

As for the provincial STBBS strategy of 2004 [13], the document acknowledges stigma and discrimination (p. 17). It describes that people most affected by HIV, namely men who have sex with men and people who inject drugs, are often marginalized. People who use drugs are highly stigmatized and discriminated against, which leads to suffering, painful experiences, rejection and solitude. It identifies the evolving needs for psychosocial support.

Only one of the regional policy documents touched on stigma and discrimination in the context of harm reduction. The street outreach document from the Montérégie region [10] refers to marginalization and social exclusion. One of street outreach's objectives is to provide a continued presence in the areas where street involved populations are located in an attempt to reduce marginalization and social exclusion (p. 21).

4.3 Quebec has policy documents that address three of the seven interventions of interest: street outreach, low-threshold opioid substitution, and supervised injection/consumption.

Street outreach

Street outreach is not mentioned in the provincial policy documents but is the specific, named focus of four regional documents, three of which are current policy documents:

- [17] *Cadre de référence pour le travail de proximité en Montérégie* (RRSSS Montérégie, 2001)
- [10] *Cadre de pratique pour le travail de rue en Montérégie* (ASSS Montérégie, 2013) (update to document above)
- [5] *Le travail de rue dans Lanaudière : Vers une vision régionale* (RRSSS Lanaudière, 2002)
- [6] *Cadre de référence pour le travail de proximité au Saguenay-Lac-Saint-Jean* (ASSS Saguenay-Lac-Saint-Jean, 2009)

Street outreach is also mentioned in three other regional strategies (two on addictions and one on STBBIs), although they do not focus specifically on this area:

- [19] *Orientations régionales en dépendances – Mauricie et Centre-du-Québec – 2008-2012* (ASSS Mauricie et Centre-du-Québec, 2008)

- [16] *Plan régional d'organisation des services en toxicomanie de la région de la Chaudière-Appalaches 2000-2003* (RRSSS Chaudière-Appalaches, 2000)
- [9] *Plan d'action intersectoriel pour la promotion d'une sexualité saine et responsable et la prévention des infections transmissibles sexuellement et par le sang à Laval. 2013-2016* (ASSS Laval, 2013)

Low threshold opioid substitution

Low threshold opioid substitution is mentioned in one provincial addictions strategy and one STBBI strategy, as well as in the provincial framework on supervised injection services. Furthermore it is included in one regional strategy on opioid substitution treatment in the Gaspésie and Îles-de-la-Madeleine region:

- [1] *Pour une approche pragmatique de prévention en toxicomanie : Orientations, Axes d'intervention, Actions* (MSSSQ, 2001)
- [13] *Stratégie québécoise de lutte contre l'infection par le VIH et le sida, l'infection par le VHC et les infections transmissibles sexuellement: Orientations 2003-2009* (MSSSQ, 2004)
- [4] *Balises pour les établissements de santé et de services sociaux et les organismes communautaires désirant offrir des services d'injection supervisée aux personnes qui font usage de drogues par injection. Cadre de référence* (MSSSQ, 2013)
- [8] *Les services de traitement de la dépendance aux opioïdes avec une médication de substitution en Gaspésie et aux Îles-de-la-Madeleine - ORIENTATIONS RÉGIONALES* (ASSS Gaspésie et aux Îles-de-la-Madeleine, 2011)

One document not only mentions **supervised injection** but is specifically focused on the subject. It offers a provincial framework with indicators for health and social services and community organizations that wish to offer supervised injection services to people who inject drugs:

- [4] *Balises pour les établissements de santé et de services sociaux et les organismes communautaires désirant offrir des services d'injection supervisée aux personnes qui font usage de drogues par injection. Cadre de référence* (MSSSQ, 2013)

Supervised consumption

The term '**supervised consumption**' is never used in any of the documents. **Needle exchange** services, or 'injection material access centres' as Quebec refers to them, are mentioned in 10 of the 19 policy documents included in this analysis, including four out of eight of the provincial level documents: the interdepartmental action plan [14] and the strategic directions on addictions [1], the intervention plan on crystal meth and other synthetic drugs [3], and the provincial STBBI strategy [13].

Two of the regional street outreach documents [10, 5] three regional strategies on addictions [7, 8, 16], and one regional mental health plan [11] mention injection material access centres.

Remaining interventions

Naloxone or **safer inhalation kits** are not mentioned in any of the 19 policy documents.

4.4 Quebec policy documents report a harm reduction approach to drug treatment, including low-threshold access

4.4.1 A harm reduction approach to drug treatment

The interdepartmental action plan on addictions [14] clearly states that the harm reduction approach has inspired innovative approaches to drug treatment programs, of which the best known is methadone substitution treatment. This program produces tangible results when it is accompanied by psychosocial care and support. The document also states that rehab centres are adopting a harm reduction approach to drug treatment. In the plan, the text describes that the harm reduction approach is used in order to improve access to services adapted to the needs of people living with addictions. Unlike traditional approaches, this approach does not require abstinence. Rather, it aims to reduce the negative consequences of alcohol and drug use. Such an approach is able to reach people who are less motivated to cease use. It values the link with people who use drugs and encourages their participation in order to foster a desire for change. It reveals itself as particularly well adapted to some clientele, namely people who use injection drugs and people who are disaffiliated. This excerpt implies that the goal of treatment and social reintegration efforts is to foster a motivation for change in people who use drugs. This aim belies the harm reduction approach, which is meant to meet people where they are at, and reveals that despite integration of the harm reduction approach, there are still residuals of wanting to fix people and change them.

The provincial strategy on prevention in addictions document [1], mainly focuses on substitution treatment, specifically methadone maintenance treatment, as an effective harm reduction approach to treatment. It mentions it as an effective intervention, and refers to the Quebec College of Physicians' and Order of Pharmacists' guidelines on methadone maintenance treatment (Collège des médecins du Québec & L'Ordre des pharmaciens du Québec, 1999), and identifies the importance of ensuring initial training as well as continuing training of physicians and pharmacists on methadone maintenance treatment and other substitution treatments.

The 2004 STBBI strategy [13] addresses the specific service needs of groups most vulnerable to STBBIs. It includes an objective to improve access to services for people who use drugs. The document explicitly expresses the need to expand the provision of harm reduction services such as opioid substitution treatment and support services, among others. The document briefly touches on drug treatment. The text describes new needs related to HIV and challenges in the clinical management of people living with HIV, such as methadone treatment and detox (p.24). The needs of some populations such as people who use drugs and people with mental illness have increased. It has become difficult to reconcile the cohabitation of clients such as people who use drugs with people who do not. It is increasingly demanding for service providers to meet the needs of people who face challenging life conditions while also caring for those who have lesser support needs.

The document also mentions that vulnerable groups can be supported in various ways by acting on vulnerability factors or on ways to reduce negative consequences (p.35). Efforts are concentrated on access to services for vulnerable groups since they are less likely to use health and social services for prevention purposes. One of the objectives of this strategy is to make services accessible to vulnerable groups. In Quebec, the majority of people who inject drugs use cocaine. Methadone treatment only works for people who use opiates, mainly heroin. Access to methadone has improved somewhat over the last few years. It is accessible in 15 regions and is complemented by psychosocial support in many cases. The number of prescribing physicians, of pharmacies and of beneficiaries has double since 1997. This momentum has to be maintained.

However, the document [13] describes that it remains difficult to find services and social inclusion for people who are actively using drugs, such as rehab services. Such services should be made available and should include support for cessation, methadone treatment and choices for less risky products. Offering injection equipment should also be explored. As recommended in ministerial strategic directions for the prevention of addiction [1], the text mentions that Quebec should experiment with pilot low threshold programs for methadone and other substitution treatments with the specific goal of reducing the frequency of injections. It should also proceed with a feasibility study for pilot projects for social inclusion and for supervised injection in order to expand our harm reduction approach.

As for regional documents, the policy document on strategic directions on addictions in the region of Lanaudière [18] identifies areas of harm reduction, which include screening and early intervention, treatment of dependence, and social reintegration. Partners involved in these services are called upon to refer to the harm reduction approach in planning and provision of services. The regional policy documents on strategic directions in addictions in the Mauricie and Centre-du-Québec region [19] alludes to past confusion and tension related to the implementation of harm reduction programs such as methadone substitution treatment, which have improved with coordination and partnership between physicians, pharmacists, the Rehabilitation Centre for Alcoholism and Addictions, and community organizations that offer housing.

4.4.2 Low-threshold access

The provincial strategy on prevention in addictions document [1] refers to low-threshold centres as an effective harm reduction intervention in the context of STBIs and injection drug use (p. 22). The document also refers to experimenting with low threshold pilot projects for methadone or other substitution treatments in order to reduce the frequency of injections (p. 46).

The provincial indicators document on supervised injection services [4] refers to low threshold service provision (p.4). Low threshold access is defined as facilitating access to health services without imposing too many restrictions; for example, abstinence will not be required, especially before any support services are offered.

In the regional policy documents, the strategic directions document on addictions from the Lanaudière region [18] mentions low threshold access in the context of opioid substitution programs. The document refers to 'low requirements programs', whereby methadone is prescribed without requirement of abstinence, without confirmatory urine tests or systematic psychosocial support. Such low-threshold programs aim to reach as many opiate users as possible, who are often in precarious situations, in order to reduce risks and harms related to the use of opioid by favouring repeated contacts with the health care system. Low barrier service provision is also briefly mentioned in the document on treatment of addictions with opioid substitution medication from the Gaspésie and Îles-de-la-Madeleine region [8].

4.5 Quebec policy documents acknowledge that harm reduction can be applied to the general population, as well as specific populations

4.5.1 Rationale that harm reduction can be applied to the general population

The provincial strategy document on prevention in addictions [1] explains that psychoactive substances have always been part of the human experience. It describes the various social and health problems that may be associated with the use of these substances as well as estimated economic costs attributed to the negative consequences of alcohol and illicit substance use. It also names the suffering and marginalization of its users and their entourage, for which the human and social costs are difficult to quantify (p. 9). It clarifies that problems associated with psychoactive substances are not unique to those who are dependent on or addicted to them. Prevention must therefore target the population as a whole. The document mentions that not all substance use leads to negative consequences for the individual, their entourage or society. Appropriate consumption is specific to a person's health, age, culture and context. In addition, the use of psychotropic substances can be considered inappropriate if it serves to cope with difficult situations.

Continuing along the same lines, the text describes (p. 11) how inappropriate use of substances can lead to physical, psychological, economic and social problems, which threaten the health, security and well-being of individuals, their entourage and communities. It states that the notion of inappropriate use is not universally defined and varies by individual. It is a notion that serves as a framework to guide priority objectives. Not all use leads to harms. Some use even has benefits. We cannot ignore that seeking well-being and pleasure is the main motivation for use of psychoactive substances for most people. We also have to account for the fact that some substances are so toxic that their use represents a high risk.

Recognizing that some types of use are not problematic has important implications for prevention objectives and actions. From now on, the ministerial strategic directions of this document aim to promote population health and well-being and to reduce human and social problems associated with inappropriate use of psychoactive substances. Ministerial objectives are therefore:

- to reduce inappropriate use of psychoactive substances;

- to reduce harms that result from inappropriate use of psychoactive substances.

Proposed areas of intervention and action lean on three complementary strategic directions:

- to act upstream of social adaptation problems
- to prevent risks of negative consequences or worsening of problems related to the inappropriate use of psychoactive substances
- to promote the adoption of coherent public policy on psychoactive substances.

This approach and language are found throughout the policy documents. The interdepartmental action plan on addictions [14] also takes this approach. It provides a rationale for the action plan that considers a worrisome situation regarding addictions and the fact that addictions affect and concern everyone. The principles of the action plan include adapted interventions and both collective and individual responsibility. The provincial STBBI strategy of 2004 [13] refers to the interdepartmental action plan on addictions [14] in terms of its approach to harm reduction, thereby implying the same principles as stated above.

The provincial intervention plan on synthetic drugs states that raising awareness among targeted groups as well as in the general population regarding the risks and consequences of synthetic drug use must be fostered [3] (p. 21).

In the provincial indicators document on supervised injection services [4], the document refers to benefits to public health and public safety from the implementation of a harm reduction intervention such as supervised injection services. In this sense, it refers to the general population.

None of the regional policy document explicitly state that harm reduction can be applied to the population as a whole.

4.5.2 Rationale for targeting actions at specific populations

Quebec policy documents refer to groups at risk, including women, youth, Indigenous communities, and men who have sex with men.

4.5.2.1 Women

The provincial strategy on prevention in addictions [1] mentions women as a group at risk with regard to the inappropriate use of prescribed drugs, especially elderly women. The provincial STBBI strategy of 2004 [13] also refers to a need to adapt services to the changing profile of HIV, specifically for people with addictions, youth, women, and men who have sex with men. The interdepartmental action plan on addictions [14] identifies pregnant women among its target populations. The provincial intervention plan on synthetic drugs [3] identifies women amongst the target populations for the intervention plan, specifically pregnant women, young mothers, and women of reproductive age. None of the regional policy documents explicitly identify women as a target population for harm reduction.

4.5.2.2 Youth

The provincial strategy on prevention in addictions [1] mentions youth as a group at risk of harms from illicit drugs, anabolic steroids and injections. Street involved youth are identified as being at risk and of using drugs by injection. The provincial STBBI strategy of 2004 [13] refers to a need to adapt services to the changing profile of HIV, specifically for people with addictions, youth, women, and men who have sex with men. The interdepartmental action plan on addictions [14] identifies youth among its target populations. The provincial intervention plan on synthetic drugs [3] states that youth in general are identified amongst the target populations of the intervention plan, as well as street involved youth and young adults aged 18 to 29 who attend raves. Three regional policy documents on street outreach refer to youth as a specific target population. [10, 6, 5].

4.5.2.3 Indigenous Communities

Like elsewhere in Canada, Indigenous health is governed by the federal government and separate initiatives exist outside of the provincial jurisdiction. Nevertheless, a few provincial policy documents touched on harm reduction in Indigenous communities. The provincial strategy on prevention in addictions [1] mentions Indigenous populations as being particularly at risk of drug-related harms. The provincial STBBI strategy of 2004 [13] identifies Indigenous communities as one of the communities particularly affected by HIV. The interdepartmental action plan on addictions [14] identifies Indigenous communities among its target populations.

4.5.2.4 LGBTQI Communities

With regard to LGBTQI communities, the provincial STBBI strategy of 2004 [13] only refers to and targets men who have sex with men, specifically those who also inject drugs. The broadest statement related to the greater LGBTQI populations, in all of the policy documents included in the analysis, was found in this document. One excerpt (p.43) speaks of provincial training programs as indispensable tools to bring about change, transfer new knowledge and enhance the adaptation of frontline practices to reflect new social and health realities. These training programs have focused on the adaptation of interventions to homosexual realities, on the harm reduction approach related to drug use, especially in prison, on methadone treatment and on the prevention of HCV and care for people living with HCV. The provincial intervention plan on synthetic drugs [3] identifies men who have sex with men amongst the target populations for harm reduction. Finally, two regional street outreach policy documents refer to men who have sex with men as a specific target population [10, 6].

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

		Total (out of 11)
	Se développer ensemble. Plan d'organisation – programme de santé mentale.	3
	Cadre de pratique pour le travail de rue en Montérégie.	0
	Cadre de pratique pour le travail de rue en Montérégie.	1
	Plan d'action intersectoriel pour la promotion d'une sexualité saine et responsable et la prévention des infections transmissibles sexuellement et par le sang à Laval. 2013-2016.	0
	Les services de traitement de la dépendance aux opioïdes avec une médication de substitution en Gaspésie et aux Îles-de-la-Madeleine - ORIENTATIONS RÉGIONALES.	0
	Orientations régionales : Programme-services Dépendances 2010-2015.	0
	Cadre de référence pour le travail de proximité au Saguenay-Lac-Saint-Jean.	0
	Le travail de rue dans Lanaudière : Vers une vision régionale.	0
	Balises pour les établissements de santé et de services sociaux et les organismes - communautaires désirant offrir des services d'injection supervisée aux personnes qui font usage de drogues par injection. Cadre de référence.	0
	Plan d'intervention sur la méthamphétamine (crystal meth) et les autres drogues de synthèse	0
	Prévenir et enrayer... Les infections transmissibles sexuellement à déclaration obligatoire : situation et orientations.	1
	Pour une approche pragmatique de prévention en toxicomanie : Orientations, Axes d'intervention, Actions	1
[1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or		

have drug problems?												
[2] Does the document affirm that people who use substances need to be involved in policy development or implementation ?	1	0	0	1	0	0	0	0	0	0	0	2
[3] Does the document acknowledge that not all substance use is problematic?	1	0	1	0	0	0	0	0	0	0	0	2
[4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community?	1	0	1	1	0	0	0	0	0	0	0	3
[5] Does the document acknowledge that harm reduction can be applied to	1	0	1	1	0	0	0	0	0	0	0	3

the general population?												
[6] Does the document target women in the context of harm reduction?	1	0	1	0	0	0	0	0	0	0	0	2
[7] Does the document target youth in the context of harm reduction?	1	0	1	0	1	1	0	0	0	1	0	5
[8] Does the document target indigenous populations in the context of harm reduction?	1	0	0	0	0	0	0	0	0	0	0	1
[9] Does the document target LGBTQI populations in the context of harm reduction?	0	0	1	0	0	1	0	0	0	1	0	3
TOTAL (out of 9 indicators)	8	1	6	3	1	2	0	0	0	3	0	24/99

preventing drug use or blood borne or sexually transmitted infections?												
[12] Does the document discuss low threshold approaches to service provision?	1	0	0	1	0	0	0	1	0	0	0	3
[13] Does the document specifically address overdose?	1	0	0	1	0	0	0	0	0	1	0	3
[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	1	0	0	0	1	0	3
[15] Does the document consider harm reduction approaches for a variety of	1	0	0	0	0	0	0	0	0	0	0	1

drugs and modes of use?												
[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	1	0	0	1	1	0	0	0	0	0	0	3
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	1	0	0	0	1	1	0	1	0	0	0	4
TOTAL (out of 8 indicators)	7	0	2	5	2	2	2	2	1	2	1	26 / 88

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

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

6.0 Conclusion

The province of Quebec released foundational reference documents on harm reduction as early as 1997 (followed by 1999) and has been prolific in developing policy that relates to harm reduction. As a province, it has consistently integrated harm reduction into strategic documents related to addictions and STBBI. The integration of a harm reduction approach and principles throughout the documents, with few exceptions, shows good coordination between stakeholders and sectors across the province. People who use psychoactive substances, however, continue to be excluded from the policy process and decisions that affect them.

The province's *Injection Equipment Access Centres* are particularly well integrated across the province, and involved frontline health services and pharmacies very early in the distribution of injection equipment. Access to injection equipment is mentioned in the majority of policy documents. Specific policy documents have focused on three interventions of interest: street outreach, low-threshold opioid substitution, and supervised injection/consumption, with drug checking receiving limited attention in one document. However, the province has not produced any policy documents that address naloxone or safer inhalation kits.

Quebec has integrated harm reduction into its approach to treatment, including low-threshold access, though the documents at times provide details that are not aligned with harm reduction. The province consistently acknowledges that harm reduction can be applied to the general population as well as to some specific populations who are disproportionately affected by drug-related harms. In terms of overall assessment of selected indicators to determine the quality of policy documents related to harm reduction, Quebec placed second in Canada, second only to British Columbia.

7.0 References

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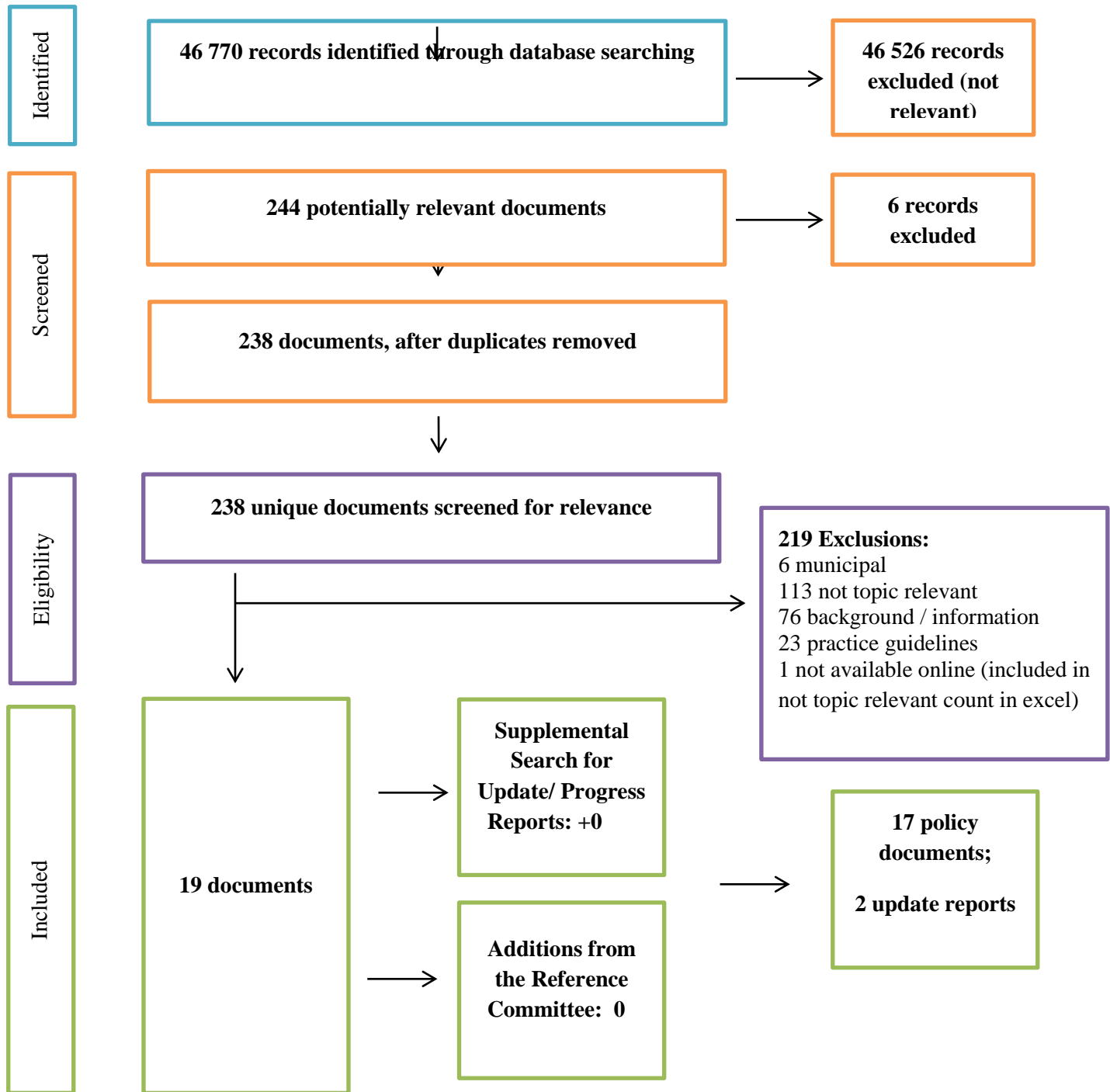
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Appendix A: Systematic search strategy flow diagram⁷



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

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

Overview

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

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

Inductive analysis

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

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

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

Deductive analysis

To facilitate cross-case comparison between the policy documents of each province and territory, we developed the CHARPP framework – a set of 17 indicators that assessed the quality of policies based on how well they described key *population characteristics* and *program features* of a harm reduction approach. The indicators were guided by principles outlined by the International Harm

Reduction Association (HRI, 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 C: Descriptive summary of current policy documents

Current Provincial Policy Documents

[1] *Pour une approche pragmatique de prévention en toxicomanie : Orientations, Axes d'intervention, Actions*

This document, *For a pragmatic approach to prevention in addictions: Strategic Directions, Areas of Intervention, Actions* [translation] (MSSSQ, 2001), was published by Quebec's Ministry of Health and Social Services in November 2001. It was prepared by a working group comprised of academic researchers and representatives from the provincial and regional health and social services, in consultation with various associations and organizations in the health and social services network, professional and corporate associations, and other ministries. The document provides strategies for upstream actions, prevention of risks, and promotion of coherent public policy related to psychotropic substances. The strategic directions pertain to alcohol, illicit drugs, prescribed psychotropic medications, as well as the use of anabolic steroids since they have some things in common with illicit substances in that they are prohibited and some are administered by injection. The document cites the foundational 1997 harm reduction document (CPLT, 1997) and uses its definition of harm reduction. It integrates the values and principles of harm reduction throughout. It then feeds into the historical interdepartmental action plan on addictions (MSSSQ, 2006c) and is cited by many other provincial and regional documents included in this analysis.

[2] *Prévenir et enrayer... Les infections transmissibles sexuellement à déclaration obligatoire : situation et orientations*

This document, *Preventing and Curbing... Notifiable Sexually Transmitted Infections: Situation and Strategic Directions* [translation] (MSSSQ, 2003a), was produced in 2003 by Quebec's Ministry of Health and Social Services. It was prepared by a working group of the Advisory Committee on STIs, comprised of physicians and nurses, in collaboration with a biologist and a microbiologist. The document offers information about the epidemiological situation at the time, prevention strategies used to control STIs, as well as the biomedical aspects related to each notifiable STI. Its contents were agreed upon by consensus by the STI Advisory Committee. Consultations were also conducted with regional public health authorities that are represented at Quebec's National Roundtable on Infectious Diseases. This document is mainly for public health professionals and their local partners. It can also be useful to anyone involved in STI related issues. This document was selected because it is an important document in the evolution of STI prevention in Quebec. Although the document does not specifically include the term 'harm reduction', it does identify people who use injection drugs as one of the affected populations of interest. Parts of the text also provide valuable insights into the frame of mind of public health professionals at the time and on the evolution of STBBI prevention efforts.

[3] *Plan d'intervention sur la méthamphétamine (crystal meth) et les autres drogues de synthèse*

This document offers an *Intervention plan on methamphetamine (crystal meth) and other synthetic drugs* [translation] (MSSSQ, 2006b). It was produced in 2006 by Quebec's Ministry of Health and Social Services. It draws extensively on Quebec's Interdepartmental Action Plan on Addictions (MSSSQ, 2006c). The intervention plan on synthetic drugs was developed as a response to the emergence of techno festivals and raves since the mid 1990s, a social phenomenon where synthetic drugs are often used. The

actions proposed in this intervention plan rest on the concerted effort and mobilization of various ministries and governmental organizations as well as on the community-based resources. The plan proposes actions to prevent and counter the harms from crystal meth and other synthetic drugs along the four axes identified in the Interministerial Action Plan on Addictions (Prevention of addictions; Early intervention; Treatment and social reintegration; and Research). The document includes interventions that are based on a harm reduction approach, though does not provide details in terms of specific interventions related to synthetic drugs.

[4] *Balises pour les établissements de santé et de services sociaux et les organismes - communautaires désirant offrir des services d'injection supervisée aux personnes qui font usage de drogues par injection. Cadre de référence.*

This document provides *Indicators for health and social services institutions and community organizations interested in offering supervised injection for people who use injection drugs. A Reference framework* [translation] (MSSSQ, 2013). It was produced by Quebec's Ministry of Health and Social Services in 2013. It is meant to assist health and social services institutions as well as community-based organizations that wish to offer supervised injection services to people who inject drugs. It clearly describes the context within which supervised injection services (SIS) have emerged, including the MSSSQ's documents that have addressed the role that SIS could play in the public health response to problematic substance use, the legal context to do so in Canada, and the indicators that must be fulfilled to meet the requirements for Ministerial approval to operate SIS. Eleven indicators are described, which institutions and organizations must draw from to define for their proposed SIS project. The document then explains the process that institutions and organizations must follow to seek approval for their SIS project first from the MSSSQ, then from Health Canada. This document was categorized as a primary document since it is a policy text that directs Quebec's health and social services institutions and community-based organizations on how to proceed to offer SIS as part of their existing harm reduction services.

Current Regional Policy Documents

[5] *Le travail de rue dans Lanaudière : Vers une vision régionale*

This document, *Street Outreach in Lanaudière: Towards a Regional Vision* [translation] (RRSSS Lanaudière, 2002), was produced by the Regional Health and Social Services Directorate of Lanaudière in 2002, in collaboration with local street outreach organizations. It emerged out of the need for a regional vision for street outreach and is meant to be a step-by-step guide when developing and implementing street outreach in the community. It focuses on youth at risk. The document adheres to a harm reduction approach of meeting youth where they are at, building trust and respect, and street outreach workers acting as a liaison between youth and services they may require to meet their specific and individual needs. Harm reduction is specifically mentioned as one of the philosophies to be espoused by street outreach workers.

[6] *Cadre de référence pour le travail de proximité au Saguenay-Lac-Saint-Jean*

This *Reference Framework for proximity outreach work in the Saguenay-Lac-Saint-Jean Region* [translation] (ASSS Saguenay-Lac-Saint-Jean, 2009) was produced by the Saguenay-Lac-Saint-Jean Regional Agency of Health and Social Services in 2009. It was developed by various relevant partners from health and social services and community organizations in the region and is largely based on a

previous street outreach document from the Monteregie region (RRSSS Montérégie, 2001). It sets parameters for proximity outreach in the region and strives to ensure uniformity in proximity outreach practice, mark out practice conditions, identify aspects of the work that should be taken into consideration by the various partners and foster knowledge and recognition of proximity outreach work in the region, specify organizational responsibilities for outreach worker support, and specify the responsibilities of the Agency in supporting organization and outreach workers. It provides information about the various approaches used in outreach work, including harm reduction. The text focuses on the distribution of condoms and injection equipment as well as health promotion.

[7] Orientations régionales : Programme-services Dépendances 2010-2015

This document on *Regional Strategic Directions – Programs and Services on Dependence 2010-2015* [translation] (ASSS Côte-Nord, 2010) was produced by the North Coast Agency of Health and Social Services for the years 2010 to 2015. It was developed by the Regional Coordinating Committee on Dependence, which included public health representatives, local organizations and rehab centres. Consultations with various other advisory committees also took place. Programs and services include services for the population (public health and general services – clinical and assistance services) and services that respond to specific issues (loss of autonomy due to aging, physical and intellectual limitations, youth in difficulty, dependence, mental and physical health). The document does not contain any mention of harm reduction specifically (and only mentions needle exchange in an appendix on priorities from 1993) though it points to a list of historical documents from 1999 on, most of which are included in this analysis, that have guided and structured strategic actions on alcoholism and addictions.

[8] Les services de traitement de la dépendance aux opioïdes avec une médication de substitution en Gaspésie et aux Îles-de-la-Madeleine - ORIENTATIONS RÉGIONALES

This document describes *Treatment Services for Opioid Dependence with Substitution Medication in the Gaspésie and Îles-de-la-Madeleine Region* [translation] (ASSS Gaspésie et Îles-de-la-Madeleine, 2011). It was produced by the Gaspésie and Îles-de-la-Madeleine Agency of Health and Social Services in 2011. This is an inaugural document in the offer of treatment for opioid dependence with substitution medication for the region, based on a previous ministerial framework and practice guide. The document explicitly identifies that the treatment of opioid dependence with substitution medication rests on harm reduction. Abstinence from or reduction of substance use are included in the objectives, as are the interruption or reduction of risk behaviours. Harm reduction is built into the approach of substitution treatment in terms of psychosocial support for people who are depend on opioids and undergoing substitution treatment. The document does not provide details as to whether this includes low threshold access to substitution treatment.

[9] Plan d'action intersectoriel pour la promotion d'une sexualité saine et responsable et la prévention des infections transmissibles sexuellement et par le sang à Laval. 2013-2016

This document provides an *Intersectorial Action Plan for the Promotion of Healthy and Responsible Sexuality and the Prevention of STBBIs in the Laval Region, 2013-2016* [translation] (ASSS Laval, 2013). It was produced by the Laval Agency of Health and Social Services in 2013. It was developed with a steering committee comprised of local partners from various organizations and health and social services, in response to an epidemic of STBBIs in Quebec. A previous 2010 Quebec report identified youth and vulnerable populations (street youth, men who have sex with men, people who inject drugs,

sex workers and people from STBBI endemic countries) as priority populations. The document's guiding principles include a holistic perspective of promotion, prevention, protection and surveillance. People who inject drugs are mentioned in the context of populations vulnerable to STBBIs, as is the need for innovative interventions to reach more individuals from these vulnerable populations, including street outreach and distribution of both injection and inhalation material.

[10] *Cadre de pratique pour le travail de rue en Montérégie*

This *Practice framework for street outreach in the region of Monteregie* [translation] (ASSS Montérégie, 2013) was produced by the Monteregie Agency of Health and Social Services in 2013. It is an update to a previous outreach document (RRSSS Montérégie, 2001). The document defines frontline work as “proximity work” and explains that this term was meant to encompass all street outreach and frontline work together, thus capturing all of the interventions that take place on the frontlines (outreach in parks, hallway work, youth facilitators, etc.). It elaborates that it has become increasingly difficult to consider both street outreach and all frontline work in the same framework and thus this document has been prepared to focus specifically on street outreach practice in the region. Street outreach started in the late 1960s to address problematic psychedelic substance use in the province of Quebec and resurged in the 1980s to address HIV, HCV and STI transmission in the context of harm reduction.

[11] *Se développer ensemble. Plan d'organisation – programme de santé mentale*

This document, *Developing Together: Organization Plan – Mental Health Program* [translation] (ASSS Laurentides, 2013), was produced by the Laurentians Agency of Health and Social Services in 2013. It focuses on the regional mental health program and services. It describes the continuum of mental health services, including prevention and promotion, primary care general medical and psychosocial services, emergency services, evaluation and treatment of mental health problems, social integration services, respite services, and secondary care services. The document does not speak of harm reduction in the context of substance use at all.