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

Four key findings are highlighted from the inductive analysis: 1) The commitment to harm reduction in Saskatchewan policy documents has weakened over time and remains strongest at the regional level; 2) Harm reduction is inconsistently defined in policy documents; 3) Disease transmission prevention is a key focus of policy documents, with a particular focus on injection drug use; 4) Current policy documents emphasize evidence, stigma reduction, and inclusion of people who use drugs. In the deductive analysis, a set of criteria were applied to current policy documents. Results are presented in a standardized Policy Report Card.

1.1 Contextual Background[1]

Saskatchewan is one of three prairie provinces in Canada, spanning 588,239 square kilometers. It has a population of one million, with 2 major cities: Saskatoon (area of 209 km; population of 222,189) and Regina (area of 145 km; population of 193,100) (Statistics Canada, 2012).

For much of its history, centre-left parties including the Liberals and New Democrats (NDP) dominated Saskatchewan's political environment. The centre-right Progressive Conservative party was briefly elected in the 1980s, however, the NDP party regained power during the

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

1990s. This lasted until 2007 when the Saskatchewan Party, a centre-right party, was elected. The Saskatchewan Party, with Brad Wall as premier, has been in power since (Leeson, 2009).

Until recent years, the Saskatchewan government had opposed various harm reduction interventions. In 2009, the provincial government attempted to limit the number of sterile syringes distributed within syringe distribution programs as a way of reducing the number of improperly discarded needles and syringes (CBC, 2009). Further to this, in 2010, provincial health officials publicly stated they had no plans to implement supervised injection facilities (Stockfish, 2011; CBC, 2010). Despite early opposition to key interventions, in 2010 the Saskatchewan Ministry of Health formally endorsed "prevention and harm reduction" as part of their strategy for reducing the transmission of HIV (Saskatchewan HIV Collaborative, 2015). This decision appears to have been prompted by increasing prevalence of injection drug use-attributable HIV, and the publication of an evaluation undertaken by the provincial government, which demonstrated that syringe distribution programs successfully reduced blood-borne infections, and generated four million dollars in annual healthcare savings (Laurence Thompson Strategic Consulting, 2008). In 2016, the Minister of Health released a statement outlining the provincial government's stance on harm reduction. This stated that the province was not considering safe injection sites at the current time, but they continued to support "prevention and risk reduction programs" aimed at protecting residents from communicable disease and connecting people who inject drugs with health care professionals and addiction service supports (Biber, 2016).

1.2 Healthcare Governance

Key stakeholders in the Saskatchewan health system include the Minister of Health, Ministry of Health, regional health authorities, and the Saskatchewan Cancer Agency. The main responsibilities of the ministry include setting policies, directions, and provincial standards, as well as distributing resources and conducting performance measurement and reporting (Saskatchewan Ministry of Health, 2011, p. 1). Dustin Duncan served as Minister of Health from 2012 to 2016. Jim Reiter was appointed Minister of Health in August 2016 (Saskatchewan Party, 2017).

The Ministry of Health assists the Minister by aiding in the development and implementation of health policy as well as evaluating the performance of the Saskatchewan health system. Additionally, the Ministry makes recommendations, monitors the health status of the

Saskatchewan population, manages and administers health programs, and works with the Saskatchewan health boards (including regional health authorities, the Saskatchewan Cancer Agency and Athabasca Health Authority) to ensure compliance and governance with legislation and standards (Saskatchewan Ministry of Health, 2011). Regional health authorities and the Saskatchewan Cancer Agency deliver the majority of health services in Saskatchewan (Saskatchewan Ministry of Health, 2016). There are currently 12 health authorities (See Appendix A for information on each), and each is responsible for delivering community health services, supportive care, hospital services, emergency response services, and operating health, wellness, and social centres in their respective region (Saskatchewan Ministry of Health, 2011).

There are two additional governing bodies not considered regional health authorities - the Athabasca Health Authority, and the Saskatchewan Cancer Agency. The Athabasca Health Authority is defined as a non-profit corporation and is comprised of First Nation bands and non-First Nation communities. The Saskatchewan Cancer Agency is responsible for planning and providing cancer care services throughout Saskatchewan (Athabasca Health Authority, 2013; Saskatchewan Ministry of Health, 2011).

The Saskatchewan health system has undergone a number of reorganizations in the last 25 years. In 1993, 400 local health boards were replaced by 32 health authorities. In 2002, The Regional Health Services Act combined the 32 health authorities to form the current 12 regional health authorities (Saskatchewan Ministry of Health, 2015). Saskatchewan's health structure, since 2002, remained relatively untouched with the exception of replacing the Cancer Foundation Act with the Cancer Agency Act and delegating the Cancer Care Agency responsibility for providing cancer services throughout the province (Institute of Public Administration of Canada, 2013).

1.3 Substance Use Trends

According to data drawn from the Canadian Alcohol and Other Drug Use Monitoring Survey (CADUMS), 43.9% of Saskatchewan respondents reported lifetime use of one or more illicit drugs, while 11.1% reported using at least one illicit drug in the past year (Statistics Canada, 2014). CADUMS data indicate that lifetime intake of certain drugs (cocaine/crack (6.9%) as well as amphetamines (1.9%) and ecstasy (4.1%)) was lower among Saskatchewan respondents compared to respondents from other Canadian provinces. In contrast, Saskatchewan respondents reported using more hallucinogens (14.2%) and salvia (4.1%) than respondents from other provinces. A total of 3.1% of respondents reported experiencing physical, emotional, or financial harm related to their substance use over the past 12 months (Statistics Canada, 2014). The 2013 Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS) found

that in 2012, 5% of Saskatchewan youth had used either MDMA, heroin, cocaine, amphetamines, or hallucinogens to get high, while 3% used glue, salvia, gasoline or other solvents to get high (Propel Centre for Population Health Impact, 2014).

As with other provinces, opioid misuse and opioid-related deaths are on the rise in Saskatchewan. Between 2010 and 2015, there were 41 fentanyl related deaths in Saskatchewan, and the annual number of deaths increased every year after 2010 (Mills, 2016). Between 2014-2015, Saskatchewan had the highest rate of hospitalizations from opioid poisonings of all Canadian provinces, at a rate of almost 21 per 100,000 people, compared to the national average of 13.4 (Canadian Institute for Health Information, 2016). In response, the province has moved towards distributing take home naloxone kits as a means of preventing overdose (Craig, 2015A ; Government of Saskatchewan, 2015). Despite the government's response to addressing fentanyl and other opioid misuse, the availability of opioids continues to outpace resources devoted to treating opioid use disorder in Saskatchewan. A 2014 study found that Saskatchewan had one of the highest increases in dispensing rates of high-dose opioid formulations by retail pharmacies when compared to the rest of Canada. Saskatchewan and Nova Scotia also had the highest rates of high-dose hydromorphone dispensing when compared to other provinces (Gomes et al., 2014). Despite the increase in opioid availability, one analysis found that the province spent approximately $0.11 on opioid use disorder treatment for every dollar spent on opioids in 2014 (Giovannetti, 2016). A 2011 report, commissioned by the Canadian Community Epidemiology Network on Drug Use (CCEDNU), found that 86% of key informants in the substance abuse field viewed opioid prescription drugs as a "very" or "somewhat serious" problem in Saskatoon (Bell et al, 2011). Further anecdotal reports from members of the Saskatoon CCENDU network have indicated that hydromorphone and morphine are the most commonly misused opioids in Saskatoon (Canadian Center on Substance Abuse, 2013). Data does not exist for other parts of the province.

1.4 Harm Reduction Services in Saskatchewan

Prevention and Risk Reduction (PRR) programs are government supported harm reduction programs that assist in reducing the spread and stigma of HIV in Saskatchewan. HIV rates in Saskatchewan are some of the highest in Canada; particularly among indigenous populations, where in 2015, rates of new infections were higher than some of the poorest countries in Africa (Leo, 2015). As a result, the government launched the *Saskatchewan HIV Strategy 2010-2014* in 2010 in an effort to reduce the prevalence and risk factors of acquiring HIV infections, as well as improve the quality of life for HIV-infected individuals (Saskatchewan Ministry of Health, 2010). PRR programs focus on reducing the spread of HIV, hepatitis C, and other blood-borne infections for people in Saskatchewan by providing harm reduction services. These include distributing supplies such as needles, providing clients with a broad range of medical and social

referrals, and providing counselling and support services. PRR programs are funded by regional health authorities, which are also responsible for the provision of harm reduction services in their jurisdiction. There are currently 24 fixed and three mobile provincially funded PRR programs in eight regional health authorities[2]. Around 56,000 clients visited PRR programs in 2014-2015; an increase of nine percent from 2013-2014. Data extracted from the *Prevention and Risk Reduction Programs & Services in Saskatchewan 2014-2015 Fiscal Year Evaluation Report* indicates that between 2011 and 2015, 18,486,353 needles were distributed throughout Saskatchewan with a return and recovery rate of 98% (Population Health Branch, 2015).

In Saskatchewan, there are five opioid dependence treatment (i.e. methadone) programs[3]. Distribution of methadone is managed by the College of Physicians and Surgeons of Saskatchewan, which sets the guidelines and standards for methadone treatment in Saskatchewan. In order to prescribe and dispense methadone, physicians must obtain a license and have the appropriate training and experience in Methadone Maintenance Treatment (MMT) among other requirements (College of Physicians and Surgeons of Saskatchewan, 2015). Saskatchewan is the only province which requires clients wishing to access MMT clinics to obtain a referral to a methadone prescribing physician, from either an addictions outpatient program, methadone counsellor, or a general practitioner. The purpose of this "gatekeeping function" is to connect physicians and addiction counselors with local communities across the province. Despite buprenorphine being covered by the Saskatchewan drug benefit program, dispensing of this medication in the province has been very low (Luce, 2011). According to the latest National Treatment Indicator report, 460 individuals in 2014 accessed opioid dependence treatment (Pirie et al, 2016). There are currently no supervised injection facilities and no drug checking interventions in Saskatchewan. A 2015 study found that if a supervised injection facility were established in Saskatoon, it would be cost effective in reducing tax payers' expenses and reduce HIV infection rates among people who inject drugs (Jozaghi & Jackson, 2015). A 2008 report found that Saskatchewan did not offer safer inhalation kits for individuals who smoke crack cocaine (Laurence Thompson Strategic Consulting, 2008). There is no information to indicate that the availability of these services has changed since then.

Regional health authorities also provide funding and support for a variety of community based organizations and outreach programs which advocate for and deliver harm reduction services. Some of the main programs include the *601 Outreach Center* operated by *AIDS Saskatoon*, which is an organization focused on providing education, outreach, and support for individuals affected and living with Hepatitis C and HIV (AIDS Saskatoon, 2016). Organizations such as the

[2] Prairie North, Saskatoon, Mamawetan Churchill River, Regina Qu'Appelle, Prince Albert Parkland, and Keewatin Yatthe.
[3] Prince Albert Co-operative Health Center Methadone Assisted Recovery Program, Regina Qu'Appelle Regional Health Authority Methadone Clinic, Parliament Methadone Clinic, Saskatoon City Hospital Methadone Assisted Recovery Program, College Park Medical Clinic.

All Nations Hope AIDS Network deliver various harm reduction services such as syringe distribution and methadone treatment for indigenous populations (Dell & Lyons, 2007).

2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. Documents produced for Saskatchewan during this period were (a) analyzed and synthesized inductively to describe historical[4] and current[5] policy developments guiding harm reduction services in the province over this time period, and (b) reviewed collectively and evaluated using a deductive coding framework comprised of 17 indicators, assessing the quality of harm reduction policies in order to facilitate cross-case comparison.

2.1 Search Process

A separate paper provides complete methodological details regarding the National search process (Wild et al., 2017). Systematic and purposive search strategies identified and verified publicly-available policy documents produced from 2000 – 2015. We defined relevant documents as harm reduction policy texts that (1) were issued by and representing a provincial or territorial government or (2) issued by and representing a regional, provincial, or territorial delegated health authority; (3) that mandated future action; and (4) that addressed one of seven targeted harm reduction interventions[6] 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.

[4] 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.
[5] 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.
[6] 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.

Three current and four historical documents were identified and analyzed using a two-step (inductive and deductive) process described below (Appendix B provides the Saskatchewan-specific search strategy).

2.2 Inductive Analysis

Each of the seven Saskatchewan documents was analyzed using a three-step process (Appendix C provides analytic details). First, relevant text[7] was extracted from each policy document and analyzed, resulting in a set of analytic notes. The focus of the analytic notes was primarily descriptive and instrumental (i.e., generating a deeper understanding of the intent and purpose of the policy document and the relevant stakeholders and their roles). Next, each document's analytic notes and a set of accompanying quantitative data (see Appendix C) were synthesized and compiled into a narrative document description. Finally, all narrative document descriptions for the case were synthesized and compiled into a single document. This resulted in a descriptive summary, describing the main themes and trends in Saskatchewan's set of harm reduction policy documents over the 15-year study period.

2.3 Deductive Analysis

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

Current Saskatchewan 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

[7] "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.

policy report card for each provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions

3.0 Documents Retrieved

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

Table 1: Descriptive Details of Saskatchewan's Policy Documents

		DOCUMENT TITLE	AUTHORS	YEAR PUBLISHED	YEARS ACTIVE
CURRENT POLICY DOCUMENTS					
Provincial Level	*1*	Working Together for Change: A 10-year mental health and addiction action plan for Saskatchewan	Dr. Fern Stockdale Winder, Commissioner of Mental Health and Addiction Action Plan	2014	2014 – *2024 (expected)*
Regional Level	*2*	Building Partnerships For Health: A strategic planning framework for injection drug use in Saskatoon	Saskatoon Health Region	2007	Not specified – no expiration
	3	Saskatoon Health Region HIV Prevention, Treatment & Support Strategy	Pamela DeBruin, Sandy Gibson and Heather Trischuk; The Health Sector and Community, Saskatoon Health Region	2010	Not specified (Implementation plan is 2010-2013 only)
HISTORICAL POLICY DOCUMENTS					
Provincial Level	*4*	Saskatchewan's HIV Strategy 2010-2014	Saskatchewan Ministry of Health	2010	2010-2014
	5	Saskatchewan's HIV Strategy 2010-2014: Update [Update document]	Saskatchewan Ministry of Health	2011	2010-2014
	6	Saskatchewan's HIV Strategy: Mid-term implementation and progress report 2012 [Update document]	Government of Saskatchewan; SK HIV Provincial Leadership Team	2014	2011-2012

	7	Saskatchewan's HIV Strategy Final Evaluation Report [Update document]	Government of Saskatchewan; SK HIV Provincial Leadership Team, HIV Strategy Coordinators	2014	2010-2014

4.0 Results: Inductive Analysis of Documents

4.1 The commitment to harm reduction in Saskatchewan policy documents has weakened over time and remains strongest at the regional level

4.1.1 Commitment to harm reduction in provincial-level policy

In Saskatchewan, there are no stand-alone harm reduction policy documents, at either the provincial or health region-level. Three current policy documents exist – only one of these applies to the province as a whole, *Working Together for Change: A 10 Year Mental Health and Addiction Action Plan for Saskatchewan [1]*. This was published by the provincial government in 2014. Notably, despite addressing addiction and mental health, this document does not reference any specific illicit substances, and makes no mention of harm reduction as an approach for illicit substance use. Given the content of this document, it can be concluded that no formal policy exists to guide harm reduction for illicit substances at the provincial level.

There was a provincial-level strategy in place from 2010 to 2014 that provided a framework for efforts to address HIV/AIDS across Saskatchewan – *Saskatchewan's HIV Strategy 2010-2014 [4].* One of four "strategic pillars" of this strategy was "prevention and harm reduction" (p. 15), and the term "harm reduction" was used 24 times throughout the document. The *Strategy* goals center around HIV, and throughout the document, injection drug use was highlighted as a key risk factor for the transmission of HIV and bloodborne pathogens. Furthermore, people who inject drugs were identified as the primary target population. Four interventions of interest were noted in the strategy: "needle distribution", "suboxone", "safer crack kits" and various outreach services. Despite mentioning these interventions, the document included few directives that could actually translate to action, particularly in regards to harm reduction. For example, one recommendation was to "establish prevention and wellbeing centers with expanded access to needle exchange programs and other harm reduction measures to promote and encourage safe and healthy behaviors" (p.15). In this case there was no information included describing what a "prevention and wellbeing center" entailed, what the "other harm

reduction measures" were, or how they would be implemented in practice.

Three update documents were published for this strategy, all of which are now considered historic [5,6,7]. Commitments to harm reduction were similarly ambiguous in these documents, although the term harm reduction was consistently used in all three (five, nine and 29 mentions). The *Final Evaluation Report [7]* asserted that the original document's "prevention and harm reduction" recommendations were deployed over the course of the strategy, including expanded access to harm reduction and prevention programming (p.27). The report stated that two new "prevention and risk reduction sites" were introduced, incorporating "risk reduction programming", but there are no details on what this entailed (p.27). The document ended with a list of recommendations for moving forward with the strategy into the future. Only one of these referenced harm reduction, albeit not specifically; "conduct a needs assessment to identify where additional prevention and risk reduction services are required in the province, including on-reserve" (p.55). Again, no details were provided on what these services might be. There was no indication that the strategy would be renewed, and no information provided regarding plans for a new strategy.

Overall, *Saskatchewan's HIV Strategy [4]* and successive update documents did not strongly promote harm reduction or the uptake of key interventions. Discussions and recommendations around harm reduction were vague and inconsistent. Furthermore, it is unclear if any interventions other than needle exchange were implemented, and to what degree needle exchange expanded or improved during the time of the strategy. Despite these shortcomings, it is notable that the *HIV Strategy [4]* at least acknowledged harm reduction for illicit drug use and was applicable on a provincial level. In contrast, the single current provincial document does not recognize harm reduction at all or reference any interventions of interest.

4.1.2 Commitment to harm reduction in regional-level policy

The absence of harm reduction in current provincial policy is particularly glaring in contrast to the remaining Saskatchewan documents – both of which are specific to the Saskatoon Health Region and incorporate harm reduction throughout. The first, *Building Partnerships for Health – A Strategic Planning Framework for Injection Drug Use [2]*, mentions the term "harm reduction" 166 times, making it the most comprehensive discussion of harm reduction amongst all policy documents retrieved for Saskatchewan. The *Framework [2]* was developed in 2007 as a planning document to guide coordinated action on injection drug use and to respond to increasing rates of HIV transmission in the Saskatoon health region. It is organized around four pillars - one of which is "Harm Reduction" (p.105). The document lists seven broad recommendations for harm reduction, including: 4) advocating for increased community-based access to harm reduction services such as community kitchens and peer groups, and expanded

needle exchange hours; 6) expanding harm reduction strategies beyond sterile syringe distribution to include the provision of a full range of injecting supplies (cookers, cotton and water); and, 7) considering implementation of a supervised injection facility for Saskatoon (p.109). Each of the seven recommendations is accompanied by short-term and long-term implementation "strategies" that suggest specific steps for realizing each recommendation, as well as expected outcomes, and a list of potential lead agencies or partner agencies. Although this document focuses on injection drug use, four harm reduction interventions of interest are mentioned encompassing other modes of use: "needle exchange", "safe injection site", "outreach services", and "pipe exchange". The document outlines a comprehensive and coordinated plan for action that dictates harm reduction policy for the Saskatoon Health Region.

The second current document that applies to this jurisdiction is the *Saskatoon Health Region HIV Prevention, Treatment & Support Strategy [3]*. The strategy was developed in 2010 in response to a "concentrated epidemic" of new HIV cases in the Saskatoon Health Region, and targets those in the community "who are most at risk and are increasingly infected and affected by HIV" (p.17). The document lists examples of "most-at-risk populations" as sex trade workers, persons who use injection drugs, and men who have sex with men (p.22). Harm reduction is mentioned 87 times in this document and is central to the first of 11 guiding principles, "introducing and basing all programming around a Harm Reduction philosophy – meet the person where they are at" (p.22). Despite this endorsement, harm reduction is never formally described or defined and is used in variable contexts. As such, it is difficult to pin down a specific understanding of the philosophy and understand precisely how "all programming" is based around it.

The document is framed around five priority "initiatives for action". Three of these list recommendations mentioning "harm reduction" – either a specific intervention or a general reference. For example, specific interventions are noted in recommendations such as, "consider the implications for the provision of crack smoking kits as an alternative to injection drugs" and "…consider integrating supervised safe injection as an element of medical clinical practice within services if and when warranted" (p.28). Elsewhere in the document, needle exchange and outreach (including mobile needle exchange) are also mentioned, totalling four interventions of interest (syringe distribution; supervised consumption services; safer inhalation kits and outreach). There are also many references in recommendations to harm reduction more generally. For example, "offering cross training to Tuberculosis Control Program staff to support clients with harm reduction strategies (including distribution of condoms) to improve client access to harm reduction tools and skills" (p.53). There is no information to indicate what these tools or skills are more specifically, other than condom distribution.

4.1.3 Summary

Together, these regional policy documents address harm reduction quite comprehensively in the largest health region in the province, serving approximately 350,000 people (Saskatoon Health Region, 2016), However, the Saskatoon Health Region is just one of 12, and none of the remaining regional health authorities appear to have formal harm reduction policies in place. Coupled with a lack of guidance at the provincial level on the matter, the harm reduction policy environment in Saskatchewan is sparse, at best. Despite a spike in new cases of HIV in the province in 2015 (Vogel, 2016), a new HIV strategy has not yet been implemented. It is not clear why efforts around harm reduction, which received support in the now-expired provincial HIV strategy, would not have been adopted into current policy related to addiction and mental health, considering the central role of injection drug use in driving Saskatchewan's' HIV epidemic (Picard, 2016).

4.2 Harm reduction is inconsistently defined within policy documents

Harm reduction is described very differently in various current and historical policy documents at the provincial and regional levels. Although some overlap does exist in terms of key ideas and harm reduction interventions discussed, there is no consistently used definition.

4.2.1 How is harm reduction defined in provincial-level policy?

The only current provincial-level policy document, *Working Together for Change: A 10-year Mental Health and Addiction Action Plan for Saskatchewan [1],* does not define or describe harm reduction for illicit substance use. Within the document there are two vague references to "reducing harm", however, neither example includes a formal description of this concept or any clarification on what this means in practice. The first example states, "Build community-specific partnerships that create opportunities for better mental health and reduced harms from substance abuse" (p.61). There is no explanation of how harms could be reduced or what substances are considered. In the second example, the document broadly recognizes the need to "reduce the harms" associated with alcohol misuse (p.36); however, none of the accompanying recommendations are in line with recognized principles of harm reduction[8]. For example, the authors recommend a "comprehensive provincial approach" to the issue including alcohol price regulation, increased awareness and guidelines to help alcohol users make good

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

decisions around drinking (p.36).

Notably, a definition of harm reduction was included in the now-historic provincial-level policy document, *Saskatchewan's HIV Strategy 2010-2014 [4]*. It read,

> *"Harm reduction, or harm minimization, refers to a range of public health policies designed to reduce the harmful consequences associated with drug use and other high-risk activities. Public health harm reduction measures are designed to reduce the harm that drugs can cause both to individuals and to the community. Examples of harm reduction initiatives include safe sex practices and general health education" (p.15).*

This definition is quite general and does not exemplify key features of a harm reduction philosophy, other than to recognize harm reduction can benefit both individuals and the community. The two examples noted (safe sex practices and general health education) do not address illicit drug use and are not recognized interventions of interest. In other parts of the document, use of the term reflected a vague understanding of the concept. For example, discussions around harm reduction included it being part of a "recovery process" (p.2), as a method of addictions prevention (p.3), and as a way to prevent HIV transmission (p.15). Throughout the document, harm reduction and prevention were used interchangeably. In *Table 4* (p.15), "prevention/well being/harm reduction services" was referred to, implying these concepts are essentially the same. Reinforcing this ambiguity, "Prevention and Harm Reduction" (p.15) was one of four key pillars in the document. When recommendations were listed under this pillar, there was no distinction between those considered prevention measures versus those considered harm reduction measures. Interventions mentioned here included needle exchange, safe sex practices, and general health education (p.15-16).

Jumping ahead to *the Final Evaluation Report [7]* of Saskatchewan's HIV Strategy, harm reduction is briefly defined again. The text states "prevention and harm reduction was included to increase access to HIV prevention and education and reduce the harmful consequences associated with drug use and other high-risk activities" (p.20). This is similar to the definition in the original *Strategy*, albeit less detailed and excluding examples. It is unfortunate that over the four years this strategy was in place, the definition did not evolve to reflect a higher level understanding of harm reduction or include a more detailed description of the approach. There is little continuity in how harm reduction is described within provincial-level documents over time, and the current provincial document provides no definition at all.

4.2.2 How is harm reduction defined in regional-level policy?

Of the three current policy documents included in this analysis, only the Saskatoon Health Region's *Building Partnerships for Health– A Strategic Planning Framework for Injection Drug Use [2]* includes a stated definition of harm reduction. In this document, harm reduction is actually defined twice. The first mention of the term describes an approach that "includes strategies that reduce the harm for people who use injection drugs and that contribute to reducing drug-related harm rather than drug use" (p. 5). Later in the document, a more comprehensive definition is provided. Harm reduction:

> *1) is an approach or strategy that aims to reduce the negative consequences of drug use, rather than to eliminate drug use; 2) can involve programs or policies that are designed to reduce drug-related harm without requiring abstinence or cessation of drug use; 3) promotes incremental improvements in the behaviours of injection drug users that are practical, achievable and ultimately lead to benefits for both users and communities" (p.105).*

The definition also outlines three conditions that must be met for an intervention to be considered harm reduction. These are:

> *1) the setting of a primary goal to reduce harm rather than drug use; 2) inclusion of strategies to reduce the harm for people who continue to use drugs; 3) employment of strategies aiming to demonstrate a net reduction in drug-related harm as an outcome.*

Additionally, the document states that harm reduction strategies should:

> *1) provide a practical alternative focusing on the consequences of potentially harmful behaviours rather than on the morality of the behaviour (meeting clients' needs 'where they are at'); 2) accept alternatives to abstinence … and promote efforts to reduce barriers to treatment options; 3) consider drug use a health and social issue with diverse determinants of health; 4) respect the rights and dignity of people who inject drugs; 5) provide accessible, appropriate services that involve people who inject drugs in planning and decision making; and 6) involve community and stakeholders (p.105).*

There is some confusion around the actual working definition of harm reduction, as it is unclear whether this information is included purely as context or is presented as the accepted understanding of harm reduction. Adding to this confusion, one recommendation calls for the development of "a clear definition of harm reduction", implying that one currently does not exist. Regardless, this section provides a comprehensive overview of what harm reduction entails and reflects a high level understanding of the principles of harm reduction. The excerpts above demonstrate an alignment with internationally recognized understandings of harm

reduction, such as targeting risks and harms (rather than drug use itself), incremental action that meets people where they are at, respecting the rights and dignity of people who use drugs, and involving people who use drugs in planning and decision making (International Harm Reduction Association, 2010).

The final current document, *Saskatoon Health Region HIV Prevention, Treatment and Support Strategy [3],* does not provide a formal definition of harm reduction or an overview of the approach. The term "harm reduction" is used in many contexts, making it difficult to pin down a specific understanding. For example, there are references to the "harm reduction philosophy" (p.26), the "harm reduction hierarchy" (p.30), harm reduction "tools and skills" (p.53), "prevention education" (p.28) and "services" (p.29).

4.2.3 Summary

In terms of the broader policy context, there is little consistency between how harm reduction is contextualized within the two regional-level documents and the provincial level document. It is clear that a standard definition is not in place across the Saskatoon Health Region or the province more generally, as only one document includes a formal definition, and that harm reduction in practice – as it applies to specific interventions – is also understood quite differently. This is particularly interesting given that that the *Saskatoon Health Region HIV Prevention, Treatment and Support Strategy [3]* states that it is generally aligned with priorities of the *Saskatchewan Provincial HIV Strategy [4]*. This explicit recognition of other related Saskatchewan policy documents should indicate some level of consistency between key conceptual understandings, however, in the case of harm reduction this is not the case. Overall, there is very little consistency in definitions of harm reduction, over time and within regions. It is evident than an overarching provincial understanding of harm reduction, even informally, does not exist in the Saskatchewan context.

4.3 Disease transmission prevention is a key focus of policy documents, with a particular focus on injection drug use

4.3.1 Disease transmission focus in current documents

Six of the seven policy documents retrieved for Saskatchewan include some degree of discussion around harm reduction – two current, one historical, and three historical updates. A reoccurring theme within these documents is the framing of harm reduction as a method of disease transmission prevention, with a particular emphasis on people who inject drugs.

Saskatchewan has the highest rates of HIV in the country, at twice the national average, and also saw the re-emergence of HIV infection in infants in 2015 (Craig, 2015B). In the face of this HIV public health emergency, harm reduction has emerged as an evidence-based method of addressing this concern. Although this is not a poor rationale for supporting harm reduction, it misses key features of a harm reduction philosophy, including humanistic values (Riley & O'Hare, 2000). Documents tend to focus on providing harm reduction interventions as a means for individual-level risk reduction and prevention of communicable disease, rather than on making connections with people, respecting human rights, and doing harm reduction 'practice'. The absence of any named-harm reduction policies reinforces this conclusion, as well as the fact only two documents mention overdose (the two current regional-level documents) and none promote (or even mention) naloxone as an intervention of interest. This framing has shifted little in recent years, and is evident in policy documents over time at both the regional and provincial levels.

Building Partnerships for Health – A Strategic Planning Framework for Injection Drug Use [2], has a clear focus on injection drug use. The primary concern of the *Framework* is to drastically reduce the spread of HIV (p.iii), and people who inject drugs are identified as a key target group. Although this document includes a comprehensive discussion around harm reduction, the approach is very much framed in the specific context of bloodborne pathogen risks related to injection drug use. In discussing harm reduction it states, "Harm reduction principles are foundational to public health and community-based programming intended to meet the needs of injection drug users" (p.105). There are additional references throughout this section to "people who inject drugs". Furthermore, six of the seven formal harm reduction recommendations in the document centre on injection drug use, either explicitly or implicitly. Examples include, to "develop an intensive education program about harm reduction that is tailored to IDUs…" (p.112), expand outreach services…to provide greater accessibility to services and access to IDUs and their families..." (p.118), and "expand harm reduction strategies beyond needle exchange" to include supplies such as filters, waters and cooker (p.129). The approach outlined in this document is framed as a response to reducing disease transmission with a focus on people who inject drugs as the target population.

The *Saskatoon Health Region HIV Prevention, Treatment & Support Strategy [3]* reflects a similar context. The development of the *Strategy* was initiated in response to the marked increase of new HIV cases in the Saskatoon Health Region, described as a "concentrated epidemic". This refers to a situation in which "HIV has spread rapidly in a defined sub-population, but it is not well-established in the general population. This epidemic state suggests active networks of risk within the sub-population" (p.21). The goal of the *Strategy* was to identify the prevention, treatment and support needs of those in the community who are most

at risk and increasingly infected and affected by HIV (p.17). Throughout the *Strategy*, harm reduction is framed as a method for addressing HIV transmission, and the four interventions of interest centre on injection drug use. “Needle exchange” and” supervised injection” explicitly so – while examples of outreach refer to HIV programming, testing and care. Interestingly, crack kits are also acknowledged as the fourth intervention of interest – although in the context of risk reduction for people who injection drugs. The recommendation states, “consider the implications for the provision of crack smoking kits as an alternative to injection drugs” (p.28). It is promising to see an intervention for a different route of administration noted, however, the focus remains on reducing the risk of blood borne pathogens amongst people who injection drugs.

4.3.2 Disease transmission in historic documents

The remaining set of documents which address harm reduction are historic – *Saskatchewan’s HIV Strategy 2010-2014 [4]* and three subsequent update documents [5,6,7]. While these do not shed light on the current state of policy, they do offer an interesting comparison of policy over time as they are the only provincial level documents in recent history (since 2000) to address harm reduction at the provincial level. In line with the regional policies described above, the *Strategy [4]* was developed to address the challenge of rising HIV rates across Saskatchewan (p.1). Document goals center around HIV, and injection drug use is highlighted as a key risk factor for the transmission of disease. Furthermore, people who inject drugs are identified as the primary target population. In the three update documents, the focus remains the same: to address new HIV infections, improve the quality of life for HIV infected individuals, and reduce risk factors for acquiring HIV.

4.3.3 Summary

The focus on HIV transmission and injection drug use is not surprising considering the objectives of these documents, and should not necessarily be viewed as a shortcoming. However, this indicates that harm reduction in Saskatchewan is primarily considered as an approach for individual-level risk reduction and prevention of communicable disease, rather than on doing harm reduction ‘practice’. For harm reduction to be most effective, it must be multifaceted and implemented as an ongoing social process which promotes many types of behavior change in the long-term, rather than just a series of singular interventions (Riley & O’Hare, 2000).

4.4 Current policy documents emphasize evidence, stigma reduction, and inclusion of people who use drugs

Despite the absence of any stand-alone harm reduction policies in the Saskatchewan document set, current and historical documents demonstrate a general alignment with several established principles of a harm reduction approach (see HRI, 2010). These include creating policy based on the best evidence available, reducing stigma and avoiding judgement, and including people who use drugs in policy development.

4.4.1 Evidence-based policy making

International best practice states that harm reduction should have a commitment to basing policy and practice on the strongest evidence available (International Harm Reduction Association, 2010). All three current policy documents acknowledge the importance of this. In *Working Together for Change - A 10-year mental health and addiction action plan for Saskatchewan [1]*, a key principle of the plan is "Evidence Based Innovation and Evaluation: Services are based on evidence from science, promising practice and traditional knowledge, and receive ongoing evaluation to ensure they continue to be relevant and appropriate" (p.5). Throughout the document, "evidence" and "evidence-based" programming is referenced frequently as justification for specific interventions, services or recommendations.

Within *Building Partnerships for Health: A strategic planning framework for injection drug use in Saskatoon [2]*, one of the guiding principles of the *Framework* is "evidence-based practice" (p.x). Within each key pillar of the document, best practices based on research and evaluation are extensively discussed to frame the recommendations that follow. In the "Harm Reduction" pillar specifically, there is a wealth of information included to support the interventions recommended. For example, in the context of needle distribution, information is included on the effectiveness of needle exchange programs in other jurisdictions (p.108).

In the *Saskatoon Health Region HIV Prevention, Treatment and Support Strategy [3],* "evidence", "best evidence guidelines" and "best evidence care" are referenced throughout, supporting specific recommendations. "Best and promising practices" are outlined to provide context for each recommendation, including those that relate to harm reduction. International agencies such as the WHO and the United Kingdom Harm Reduction Alliance are cited here, and a "Key Intervention" included in the harm reduction section is to "conduct applied research to better understand the context for needle sharing in our various communities" (p.28). Overall,

the current policy set fully endorses evidence-based policy making.

4.4.2 Stigma

The treatment of people who use drugs with dignity and compassion, in a non-judgemental manner, is a cornerstone of the harm reduction philosophy (International Harm Reduction Association, 2010). Working to end stigma around drug use and people who use drugs is a key feature of this, and is acknowledged in all current policy documents. In *Working Together for Change [1]*, one of the key system goals of the plan is to "Reduce Stigma and Increase Awareness" (p.55). There are various recommendations listed including "Reduce stigma and increase awareness of mental health and addictions issues" (p.55) and "develop a public education and awareness program that helps people readily identify mental health and addictions issues and that makes it socially acceptable to seek help" (p.56). As this document does not reference harm reduction, this principle is endorsed in the context of addictions.

Building Partnerships for Health [2] includes extensive consideration of stigma in various contexts including injection drug use, harm reduction techniques, and HIV and HCV more generally. Ideas around reducing stigma and discrimination against injection drug users, and respecting the rights of people to access judgment-free services, are included right in the foundational text of the document (p.1). Furthermore, many specific recommendations address this, including to "Advocate for the reduction of community and professional stigma about harm reduction techniques" (p.113) and "Develop a social marketing campaign to reduce stigmatization and discrimination of people living with HIV/AIDS and of injection drug users" (p.80). The entire framework is underlined by an appreciation of the need to work towards reducing stigma and treating people who use drugs with dignity and compassion.

Saskatoon Health Region HIV Prevention, Treatment and Support Strategy [3] includes various references to stigma and discrimination, in some cases directed at people who use injection drugs. "Stigma and Discrimination" is also recommended as a key area to address in order to strengthen and expand health systems. One recommendation focuses on reducing stigmatizing attitudes and discriminatory behaviors on behalf of health care staff (p.64).

4.4.3 Accountability and participation

A key principle of harm reduction is the inclusion of a wide range of stakeholders in policy

development and program implementation (International Harm Reduction Association, 2010). The inclusion of people who use drugs, and other closely affected groups, should also be involved in decision making that influences them. All three current policy documents acknowledge the importance of consulting a wide range of stakeholders, although only two include information to indicate that their respective document utilized this process in practice. In *Working Together for Change [1]*, the report is described as the culmination of extensive public consultations across the province with a particular emphasis on the voices of people with lived experience of mental health and addictions issues and their family members (p.3).

The *Saskatoon Health Region HIV Prevention, Treatment & Support Strategy [3]* notes that a critical component utilized in the development of the strategy was consultation with persons affected by HIV or injection drug use (p.17). Feedback from this group, as well as other stakeholders including community health sector partners, was compiled to create the themes of the document and identify strengths and gaps in care. Within the document, specific examples are drawn from "client consultations". Notably, this document acknowledges that not all important groups were consulted, such as First Nations and Metis peoples, and states that additional consultations are built into the strategic plan to address this shortcoming (p.17).

The third document, *Building Partnerships for Health [2]*, does not explicitly state that people who use drugs were consulted or involved in policy development. The document notes that in the future, "emphasis should be placed on the importance of active participation of Aboriginal stakeholders, communities, youth and IDUs" (p.4). Although there is nothing to indicate that people who use substances were specifically involved in the development of the present document, as some of the language is vague regarding who involved stakeholders were, it is also not explicit that this group was excluded. Regardless, it is promising to see that the importance of this process is acknowledged and that there are plans for consultation with people who use drugs to occur in the future.

4.4.4 Summary

As the above discussion demonstrates, current policy in Saskatchewan reflects a general alignment with key principles of a harm reduction philosophy. These include creating policy based on the best evidence available, considering stigma and avoiding judgemental attitudes, and including a wide range of stakeholders in policy development (including people who use drugs). This shows the potential for more directive harm reduction policy to fit within the existing policy context. The introduction of specific policy documents to address harm

reduction would be an easy transition, as many fundamental principles of the approach are already supported across the region.

5.0 Results: Deductive Analysis of Current Documents (Saskatchewan 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

	Working Together for Change: A 10-year mental health and addiction action plan for Saskatchewan	Building Partnerships For Health: A strategic planning framework for injection drug use in Saskatoon	Saskatoon Health Region HIV Prevention, Treatment & Support Strategy	**Total (out of 3)**
[1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or have drug problems?	1	1	1	**3**
[2] Does the document affirm that people who use substances need to be involved in policy development or implementation?	1	1	1	**3**
[3] Does the document acknowledge that not all substance use is problematic?	0	1	0	**1**
[4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community?	0	1	0	**1**
[5] Does the document acknowledge that harm reduction can be applied to the general population?	0	0	0	**0**

[6] Does the document target women in the context of harm reduction?	0	0	0	**0**
[7] Does the document target youth in the context of harm reduction?	0	1	0	**1**
[8] Does the document target indigenous populations in the context of harm reduction?	0	0	0	**0**
[9] Does the document target LGBTQI populations in the context of harm reduction?	0	0	0	**0**
TOTAL (out of 9)	**2**	**5**	**2**	**9 (of 27)**

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

	Working Together for Change: A 10-year mental health and addiction action plan for Saskatchewan	Building Partnerships For Health: A strategic planning framework for injection drug use in Saskatoon	Saskatoon Health Region HIV Prevention, Treatment & Support Strategy	**Total (out of 3)**
[10] Does the document acknowledge the need for evidence-informed policies and/or programming?	1	1	1	**3**
[11] Does the document acknowledge the importance of preventing drug related harm, rather than just preventing drug use or blood borne or sexually transmitted infections?	0	1	0	**1**
[12] Does the document discuss low threshold approaches to service provision?	0	1	1	**2**
[13] Does the document specifically address overdose?	0	1	1	**2**

[14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach?	0	1	0	**1**
[15] Does the document consider harm reduction approaches for a variety of drugs and modes of use?	0	1	1	**1**
[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	0	1	0	**1**
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	0	1	0	**1**
TOTAL (out of 8)	**1**	**8**	**4**	**13 (of 72)**

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 current policy environment in Saskatchewan does very little to promote a harm reduction approach for illicit substance use across the province. No stand-alone harm reduction policies exist, and the approach is absent entirely from the sole provincial-level document that is still in operation. The commitment to harm reduction at the provincial level is essentially non-existent; however, it is relatively strong for the Saskatoon Health Region – the largest of 12 health regions in the province. Current documents that direct action for harm reduction are confined to two policies for the Saskatoon Health Region.

Disease transmission prevention is a key focus of the Saskatchewan policy set, with a particular focus on people who inject drugs. This is often presented as a solution to the HIV public health emergency plaguing the province. In policy, harm reduction is promoted via interventions as a means for individual-level risk reduction and prevention of communicable disease, often leaving out cornerstones of a broader, long-term "practice" of harm reduction at the societal level. Other than this shared framing of harm reduction, the documents are fragmented and do not reflect an overarching provincial understanding of harm reduction.

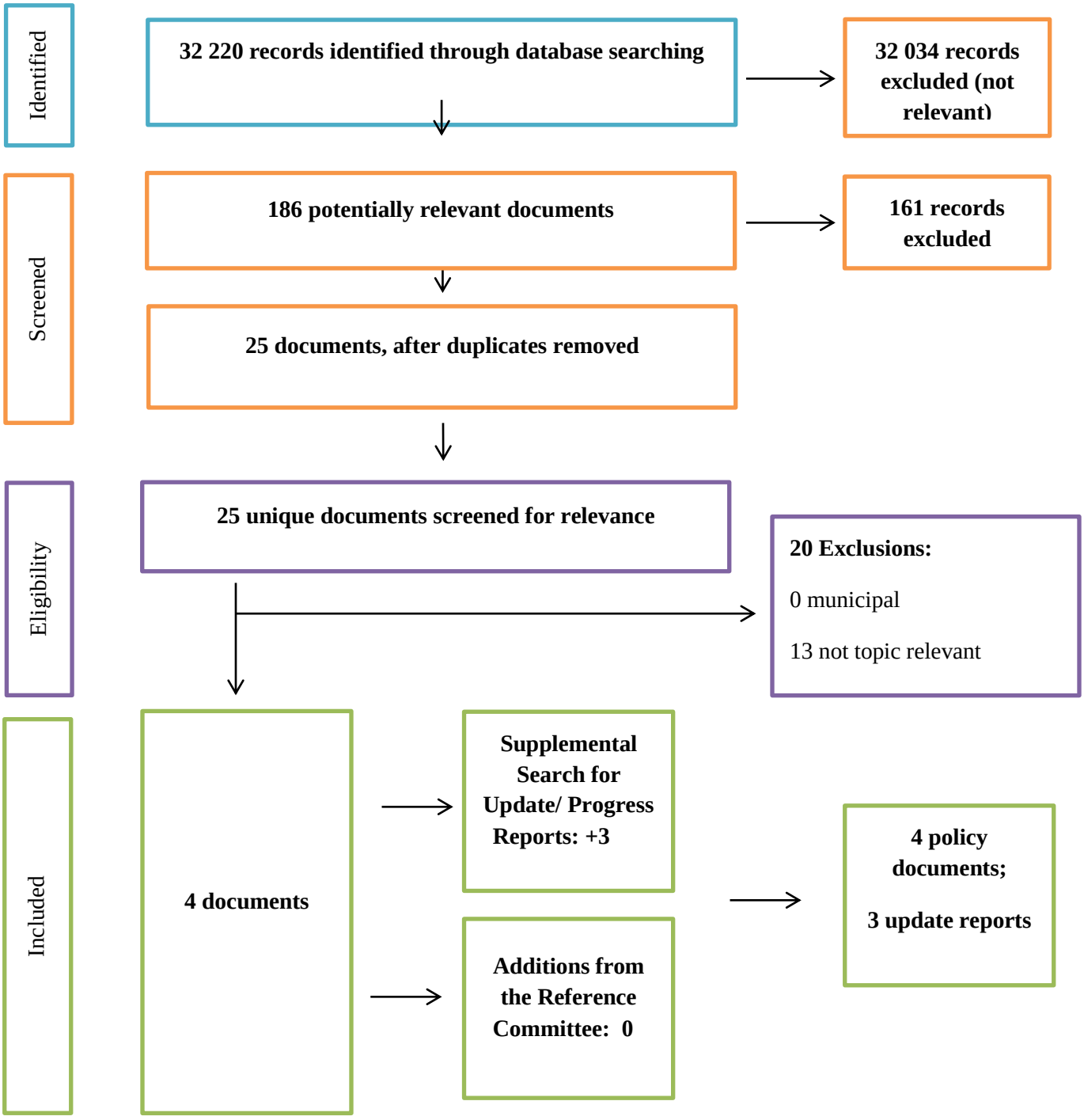
Despite the dearth of harm reduction policy in Saskatchewan, existing current documents reflect a general alignment with key principles of a harm reduction philosophy. This shows the potential for more directive harm reduction policy to fit within the existing policy context. The introduction of a stand-alone harm reduction policy would be an easy transition, as many fundamental principles of the approach are already supported across the region.

Appendix A: Regional Health Authorities

Regional Health Authority	Area (km2)	Population
Cypress Hill	44,000	43,000[9]
Five Hills	18,000[10]	54,000[11]
Heartland	41,770	44,567[12]
Keewatin Yatthé	unknown	12,312[13]
Kelsey Trail	44,369	42,650[14]
Mamawetan Churchill River	133,900	24,000[15]
Prairie North	30,000	96,000[16]
Prince Albert Parkland	29,000	82,578[17]
Regina Qu'Appelle	26,663	287,000[18]
Saskatoon Health Region	34,120	350,000[19]
Sun Country Health Region	33,239	56,529[20]
Sunrise Health Region	23,214[21]	58,909[22]

[9] Cypress Health Region, n.d
[10] Five Hills Health Region, n.d.A
[11] Five Hills Health Region, n.d.B
[12] Heartland Health Region, 2016
[13] Keewatin Yatthe Regional Health Authority, 2015
[14] Kelsey Trail Health Region, 2015
[15] Mamawetan Churchill River Health Region, 2015
[16] Prairie North Health Region, 2016
[17] Prince Albert Parkland Health Region, 2016
[18] Regina Qu'Appelle Health Region, 2015
[19] Saskatoon Health Region, 2016
[20] Sun Country Health Region, 2016
[21] L. Martinuk, personal communication, October 14, 2016
[22] Sunrise Health Region, 2016

Appendix B: Systematic search strategy flow diagram[23]



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

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

Overview

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

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

Inductive analysis

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

Next, each document's analytic notes and accompanying quantitative data (see next page) were synthesized and compiled into a narrative document description. Combining the quantitative and qualitative data at this stage was useful for two reasons; (1) quantitative data presented at the start of each document description provided a quick means to compare across documents in each case; and 2) presenting the quantitative data at the start of the synthesis facilitated review of the analytic notes to ensure that they contained adequate qualitative information to contextualize each quantitative data point. For example, if the quantitative data indicated that there is mention of funding mechanisms in the report, 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 complied into a standardized *policy report card* for each provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions. Formal policies that score highly on CHARPP indicators are high-quality because they conceptualize and describe a harm reduction approach in close accordance with its internationally-recognized attributes and principles. Conversely, poor-quality harm reduction policies score low on CHARPP indicators because they refer to the approach only sparingly, and/or do not elucidate its key attribute and principles.

Accompanying Quantitative Data

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

Appendix D: Descriptive summary of current policy documents

Working Together for Change: A 10-year mental health and addiction action plan for Saskatchewan

Working Together for Change, a 10 Year Mental Health and Addiction Plan for Saskatchewan, was published in 2014. It was produced by Dr. Fern Stockdale Winder on behalf of the Government of Saskatchewan, and based on extensive public consultation. The plan was developed to help refocus efforts on mental health and addictions, given the prevalence of mental health and addictions issues, global trends, and changing demographics in Saskatchewan. It provides a direction for the next 10 years (2014-2024) to better respond to the mental health and addictions needs of the citizens of Saskatchewan. Harm reduction for illicit substances is never mentioned in this report, and the only specific substance named is alcohol. More generally, the document demonstrates an alignment with few key harm reduction principles. It does not mention any interventions of interest.

Building Partnerships for Health: A strategic planning framework for injection drug use in Saskatoon

Building Partnerships for Health – A Strategic Planning Framework for Injection Drug Use in Saskatoon, is a publication of the Saskatoon Health Region Public Health Services. It is a regional health authority level policy document, published in 2007, and has no update reports or timeframe. *Building Partnerships for Health* outlines findings of the *Injection Drug Use Task Force* - a group called to action by the Medical Health Officer of the region, to plan for the needs of injection drug users. A harm reduction philosophy is embedded throughout the document and the concept is discussed extensively. The term itself is used 166 times, including mentions in all four core pillars, one of which is focused exclusively on harm reduction. Four interventions of interest are noted in the document; syringe distribution, supervised consumption services, safer inhalation kits ("pipe exchange") and outreach. Despite the comprehensive acknowledgement of harm reduction, that is not the stated focus of the document. The purpose is to address the many and complex challenges associated with injection drug use in the Saskatoon Health Region.

Saskatoon Health Region HIV Prevention, Treatment & Support Strategy

The *Saskatoon Health Region HIV Prevention, Treatment & Support Strategy*, published in 2010, was developed with the participation of various partners in the regional health sector and broader community. The development of the *Strategy* was initiated in response to the marked increase of new HIV cases in the Saskatoon region. The *Strategy* is targeted towards those most at risk and over-represented in current HIV numbers. It follows 11 guiding principles, reflecting a mix of community, expert and literature viewpoints. The first principle is: "Introducing and basing all programming around a Harm Reduction philosophy – meet the person where they

are at" (p.22). Throughout the document, the term harm reduction is used 87 times. The term "risk reduction" also appears 10 times and seems to be used interchangeably. Neither term is introduced or defined. Harm reduction is used in variable contexts, making it difficult to pin down a specific understanding within the document. Four interventions of interest are noted: syringe distribution, supervised consumption services, safer inhalation kits and outreach.

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