

# Yukon Policy Analysis Case Report

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*Canadian Harm Reduction Policy Project (CHARPP)*

*July 2017*

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

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### ***Related citations:***

*Wild, T. C., Pauly, B., Belle-Isle, L., Cavalieri, W., Elliott, R., Strike, C., ... & Hyshka, E. (2017). Canadian harm reduction policies: A comparative content analysis of provincial and territorial documents, 2000–2015. *International Journal of Drug Policy*, 45, 9-17.*

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## 1.0 Overview

This document provides a descriptive and analytical account of Yukon’s provincial harm reduction policy context. The study sought to identify provincial-level harm reduction documents produced between 2000 and 2015, however, no such documents were found for Yukon. 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. The 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 Yukon’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. As no relevant policy documents were found for Yukon, the absence of any formal policy directives is the key finding of this report.

## 1.1 Contextual Background<sup>1</sup>

Yukon is one of three northern territories in Canada, spanning 474,712 square kilometers. It has a population of around 33,897, with Whitehorse being its only major city (area of 8,488 km; population of 26,028) (Statistics Canada, 2012).

Yukon is the only territory in Canada that operates under a responsible government model rather than a consensus model. Between 2011 and 2016, Darrell Pasloski was premier of Yukon. In 2008, Premier Pasloski publicly stated he had no stance on various harm reduction interventions, such as safe-injection sites or needle-exchange programs, due to not having “enough information”. He would not say whether he personally supported harm reduction strategies or not, only that he supported the platform of the (conservative) party in this regard (Mostyn, 2008). More recently, Sandy Silver was elected Premier in November 2016, representing the Yukon Liberal Party. He has not publicly expressed an opinion on harm reduction or relevant interventions (Yukon Government, 2017). None of the current or previous Ministers of Health and Social Services have publicly spoken about harm reduction in the region, or endorsed any particular stance.

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

## 1.2 Healthcare Governance

The Department of Health and Social Services (DHSS) is responsible for all aspects of healthcare delivery as well as policy development and implementation (Institute of Public Administration of Canada, 2013). While the DHSS provides the overall strategic vision of healthcare in Yukon (Yukon Health and Social Services, 2015A), the corporate services division is primarily responsible for the development of health policies and programs for the territory (Yukon Health and Social Services, 2015B). The remaining three divisions are the main shepherds of health care in the Yukon. The Health Services division is responsible for a plethora of healthcare initiatives such as disease prevention and treatment services and programs (Yukon Health and Social Services, 2015C). The continuing care branch is focused on developing and delivering a full spectrum of health services for the senior and physically disabled population of Yukon (Yukon Health and Social Services, 2016A). Lastly, the social services wing of the department manages and administers programs focused on addressing issues that Yukoners may face such as addiction and mental health, as well as economic and social issues (Yukon Health and Social Services, 2015D).

Since 2013, the Yukon Hospital Corporation (YHC) has operated Yukon's three hospitals. The YHC also operates various programs oriented for indigenous populations in the territory. Eleven of the 14 indigenous communities are self-governing. These 11 groups govern their own lands and are responsible for healthcare delivery and health policy development and implementation. For much of Yukon's history, healthcare delivery and policy were the responsibility of the federal government. The transfer of power from the federal government to Yukon began in 1993 by transferring the responsibility of the Whitehorse General Hospital to the Yukon Hospital Corporation. The full transfer of power was complete in 1997 whereby the DHSS became responsible for Yukon's healthcare delivery in the territory (Institute of Public Administration of Canada, 2013).

## 1.3 Substance Use Trends

Substance use data is very limited in Yukon. According to the *2015 Yukon Health Status Report*, information and data regarding illicit drug abuse in Yukon is limited as the population "is not routinely surveyed on drug use" (Yukon Health and Social Services, 2015E, pg. 47). Latest information regarding illicit drug use is drawn from the *2008/2009 Regional Health Survey of First Nations* and the *2005 Yukon Addictions Survey* (Government of Yukon, 2005; Yukon Health and Social Services, 2015E). Latest trends of substance use among Yukoners showed that in 2005, 3% of Yukoners reported using cocaine, while 1% used either hallucinogenic drugs or ecstasy in the previous 12 months. These numbers are comparable to the Canadian population for that year. Despite having considerable access to illegal drugs, the use of illicit substances is

relatively low (Government of Yukon, 2005). However, a strategic sample of people in this survey at “high risk of experiencing harmful consequences of drug use” (p.3), reflected considerably higher rates. This survey recruited respondents from downtown Whitehorse, in and around social agencies, street corners and a skate park. Of this population, 40% reported using cocaine, 18% hallucinogenic drugs, 16% ecstasy and 7% methamphetamines in the previous year (Government of Yukon, 2005).

Data drawn from the *2008/2009 Regional Health Survey of First Nations* indicates that 7% of indigenous respondents reported lifetime use of LSD or heroin, while 10% reported using cocaine (as cited by Yukon Health and Social Services, 2015E). Information regarding harm from illicit drug use is also non-existent or difficult to come by. Personal communication between the authors of the *2015 Yukon Health Status Report* and the Yukon Royal Canadian Mounted Police (RCMP) revealed that cocaine and cannabis are the most widely used illicit substances in Yukon, while methamphetamine use among Yukoners is on the rise. The RCMP also indicated that use of opioids such as prescription medication and heroin is of rising concern in Yukon (Yukon Health and Social Services, 2015E).

Other sources of information regarding substance use trends come from the Whitehorse I-Track Report (Machalek et al., 2014). Authors of this report interviewed over 103 participants; 55 of whom were currently using injection drugs. Over half of respondents (55.6%) who were currently injecting indicated that they injected non-prescribed morphine in the six months prior to being interviewed. Non-prescribed morphine was the also the drug of choice among the 55 respondents. A total of 74.1% indicated that they injected cocaine six months before being interviewed. Other drugs injected by current users included: dilaudid (24.1%), heroin (24.1%), crack (29.6%), and OxyContin/ oxycodone (33.3%). Out of all the 103 participants, 93.2% reported using crack cocaine, 62.1% reported using cocaine, and 37.9% reported using codeine in the last six months (Machalek et al., 2014).

#### **1.4 Harm Reduction Services in Yukon**

As a territory, Yukon is supportive of harm reduction interventions tailored to illicit drug use (Canadian Harm Reduction Network & Canadian AIDS Society, 2008). The health promotion unit, under the direction of the health services division, is responsible for funding certain harm reduction services such as the Blood Ties Four Direction center (Yukon Health and Social Services, 2016B). Similar to the Northwest Territories, the DHSS provides a lump sum budget, in which a portion could be directed towards needle exchange programs (Klein, 2007). One of the departments’ strategic goals, outlined in the *Health and Social Services Strategic Plan (2014-2019)*, is promoting optimal physical and mental wellbeing. To accomplish this goal, the

department works with communities and other departments in an effort to reduce high-risk behaviors (Yukon Health and Social Services, 2015A). Despite the department providing funding to various centers that operate under a harm reduction philosophy, the department has not specified harm reduction as one of its goals in dealing with illicit drug use. Historically, harm reduction in Yukon has been a community initiative. According to Cavalieri and Riley (2012), Yukon's approach to harm reduction is one of broad community collaboration in which volunteers, agencies, and various community organizations and businesses come together to address poverty and drug use. A number of harm reduction programs and interventions in Yukon, namely the street outreach and safe crack kit programs, are evident of this practice and have been led by the *Substance Abuse Prevention Coalition*.

The *Substance Abuse Prevention Coalition* is comprised of various health care workers and communal agencies including the Kwanlin Dun Health Centre, Blood Ties Four Direction, Yukon College, and the Yukon Family services Association. This coalition formed various harm reduction services including the Street Outreach Van Program and the Safe Crack Kit Program (Canadian Harm Reduction Network & Canadian AIDS Society, 2008). The No Fixed Address Outreach Van Program has been in operation since 2000 and offers clean needle exchanges, food, and hygiene supplies to the homeless population of Whitehorse (CBC News, 2009). The safer crack kit program has been in operation since 2005 and provides free sterile crack kits to anyone that requires it. The crack program is operated through the street outreach van and blood ties program (Canadian Harm Reduction Network & Canadian AIDS Society, 2008). While the territorial government allows safer inhalation kit distribution, the program's funding is dependent on the local rotary Club (Cavalieri & Riley, 2012).

The Blood Ties Four Directions Centre is a harm reduction agency that offers education and support for agencies as well as communities, families, and individuals affected by hepatitis C and HIV/AIDs (Canadian Harm Reduction Network & Canadian AIDS Society, 2008). The center offers safe crack kits, free sterilized needles and exchanges, health education programs, outreach nursing and counselling services for individuals (Blood Ties Four Directions Centre, 2016). Additionally, there is an outreach clinic located in Whitehorse. The Downtown Outreach Clinic operates from the Salvation Army by providing immunizations, information on hepatitis C, health promotion, and harm reduction education among individuals who are living with hepatitis C and HIV/AIDs (Yukon Health and Social Services, 2012).

Methadone is currently available in one location. The methadone clinic is low barrier as patients who are intoxicated are allowed to be admitted (Yukon Health and Social Services, 2015F). Additionally, there is a pharmacy in Whitehorse that dispenses methadone, however, there is concern that there is no adequate counselling or adequate follow-up (Luce, 2011). In

order for physicians to administer methadone for opioid dependence, physicians must submit to the Yukon Medical Council a completed application form after successfully completing an approved course on methadone (Yukon Medical Clinic, 2010). There is unknown data regarding Buprenorphine. There are also neither supervised injection sites nor drug checking interventions in the territory.

In addition to the aforementioned organizations and services, other organizations are involved in harm reduction services in the Yukon. The Yukon Communicable Disease Control unit is focused on controlling and preventing infectious diseases though the Territory. The unit, which is operated by the Department of Health and Social Services, operates an outreach program where a registered nurse offers harm reduction counselling and Sexually Transmitted Infections Testing (Yukon Department of Justice, 2009). The Salvation Army in Whitehorse has also adopted a harm reduction model where it would allow intoxicated individuals to access their services (Morin, 2015).

As of late 2016, the Yukon government was piloting a Naloxone program, with kits available at two locations: the Blood Ties Four Direction Centre and the Taiga Medical Clinic in Whitehorse (Bird, 2016). The Yukon government stated their intention to have Naloxone available to people who use drugs across the territory within one year from December 2016 (Bird, 2016).

## 2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. Documents produced for Yukon during this period were meant to be (a) analyzed and synthesized inductively to describe historical<sup>2</sup> and current<sup>3</sup> policy developments guiding harm reduction services in the territory 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

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<sup>2</sup> A document was considered historical when (1) the years the policy applied to had passed, (2) the document was replaced by a newer document, or (3) the document was no longer available online.

<sup>3</sup> A document was considered current when (1) the policy was in effect in 2015 (2) the document was the most recent version retrieved for the case and had not been replaced by a newer document of the same focus, and/or (3) the document had no stated end date.



publicly-available policy documents produced from 2000 – 2015. We defined relevant documents as harm reduction policy texts that (1) were issued by and representing a provincial or territorial government or (2) issued by and representing a regional, provincial, or territorial delegated health authority; (3) that mandated future action; and (4) that addressed one of seven targeted harm reduction interventions<sup>4</sup> or (5) were produced as either a stand-alone harm reduction policy or as part of a strategy document guiding services for substance use, addiction, mental health, and/or prevention of blood-borne or sexually transmitted infections. We excluded documents that described services at the municipal level, in prisons, and on First Nation reserves (where health services are the responsibility of the federal government). Additionally, given our focus on provincial and territorial policy frameworks, and not harm reduction practice, we excluded government or health authority authored documents exclusively focused on best practice guidelines for frontline service providers.

No current or historical documents were identified in the search. Appendix A provides the Yukon -specific search strategy.

## 2.2 Inductive Analysis

As no relevant documents were found for Yukon, no further analysis took place for this case. Appendix B provides details of the planned analysis, had relevant documents been returned.

## 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 policy documents would have been content analyzed using this framework. Further details of the intended strategy are outlined in Appendix B.

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<sup>4</sup> The seven harm reduction interventions of interest to this research are 1) syringe distribution, 2) Naloxone, 3) supervised consumption, 4) low threshold opioid substitution, 5) outreach, 6) drug checking, 7) safer inhalation kits.

### **3.0 Documents Retrieved**

We were unable to retrieve any unique territorial-level policy documents in our search.

### **4.0 Results:**

Despite evidence that a modest array of harm reduction services are available in the Yukon, including distribution of safer crack kits, needle exchange, street outreach, and a Naloxone pilot program, there is no recognition of harm reduction or related topics in any formal, territorial-level policy. As we are interested in policy frameworks, and not harm reduction practice, we conclude that no formal policy commitment to harm reduction exists in Yukon.

Existing services have been developed ad hoc, rather than as part of any comprehensive policy frameworks. The provision of harm reduction has been community-driven to date, led by volunteers, agencies, community organizations and businesses working to provide much needed services for people who use drugs, without the formal support of the Yukon government.

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

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

NOT APPLICABLE

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

NOT APPLICABLE

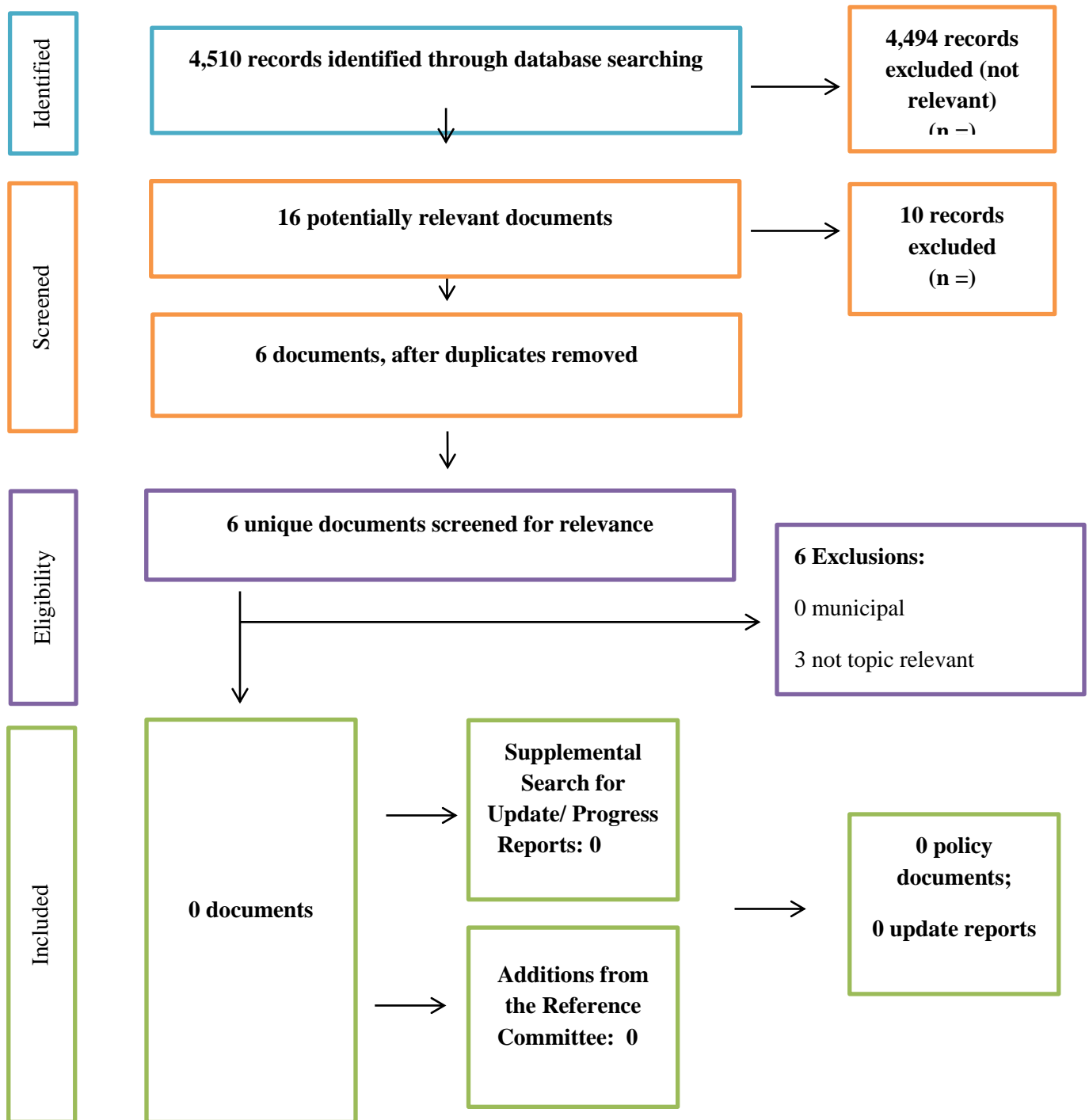
Table 3: Proportion of policy quality indicators endorsed for all documents within cases

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%)
<b>Yukon (0)</b>	<b>n/a</b>	<b>n/a</b>
North West Territories (2)	2/18 (11%)	1/16 (6%)
Nunavut (2)	3/18 (17%)	5/16 (31%)
<b>Canada (54)</b>	<b>109/486 (22%)</b>	<b>153/432 (35%)</b>

## 6.0 Conclusion

Yukon is the only provincial or territorial jurisdiction in Canada with no formal harm reduction policy, and therefore represents the poorest indicators on all fronts. We conclude that no formal policy commitments or support exist in this territory on behalf of the Yukon government. The provision of harm reduction services to date has been primarily community-driven, operating without the infrastructure or funding commitments of the Yukon government.

Appendix A: Systematic search strategy flow diagram<sup>5</sup>



<sup>5</sup> Adapted from PRISMA 2009 Flow Chart (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009).

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

### Overview

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

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

### Inductive analysis

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

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

Finally, the narrative document descriptions were synthesized and compiled. Descriptive comments summarized the overall scale and scope of the documents contained in

each case, and described the main features of the set of policy documents. Particular attention was paid to identifying points of convergence and divergence within and between policy documents.

### **Deductive analysis**

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

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

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

Each document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria not met) of each quality indicator. Dichotomous scores for each indicator were justified with an accompanying written rationale. Scores and rationales were then compiled into a standardized *policy report card* for each provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions. Formal policies that score highly on CHARPP indicators are high-quality because they conceptualize and describe a harm reduction approach in close accordance with its internationally-recognized attributes and principles. Conversely, poor-quality harm reduction policies score low on CHARPP indicators because they refer to the approach only sparingly, and/or do not elucidate its key attribute and principles.



### **Accompanying Quantitative Data**

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

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