

Causing More Harm Than Good?
Characterizing harm reduction policy beliefs in British Columbia

by

Mikaela Brooks
Bachelor of Business Administration (University of Winnipeg, 2011)

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Supervisory Committee

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Abstract

Despite harm reduction's social justice roots, the broader understanding of harm reduction is often influenced by morals and values which leaves harm reduction to be conceptualized within a morality policy domain. This study adopts the Qualitative-Narrative Policy Framework (Q-NPF) (Gray & Jones, 2016), to explore the policy beliefs and values that steer current harm reduction policy documents in British Columbia. Four questions guide this study: i) What are the underlying beliefs and values steering harm reduction policy in B.C.? ii) How are these beliefs and values narrated through policy?, iii) In what way do the underlying policy beliefs align with principles of social justice for harm reduction?, and iv) How have policy beliefs shifted since the 2016 public health emergency declaration? The social justice lens for harm reduction (Pauly, 2008) serves as this study's analytical framework and is supplemented by the Systems Health Equity Lens (Pauly, Shahram, van Roode, Strosher & MacDonald, 2018); both of which emphasize the need for harm reduction to acknowledge and address social and structural conditions that contribute to substance use harms and their inequitable distribution. As this study reveals, there is an ongoing tension between equity-related and non-equity policy beliefs and values characterized within policy documents, thus fueling a policy climate with incongruent and contradictory beliefs. Further, equity-related beliefs are positioned in the confines of equitable access, thus they are not equity-oriented in entirety. Additionally, there have been minimal shifts in policy beliefs since the post-2016 public health emergency declaration yet shifts occur in terms of the specific constructs which form equity-related and non-equity beliefs. Finally, the study outlines potential implications of these beliefs and proposes recommendations to improve harm reduction policy in terms of becoming equity-oriented. This study also outlines methodological contributions to the Q-NPF for future policy narrative and analysis studies.

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Dedication

In hopes that this work may in some way contribute to the equity of those who use substances, this thesis is dedicated to my sister, Tina. Your courage to confront adversity is a testament to your strength and perseverance. Thank you for teaching me the importance of practicing compassion, the role and value of harm reduction, and the importance of meeting people where they are at.

Chapter 1: Introduction

Substance use has been one of the most enduring societal problems of all times (Anderson, Swan & Lane, 2010). However, how the problematization of substance use is constructed differs and varies based on the current state of our social and political environment. While there is a web of personal, social, and circumstantial factors underpinning individuals' motivations and decisions to use substances, unsafe substance use poses considerable risk to individuals' physical and social wellbeing.

Over the last three years, more than 15,000 apparent opioid-related deaths occurred throughout Canada; British Columbia (B.C.) has borne the majority of these deaths (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020) and over the last decade, illicit drug toxicity has claimed over 7,500 lives throughout B.C. (British Columbia Coroners Service, 2020). In April 2016, the Provincial Health Officer declared a public health emergency in response to the surging rates of opioid-related overdoses and deaths (Government of B.C., 2016, para 1).

Most recently, the coronavirus (COVID-19) pandemic precipitated enduring impacts to the safety and wellbeing of persons who use drugs (PWUD). In May 2020, there were 170 suspected illicit drug toxicity deaths, representing the highest number of related deaths ever recorded in a month in B.C., and a 93% increase compared to the number of deaths recorded in May 2019 (British Columbia Coroners Service, 2020). A contributing factor to the significant increase in deaths stems from an unsafe supply of drugs, in which post-mortem toxicology results concluded a greater number of cases with extreme fentanyl concentrations compared to previous months. Interestingly, no deaths were reported at supervised consumption or drug overdose prevention sites during COVID-19, at the time of writing (British Columbia Coroners Service, 2020).

As distressing as the statistics seem, they illustrate a broader issue: how to preserve the dignity and protect the health of PWUD while reducing harm. In the context of substance use, harm reduction refers to policies, programs, and practices that aim to minimize negative health, social, and legal impacts associated with substance use, drug policies and drug laws. It is grounded in justice and human rights and is focused on positive change and working with PWUD without judgement, coercion, discrimination, or requiring abstinence of drug use as precondition of support (Harm Reduction International, 2019). Harm reduction can include services that aim to reduce risks towards physical health harms stemming from substance use, such as the spread of blood-borne infections and diseases, overdoses and deaths, along with social harms such as racism, sexism, poverty, stigma and discrimination (MacNeil & Pauly, 2010; Parker et al., 2012; Small, 2012). Harm reduction also encompasses a health promotion component in which there is a concerted effort to provide education and awareness of health risks and increasing access and connection to health care and social services and supports (Bierness, Jesseman, Notarandrea & Perron, 2008).

Harm Reduction International has made significant strides through years of extensive research on substance use, public health, and human rights to present the following four evidence-based principles of harm reduction:

1. **Respecting the rights of those who use drugs:** grounded in protecting human rights and to improve public health; treating people who use drugs with compassion and dignity; the use of drugs does not equate to people forfeiting their entitlement to highest standard of health, social services, privacy and freedom.
2. **A commitment to evidence:** policies and practices are informed by a strong body of evidence that proves the value of harm reduction, namely for practicality, feasibility, safety and effectiveness.
3. **A commitment to social justice and collaborating with network of people who use drugs:** harm reduction is committed to addressing discrimination and ensuring there is no exclusion from health and social services, especially on the

basis of drug use, race, gender, gender identity, sexual orientation, choice of work, and economic status. Access to such services must be without unnecessary barriers, including burdensome and discriminatory regulation. There must be meaningful involvement of those who use drugs in designing, implementing and evaluating programs and policies.

4. **The avoidance of stigma:** practitioners must accept people who use drugs as they are and are committed to meeting them “where they are” in their lives without judgement. Terminology and language must always convey respect and avoid stigmatizing language that perpetuates harmful stereotypes.

(Harm Reduction International, 2019)

One concept integral to the harm reduction philosophy and practices is health equity. For the context of this study, health equity refers to addressing unfair and unjust conditions so that everyone can attain the highest level of health possible (Pauly, Shahram, van Roode, Strosher & MacDonald, 2018). Health equity is an integral component to understanding harm reduction given the extensive evidence that illustrates substance use harms are not distributed equitably as the risk and occurrence of substance use harms influenced greatly by one’s social position inclusive of race, class, gender, age, and sexual orientation (Pauly, MacDonald, Hancock, Martin, & Perkin, 2013; Fischer et al., 2005; Rhodes, 2002; Rhodes, 2009; Smye, Browne, Varcoe & Josewski, 2011; Seddon, 2006; Galea, & Vlahov, 2002). As noted above, the very core principles of harm reduction are grounded in social justice in which harm reduction seeks to not only address and reduce physical harms related to substance use, but also seeks to address underlying social and systemic factors that influence and perpetuate harm and further compound social inequities.

Health equity is also a component of the public health policy direction in B.C. In 2005, the core public health functions framework specifically highlighted that a health equity lens should be applied to all public policies and programs (BC Ministry of Health Services, 2005),

which includes harm reduction. This was also reinforced in 2013 through B.C.'s *Guiding Framework for Public Health* (BC Ministry of Health, 2017).

Despite the well delineated principles and values of harm reduction, and a government commitment to apply a health equity lens to public health policies and programs, the broader understanding of harm reduction is often rooted in morals and values that arise from judgement, criminalization and stigma of substance use. This has propelled harm reduction to be discussed and debated within the morality policy domain. Morality policy refers to policies that are shaped and conceptualized by personal values and beliefs towards a public issue as opposed to objective evidence and facts (Bowen, 2012). Further, morality policies are those that address topics that are generally assumed to refer to decisions and conflicts about societal values (Heichel, Knill & Schmitt, 2013, p. 319). Recent Canadian research has noted a presence of beliefs and values entrenched in harm reduction policy frameworks in which the understanding of harm reduction is based on values and normative beliefs about substance use (Hyshka et al., 2017). Despite this acknowledgement, and as this thesis will demonstrate, very little research has explicitly identified the policy beliefs that shape harm reduction policy at the provincial and health authority level. B.C. is known as a jurisdiction that has championed innovative harm reduction responses, has one of the most robust harm reduction policy framework in Canada, and is the birthplace of North America's first safe injection site (Hyshka et al., 2017; Wood, Tyndall, Montaner & Kerr, 2006). As such, there is an opportunity to enhance our understanding of harm reduction policy by seeking to identify the policy beliefs and values that implicitly shape the conceptual understanding of harm reduction and substance use within a policy context, and seek to understand the degree to which these beliefs and values respect the social justice roots and principles of harm reduction.

1.1 Situating the Research

To situate the research accordingly, a brief discussion of the history of harm reduction policy in B.C. is required, in addition to an overview of the intersection of social inequities and substance use, and policy narratives surrounding harm reduction in B.C.

A Brief History of Harm Reduction Policy in B.C.

While the federal Government of Canada has authority in setting a national health care agenda and for services governed under the *Canada Health Act*, addiction and mental health care predominantly falls under the auspices of the provinces and territories in which they are required to determine how best to utilize existing provincial health care budgets and federal funding for services related to substance use. As such, the B.C. Ministry of Health is responsible for setting the agenda for health care policy, guidelines, and legislation for the province, governing the overall framework and tone for harm reduction. The provision of harm reduction services is then guided and delivered by six regional health authorities within B.C. These include: Fraser Health Authority, Interior Health Authority, Northern Health Authority, Vancouver Coastal Health Authority, Vancouver Island Health Authority, and First Nations Health Authority. The First Nations Health Authority works specifically to address health disparities confronting B.C.'s First Nations and Aboriginal peoples (First Nations Health Authority, 2016). Additionally, the seventh health authority is the Provincial Health Services Authority which is responsible for coordinating the delivery of provincial programs. Each of these public institutions have a role in shaping and communicating the broader policy direction for harm reduction in B.C.

In terms of B.C.'s harm reduction history, the earliest harm reduction service was provided in 1959 in which methadone treatment was first dispensed in Vancouver by the Narcotic Foundation of B.C., followed by the first needle exchange service in Victoria, BC in

1988 (Toward the Heart, 2018; MacNeil & Pauly, 2010). Soon thereafter, Vancouver's Downtown East Side opened its first needle exchange in 1989 (Toward the Heart, 2018). Similar to the rest of Canada, early harm reduction approaches were predominantly peer-driven and included informal syringe distribution programs situated in major cities, as seen in Vancouver and Victoria (Hyshka et al., 2017). In the late 1990's, drug-related harms began to peak in Vancouver, as apparent in increasing HIV infection rates and fatal overdoses amongst those who inject drugs, leading to a public health emergency declaration in 1997 (Kerr, Mitra, Kennedy & McNeil, 2017). In response to the increasing rates of infectious disease and overdoses amongst PWUD, Canada's first medically supervised safe injection site, Insite, was granted legal exemption to operate on the condition that its impacts would be evaluated (Hathaway & Tousaw, 2008; Kerr et al., 2017; Wood et al., 2006).

Following the pilot of Insite, the Government of B.C. implemented its first harm reduction policy response that same year, *Priorities for Action*, to guide and support community and health authority efforts to manage the HIV/AIDS epidemic (Ministry of Health, 2003). Soon thereafter, the Ministry of Health implemented its first community harm reduction guide in 2005 (Ministry of Health, 2005). During the mid-2000's, the federal government recognized the value of harm reduction as a key pillar of drug policy and continued its support (Hyshka et al, 2017). While B.C. was progressive in terms of championing ground-breaking harm reduction initiatives, these investments were not devoid of political debate and public controversy. After the federal Conservatives (under the leadership of Stephen Harper) were elected in 2006, harm reduction became an area of political struggle between the federal government and provincial jurisdictions. In 2008, the former Progressive Conservative federal health minister, Tony Clement, refused to grant Insite an exemption to continue its operations while openly questioning the validity of

scientific and social research evidence that supported Insite's operations, even once referring to Insite as an abomination at a public conference (Hyshka, Bubela & Wild, 2013; Hyshka et al, 2017).

Despite the stall in federal permission to operate, it took a cadre of Insite's operators and clients to advocate for and pursue legal action, an effort that led to the 2011 Supreme Court of Canada ruling which obligated the provincial health minister to grant exemption for Insite to continue to operate (*PHS Community Services Society v. Attorney General of Canada, 2008*; *Attorney General of Canada v. PHS Community Services Society, 2011*). The basis of this legal ruling was in reference to a clients' right to life, liberty and "security of the person" and the interests of fundamental justice. Further, the Supreme Court ruling directed the minister to diligently balance the interests of public health with the interests of public safety when weighing future exemptions (*Attorney General of Canada v. PHS Community Services Society, 2011*). Despite this ruling, the politicization of harm reduction carried on, as prominently seen in the federal government's immediate response to the Supreme Court ruling which entailed implementing a restrictive legislative framework that created an onerous process for obtaining an exemption for supervised injection facilities to operate without fear of prosecution (Vallee, 2016).

Since its inception in 2003, there have been more than 3.6 million visits to Insite to inject drugs under supervision, over 48,000 clinical treatment visits, and over 6,000 overdose interventions without any deaths (Vancouver Coastal Health Authority, 2018). Additionally, Insite has led to a reduction in public injections and a reduction in publicly discarded syringes and injection-related litter (e.g. syringe wrappers, syringe caps, sterile water containers and "cookers") (Wood et al., 2004).

Political ideology aside, harm reduction services, such as Insite, yield positive health and social outcomes for PWUD. This includes reduced rates of public injections; increased referrals to support programs, health and social services; reduction in stigma; increased access to health services; reduced sharing of substance use equipment; reduced rates of Hepatitis C and HIV; reduced overdose deaths; and increased knowledge surrounding safe substance use (HealthLink B.C., 2020). Harm reduction's value on mitigating substance use harms has also been a longstanding area of interest within academia. For example, evaluative research substantiated harm reduction as an effective public health model in North America, as it increases connection to treatment and health care services, reduces public drug use and syringe debris in neighbourhoods, and does not lead to drug-related crime (Kennedy-Hendricks, Bluestein, Kral, Barry & Sherman, 2019; Marshall, Milloy, Wood, Montaner & Kerr, 2011; Kerr, Tyndall, Lai, Montaner & Wood, 2006). In addition, a systematic review, predominantly comprised of studies from B.C. confirmed that safe injection sites have a positive association with participation in addiction treatment programs, healthier drug-use behaviours such as using clean syringes, and an increased likelihood of seeking medical treatment for concurrent health issues. Most importantly, the review noted that over the last three decades, not a single overdose was reported in the 47 studies (Kennedy, Karamouzian & Kerr, 2017). Further, an additional study found harm reduction organizations act as a safe, supportive space where individuals can seek information and referrals to other health care services without feeling stigmatized or judged (Parker et al., 2012).

One B.C. study not only underscored the importance of harm reduction to reduce physical harms, but also highlighted the importance of harm reduction being inclusive of mediating social inequities. Wallace, Kennedy, Kerr & Pauly (2019) examined factors associated with non-fatal overdoses during B.C.'s unprecedented rates of illicit drug overdoses and increasing prevalence of fentanyl in overdose deaths. Wallace et al. (2019) found public injection and fentanyl injection were directly related to an increased risk of a non-fatal overdose in which the scholars highlighted the need and importance of harm reduction supports and services inclusive of drug checking, safe injection sites and interventions, and a safe supply of opioids. Equally important, Wallace et al.'s study also underscored the importance of equity in which they acknowledge their data sample featured a high representation of people who are homeless and who frequently inject in public (p.43). In the context of substance use, Wallace et al. (2019) referred to this underlying inequity as a double vulnerability, in which they advocated for harm reduction strategies to extend to and encompass housing and responses to homelessness.

Similarly, Irvine et al. (2019) completed a statistical modeling framework to determine the impact of overdose interventions in B.C. from 2016 to 2017, including take-home naloxone kits, overdose prevention/safe consumption sites and opioid agonist therapy on the number of opioid-related deaths. In total, over 3,000 death events were averted as a result of the three interventions combined; during the same period, over 2,000 overdose deaths were observed. While the study found the absolute number of overdose deaths to remain unchanged since 2016, this was not by fault of harm reduction interventions as the number of deaths averted increased. Rather, Irvine et al. (2019) suggested the steady number of deaths caused by opioid/fentanyl points towards point towards a broader issue, which is the need to implement interventions that address an unsafe supply of illicit drugs in conjunction with overdose interventions (p.1610).

Since 2003 and the establishment of Insite, B.C. has worked to scale up harm reduction services as a key strategy in response to substance use harms. This includes a take-home naloxone program in 2012, in which naloxone is distributed to individuals at risk of experiencing an opioid overdose (BCCDC, 2019); followed by Vancouver becoming the first city to implement a vending machine for clean crack pipes (Lawrence, 2014). In 2016, B.C. also became the first province to implement overdose prevention sites (OPS), an unprecedented policy response which allows an expedited service delivery model that permits community-led sites where individuals can use drugs safely (Wallace, Pagan & Pauly, 2019). During the first year of implementation alone, there were over 550,000 visits amongst 20 sites in which no overdoses were reported (Wallace, Pagan & Pauly, 2019).

A subsequent study evaluating the impact of OPSs featured interviews with OPS workers and service users (Pauly, Wallace, Pagan, Phillips, Wilson, Hobbs & Connolly, 2020). Notably from the perspective of PWUDs, OPSs provide a secure, sanctioned space to use safely and under supervision if need be. Further, OPSs provide reassurance to people who use these services that they have a low risk of experiencing overdoses as there are individuals on site who are available to monitor and overt overdoses. Equally important, the study found OPSs helped reduce the stigma and discrimination attached to substance use as service users no longer had to conceal their drug use or fear being caught with substances. This ultimately reduced their risk of being arrested from police for using drugs publicly, and some service users noted the positive social connections they were able to build and maintain with OPS workers. Overall, Pauly et al. (2020) noted the implementation of OPSs made notable shifts in the contexts of harm reduction, including shifting harm reduction services from a crisis response to preventing overdoses and reduced trauma, shifting from safer supplies to safer spaces to use substance, and mitigating the

stigma and shame PWUD face while increasing opportunities for positive, trusting relationships (p. 13).

In more recent events, the need for accessible harm reduction responses continues to be a prominent topic in the public health discourse during the COVID-19 pandemic. While substance use harms and the need for equity-oriented harm reduction was a priority before COVID-19 however, COVID-19 increased the visibility and further compounded substance use harms. During the height of COVID-19, there were more deaths in B.C. related to toxic illicit drug use than deaths stemming from the virus itself (Schmunk, 2020). In addition, public health measures and protocols enforced to reduce the risk of spreading COVID-19, such as self-isolation and physical distancing requirements, inadvertently placed PWUD at a higher risk for substance use harms. For example, anecdotal information released to news media noted how physical distancing requirements make it more difficult for people to connect with friends and family which potentially isolates substance use (Schmunk, 2020). Furthermore, social distancing requirements and a shortage of supplies left harm reduction services such as safe consumption and overdose prevention sites at a disadvantage as they were forced to either reduce capacity, reduce hours of services (Cheung, 2020), or in some cases services were closed or relocated (Fraser, 2020). Despite these risks, there were local efforts made by existing harm reduction service providers to reduce substance use harms, such as some safe consumption sites transferring to a mobile delivery model (“Victoria Supervised Consumption Site to Go Mobile, 2020). Further, the Ministry of Mental Health and Addictions implemented new guidance in March 2020 to support the provision of safe prescription alternatives to the illegal drug supply as part of B.C.’s COVID-19 pandemic response strategy (Ministry of Mental Health and Addictions, 2020; BCCSU, 2020). This was also supported by a short-term federal exemption to

the *Controlled Drugs and Substances Act* to allow physicians and pharmacists to prescribe, sell or provide controlled substances to help maintain access to substances for medical treatment, such as treatment of substance use disorders and chronic pain (Health Canada, 2020).

While changes to service delivery models and legislative amendments were valuable in terms of reducing the risk of drug toxicity and unsafe substance use practices, I believe it is arguably accurate to suggest these underlying measures did little to also ensure the safety of the social conditions in which substance use takes place, such as housing to self-isolate, income stability to address socioeconomic barriers, and food security to maintain nutritional health. Additionally, while the federal exemption legally permitted the sale and prescription of controlled substances, it did little to address the social and structural conditions that impact accessibility to a physician or pharmacist (a requirement to receive a safe supply of drugs). Responses such as these demonstrate that while many harm reduction services and supports are grounded in good intentions to reduce harm, they are ill-equipped to do so if they do not also take into account the social and structural conditions in which substance use occurs, and recent changes in services as outlined above reflect this.

Beyond Physical Harm

The harm reduction health care model attempts to reduce negative health impacts associated with drugs without necessarily eliminating the use of drugs (Small, 2012), recognizing that the reasons behind drug use are multi-faceted. Similar to the findings in Wallace et al. (2019), research has and continues to show substance use harms stem beyond the actual substance itself, as PWUD tend to face multiple social and systemic inequities, such as criminalization, poverty, homelessness, physical and mental comorbidities, and social exclusion and marginalization, all of which further influence and perpetuate the risk of substance use harm

(Pauly, MacDonald, Hancock, Martin, & Perkin, 2013; Fischer et al., 2005; Rhodes, 2002; Smye et al., 2011; Seddon, 2006; Galea, & Vlahov, 2002). However, harm reduction interventions alone are insufficient to address the social conditions that produce inequities and further compound the risk of harm (Pauly, 2008).

Wallace, Barber & Pauly (2018) explored the implementation of harm reduction homeless shelters during B.C.'s emerging overdose emergency in which they interviewed shelter residents, shelter staff and harm reduction workers on the challenges of implementing harm reduction supports and services. Specifically, the study noted the micro-environmental level factors within emergency shelters and macro-level influences that produce and sustain structural vulnerabilities (p.84-85); both of which should be viewed as harms and factors that exacerbate the risk of substance use harms. Wallace, Barber & Pauly (2018) identified four key themes related to micro-environmental factors that directly impact the risk of harm for PWUD. This included: 1) providing harm reduction supports, such as clean supplies, during a climate of prohibition; 2) providing harm reduction in the confines of clean supplies but not practising the philosophy of harm reduction in its entirety; 3) lack of safe space to use drugs; and, 4) the increased responsibility to act as a first line of defense for overdoses and potential deaths (pp. 85-87). Micro-environmental factors such as these directly impacted and influenced the safety and wellbeing of PWUD. For instance, Wallace, Barber and Pauly (2018) noted how organizational policies that prohibit individuals from consuming drugs within the emergency housing shelter environment further criminalized substance use and directly conflicted with public health policies, such as harm reduction (p.86). An unintended consequence of this policy left shelter residents discouraged, apprehensive or unable to access the clean drug supplies they needed from shelter staff for fear of being asked to leave the shelter. Additionally, the study

confirmed that people who experience socioeconomic disadvantages, such as poverty and homelessness, and use drugs bear a disproportionate burden of risk of harm by result of the social and economic conditions in which they live (p. 84).

Vallance et al. (2018) completed a similar study to Wallace, Barber and Pauly (2018) in which they assessed the influence of and difference in individual and structural factors associated with risks and harms amongst individuals who inject drugs in street-based settings in Victoria and Vancouver, B.C. Street-based or public injection referred to locations such as public washrooms, streets, parks, alleyways, malls, restaurants, cafes, coffee shops, night clubs, bars, pubs and abandoned and vacant buildings; all of which are deemed unsafe based on longstanding evidence from the literature (p. 40). Factors assessed in the study included substance use patterns (e.g. injection frequency, needle sharing), health outcomes (i.e. overdose rate) and sociodemographic status (p. 40). Vallance et al. (2018) found that unstable housing, needle-sharing, sexual minority status (gay or bisexual) were significantly associated with risks of public injection and risks were further increased for those residing in Victoria; a city without a safe injection site like Vancouver. As such, Vallance et al. (2018) found that accessible community based services, such as safe injection sites, can help reduce harms for people who inject drugs, and the risk environment for substance use stems beyond the physical harms; rather reducing harm requires attention towards the micro and macro-level social factors such as housing and access to culturally safe services for minority demographics.

Finally, a community-based participatory research study conducted by Boucher et al. (2017) interviewed PWUD in Ottawa, ON to capture their perspective on harm reduction, most notably the ways in which PWUD conceptualize harm reduction strategies, and improvements needed for services and supports to enhance equity in health and social services. It was found

that PWUD use harm reduction for multidimensional reasons apart from safe use. This includes obtaining moral support, acquiring positive social interactions, connecting with a community and accessing social and health services (p. 6). Additionally, harm reduction is used by some as a means to manage substance use and reduce the impact substance use has on their personal life, such as learning cognitive and behavioural strategies for interpersonal conflict.

As these studies clearly articulate, the risk of substance use harms varies amongst the social gradient, and risks are not exclusive to physical harms (e.g. overdoses, deaths); rather there are underlying social and systemic conditions and inequities that further magnify harms for PWUD. Thus, it is crucial for harm reduction to stem beyond addressing drug-related risks; it needs to address risks apparent in social and political environments.

A notable risk environment factor that influences substance use harms is the moral beliefs we, as a society, attach to substance use. These morals and beliefs are also felt at a health systems level, especially in societies where PWUD are often viewed as failing to take individual responsibility for changing harmful and addictive patterns of illicit substance use, leading to little consideration or attention to the social conditions that shape drug use and individual behaviors (Pauly, McCall, Browne, Parker & Mollison, 2015 p.132). For instance, nurses and physicians with socially conservative values and beliefs tend to have more negative attitudes towards PWUD but only to the extent that they view substance use as under the individuals' control (Brener, Hippl, Kippax & Preacher, 2010). As noted by Brener et al. (2010), the degree that people perceive drug use as controllable, they are also likely to believe that drug users have caused their own health problems. Thus, beliefs of controllability and personal responsibility are likely to be associated with beliefs that the health care problems for persons who inject drugs are caused directly by their injecting drug use. (p.1009).

Such moral values and attitudes towards substance use and PWUD further perpetuates stigma and there is no shortage of research that has documented the negative and adverse social and health outcomes correlated with stigma towards PWUD, including mental illness, social alienation, unsafe substance use practices, refusing to access care and treatment for fear of discrimination and mistreatment (Link, Struening, Rahav, Phelan & Nuttbrock, 1997; Young, Stuber, Ahern & Galea, 2005; Livingston, Milne, Fang & Amari, 2012; Chan Carusone et al., 2019). As this thesis will discuss in more detail in Chapter 2, an equity-oriented lens is useful in understanding and evaluation harm reduction policy as it acknowledges that substance use harms are not exclusively physical; rather harms are often the product of longstanding social and systemic inequities that are perpetuated and reproduced in policy. These intersecting social and systemic inequities directly contribute to the distribution of harm amongst PWUD.

Policy Narratives and Harm Reduction in B.C.

Drug policy such as harm reduction is usually based on a process of problematization whereby a specific issue is identified as a problem and solutions are based on how that problem is framed (Boyd, Carter & MacPherson, 2016, p. 3). Analyzing the underlying sociopolitical factors that frame harm reduction policy serves as the foundation for the Canadian Harm Reduction Policy Project (CHARPP), a mixed-methods, multiple case study research project that aims to describe how harm reduction policies are positioned within and across Canada and to improve the understanding of variations in harm reduction policy (Wild et al., 2017; Hyshka et al., 2017).

The first policy analysis study was completed by Wild et al. (2017) in which the scholars conducted a content analysis of harm reduction policy documents to assess policy governance. The authors analyzed policy texts for managerial roles and function, the type of interventions

endorsed within harm reduction policy, client characteristics and environmental variables, such as funding and level of government authority oversight. What they found is that a scant 12% of provincial harm reduction policies are explicitly designed to guide harm reduction resources as its primary purpose. Further, the study confirmed a wide variation in harm reduction policies exists, with some provinces having few or no policies at all (Wild et al., 2017). Accompanying provincial-level analyses stemming from this study illustrated the nuances of B.C.s harm reduction policy landscape in which it was revealed that sanctioned harm reduction interventions primarily focus on health harms and do very little to address social and economic harms despite acknowledging the impact of social and economic factors related to substance use (Anderson-Baron, Karekezi , Koziel & McCurdy, 2017).

From the purview of policy content, Hyshka et al. (2017) analyzed the quality of harm reduction policy throughout Canada by means of its communicative function in which the group of scholars coded and analyzed policy documents for quality indicators as per the CHARPP Framework¹. Most notably, Hyshka et al. (2017) found that policy preaches harm reduction in name but contains very little characteristics and principles related to harm reduction. Further, there is a host of beliefs and values that shape the understanding of harm reduction policy as it tends to operate as morality policy where one's understanding of harm reduction is based on their values and normative beliefs about substance use (p.9). As discussed in more detail in Chapter 2, there are multiple studies that substantiate that the ways in which harm reduction and substance use is framed in policy is reflective of beliefs and values surrounding substance use, harm reduction and equity.

¹ The CHARPP Framework outlines 17 indicators grouped according to whether policies adequately specify population characteristic and program features (<https://crismprairies.ca/wp-content/uploads/2018/06/CHARPP-Framework-description.pdf>).

Critically analyzing the ways in which policy actors understand and think about a policy issue serves as a core part of the public policy analysis and evaluation process (Lancaster & Ritter, 2014). Over a decade ago, research called for further exploration towards the underlying values and ethical framework guiding harm reduction policies and practices (Pauly, 2008), specifically noting the “the presence of neo-liberal values that stigmatize and further marginalize those who use drugs” (p. 8). It is my view that beliefs and values situated and narrated in policy texts can shape and influence the broader understanding of harm reduction for substance use within the health policy and health care community. As such, there is a need to explore and identify what these policy beliefs are and if they respect the rights of PWUD and aim to improve equity.

1.2 Research Purpose and Questions

To explore policy beliefs and values surrounding harm reduction, this study conducted a qualitative narrative policy analysis by analyzing the content of harm reduction policy documents currently in effect in B.C. To be ‘current’, policy documents had to have an effective or enforcement date inclusive of December 31, 2019 or later, or have no effective/enforcement listed at all. The motivation for this study and rationale for the choice of location stems from the current climate in which B.C. continues to experience the highest rates of drug-related overdoses and deaths in Canada (Canadian Institute for Health Information, 2018; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020).

While related, this study deviates from CHARPP’s recent studies (Wild et al., 2017; Hyshka et al., 2017) as the objective of this thesis is to explore what policy beliefs shape government’s understanding of substance use harms and harm reduction, and the matter in which these beliefs are receptive to and align with harm reduction’s social justice roots. As Chapter 2

will discuss more detail, apart from CHARPP, the extant literature surrounding harm reduction policy analyses have yet to explore and identify values and beliefs that shape the understanding of substance use harms and harm reduction within the drug policy realm. This study seeks to address this gap through the following four questions:

1. What are the underlying beliefs and values steering harm reduction policy in B.C.?
2. How are these beliefs and values narrated through policy?
3. In what way do the underlying policy beliefs align with principles of social justice for harm reduction?
4. How have policy beliefs shifted since the 2016 public health emergency declaration?

1.3 Research Design

The Qualitative-Narrative Policy Framework (Q-NPF) (Gray & Jones, 2016) grounded the design framework of this study. The Q-NPF is a recent extension of the traditional Narrative Policy Framework (Gray & Jones, 2016). The NPF is a theory of political process that offers a systematic approach to analyze and understand how policy narratives are structured and influence the overall policy process (McBeth, Jones & Shanahan, 2014). The NPF asserts policy actors reduce policy problems into stories, referred to as policy narratives, to shape and influence the broader understanding of a complex policy issue consistent with their own view. Essentially, policy narratives as socially constructed stories, metaphors and arguments used to support policy stakeholders' specific lines of argumentation for a specific purpose (Miedziński, 2018).

The NPF is premised on the understanding that all policy narratives possess both structural and content elements that can be generalized across space and time to different contexts (McBeth et al., 2014, p.228). In terms of narrative content, the NPF assumes beliefs and values toward a policy issue are not generated spontaneously; rather policy actors are stable in their orientation

towards certain values (i.e. equality, liberty, human rights). As such, researchers ought to think about and identify the operating beliefs influencing policy debates and link these beliefs to their theoretical equivalents (McBeth et al., 2014; Shanahan, Jones &McBeth, 2018). The NPF measures policy beliefs using policy narrative characters inclusive of villain, victim and hero (Jones, McBeth & Shanahan, 2014). In the purview of this study, the ways in which policy documents narrate and characterize substance use harms and harm reduction will help reveal the values that underpin harm reduction policy. However, this thesis demonstrates a notable contribution to the NPF literature by including the moral of the story construct as a means to measure policy beliefs. Chapter 3, 4 and 5 discusses the implications of this methodological choice in more detail.

1.4 Analytical Framework

Pauly's (2008a) social justice lens for harm reduction was used as the core analytical framework and was supplemented by the Systems for Health Equity Lens (SHEL) framework (Pauly et al, 2018). Both resources were used to analyze and ground the findings related to policy beliefs in theory. Pauly's social justice lens for harm reduction (2008a) is a framework that acknowledges the multiple harms associated with substance use, including social and structural inequities that further perpetuate and magnify substance use harms. This includes inequities in access to health services, inequities in health status, and social inequities stemming from stigma and discrimination (p. 5). As such, a social justice lens acknowledges and seeks to address these social and structural inequities that perpetuate and magnify substance use harms.

Pauly (2008a) reviews different notions of justice as a potential lens through which to view inequities associated with substance use (p. 7). The most common conception of justice often used in health care has been various forms of distributive justice including utilitarian, egalitarian,

communitarian and libertarian beliefs towards harm reduction. Utilitarian beliefs would suggest approaches that are best for the overall population, rather than subgroups of a population or social conditions. As referenced in Pauly (2008a), utilitarian approaches often promote abstinence-based values (p.7). Egalitarian beliefs are premised on the need to ensure PWUD have the same access to opportunities as everyone else to access to health care resources, negating the social and political factors influencing harm and access; and libertarian beliefs focus towards concerns related to protecting the rights of individuals so long as they do not interfere with the rights of others (Pauly, 2008a, p.7).

With reference to libertarian perspectives, research from occupational health and safety has documented a similar approach. Gray (2009) discussed the responsiblization of risk in the confines of workplace health and safety and while the context of his analysis is outside the parameters of substance use and harm reduction, it is applicable and transferable for analyses surrounding social justice beliefs for harm reduction. For example, Gray (2009) found neoliberalist ideals and values towards individuals' responsibility for their own health and safety led to individuals being held accountable and judged for harm subjected to them and are sanctioned through this lens. This responsabilization of risk strategy reconfigures employee individual responsibility for risk while neglecting the social and political culture in which individual responsibility is embedded and experienced (p. 328). In the context of harm reduction, and in congruence with neoliberal-libertarian concepts of equity and justice, such an approach would neglect the social and political factors in which substance use occurs and is experienced and place more onus and responsibility on PWUD for the substance use harms they are subjected to. As noted by Pauly (2008a), "the presence of neo-liberal values that stigmatize and further marginalize those who use drugs" (p. 8).

Pauly (2008a) draws on earlier work from Iris Marion Young to argue that many beliefs from the distributive justice paradigm do not operate in ways that promote equity as such approaches negate the social structures, policies and practices that affect those who use substances, and further increase the risk of substance use harms. Thus, she argues that a social justice paradigm ought to be used as a lens to understand harm reduction as it takes into account the social and systemic inequities that contribute to harm. For example, Pauly (2008a) notes a social justice lens would acknowledge homelessness or a lack of residential address as a barrier to accessing health care services given the institutional policy of requiring personal identification to access health care services in many settings (p. 8). Additionally, a social justice lens asserts that inequities in health stem from structural inequalities such as homelessness, unemployment, poverty and lack of social support. Further, structural inequities exist along a social gradient and vary along the lines of gender, class, ethnicity and other social factors (p. 8). Finally, Pauly (2008a) notes the application of a social justice framework to policy has the potential to illuminate underlying values and potential harms associated with the social context of drug use.

Pauly's social justice framework (2008a) incorporates some beliefs from the distributive justice paradigm, such as the egalitarian belief of equitable access to health services, and communitarian beliefs, but provides much needed expansion. For example, the social justice lens for harm reduction supports egalitarian belief of access to health services but strongly advocates for equitable access in which there are considerations made to reduce barriers for sub-groups of the population. Similarly, the social justice lens applies elements of communitarian beliefs in the sense that it recognizes community involvement is necessary of community involvement. However, communitarian beliefs are premised on the idea of broad community engagement and

inclusion whereas the social justice lens maintains a focus on prioritizing the communities most affected and impacted². However, the social justice lens links differences in access and lack of community involvement with social and institutional structures that have caused and perpetuated these differences. Further, a social justice lens for harm reduction recognizes that reducing substance use harms requires addressing the social and institutional inequities that cause social and health differences and exacerbate substance use harms. As Pauly (2008a) states, “harm reduction driven solely by reducing the harm of drug use is not sufficient to address inequities in health and access to health care.... conceptions of social justice shift from distribution of existing material resources to a focus on social structures hold promise by surfacing the root causes of problematic substance use and homelessness; conditions that harm reduction alone cannot ameliorate (p. 8).”

To apply Pauly’s social justice lens for harm reduction, I found the Systems Health Equity Lens (SHEL) framework to be useful. SHEL is founded on the values of social justice to support health equity across health systems, building from the notable work of Pauly (2008a) and is premised on evidence that confirms inequities in health largely stem from and relate to social and structural inequities. SHEL provides a dual-pronged approach to health equity, as it is 1) focused on understanding and recognizing the root causes of health inequities; and 2) it aims to strengthen actions that promote health equity (Pauly et al., 2018). It serves as a guide to determine the manner in which policy aligns with principles of health equity. The SHEL framework is discussed in more detail in Chapter 2 (subsection 2.3).

² Personal communication with Dr. Bernie Pauly that clarified the ways in which the social justice lens for harm reduction applies elements of the beliefs from the distributive justice paradigm (July 14, 2020).

1.5 Significance

Over a decade ago, research called for an explicit analysis of the values underpinning harm reduction to ensure harm reduction is enacted in a manner consistent with reducing inequities in health and access to health care (Pauly, 2008a). It is my view that Pauly's call for action applies to harm reduction policy documents as policies are important as they set the overall direction of harm reduction services and supports within the health care and social system.

While CHARPP's studies have confirmed the state of harm reduction policy (e.g. governance, policy quality), there has yet to be a study that explicitly identifies what beliefs are shaping the understanding of substance use harms and harm reduction within policy, specifically in relation to the social justice paradigm in which harm reduction is rooted. As such, this study addresses this gap by identifying the beliefs entrenched in harm reduction policy relative to health equity as outlined in Pauly (2008a) and Pauly et al. (2018), and discusses potential implications stemming from the identified beliefs.

1.6 Ethical Considerations

Ethics approval was not required for this study as I relied exclusively on publications issued and/or commissioned by the Government of B.C and its respective health authorities. Further, as there was no human participation involved, this study posed no risk of harm. To avoid perpetuating the social stigma associated with drug use, I adopted first person-language to refer to individuals who use drugs. As such, all references of such individuals in this thesis are referred to as "people/persons who use drugs (PWUD), aligning with terminology viewed as best practice within the substance use research community (Broyles et al., 2014) and best practices enforced by national and global journalistic reporting standards.

While it is essential for researchers to situate themselves in their research by exercising a degree of reflexivity towards their research decisions and actions (Charmaz, 2014), I believe researchers also have an ethical imperative to be reflexive and transparent of their motivations that steer their research interests. While I do not possess direct personal experience with the spectrum of substance use harms, I have witnessed such experiences. As a sibling to someone who uses illicit drugs, I have been privy to life experiences associated with unsafe substance use, including harms stemming from the social and political context of substance use and the lack of effective harm reduction supports, including watching someone overdose, the psychological toll resulting from social stigmatization; and inaccessibility to necessary health and social services. Bearing witness to these experiences has provided me with a personal appreciation for harm reduction and fuels my personal motivation to ensure equity for PWUD. While my research is motivated by personal experiences, these experiences are what drive this study's intention to ensure that harm reduction policy frameworks are responsive to the wide spectrum of harms PWUD face, are grounded in principles of health equity, and adequately address the social and structural systems that have made PWUD vulnerable to harm.

Chapter 2: Literature Review

This literature review provides background on three areas pertinent to this study. The first section highlights the social and communicative function of policy documents to present the argument that policy documents are not exclusively objective forms of information. Rather, policy documents contain implicit beliefs and values that communicate and shape a preferred understanding towards issues of public interest. The second section presents key findings from studies that have characterized and analyzed latent values in drug policy, and notes limitations stemming from the literature in which this thesis hopes to address. Finally, the third section demonstrates how an equity-oriented lens is a valuable framework for policy analyses, especially in the context of exploring policy beliefs for harm reduction.

This review will demonstrate that while there is a substantial amount of literature available that confirms policy beliefs indeed shape the broader understanding of public issues, there is an apparent need and gap for further research to identify what these beliefs are and what values ground these beliefs, most notably for harm reduction. As such, it is important to address this gap through a comprehensive characterization of harm reduction policy to enhance our understanding of how policy conceptualizes substance use harms and harm reduction, which poses implications to the health equity of PWUD.

2.1. The Communicative Function of Policy

Exploring latent meaning in policy documents, such as policy beliefs and values, requires a shift in one's view of what policy documents represent. According to Lancaster and Ritter (2014), policy documents are not merely objective government documents, rather they are texts riddled with contested meanings and values in which how they frame the nature of problems serves as point of reference for a wide variety of policy actors to justify their actions. This understanding has been echoed by other scholars, such as Pierce (2011) who argues that support for a specific policy or law tends to be primarily because of its expressive function, specifically the statements it makes about underlying values related to issues of public interest. This expressive function converts a state of action, which is the policy document itself, into a message about underlying values, which intentionally or not, is likely to influence attitudes and behaviors (p. 53). Additionally, the expressive function of policy can be understood as an articulation of values in pursuit of a specific goal; policies can either reinforce an existing norm (such as health equity in the context of this study) or seek to refine, modify or create a norm relative to the issue at hand (p. 54). As such, the expressive function of policy is instrumental in achieving public goals (p. 55) and careful consideration needs to be asserted towards the messages it conveys in the adoption of particular policies (p. 61).

In addition to discussing the matter in which policy documents reflect beliefs, it is important to first define and clarify what policy beliefs are. Sabatier and Jenkins-Smith (1997) offer a comprehensive definition and explanation of policy beliefs in their analysis of the Advocacy Coalition Framework, a model of policy process which posits coalitions of actors advocate their own beliefs about policy problems and solutions within various policy sub-systems (p. 119). According to Sabatier and Jenkins-Smith (1997), public policies incorporate

implicit theories about how to achieve their objectives and thus can be conceptualized in much the same way as belief systems. Thus, policy beliefs are value priorities, which are perceptions of important causal relationships and perceptions of world states, including the severity of the policy problem, and perceptions/assumptions concerning the efficacy of various policy solutions entrenched in the general discourse (pp. 119-20). These discourses could include debates, personal narratives, and as this thesis suggests, policy narratives. Sabatier and Jenkins-Smith (1997) also outline a hierarchy of policy beliefs. At the first is deep core beliefs which are “basic ontological and normative beliefs, such as the relative value of individual freedom versus social equality, which tend to operate across all policy domains” (p. 121). The second is policy core beliefs, which represent a coalition’s basic normative commitments across a policy domain or subsystem. This would include fundamental value priorities such as relative importance of economic development versus environmental protection (p. 122). What is most integral from Sabatier and Jenkin-Smith’s findings is that policies cannot be taken for face value. Policies contain motivations and beliefs that shape how a policy issue, such as substance use harms, is framed and understood by various actors.

A recent study by Rhodes and Lancaster (2019) bridged the findings between the communicative function of policy and policy beliefs within the morality policy domain. Rhodes and Lancaster acknowledge the communicative function of policy documents as they assert policy documents act as evidence-making interventions and introduce the evidence making intervention (EMI) conceptual framework, which “focuses on the processes and practices through which ‘evidence’, ‘intervention’ and ‘context’ come to be” through implemented policy (2019, p.1). Through this framework, policy acts as an evidence-making process through the narratives contained in policy which define the parameters of an issue and what is deemed to be

the most effective solution. Interestingly, Rhodes and Lancaster (2019) use drug policy as a case study by analyzing the ways in which methadone treatment is communicated and implemented through policy in different countries and contexts. For example, the scholars note methadone treatment in Kenya is communicated in a national context as a necessary HIV prevention treatment; however, it is viewed locally as a solution to alleviate personal and community problems related to substance addiction (p. 3). Conversely, methadone treatment in Eastern Europe contains a discourse that constitutes methadone as a toxic drug of addiction (p. 4).

Work from Garvin (2001) substantiates Rhodes and Lancaster's (2019) claims as Garvin argues the function of policy delineates a different role for knowledge and evidence in policy. This includes knowledge that is scientifically linked to traditional conceptions of objective truths; alternatively, knowledge, as it is portrayed as evidence in policy, can be relative in which it is partial and used as a tool by policy makers for strategic, political goals. A third approach consists of knowledge and evidence being contextual and instrumental in which it becomes one of many tools to validate socially acceptable policy options (p.448). Regardless of the type of knowledge constructed in policy, evidence and knowledge are tools for argument and persuasion (p.449). As such, Garvin (2001) argues policy documents embody the socially constructed nature of knowledge and evidence in which they are laden with values that present themselves as logical conclusions.

Both Garvin (2001) and Rhodes and Lancaster (2019) demonstrate that not only are there multiple ways to conceptually frame and understand an issue, there are also multiple ways in which policy can make interventions 'matter' in relation to specific social and political concerns (Rhodes & Lancaster, 2019, p. 3). For instance, how harm reduction is understood is determined, by some degree, by the ways in which it is narrated and characterized in policy.

2.2. Characterizing Drug Policy

Findings such as those in Pierce (2011), Sabatier and Jenkins-Smith (1997) and Rhodes and Lancaster (2019) illustrate a need to characterize policy documents beyond their explicit features. With the understanding that policy documents are interventions that seek to communicate norms and values related to an issue, there are numerous studies that have adopted several methods useful to characterizing policy narratives (i.e. the ways in which policy issues are communicated) and policy beliefs.

A method predominantly used for policy analysis studies is critical discourse analysis, the examination of how language is used to reflect understandings surrounding a topic of interest. Lancaster and Ritter (2014) completed a critical discourse analysis of five national drug strategies in Australia to determine how drug problems are constructed and represented through the language of drug policy over time, and the implications stemming from language choice. As the authors note, critically analyzing the ways in which policy language constructs and represents policy problems is integral, as these constructions have implications for how we are invoked to think about and justify possible policy responses (Lancaster & Ritter, 2014). Lancaster and Ritter's study revealed that government uses various language choices when presenting substance use as a policy problem. This includes managerial and bureaucratic discourses, which tend to assert authority over the state to resolve drug problems, and quantify dollar-value costs to justify proposed strategies by presenting the substance use problems, "primarily in terms of the economic costs of drugs to society, rather than social outcomes" (pp. 83-4). Additionally, it was found that the changing emphasis on either drug use or drug-related harms altered how the problem of drugs was represented over time and, ultimately, the orientation of the policy framework. As the authors note, in deliberately presenting specific knowledge, values and

beliefs, policy texts reinforce the preferred understanding of illegal drug use and harm reduction (p. 86).

While Lancaster and Ritter's analysis "demonstrates [that] different constructions are produced very subtly, through the possibly incidental use of language, and that these constructions become embedded slowly over decades of policy development" (p. 86), it did not offer an exploration of the underlying beliefs that shape these constructions and understandings of substance use. Rather, it confirmed language choice adopted by public institutions and the matter in which language choices demarcate policy shifts. Thus, there remains a need to bridge not only the narrative discourse within a policy frame, but the characterization of who/what is also deemed the problem and the solution, and what values and beliefs are potentially underpinning these characterizations and discourses. Rather than look at meanings behind language choices, this study seeks to observe meaning in narrative frames, vis a vis who/what is framed as responsible as a risk factor substance use harm, who/what is harmed, and what solutions are put forth in harm reduction policy as a means to reduce substance use harms.

Similar to Lancaster and Ritter (2014), an international study analyzed six decades (1950 – 2010) of substance use and gambling policies in Germany and the Netherlands to distinguish how government frames morality policy issues (Euchner, Heichel, Nebel & Raschzok, 2013). Euchner et al. (2013) found policy documents tend to adopt a variety of narrative frames to present the problem and impact of substance use and gambling. This includes a morality frame in which drug use and gambling is presented as a wrong and inherently bad behaviour; a health and social frame that stresses the need to protect consumers' health and social conditions; the security and public order frame which summarized arguments related to threats from criminal activities such as the national and transnational drug trade, gambling fraud and money

laundering; and lastly the economic and fiscal frame, in which substance use and gambling is accepted as a regular leisure and economic activity, albeit one that requires regulation (p. 377). Euchner et al.'s (2013) study concluded that how an issue is framed for morality policies has a significant effect on how morality policy issues are understood by the broader policy community (p. 386). Further, this study demonstrated that issues within the morality policy domain, such as substance use, are often regarded in terms of values, norms and morals. As such, it confirmed there are entrenched beliefs that shape government's conceptualization and framing of substance use, in which policy documents serve as the vehicle to communicate these beliefs and values.

Earlier work from Iannantuono and Eyles (1997) demonstrated the matter in which discourse analysis can reveal underlying assumptions and meanings. Iannantuono and Eyles (1997) analyzed one of Canada's most important historical policy documents, *Achieving Health for All* and demonstrated that by virtue of its discourse, the policy instilled and established a narrative frame of individual responsibility, individual rights, and health promotion as the precipice of health equality. As such, health equality was limited by the commitment of each citizen to improving their own health, and as the authors note, while the language of equity and well-being are present, they are based contradictorily on the values of individual rights and responsibilities (p. 1619). This analysis contributed to the broader understanding of policy documents as they represent consensus positions at particular points in the ongoing, contested policy decision-making process, revealing the values, ideas and interests which dominate policy debates (Iannantuono & Eyles, 1997).

Finally, drug policy analyses have also characterized the use of metaphors and linked these characterizations to beliefs and ideologies. Moore, Fraser, Törrönen and Tinghög (2015) completed a comparative analysis of policy documents in Sweden and Australia to determine the use of metaphors related to themes of addiction, social exclusion and gender, and to consider the political effects of these characterizations. Their findings revealed that individualistic ideology predominantly shapes the understanding of substance use and its harms in drug policy, in addition to paternalistic models of citizenship in which harms are presented as affecting everyone equally (p. 426). Further, the study revealed unique nuances in Sweden and Australia's policy landscape. For example, Swedish policies adopt metaphors that convey drug users as excluded from society, not because they are fundamentally different from non-users, but because drug users are understood to be suffering from a temporary and curable personal affliction. As such, the goal of the policy framework is to return PWUD to a state of 'sameness' through care and treatment (p. 425).

As previously mentioned in Chapter 1, recent scholarly contributions have demonstrated the value of content analysis to characterize values in harm reduction policy. These contributions originate from CHARPP which features two studies that specifically relate to and support this thesis. The first CHARPP policy analysis was published by Wild et al. (2017), who systematically described the variations of provincial/territorial level harm reduction policy frameworks from 2000 to 2015 in Canada. The policy documents were coded for 18 variables to measure policy governance. This included managerial roles and functions, treatments, client characteristics and environmental factors (p. 13). Overall, the study found a lack of clarity regarding what harm reduction entails at the policy level, as policy documents tend to convey nonspecific references to harm reduction more often than references to a specific harm reduction

intervention or service (p. 13). Additionally, Wild et al. (2017)'s analysis revealed a wide variation across jurisdictions in both volume and specificity of policies that guide the planning and organization of harm reduction and services in Canada (p. 14). This led to their conclusion that from the perspective of policy governance, harm reduction policy may have been written more for rhetorical purposes than for health system planning, reinforcing the authors' view that Canadian policies governing harm reduction services are a product of a morality policy environment, in which policymakers appear to view specific harm reduction interventions as too politically contentious to be named or supported, preferring instead to endorse the generic concept of harm reduction (p. 15). While Wild et al. were the first to conduct a policy analysis of this kind, the authors acknowledged it was limited in its ability to tease out implicit messages about the underlying values within policy documents and frameworks (p. 15). This limitation served as the impetus for what would be CHARPP's second policy analysis study by Hyshka et al. (2017).

Hyshka et al. (2017) continued the work led by Wild et al. (2017). However, their study aimed to assess policy quality relative to how well policy documents described key population and program aspects of a harm reduction approach. As such, the group of scholars deductively coded the content of provincial/territorial policies using the CHARPP coding framework, which is a set of evidence-based indicators designed to assess the quality of harm reduction policies based on the strength of their communicative functions (p. 4). The framework features 17 program and population quality indicators, including: recognizing that stigma and discrimination are issues faced by people who use illicit drugs, affirming that Indigenous people are a key population, acknowledge the need for evidence-informed policies and/or programs, specifically address overdose, and consider the social determinants that influence drug-related harm (Hyshka

et al., 2017, p. 5) (this is not an exhaustive list and readers are encouraged to consult Hyshka et al., 2017 to view the CHARPP framework). Hyshka et al. (2017) reviewed policy documents for the presence of each quality indicator and found the generally accepted principles and attributes of harm reduction are weakly defined in policy, in which only three policy documents from B.C. met all program quality indicators (p.7). Further, provinces and territories tend to locate harm reduction under broader strategies related to addiction, mental health, and sexually transmitted infection and bloodborne pathogens. Most importantly, most formal provincial/territorial policies failed to define harm reduction according to internationally accepted key principles and attributes, specify core interventions, or endorse efforts to prevent overdose or address stigma towards PWUD (Hyshka et al., 2017). As noted by Hyshka et al. (2017), this analysis concluded that policy documents endorse harm reduction in name (i.e. in theory) but not in substance (i.e. in reality), and policy documents may be communicating a general lack of support for key aspects of the approach to a diverse array of policy stakeholders, and thereby indirectly to a broader public (p. 11). As noted by Hyshka et al. (2017), policy documents are designed to be aspirational and expressive, and convey government's core messages and values in relation to a specific policy area (p. 11). However, an identification and explanation of what these specific values and norms were not made explicit in the analysis.

These studies demonstrate that analyzing harm reduction policy is not exclusively limited to characterizing policy in terms of explicit features, such as indicators, governance framework, or categories of proposed solutions. Both Hyshka et al. (2017) and Wild et al. (2017) explored policy values within the confines of policy governance, communicative function and prevalence of harm reduction principles; all of which are integral to providing a fulsome understanding of the variations of harm reduction policy. However, there remains a gap in the literature with

respect to studies that have explicitly identified the policy beliefs and values surrounding harm reduction and substance use which underscore policy documents and shape the broader understanding of substance use. I contend this can be identified by exploring the ways in which policy documents narrate the characterization of substance use and harm reduction most notably through the Q-NPF. While related, this thesis deviates from CHARPP's previous studies, as my interest is grounded in distinguishing what specific policy beliefs shape and inform government's understanding of substance use harms and harm reduction through the policies government implements. Most importantly, as harm reduction is premised on the principles of social justice (Harm Reduction International, 2019), I aim to adopt an analytical framework similar to Iannantuono and Eyles (1997) to determine the matter in which policy beliefs respect the principles and foundations of equity.

2.3. Health Equity Lens for Policy Analysis

As discussed in Chapter 1, a health equity lens is a way of approaching public health policy and program development that considers disadvantages suffered by individuals as a result of their social positioning, such as race, socioeconomic status, and homelessness (Pauly et al., 2013). As such, policy beliefs premised on health equity would consider and reflect the various health experiences dependent upon one's social positioning, and aim to reduce barriers in access to health both through health systems and by aiming to address social systems that have resulted in social disparities, such as poverty, racism, and stigma. Health equity in this sense does not imply 'sameness'. Rather, it is informed by a social justice perspective which requires consideration of the social context of health and how members of different social groups may be collectively affected by policies that ultimately result in the creation or perpetuation of inequalities in access to health and social services (Pierce, 2011, p. 57). In the context of

substance use harms, Rhodes (2009) referred to this social context as the ‘risk environment’. The risk environment views drug harms as the product of social situations and the social environment in which substance use occurs (p. 193) and advocates for the need to reduce risks within the social environment to reduce substance use related harms. This includes social discrimination, unjust and discriminatory enforcement practices, and socioeconomic factors (p. 194). The risk environment shifts responsibility to social and systemic processes for harm as opposed to individual action and responsibility as a primary determinant of harm (p. 194).

In acknowledgement that there are multiple social factors that cause substance use harms, drug policy decisions can cut across a number of other public policy domains, such as housing, social assistance, and education (Boyd et al., 2016, p. 3). This often fuels an ambition amongst government to bridge social determinants of health with health inequities. However, as Graham (2004) notes, both often become conflated when integrated into health policy. In her review of public health policy, new health strategies that target social determinants are often used as a way of launching a joint attack on the social causes of health and disparities in health. This has resulted in a dual meaning, referring both to the social factors promoting and undermining the health of individuals and populations and to the social processes underlying the unequal distribution of these factors in society (p. 102). What is problematic is that policy frameworks tend to emphasize the social determinant of health model to reduce health inequities, which blurs the distinction between social factors that influence health and the social processes that determine unequal distribution (Graham, 2004). Graham states, “the blurring of this distinction can feed the policy assumption that health inequalities can be diminished by policies that focus only on the social determinants of health” (p. 109). Thus, improving individuals’ health requires a combined attack on the social causes of health and health inequalities. It requires engaging with

not only the social influences on health and how people's social conditions can damage their health, but also engaging with how social inequalities are maintained over time and across generations. (p. 114). As Graham exemplifies, health equity goals need to concentrate on reducing socioeconomic inequalities in health, and the targets should be set to reduce inequalities in living standards, environmental exposures, and behavioral risk factors amongst various socioeconomic groups (p. 115).

What is important to recognize from Graham (2004) is that harm reduction needs to stem beyond physical harms. As evidence has confirmed, harm reduction interventions alone are insufficient to address the harms related to substance use (Pauly, 2008a; Boucher et al., 2017). Further research from Pauly echoed this sentiment, especially in instances where other social factors further compound harms, such as homelessness, in which harm reduction needs to encapsulate supports that align with the social environment in which substance use takes place, such as housing (Pauly, Reist, Belle-Isle & Schactman, 2013). Individuals who face social disadvantages such as homelessness and use substances also experience barriers to healthcare in which their inaccessibility is the product of a variety of complex and multifaceted reasons, most of which are rooted in social systemic issues such as stigma, criminalization of drug use, poverty, and lack of system capacity (Pauly, 2008a; Pauly, MacKinnon & Varcoe, 2009). In this instance, providing adequate, safe housing should be deemed a component of harm reduction as substance use and homelessness often overlap (Pauly et al., 2009, p. 288) and the harms subjected to those who are homeless are vastly different than those who use substances and have a safe space to do so.

Research from Ti et al. (2012) provided evidence that inaccessibility to harm reduction supports, such as safe use paraphernalia, often has little to do with substance use itself. Their longitudinal study identified factors associated with difficulty accessing crack pipes in Vancouver, B.C., specifically in settings where pipes were available at no cost. The study found one in three PWUD report challenges accessing pipes and factors independently associated with inaccessibility included social factors, such as sex work involvement, difficulty physically accessing community, health and counselling services, and police presence where one buys/uses substances (p.894). Similar sentiments were echoed in Milne et al. (2015) who found barriers to accessing Hepatitis C treatment and care for persons who inject drugs are often related to social factors such as housing, socioeconomic status, social exclusion, and food security. Similarly, Boucher et al. (2017) found barriers to harm reduction supports were strongly related to social and structural inequities, such as fear or aversion of accessing supports based on experiences of discrimination or stigmatization from their substance use, as well as other reasons such as having a mental illness, being homeless, having an infectious disease, gender, race, sex work, or having a criminal record. As such, it is imperative for harm reduction services to reach beyond addressing barriers of accessibility and provide supports related to the social factors and conditions that influence accessibility, such as financial security, poverty, housing and discrimination.

Applying an equity-oriented lens policy documents is useful in identifying the ways in which issues surrounding inequities are framed and conceptualized. Pinto et al. (2012) undertook a comparative analysis of public health documents in Ontario and B.C. in which several documents were inductively coded to identify themes related to how health equity was conceptualized and integrated into standards for public health renewal. The study revealed both

differences and similarities in the ways in which health equity is conceptualized in policy documents. This included B.C. emphasizing social determinants of health as a means to prioritize health equity whereas Ontario emphasized addressing ‘priority populations’ as a proxy for health equity. Interestingly, very few protocols in Ontario provided further direction or specificity towards how health equity could be achieved, which as the authors note indicates a theoretical commitment to health equity (p. 4) and a gap for health equity in practice. Additionally, documents from both provinces did not contain an analysis of systemic factors and a deeper analysis about the roots of inequities (p. 8). What is most applicable from this study to this thesis is that it demonstrates there are variations in how health equity is conceptualized and framed in similar health policy domains. Further, it provides a necessary foundation for future research, such as this thesis, to identify other ways health equity is framed and conceptualized in policy such as policy beliefs.

Recent work evaluated the use of equity-oriented approaches in harm reduction supports and services. MacKinnon et al. (2019) completed a scoping review of the literature that used a health-equity oriented approach for preventing and reducing the harms of stigma and overdoses for PWUD or misuse prescription opioids. The review found that while the literature reports inequities in opioid-related deaths, there remains a lack of equity-oriented responses within the health system, primarily those that address the social contexts of harm as part of overdose prevention (i.e. approaches that attend to age, sex, ethnicity, and gender differences) (p. 641). In addition, the scoping review confirmed that feelings of being unsafe in health care settings due to fear or experiences of judgement impact PWUD’s ability to access the care they require. Thus, cultural safety is a necessary component of equity-oriented approaches and should extend beyond cultural sensitivity and competence at the health professional level and focus on restoring

power balances, addressing institutional discrimination, and inequitable positioning of certain groups within the health care institution dynamics (MacKinnon et al., 2019).

Reimer-Kirkham et al. (2016) posit an equity-oriented lens helps determine the degree to which care is responsive to the needs of those who experience intersecting social health and social concerns. While their study takes place in the context of palliative care, Reimer-Kirkham et al.'s (2016) core findings ring true for harm reduction. For instance, Reimer-Kirkham et al. (2016) found that most definitions of palliative care and palliative care approaches do not dedicate additional attention to address social and structural inequities that profoundly shape health, illnesses and dying experiences for people who are vulnerable by sociopolitical, economic, cultural and historical forces (p.294). This vulnerability is referred to as structural vulnerability and an equity-oriented lens aims to uncover underlying social causes of health inequities (p. 294). Further, similar to Graham (2004), Reimer-Kirkham et al. (2016) argue that focusing on social determinants of health is not enough to ensure health equity as it tends to focus on material resources such as housing, income and education. Rather, more attention must be given to the conditions that social positioning and influence the allocation of resources.

Similar to Pinto et al. (2012), a group of scholars recently interviewed health system leaders in B.C. to explore the various ways in which they construct and understand health equity in a time of health system renewal and transformation (Pauly, Shahram, Dang, Marcellus & MacDonald, 2017). Pauly et al. (2017) confirmed that definitions and conceptual understanding of health equity vary between health system leaders and this was reflected by different understandings of vulnerability (structural versus individual), determinants of health (material versus social), and appropriate health system responses to address health equity (e.g. targeted versus proportionate universalism; individual versus structural interventions). Even more critical,

health system leaders acknowledged that applying an equity-lens to health systems is challenging because of the lack of consistent understanding of what health equity is, the lack of guidance surrounding how an equity lens can be applied, and it is not often linked to social justice (p.504).

Applying an equity lens for policy analysis studies does not need to be a daunting task, thanks to the recent development of the Systems Health Equity Lens (SHEL) by Pauly et al. (2018). As previously discussed in Chapter 1, the SHEL framework is founded on the values of social justice to support health equity across health systems and is premised on evidence that confirms inequities in health largely stem from and relate to social inequities. As such, health and social inequities need to be resolved simultaneously. SHEL provides a dual-pronged approach to health equity, as it is 1) focused on understanding and recognizing the root causes of health inequities; and 2) it aims to strengthen actions that promote health equity (Pauly et al., 2018).

Rather than honing on individualized factors, such as one's status as a marginal or vulnerable person, SHEL is concerned with identifying and addressing systematic patterns of disadvantages, differences in power and privilege, and focuses on systems and social structures that create and further perpetuate disadvantage and vulnerability (p. 2). This is integral to harm reduction as health care systems make key drug policy decisions, especially when they determine the level of services they will provide to people who use drugs (Boyd et al., 2016, p. 3) As noted in the SHEL framework, "it is essential to explore where these social processes intersect with health systems...how is racism, sexism or ageism expressed in health systems? How will such inequities be addressed" (Pauly et al., 2018, p. 2)? Essentially, SHEL aims to address and mitigate the "why" behind inequity, as opposed to leaving the analysis exclusively at 'who'/'what' is affected and responsible. This includes developing strategies based on

proportionate universalism that take into consideration the fact that health inequities are distributed across the entire social gradient (Pauly et al. 2018).

To encourage policy that is grounded in and reflects health equity, SHEL advances several recommendations to improve health systems, one of which is policy-oriented. This includes orienting the health system organizationally through the means of adopting clear policies that aim to implement health equity strategies and are developed across all relevant ministries and sectors to create conditions for health and take action on social determinants of health to reduce structural vulnerability (Pauly et al., 2018, p. 5). Most importantly, health equity must include comprehensive strategies for health systems and offer practical guidance in terms of its application. SHEL proposes a general frame for what this would entail, which includes prioritizing health promotion, health protection for those who face higher involuntarily risks to illnesses and health harms, and ensuring all individuals have equitable access to diagnosis, treatment and care (p. 6). Policy frameworks must also feature health equity indicators to enable measuring, monitoring and reporting on both health inequities as well as health equity. Most importantly, SHEL does not promote equality in the context of inferring everyone has the same access to health and social services. Rather, it employs proportionate universalism in which it balances targeted and universal approaches to equity through actions that are proportionate and responsive to both needs and levels of those who are disadvantaged and marginalized in a population (p. 6). This ensures the most vulnerable are not forgotten both in policy and practice.

SHEL serves as a valuable framework for analyzing health and social policy as it provides a guide to determine the matter in which policy beliefs align with principles of health equity and identifies the need for action to address inequities. For instance, policy beliefs premised on health equity would provide a focus on marginalized groups, identify the matter in

which substance use harms are disproportionately distributed amongst the social economic gradient, acknowledge the history and intersecting nature of social factors that influence harm (i.e. racism, stigma, sexism, poverty, etc.), and promote solutions that aim to take action on the broader social inequities and conditions that influence health.

This literature review has indicated that policy documents contain the power to influence preferred understandings of an issue, and these preferred understandings pose consequences for the health and wellbeing of all individuals. However, the most significant consequences are borne to those who are made vulnerable or marginalized by underlying social and structural inequities. This is why it is imperative to not only distinguish what policy beliefs are prevalent through the ways in which policy documents narrate substance use and harm reduction; but also, the matter in which these beliefs are oriented in health equity. Thus, this study contributes to the existing literature by identifying what policy beliefs are implicitly communicated in provincial harm reduction policy and the matter in which these beliefs are equity-oriented or oriented towards other beliefs surrounding substance use.

Chapter 3: Research Design & Methodology

Measuring policy beliefs and values can present a methodological challenge (McBeth, Shanahan, Hathaway, Tigert & Sampson, 2010) and like all forms of research, selecting an appropriate research design and methodological framework is integral. This study adopted the Qualitative-Narrative Policy Framework (Q-NPF) to complete a content analysis of public policy documents. The Q-NPF was the preferred method as it offers a systematic framework to qualitatively characterize and analyze nuances of policy issues and debates, ultimately broaching a richer understanding towards the ways in which policy issues are understood and conceptualized.

3.1. The Qualitative-Narrative Policy Framework (Q-NPF)

The Q-NPF is an extension of the Narrative Policy Framework (NPF). The NPF was introduced in 2010 as a “quantitative, structuralist and positivist approach to the study of policy narratives” (Jones & McBeth, 2010, p.330). The NPF serves as a theory of policy process that offers a systematic, scientific approach to understand and analyze the social construction of policy realities – referred to as policy narratives (Jones & McBeth, 2010; Shanahan, Jones, McBeth & Ross, 2013; McBeth et al., 2014). The term *policy narrative* describes the reduction of issues/problems into stories and the NPF posits all policy narratives contain structural and content elements that are generalizable across space, time and different contexts (McBeth et al., 2014, p.228). As outlined in Shanahan et al. (2018), core assumptions of the NPF include:

1. **Social construction:** meaningful parts of policy reality are socially constructed.
2. **Bounded relativity:** the meaning of such social constructions varies to create different policy realities; however, this variation is bounded by belief systems and ideologies, thus it is not random but stable over time.
3. **Generalizable structural elements:** narratives have specific and identifiable structures

4. **Three interacting levels of analysis:** narratives operate at three interacting levels, micro (individual), meso (group) and macro (cultural and institutional).
5. **Homo narrans model of the individual:** narrative is understood to play a central role in human cognition and communication.

As per the NPF, the generalizable structural elements of all policy narratives include:

1. **Setting:** Provides the context of the policy climate. The setting situates the legal and constitutional parameters, geography, scientific evidence, economic conditions, agreed-on norms, and other factors deemed relevant or pertinent by the policy actors involved or associated with a public policy issue;
2. **Characters:** The prominent actors involved in the policy issue. This typically includes villain (who/what is most responsible for the policy issue (issuing harm)), victim (who is affected/harmed by the policy issue), and hero (who is responsible for mitigating/resolving harm);
3. **Plot:** Situating the characters in the policy issue; how the characters interact and coincide with each other; and
4. **Moral of the story:** the proposed solution to the problem (McBeth et al., 2014).

Further to systematically analyzing the structure of policy narratives, the NPF assumes narrative content itself can be systematically analyzed, specifically for policy beliefs and narrative strategies (McBeth et al., 2014). This study took exclusive interest in measuring policy beliefs which is explained in more detail in subsection 3.2.

The NPF stipulates that to be considered a policy narrative, content must, at a minimum, reference one character and be in relation to a policy issue of public interest (Shanahan et al., 2013, p.457). Additionally, the NPF outlines three levels of analysis pertinent to examining policy narratives, in which NPF studies adopt one of the following (Jones et al., 2014, p.10):

Micro: the evaluation of how individual opinion is persuaded and shaped by policy narratives, often relying exclusively on quantitative methodology and scientific experimentation;

Meso: the evaluation of the strategic use of policy narrative deployed by policy actors and coalitions; and,

Macro: the evaluation of the role of institutional and cultural policy narratives over a historical period.

This study adopted a meso-level analysis as it was concerned with examining, “the strategic construction and communication of policy narratives to achieve a desired policy goal” (Jones et al., 2014, p. 15). Additionally, a meso-level analysis was well-suited for this study as I aimed to explore the variation in policy narrative elements to help explain policy learning and policy change (p. 17).

It is important to highlight that while the NPF is the product of post-positivist scholarship, it was initially promoted as an attempt to apply positivist methodological approaches to understand the subjective social reality that is policy narrative (McBeth et al., 2014). In 2010, Michael D. Jones and Mark K. McBeth explicitly noted they do not see the NPF as a threat to post-positivism. Rather, they acknowledged that narratives matter and by studying them empirically, positivists and post-positivists can engage in more productive debates over how stories influence and shape the broader understanding of public policy issues (p.339). Despite the intent of the NPF to bridge the epistemological divide of the social sciences, the bulk of NPF scholarship has largely been quantitative (Pierce, Smith-Walter, & Peterson, 2014). It was not until 2016 when two scholars, one of whom was responsible for the NPF, demonstrated the transferability and applicability of the NPF to qualitative, small-sample studies that privilege social constructivist/interpretive epistemology.

Gray and Jones (2016) were the first to conduct a qualitative NPF study in which they analyzed policy narratives to identify narrative strategies deployed by various political actors surrounding U.S. campaign finance reform. Gray and Jones (2016) kept the NPF framework intact in terms of its assumptions, narrative elements, and levels of analysis; however, they

recalibrated the NPF to incorporate qualitative methods for data coding, data analysis and research evaluation. While the NPF served as their deductive coding framework to characterize interview transcripts (e.g. setting, plots, characters, and policy solutions), they followed the principles of grounded theory in which they coded for patterns, themes and concepts relative to setting, plots, characters and policy solutions (p.202). As noted by the authors, inductive coding facilitated their ‘narrative strategy’ code to identify the intentional use narrative elements to persuade support.

Privileging qualitative methods and evaluation criteria allowed Gray and Jones (2016) to leverage a richer understanding towards the unique narrative strategies deployed by various actors. For example, the authors were able to operationalize additional codes to describe different motivations and accounts of villains in policy debates (p. 202). This may have not been accomplished if they maintained the traditional positivist practice of grounding codes in presupposed theories and priori hypotheses. Most importantly, Gray and Jones proved the NPF is adaptable for all epistemologies (p. 198) as one can still use the NPF in conjunction with qualitative forms of inquiry and evaluation criteria without sacrificing rigour or trustworthiness (p. 198). It was through these conclusions the Q-NPF was born and the Q-NPF has paved the way for other scholars to measure policy narratives qualitatively (e.g. McMorris & Jones, 2019). As such, I chose to follow in Gray and Jones’ (2016) footsteps and adopt the Q-NPF as this approach would provide more detailed explanations of the intricate nuances shaping the policy arena (Gray & Jones, 2016, p. 215). Further, I chose the Q-NPF because it is a relatively new theory, in which at the time of writing, only one study applied the NPF to actual policy documents (O’Leary, Borland, Stockwell & MacDonald, 2017). Additionally, there was an

absence of studies that applied the NPF specifically to health policy documents. Thus, selecting the NPF provided an opportunity to contribute to the NPF and Q-NPF literature.

3.2. Measuring Policy Beliefs with the Q-NPF

As previously highlighted in Chapter 1, narrative content is relative to the context of a story (Jones et al., 2014, p.7); however, the NPF assumes beliefs and values towards a policy issue are not generated spontaneously. Rather, policy actors are stable in their orientation towards certain values over time (e.g. equality, liberty, human rights) (Jones et al., 2014). The NPF traditionally measured policy beliefs using the character constructs of the NPF, primarily through analyzing who/what is scripted to fulfill the roles of villains, victims, and heroes (Jones et al., 2014). The first study to do so, and deemed the birthplace of the NPF, (Shanahan et al., 2018), was from McBeth, Shanahan and Jones (2005). The group of scholars suspected analyzing who/what fulfills the character constructs in a political narrative can reveal the underlying beliefs and values shaping one's definition and understanding of a policy problem. Thus, McBeth et al. (2005) embarked upon a narrative policy analysis of two competing interest groups narratives related to nature and wildlife conservation efforts in Yellowstone Park, USA. The authors grounded their coding and analysis in positivist practice in which they rooted their codes in theories stemming from the literature. This included theories of federalism, the use of science, and human-nature relationships (e.g. biocentrism, anthropocentrism) (McBeth et al., 2005, p. 420-21). As such, the authors operationalized the definitions of narrative characters (ally and villain) to align with each respective theory and developed priori hypotheses to determine if these policy beliefs were indeed prevalent in the narrative content. For example, federalism was coded by operationalizing the definition of 'allies' in the policy narrative in which locally based

allies suggested a compact theory of federalism whereas nationally based allies suggested a nationalism theory of federalism (McBeth et al., 2005, p.420).

Shanahan et al. (2013) adopted a similar process to identify beliefs shaping the policy debate surrounding wind farm installations in Cape Cod, USA. They relied on theories from the literature to develop priori hypothesis for policy beliefs and operationalized the definition of victims and villains in alignment with these theories. For example, the human-nature policy belief (preservationist vs. conservationist) was calculated by coding for narratives that cast humans and wildlife/environment as victims in the policy narratives. Similarly, the business-conservation belief was operationalized through the characterization of conservation efforts or commerce efforts as heroes to the policy problem (p. 465-66). As seen in Shanahan et. al. (2018), previous NPF studies adopt a similar process in which they leverage policy values shaping policy realities through quantitative forms of measurement (e.g. Ripberger, Gupta, Silva, & Jenkins-Smith., 2014).

NPF scholarship has advised scholars to heed with caution when coding for and analyzing policy beliefs. This warning specifically came from McBeth et al. (2010) who recounted on previous quantitative policy analyses that attempted to code for policy beliefs based on general knowledge of the history or current situation of the policy debate. The authors reflected that while regional knowledge is important, resting one's coding framework on general knowledge is problematic as such an approach "leads to problems of subjectivity and replication" (p.393). As such, the NPF scholars argue determining beliefs engenders rigorous grounding in well-established theory, which involves operationalizing the codes of NPF

characters with a theoretical equivalent (McBeth et al., 2010; Jones et al., 2014; McBeth et al., 2014; Shanahan et al., 2018)³.

While I appreciate, and to an extent agree, with the recommendations from the NPF scholars, I suspect these assertions are more of a reflection of epistemological and ontological position, and not the constraints of the NPF. First, I agree one must become intimately familiar with the history and current state of a public policy issue, in addition to linking policy beliefs to theoretical equivalents for a reliable, credible and comprehensive policy analysis. This can be achieved through an extensive and comprehensive literature review and through exposure to the history of a public policy debate, which I have satisfied for this thesis. However, I disagree with the aforementioned NPF scholars' recommendation that the most optimal way to ground beliefs in theory is through deductive, quantitative coding. For example, Gray and Jones (2016) used the NPF qualitatively without constraining their code definitions to presupposed theories to identify narrative strategies. Furthermore, grounding one's codes in presupposed theory with priori hypothesis is most effective when proving a presupposed belief is prevalent. Given that this study is exploratory in which it aims to explore what policy beliefs and values may be shaping the understanding of harm reduction, it was my view that grounding the codes in presupposed theory and seeking to answer priori hypothesis would be limiting. If it is viewed and understood that policy narratives are relative and based on subjectively constructed views, it may be most appropriate to adopt the Q-NPF and employ qualitative methods to code inductively for policy values to allow the data itself to reveal what these beliefs and values are. To reiterate, I agree that researchers who use the NPF to measure policy beliefs ought to link beliefs to theoretical

³ I approached Dr. Mark K. McBeth directly to garner his input on coding inductively and qualitatively for policy beliefs in which he strongly recommended operationalizing the codes based on theory if there is existing literature that presupposes ideological theories engendered in a policy debate. Further, he recommended the use of inductive, qualitative coding only in the event that there is no literature on possible theories and ideologies (M. McBeth, personal communication, October 30, 2019).

equivalents (McBeth et al., 2014; Shanahan et al., 2018); however, I believe there is room for researchers to achieve this qualitatively by analyzing beliefs that appear inductively in the data in relation to theory, rather than coding for theory. As such, this study's adoption of a qualitative, inductive approach permitted me to first identify what beliefs are shaping the understanding of substance use and harm reduction, and then to compare the matter in which these beliefs align with the principles of the social justice lens for harm reduction (Pauly, 2008a).

Finally, given that the NPF aspires to empirically operationalize policy beliefs (e.g., McBeth et al., 2005), belief variation can be examined for presence before and after an external event (Shanahan et al., 2013). As such, the Q-NPF and its preference for inductive coding was valuable to my study as I sought to explore the matter in which policy beliefs changed after the 2016 public health emergency declaration.

3.3. Research Methods

Keeping intact the Q-NPF, I completed a content analysis of current provincial harm reduction policy documents in British Columbia, aligning with the methodological approach of Wild et al. (2017) and Hyshka et al. (2017). Content analysis was my preferred method as it is an unobtrusive method, allows for reliability analysis, permits longitudinal analysis, and is efficient and inexpensive (McBeth et al., 2007, p.93). Further, Shanahan et al. (2018) acknowledged the NPF has its roots in content analysis, as evident in McBeth et al. (2005). Finally, my methodological choice aligns with my level analysis (meso) for policy narratives as most meso-level NPF studies employed content analysis to analyze the structure and content of policy narratives (e.g. McBeth et al, 2010; Shanahan et al., 2013; Gray & Jones, 2016).

The decision to use policy documents as my data source was made for three reasons. First, policy documents are valuable sources of qualitative data as they convey, shape and

reinforce preferred understandings of substance use, harm reduction and desired policy responses (Hyshka et al., 2019; Hyshka et al., 2017; Pauly, 2008a). They also serve as essential tools that guide thinking and acting in relation to framing a public problem (Smith et al., 2009, p. 219). Therefore, policy documents should not be narrowly viewed as objective government documents as they contain both manifest and latent meanings, which reveal the values and beliefs underpinning a specific policy issue and can reveal which beliefs and values are privileged over others (Lancaster & Ritter, 2014; Schon & Rein, 1994). Furthermore, these underlying values possess a degree of persuasiveness as they are found to likely to influence attitudes and behaviour of the public in terms of understanding the policy issue (Pierce, 2011).

Second, public policy documents have communicative functions in which they serve to communicate narratives or positions to policy stakeholders to garner a collective understanding for a given issue (Howlet, 2009). Finally, as my interest lays in exploring and characterizing policy beliefs espoused at the public institution level (government), policy texts reflect the final policy position government has adopted for a policy issue. Conversely, if I had selected media articles or transcripts from legislative debates, I would have limited the scope of my analysis to understanding policy beliefs from other actors such as media, political leaders, and legislative members.

Data Criteria

In recognition of the substantial contributions CHARPP has made thus far in terms of analyzing harm reduction policy in Canada, my data selection and search process was informed by the selection and search process outlined in CHARPP's publications, specifically Wild et al. (2017), in which I supplemented the criteria with additional search terms and inclusion/exclusion criteria.

First, I developed a date and authorship inclusion criterion in which documents for this study had to be current and published by the provincial B.C. government and/or its delegated health authorities. I defined ‘current’ as any policy document that had an effective/enforcement date inclusive of December 31, 2019 or later, along with any documents in which an effective or enforcement period was not identified as it was presumed it was still in effect. The specific date criterion of December 31, 2019 or later recognizes that a considerable amount of harm reduction policy currently in effect in B.C. stems from 2003, when the first harm reduction policies were introduced to respond to the HIV/AIDS epidemic. Further, including all current policy regardless of implementation date will help determine the ways in which policy beliefs may have shifted after the 2016 public health emergency declaration (Government of British Columbia, 2016). This will help determine if newly implemented policies feature similar beliefs that appeared in earlier policy texts.

In addition to the date criteria, I also adopted Wild et al.’s (2017) data inclusion and exclusion criteria for defining what a harm reduction policy document is. As such, documents had to meet the following inclusion criteria for this study:

1. Issued by, and representing, the Government of British Columbia;
2. Issued by, and representing, a regional health authority that is operating in British Columbia as defined in the *Health Authorities Act*. This includes
 - a) Fraser Health Authority (FHA)
 - b) Interior Health Authority (IHA)
 - c) Northern Health Authority (NHA)
 - d) Vancouver Island Health Authority (VIHA)
 - e) Vancouver Coastal Health Authority (VCHA)

- f) Provincial Health Services Authority
 - g) First Nations Health Authority
3. Mandates a future action;
 4. Addresses harm reduction services and interventions, defined as one or more of the following: needle distribution, safe consumption site(s), safe injection site(s), overdose prevention site(s), naloxone, low threshold opioid substitution (or maintenance) treatment, buprenorphine/naloxone (suboxone), drug-checking, and safer inhalation kits; and/or
 5. Produced as either a stand-alone harm reduction policy or part of a strategy document that guides services for addiction, mental health and/or sexually transmitted and/or blood borne infections (STBBIs)⁴.

Similarly, I adopted the exclusion criteria outlined in Wild et al. (2017) along with including three additional exclusion criteria denoted with footnotes for rationale:

Exclusion criteria outlined in Wild et al (2017):

1. Documents that govern or legislate the delivery of harm reduction services, such as provincial and federal legislation;
2. Professional and clinical practice directives for health professionals and/or service providers for the provision of harm reduction services;
3. Policy texts at the municipal level, or are directed towards the provision of municipal-level harm reduction services⁵;

⁴ Includes progress reports stemming from earlier policy documents, as long as they included reference to future actions.

⁵ I added this as a supplementary inclusion criterion related to Wild et al. (2017) criteria. This excludes documents such as *Harm Reduction: A British Columbia Community Guide* (2005) in which the documents are published by the provincial government yet are targeted towards municipal-level services and service providers. Specifically, Wild et al. (2017) and Hyshka et al. (2017) excluded *Harm Reduction: A British Columbia Community Guide* from analysis, presumably for the same reason.

4. Policy texts at the federal level or are directed towards the provision of federal harm reduction services;
5. Policies pertaining to Canadian federal prisons; First Nations reserves;

Supplementary exclusion criteria:

6. Legislative or public stakeholder consultations reports⁶;
7. Program evaluation reports⁷;
8. Descriptive data reports⁸; and
9. Committee/Task Force progress reports⁹.

It is important to note that given this study's focus on provincial policy frameworks, and not aspects of harm reduction practice, I excluded both government and health authority-authored documents that focused exclusively on best practice guidelines for service providers and community organizations. This aligned with criteria in Wild et al. (2017) and Hyshka et al. (2017). However, this criterion excluded a harm reduction document that is still used today, *Harm Reduction: A British Columbia Community Guide*. As such, this criterion posed a limitation to this study (and is discussed in more detail in Chapter 5) as it excludes policy

⁶ While Legislative Standing Committee reports appeared during the systematic search process, these documents reflect a public reporting of stakeholder opinions as part of the democratic public consultation process. These reports do not reflect final policy implemented by government, rather they reflect an analysis of opinions and recommendations stemming from public opinion from a committee of elected political officials.

⁷ Evaluative reports of health programs and provincial progress reports were excluded as these types of documents do not mandate a future action. Rather, they are concerned with reflecting performance measures and/or outcomes of existing services and reflect actions government completed thus far in improving program services (See *Ministry of Mental Health and Addictions Responding to BC's Illegal Drug Overdose Epidemic Progress Update January 2018*).

⁸ This included documents such as the BC Coroner's monthly report "Illicit Drug Toxicity Deaths in BC" and the First Nations Health Authority's "Overdose Data and First Nations in BC" and bi-monthly progress updates. These documents provide a report and summary of statistics related to substance use and reference actions completed by government thus far in terms of implementing programs and health service responses. These documents do not discuss policy strategy, context, implications or recommendations related to substance use and harm reduction.

⁹ Similar to program evaluations and descriptive data reports, the provincial Joint Task Force on Overdose Prevention and Response annual reports were excluded from analysis as these documents are not deemed provincial policy documents as they are not considered stand-alone policy documents which guide the delivery of harm reduction services. Rather, these reports outline progress made by government, health authorities, and other government/community partners with respect to specific initiatives.

documents that may currently be used by service providers despite not meeting the scope of this study's inclusion criteria.

Data Collection

To source policy documents, I completed both a systematic and purposive search. Figure 1 illustrates the data collection process. As I adopted Wild et al.'s (2017) data search and collection framework I first consulted CHARPP's corpus of policy texts for B.C. as they already met the inclusion criteria adopted for this study. This list was publicly available on CHARPP's website where they published provincial policy analysis reports (Anderson-Baron et al., 2017). In total, CHARPP's list featured 29 policy documents for B.C. published from 2003 to 2015. I screened the list to confirm which documents had an effective end date of December 31, 2019 or later. This excluded 22 documents and left me with a preliminary sample of 7 documents. Appendix A outlines CHARPP's document list. Those highlighted in grey denote those that were included in the study as they met the enforcement date criteria thus meeting the definition of 'current'. Those not highlighted denote all CHARPP documents excluded from this analysis.

Given that CHARPP's corpus of policy texts only included documents published up to 2015, I then had to systematically search for policy documents published from January 1, 2015 to December 31, 2019 inclusive by entering 37 search terms (Appendix B) into an internet search engine (Google) and the Government of British Columbia website search engine. I adopted the search term framework outlined in Wild et al. (2017). However, I included four additional terms in recognition that policy advancements and significant public events occurred since 2014, such as overdose prevention sites, and a public health emergency declaration. Terms outlined in Appendix B with an asterisk delineate these new terms. To complete my systematic search, I followed a similar process outlined in Wild et al. (2017) where I conducted Boolean searches by

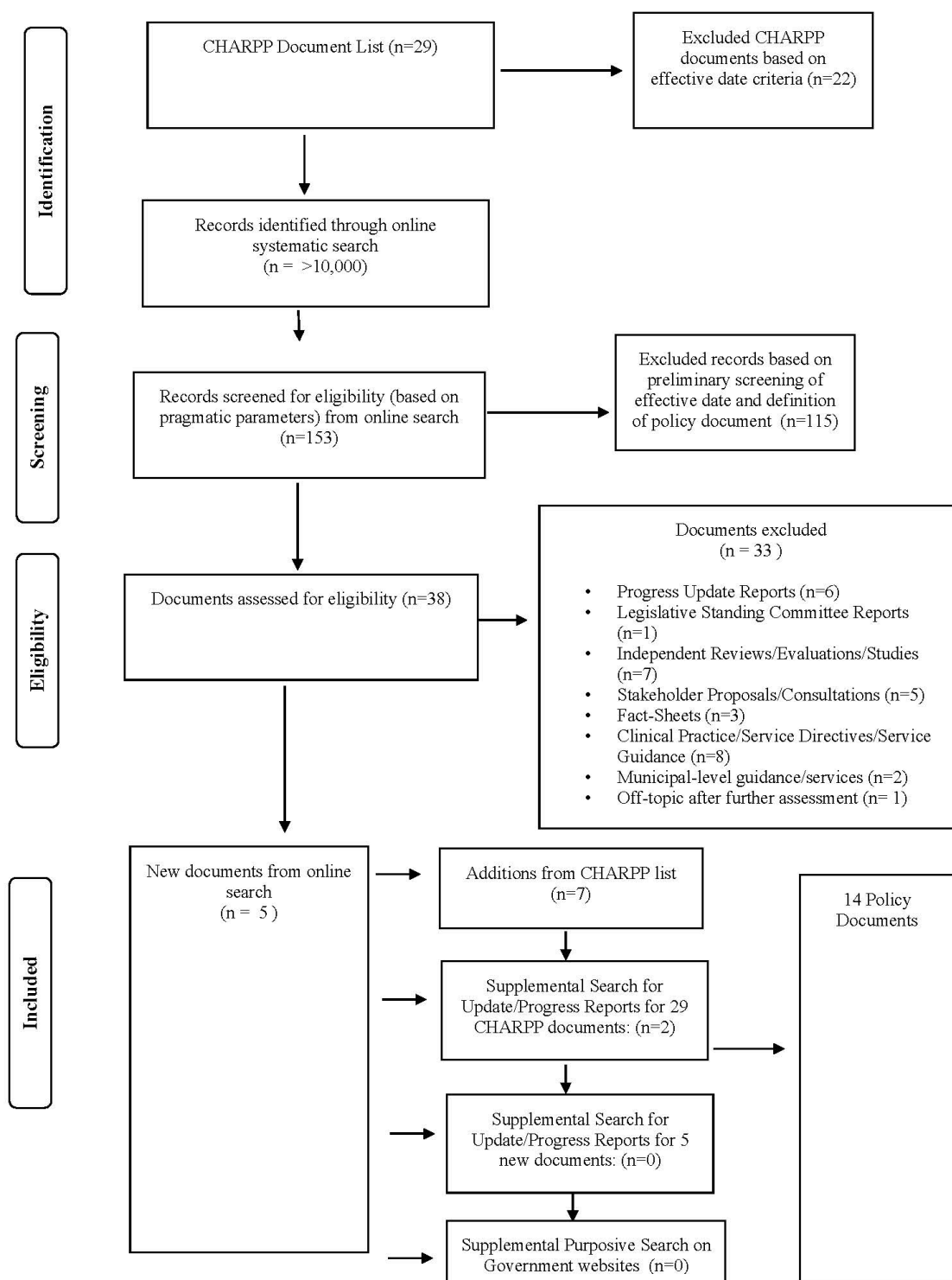
entering each core term along with “British Columbia”, then with separate searches, one of the following key words: ‘policy’, ‘plan’, ‘strategy’, or ‘response’. I completed the same process for health-authority level documents by entering each core term in conjunction with the health authority name and then ‘policy’, ‘plan’, ‘strategy’, and ‘response’. Given limitations in project scope, I had to apply pragmatic parameters to make the data review process manageable given the sheer volume of documents, news media articles, and other publications that resulted from the search term framework. For example, one single term search resulted in over 800,000 results alone. In total, the systematic search yielded 153 records for which I completed screening for eligibility. During my initial screening, I excluded 115 records on the basis that they were predominantly news media reports and commentary pertaining to harm reduction in B.C. This left 38 documents for screening for eligibility based on this study’s inclusion and exclusion criteria. Of the 38 documents screened, 5 were eligible for inclusion. Excluded documents included provincial and health authority (regional) fact sheets, stakeholder consultation reports, special investigation reports issued by the Office of the Provincial Health Officer, service delivery guidelines and frameworks to guide professional provision of harm reduction services, documents that referenced harm reduction in passing, directives/clinical guides for the provision of harm reduction services and supports, survey and statistical data reports, provincial committee progress reports, case studies, and policy proposals submitted by health professional associations.

After completing the systematic search, I completed a purposive search (Patton, 2002, p. 230) to see if any additional or accompanying policy documents were published in relation to the five new policy documents published from 2015 to 2019. This involved first entering the title of each of the newly discovered documents with the following terms: ‘progress’, ‘update’,

‘amendment’, and ‘status report’. This yielded no new records. Second, I wanted to confirm if new policy documents were published on the Government of British Columbia’s Ministry of Health website, the Ministry of Mental Health and Addictions website, and each health authority website that were in relation to harm reduction and were potentially missed during the systematic search. This involved navigating the publications section of each respective Ministry’s and health authority’s website to identify any publications that did not appear in my systematic search process. This did not yield any additional documents that met the inclusion criteria which confirms the search term framework was robust enough to capture documents featured on the provincial government ministry websites.

Finally, I wanted to confirm if any updates were made to the 29 documents CHARPP collected since 2015. To do so, I entered the title of each document with the following terms: ‘progress’, ‘update’, ‘amendment’, and ‘status report’. This yielded two additional documents: *From Hope to Health: Towards an AIDS-Free Generation 2015/16 Progress Report*, and *From Hope to Health: Towards an AIDS-Free Generation 2015/16 Progress Report*. These documents were not included in CHARPP’s studies as they were published after 2015. In addition, these documents were included despite falling under the exclusion criteria of ‘progress report’ as they were part of an initial harm reduction policy document (*From Hope to Health, 2012*) and set forth priorities and policy solutions to be implemented by 2020, therefore it had an enforcement expiration of 2020. Appendix C identifies all documents included in analysis and Appendix D outlines excluded documents from the systematic search.

Figure 1 Data Collection Process



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Coding and Analysis

Data coding and analysis was completed with the assistance of ATLAS.ti (version 8.4), a commonly used qualitative software program. Following the coding process outlined in Gray and Jones (2016, p.202), I deductively and inductive coded the policy documents.

The deductive aspect of my coding involved using the traditional NPF narrative codes: setting, plot, characters and policy solutions. As this chapter highlighted earlier, the NPF consists of constructs to inform the deductive aspect of coding for NPF studies. This includes the following (and is outlined Appendix E):

- ***Setting*** - The legal, social, and political factors narrated as relevant to the time in which the policy document was published and implemented.
- ***Plot*** – narrative element that links characters to each other and to the setting. Organizes actions, draws attention to facets of the setting and highlights moral of the story.
- ***Villain*** - Factors and/or characters narrated as responsible for influencing risk of substance use harms.
- ***Victim*** – Factors and/or characters narrated as harms resulting from substance use.
- ***Moral*** - Proposed solutions outlined in policy documents as necessary responses to mitigate substance use harms.

The NPF narrative codes can be also be viewed as sensitizing concepts, a term drawn from grounded theory (Charmaz, 2006; 2014) to describe notions or initial material that help researchers focus inquiries and to notice and name aspects of data/phenomena they might have otherwise overlooked (Gilgun, 2019). The NPF constructs provided the codes to determine the ways in which government narrated what risk factors of substance use produce harms (villain), who/what is harmed by substance use (victim), and the policy solutions recommended in harm reduction texts that are believed to mitigate such harms (moral of the story). Contextual

information based on historical details of harm reduction in B.C. along with details provided in the policy texts acted as the NPF's setting and is presented as a narrative summary in Chapter 4. The complete codebook appears in Appendix ¹⁰.

While the Q-NPF typically defines the characteristics of a policy narrative (villain, victim) as individuals and/or groups (Gray & Jones, 2016), recent scholarship has noted that the NPF contains a degree of flexibility for researchers to amend the operational definitions of the structural elements to be inclusive of characters that have both human and non-human agency, such as casting global warming as a villain or political empowerment as a victim (Shanahan et al., 2018). As such, I chose to extend the definition of victims and villains to include characters that espouse both human and non-human agency. Based on findings from the literature and findings from Pauly's social justice framework (2008a), this allowed me to extend the villain code to include various risk factors that perpetuate and compound substance use harms, including unsafe supply, social determinants of health, accessibility to services, individual demographic characteristics (i.e. sex, age), and social conditions. Additionally, the villain code definition was extended to also include characterizations reflective of various justice paradigms as noted in Pauly (2008a), such as criminalization and personal responsibility. Further, the victim code was operationalized similarly to be inclusive of both human and non-human based consequences associated with unsafe drug use to reflect the various physical and non-physical harms associated with substance use, such as the representation of marginalized and vulnerable groups, physical health outcomes (overdoses, fatalities, HIV/AIDS, Hepatitis C), economic costs, public safety, and social harms (i.e. homelessness, poverty, discrimination).

¹⁰ Codebook is based from unpublished supplement from Gray and Jones (2016); provided by Dr. Garry Gray November 2019.

Scholarship pertaining to the NPF also confirmed that researchers are not required to identify all of the character types nor be forced to include a particular type if it is not pertinent to the study's focus (Pierce et al., 2014). Thus, I did not code for 'hero' (i.e. who/what is responsible for addressing the policy issue) as this code is self-evident in policy documents given that government and its respective health authorities are assuming the role of hero by setting themselves up to address the policy issue of harm reduction by virtue of introducing and implementing the policy document. As Shanahan et al. (2018) note, "a hero could be governing bodies as they are the ones to "pass policies" and thus fix the problem" (p.335). For this study, the Government of British Columbia and its respective regional health authorities are the governing authorities responsible for issuing and implementing harm reduction policy as a means to 'resolve' the issue of substance-related harms.

Secondly, I applied the principles outlined in Kathy Charmaz's grounded theory (2006, 2014) in conjunction with Saldana's qualitative coding principles (2013) to inductively code for emerging patterns, themes and concepts. To obtain a high degree of abstraction, I read and coded the documents in three iterations. The first iteration included descriptive line by line coding to inductively summarize observable actions related to the setting, villain, victim, moral and plot codes (Saldana, 2013). This enabled me to observe variations in the accounts provided in the policy document about the various risk factors associated with substance use, how such risk factors evoke harm onto different victims, and the various policy solutions recommended in each document. This inductive coding approach generated sub-codes of victim, villain, moral and setting based on what I read and analyzed in the data (Charmaz, 2006, p.46) as opposed to limiting my coding exclusively to pre-determined patterns, concepts and theories. After my first

iteration, I had a total of 77 codes distributed throughout the villain, victim, moral, setting categories.

The second iteration involved axial coding where I completed a comparative process of the data and sub-codes to discern core patterns and themes for each category (Charmaz, 2014, p.144). Throughout the first and second iterations, I created memos to capture ideas and questions I had about health equity and statements prevalent in the policy documents as understanding emerged and changed. The memos were useful in tracking my own reflexivity and increasing confidence in themes that emerged pertaining to health equity and other theoretical categories.

Finally, the third iteration involved theoretical coding (Saldana, 2013) in which I completed a thematic analysis of the common code categories to reduce them into primary themes that captured the constitutive elements of Pauly's (2008a) social justice framework for harm reduction. This was completed both inductively and deductively based on the concepts outlined in Pauly's theoretical framework and to remain reflexive and open to emerging themes in the data that are not captured in the theoretical framework. This resulted in translating the 77 sub-codes into 31 final code categories (Appendix D). The primary themes evident in villain, victim, moral and setting categories facilitated the addition of the policy belief codes pertaining to substance use and harm reduction in policy documents. By grounding the final codes in theory, I satisfied the requirement set forth by previous NPF scholarship which stipulates policy belief codes must be grounded in theory. By subsequently grounding the codes through inductive analysis, I was able to code for additional themes related to underlying policy beliefs, including the generation of the non-equity-based belief category and its respective codes.

3.4. Reliability and Trustworthiness

To ensure the validity and reliability of the study's findings, I used Lincoln and Guba's (1985) four dimensions of trustworthiness framework. Lincoln and Guba (1985) present the four criteria to ensure rigour in qualitative research:

1. Credibility: confidence in the truth of the research findings
2. Transferability: findings are applicable for other contexts
3. Dependability: research process is consistent and can be replicated in other contexts
4. Confirmability: results possess a degree of neutrality and are supported by the sources from which the data originates from or other external sources.

Lincoln and Guba's framework has been proven effective in measuring a qualitative study's robustness, as demonstrated by Gray and Jones (2016) who applied the criteria to assess the validity and reliability of their Q-NPF findings. More recently, Lincoln and Guba's criteria were applied in medical science research. Forero et al. (2018) found that assessing qualitative methodology against Lincoln and Guba's framework yielded just as rigorous research findings for health care related topics as quantitative research. Further, Forero et al. recommended for future research in medicine sciences to consider Lincoln and Guba's criteria to achieve trustworthy qualitative findings (2018, p. 9). Chapter 5 outlines how this study meets each criterion in more detail.

Chapter 4: Results

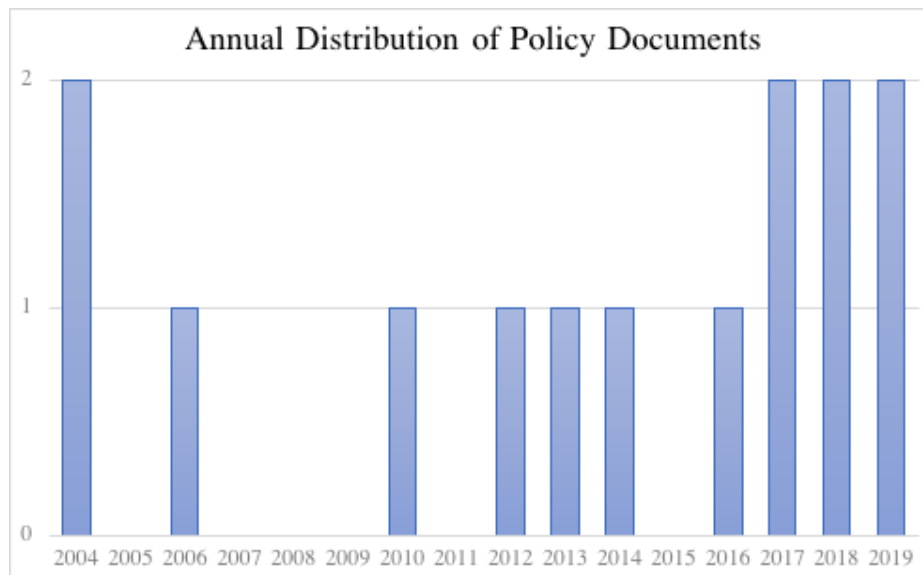
Results from the coding process are presented in three sections. The first section introduces the data through a descriptive analysis related to key notes on the coding and analytical process, and an overview of the setting of the policy documents. The second section outlines the two predominant policy beliefs/values observed through the coding and analysis process: health equity-related and non-equity beliefs. Finally, the third section provides a description of the ways in which the two policy beliefs have shifted between the pre-2016 and post-2016 period.

4.1. Introducing the Data

As the previous chapter confirmed, the data search and selection process yielded 14 policy documents that featured an effective/enforcement date of December 31, 2019 or later. Appendix C outlines the descriptive information pertaining to each document including its title, authorship, publication date, enforcement period, and page count. Overall, the policy documents were equally distributed between pre-2016 documents (n=7) and post-2016 documents (n=7). I found the distribution of current harm reduction policy documents important to note as it demonstrates the extent to which government relies on historical policy to inform its current position on harm reduction, in addition to the value and significance historical harm reduction policy has in the B.C. public administration. Figure 2 depicts the number of policy documents published per year for the dataset. The years that show no documents were published are exclusive to this study and do not represent the historical policy documents that were published during those years that did not meet the effective/enforcement period criteria as they had an enforcement period that ended before December 31, 2019, therefore they were excluded from this study. As seen in Appendix A, there are multiple historical policy documents published

during 2007 – 2009 yet they were excluded as they were considered no longer current based on this study's definition. This limitation is discussed in more detail in Chapter 5.

Figure 1 - Annual Distribution of Policy Documents



4.2. Analysis Considerations

Interestingly, I did not find the ‘plot’ code to be applicable in coding for and characterizing policy beliefs, which coincides with previous NPF studies that examined policy beliefs in which the NPF character codes were used exclusively to formulate the analysis (McBeth et al., 2005; Shanahan et al., 2013). As mentioned in Chapter 3, the NPF asserts the plot as the narrative element that links characters to each as other as well as the setting. The plot organizes actions, drawing attention to facets of the setting and highlighting the moral of the story (i.e. policy solution) (Shanahan et al., 2018). As noted by Shanahan et al. (2018), previous NPF studies have used story lines as plots, such as rags-to-riches or doomsday to describe the plot of a policy narrative. During the first iteration of coding, I did not find the ‘plot’ code to provide value to the characterization of policy beliefs, aligning with previous NPF studies (e.g. McBeth et al., 2005; Shanahan et al., 2013). In addition, when applied to policy documents, I found the plot code to be repetitious of the setting and character codes, in which the plot code

essentially overlapped with and confirmed the codes I applied for setting, villain, victim and moral of the story constructs. As such, the plot code did not yield relevant findings in the context of coding for policy beliefs and this is discussed in more detail in Chapter 6 as this poses consideration for future NPF applications, both in the confines of exploring policy beliefs, and for the NPF's overall research design.

Secondly, as one of my research questions was concerned with seeing if policy beliefs changed before and after the 2016 public health emergency declaration, I grouped the policy documents into two groups for analysis: 1) Post 2016 Harm Reduction Policy (n=7), and 2) Pre-2016 Harm Reduction Policy (n=7). As there was significant variation in document length, relying on absolute counts of the codes to analyze shift in policy beliefs¹¹ would have skewed and misrepresented the results of how prevalent the codings were in the texts. As such, I completed a normalized row-relative analysis in ATLAS.ti., which is discussed and elaborated upon later in this chapter, as the most current ATLAS.ti manual recommends researchers use normalization and relative frequencies when documents are of unequal length, which was a key characteristic of this dataset (Friese, 2019, pp. 170-4). A detailed description of this process and findings stemming from this analysis are presented in section 4.4.

The following subsections present the findings stemming from the NPF constructs. This includes subsection 4.3 which discusses the overall setting (i.e. motivation) of harm reduction policy frameworks in B.C., as achieved through the setting code. Sub-section 4.4. outlines the two core policy beliefs represented in the policy documents overall, as depicted through the villain, victim and moral codes. It is important to note, and will be repeated in subsection 4.4.,

¹¹ As noted in the previous chapter, policy beliefs are operationalized through who/what is narrated as a villain, victim, and proposed policy solutions.

that the policy beliefs are not exclusive to specific documents (i.e. one document characterized exclusively as one belief). Rather, the narrations within the harm reduction policy documents revealed a simultaneous presence of both beliefs. The potential implications of this are discussed in Chapters 5 and 6.

4.3. The Setting of Harm Reduction Policy in B.C. (Setting)

The NPF's 'setting' code is intended to help readers understand the motivation behind the policy document. The setting code situates the data in legal parameters, geographic factors, economic conditions, and other factors deemed relevant or pertinent by either the policy actors involved or associated with a public policy issue (McBeth et al., 2014). As such, the setting code was used to understand the underlying motivation for the harm reduction policy document and how harm reduction is situated within the documents.

This study yielded findings similar to Wild et al. (2017) in which there was a scant number of policy documents that articulate harm reduction as its primary purpose. For this study, there were only two policy documents (*BC Harm Reduction Strategies and Services Policy and Guidelines, 2014; HRSS Policy Indicators Report, 2017*) that featured harm reduction as its primary purpose:

“Harm reduction is an approach to practice, policy-making, and programming that aims to minimize adverse health, social, and economic consequences associated with drug use. Harm reduction is important in informing strategies and services related to substance use and sexual health. Harm reduction measures related to injection drug use have been particularly pertinent in British Columbia (BC) recently, given the increasing rates of overdose and overdose deaths” (BC HRSS Policy Indicators Report, 2017, p.3).

“Harm reduction is an integral component of the health promotion and illness prevention, treatment and care continuum. Through client-centred approaches, effective harm reduction policy and programming can achieve positive population health outcomes and reduce stigma and discrimination against those whose use of substances and/or sexual activity make them vulnerable to illness or other health harms” (BC HRSS Policy and Guidelines, 2014, p.2).

In comparison, the remaining 12 documents embedded and positioned harm reduction to address other issues such as substance crises, HIV/AIDS, problematic substance use/addiction, and mental health. For example, five policy documents (*Escalating BC's Response to the Overdose Emergency, 2019; The Hidden Epidemic, 2018; Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018; Position on the Prevention of Problematic Substance Use with a Focus on Alcohol, 2012; Crystal Meth and Other Amphetamines: An Integrated BC Strategy, 2004*) positioned harm reduction to be in response to a substance use crisis or threat. Specifically for post-2016 documents, the motivation for harm reduction was narrated as a response to the overdose crisis, as seen in the following excerpts:

“In just a few years, the number of overdose deaths has surpassed the combined total of suicides, homicides, and deaths due to motor vehicle collisions; they are now the leading cause of unnatural death in BC. For the first time in decades, life expectancy at birth in British Columbia has declined due to the rise in overdose death....As tragic as the numbers are, the toll would be much higher if not for the work of service providers, peers, first responders, and community volunteers on the front lines throughout BC. They have reversed thousands of overdoses using naloxone — and they have worked tirelessly to advocate for urgent measures to save lives.” (Escalating BC's Response to the Overdose Emergency, 2019, p.3 - 4).

“Heroic efforts have been made to mitigate the impacts of the opioid overdose crisis in our region. Extraordinary work by our frontline staff, leaders and partners have led to significant progress in immediate response measures such as improving access to life saving drugs (i.e., naloxone); reducing harms of using illicit substances with supervised consumption and overdose prevention sites; and expanding first-line treatment services. However, more work remains. Analyses like the ones in this report are critical to ensuring that our actions are evidence-based and meet the needs of the people we serve” (The Hidden Epidemic, 2018, p.2).

In this context, the policy documents note the physical toll the overdose crisis has had on B.C., and then situates the value of harm reduction, as narrated by service providers reversing overdoses through the use of naloxone. In the case of the following policy document, the setting of the policy framework is intended to provide an evaluation of existing interventions, including

harm reduction supports such as safe consumption sites and overdose prevention sites.

However, the setting of the following document sets harm reduction as an intervention that will be evaluated to determine its impact on managing overdoses and deaths:

“The overdose crisis is a result of a complex interaction between the characteristics and circumstances of people at risk of overdose, an unregulated illegal drug supply, and the environments in which people use psychoactive substances. There is no single or simple solution. However, a better understanding of the determinants of the crisis in VCH, such as patterns of drug use, the nature of the illegal drug supply, the challenges experienced by those using substances, and evaluations of interventions that have been implemented thus far can provide a roadmap for future response” (Response to the Overdose Crisis in Vancouver Coastal Health, 2018, p.5).

These documents provide support to Hyshka et al.’s (2019) conclusion that harm reduction policies “are typically crisis driven and often implemented in response to observed or expected increases in morbidity or mortality from imminent health threats (p. 146)”. Crisis-driven policy was echoed in pre-2016 documents featured a similar theme in terms of situating harm reduction in crisis-driven responses, such as the increased use of methamphetamine (*Crystal Meth and Other Amphetamines, 2004*), and alcohol (*Position on the Prevention of Problematic Substance Use, 2012*), thus a focus on crisis-driven harm reduction.

Two documents (*From Hope to Health: Towards an Aids-Free Generation, 2016*; *Collaborating for Action: Provincial Health Services Authority HIV/AIDS Strategic Framework, 2006*) positioned harm reduction as a means to manage and prevent the spread of HIV/AIDS:

“HIV/AIDS remains a persistent epidemic in British Columbia. While persons testing newly positive for HIV in B.C. declined from a peak of 30.5 per 100,000 in 1987 to 10.4 per 100,000 in 1999, the annual HIV rate has stalled at around 10 per 100,000 since then. It is currently estimated that there are between 8,000-13,000 people living with HIV in the province.... the Ministry of Health (MOH) forewarns, if left unaddressed, HIV/AIDS will result in considerable downstream personal and social costs but would also place enormous additional burden on B.C.’s health-care system...these changes signal a need for a strong coordinated provincial response to HIV/AIDS that supports regional health authorities and considers prevention, treatment, care, and support.....

However, the PHSA needs to enhance the effectiveness of its support to the regional health authorities in their HIV/AIDS and blood borne pathogens work. This document presents a framework on how the PHSA can implement this expanded role” (Collaborating for Action, 2006, pp.2-5).

Similar to other documents, the link to harm reduction is not expressed concretely, however as serving as a harm reduction policy document, it narrates its motivation as a need to provide a harm reduction framework to help support service providers in their work to reduce the spread and infection of HIV/AIDS. Subsequent harm policy documents stemming from historical documents also promoted the need for continued efforts to address HIV/AIDS:

“In 2013, the Ministry of Health released From Hope to Health: Towards an AIDS-free Generation (From Hope to Health). This policy framework serves as a guide to implement the successes from the Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS) pilot program (2009-2013). The goals, milestones and targets contained in From Hope to Health ensure continued improvement to reach and engage British Columbians in HIV prevention, testing, linkage to care, treatment and support, and provide targets for success to achieve an AIDS-free generation” (From Hope to Health, 2016, p.3).

It is important to note that while only two of the 14 included documents were premised on HIV/AIDS, historical policy documents from the pre-2106 period contained a greater focus on HIV/AIDS, as noted by the 14 HIV-AIDS exclusive documents from CHARPP that were excluded from this study, (Appendix A). This speaks towards the historical context of harm reduction policy in B.C. which was grounded in addressing the increased rates of HIV/AIDS in the late 1990’s and early 2000’s.

Only one document (*Every Door is the Right Door, 2004*); situated harm reduction as component of a broader provincial substance use and addiction framework and it was during the pre-2016 period:

“The planning framework will guide and support health authorities to ensure British Columbia has a comprehensive, compassionate, and effective response to addictions and problematic substance use within our current resources.... British Columbia recognizes addiction is a chronic health condition and is often linked to concurrent mental illness.

Effective services help people develop the resources to recover, improve their wellness and manage their long-term health” (Every Door is the Right Door, 2004, p. iv).

As this excerpt demonstrates, harm reduction is not recognized specifically, and substance use is embodied through a medicalized lens in which it is viewed as a disorder or chronic health condition.

Four documents (*A Pathway to Hope, 2019; BC’s Mental Health and Substance Use Strategy, 2017; A Path Forward, 2013; Healthy Minds, Healthy People, 2010*) positioned harm reduction as a means to providing a conjoined response to mental health and substance use.

In this specific context, harm reduction policy is framed as a priority to ensure there are adequate services to address complex mental health needs as seen in the following examples:

“At the heart of A Pathway to Hope is a powerful determination to make positive, lasting changes, so that B.C.’s system of mental health and addictions care works for everyone—no matter who they are, where they live, or how much money they make. Our vision is one where every one of us can live in a state of physical, spiritual, mental and emotional well-being...Mental health and substance use are tied to our general social, economic and physical well-being. Without good physical health, a safe place to live, good food to eat, and people who love and care about us, it is hard to remain mentally healthy in the long term” (A Pathway to Hope, 2019, pp.1,3).

“This is the first time that a First Nations and Aboriginal People’s Mental Wellness and Substance Use Ten Year Plan has been developed in the province of BC. A Plan was needed to transform systems and improve capacity to better meets the needs of First Nations and Aboriginal infants, children, youth, adults and Elders. This Plan is a beginning; it involves a growing family of collaborative partners committed to improving the mental wellness outcomes and reducing substance use challenges faced by First Nations and Aboriginal people. It involves everyone in as much as mental wellness and substance use matters touch everyone’s lives” (A Path Forward, 2013, p.5).

While these documents are intended to serve as harm reduction policy, they are premised heavily on the need to improve mental health.

Overall, the majority of 14 harm reduction documents do not situate harm reduction as its primary purpose. Rather harm reduction is often situated as a conjoined response to address other issues, such as mental health, substance use crises, and the spread of HIV/AIDS. This directly supports findings from Hyshka et al. (2017) who found provinces and territories tend to locate harm reduction under broader strategies related to addiction, mental health, and sexually transmitted infection and bloodborne pathogens.

4.4. Policy Beliefs and Values

The Q-NPF helped reveal two fundamental policy beliefs steering harm reduction policy documents: 1) health-equity related beliefs; and 2) non-equity beliefs. The analysis of the two policy beliefs are presented separately and are distinguished between the ways in which they conceptualize who/what is a risk factor for substance harms (villain), who/what is narrated as being subjected to harm (victim), and what is proposed as a solution to resolve and/or mitigate substance use harms (moral). It is imperative to remind the reader once again that the policy beliefs identified are not exclusive to specific documents (i.e. one policy document did not contain health-equity related beliefs exclusively). Rather, both beliefs were narrated simultaneously in the documents. The implications of this will be discussed in more detail in Chapter 5.

4.4.1. Health Equity-Related Beliefs and Values

Health equity-related beliefs are those that acknowledged health equity principles as outlined by Pauly (2008a) and the supplementary System Health Equity Lens (SHEL) framework (Pauly et al., 2018). This includes beliefs premised on acknowledging inequities in access to health and social services, social conditions that cause and are a result of substance use harm, and policy and program frameworks that further perpetuate health inequality and harm in the

context of substance use as well as programs and policies that emphasize promotion of health equity. Table 1.0 provides a summary of the NPF constructs representative of health equity beliefs. It was a deliberate choice to label this policy belief ‘health equity-related’ as it will be demonstrated that this policy belief does not encapsulate nor reflect health equity in its entirety based on Pauly’s (2008a) social justice lens for harm reduction and SHEL (Pauly et al., 2018). Rather, the equity-related policy belief acknowledges and reflect principles of health equity at a rudimentary level and tends to privilege equity in the confines of equitable access. The implications of this are discussed in more detail in Chapter 5.

Table 1.0 - Health Equity-Related Beliefs

<p>Villain: factors and/or characters narrated as responsible for influencing risk of substance use harms</p>	<ul style="list-style-type: none"> • Inaccessibility • Policy and Program Inequities • Social Conditions (e.g. stigma, discrimination, social determinants) • Individual Demographics/Personal History (e.g. race, gender, sexual orientation, socioeconomic status)
<p>Victim: factors and/or characters narrated as harms resulting from substance use</p>	<ul style="list-style-type: none"> • Vulnerable and Marginalized Groups • Social Harms (e.g. family breakdown, violence, crime, child neglect, absenteeism from work, unemployment, financial, and legal problems, and drug-related criminal activity)
<p>Policy Solutions (Moral): Proposed solutions outlined in policy documents as necessary responses to mitigate substance use harms</p>	<ul style="list-style-type: none"> • Improve Access • Equitable Policy and Programs • Address and Improve Social Conditions and Inequities • Community Empowerment and Collaboration • Promote Safe Substance Use

Villain

As confirmed in Chapter 3, the Q-NPF villain construct refers to factors and/or characters narrated as responsible for influencing risk of substance use harms. As it will be discussed, health equity-related beliefs were those that cast inaccessibility, systemic inequities from policy and program frameworks, social conditions, and one's social position/demographic as risk factors for harm.

The most predominant villain was the narration of inaccessibility as a risk factor for harm. Despite this acknowledgement, the identification and elaboration of the diverse social conditions that underscore and influence access were largely absent from the narratives. Instead, disparities in access were limited to geographical barriers, availability of harm reduction supplies, and availability of health and social services and programs. Such examples include select documents (*HRSS Policy Indicators, 2017; From Hope to Health, 2016; Collaborating for Action, 2006*) that noted the variation between health authorities in the reach of harm reduction supplies as an imposing risk of harm (i.e. naloxone, methadone, syringes), including the risk of contracting and spreading HIV/AIDS. In short, health equity in this form of understanding is limited to equity of access (Pauly et al., 2017).

There were few instances where access was linked to degrees of social marginalization and as a result, deemed a risk factor responsible for substance use harm. For instance, *A Pathway to Hope (2019)* acknowledged a lack of culturally safe care (i.e. care appropriate to the needs of marginalized groups) in combination with harm reduction in which it states,

“During our consultations, people from many different social, cultural and economic communities — including Indigenous, LGBTQ2S+, Chinese and South Asian communities — said a lack of accessible, culturally safe, non-discriminatory care was a barrier to getting the help they needed” (p.14).

Furthermore, documents that provided a lens on First Nations and Aboriginal substance use patterns attributed intersecting systemic social and political conditions as factors impacting equitable access to health services:

“First Nations and Aboriginal people often have a more difficult time accessing health services and related support services. Reasons for this include geographic location, jurisdiction, and the availability of services that consider First Nations and Aboriginal customs, values and beliefs, and histories of trauma. These service inequities are often compounded by other factors, such as gender, sexual orientation, and highly stigmatized diseases such as HIV or disorders like Fetal Alcohol Spectrum Disorder (FASD)” (A Path Forward, 2013, p.6).

An earlier policy document acknowledged the role of health care governance as a policy framework that impacts disparities in access to health programs and services for First Nations and Aboriginal communities in which, “jurisdictional conflicts between federal, provincial and territorial governments have resulted in unequal access to programs for Aboriginal people and a “confusing and unsatisfactory” funding situation” (*Every Door is the Right Door, 2004, p.21*).

Lastly, inaccessibility was largely narrated as an inability to meet the service needs of B.C.’s population. This was evident in policy documents that contained a focus on substance use and mental health:

“When it comes to delivering mental health and substance use programs on the ground, service demand exceeds service capacity. It’s as simple as that. The results of the systematic barriers to care have huge implications for British Columbians. Too many people end up not getting the care they need until their condition is severe and requires more extensive and expensive treatment. Those treatments often tend to be fragmented, with people having difficulty navigating their way between primary, community and acute or emergency services” (A Pathway to Hope, 2019, p.5).

In this context, it was acknowledged there are systemic barriers in preventing substance-harm.

However, very little elaboration was provided regarding the context and relevance of these barriers and the matter in which they further compound harm.

Health equity-related beliefs were also those that narrated multiple inequities from the standpoint of policy and programs. This included illegal/unsafe supply, criminalization, colonialism, and the lack of cultural safety and awareness in health and social services. Two documents situated in response to the overdose crisis acknowledged the ways in which the illicit nature of some substances further compounds the risk of harm for PWUD, both in the contexts of regulatory parameters for illicit drugs, and the presence of an illicit supply:

“Illegal drug overdose deaths are most closely influenced by the rapidly changing composition of local illegal drug supplies, and simply expanding treatment for opioid use disorder will be insufficient to eliminate the risk of opioid overdose death...It (a public health, regulatory approach) is an acknowledgement that psychoactive substances, including opioids, will continue to be used by people for a variety of reasons, and the illegal nature of these substances is the primary risk factor for overdose death” (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.29).

“The presence of lethal opioids such as fentanyl in the illicit drug supply is drastically increasing the risk of overdose. As a result, people are at higher risk of overdose” (The Hidden Epidemic, 2018, p.3).

Additionally, pre-2016 documents noted the influence of drug policy and enforcement practices on substance use harms:

“There is growing evidence that many of the harms associated with problematic substance use are related to policies and enforcement practices that prohibit such substances” (Position on the Prevention of Problematic Substance Use, 2012, p.3).

“The criminalization of people who use illegal drugs often compounds stigma and associated health harms” (BC HRSS Indicators, 2014, p.2).

Despite these narrations coinciding with health equity, there was no further elaboration offered to illustrate in what way policy and governance structures directly impart harm onto PWUD.

Health equity-related beliefs also assert substance use harms can be the result of historical policy flaws that were grounded in inequities. This was apparent in narrating the colonial history of B.C. and Canada as a direct threat to health outcomes for Indigenous communities and a risk factor for substance use harm:

“As a result of the history of trauma, in some communities Indigenous children and youth are at higher risk for mental health and substance use challenges” (BC’s Mental Health and Substance Use Strategy, 2017, p.8).

“The experience of colonization and residential schools has had devastating consequences for the health and well-being of Aboriginal people. One such consequence is that Aboriginal people experience many health inequities, of which problematic substance use is a prominent example” (Every Door is the Right Door, 2004, p.21).

A surprisingly few documents elaborated on the impact colonial practices have posed towards the experiences of Indigenous peoples within the health care institution, primarily through the lack of cultural safety and awareness provided in the provision of care:

“Colonial practices, past and present, mean that Indigenous peoples often do not have access to culturally safe care or care that integrates cultural practices and builds on individual and community resilience. As a result, Indigenous peoples and communities experience far poorer mental health and substance use outcomes. Indigenous peoples continue to experience stereotyping, racism and discrimination in the broader health-care system. Despite the need for services that are culturally safe and that integrate culture in the path to wellness, Indigenous peoples experience the greatest barriers to care” (A Pathway to Hope, 2019, p.7).

As noted in a policy document issued by the First Nations Health Authority, the lack of cultural safety and awareness in health care is as much a health care issue as it is a social justice one:

“First Nations and Aboriginal people need a range of culturally safe services and supports that respect their customs, values, and beliefs. Cultural safety in health care is about empowering individuals, families, and communities to take charge of their own health and well-being. It is important to note that achieving cultural safety requires that health institutions and service providers respect the diversity between and amongst First Nations and Aboriginal people and their worldviews. Currently there is an abundance of evidence to show that First Nations and Aboriginal people do not receive the same quality of health services or report health outcomes on par with other Canadians” (A Path Forward, 2013, p.6).

This excerpt embodies the foundation of a health equity lens for harm reduction as cultural safety and awareness aims to not only respect and honour the customs and values of others, but also seeks to ensure equitable health services and health outcomes. Further, this specific excerpt

demonstrates the importance of reconciliation with Indigenous peoples and the importance of healing to ensure health parity and overall wellness.

Equity-related beliefs strived to provide a holistic frame of substance use harm by narrating underlying social conditions, and their impact individuals' lives, as risk factors for harm. The most comprehensive narration appeared in a 2013 document published by the First Nations Health Authority:

“Many factors have contributed to the current mental wellness and substance use realities and concerns for First Nations and Aboriginal people; some of these factors include: colonization, residential schooling, assimilation, physical, emotional, mental and sexual abuse, systemic discrimination, child apprehension, over-representation of First Nations and Aboriginal people in the criminal justice system, and a loss of tradition, territories, language, and culture. These factors have created an environment that has negatively impacted the social and economic structures, personal psychology, and coping strategies of many First Nations and Aboriginal individuals, families, and communities. Adverse, multi-generational health effects are at the root of inequities in the health and well-being of First Nations and Aboriginal individuals, families and communities” (A Path Forward, 2013, pp.5-6).

Select documents (*Escalating BC's Response to the Overdose Emergency, 2019; Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018; A Hidden Epidemic, 2018; HRSS Policy Indicators Report, 2017; A Path Forward, 2013; Healthy Minds, Healthy People, 2010; Every Door is the Right Door, 2004*) also narrated social determinants of health (SDOH) as social conditions that influence risk to harm. However, very little specification or elaboration was provided in terms of what specific SDOH factors were included in this distinction and the matter in which SDOH factors are interconnected with and further exacerbate substance use harm. Rather, there were straight-forward characterizations of SDOH as a villain for substance-related harm. This includes general statements such as *“social determinants of health may exacerbate the stigma and discrimination experienced by peers. It is at the core of health equity practices such as harm reduction” (BC HRSS Policy Indicators Report, 2017, p.33)*. One

regional report substantiated social determinants of health as posing risk to developing problematic substance use, specifically noting:

“there are many complex, often co-existing risk factors for problematic substance use, including early childhood trauma, intergenerational trauma due to the history of colonialism among Indigenous people, and acute and chronic pain. Other social determinants, including poverty, contribute to the risk” (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.31).

An identical narration was also featured in 2004:

“a number of risk factors have been identified which predispose some people to the development of problematic substance use. These risk factors include: physical, sexual or emotional abuse; growing up with a parent who is mentally ill, suicidal, in prison, addicted, or absent; having a concurrent mental illness; and/or having limited or no social supports or a social group which is typified by substance use” (Every Door is the Right Door, 2004, p.11).

Other social conditions framed as risk factors for substance use harm included stigma and discrimination. As noted by the BC HRSS Policy Indicators Report (2017), stigma is defined as:

“an attribute or quality which discredits an individual in the eyes of others. Stigma is also defined as a process in which society devalues and excludes people with a socially undesirable attribute by associating this attribute with negative stereotypes. It can negatively affect a person’s self-esteem, cause shame about their substance use and may prevent those with substance use disorder from accessing harm reduction and treatment services or telling friends or family members about their health challenges” (p.33).

Stigma and discrimination were narrated as direct threats to PWUD, predominantly in the confines of health outcomes and social wellbeing. As reflected in a 2012 Northern Health document:

“In those with substance use disorders, stigma contributes to adverse outcomes. Adverse outcomes may include the development of poor mental and physical health; not seeking, entering or completing treatment; delayed recovery and reintegration and increased risky behaviour (e.g., needle sharing). Stigma exacerbates social alienation and impacts other domains of life and determinants of health, such as education, employment, income, housing and social relationships” (p. 7)

An additional document clearly illustrated stigma as a systemic factor that influences harm, noting the manner in which stigma influences the risk of engaging in unsafe substance use practices, such as using in isolation:

“Individuals who use drugs alone are at particularly high risk of death. While some individuals prefer the experience of using drugs alone, others use alone because of the stigma of drug use and because they are trying to cope with mental health issues or other stressors by themselves” (The Hidden Epidemic, 2018, p.12).

Further, the most recent document, *A Pathway to Hope (2019)*, explicitly characterized stigma, in conjunction with affordability, as a barrier to accessibility:

“Stigma and affordability stand out as substantial systemic barriers to care. Fear and misunderstanding often lead to prejudice against people with mental illness, substance use and addiction challenges — and this discrimination comes far too often from health and social service providers themselves” (p.6).

What was most profound from this specific narrative was the acknowledgement of the rapprochement between one’s personal view of substance use and addiction and the professional provision of health care services for PWUD. This illustrated the ways in which social conditions can shape and inform conditions within the health care institution and interactions between care providers and PWUD.

Finally, health equity-related beliefs narrated one’s individual social position and demographic characteristics as risk factors that place PWUD at greater vulnerability for harm. This included sex, gender, sexual orientation, race, socioeconomic status, criminal activity and diagnoses of concurrent mental health illnesses; however, little elaboration was provided in terms of the depth and breadth of these factors, how these factors may magnify substance use harms, and how they should be addressed in policy. As noted in the most recent document:

“Some people have a predisposition to substance use disorder based on genetic risks, or experience environmental (e.g. stress, trauma) risks or social inequalities and challenges (i.e. poverty, housing affordability)” (A Pathway to Hope, 2019, p.24).

Select documents explicitly acknowledge the impact of sexism and the prevalence of gender-based violence as a factor for substance use harms:

Differences also occur as a result of higher rates of sexual abuse, exploitation and violence against women. The development of problematic substance use and mental disorders can be a result of histories of sexual and physical abuse. Girls are more vulnerable to sexual assault and abuse while under the influence of substances. They are also more likely to be forced into the sex trade and be exposed to associated substance use harms. (Every Door is the Right Door, 2004, p.19)

Further, HIV/AIDS-focused documents narrated sexual orientation as a compounding risk factor for substance use harm in which, “men who have sex with men and intravenous drug users were viewed as factors that pose significant risk to HIV/AIDS, a major substance-related harm” (Collaborating for Action, 2006, p.2).

Victim

The victim construct refers to actors and/or characters narrated as harms resulting from substance use. Equity-based policy beliefs predominantly characterized two factors as victims of substance use harms: 1) marginalized, vulnerable groups, and 2) social harms.

In terms of marginalized, vulnerable groups, policy documents narrated those who are homeless, living in poverty, incarcerated, in the sex trade and are of First Nations/Aboriginal ancestry as facing greater victims of harm. Explicit narrations of the intersection between substance use and social vulnerability included:

“The most affected population in VCH faces greater social and economic inequalities than populations affected elsewhere. Those who died in VCH in 2017 were less likely to be employed and more likely to live in social or supportive housing than those who died outside VCH” (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.26).

“Although substance use is common across BC, regardless of race, ethnicity or background, the opioid crisis is disproportionately affecting First Nations peoples and communities Status First Nations people are five times more likely to have an overdose event and three times more likely to die than non-First Nations people. Unlike non-First Nations people, where overdoses are occurring more frequently in men, overdoses are occurring more equally among men and women in First Nations people” (The Hidden Epidemic, 2018, p.5).

“The First Nations population is five times more likely to be hospitalized due to psychoactive substance use. In 2006, the rate of alcohol related deaths was 15.1 per 10,000 compared to 3.4 per 10,000 for other residents.10 41% of deaths resulting from motor vehicle accidents were alcohol related, which is more than twice the percentage of other BC residents” (A Path Forward, 2013, p.19).

“People with problems associated with mental health and/or substance use are disproportionately represented in homeless shelters and correctional facilities” (BC’s Mental Health and Substance Use Strategy, 2017, p.9).

There was a stark observation where two documents simultaneously identified the disparate impact of harms on marginalized groups yet sought to present harm as a universal risk:

“While marginalized people living in poverty are over-represented in this crisis, it has impacted people from all walks of life, nearly all ages, education levels, professions, and incomes, from every region in BC” (Escalating BC’s Response to the Overdose Emergency, 2019, p.3).

“It’s important to remember that use of illicit substances and receiving income or disability assistance do not always go together. Not everyone who uses illicit drugs receives income or disability assistance, and not everyone who receives income or disability assistance is at risk of overdose” (The Hidden Epidemic, 2018, p.6).

Granted, while everyone faces some degree of risk to substance-related harms, these statements exemplify attempts to narrate substance use harms as non-discriminatory, and while there is arguably some truth that everyone is at some risk of substance-related harm, the literature has extensively highlighted the various ways in which underlying social inequities magnify the risk and effects of substance use harms, thus risks are unequally distributed (e.g. Pauly, 2008a, Pauly, 2008b; Galea & Vlahov, 2002; Smye et al., 2011). On the other hand, it is also important to acknowledge the policy narratives may have attempted to recognize that anyone who accesses an

illicit drug market is vulnerable to overdose, which is correct in terms of physical harms.

However, these narrations failed to acknowledge or elaborate on the ways in which substance harms vary throughout a social gradient in which harms increase in the context of inequities, such as for those who are homeless compared to those who have stable housing; those who are receiving social/income assistance compared to those who have stable income.

One document narrated victimization of substance-related harms on the basis of sex and socioeconomic status. For example, a regional report noted the majority of those who died from opioid use were unemployed at the time (*Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018*); however, very little explanation followed to explain or link socioeconomic status to substance-related harm, or the ways in which socioeconomic status challenges such as unemployment will be addressed. In comparison, one document (*A Pathway to Hope, 2019*) identified affordability as a barrier to accessing counselling supports and residential substance use services; however, there was no specificity pertaining to the context of access to substance use services. One could assume this was in reference to the lack of available publicly funded rehabilitation centres and psychological health services and professionals in B.C.

Additional documents, both regional and provincial, narrated sex differences in victimization of substance-related harms noting the overdose crisis has greatly impacted men in the specific region, in addition to age whereby those aged 30-39 had the highest amount of opioid-related deaths (*The Hidden Epidemic, 2018*). Policy documents prior to the overdose crisis featured a similar pattern in which there was notation of sex differences in substance-related harms for women. For example, a 2004 document stated:

“Women suffer more severe health consequences from drinking, smoking and illegal drug use, including lung damage, brain damage, cardiac problems, liver disease and reproductive health problems. This may be partially because women metabolize alcohol and other psychoactive substances more slowly than men, allowing harmful metabolites to remain in the body longer” (Every Door is the Right Door, 2004, p.19).

As these narratives exemplify, harms stemming from substance use were limited to the individual biological level and this pattern remained constant in policy documents that narrated social harms as ‘victims’. For instance, acknowledging social harms resulting from substance use were limited to social costs at the individual level such as job loss, familial breakdown from financial strain, emotional turmoil and child neglect. As noted in a 2004 document:

“problematic substance use of methamphetamine and other illicit drugs affects a large proportion of the population both directly and indirectly. These harmful impacts may include loss of productivity and wages, disability and death due to overdose, as well as enforcement, social and health costs. These detrimental effects to the health and well-being of individuals, families and communities can be prevented and reduced (Meth Strategy, 2004, p.5)

Other narrations acknowledged social harms more broadly, including:

“Harms caused by or associated with problematic substance use are broad. They include harms at the individual level, system level, and societal level. Social harms include family breakdown, violence, crime, child neglect, absenteeism from work, unemployment, financial, and legal problems, and drug-related criminal activity” (Position on the Prevention of Problematic Substance Use, 2012, p.3).

Interestingly, social conditions seemed to be narrated more often as a risk factor for substance use harms (villain) as opposed to narrating the ways in which substance use can exacerbate social conditions and social inequities (i.e. as victims of harm). Overall, there was a considerable lack of acknowledgement and specificity towards the ways in which broader social harms, such as racism, poverty and homelessness, are further compounded as substance use harms in addition to influencing the risk of harm. Even more glaring was the absence of narrating inequitable social conditions outside of individual characteristics as victims of

substance use harms in post-2016 documents. As noted in the previous excerpts, post-2016 documents typically narrated social conditions as a victim of harm at the individual level, such as gender, socioeconomic status, and race. Yet, they failed to identify and narrate the underlying social conditions such as systemic racism, sexism, and discrimination as the basis for these harms. Instead, there was more emphasis on individual characteristics of those who are harmed.

Proposed Solutions (Moral)

The moral construct of the Q-NPF was in reference to the proposed solutions outlined in policy documents. As this section will illustrate from examples from the policy documents themselves, equity-based policy beliefs are those that promote solutions that aim to increase equitable access to services, improve social conditions, improve systemic equity at the policy and program level, increase community engagement and empowerment, and preserve an individual's right to safe substance use.

Given that accessibility was narrated as a risk factor for substance-related harm, it was no surprise to see solutions premised on ensuring equitable access. This was actualized in policy documents that advocated for and recommended a need to improve accessibility both in terms of increasing reach of harm reduction services and access to social and health services, such as expanding affordable community counselling and team-based primary care and specialized services (A Pathway to Hope, 2019), or expanding access to specific treatment for people at high risk (BC's Mental Health and Substance Use Strategy, 2017-18; BC HRSS Policy and Guidelines, 2014). While health equity-related beliefs seek to improve accessibility for those who face barriers, there was little to no guidance offered towards how access will be improved through these measures, nor resolutions that seek to address the underlying social conditions shaping accessibility. For example, there were more instances where improving accessibility was

narrated in the context of improving service delivery, either by connecting individuals to non-health services or increasing the availability of programs and initiatives. This included recommendations such as:

“Facilitate referrals targeted for housing, income support, food services, gender-specific services (no example provided in text), parenting assistance, youth services, public health, primary care, mental health services, legal services/victim services, disease testing/management/treatment, and other related services” (BC HRSS Indicators, 2014, p.9).

“to expand the reach and range of harm-reduction services that prevent and reduce the health, social and fiscal impacts of illegal drug use” (Healthy Minds, Healthy People, 2010, p.23).

“Community counselling services will be expanded to help people access psychotherapy that they may not be able to afford because they do not have an Employee Family Assistance Program or Extended Health Plan. Through grants to non-profit organizations across the province that provide sliding scale or free counselling services, this initiative will create multiple, easy-to-access entry points that extend counselling beyond mainstream programs, including for individuals who face barriers related to race, ethnicity, religion, gender, age, social class and/or sexual orientation” (A Pathway to Hope, 2019, p.27).

A health equity framework also values and recommends the need to develop public policies that create the conditions for health and reduce structural and social vulnerabilities (Pauly, 2008a; Pauly et al., 2018). This was reflected in documents that narrated improvements to the design and delivery of public policies and programs by tailoring them to the needs of marginalized group as proposed actions/solutions:

“Lesbian, gay, bisexual and transgendered (LGBT) people require tailored interventions and supports, planned in partnership with these communities. People from this group may face challenges in terms of acceptance or marginalization in the form of homophobia. Substance use is perceived by some in the LGBT populations to be a part of their social world, so preventing or getting help for problematic substance use may pose more difficulty. Initiatives need to be developed that build on the culture and communication strengths of LGBT individuals and their communities” (Every Door is the Right Door, 2004, p.22)

“Northern Health should collaborate with other health authorities, the Ministry of Health, community organizations and academic groups to enhance monitoring and

surveillance; monitor characteristics of vulnerable populations within the health authorities, taking into account the social, economic and environmental determinants of health; gather, assess and report statistical information from a range of sources to reflect current status and trends related to the use and harm of alcohol, cannabis and other psychoactive substances, and establish an evaluation framework for the program on prevention of harms associated with substances” (A Position on Problematic Substance Use, 2012, p.12).

“Acknowledge and collaboratively develop programs to support the diversity of people seeking help for problematic substance use, such as differences in gender, age, ethnocultural background and sexual orientation” (A Position on Problematic Substance Use, 2012, p.12).

“Develop policies and standards to support equitable access to and reach of health and human services for First Nations and Aboriginal people” (A Path Forward, 2013, p.25).

The OERC will identify legislation, regulation and policies that may inhibit people at risk of overdose from accessing health and social services and make recommendations for changes. (Escalating BC’s Response to the Overdose Emergency, 2019, p.11).

Additionally, health-equity beliefs narrated solutions that aimed to promote the provision of culturally-safe care. As noted in *A Path Forward* (2013), “cultural safety in health care is about empowering individuals, families, and communities to take charge of their own health and well-being. It is important to note that achieving cultural safety requires that health institutions and service providers respect the diversity between and amongst First Nations and Aboriginal people and their worldview” (p.6). Cultural safety, in this context, aligns closely with elements of equity as outlined in Pauly (2008a) and Pauly et al. (2018) in which the community and its members are empowered to be involved in the design and delivery of the interventions and services. This also aligns with the founding principles of harm reduction, the commitment to collaborating with network of people who use drugs (Harm Reduction International, 2019). Cultural safety was featured in narratives that advanced the priority to ensure Indigenous communities were also included and reflected in in the design and delivery of programs and initiatives that aim to improve health outcomes:

“Support the development and implementation of Aboriginal-specific prevention and harm reduction plans to address problematic substance use” (Position on Problematic Substance Use, 2012, p.10).

To improve services, supports, and health outcomes for all First Nations and Aboriginal people in BC; To keep First Nations and Aboriginal people’s well-being at the center of our initiatives, while maintaining a high operational standard, and cross- sectoral integration; To ensure that mental wellness and substance use strategies and actions for First Nations and Aboriginal people reflect individual and family needs and are Community-driven and Nation-based; To engage First Nations and Aboriginal people in the journey towards improving health outcomes” (A Path Forward, 2013, p.14).

These two excerpts were focused primarily on increasing interventions and services that are tailored to the needs of specific populations, rather than embodying the core of equity as outlined in Pauly (2008a) and Pauly et al. (2018). In comparison, one narration specifically noted the need to ensure Indigenous communities are empowered to lead and provide direct input into the provision of care:

“The Province recognizes that Indigenous communities are in the best position to make decisions about the health and wellness of their people. A key focus of this framework is continuing to build, strengthen and evolve our partnerships with Indigenous peoples...by funding and supporting Indigenous-designed, Indigenous-led and Indigenous-delivered care, we are supporting self-determination” (A Pathway to Hope, 2019, p.21).

Here, the focus is centred on ensuring people are involved in decisions that directly affect their lives as opposed to creating services targeted for a specific population group. In addition, two 2017 documents coupled cultural safety with harm reduction for Indigenous people:

“Enhance land-based and culturally-safe healing and substance-use treatment for First Nations communities. This will expand access to innovative treatment services that take place on the land, are rooted in ceremony, and include traditional land-based activities such as hunting and fishing. Program activities may include culturally based assessment, detox, case management, treatment services with appropriate follow up/referrals, aftercare, and ongoing monitoring” (BC’s Mental Health and Substance Use Strategy, 2017, p.21).

“Those healing journeys include opportunities to reclaim wellness through ensuring culturally- safe health and social services; emphasizing a connection to land, culture, and traditional healing; reducing the stigma around substance use; and providing

alternatives to abstinence-only healing approaches” (Escalating BC’s Response to the Overdose Emergency, 2019, p.7).

Similar to other proposed solutions, the need to adopt and implement culturally safe care and culturally safe practices was often devoid of specific guidance on what that would entail in practice, as apparent in the following narratives:

“This is all supported by a commitment to strengthen cultural safety and humility across the mental health and addictions system to ensure Indigenous peoples have access to care that is free of all forms of racism and stigma, and that the system includes significant cultural supports and interventions” (A Pathway to Hope, 2019, p.22).

“Ensure health care providers apply an integrated approach to assessments, referrals, diagnosis, treatment, and after-care for First Nations and Aboriginal people experiencing mental wellness and/or substance use issues, including those with chronic diseases” (A Path Forward, 2013, p.29).

“In practical terms, we need to ensure services are culturally safe, trauma informed and rooted in culture and community. As such, a key area of focus will be to embed cultural safety through humility in all programs and services, and ensure care is informed by an understanding of the intergenerational trauma experienced by Indigenous people” (BC’s Mental Health and Substance Use Strategy, 2017, p.8).

“In partnership with FNHA and key stakeholders, MMHA will promote a spectrum of culturally-based, culturally-safe and trauma-informed substance use treatment and recovery services, including First Nations and Indigenous land-based detox and treatment services. We will ensure that all programs and services are consistent with joint mental health and wellness principles: person-and family-centred, wellness-focused and recovery- oriented, trauma-informed and responsive, aligned with cultural safety and humility, and culture- and community-centred” (Escalating BC’s Response to the Overdose Emergency, 2019, p.14).

“Make sure that health and human service providers work in a manner that is culturally safe and respects individual customs, values, and beliefs” (A Path Forward, 2013, p.24).

Health-equity related beliefs were also characterized by narratives that promoted the need to foster the inclusion and engagement of individuals with lived experience of substance use in the policy and program development process, aligning the basic principles of harm reduction (Harm Reduction International, 2019). This was prevalent in policy recommendations that

acknowledged the importance of including PWUD in policy development, knowledge exchange, program design and service delivery. For example, the *BC HRSS Policies and Guidelines* (2014) narrates the importance of engagement and participation of PWUD: “the meaningful participation and active engagement of people who use psychoactive substances, and those who may experience sexual health harms, in the design and delivery of policy, programs and services is central to effective development and provision of harm reduction interventions” (p. 2).

Furthermore, the most recent policy document (*A Pathway to Hope, 2019*) framed the inclusion and engagement of PWUD as an integral component to the future direction of policy and services as “people with lived experience inform and are leaders in mental health and addictions policy, planning and delivery of services and support” (p. 14). Specifically, for HIV/AIDS harm reduction policy, the inclusion and engagement of younger British Columbians, especially younger men who have sex with men, and people who inject drugs, is vital to secure adherence to treatment and achieve viral suppression (*Collaborating for Action, 2006; From Hope to Health, 2016*).

Health-equity related beliefs seek to address underlying social conditions and structural factors, such as criminalization, as means to reduce harm. This was apparent in narrations where there was a communicated need to ensure a safe supply regulation to decriminalize PWUD and reduce the risk of drug-related fatalities:

“A regulated supply of pharmaceutical opioids is necessary to reduce the risk of death in a number of high-risk populations.... establishing a public health, regulatory approach to psychoactive substances is recommended by the Health Officers’ Council of BC to reduce the risk of harm from illegal and legal psychoactive substances. It is not an alternative to expanding prevention and treatment, but a critical additional strategy to reduce population harms. It is an acknowledgement that psychoactive substances, including opioids, will continue to be used by people for a variety of reasons, and the illegal nature of these substances is the primary risk factor for overdose death” (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.29).

This recommendation was limited to three documents in the dataset, two of which were premised on responding to the overdose crisis (*Position on Problematic Substance Use, 2012; Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018; Escalating BC's Response to the Overdose Emergency, 2019*).

Equity-based beliefs also promoted solutions to address underlying social conditions and social inequities that intersect with substance use harms, such as social determinants of health, homelessness and social stigma. In earlier documents, this was promoted through the proposed solution to incorporate a population health perspective in health service planning:

“The population health concept provides the most promising long-term prevention strategy and pathways for effective interventions. The population health approach considers the influence of living and working conditions, social environments, culture and access to health services on health and well-being of groups of people. It recognizes adequate income, employment, housing and social support are as important to keeping people healthy and safe as access to health care” (Every Door is the Right Door, 2004, p.25)

Documents published after 2004 featured policy solutions that stressed the importance of addressing social determinants in terms of substance use; however, narrations did not specify which specific social determinants were of priority and in what capacity they will be addressed:

“Building on the established tripartite health partnership, Canada, British Columbia and B.C. First Nations will continue to work together over the next few years on a vision for a 10-year strategy to address social determinants of health and improve the conditions in which people in First Nations communities are born, grow, work, live and age, and the wider set of forces shaping the conditions of life” (A Pathway to Hope, 2019, p.22).

“The determinants of health need to be acknowledged and addressed through broader public health and social policy. The health system must work with partners outside the health sector to shape policies and decisions that affect large segments of the population (e.g., safe school environments). ActNow BC has demonstrated that the most effective responses to complex health concerns require broad sectoral engagement in order to influence the social and environmental factors that can determine health status” (Healthy Minds Healthy People, 2010, p.11).

Solutions that narrated the importance of addressing underlying social conditions were few in post-2016 documents. For instance, a 2018 regional document (*Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018*) promoted the need to “enhance strategies to reduce poverty, including access to adequate housing and social enterprises that can lead to meaningful employment for those at risk of overdose death” (p.31).” Additionally, another document featured recommendations dedicated to improving homelessness, yet little regard to resolving the multitude of factors that influence homelessness:

“Wellness also refers to ensuring people have the resources to care for themselves and their families. The Government of B.C. is investing \$65 million to provide housing for people with mental-health or substance-use challenges. A mix of new housing will be developed to meet the needs of a wide variety of people in communities throughout the province. This funding is in addition to the \$855 million committed to support the purchase, construction or renovation of affordable housing rental units throughout the province. With this new investment, government has committed a total of \$920 million to support 5,280 housing units provincewide (BC’s Mental Health and Substance Use” Strategy, 2017, p.15).

Similarly, one document acknowledged that housing is a determinant of health, which was used to rationalize the need to invest in solutions that resolve homelessness. However, the call to address homelessness was supported by an argument about the economic benefits stable housing would provide to fiscal management as opposed to the social benefits:

“Housing is an important determinant of both physical and mental health. Individuals with severe mental illness and substance use problems experience significant difficulties securing stable housing. Specific populations such as Aboriginal persons and women are overrepresented among those with unstable housing. Providing adequate housing support is cost effective. An adult with severe substance use and/or mental illness who is homeless or lives on the street costs the public system in excess of \$55,000 per year – the provision of adequate housing and supports is estimated to reduce this cost to \$37,000 per year” (Healthy Minds, Healthy People, 2010, p.34).

Additional recommendations to improve social conditions were focused on reducing social stigma, as one documented noted, “tackling stigma and discrimination is an essential step in creating a system that is inclusive, accessible, and sustainable. The need to change the language of mental illness and to focus on the concept of recovery rather than on the illness and its severity is emphasized (*Healthy Minds, Healthy People*, 2010, p.10). To reduce stigma, solutions were typically geared towards increasing public education and awareness as evident in the following proposed solutions:

“Increase activities to reduce stigma and discrimination against people who use drugs, and raise public awareness and understanding of harm reduction principles, policies and programs among professionals in the health, social and criminal justice systems, officials in all levels of government, and the general public” (BC HRSS Policy and Guidelines, 2014, p.3)

“The Ministry of Mental Health and Addictions (MMHA) will continue to work with private- and public-sector partners to deliver overdose awareness messages to reduce stigma and discrimination, and to increase public education and awareness; MMHA will continue to explore opportunities to reduce stigma through partnerships with the Government of Canada, FNHA, and First Nations and Indigenous organizations. MMHA will continue to support health authority-led anti-stigma and anti-discrimination campaigns targeted at health care providers” (Escalating BC’s Response to the Overdose Emergency, 2019, p.10).

“Address stigma and discrimination towards people with problematic substance use. Become role models in communities through organizational policies and practices which ensure programs and services reflect positive, respectful and compassionate attitudes and behaviours towards those who use substances” (Position on Problematic Substance Use, 2012, p.13).

Equity-based beliefs further promoted solutions that emphasize the importance of collaborating with and empowering communities to address substance use harms. As outlined in *Every Door is the Right Door* (2004), community capacity building involves the identification of key community assets and the development of networks and partnerships. It can prevent problematic substance use and mental health problems by strengthening individual resilience,

empowering organizations, mobilizing social and economic resources, and encouraging shared responsibility and collaboration. While many recommendations throughout the documents featured community partnerships and community capacity building, very little guidance was provided in terms of specifying how this will be achieved and what harms will be addressed through this approach. This was most evident in proposed solutions such as:

“Support integrated community safety initiatives that work in collaboration with other human service providers to address developing or existing community problems before they become larger community issues. In most cases, the goal is to strengthen collaboration amongst justice, health, and social service partners to better address the root causes of existing and emergent issues, such as crime and mental health, in the identified community” (BC’s Mental Health Substance Use Strategy, 2017, p.22).

“The success of the Plan will depend upon partnerships and relationships that have reciprocal accountability. It means that each Partner is accountable to the other for its actions, and for the effective implementation and operation of their responsibilities and systems, recognizing that our work as Partners is interdependent and interconnected. This means that we will need to work together at all levels in a collaborative manner to achieve our shared goals related to mental wellness and substance use challenges” (A Path Forward, 2013, p.5).

Community capacity building involves the identification of key community assets and the development of networks and partnerships. It can prevent problematic substance use and mental health problems by strengthening individual resilience, empowering organizations, mobilizing social and economic resources, and encouraging shared responsibility and collaboration (Every Door is the Right Door, 2004, p.27)

Select documents narrated community responsibility as increasing public financial support for communities to provide substance use and mental health services:

“Government has recognized that addressing mental health and substance use is a shared responsibility. A \$10-million grant from the provincial government in 2008 established the Community Action Initiative. The initiative is supporting community action to promote mental health, prevent substance use problems and support treatment when problems occur” (Healthy Minds, Healthy People, 2010, p.11).

Finally, health-equity related beliefs were those that narrated solutions that preserved the right for people to use substances. This was depicted in proposed solutions that emphasize safe substance use, such as recommendations to increase the distribution of and access to substance use paraphernalia, provide safe spaces to consume drugs, and empower PWUD to become informed of the risks and harms associated with substance use. Policy responses such as Overdose Prevention Sites (OPS) and safe injection sites were narrated favourably to illustrate the benefits stemming from services that promote safe substance use:

“The goal of OPS is to provide a space for people to inject their previously obtained illicit substances with sterile equipment in a setting where OPS staff can observe and intervene in overdoses as needed” (BC HRSS Policy Indicators Report, 2017, p.33).

“With significant increases in the number of people dying from overdoses in B.C. (and a public health emergency called in April 2016) improving the reach and range of these supplies and services is crucial for both HIV prevention and safer drug use consumption” (From Hope to Health, 2016, p.3).

These two excerpts align with the principle of harm reduction, respecting the rights of those who use drugs (Harm Reduction International, 2019) in which there is a concerted focus on harm reduction being about providing a safe space to use substances, and providing an environment where one’s use of substances does not impede upon their entitlement of to the highest standard of care, social services and personal freedom. Rather, it facilitates it. Other narrations were also premised on harm reduction that respects the right to use substances. However, there was more emphasis on harm reduction as a space that reduces physical harms:

Drug checking can also provide useful information about the presence of other substances, like synthetic cannabinoids, metformin, detergent, and plaster, that can cause harm to people who unknowingly ingest them (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.7).

“At Insite people can consume substances under supervision of staff who are trained to respond to overdoses. Insite also provides nursing support and opportunities to link to services including addictions care. Insite has been extensively evaluated and

demonstrated to reduce harms associated with injection drug use” (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.13).

4.4.2. *Non-Equity Beliefs*

Non-equity policy beliefs evident in harm reduction policy texts were those that predominantly conveyed other paradigms of distributive justice outlined in Pauly (2008a), including utilitarian belief (as apparent in abstinence /desistance narratives) and liberal individualist/neo-libertarian beliefs (as seen in narrations that emphasize personal responsibility and fault for harm). Additionally, non-equity beliefs were those that placed responsibility on the design and delivery of services and interventions to address substance use harms. As the reader will recall, non-equity beliefs were present alongside equity-related beliefs in the policy documents therefore it is important to take this into account during this analysis as non-equity beliefs in this context are less problematic than if policy documents reflected non-equity beliefs exclusively. Table 2.0 provides a summary of what categories operationalized the constructs of non-equity beliefs.

Table 2.0 - Non-Equity Beliefs

Villain: factors and/or characters narrated as responsible for influencing risk of substance use harms	<ul style="list-style-type: none"> • Individual Substance Use Behaviour and Practices • Service and Program Delivery Flaws
Victim: factors and/or characters narrated as harms resulting from substance use	<ul style="list-style-type: none"> • Economic Harms • Service Harms • Physical Health Outcomes • Threat to Public Safety and Order
Policy Solutions (Moral): Proposed solutions outlined in policy documents as necessary responses to mitigate substance use harms	<ul style="list-style-type: none"> • Desist or Abstain from Substance Use • Increase Interventions and Treatment • Improve Service Delivery • Improve Physical Health • Enhance Individual Responsibility for Harm • Secure Public Safety and Order

Villain

Non-equity beliefs tend to narrate individual behaviour and service/intervention design flaws as risk factors responsible for substance harm. Individual responsibility for harm was apparent in narrations that attributed individual substance use practices and behaviour, such as sharing equipment, method of consumption, and substance choices, as factors deemed responsible for harm:

“The vast majority of newly acquired HCV is due to sharing injection equipment” (BC HRSS Policy Indicators Report, 2017, p.6).

At an immediate level, this excerpt contains truth in that new HCV rates stem from sharing equipment. However, it is problematic as it fails to account for proximal social factors that contribute to sharing equipment, such as lack of services or supplies. Other documents attributed substance use practices with harm:

“People who smoke crack often use wire wool (frequently referred to by the brand name ‘Brillo®’) as screens. This practice has been associated with injury, as small pieces of steel wool may break off, which can cause burns on the lips or mouth” (BC HRSS Policy Indicators Report, 2017, p.26).

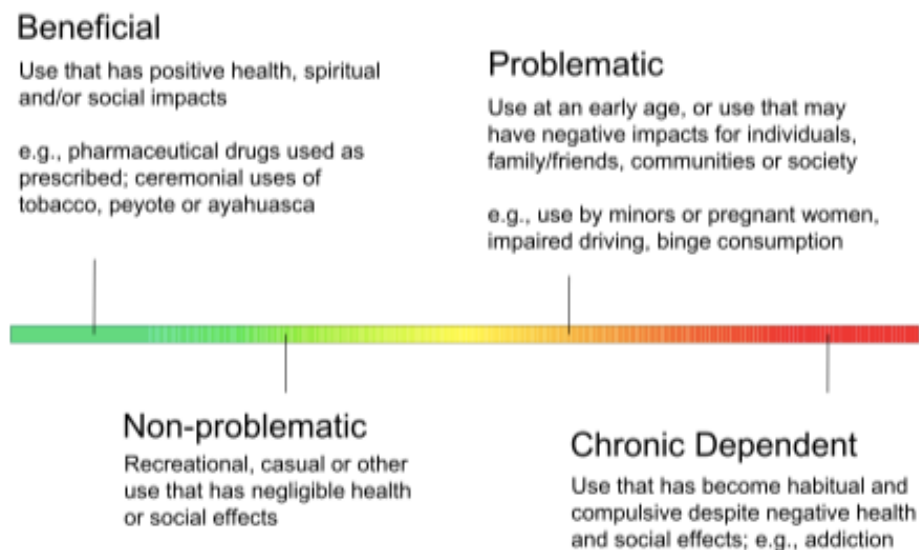
“Methamphetamine is rarely used in isolation. In fact, methamphetamine use may occur together with other illicit drugs or prescription amphetamine misuse, including in dangerous combination with other substances: cocaine or crack, marijuana, heroin and alcohol” (Crystal Meth and Other Amphetamines, 2004, p.5).

Despite narrating individual substance choice and practices as risk factors for harm, there was a lack of acknowledgement that sharing substances is a common practice in drug culture, especially for individuals who do not have access to safe equipment or can afford to purchase substances themselves. Only one document identified that using non-sterile equipment often stems from a lack of availability and affordability (*HRSS Policy Indicators Report, 2017*).

Other substance use behaviour patterns narrated as risk factors for harm included problematic substance use. As defined in the policy document, *Position on the Prevention of Problematic Substance Use*, “problematic use refers to substance use that negatively impacts individuals, families, friends or the community and a subset of problematic use includes chronic dependent use (i.e. addiction) (2012, p. 2).” Figure 3 depicts the visual representation of the substance use spectrum outlined in three policy documents (2012 FNHA (source of image); 2013 NHA; 2010 Healthy Minds).

Figure 2 - Spectrum of Substance Use

The spectrum of use visually conveys the categories of instances or patterns of substance use, ranging from beneficial and non-problematic, to problematic or dependent uses.



Approximately fifty percent of the policy documents (Pre-2016 = 5; Post-2016 = 2)

narrated problematic substance use as a general risk factor for harm:

“Problematic substance use represents a profound challenge to our services and our communities. This challenge can be met through an integrated, multi-faceted approach which balances prevention, treatment, self-management and harm reduction within a comprehensive response in which every door is the right door. This framework has been created to support this response” (Every Door is the Right Door, 2004, p.2).

“The spectrum of psychoactive substance use shows how people can have a variety of relationships with alcohol or other drugs that alter consciousness or affect our minds. Some people choose abstinence and use no substances at all.... some people who use substances do so in beneficial or non-problematic ways, such as drinking coffee to stay alert, or ceremonial uses of tobacco, peyote, or ayahuasca; others drink alcohol moderately in social situations and do not experience problems. Some people engage in problematic substance use—for example, using at an early age, using while pregnant or driving while impaired—which increases the risk of harms that can and should be prevented. Some people develop chronic dependent substance use, or addiction, which may require treatment or other drug-related health and community supports. (A Path Forward, 2013, p.20)

It is important to highlight that these excerpts are individual interpretations of impact of problematic substance use and fail to acknowledge the historical, social, economic and political factors that often drive substance use harms. In comparison, health-equity related beliefs contained narrations where there was a link between colonialism, historical trauma, racism and substance use.

Documents in specific reference to the overdose crisis also depicted opioid overdoses and deaths as the result of problematic substance use:

“A significant percentage of those who died of opioid overdoses had primary alcohol use disorder and/or stimulant use disorder.... While the current crisis has focused most urgently on reducing the risk of overdose death, preventing development of problematic substance use must be part of the ongoing response” (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.26, 31).

“Nearly 75% (of non-fatal overdoses based on health charts of 90 men) had a diagnosed alcohol or substance use disorder, and half had previously participated in substance use

treatment. Most used drugs on a frequent basis – only 16% used occasionally or for the first time” (The Hidden Epidemic, 2018, p.9).

These narratives that characterize problematic substance use as a risk factor for harm resembled similar conclusions from Anderson-Baron et al. (2017) review of B.C.’s current and historical harm reduction policy in which they found a tendency for documents to convey substance use as problematic for individuals and as an individual problem without the social, political historical and economic context in which substance use occurs.

Finally, non-equity beliefs narrated service delivery flaws as a risk factor responsible for substance use harms. This different from health-equity related beliefs which focused on system flaws that have caused barriers to services and service quality issues that are not responsive to the needs of specific population groups. Rather, non-equity beliefs focused on service delivery issues in the confines of lack of standards and evidence-based practices for harm reduction and health care services; lack of training amongst health care providers in substance use and substance use disorder; insufficient coordination of services within the provincial system for HIV/AIDS treatment:

“We know that the services needed to address these challenges aren’t keeping pace with needs. Even worse, because of the patchwork of services, the inconsistent way they are delivered, and their disconnect from each other and the overall health system, we don’t have a clear picture of the magnitude of need” (A Path Forward, 2019, p.5).

“While provincial guidelines for the management of opioid use disorder have been developed and published by the BC Centre on Substance Use, not all physicians and health care providers who care for patients with opioid use disorder have received the training needed to provide appropriate care” (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.28).

“There are a number of gaps that have caused a less than ideal response to the HIV/AIDS epidemic in B.C. These gaps include insufficient coordination when it comes to provincial HIV/AIDS planning and program implementation; evidence-based practice and best practices have not been fully integrated into HIV/AIDS programming; lack of communication between all stakeholders working on HIV/AIDS in the province; and

limited dedicated resources to support the goals laid out in the Priorities for Action” (Collaborating for Action, 2006, p.8).

Select post-2016 documents acknowledged the impact of prescribing practices for prescription opioids as a factor responsible for substance-related harms. However, one pre-2016 document forewarned the risk of prescribing patterns for substance use harm:

“The risk of overdose is increased when opioids are combined with other drugs like benzodiazepines. Benzodiazepines are medications sometimes prescribed for conditions like insomnia and anxiety” (The Hidden Epidemic, 2018, p.4).

“Medications initiated during hospitalization can also increase the chance of falling in the hospital and after discharge. Elderly women are more likely to be prescribed psychoactive medications such as benzodiazepines. Men consume larger amounts of alcohol, but women are at greater risk for dependency on prescription drugs” (Every Door is the Right Door, 2004, p.18).

Interestingly, while these factors do not acknowledge the social determinants that influence harm, they are relevant for health systems transformation. However, as it will be shown in the analysis for policy solutions (moral), policy documents contain a lack of narrations that explicitly link these factors to health system transformation and health equity and tend to focus service delivery solutions at an individualized, service provider level.

Victim

Non-equity-based beliefs narrated economic harms, systems harms, physical harms, and threats to public safety and order as victims of substance use.

Policy documents conveyed economic impacts as a harm stemming from substance use, primarily one that effects everyone. This was often narrated in terms of substance use placing an economic burden on the overall economy and the health care system in which most policy documents quantified this impact. Interestingly, the current estimated financial impact of substance use on B.C.’s economy stands at \$6.6 billion annually (*A Pathway to Hope*, 2019), a figure borrowed from policy in 2010:

“The consequences are felt by us all. B.C. has the country’s highest rate of hospitalization due to mental illness and substance use...the estimated impact on B.C.’s economy stands at \$6.6 billion annually” (A Pathway to Hope, 2019, p.5).

“A recent Canadian study has suggested that mental illness costs the Canadian economy \$51 billion annually in lost productivity – B.C.’s proportional share of this burden would be more than \$6.6 billion each year. Indirect costs of lost productivity related to alcohol use alone are estimated at \$1.1 billion” (Healthy Minds, Healthy People, 2010, p.2).

Narrating economic burdens as a victim of substance use also appeared to be a longstanding practice in policy documents prior to 2016:

“Substances that contribute to the greatest health harms and health system costs are identified in the distribution of the burden of disease. In BC, these include tobacco (12%), alcohol (10%), and illegal substances (2%). When the economic costs are considered, in 2002 nearly \$40 billion was attributed to problematic substance use in Canada....illegal substances account for over 20% of the economic burden of substance use even though it only contributes to 2% of the burden of disease” (Position on the Prevention of Problematic Substance Use, 2012, p.1).

“Problematic substance use consequently represents a significant public health challenge in British Columbia. It affects, directly and indirectly, a large proportion of the population. It also represents a substantial financial cost, estimated at 2.3 billion dollars in 1992” (Every Door is the Right Door, 2004, p.7).

Narrations such as these are problematic and represent non-equity beliefs as they are rooted in a capitalist understanding of economics that is then used as a rationale for why harm reduction is necessary. Rather than rationalize harm reduction in equity-oriented understandings, it is rationalized in terms of cost, aligning with utilitarian beliefs for harm reduction (Pauly, 2008a).

In addition to direct financial costs, non-equity beliefs narrated burdens towards existing health systems and services as victims of harm, such as increased hospitalizations, long waitlists for treatment and recovery services, and increased health needs due to illnesses and diseases:

“Alcohol causes more hospitalization than all major illicit drugs combined. In 2009, alcohol-related hospitalizations were over five times higher than those related to the use of illicit drugs. People may be hospitalized for a range of issues related to alcohol, including: some types of cancers, diabetes, neuropsychiatric disorders (e.g., alcoholic

psychosis, alcohol dependence syndrome, etc...), cardiovascular diseases and digestive disorders. In some cases, the majority of hospitalizations may be related to alcohol use (e.g., liver cirrhosis)” (Position on the Prevention of Problematic Substance Use, 2012, p.5).

“Even the most common mental health disorders for adults, if left untreated, can result in significant costs to individuals, families, communities and our economy. These individuals may not seek services until they are in a mental-health crisis, walking through the hospital emergency room doors because they did not receive the supports they needed earlier” (BC’s Mental Health and Substance Use Strategy, 2017, p.14).

While the most recent document (*A Pathway to Hope*, 2019) acknowledged there is disparate access to health care services, there was a stronger emphasis on the burden this placed on the health care system as opposed to the burden on health equity:

“Compounding this fragmentation of services is the increased demand on systems of care. For example, increasing rates of alcohol-related hospitalization and climbing death rates involving alcohol have coincided with the emergence of fentanyl in the illicit drug supply to heighten the demand for addiction prevention, treatment and recovery services” (A Pathway to Hope, 2019, pp.5-6).

In this context, non-equity beliefs inadvertently places blame on PWUD for causing these burdens rather than discussing the ways in which these burdens may be systematically produced by multiple systems.

Similarly, an additional document featured a similar pattern of conflicting health equity-related policy beliefs and non-equity beliefs by recognizing there are indeed social costs associated with substance use, but privileged a narrative focused more on economic impacts:

“The Ministry of Health (MOH) forewarns, if left unaddressed, HIV/AIDS will result in considerable downstream personal and social costs but would also place enormous additional burden on B.C.’s health-care system. The Ministry calculates that each new HIV infection will cost the B.C. healthcare system somewhere between \$180,000 and \$225,000 in direct costs per person per lifetime. When indirect expenses related to sickness and years of life lost are taken into account, the real cost of the epidemic rises to \$1 million per lifetime for every person living with HIV/AIDS” (Collaborating for Action, 2006, p.3).

Non-equity beliefs also emphasize the negative impact substance use poses to health status and outcomes, focusing narrowly on physical health and wellbeing, and less towards the ways in which health outcomes vary depending on one's social position:

“The effects of substance use (including alcohol and tobacco) take a major toll on both physical and mental health — for example, alcohol use is the seventh leading risk factor for death and disability globally (and is the leading risk factor for people who are 15 to 49 years old)” (A Pathway to Hope, 2019, p.5).

“Lemon juice and vinegar are often used as acidifiers due to availability, but these harsher acids can cause more pain, irritation, and damage to the veins. Repeated damage causes veins to collapse, and so an individual may begin to use veins closer to major arteries, which, if accidentally hit, may lead to life-threatening blood loss. Furthermore, vinegar and lemon juice may be contaminated with bacteria or fungus, which may lead to infection” (BC HRSS Policy Indicators Report, 2017, p.23).

“Excessive doses can cause mental confusion, severe anxiety, paranoia, violence and psychosis. In extreme instances, methamphetamine can cause hyperthermia, cardiovascular system collapse and stroke. There is little information on the long-term, harmful effects of methamphetamine use on an individual's health. However, available information suggests that possible long-term effects may include structural changes to the brain, memory loss, difficulty completing complex tasks and permanent psychotic symptom” (Crystal Meth and Other Amphetamines, 2004, p.4).

While I characterized non-equity beliefs as those that narrate physical harms as victims of substance use, it is important to reflect and note that this is not to dismiss physical harms as not being a critical component of equity as they are a substantial harm. What makes this characterization part of the non-equity policy belief is that the narration of physical harms in the policy documents fails to acknowledge the social conditions in which substance use occurs, and thus influences the risk physical harm. There tends to be a sole focus on physical harms resulting from the substance itself, and not the physical harms resulting from the social context of substance use such as injecting publicly, using substances in isolation, being homeless or using a tainted supply of drugs. In the context of this study, physical harms were primarily narrated as

being the result of individual choices with little regard towards the social, environmental and political elements that influence these choices.

In addition to victimizing the health care system and individual health outcomes, non-equity-based beliefs frame substance use as posing threats to public safety. However, there is no elaboration towards the magnitude of this threat, or what specific context of the type of harm the public is subjected to:

“After tobacco, the greatest harms (and costs) from substance use are from alcohol, including chronic diseases such as cirrhosis of the liver and cancers, injuries and public safety issues” (Healthy Minds, Healthy People, 2010, p.16).

“Problematic substance use and mental disorders directly affect hundreds of thousands of British Columbians of all ages. Indirectly, problematic substance use negatively affects families, neighborhoods and communities across the province” (Every Door is the Right Door, 2004, p.63).

The following excerpt indirectly links substance use with public safety issues, implying that substance use is often coupled with crime which further perpetuated a criminalized and stigmatized view of substance use:

“The damage from the trade and use of highly-toxic drugs affects all of us, from the impact on the health and well-being of people who use drugs to the widespread social and economic harm to our communities....While health officials work to address the immediate health needs related to the overdose emergency, police throughout the province are working diligently alongside them to disrupt drug trafficking” (Escalating BC’s Response to the Overdose Emergency, 2019, p.17).

Policy Solutions:

Non-equity beliefs narrate solutions that conveyed the need to desist substance use (especially problematic use), emphasize the need for intervention and treatment, ensure optimal service delivery pathways, manage physical health risks, secure public safety and order, and improve individuals' knowledge of harms and responsibility for risk.

Recommendations aligning with the value of desistance were reflected in recommendations that promoted recovery of and preventing substance use:

“It’s clear that the time has come to devote more available dollars to upstream services that deliver services focused on health promotion, early intervention and keeping people supported and healthy when they achieve recovery” (A Pathway to Hope, 2019, p.12)

Connecting British Columbians to evidence-based and trauma-informed treatment and recovery services/supports requires a clear roadmap for developing quality, effective, efficient and innovative service delivery models in the years ahead” (A Pathway to Hope, 2019, p.25).

“For those individuals and their families who are struggling with chronic or recurring mental illness or problematic substance use, the belief that recovery is possible is critical. Programs and services will reflect best practices in approaches to supporting a recovery-oriented approach to care” (BC’s Mental Health and Substance Use Strategy, 2017, p.14).

“A responsive service system will ensure that at risk groups are identified and people involved in service systems have the specific skills to prevent, treat and reduce methamphetamine use in these target populations” (Crystal Meth and Other Amphetamines, 2004, p.16)

Treatment, in this context, was interpreted as an abstinence-based narrative as it illustrated a belief that it is substance use itself that is the harm, thus it is imperative to treat or resolve substance use rather than accept substance use and address and mitigate the harms stemming from substance use. This aligned with conclusions from Anderson-Baron et al. (2017) who noted that policy documents that tend to frame substance use within the confines of problematic substance use will also support approaches that aim to reduce problematic substance use.

Further, narrations such as these imply that harm reduction is something that has to be integrated into a system where there are policy beliefs rooted in abstinence.

In terms of policy and program improvements, emphasis was placed on offering more interventions supports that reduce harms of substance use. However, similar to the pattern observed in equity-based beliefs, there was often no definitive parameters surrounding what prevention entailed (i.e. prevention of harm, prevention of substance use, prevention of disease and illness). Select documents did define prevention when outlining recommendations, such as *Every Door is the Right Door (2004)*, which offered a comprehensive definition and framed prevention as a balance between desisting substance use and reducing exposure to harm:

“Prevention initiatives strive to: delay age of first substance use, avoid high-risk substance use by children and youth, prevent alcohol and other substance use by pregnant women, and/or prevent problematic use of alcohol or medications by adults and seniors. Primary prevention prevents the onset problematic substance use and includes the aim to strengthen protective factors and minimize risk factors within individuals, families and communities.... Secondary prevention includes early detection and intervention to identify and reduce substance use problems. It targets people with early signs of problematic substance use. It aims to reduce harms, limit disability, prevent dependency, and promote social inclusion and community functioning.... Tertiary prevention lessens the disability resulting from problematic substance use and mental disorders, reduces co-morbidity and restores effective functioning. It aims to reduce further damage or impact of long-term disease and disability to people with substance use disorders. Tertiary prevention minimizes suffering and maximizes life expectancy and quality of life” (pp.30-33).

More specifically, this excerpt framed prevention within an abstinence-based narrative, noted specifically by framing prevention as a need to delay, avoid or prevent use. Subsequent documents published after 2004 did not contain the same degree of clarity towards what prevention entailed. For example, select post-2016 documents identified that it is imperative to implement preventative approaches without defining what these approaches were and what exactly was intended to be prevented:

“One of the core principles of public health is that prevention is better than treatment. It leads to healthier outcomes and has benefits for everyone: patients do not have to suffer from a disorder, our health care system does not have to pay for treatment and recovery, and society does not have to shoulder social and economic costs.... By building on successful BC initiatives and drawing on experience from outside our province, we can design a series of prevention programs geared to meeting the needs of British Columbians throughout their lives” (Escalating BC’s Response to the Overdose Emergency, 2019, pp.15-16).

“Prevention focuses on opportunities to reduce risk factors for mental health and substance use problems, and increase the protective influences that support wellness.... Preventive approaches to care can be implemented across multiple settings, for groups or individuals. Examples of effective prevention strategies include programs that support vulnerable new mothers, school-based resiliency programs and supporting skills-development for parent” (BC’s Mental Health and Substance Use Strategy, 2017, p.14).

Prevention in these parameters was not only more generalized but was limited to focusing on the prevention of substance use rather than the prevention of any kind of harms. As such, prevention in this context was interpreted in alignment with abstinence-based values.

Select documents framed prevention as reaping economic benefits, building a business case for the proposed policy solution:

“That’s why a central tenet of this roadmap is to increase the prevention and wellness programs and services, so we can help prevent problems before they start or, at a minimum, from becoming ongoing or lifelong issues. This will reduce the pressures on acute health care services, reduce costs and provide a better experience for service providers and people experiencing or who are vulnerable to mental health and substance use challenges” (A Pathway to Hope, 2019, p.12).

“Beyond the fact that prevention of mental health and substance use problems vastly improves the quality of life for people, their families and their communities, it also makes better financial sense. At present, the most expensive treatment services are specialized services for those who need complex care, and emergency and hospital-based services. While B.C. will always offer acute and specialized services, the areas of prevention and promotion remains a focus, recognizing the potential of upstream strategies to reduce costlier and potentially more intrusive interventions later” (BC’s Mental Health and Substance Use Strategy, 2017, p.10)

Moreover, two documents emphasized the anticipated economic savings as a rationale for promoting prevention and treatment. However, little explanation was provided regarding what specific preventions supports would yield such savings:

“As a province, we need to put behind us the years where little was done in the field of addictions care, and embrace the value of providing expanded and more efficient evidence-based prevention and treatment. For instance, according to the U.S. National Institute on Drug Abuse, for every dollar spent on evidence-based addictions treatment, the taxpayer saves \$12 in health and social costs” (A Pathway to Hope, 2019, p.3).

“Beyond the fact that prevention of mental health and substance use problems vastly improves the quality of life for people, their families and their communities, it also makes better financial sense. At present, the most expensive treatment services are specialized services for those who need complex care, and emergency and hospital-based services” (BC’s Mental Health and Substance Use Strategy, 2017, p.10).

Additional program and policy recommendations included the need to enhance interventions and treatment. Yet, in the context of substance use it is critical to define what is meant by ‘treatment’. Is it the treatment of substance use disorder, the treatment of transmitted disease and illnesses stemming from substance use, or the treatment in the sense of detox or rehabilitation centres with the ultimate goals of abstinence? One document provided specific parameters for what treatment entailed in the context of substance use:

“treatment includes a range of specialized services, such as withdrawal management (inpatient detox, daytox, home-detox), inpatient and outpatient treatment (individual counselling, family therapy, cognitive behavioural therapy, social skills training), case management, residential treatment, client monitoring and relapse prevention” (Every Door is the Right Door, p.36).

The remaining policy texts promoted treatment as a solution to mitigate harm; however, most did not explicate what treatment entails. Such recommendations included:

“To support the healing journeys of First Nations individuals, families and communities, funding is being provided to the FNHA to renovate, replace, expand and build First Nations-run treatment centres throughout B.C This investment will support the construction of two new urban treatment centres and urgent renovations to a number of

existing treatment centres. This investment is an important step to increase access to culturally safe substance use service” (A Pathway to Hope, 2019, p.22).

“Early treatment, like secondary prevention, is intended to slow progression of substance use disorders and mental disorders, limit disability and promote individual functioning within the family and community” (Every Door is the Right Door, 2004, p.34).

These narrations display that the understanding of treatment is positioned closely with ideas of abstinence in which treatment is viewed as a service or modality that will stall substance use and is focused on providing medicalized access to care.

Select post-2016 documents acknowledged that treatment was in reference to treating symptoms associated with opioid-use disorder via opioid agonist therapy (OAT), positioning treatment with a medicalized, disordered perspective in which one requires treatment if they have a substance use disorder:

“The most effective, evidence-based treatment for opioid-use disorder is OAT. OAT uses a range of prescription opioid medications to decrease cravings and withdrawal symptoms, reduce illegal opioid use, prevent overdose and death, and improve overall health and wellness” (Responding to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.20)

“This means identifying people with opioid use disorder through screening and referral; providing a central point of access to engage in care; supporting people in starting OAT and ensuring a wide range of OAT and other options meet individual needs” (Escalating BC’s Response to the Overdose Emergency, 2019, p.1).

“Expanding treatment services is important, but treatment alone cannot meet the mental health and substance use needs of children and youth. We must also focus on prevention, screening and early intervention to reduce the number of children and youth affected” (A Pathway to Hope, 2019, p.18).

In similar fashion to characterizing treatment, there was no guidance or definitive clarification towards what is considered an intervention in harm reduction policy. The majority of policy documents stated there needs to be more efforts on early intervention, yet only one document offered a succinct definition on what that entailed:

“Early intervention includes such measures as providing early parenting supports at home, taking action when social and emotional problems are observed at school, and providing additional supports through early adulthood for youth transitioning from care. The key is intervening early to address problems and promote healthy development. (Escalating BC’s Response to the Overdose Emergency, 2019, p.11).”

Non-equity beliefs also narrated service delivery solutions as a means to reduce substance-related harm, presumably to align with the belief that it is the fault of flawed services that perpetuate substance use harms. Service-level solutions included those that aimed to make improvements to health care services and health system process at the service provider level, including implementing care standards and guidance, improve service coordination, and shifting focus to health promotion (however, it will be demonstrated that health promotion is individualized in the narratives):

“The expansion of team-based care will improve access and quality for adults seeking mental health and substance use care. Co-ordinating care will create a network of services so that people can access the type and level of care they need, whether it be from a mental health or substance use worker, family physician or nurse, or through specialized services for more medically complex patients. Ultimately, this system will connect people proactively to culturally safe and effective care in a timely way” (A Pathway to Hope, 2019, p.27).

Despite this excerpt emphasizing connecting people to care and services, very little offered in terms of anticipated outcomes or guidance as to how these solutions will be delivered and the ways in which they will reduce intersecting substance use harms.

Other narratives were focused on improved clinical guidance frameworks to reduce harms:

Given the increased risk of overdose, our Pharmacy team is working with staff to identify patients who are in, and being discharged, from hospital with both opioid and benzodiazepine prescriptions to promote safer prescribing practices (Fraser Health 2018, p.4)

“Implement standards of care with clear deliverables (e.g. targets for OAT starts and retention) in all VCH operated and funded withdrawal management, recovery, community and primary care services serving those with opioid use disorder” (Response to the Opioid Overdose Crisis in Vancouver Coastal Health, 2018, p.27).

“Develop guidelines to ensure that youth and adults with a mental illness and/or problematic substance use who are in contact with the criminal and youth justice system have access to appropriate transition and support services” (Healthy Minds, Healthy People, 2010, p.38)

In addition, other narratives premised on service-level solutions spoke towards a need to improve coordination and planning with other domains:

“Developing and enhancing joint planning structures to improve co-ordination across social ministries, increasing integrated service delivery and simplifying service system pathways for individuals and families dealing with mental health and substance use issues as well as closing service gaps” (BC’s Mental Health and Substance Use Strategy, 2017, p.26).

“Provide timely assessments and diagnosis, comprehensive supports, residential placements, alternatives to incarceration, and family follow-up services for First Nations and Aboriginal people living with FASD” (A Path Forward, 2013, p.32).

The College of Physicians and Surgeons, College of Registered Nurses the BC PharmaCare program, and the College of Pharmacists will continue initiatives to identify and educate high volume prescribers of opioids and other potentially harmful medications where there is a history of unsafe prescribing practices. This includes preventing prescription forgeries and inappropriate prescriptions for new patients. (Escalating BC’s Response to the Overdose Emergency, 2019, p. 16)

While these solutions are imperative for health system transformation, they fail to specifically identify the social and structural factors that have contributed to these service flaws and ought to be addressed in order to make substantive changes in the design and delivery of services. If the underlying social and structural factors are not addressed, this does very little to improve health equity and risks repeating similar challenges in the future.

Non-equity policy beliefs often privileged policy solutions concerned with increasing positive physical health outcomes, such as disease risks and management. To reiterate, ensuring optimal physical health is indeed an integral component of harm reduction and health equity confirms and validates the concomitant effects of social conditions and physical health harms

(Pauly, 2008a; Pauly et al., 2018). However, in the context of non-equity beliefs, physical health outcomes were often promoted in various policy texts in the confines of managing illnesses, reducing disease rates and reducing risk to health harms with little acknowledgement of the social and structural conditions that influence health harms:

“British Columbia recognizes addiction is a chronic health condition and is often linked to concurrent mental illness. Effective services help people develop the resources to recover, improve their wellness and manage their long-term health” (Every Door is the Right Door, 2004, p. i).

“Recent population level and economic evaluation has estimated that over 3,000 new HIV cases were averted between 1996 and 2013 as a result of the combined effect of the expansion of harm reduction services and HIV drug treatment coverage” (From Hope to Health Progress Report 2015/16, 2016, p. 4)

“Methadone maintenance treatment is a key part of B.C.’s response to opioid dependence, and a fundamental component of provincial efforts to prevent HIV, hepatitis C and other blood-borne pathogens” (Health Minds, Healthy People, 2010, p. 32).

Select documents (as noted below) had visible competing tension between equity-related and non-equity beliefs in which there was an acknowledgement of social harms associated with substance use; however, there was emphasis on the positive health outcomes harm reduction can reap as opposed to equally narrating the social benefits harm reduction supports can provide:

“Through client-centred approaches, effective harm reduction policy and programming can achieve positive population health outcomes and reduce stigma and discrimination against those whose use of substances and/or sexual activity make them vulnerable to illness or other health harms” (BC Harm Reduction Strategies and Services Policy and Guidelines, 2014, p. 2).

“Sterile syringe distribution and recovery programs offer people who inject substances – who can be highly marginalized – a point of contact with the health system. Research from B.C. and around the world shows that supervised injection sites can reduce fatalities from unintentional overdose, reduce sharing of injecting equipment, reduce public disorder, and increase uptake into detoxification and treatment services” (Healthy Minds, Healthy People, 2010, p.23).

Non-equity-based beliefs also promoted policy solutions that emphasize the need to preserve public order. Similar to other policy recommendations, documents failed to specify what public safety harms entailed and how these harms will be mitigated. Rather, documents articulated that the public will be protected, exclusively from drug paraphernalia and drug trafficking:

“Health Authorities, contracted agencies and community partners will take appropriate steps to protect the public from inappropriately discarded injection equipment and drug paraphernalia” (BC HRSS Policy and Guidelines, 2014, p.6).

“The province and its law enforcement partners will develop tools to enhance police ability to interdict the drug supply, including the use of specialized drug detection equipment. The province will increase its support to the Combined Forces Special Enforcement Unit – BC to target high-level drug traffickers; BC will work with the federal government and advocate higher penalties for opioid traffickers; and provincial investments in equipment and training will allow police experts to effectively and safely identify, dismantle, and process clandestine laboratories producing opioids” (Escalating BC’s Response to the Overdose Emergency, 2019, p.18).

“We will continue to work with our partners and every British Columbian to support efforts to prevent crime and build safer communities. This will require the involvement of all partners and sectors in our communities, including the police, school districts, businesses and other community organizations” (Crystal Meth and Other Amphetamines, 2004, p.15).

These excerpts display narratives that interpret substance use as a criminalized activity, one that requires more enforcement, which tends to reflect broader drug policy and can add to the risk of substance use harms, especially in terms of further stigmatizing PWUD as criminals and substance use as a criminal activity.

Finally, non-equity beliefs place a certain degree of responsibility on individuals to be informed about substance use risks to increase their resilience to substance use harms through health promotion actions:

“Increased knowledge about mental health and substance use can benefit everyone, and can build the collective capacity to support the mental well-being of others. Schools must continue to foster resilience in children. They can do this through supportive

environments and through daily lessons with skill-building exercises for younger students and their teachers in order to build resiliency and ensure students are connected to supportive adults. Workplaces can offer early and effective support to their employees” (BC’s Mental Health and Substance Use Strategy, 2017, p.15).

“The goal for all British Columbians is to increase their capacity to achieve and maintain sound mental health, as well as creating environments in which the healthy choice is the easy choice. Building strengths, resilience and enhancing healthy living are key objectives as they equip people to thrive, to cope with adversity, and to make health-promoting decisions” (Healthy Minds, Healthy People, 2010, p.13).

“There will be a focused public information campaign to increase awareness among the public and high-risk populations about methamphetamine use, its harmful impacts, prevention, early intervention and treatment. Messaging will be accurate, factual and consistent to increase public awareness of the risks of methamphetamine use and addiction” (Crystal Meth and Other Amphetamines, 2004, p.14).

In this sense, the focus on prevention of use and health promotion is framed as resilience through preventing substance use rather than enhancing community capacity and their participating as a means of health promotion. Framed in this way, these narratives are congruent with findings from Pauly et al. (2017), which noted health prevention was often understood in the context of individual choices and individual factors rather than addressing structural change. Additionally, building individual resilience to harm inadvertently places more responsibility on individuals/the general public to ensure their health and wellbeing (Pauly, 2008a; Gray, 2009).

4.5. Shifts in Policy Beliefs (Pre-2017 vs. Post-2016)

As previously mentioned, a normalized row relative analysis was completed in ATLAS.ti to analyze the matter in which policy beliefs shifted after the post-2016 health declaration. A row relative analysis in ATLAS.ti is used to compare code distributions across documents or document groups. For this study, I completed a row relative analysis across two document groups: 1) Pre-2016 documents and 2) Post-2016 documents. As the documents vary in length, it was not appropriate to rely on absolute frequencies of the codings to compare how prevalent

equity and non-equity-based beliefs were in the documents. Rather, ATAS.ti recommends users to normalize the frequencies for comparison (Friese, 2019). Normalization corrects for the number of codings in the documents by adjusting the size of documents into consideration to provide accurate results for comparison. The reference point for normalization is the document with the highest quantity of quotations for selected codes. Thus, the number of quotations per code for all other documents is multiplied by the ratio of the sum of all quotations per code of the reference document and the sum of all quotations per code of the respective other documents. Without normalizing the data, one would get the impression that a certain code was mentioned more strictly by virtue of the length of the document (Friese, 2019). A normalized row relative analysis was completed for each code group: Villain (Equity and Non-Equity), Victim (Equity and Non-Equity) and Moral (Equity and Non-Equity).

For this analysis, tables are to be interpreted by horizontally by row, left to right. As noted in Table 3.0 there appeared to be an ongoing tension between health-equity related beliefs and non-equity beliefs in harm reduction policy documents for both the pre and post-2016 documents in regard to narrating risk factors for harm (villain) and proposed solutions to mitigate harm (moral). There was a slight disparity in the prevalence of health equity-related and non-equity policy beliefs in terms of narrating harms (victim) between pre-2016 and post-2016 documents. Specifically, there was a decrease in recognizing equity-related harms post-2016 compared to pre-2016; this reduction brought a relative increase in policy documents narrating non-equity-based harms (i.e. service burdens, economic cost, public order) more often in post-2016 documents than pre-2016. Interestingly, proposed policy solutions saw no change.

Table 3.0 - Shifts in Policy Beliefs Overall

	Pre 2016 Documents	Post 2016 Documents
VILLAIN		
<i>Health-Equity</i>	51%	49%
<i>Non-Equity</i>	48%	52%
VICTIM		
<i>Health-Equity</i>	55%	45%
<i>Non-Equity</i>	46%	54%
MORAL		
<i>Health-Equity</i>	50%	50%
<i>Non-Equity</i>	50%	50%

While Table 3.0 reflects overall shifts, I was also interested in determining if there were shifts within the specific constructs of the beliefs (villain, victim and moral).

4.5.1. Health Equity-Related Beliefs

As Table 4.0 reflects, inaccessibility was narrated as a villain significantly more often (72%) in post-2016 documents compared to pre-2016 (28%). Surprisingly, social position (i.e. sex, gender, race) was narrated as a risk factor for substance use harms more often in pre-2016 documents compared to post-2016 documents. There was almost equal representation of social conditions characterized as risk factors for harm between pre-2016 documents (51%) and post-2016 documents (49%), indicating minimal shift in that specific equity belief. Interestingly, inequity characteristics in policies and programs was narrated as a villain for substance harm more than in post-2016 documents compared to pre-2016, yet policy solutions for this specific area were not as prevalent (as seen in Table 6.0).

Table 4.0 - Shifts in Health-Equity Related Policy Beliefs (Villain)

	Pre 2016 Documents	Post 2016 Documents
VILLAIN		
<i>Inaccessibility</i>	28%	72%
<i>Social Demographics</i>	63%	37%
<i>Social Conditions</i>	51%	49%
<i>Policy and Programs</i>	45%	55%

Table 5.0 displays a stark shift in health equity-related beliefs for characterizing victims of substance use harms. For instance, there was a complete absence of social harms in post-2016 documents, and while the representation of the social harm code was overall low, all social harms codes were represented in pre-2016 documents.

Table 5.0 - Shifts in Health Equity Related Beliefs (Victim)

	Pre 2016 Documents	Post 2016 Documents
VICTIM		
<i>Vulnerable/Marginalized Populations</i>	43%	57%
<i>Social Harms</i>	100%	Nil.

Proposed solutions representative of health equity beliefs experienced notable shifts between post-2016 and pre-2016 documents as outlined in Table 6.0. This included a shift in recommending solutions geared towards improving equitable access, appearing substantially more in post-2016 documents (66%) than pre-2016 documents (34%), and less focus on social conditions. Surprisingly, while post-2016 documents did not narrate social harms as a victim of substance use, they did feature solutions targeted to improve social conditions. This may have been in reference to addressing social harms with the understanding that social factors are a risk for harm, and not recognizing the ways in which social factors can be further compounded from substance use. Despite post-2016 documents featuring solutions to improve social conditions,

this recommendation appeared more often in pre-2016 documents (57%). A second notable shift for health-equity beliefs was the prevalence of recommendations for safe-substance use.

Proposed solutions intended to increase the safety of substance use appeared more in pre-2016 documents (57%) than post-2016 documents (43%). Finally, the most notable shift was with respect to recommendations to improve/enhance community collaboration and empowerment to mitigate substance use harms in which this recommendation was featured substantially more in pre-2016 documents (70%) compared to post-2016 (30%).

Table 6.0 - Shifts in Health Equity-Related Beliefs (Moral)

	Pre 2016 Documents	Post 2016 Documents
MORAL		
<i>Improve Access</i>	34%	66%
<i>Address/Improve Social Conditions</i>	57%	43%
<i>Equity-based Policies and Programs</i>	53%	47%
<i>Promote Safe Substance Use</i>	57%	43%
<i>Improve Community Collaboration/Empowerment</i>	70%	30%

4.5.2. Non-Equity Beliefs

As noted in Table 7.0, assigning individual responsibility, by virtue of substance use behaviour and practices, appeared less in post-2016 documents (45%) compared to pre-2016 documents (55%). Characterizing service delivery/program flaws, such as unresponsive policies and programs and prescribing practices, as a risk factor for substance harm appeared more in post-2016 documents (63%) compared to pre-2016 documents (37%).

Table 7.0 - Shifts in Non-Equity Beliefs (Villain)

	Pre 2016 Documents	Post 2016 Documents
VILLAIN		
<i>Substance Use Practices</i>	55%	45%
<i>Service/Program Flaws</i>	37%	63%

Table 8.0 outlines the categories of non-equity beliefs in terms characterizing substance use harms. The most profound shifts were also found in factors conceptualized as harm resulting from substance use. The narration of economic impacts as a harm resulting from substance use appeared significantly less in post-2016 documents (26%) compared to pre-2016 documents (74%); there was a substantial increase in characterizing physical health status/health outcomes as harms in post-2016 documents (66%) compared to pre-2016 documents (34%). Negative impacts to the health care system were narrated as substance use harms significantly more often in post-2016 documents (64%) compared to pre-2016 documents (36%); it can be reasonably assumed this partly the result of an increase in overdoses and hospitalizations from substance use. Lastly, narrating risks of harm to public safety and order were narrated as a harm more often in pre-2016 documents compared to post-2016.

Table 8.0 - Shifts in Non-Equity Beliefs (Victim)

	Pre 2016 Documents	Post 2016 Documents
VICTIM		
<i>Economic Harms</i>	74%	26%
<i>Physical Harms</i>	43%	57%
<i>Service Harms</i>	36%	64%
<i>Public Safety & Order</i>	58%	42%

Given the magnitude of overdoses and deaths stemming from both opioids and illicit substances, it was not surprising to see an increase in promoting desistance-related solutions in harm reduction policy from pre-2016 to post-2016 documents (Table 9.0) The majority of recommendations representative of non-equity policy beliefs experienced significant shifts in

which there was more prevalence of non-equity related beliefs for policy solutions in post-2016 documents. Three exceptions included recommending improvements to health systems and processes, which appeared equally in pre- and post-2016 documents, indicating no shift in beliefs. Additionally, recommending solutions to secure public safety and order appeared substantially more in pre-2016 documents (65%) compared to post-2016 documents (35%), along with enhancing individual responsibility for risk of harm (65% in pre-2016 documents compared to 35% in post-2016 documents).

Table 9.0 - Shifts in Non-Equity Beliefs (Moral)

	Pre 2016 Documents	Post 2016 Documents
MORAL		
<i>Substance Use Desistance/Abstinence</i>	36%	66%
<i>Economic Savings</i>	35%	65%
<i>Increase Intervention and Treatment</i>	46%	54%
<i>Improve Service and System Design</i>	50%	50%
<i>Secure Public Safety & Order</i>	67%	33%
<i>Enhance Individual Responsibility for Risk</i>	65%	35%
<i>Improve Physical Health</i>	42%	58%

Chapter 5: Discussion and Analysis

Policy documents are shaped by a myriad of values and beliefs that seek to advance a preferred understanding towards an issue of public interest (Lancaster, 2014; Pierce, 2011). This, coupled with the fact that harm reduction operates within the morality policy domain (Bowen, 2012; Heichel et al., 2013) provides a valid argument as to why it is integral to understand the beliefs and values that have shaped conceptual understandings of harm reduction at the policy level, and the manner in which they are communicated and framed vis-a-vis policy texts (Euchner et al., 2013; Howlet, 2009). Given that harm reduction is grounded in social justice, it is also imperative to determine the degree to which policy beliefs align with values of social justice and health equity.

The purpose of this study was to i) explore what underlying beliefs steer harm reduction policy in B.C.; ii) identify how these beliefs are narrated in policy; iii) analyze the degree to which policy beliefs align with principles of social justice for harm reduction and health equity; and iv) the manner in which policy beliefs have shifted after the 2016 Public Health Emergency Declaration (Government of British Columbia, 2016). Given that previous literature surrounding harm reduction policy Canada and B.C. has limited its exploration to beliefs and values surrounding policy governance and policy quality, the intent of this study was also to contribute to the existing literature and to fill a gap in this discourse.

5.1 Equity in Name, Not in Theory

The results of this study revealed a competing tension between equity-related and non-equity beliefs steering harm reduction policy. What was most interesting was the degree to which equity-related beliefs reflect health equity in its entirety. Specifically, equity-related beliefs were similar to the findings from Hyshka et al. (2017) in which they foster equity in name, yet not in

theory or in policy documents. As this study revealed, the commitment to equity is more rhetorical in which policy texts tend to feature equity-related terminology with very little elaboration on the social and structural factors that influence and exacerbate substance use harms, the manner in which substance harms vary across a social gradient, and specific guidance towards addressing the social and structural factors.

Policy documents acknowledged, to a degree, that social position influences the risk of substance use harm and this was achieved by identifying marginalized groups (e.g. homeless, Women, LGBTQ+, Indigenous, Aboriginal) who are disproportionately represented in rates of overdoses or substance use harms. This was congruent with findings from Pauly et al. (2017) in which even though policy narratives made an attempt to identify social groups that experience inequities, they were rarely narrated in a manner that identified how one's social position (e.g. age, race, sex/gender, socioeconomic status) is constituted within a set of social relations and elaborated on the ways in which other forms of discrimination are the source of health inequities (Pauly et al., 2017). Additionally, policy needs to heed with caution in term of naming groups or populations as vulnerable or marginalized as without acknowledging the structural conditions that have contributed to inequitable outcomes in the first place, this poses risk to further marginalize and stigmatize populations (Pauly et al., 2017).

Similarly, policy narratives surrounding social harms failed to offer a definition of what these social harms were beyond the individual level. As seen in the policy narratives, this was framed in examples such as familial breakdown, violence, and unemployment. All these factors lacked an acknowledgement on the ways in which they are linked with substance use, and they failed to acknowledge social determinants at the social and structural level. This translated to policy solutions targeted for social harms and social conditions that lacked guidance towards

what outcomes they will achieve. For example, documents recognized there were sex and racial differences in substance use harms, in addition to differences stemming from socioeconomic status, yet there was no discussion surrounding: 1) the social and structural conditions and processes that have influenced the distribution of harm on the basis of sex/gender, age, socioeconomic status, and race/ethnicity. 2) the matter in which these social inequities are the root of substance use harms; and 3) the matter in which proposed solutions will alleviate and address the social and structural conditions and processes such as sexism and racism. The only exception were discussions surrounding equitable accessibility in which policy narratives identify sexism, racism and classism, and other forms of discrimination as impeding access to health care and social services. However, proposed solutions to increase equitable access did not contain specific guidance or acknowledgement towards the ways in which sexism, racism, and classism will be improved.

Documents published by the First Nations Health Authority and Northern Health Authority were also an exception as they narrated a concrete explanation towards the ways in which the history of colonialism, combined with systemic racism, has led to a higher prevalence of problematic substance use and inequities in health amongst First Nations and Indigenous populations. Moreover, select policy documents (*BC's Mental Health and Substance Use Strategy, 2017; Escalating BC's Response to the Overdose Emergency, 2019*) coupled cultural safety with harm reduction for Indigenous people, which serves as evidence that policy can be grounded in equity as equity-oriented harm reduction must account for culturally-safe ways of working.

Overall, the concept of health equity by virtue of the policy narratives was limited to being positioned in the confines of equitable access. As such, equity-based beliefs align more closely with egalitarian-based beliefs (Pauly, 2008a) for harm reduction in which there is a concern about ensuring everyone has equal access to health resources. While these solutions are a step in the right direction, they represent a ‘band-aid’ solution as they fail to account for and resolve the social processes and factors that hinder access and must be addressed in order to redress inequities (Pauly, 2008a, p. 5). Thus, equity-beliefs are limited in the sense that they narrate vulnerable and socially marginalized populations as victims of substance use harms, yet the proposed recommendations for harm reduction are situated towards increasing access to social and health services with little prescriptive advice and guidance towards the ways in which such solutions will address the underlying social and structural factors that have contributed to such vulnerabilities and marginalization in the first place. This includes addressing harms that result from drug policy as seen in the criminalization of substance use and PWUD.

Equity-related beliefs are also congruent with communitarian beliefs surrounding harm reduction (Pauly, 2008a) as they tend to advance solutions that aim to improve community involvement in program and policy design. Additionally, there are elements of liberal individualism values in health-equity beliefs as reflected in solutions that aim to respect an individual’s right to use substances so long as it does not infringe upon the safety of the general public (Pauly, 2008a). This creates a challenge within the equity-belief paradigm as Pauly (2008a) notes that when communitarianism is enacted within a distributive paradigm driven by liberal individualism, there will most likely be a lack of attention to power inequities among groups or ensuring processes for fair and equitable participation of all groups. As a result, those most vulnerable and on the margins of society tend to be absent or underrepresented in the

policy-making process (p. 7). While this study did not seek to determine the matter in which PWUD were consulted and involved in the policymaking process, findings from Anderson-Baron et al. (2017) revealed that approximately 70% of current policy documents in B.C. (limited to 2015) recognize it is imperative for PWUD to be involved in the policymaking process (p. 34). A preliminary review of all the texts in this study, however, revealed that there was no confirmed documentation of the specific activities government completed to engage and consult PWUD in the development of these policy documents and the level of involvement PWUD had in shaping recommendations in the policy documents.

What is most critical to take away from the narratives that shape equity-related beliefs is that simply identifying social differences in substance use harms (e.g. race, age, sex/gender, socioeconomic status) and identifying social factors that contribute to substance use harm is not enough to foster an equity-oriented policy environment. To be equity-oriented requires a comprehensive analysis and discussion of the social relations involved that have created these social positions and a clear depiction of the ways in which racism, sexism, and classism not only influence substance use harms, but also impact equity for PWUD. As noted in SHEL, this also includes determining how racism, sexism, ageism, and colonialism are expressed in health systems and how such inequities will be addressed (Pauly et al., 2018). While the policy documents acknowledge these social inequities are prevalent in the context of substance use, they fail to fully explore how they intersect with health systems.

5.2 A Moral Divide: The Prevalence and Potential Risk of Non-Equity Beliefs for Harm Reduction

In conjunction with equity-related beliefs, non-equity related beliefs seem to also shape the broader understanding of harm reduction, primarily those premised on libertarian and utilitarian values (Pauly, 2008a). For instance, utilitarian approaches to harm reduction tend to promote abstinence or desistance of substance use (Pauly, 2008a). As the results of this study highlighted, most policy documents were heavily situated in policy solutions that promote treatment and prevention. However, documents either lacked specificity surrounding what treatment and prevention entails or documents promoted prevention with the understanding that substance use is prevented, which contradicts the very founding principles of harm reduction (Pauly, 2008a). Additionally, some documents included a medicalized view of substance use in which one requires treatment if they have a substance use disorder. Regardless if treatment and prevention was intended to refer to preventing blood-borne diseases and infections, or providing opioid replacement treatment for those with problematic opioid use, solutions put forth for treatment and intervention were narrated largely in the discourse of abstinence or the traditional ‘treat the disorder’ medical model of care. This belief also aligns with Euchner et al.’s morality frame (2013) in which substance use is presented as a wrong behaviour that must cease. This is problematic and poses implications to health equity as beliefs that promote zero-tolerance approaches, such as abstinence or desistance, are ineffective and treatment that promotes abstinence-only approaches functionally deny services to those unwilling to eliminate use (Toumbourou et al., 2007, p. 1393). Additionally, such approaches threaten the freedom of PWUD, damage their health and constitute them as marginal and stigmatised subjects excluded from normative categories of citizenship; any form of prohibition is not only irrational but

immoral because it violates the autonomy of the individual that is at the core of what it is to be human. (Keane, 2003, p. 229).

Non-equity beliefs also featured individual liberalist/libertarian values (Pauly, 2008a) in which there is respect for the right for individuals to consume substances if they so desire; however, a significant portion of responsibility is transferred towards individuals to be aware of and take responsibility for the risks and harms subjected to them. As such, any failure to take personal action to resolve these harms translates to substance use being viewed as a personal failure (Pauly, 2008a). This was most apparent in policy texts that villainized substance use practices and substance choices as factors most responsible for harm. Individual liberalist values were also apparent in proposed policy solutions that narrated increasing individual awareness and education of harms as an effective solution to reduce substance use harms. This is not to suggest that individuals should not be presented with evidence-based information on the risks associated with substance use; but that information should extend beyond the risks of consuming specific substances and discuss the ways in which risks are exacerbated by social and political structures. Such policy beliefs are potentially problematic as they unintentionally negate the influence of the risk environment in which substance use occurs (Rhodes, 2009).

Beyond Pauly's (2008a) social justice framework for harm reduction, there were other values embedded in non-equity beliefs. This included capitalist economic values in which substance use is narrated as a burden on the economic costs of the health care system and taxpayers. This also aligns closely with libertarian values in which individuals can consume drugs so long as it does not encroach upon public funds. Further, such neoliberal beliefs circumvent and ignore the fact that PWUD rightfully deserve care should they require it without the need to quantify the costs associated with required care. Rather, PWUD are framed as a financial burden on the health care

system in which harm reduction is framed as a service that makes economic sense. Such values align closely with Lancaster and Ritter's (2014) managerial and bureaucratic discourse frame in which narrations in drug policy tend to quantify the dollar-value costs associated with substance use to society as opposed to social harms/outcomes to justify proposed actions (pp. 83-4). Additionally, non-equity beliefs in B.C.'s harm reduction policy framework substantiates findings from Miller (2001) in which it becomes clear that B.C. has adopted a harm minimization approach in the confines of economic rationalism, which does very little to challenge the structural inequities that contribute to drug use (p. 176).

Non-equity beliefs also promoted values premised on securing public safety as a basis for harm reduction, as seen in narrations in which threats to public safety are the result (i.e. victim) of substance use. This aligns closely with Euchner et al.'s security and public order frame (p.377) in which substance use is viewed as a threat to public order and safety and solutions for harm reduction must aim to protect and preserve public safety through enforcement measures. This belief reflects an approach to criminalizing substances that has been deeply entrenched and maintained in Canada's drug policy history, which features a prohibitionist approach as seen in policy and legal frameworks where possession of illicit substances is a criminal offense and penalties remain disproportionate compared to penalties for more violent crimes (Office of the Provincial Health Officer, 2019). Policy beliefs that promote a heavy-handed enforcement approach do very little to protect PWUD. As noted by Pauly (2008a), such prohibitionist strategies ignore the structural differences that can reduce inequities in health and access to care (p. 8) and Keane (2003) noted that prohibitionist values and policies cause more harm as they threaten the freedom of PWUD and pose detriments to their health. In fact, B.C.'s Provincial Health Officer, Dr. Bonnie Henry, publicly recommended the provincial government to

decriminalize the possession of illegal drugs as existing drug laws were found to further stigmatize PWUD as it leads them to hide their substance use, creates barriers to accessing harm reduction services, and contributes to the shame and blame associated with illegal substance use (Office of the Provincial Health Officer, 2019).

Finally, non-equity beliefs also narrated poor health program and design as factors most responsible for harm (i.e. villain). Yet, as discussed in Chapter 4, these narrations differ from an equity-oriented lens as they are centred around improving the delivery of programs in terms of design at the service provider level and the need to increase service utilization as opposed to tailoring programs to the needs of PWUD and other population groups, or addressing social and systemic barriers to programs. As noted in Pauly et al. (2017), emphasizing service utilization as a measure of access, and in this case equity, is problematic as there are multidimensional conditions that shape access to health care. Further, placing onus on the fault of program delivery models blatantly ignores social and political conditions that may have impacted the successful implementation and reach of programs. Additionally, proposed solutions to improve service delivery were often targeted for those focused on improving physical health. Most recommendations for social programs were discussed quite generically, such as increase housing availability. Overall, scaling up health programs without a proportionate response for social policy and programs creates a disjointed policy climate for harm reduction as it contradicts longstanding evidence that proves substance use harms and health inequities cannot be fully addressed until underlying social inequities are addressed (Pauly, 2008a).

The identification and exploration of non-equity beliefs was a cornerstone to this study as it illustrated that while policy frameworks are ‘pro-harm reduction’, there are multiple, nuanced beliefs behind how harm reduction is understood and promoted, including beliefs that run

contradictory to social justice and equity. This is congruent with longstanding arguments that assert while harm reduction is representative of the public health model, it also tends to be conveyed or conceptualized in other models (Pauly, 2020). This includes a moral model in which individuals are either blamed or deemed responsible for risk of harm; a criminal model where there is an emphasis on increasing sanctions and penalties for substance use; and the medical model in which substance use is conceptualized as a disease and harm reduction would translate to ‘treating’ substance use (Pauly, 2020). Non-equity beliefs characterized in this study confirm harm reduction is conceptualized simultaneously with characteristics representative of the moral, criminal and medical model. Furthermore, equity seems to be limited by the commitment of each citizen to improving their own health, and as the authors note, while the language of equity and well-being are present, they are based contradictorily on the values of individual rights and responsibilities (Iannantuono & Eyles, 1997, p. 1619).

In terms of addressing the research question surrounding how policy beliefs have shifted since the 2016 public health emergency declaration, in this analysis I found policy beliefs for current policy frameworks have shifted very little since the 2016 public health declaration. However, there were notable shifts with respect to specific characteristics of equity and non-equity beliefs. This included an increase in acknowledging inaccessibility and unresponsive policies and programs towards the health needs of PWUD as risk factors for harm and acknowledging vulnerable and marginalized as facing disproportionate levels of harm. There was also an increase in promoting desistance-based solutions and assigning more individual responsibility for health and substance use-related harms.

Andrew Hathaway (2001) once noted that harm reduction, both in policy and practice, often downplays tolerance and respect for civil liberties, that is an individual’s right to use substances,

in favour of value neutrality (p.126). This causes harm reduction to occupy a middle road between prohibitionist and libertarian beliefs, in which harm reduction is often coopted by programs inimical to tolerating drug use (p. 135). Based on the ongoing tension between equity-related beliefs and non-equity beliefs, it is my belief and understanding that harm reduction is being coopted by policies that are inadvertently inimical to preserving and ensuring the right of health equity for PWUD. Furthermore, the ongoing tension between equity and non-equity beliefs within policy substantiates Hathaway's (2001) findings as it confirms harm reduction in B.C. has taken the middle road in which it strives to maintain value neutrality by downplaying tolerance and respect for an individual's right to use substances (p. 126). In addition, this study revealed that policy beliefs seek value neutrality by downplaying the role and influence of social and political processes that influence and magnify substance use harms.

5.3 Limitations

There were a number of limitations for this study. First, without further corroborating evidence, it is difficult to know for certain if the identified policy beliefs bear any influence or impact on the ways in which harm reduction policy is integrated into frontline services. This study only highlighted that elements of these beliefs are reflected in policy by the matter in which substance use and harm reduction is narrated; this study was unable to prove that these beliefs are reflective of human actors involved in the policymaking process, or if these beliefs influence the understanding of harm reduction from the position of health care and other service providers in the provision of harm reduction services for PWUD. As such, this limitation impacts the transferability and validity of these findings. Corroborating evidence could be produced through interviews with policy stakeholders, primarily those that have direct input and involvement in the policymaking process and those that directly provide harm reduction services.

CHARPP has recently initiated this type of work, as noted in Hyshka et al. (2019), in which multiple provincial policy actors were interviewed to garner their input and evaluation of harm reduction policy and its influence on frontline services.

Second, the NPF has traditionally been used to examine both sides of a policy debate (pro/opposed narratives); however, as previously noted in Chapter 3, a small selection of studies have used the NPF to examine one side of the debate for a single policy actor. Regardless, a limitation of this study is that I restricted my analysis to policy beliefs for a single policy actor. This is important to note as substance use and harm reduction is an issue of public importance that contains multiple policy narratives and policy beliefs from various stakeholders, such as unions, professional associations, policy institutes, political leaders, and news media. These additional narratives were absent from the analysis as I relied exclusively on policy documents which reflects positions taken by public administration bodies, such as government and health authorities. Therefore, this study is unable to substantiate the matter in which the identified policy beliefs are represented in other narratives from other actors in this policy domain. Again, I recommend readers to look towards CHARPP who is currently conducting studies related to media depictions and narratives surrounding substance use and harm reduction.¹²

Other limitations stem from the data collection methods. First, due to resources and to ensure a reasonable workload, I was unable to include historical policy texts in the study in which any policy that was no longer in effect was excluded; therefore, I was unable to substantiate the policy beliefs for B.C. harm reduction policy in its entirety. Second, while I relied exclusively on policy documents, my inclusion and exclusion criteria created limitations for this study. For example, I only included policy documents that had an enforcement period of December 31,

¹² <https://crismprairies.ca/charpp/>

2019 or later which left out all historical policy documents, many of which are still used by service providers today, such as *Harm Reduction: A British Columbia Community Guide (2005)*. As such, this analysis can only be used to provide an understanding of policy beliefs for documents that are current by virtue of their effective/enforcement period, not for policy that is currently used on the frontlines. I strongly recommend future research studies to include all documents currently used by policy stakeholders and harm reduction service providers, regardless of effective/enforcement date to ensure they capture policy beliefs representative of the current policy environment as seen in front line practice. Additionally, there may be a probability that there are current policy documents internal to government ministries or other health stakeholders that have been excluded by means of not being publicly accessible. This limitation may impact the validity of my findings and I recommend future research to allocate enough time and resources to complete requests under relevant access to information regulations and statutes to source all pertinent and relevant policy documents from government and health authorities. Finally, by setting 2016 as the marker to measure shifts in policy beliefs I unintentionally exclude other notable political and health events that may also be useful in measuring shifts in policy beliefs. This includes the election of a new government in 2017, and the introduction of a public health framework in 2005 that prioritized health equity (BC Ministry of Health Services, 2005).

The lack of intercoder reliability during the data coding and analysis phase also poses limitations to this study. Intercoder reliability refers to a numerical measure of agreement between different coders regarding how the same data should be coded (O'Connor & Joffe, 2020, p. 2). Intercoder reliability increases the credibility and trustworthiness of the findings as a high intercoder reliability score suggests the analytic structure of the data has meaning that

extends beyond an individual researcher (p. 3). Given resource constraints, I was the sole coder for this study. As such, there was no measure to confirm that my interpretation of the data aligns with the interpretation of other researchers. If I would have had the means to hire additional coders, I would have been able to numerically measure intercoder reliability through ATLAS.ti, thus increasing the credibility and trustworthiness of my findings. It is highly recommended for future research to take heed of this limitation and ensure there is at least one additional coder to verify and validate the coding and analytical frame.

5.4 Evaluating Trustworthiness

As previously discussed in Chapter 1 and 3, I relied on Lincoln and Guba's (1985) four criteria of research trustworthiness (credibility, transferability, dependability and confirmability) to assess the robustness of this study. To operationalize these four criteria, I followed the process outlined in Gray and Jones (2016), in which I relied on recommendations outlined in Shenton (2004), in addition to recommendations in Tobin and Begley (2004) and Nowell et al. (2017).

First, dependability refers to consistency in the research process, specifically when the process is logical, traceable, and documented (Lincoln & Guba, 1985). Further, dependability is demonstrated through an audit trail, where others can examine the documentation of data, methods, decisions and final results (Tobin & Begley, 2017, p.392). My transparency in detailing my research design, data collection criteria and procedures, and analytical framework helped my study meet the criterion of dependability. Similar to Gray and Jones (2016), my results may not be replicable in a scientific sense; however, they can be repeated in which one could use the same instrument (the Q-NPF) and the same data collection procedures, both of which satisfy the dependability criteria (Shenton, 2004, p.71; Nowell et al., 2017, p.3).

Second, research should be credible to those from which the information was gathered and to critical readers (Lincoln & Guba, 1985). In addition, Shenton (2004) asserts a researcher's reflexivity can contribute to the credibility of a study in which researchers consistently engage in a process of internal questioning and critique towards their methodological choices and data analysis (p. 68). To ensure my own personal beliefs did not pre-empt the results of my study, I completed comprehensive research memos in which I reflected my thoughts towards the data, and engaged in routine self-reflexive exercises to ensure I was accountable to the data and did not permeate my own thoughts, experiences, and beliefs into the results. Furthermore, Shenton (2004) encourages qualitative studies to employ specific procedures and methods of data analysis derived from those that have been successfully used in previous comparable projects. As such, I adopted the data collection procedures outlined in Wild et al. (2017), which is one of the most extensive harm reduction policy analysis studies in Canada. Additionally, I used an established theoretical framework (the Q-NPF) as the foundation of my study. As noted in Gray and Jones (2016), the NPF has a history of producing valid and reliable findings dating back a decade or more (see Shanahan et al., 2018). Most recently, Gray and Jones (2016) proved the Q-NPF contains the same degree of validity and reliability when used in conjunction with rigorous qualitative methods. As such, the Q-NPF in and of itself lends credibility to my qualitative study as it allowed me to draw on legitimized frameworks.

The transparency of my findings also lends support to their credibility as I included a detailed description of my data and methods. I have also reflected and accounted for the context of harm reduction policy in British Columbia by including all current policy documents in my sample. Thus, I believe I had a concrete sample and was transparent about the limitations stemming from the sample that was used to generate my conclusions. As noted earlier in this

chapter, I also examined my findings in relation to previous findings from the literature in terms of harm reduction policy and health equity to assess the degree to which my results are congruent with those of past and similar studies, satisfying the credibility requirement (Shenton, 2004, p.69).

Third, confirmability refers to results that are supported by the source of which they are derived from and other external sources whenever possible (Lincoln & Guba, 1985). Transparency makes it easier for the reader to determine if the findings are “the result of the experiences and ideas of the informants” (Shenton, 2004, p. 72). As policy documents are non-human informants, satisfying this criterion deviated from the process adopted by Gray & Jones (2016) who conducted informant interviews. Instead, I relied on the excerpts from the policy documents to inform my analysis. By including examples of excerpts from the policy documents and citing bibliographic information of each excerpt, I was transparent about where I found the information that grounded my analysis. Further, while the NPF formed my deductive coding schemes, which arguably would have confined my analysis to preconceived categories, I employed inductive coding free of priori constructs to form the sub-codes and final code categories and themes. As noted in Gray and Jones (2016), it is my transparency of the ways in which I conducted my research that makes it possible for the reader and other researchers to make the determination of credibility for themselves (p.213).

Lastly, transferability refers to the matter in which results from the study can be transferred from one context to the next (Lincoln & Guba, 1985). Since the findings of a qualitative project are specific to a small number of particular environments and individuals, it is impossible to demonstrate that the findings and conclusions are applicable to other situations and populations (Shenton, 2004, p. 69). To mediate this challenge, the results of a qualitative study must be

understood within the context of the particular characteristics in which the fieldwork was carried out (p. 70). As noted in Gray and Jones (2016), the NPF provides a theoretical bridge for qualitative and quantitative studies by allowing theoretical objects (e.g., characters, plots) to be compared, evaluated, and critiqued via different methodologies. As such, findings from qualitative studies can morph from being transferable, to testable hypotheses that inform, challenge, or modify the theories invoked by quantitative scholars to build their NPF models (p. 22). Thus, my findings are transferable as they could be used to test future hypotheses for the purpose of determining their generalizability. For example, future NPF researchers could explore hypotheses that test the extent to which health equity beliefs are prevalent or permeate to other health policy areas apart from harm reduction. Additionally, findings from my study could be transferred to quantitative NPF studies that aim to test the prevalence of health equity beliefs using a similar approach to McBeth et al. (2005) and Shanahan et al. (2013). As such, subsequent studies can potentially transfer my findings to different contexts and allow for comparisons with similar Q-NPF and NPF studies in different policy areas.

Beyond Lincoln and Guba's framework, this research contained additional features that lend to its trustworthiness. For example, prior examination of the literature and a detailed understanding of harm reduction policy and health equity lens contributes to my research study's trustworthiness. Gray & Jones (2016) state that such an understanding lends itself to a study's credibility and trustworthiness, whereby one might assess how closely our findings align with the academically accepted 'reality'. My findings were also corroborated with evidence-based findings and best practices for health equity principles as my analysis was situated within the literature and analytical framework of Pauly (2008a) and Pauly et al. (2018).

Chapter 6: Conclusion

As longstanding evidence confirms, one's vulnerability to risk can be influenced and exacerbated by social and structural conditions. How we view and address this vulnerability speaks volumes of the dominant values and beliefs our society upholds, especially in the context of substance use harms and harm reduction. As this study has confirmed, policy documents are information-rich sources that can reveal beliefs and values that inadvertently shape the broader understanding of a policy issue. By employing the Q-NPF, this study was able to illuminate the various ways in which the provincial government, and respective health authorities, characterize and narrate substance use harm. Through these narrations, the Q-NPF helped identify core policy beliefs permeating B.C.'s provincial harm reduction policy framework.

The core objective of this study was to not only identify underlying beliefs and values that steer harm reduction policy in B.C., but to also determine the matter in which such beliefs and values align with the social justice principles rooted in harm reduction and required to create and maintain equity for PWUD. As the findings revealed, policy beliefs feature notable elements of health equity. However, they arguably fall short on representing and narrating equity principles in entirety on the basis that there is an overt absence of fully acknowledging, explaining, and mediating intersecting social and systemic challenges that create and compound substance use harms. Rather, equity is narrated more often in terms of ensuring equitable access to services and supports with little attention towards the social and systemic barriers that impede upon accessibility; equity in this sense aligns closely with egalitarian principles of justice (Pauly, 2008a).

In aiming to understand health equity in the context of substance use, it is imperative to not conflate equity with sameness— as doing so may unintentionally negate systemic disparities that exist amongst PWUD. Rather, equity in the context of substance use is about recognizing the inequitable distribution of risks and harms related to substance use, and advancing solutions that recognize and aim for proportional universalism in which priorities for policies and programs include a range of responses relative to the needs and levels of social disadvantage in a population to ensure everyone has proportionally allocated services, and emphasize the systemic factors that impact health outcomes (Pauly et al., 2018).

This study also confirmed an ongoing tension between equity-related and non-equity beliefs. As previously discussed, non-equity beliefs contradict the social justice principles of harm reduction as they are premised on values representative of utilitarian and individual-liberalist theories of justice. Further, non-equity belief conveyed narrations of substance use and substance use harms that align more closely with the moral, criminal and medical model of substance use (Pauly, 2020). This tension is realized through almost equal prevalence of equity-related and non-equity policy beliefs both pre and post a major public health emergency, indicating very minimal shifts in beliefs surrounding substance use and harm reduction.

6.1. Contributions to the Literature

This study made two key contributions towards the literature surrounding harm reduction policy and equity. As discussed in Chapter 2, a notable gap in the literature consisted of studies that identified policy beliefs for harm reduction and substance use, with the most recent Canadian harm reduction policy analyses focused on policy quality, communicative function, and policy governance (Hyshka et al., 2017; Wild et al., 2017;). This study was the first to characterize harm reduction policy in BC within the confines of policy beliefs; providing a basis

to expand the general understanding of harm reduction policy characteristics. Additionally, findings from this study also substantiate the findings from previous CHARPP studies in which it was confirmed there remains a notable absence of equity-based principles and principles founded on the roots of social justice, in which harm reduction policy fails to address the spectrum of harm PWUD face, and fail to acknowledge that harms are not distributed equally (Hyshka et al, 2017; Wild et al., 2017).

This study also provides contribution to the transferability, applicability and versatility of the social justice lens framework for harm reduction (Pauly, 2008a) and the SHEL framework (Pauly et al., 2018) in their ability to evaluate and characterize public policy documents through an equity-oriented lens. As a result, this study contributes to recent literature that has applied an equity-based lens to assess and evaluate various policy issues in health, such as palliative care (Reimer et al., 2016) and reducing the harms of stigma and overdoses for those who use illicit drugs (MacKinnon et al., 2019). Specifically, opportunities to employ the SHEL framework for future research efforts are discussed in more detail in subsection 6.3.

6.2. Methodological Contributions to the Q-NPF

This study produced a methodological contribution in terms of expanding the application of the Q-NPF and broadening the understanding of the Q-NPF's strengths in relation to the traditional NPF. First, this study contributed to the limited NPF literature that examined policy narratives of a single policy actor. Prior to this study, only two NPF studies used the NPF to characterize the policy narratives of one policy actor over a period of time (McBeth et al. 2010; McBeth, Shanahan, Arrandale Anderson & Rose, 2012). This study represents one of the first to use the NPF to characterize policy beliefs for a single actor and one of the first to characterize policy beliefs for public administration bodies. Interestingly, at the time of writing this study was

the first to use the Q-NPF within the confines of drug policy, which was surprising given the emerging scholarship dedicated to analyzing drug policy. This study was also one of the first to apply the Q-NPF to actual policy texts. While one can only speculate the reasons why NPF and Q-NPF scholars have refrained from using policy texts as sources of policy narrative data, it is my view that policy texts are rich sources of information as they provide accounts towards what beliefs and values underpin final policy outcomes implemented by the state and its respective public bodies that govern health and social services.

This study highlighted key contributions the Q-NPF yields for policy analysis and narrative studies, which simultaneously identified limitations of the traditional NPF. First, this study has proven that the Q-NPF is well-suited to explore and analyze the nuances for one side of the debate as it reveals that there are multiple ideological and political positions within a pro-harm reduction stance, some of which are counterintuitive to the principles of harm reduction.

This study also proved scholars can examine policy beliefs through the construction of characters in policy narratives in addition to the construction of proposed policy solutions (the moral of the story). In comparison, previous NPF studies that measured policy beliefs relied exclusively on the construction of characters (villain, victim, hero) to reveal policy beliefs. Furthermore, as this study did not find the plot code to be applicable in exploring policy beliefs, this may not be the case for other and future NPF studies. Thus, this study not only illustrates the versatility of the Q-NPF to measure policy beliefs, it also illustrates an opportunity for scholars to include other components of the NPF to analyze policy beliefs that were absent from this study, such as the plot and setting.

Finally, this study demonstrates that the Q-NPF is equipped to explore and analyze policy beliefs while maintaining a rigorous engendering of theory; however, it deviates from the

traditional NPF in terms of how theory is operationalized and applied in analysis. The traditional NPF engenders theory by operationalizing the definitions of the NPF structure to align with theoretical definitions. While this is indeed a valuable and evidence-based recommendation, it also poses limitations to analysis. This traditional approach is ideal for studies that seek to test presupposed theories and priori hypotheses to measure the prevalence of specific beliefs, not necessarily to explore what beliefs are entrenched in narratives. For instance, if I had heeded the advice from traditional NPF scholars by grounding the definitions of the NPF characters in theory, I would have limited my study and analysis to confirm how prevalent health equity beliefs were in policy texts and would have missed other themes related to policy beliefs outside the confines of Pauly's theory (though related), such as those premised on abstinence, or service delivery improvements. The Q-NPF can still maintain a strong foundation in theory by linking identified beliefs to theoretical equivalents, primarily by adopting a specific theory as an analytical framework for research, not exclusively as the coding framework as seen in the traditional NPF. Thus, the traditional NPF is most useful to confirm preconceived hypotheses and theories related to policy beliefs whereas the Q-NPF provides space for scholars to engage in exploratory analysis and allow the data to reveal the beliefs to the researcher. If we are to trust the literature that policy narratives and policy documents are socially constructed realities, the Q-NPF provides a trusted foundation to utilize social constructive methodology without compromising trustworthiness and rigour.

These methodological contributions hold promise that the NPF does not need to be demarcated by those who study them scientifically and those who adopt post-positivist/social constructivist/interpretivist approaches. There is space for both and the decision to use either the traditional NPF or Q-NPF is dependent upon a researcher's motivations. To test if a theoretical

belief is indeed prevalent, then the traditional NPF is an appropriate method; to explore all possible beliefs, qualitative is well-suited for that approach. Alternatively, there may be a way to utilize both, but regardless qualitative methods will not limit one's analysis to preconceived hypotheses or notions of what beliefs are. As such, it is my hopeful expectation that the rigid requirements from traditional NPF scholars regarding when and how to use the NPF is soon replaced with an open understanding and acceptance of the benefits and limitations of both approaches, and an appetite to collaborate with qualitative research to further expand and apply the NPF in other academic disciplines and policy domains.

6.3. Recommendations for Future Research

The findings and implications from this study provides a basis for future research efforts. First, I recommend future policy-based studies to employ the SHEL framework (Pauly et al., 2018), either as an analytical framework, coding framework, or a combination of the two. As this study demonstrated, SHEL serves as a valuable resource to inform and guide research in various disciplines and contexts that seek to identify the degree to which principles of health equity are prevalent in policy and program frameworks and the provision of health care and social services.

The contributions outlined above towards the Q-NPF indicate a need for future studies to employ the Q-NPF to explore policy beliefs in other policy domains, including health policy. Given the Q-NPF's transferability, versatility and flexibility, it is recommended for researchers to consider the Q-NPF as a notable research design and coding framework to understand the nuances of various components that shape policy debates and policy texts, as evident in both policy beliefs and narrative strategies. More specifically, future research concerned with harm reduction policy could employ the Q-NPF to identify and compare policy beliefs for those that are pro-harm reduction and those that are opposed. Such a study aligns with the key purpose of

the Q-NPF and traditional NPF, which is examine both sides of a policy debate; a study of this nature would also broaden our understanding of the various policy beliefs entrenched in what is one of the most morally contentious policy debates of our time. Additionally, there is an opportunity to employ the traditional NPF process to quantitatively code for policy beliefs to determine the prevalence of equity and non-equity beliefs in harm reduction policy documents.

Finally, in recognition of the research CHARPP is championing with respect to harm reduction policy analyses, there is an opportunity to bridge this study's findings with the work completed by Hyshka et al. (2017) in which a potential focus could be to link harm reduction policy beliefs with harm reduction policy quality indicators.

6.4. Recommendations for Policy

It is undeniable that harm reduction approaches should reflect an understanding of and commitment to addressing the historical, socio-cultural and political conditions and processes that shape social and health care responses to substance use and addiction (Smye et al., 2011). Further, it is undeniable that harm reduction must move beyond a narrow concern with drug-related harms and seek to simultaneously address the social determinants associated with substance use (Pauly, 2008a). Findings from this study present several recommendations to improve harm reduction policy at a practical level.

First, it is imperative for harm reduction policy documents to specify the ways in which social and structural conditions intersect with substance use and further influence and exacerbate the risks of harm for PWUD. As noted in SHEL, the systematic application of health equity principles is needed across all policies to ensure that they align with health improvement and principles of social justice, and consider the potential for harm, as well as potential influence on health inequities and population health (Pauly et al., 2018). As it is well documented that

substance harms stem beyond the physical act of consuming substances, health equity requires harm reduction policy to operate in tandem with social policy to improve the social conditions that contribute to harm. Essentially, harm reduction policy ought to consider social conditions such as housing, income security, food security and social equity (e.g. racial equity, gender equity) as examples of harm reduction.

Further, many of the policy texts were typically set in the context of reducing harm for a single substance, such as opioid use, methamphetamine, or alcohol. This is problematic as it infers harms are produced from specific substances whereas issues pertaining to overdoses, mortality, physical and social harms are representative of all substances, not just one. Such settings frame harm reduction in a solitary lens. Additionally, situating harm reduction policy as a response to a crisis negates the social and environmental factors that influence the risk of harm. Harms stemming from substance use have been prevalent prior to any ‘meth crisis’ or ‘opioid crisis’. Rather, these crises magnified the harms that have always been there. It is recommended for harm reduction policy to be situated as a response that reduces harms associated with substance use overall and in relation to the risk environment (Rhodes, 2009).

Regardless of policy beliefs, all policies possessed a lack of specific guidance or directives surrounding how specific initiatives will address accessibility, improve social conditions and address non-physical harms associated with substance use. Policy must be clear on defining what constitutes a harm reduction ‘intervention’ and specific guidance on how health care providers and health care partners are to implement the proposed solutions and interventions. Additionally, harm reduction policy needs to elaborate on the matter in which substance use harms are not distributed equitably and are influenced and further compounded by intersecting social inequities rooted in one’s social position. This includes clearly delineating the relationship and impact of

substance use with inequities such as poverty, racism, homelessness, stigma, and gender-based issues.

6.5. Closing Remarks

Equity-oriented harm reduction requires a consideration of social and political circumstances, one's social position, and physical conditions (e.g. geographic locations) that impact access to services and influence the risk and distribution of substance use harms. Even more important, equity-oriented harm reduction requires significant efforts to address deep-seeded social, political, and economic inequities. A social justice lens for harm reduction calls for a shift from distributing existing material resources (such as income, access to resources) to a focus on social structures, with the hope of surfacing and the root causes of substance use harms (Pauly, 2008a). A social justice lens for harm reduction would encourage harm reduction policy to move past the personal values and beliefs we attach to substance use and seek to view PWUD as deserving to the most optimal level of care and services they require as part of mitigating unfair and unjust social conditions. Adopting a social justice lens in policy invokes a need to view substance use harms as a mirror that displays the inequities our social and political structures have long perpetuated and magnified to many population groups, and seeks to modify and improve these structures to ensure power, privilege and determinants of health are distributed more fairly. It is with my sincere hope that we, as a society, can agree there is nothing politically or morally contentious about a social justice lens for harm reduction. As this study has clearly denoted, an absence of a social justice lens by any means will inadvertently continue to cause more harm than good.

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Appendices

Appendix A – Canadian Harm Reduction Policy Project (CHARPP) B.C. Policy Document Corpus

Document #	Document Name	Authors	Publication Year	Enforcement Period
1.	BC Harm Reduction Strategies and Services Policy and Guidelines	BC Harm Reduction Strategies and Services Committee	2014	No specified end date
2.	Crystal Meth and Other Amphetamines: An Integrated BC Strategy	BC Ministry of Health Services, Mental Health and Addictions	2004	No specified end date
3.	Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction	BC Ministry of Health Services, Mental Health and Addictions	2004	No specified end date
4.	From Hope to Health: Towards an AIDS-free Generation	British Columbia Ministry of Health Services	2012	2012-2016
5.	Healthy Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in BC	British Columbia Ministry of Health Services	2007	2007-2017
6.	Healthy Pathways Forward: Progress Report 2011	Clinical Prevention Services BC Centre for Disease Control & Population and Public Health Ministry of Health	2007	2007-2017
7.	Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia	Ministry of Health Services and Ministry of Children and Family Development	2010	2010 - 2020

Document #	Document Name	Authors	Publication Year	Enforcement Period
8.	A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - A 10 Year Plan	First Nations Health Authority	2013	2013-2023
9.	Collaborating for Action: Provincial Health Services Authority HIV/AIDS Strategic Framework	Provincial Health Services Authority	2006	No specified end date
10.	Position on the Prevention of Problematic Substance Use with a Focus on Alcohol An Integrated Population Health Approach	Northern Health Authority	2012	No specified end date
11.	BC Harm Reduction Strategies and Services Policy and Guidelines 2009	BC Harm Reduction Strategies and Services Committee	2009	2009-2014
12.	BC Harm Reduction Strategies and Services Committee Policy Indicators Report (2013)	BC Harm Reduction Strategies and Services Committee	2011	2011
13.	BC Harm Reduction Strategies and Services Committee Policy Indicators Report (2014)	BC Harm Reduction Strategies and Services Committee	2012	2012
14.	Crystal Meth and Other Amphetamines: 6 Month Progress Report	British Columbia Ministry of Health Services	2004	2004-2005
15.	From Hope to Health: Progress Report 2013-14	British Columbia Ministry of Health Services	2013	2013-2014

Document #	Document Name	Authors	Publication Year	Enforcement Period
16.	From Hope to Health Progress Report Source Data and Technical Information	British Columbia Ministry of Health Services	2013	2013-2014
17.	Healthy Minds, Healthy People: Monitoring Progress: 2012 Annual Report	Ministry of Health; Ministry of Child and Family Development	2011	2011
18.	Healthy Minds, Healthy People - First Annual Report 2011	Ministry of Health; Ministry of Child and Family Development	2010	2010
19.	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007	BC Ministry of Health Planning; Ministry of Health Services	2003	2003-2007
20.	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007: 2004 Annual Progress Report	BC Ministry of Health	2003	2003-2004
21.	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007: 2005 Annual Progress Report	BC Ministry of Health	2005	2005
22.	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007: 2006 Annual Progress Report	BC Ministry of Health	2006	2006
23.	Priorities for Action in Managing the Epidemics: HIV/AIDS in BC: 2003-2007: 2007 Annual Progress Report	BC Ministry of Health	2007	2007

Document #	Document Name	Authors	Publication Year	Enforcement Period
24.	Interior Health's Action Plan for Blood-Borne Pathogens	Interior Health Authority	2006	2006-2009
25.	Meeting the Challenge: A Blood-borne disease strategy for Northern Health	Northern Health Authority	2005	2005-2009
26.	Meeting the Challenge: A 2007 Blood Borne Disease Update for the Northern Communities	Northern Health Authority	2007	2005-2006
27.	Meeting the Challenge: A Blood Borne Disease Update for the Northern Communities, December 2008	Northern Health Authority	2008	2007-2008
28.	Mental Health and Addiction Services: Strategic Plan Fraser Health	Fraser Health Authority	2007	2007-2012
29.	Closing the Gap: Integrated HIV/AIDS and Hepatitis C Strategic Directions for Vancouver Island Health Authority	Vancouver Island Health Authority	2006	2006-2009

Appendix B – Search Term Framework

Addiction	Methadone maintenance	Safe supply*
Blood borne pathogen	Naloxone	Street drug
Buprenorphine	Narcan	Street drug use
Drug checking	Needle	Substance misuse
Drug misuse	Opioid maintenance	Substitution
Drug use	Overdose crisis*	Supervised consumption
Harm minimization	Overdose prevention*	Supervised injection
Harm reduction	Overdose*	Syringe
Hepatitis C	Reducing harm	
HIV/AIDS	Reducing risk	
Illicit drug use	Risk management	
Injection drug use	Risk reduction	
Low threshold methadone	Safe crack	
Low threshold opioid	Safe inhalation	

Appendix C – Policy Documents Included in Analysis (Descriptive Information)

Document #	Document Name	Authors	Publication Year	Enforcement Period	Length (Pages)
1.	A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia	British Columbia Ministry of Mental Health and Addictions	2019	2019 - 2019	33 pp.
2.	Escalating BC's Response to the Overdose Emergency	British Columbia Ministry of Mental Health and Addictions	2019	no specified end date	19 pp.
3.	Response to the Opioid Overdose Crisis in Vancouver Coastal Health	Vancouver Coastal Health Authority	2018	no specified end date	33 pp.
4.	The Hidden Epidemic: The Opioid Overdose Emergency in Fraser Health	Fraser Health Authority	2018	no specified end date	13 pp.
5.	BC Harm Reduction Strategies and Services Committee Policy Indicators Report	BC Harm Reduction Strategies and Services Committee	2017	no specified end date	35 pp.
6.	B.C.'s Mental Health and Substance Use Strategy	British Columbia Ministry of Health	2017	2017 – 2020	27 pp.
7.	From Hope to Health: Towards an AIDS Free Generation 2015/16 Progress Report ¹³	British Columbia Ministry of Health	2016	2016-2020	36 pp
8.	BC Harm Reduction Strategies and Services Policy and Guidelines (FROM CHARPP)	BC Harm Reduction Strategies and Services Committee	2014	No specified end date	24 pp.

¹³ From Hope to Health Progress Report 15/16 – This progress report was included in analysis as it set forth priorities and recommended solutions to be implemented by 2020.

Document #	Document Name	Authors	Publication Year	Enforcement Period	Length (Pages)
9.	A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - A 10 Year Plan (FROM CHARPP)	First Nations Health Authority	2013	2013-2023	48 pp.
10.	Position on the Prevention of Problematic Substance Use with a Focus on Alcohol An Integrated Population Health Approach (FROM CHARPP)	Northern Health Authority	2012	No specified end date	20 pp.
11.	Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (FROM CHARPP)	Ministry of Health Services and Ministry of Children and Family Development	2010	2010 - 2020	40 pp.
12.	Collaborating for Action: Provincial Health Services Authority HIV/AIDS Strategic Framework (FROM CHARPP)	Provincial Health Services Authority	2006	No specified end date	21 pp.
13.	Crystal Meth and Other Amphetamines: An Integrated BC Strategy (FROM CHARPP)	BC Ministry of Health Services, Mental Health and Addictions	2004	No specified end date	38 pp.
14.	Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction (FROM CHARPP)	BC Ministry of Health Services, Mental Health and Addictions	2004	No specified end date	106 pp.

Appendix D: Excluded Documents from Systematic Search (n=33)

Document Name	Rationale for Exclusion
Harm Reduction: A British Columbia Community Guide (2005)	Guidance for municipal scope as noted in document (p.2)
Responding to BC's Illegal Overdose Epidemic – Progress Update (Ministry of Mental Health & Addictions, 2018))	Progress report, no mandate of future action
Looking Forward: Improving Rural Health Care, Primary Care, and Addiction Recovery Programs (2017)	Legislative Committee Report (Standing Committee on Health)
FNHA Policy on Mental Health & Wellness (no date listed)	Off topic subject matter –focused exclusively on mental health; harm reduction appeared twice in general reference
VIHA Compassion as a Guiding Action (2017)	Guidance re: best practices for service providers
Stopping the Harm: Decriminalization of People Who Use Drugs in BC (2019)	Independent Review Report – Provincial Health Officer's Special Report
Overdose Data and First Nations in BC: Preliminary Findings (2017)	Independent Report/Data Summary Report
Responding to British Columbia's Overdose Public Health Emergency - An Ethics Framework (2017)	Guidance/Directive re: ethical decision making
Fraser Health Consultations for Supervised Consumption Services In Surrey (2017)	Stakeholder Consultation Report
FNHA Nasal Naloxone Fact Sheet (2019)	Fact Sheet
FNHA Naloxone Information for the Community (2019)	Fact Sheet
Teaching Guide for Taking Care of Each Other (Vancouver Coastal Health and FNHA, no date)	Teaching Guidance for harm reduction video series
Respectful Language and Stigma Regarding People Who Use Substance (2017)	Guidance/Directive
Understanding Harm Reduction: Substance Use (2015)	Fact Sheet
Interior Health OAT Clinical Resource Guide (2019)	Clinical Guide/Directive
Construction Industry Roundtable on the Opioid Overdose Crisis (2018)	Consultation Report
Health and Safety During the Opioid Overdose Emergency: Northern Health's Recommendations for Industrial Camps (2018)	Consultation Report
Northern Health Update on the Overdose Emergency Response (2018)	Stakeholder Report/Presentation

Document Name	Rationale for Exclusion
Pilot Project Report: Survey on Drug Use Among Harm Reduction Clients (2012)	Independent Project Report
B.C.'s Opioid Overdose Response One-Year Update (2017)	Progress Update
Progress Update on B.C.'s Response to the Opioid Overdose Crisis (2016)	Progress Update
Progress Update on B.C.'s Response to the Opioid Overdose Public Health Emergency (2017)	Progress Update
Responding to BC's Overdose Emergency Progress Update (2018)	Progress Update
Illicit Drug Overdose Deaths in BC: Findings of Coroners' Investigations (2018)	Independent Investigation Report
FNHA Overdose Response Case Study Report (2019)	Independent Report – Case Study
BC College of Family Physicians Submission: Mental Health and Addictions Strategy Development (2018)	Stakeholder Consultation/Submission
Responding to British Columbia's Public Health Emergency Progress Update (March – July 2019)	Progress Report
Interior Health Guide to Harm Reduction For Frontline Staff Who Provide Service Delivery and Management of Harm Reduction Service (2017)	Clinical/Practice Guidance
Fraser Health Overdose Prevention Site Manual (2018)	Guidance for OPS
BC Overdose Prevention Services Guide (BCCDC, 2019)	Guidance: intended for service providers and practitioners offering OPS in the community
Evaluation of Overdose Prevention Sites: Campbell River, Courtenay, Cowichan Valley, and Port Alberni (2018)	Independent Report/Evaluation
Fraser Health A Proposed Abbotsford Harm Reduction Service Plan Version 1 (2012)	Guidance (Proposed) – municipal scope
Time to Listen: Youth Voices on Substance Use (2018)	Independent Report

Appendix E: Codebook

NPF CODE	Operational Definition	Final Code Groups
Setting	The legal, social, and political factors narrated as relevant to the time in which the policy document was published and implemented	Setting_HIV Setting_Overdose Setting_Deaths Setting_OpioidCrisis Setting_SubstanceUse Setting_Substance Specific Setting_Mental Health Strategy
Villain	Factors and characters narrated as responsible for influencing risk of harm	Villain_Equity_Inaccessibility Villain_Equity_Policy&Programs Villain_Equity_IndividDemographic&History Villain_Equity_SocialConditions Villain_NonEquity_Individ SubUseBehav&Practices Villain_NonEquity_SystemFlaws
Victim	Factors and characters narrated as harms resulting from substance use	Victim_Equity_Marginalized/VulnerableGroups Victim_Equity_SocialHarms Victim_NonEquity_EconomicHarms Victim_NonEquity_ServiceHarms Victim_NonEquity_PhysicalHarms Victim_Non-Equity_PublicSafety&Order
Moral of the Story	Proposed solutions to mitigate substance use harm	Moral_Equity_Improve Access to Services Moral_Equity_Policy and Program Equity Moral_Equity_AddressSocialConditions&Inequity Moral_Equity_Community_Empowermen&Collab Moral_Equity_PromoteSafeSubUse Moral_NonEquity_DesistSubUse Moral_NonEquity_EconomicSavings Moral_NonEquity_ServiceImprovements Moral_NonEquity_ImprovePhysicalHealth Moral_NonEquity_Increase_Intervention&Treatment Moral_NonEquity_SecurePublicSafety&Order Moral_NonEquity_EnhanceIndividResponsibility
Plot	The ways in which policy documents situate drug use in the context of harm reduction (i.e. how do villains/victims interact/coincide).	Refer to Chapter 4.