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Policy Analysis

Principles, practice, and policy vacuums: Policy actor views on provincial/territorial harm reduction policy in Canada

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ABSTRACT

Introduction: Canada is experiencing a new era of harm reduction policymaking and investment. While many provinces and territories are expanding access to these services, harm reduction policy and policymaking varies across the country. The present study, part of the Canadian Harm Reduction Policy Project (CHARPP), described policy actors' views on formal harm reduction policies in Canada's 13 provinces and territories.

Methods: As part of CHARPP's mixed-method, multiple case study, we conducted qualitative interviews with 75 policy actors, including government officials, health system leaders, senior staff at community organizations, and advocates with self-identified lived experience of using drugs. Interviews were conducted in English or French, and recorded and transcribed verbatim. We used latent content analysis to inductively code the data and generate main findings. NVivo 11 was used to organize the transcripts.

Results: Participants expressed divergent views on formal provincial/territorial policies and their impact on availability of harm reduction programs and services. While some identified a need to develop new policies or improve existing ones, others resisted bureaucratization of harm reduction or felt the absence of formal policy was instead, advantageous. Instances where harm reduction was advanced outside of formal policymaking were also described.

Discussion: Previous CHARPP research documented wide variability in quantity and quality of formal harm reduction policies across Canada, and characterized official policy documents as serving largely rhetorical rather than instrumental functions. The present findings highlight diverse ways that actors used their discretion to navigate these weak policy contexts. Participants' views and experiences sometimes referred to strengthening policy support, but institutionalization of harm reduction was also resisted or rejected. Results suggest that actors adopt a range of pragmatic strategies to advance harm reduction services in response to policy vacuums characteristic of morality policy domains, and challenge assumptions about the utility of formal policies for advancing harm reduction.

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Background

A harm reduction approach includes policies and programs that aim to help people who use drugs (PWUD) be safer and healthier without requiring abstinence or reductions in use. Canada—alongside the Netherlands, United Kingdom, and Australia—is recognized as an early pioneer of contemporary harm reduction, which developed in the 1980s in response to the HIV/AIDS epidemic amongst PWUD (Erickson, 1999; Riley, Pates, Monaghan, & O'Hare, 2012), and the country continues to be an important contributor to the approach's large and growing international evidence base (Hyshka, Strathdee, Wood, & Kerr, 2012; Kennedy, Karamouzian, & Kerr, 2017; Oviedo-Joekes et al., 2016). However, this reputation belies the fact that harm reduction has been implemented inconsistently across the country (Carter & MacPherson, 2012) and access to services and programs varies widely according to geography (Wild et al., 2017). This disparity reflects Canada's decentralized federal structure, as well as historically variable federal support for harm reduction. Although the federal government provides block health funding transfers to the provinces and territories, sets national drug policy direction (including international treaty compliance) and disperses targeted funding for substance use initiatives, the funding, planning, administration, and delivery of health services—including those targeting PWUD—is largely left up to the provinces and territories, resulting in 13 different health service delivery systems and diverse harm reduction policies and policymaking.

Brief history of harm reduction in Canada

Harm reduction goals were first endorsed in Canadian federal policy in 1987 (Hathway & Tousaw, 2008). In 1989, the federal government partnered with five provinces to pilot eight formal syringe distribution programs (though this move was preceded by informal initiatives led by PWUD). When federal funding ended two years later, the provinces assumed responsibility for these programs (Hankins, 1998). In 1992, a renewed federal drug strategy continued rhetorical support for harm reduction, and in 1998, an overhaul of the policy incorporated harm reduction as one of four officially supported approaches that included enforcement, prevention, and treatment (Hathaway & Erickson, 2003). Millions of dollars of federal funding were spent on harm reduction interventions in the ensuing decade. The federal government also facilitated implementation of the scientific pilot of Insite, Vancouver's first supervised consumption service (Wood et al., 2004), and a heroin-assisted treatment clinical trial (Oviedo-Joekes et al., 2009) during this time.

Federal support for harm reduction provided a symbolic endorsement of this approach as both appropriate and necessary for addressing illegal substance use. However, the government was criticized for a lack of investment in harm reduction programs, relative to spending on enforcement, treatment and prevention. For example, only 3% of federal expenditures on illegal drug responses were allocated to harm reduction in 2004–2005 (deBeck, Wood, Montaner, & Kerr, 2006). Others critiqued the federal government for embracing harm reduction in theory but not practice (Hathaway & Erickson, 2003), and overemphasizing reconciliation of public health objectives within a prohibitionist framework, to the detriment of broader drug policy reform (Erickson, 1998; Fischer, 1999; Hathway & Tousaw, 2008).

Federal endorsement of harm reduction continued until 2006, when a Conservative government was elected and proceeded to oppose harm reduction for its entire decade in power (Hyshka et al., 2017; Smith, 2016). This left the provinces and territories as the main stewards of harm reduction. Although those jurisdictions had the power to articulate harm reduction policy and funding commitments irrespective of federal political opposition (Wild et al., 2017), efforts to expand services were modest at best during this period (Carter & MacPherson, 2012). Despite growing national concern over sharp increases in opioid-related morbidity and mortality (Fischer, Gooch, Goldman, Kurdyak, & Rehm, 2014; Fischer, Rehm, & Tyndall, 2016), until the end of 2016, supervised consumption services and injectable opioid agonist treatment (i.e. supervised injections of hydromorphone or diacetylmorphine) were only available in one city, Vancouver; take-home naloxone programs were largely limited to Alberta, Ontario, and British Columbia; and sterile injection and safer inhalation equipment remained difficult to access in many parts of the country (Hyshka et al., 2017).

The Canadian Harm Reduction Policy Project (CHARPP) was developed as a mixed-method, multiple case study, to improve understanding of variations in harm reduction policy and policymaking across Canada's 13 provinces and territories. The first stage of CHARPP included a comparative analysis of publicly available formal harm reduction policies published between 2000–2015. 'Formal policy' includes statutes, regulations, strategies, documents, and other 'formalizing text'—rather than 'settled practices' or 'routine functions' of government (Burris, 2017). Formal policy may be developed at the program, regional, provincial/territorial, or federal levels. In keeping with CHARPP's main objective, our analysis of formal policies included only those documents generated by provincial/territorial governments and their delegated (provincial/territorial or regional) health authorities, which provided forward direction that mandated action.

We found that provincial/territorial harm reduction policy documents produced through 2015 were largely rhetorical and vague (Hyshka et al., 2017; Wild et al., 2017). Very few identified governance of harm reduction services as their primary named purpose (Wild et al., 2017). Instead, provinces and territories typically locate harm reduction under broader addiction and mental health, or sexually-transmitted infection and bloodborne pathogen (STI/BBP) strategies. Most formal provincial/territorial policies did not define harm reduction according its internationally-accepted key principles and attributes [including a focus on preventing harm and not substance use *per se*, tailoring approaches to specific needs of populations, addressing underlying causes of drug-related harm, involving PWUD in decision-making, evidence-based, rights-orientated, and other qualities delineated by international position statements and guidelines], specify its core interventions, or endorse efforts to prevent overdose or address stigma towards PWUD (Hyshka et al., 2017). Moreover, while the majority of documents identified the roles and responsibilities of service providers, far fewer declared how services would be funded or referenced supporting legislation (Wild et al., 2017). Most jurisdictions had few formal provincial/territorial harm reduction policy documents, and the majority of policies in our analysis came from only two jurisdictions—British Columbia and Quebec (Wild et al., 2017). When ranked on 17 quality indicators all jurisdictions performed poorly. British Columbia's policy documents performed best overall, scoring positively on 53% of indicators; the average score across all jurisdictions was 29% (Hyshka et al., 2017).

Rationale and research objectives

The policy studies literature provides insights for understanding the weak state of formal provincial/territorial harm reduction policies documented by CHARPP, suggesting that the politicized nature of policymaking in the illegal drugs field is at least in part to blame. That is, harm reduction policy is a prototypical example of a 'morality policy' (Engeli, Green-Pedersen, & Larsen, 2013; Heichel, Knill, & Schmitt, 2013)—i.e. policymaking that typically devolves into debates about deeply rooted values and political commitments, rather than dispassionate consideration of instrumental-rational data (Bowen, 2012; Euchner, Heichel, Nebel, & Raschzok, 2013). Our policy analysis findings are consistent with previous research that has demonstrated how policies created in highly politicized domains are often rhetorical and vague, leaving government officials and other policy actors with discretion to sort out crucial details regarding implementation (Epstein & O'Halloran, 1994). This discretion may serve to either strengthen or weaken the impact of formal policies, depending on the dynamics of a

given policy community (Wu, Ramesh, Howlett, & Fritzen, 2017), and suggests that describing the quality of formal policy documents alone is insufficient for predicting their impact on programs and services within their scope.

On this reasoning, understanding the causes and consequences of Canada's weak provincial and territorial harm reduction policy frameworks requires moving beyond analysis of formal policies, to assessing the perspectives of policy actors advocating for such programs and services in the provinces and territories. Although some previous research has described federal harm reduction policy and policymaking (Erickson, 1998; Hathway & Tousaw, 2008; Hyshka, Bubela, & Wild, 2013; Watson, 2014), research to date has not examined policy actors' views on formal harm reduction policy within and across the provinces and territories.

The second phase of CHARPP addressed this gap by collecting qualitative interview data from a purposive sample of 75 provincial/territorial policy actors from across Canada. Our overall goal was to generate a more in-depth description of actors' perspectives on harm reduction and related policy and policymaking in the provinces and territories. Specifically, we addressed the following research question: *How do provincial/territorial policy actors view formal harm reduction policies operating within their own jurisdictions, and what are the perceived impacts of these policies on efforts to expand harm reduction programs and services therein?* Results were intended to provide insights into sources and consequences of harm reduction policies in the Canadian provinces and territories, and possibly other federal countries where harm reduction policy and services are largely under the purview of subnational governments.

Methods

Study context

Interviews were conducted between November 2016 and December 2017, during a period of renewed interest in harm reduction stimulated by a dramatic increase in opioid-related overdoses in some provinces and territories, and the election of a new federal Liberal government (Hyshka et al., 2017). Although opioid-related morbidity and mortality had been steadily increasing for close to two decades in Canada (Orpana et al., 2018), the Western provinces began experiencing a sharp escalation in the number of deaths attributable to fentanyl and other clandestinely-produced synthetic opioids in 2014. For 2017, there were 1415 (29.4 per 100,000 population) apparent accidental illegal drug related deaths recorded in British Columbia, and 690 (16.1 per 100,000 population) apparent accidental opioid-related deaths in Alberta. Fentanyl or its analogues were detected in 84% and 81% of these deaths, respectively. Other parts of Canada were also significantly impacted by opioid overdoses, with an estimated 3679 (10.0 per 100,000 population) apparent accidental opioid-related deaths recorded nationally in the same year (Public Health Agency of Canada, 2018).

Design

The data presented below were collected as part of the CHARPP multiple case study, which includes four data sources (formal policy documents, qualitative interviews, media texts, and a national public opinion survey—see Wild et al. (2017) for additional details). The present study was a sub-analysis of a single CHARPP data source—qualitative interviews—focused on policy actor views of formal harm reduction policies, cross-jurisdictionally at the provincial/territorial-level. While systematic jurisdiction-by-jurisdiction comparisons are outside the scope of this paper, we highlight regional differences below, when appropriate.

Participants

Ethical approval for this study was obtained from the University of Alberta Research Ethics Board. We recruited key informants who were knowledgeable about provincial/territorial harm reduction policies, and had participated in policymaking in some capacity (through advocacy, stakeholder consultation, policy formulation and implementation, etc.). Potential participants were identified through recommendations solicited from CHARPP's National Reference Committee: a group of policymakers, service providers, and researchers recruited from across Canada to provide ongoing feedback on CHARPP. Using purposive sampling, we sent an email invitation to potential participants in each jurisdiction outlining the study objectives, eligibility criteria, and informed consent process. Additional participants were recruited via snowball sampling once interviews were underway. To balance representativeness with feasibility, we set recruitment targets—between a minimum of two and a maximum of 10 participants per jurisdiction. Within each province/territory, we recruited a mix of policy actors to achieve a balance between those occupying roles in government or health authorities, and those working in community-based organizations, when possible. We also attempted to recruit at least one policy actor who identified as a person who uses drugs or someone with lived experience in each jurisdiction (though this was not feasible in all provinces/territories). In total, we contacted 119 potential participants, 75 (63%) of whom agreed to participate, while 10 (8%) declined, and 34 (29%) did not respond to an initial or follow-up email.

Data collection

JA, EH, and LBI conducted the interviews in English or French by telephone, Skype, or in-person, when feasible. A semi-structured interview guide elicited policy actors' perspectives on provincial/territorial efforts to address illegal drug use, how formal provincial/territorial harm reduction policies developed, the influence of formal policies on harm reduction programs and services, and other factors that may facilitate or constrain the availability of harm reduction in the provinces and territories. Prior to conducting interviews in a given jurisdiction, the interviewers reviewed the corresponding provincial/territorial descriptive case report [prepared during the policy analysis phase of CHARPP] to ensure they were familiar with its formal harm reduction policies. All provinces and territories, except the Yukon, had current formal policies related to harm reduction (Hyshka et al., 2017). Interviews ranged from 38 to 115 min in length. Policy actors who participated outside their normal employment duties ($n = 14$) were offered a $40 CAN honorarium. Interviewers compiled descriptive and analytic field notes (i.e., summaries of policy actor perspectives, feedback on the interview, and preliminary interpretations to be further explored in subsequent interviews) during and after each interview. Interviews were recorded, transcribed verbatim, and transcripts checked for accuracy. Interviews conducted in French were translated and transcribed by the bilingual interviewer, LBI. Each policy actor was assigned a generic role category (e.g. provincial health official, community-based service provider) to protect participant confidentiality in the context of relatively small policy communities. In total, 73 interviews were conducted with 75 policy actors (two interviews included two participants each).

Analysis

Transcripts and field notes were organized using NVivo 11. JA and AP conducted the analysis with ongoing feedback and input from EH. Using an approach described by Haines-Saah, Moffat, Jenkins, and Johnson (2014), we initially read each transcript in its entirety, from which an initial list of eight broad codes (i.e. formal policy and policymaking, opioid crisis, criminalization, harm reduction barriers and

facilitators, media, stigma, harm reduction definitions) was identified and then applied to the dataset. We generated these initial codes from the topics covered in the interview guide and inductively from themes that recurred across the 73 interviews. The 8 initial codes were sufficiently broad to be exhaustive but were not mutually exclusive. For the present analysis, we focused on text excerpts that were coded as 'formal policy and policymaking.' For those text excerpts, we conducted a latent content analysis (Mayan, 2009), which involved reading those parts of the transcripts in full and making memos, followed by a second reading in which persistent words, ideas, and concepts were coded. A preliminary list of sub-codes was developed and refined. Sub-codes were collapsed, expanded, and reconsidered and then sorted into overarching categories. Coded text was revisited to confirm it fit well within each category. To ensure rigor, the core study team held frequent meetings to review coding and discuss developing findings, used an audit trail and procedural note-taking (i.e. recording methodological decisions as they occurred), co-coded subsamples of transcripts, and attended to negative cases (e.g. minority views) in the data.

Participants

Table 1 summarizes the number of participants recruited from each of the 13 provinces and territories. Participants included senior staff at harm reduction or other health and social service organizations (n = 22), provincial or territorial government officials (n = 22), regional government or health authority officials (n = 14), frontline harm reduction service providers or advocates (n = 11), healthcare professionals (n = 2), law enforcement officials (n = 2), and researchers (n = 2). Nine of these participants (12%) also self-identified as a person with lived experience (in addition to their assigned role category).

Results

Variable awareness of formal harm reduction policies amongst policy actors

Prior to eliciting their views on formal harm reduction policies, we asked participants to identify policies relevant to harm reduction operating in their province or territory. Consistent with earlier CHARPP analyses of formal policy documents (Hyshka et al., 2017; Wild et al., 2017), a number of participants described one or more past, current, or forthcoming provincial/territorial government or health authority-authored policies addressing substance use, addiction and mental health, or STI/BBP strategies:

> "The Oxycontin Task Force report came out in 2005. Okay, that's the document that essentially said to the Newfoundland government, implement harm reduction strategies. So, have you looked at the Oxycontin Task Force? That's a key document for here." – Community-based harm reduction service provider, Newfoundland and Labrador [NFLD1]

In addition, some respondents also identified broader, macro-level provincial or territorial policies that govern structural conditions—housing, welfare, indigenous relations, law enforcement, health system governance, etc.—that shape patterns of risk and harm amongst PWUD. Those formal policies were perceived as being important for harm reduction even though they were not specifically focused on addiction and mental health, substance use, or blood borne pathogen-focused programs and services:

> P: There's the 'Patients First Action Plan' that speaks to, it's not specific to harm reduction, no.
> I: Does it include any mention of harm reduction?
> P: No, not specifically, I don't think. But it's the principles that underlie it. […] Patient centered care. Being able to get care and support that they need where they are. – Provincial government official, Ontario [ON8]

Several other participants, despite being acutely aware of the political dimensions of harm reduction services within their province or territory and the positions of other stakeholders or content of recent public debates, had difficulty identifying and describing formal provincial/territorial-level policies at all, even when prompted:

> One of the things that we are actually trying to figure out too is whether or not there are formal [provincial] policies that are for or against the harm reduction approach– Community-based harm reduction manager, New Brunswick [NB1]

Amongst those who could identify one or more relevant policies, there was often very little consensus regarding which formal policies were most influential in a given jurisdiction. For example, in Quebec, three policy actors could not name any formal policies, provincial-level or otherwise, and responses from the remaining five identified different policies as the most influential, ranging from the Canadian AIDS Society's "*Peerology*" (Canadian AIDS Society, 2015) a national guide developed by and for PWUD, to "*L'approche de reduction des méfaits: sources, situation, pratiques*" (Brisson, 1997), a 1997 report advising the Quebec Minister of Health and Social Services on how to address substance use.

Differential impacts of formal harm reduction policies across the provinces and territories

Participants held diverse perspectives on the impact of formal provincial/territorial harm reduction policies on efforts to advance harm reduction within their own jurisdictions. Some described a direct relationship between formal policy documents and availability of harm reduction programs, where provincial or territorial policies clearly constrained or enabled service provision:

> [The Ministry of Health] impacts us in the way that we would interact with clients. […] We still can't distribute safe inhalation supplies with government dollars because that is not in the policy, right, that's not something they've addressed yet. So they impact us because we have to operate within the scope of their policy. – Community-based harm reduction manager, Alberta [AB5]

Other participants described the relationship between formal policy and harm reduction services as less direct. They articulated how formal policies could help support or protect existing work, and provide public endorsement of harm reduction, but that such policies were rarely a factor in determining the availability of programs or services on their own. As one provincial health official in Manitoba explained,

> I think [formal policy has] allowed people who are champions within the various regional health authorities to use those documents as support and even direction to move forward with harm

Table 1
Harm reduction policy actors (n = 75) recruited by jurisdiction (n = 13).

Province/Territory	# of participants
British Columbia	10
Alberta	10
Saskatchewan	7
Manitoba	8
Ontario	9
Quebec	8
Nova Scotia	6
Prince Edward Island	2
New Brunswick	4
Newfoundland	3
Northwest Territories	2
Yukon	3
Nunavut	3
Total	**75**

reduction in their communities or in their regions […] I think it just lends further support for them to be able to do their work. [MB7]

Other participants cited instances where provincial or territorial policies were insufficient for improving access to services on the ground. They cited examples where even strong harm reduction policies were not implemented consistently due to a lack of accountability measures, inadequate funding, divergent stakeholder priorities, or local political opposition. For example, Ontario has legislated ("law on the books") standards requiring public health units to deliver syringe distribution programming as a criterion for receiving provincial public health funding, but as one participant described, these services are not consistently implemented because "there's a lot of flexibility given to boards of health and medical officers of health to adjust programs to address local circumstances" (Regional public health official, Ontario [ON7]). A similar phenomenon was discussed in British Columbia:

There's five regional health authorities in British Columbia and they all have their own infrastructure and decision-making so the Ministry can make policies and strongly suggest that the health authority adopts them, but there's nothing to make them do it – Provincial public health professional [BC4]

In contrast, other participants felt that in their jurisdiction the relationship between formal policy documents and the availability or expansion of harm reduction was reversed. These participants described how formal policies often lagged behind harm reduction practice, and when policies were developed or amended it was only after the services and programs they addressed had already been made available in the community:

I don't really feel like the Province is giving us a policy and the things we're doing are fitting into that. I feel like it's the other way here, where what's happening in the community will hopefully, eventually, inform our provincial government and the policies they create. - Community-based harm reduction advocate, Saskatchewan [SK4]

Formal provincial/territorial policies not necessarily required to support or expand harm reduction

In discussing the impacts of formal provincial/territorial policies on harm reduction, many participants could point to instances where services were advanced by *ad hoc* provincial and territorial government funding decisions, rather than through coordinated efforts to capture and communicate mutually agreed upon principles and priorities into formal policy documents. They described such *ad hoc* efforts as typically crisis-driven, and often implemented in response to observed or expected increases in morbidity or mortality from imminent health threats. For example, several policy actors recounted how historically many provincial/territorial harm reduction efforts developed in response to the HIV epidemic. Similarly, many outlined how Canada's escalating opioid crisis has been motivating some provinces and territories to take new action on harm reduction. Examples of new or augmented initiatives included take-home naloxone programs in several jurisdictions, emergency provision of overdose prevention sites (federally-unsanctioned supervised consumption services) in British Columbia, and increased funding for harm reduction programs. In some instances, new programs were implemented in the absence of formal policies to guide implementation. This was especially evident in Western Canada where opioid-related mortality was most acute. As one participant described the implementation of a provincial naloxone distribution program:

I wasn't aware of any specific policies around it, within [the provincial health authority] or the Ministry…So it wasn't sort of a deliberate policy-based approach, it was a kind of reactive needs-based approach. - Provincial health official, Alberta [AB6]

Policy actors from other jurisdictions where overdose death rates had not increased on the same scale also reported that the opioid epidemic was stimulating renewed interest and investment in harm reduction. They were thankful that governments were implementing programs quickly and proactively in anticipation of potential escalations in morbidity and mortality:

I figured fentanyl overdoses would have to start happening here before we got the naloxone kits out, but it didn't happen that way. We got ahead of it and I was really impressed with how fast that happened…I think fear is what drove that. - Community-based service provider, Newfoundland and Labrador [NFLD2]

A number of participants also described using other strategies beyond formal harm reduction policy development to preserve existing programs or implement new initiatives during periods of waning political support. Such strategies included refraining from using the term "harm reduction" publicly, employing synonyms like "risk mitigation" instead, and creatively interpreting vague formal policies to argue for support. For example, after the federal Conservative government was elected and removed harm reduction from official policy,

[one organization] changed its name specifically because it had harm reduction in it […] And then they changed everything that said 'harm reduction' to 'best practices'. […] And they had allies in the provincial government, even in the federal government, who […] helped navigate all of that. - Community-based service provider, Manitoba [MB1]

Participants discussed several instances where they were able to secure provincial/territorial investments even in the face of political or public opposition. However, in these cases, funding was typically offered quietly, in the absence of public pronouncements or formal policy commitments. This gave rise to situations where programs were treated like a "dirty secret" (Regional health official, Manitoba [MB4]); they were funded but "not necessarily labeled as harm reduction or as PWUD lives mattering" (Provincial government official, Ontario [ON3]).

Policy actor ambivalence towards efforts to strengthen formal harm reduction policies

In eliciting their views on the impacts of formal policy, we also observed ambivalence amongst policy actors regarding the utility of further efforts to strengthen policy. Some participants reported a desire to see new or improved provincial or territorial strategies that reflected a strong commitment to harm reduction and its principles. These policy actors felt additional policy development could lead to an expansion of services through dedicated funding streams, mandated action, and policy frameworks capable of coordinating cross-sectoral activities to reduce harm from substance use at a population level:

I want to see a defined harm reduction strategy for the province. One that is dealing with the whole scope around substance use […] But it's not just about injection drug use, it is about upcoming cannabis law changes, it's about party drugs, it's about alcohol and managed alcohol programming, it's about vaping. - Community-based harm reduction manager, Alberta [AB3]

In contrast, other participants expressed indifference towards the development of formal policy. They felt that provincial/territorial harm reduction policies mainly constrained service providers' ability to meet the needs of PWUD, or bureaucratized bottom-up harm reduction initiatives:

I find it's very refreshing not to get bogged down in our documents. And it's more what are we doing on the ground based on the relationships that we have with people in our communities. – Territorial government official, Yukon [YK1]

Still others expressed principled opposition to formal policy development. To these participants, formal policies were out-of-touch, inflexible, and not reflective of the realities of PWUD or frontline service providers. These policy actors were skeptical of the potential for government or health authority harm reduction policies to ever be relevant, and felt that a dearth of provincial/territorial policy was advantageous:

> …it's given us a lot of liberty to kind of decide how we best interpret our mandates. So you know there is certainly an advantage to being in a bit of a policy vacuum to be able to just initiate your own things without having a bureaucratic structure that imposes some accountabilities that we don't think are meaningful. - Community-based harm reduction manager, Ontario [ON5]

Other policy actors echoed similar skepticism towards formal policy development and suggested that efforts to expand harm reduction would be better focused on reducing stigma towards PWUD and shifting social values and attitudes, rather than on development of additional policies: "and a policy, like a directive policy when you're dealing with something that people still struggle with, it doesn't resonate with them. I've come to, I think, the conclusion that policy's not the way to go." – Regional health official, British Columbia [BC10].

Discussion

Our previous CHARPP research (Hyshka et al., 2017; Wild et al., 2017) assessed the strength of instrumental and symbolic functions of provincial/territorial harm reduction policy frameworks, and demonstrated the overall weak state of such policies in Canada. In this study, we documented how policy actors navigated these policy environments in order to better understand the impact of largely vague and rhetorical provincial/territorial policy documents on efforts to expand harm reduction programs and services in these jurisdictions.

We observed considerable heterogeneity amongst provincial/territorial harm reduction policy actors regarding their awareness of formal policies, agreement on which are influential, and their perceptions regarding the impact of official policies on harm reduction. Participants in our study described a complex relationship between formal policy and harm reduction programs and services. They characterized the impact of formal policy on harm reduction as variously: *direct*—formal policy enabled or constrained the provision of new services; *indirect*—formal policy only strengthened existing efforts to implement services; *discontinuous*—formal policies did not result in new services; or *reversed*—formal policies were enacted to address programs or services that had already been initiated in the community. These accounts highlight diverse perspectives on relationships between formal policies and program and service delivery that can arise in morality policy environments, like Canada's, that prioritize rhetorical functions of formal documents and allow for wide variation in quantity and quality of governance. As such, our results are consistent with past policy scholarship suggesting that policies in highly politicized domains often leave significant discretion in the hands of policy actors to either strengthen or weaken implementation of policy objectives (Wu et al., 2017).

The policy actors we interviewed were all proponents of expanding harm reduction as an approach to illegal drug use in their respective jurisdictions. Given this support, we were surprised to observe considerable ambivalence towards further efforts to strengthen formal provincial/territorial policies amongst participants in our sample. Although some expressed a desire to improve policies or secure official endorsement of community-driven initiatives, others were more skeptical of the potential impact of such efforts. This included some actors who opposed further formal policy development or suggested that a policy vacuum was actually preferable because it allowed them to be more creative or responsive in their own program and service delivery. Policy actor ambivalence may reflect the fact that even in jurisdictions that produce (i.e. more or higher quality) policy statements with concrete governance mechanisms, these policies were not always sufficient for advancing services. This was evident in comments of participants from British Columbia and elsewhere, which expressed frustration that health authorities and other providers did not always follow through and implement otherwise robust (even legislated) provincial/territorial-level harm reduction policies. These instances may be attributable to the controversial nature of harm reduction, and a resultant reluctance of governments or health authorities to force formal policy implementation on unwilling service providers, even when they otherwise have the authority to do so. Alternatively, other researchers have also documented general hesitation of provincial/territorial governments to direct health authorities and their service providers to implement overarching formal policies (Tomm-Bonde et al., 2013); this may thus be a routine feature of health system governance in these jurisdictions. Further research is needed to better understand this phenomenon, and outline what constitutes effective formal policy in the harm reduction field both within the Canadian provinces and territories, and in other jurisdictions where harm reduction services fall under similar health system governance structures.

Policy actors' ambivalence towards efforts to improve formal policy may also be attributable to the fact that many reported instances where securing provincial/territorial funding for harm reduction initiatives occurred in the absence of formal policy commitments. Such investments were largely made during periods of either crisis or acute need, or political antipathy towards harm reduction. Some policy actors may therefore be reluctant to invest finite time and energy in the development of improved formal provincial/territorial policy, when such policies are not necessarily required to obtain funding to provide harm reduction services. Instead they may prefer to focus on other more pressing concerns including responding to a worsening overdose epidemic that is straining the capacity of many working in the sector, advancing other potentially more expedient strategies to secure resources or new services, and/or advocating for broader drug policy reform (e.g., decriminalization) at the federal level. Reforming federal drug policy has long been seen as an important policy objective amongst more "rights-oriented" members of Canada's harm reduction policy community (Hathaway, 2001; Hathway & Tousaw, 2008; Smith, 2016), and decriminalization of drug possession has been a key advocacy objective for many harm reduction proponents in recent years (Weeks, 2018). Advocates seeking to improve formal provincial/territorial policy should therefore not assume all harm reduction policy actors are willing to commit their efforts to this objective.

Policy actor reports of service expansion occurring in the absence of formal policy development and implementation are indicative of some potentially positive aspects of governance in provincial/territorial harm reduction policy arenas. Participants from several jurisdictions in our study applauded the responsiveness of their governments in implementing new harm reduction services, such as take home naloxone programs, to address the overdose epidemic. This included some settings where significant increases in opioid-related mortality had not yet been observed. This reaction is consistent with past research on the policy process, which has emphasized the ability of both internal and external 'focusing events' to disrupt institutional inertia and prompt new policy directions (Nohrstedt & Weible, 2010). Such responsiveness has been identified as a feature of good policy coordination in the drugs field, because it is indicative of the ability of policy actors to identify and address emergent issues urgently (Hughes, Ritter, & Mabbitt, 2013). Participants also described instances where bureaucratic structures acted to provide protection for harm reduction services, even in the absence of formal policy support for the approach. This ability may be especially important in morally-contested policy arenas like harm reduction and psychoactive substance use (Hughes, 2009). However, it is pertinent to consider the potential implications of funding harm reduction in the absence of express rhetorical support for the approach. Illegal drug use is highly stigmatized in Canada, and by treating harm reduction services as a "dirty secret," governments may preserve them

in the short term, but do little to educate the general public on the social and economic value of these services in the long run, potentially engendering further antipathy towards the approach.

Overall, our results suggest that actors recognize a range of pragmatic strategies to advance services in response to policy vacuums created in morality policy environments, and challenge assumptions that formal harm reduction policies are required to advance these services. Our findings indicate that in highly politicized policy domains, other factors beyond formal policy contribute to the advancement of programs and services, and point to a need for additional implementation research to parse what features of formal policies increase the likelihood of a direct impact on services, and systematically analyze other factors that predict the inhibition or expansion of services. Our findings are instructive for future efforts to conduct comparative harm reduction policy analysis. In particular, perceptions of a highly contingent relationship between formal harm reduction policies and availability of programs and services suggests a need for future research in this area to carefully measure not just the content and features of formal policy, but also the implementation context and indicators associated with each formal policy, prior to drawing generalizations regarding the effect or relative impact of various formal harm reduction policies on the availability of services across jurisdictions.

Strengths and limitations

Very little research has described provincial/territorial-level harm reduction policies. This study provides the first empirical data examining policy actors' views on formal harm reduction policies and the perceived impact on programs and services across Canada's 13 provinces and territories. However, some provincial/territorial sub-samples were too small to facilitate robust and systematic jurisdiction-by-jurisdiction comparisons of policy actor views. Future CHARPP analyses are planned to triangulate interview data with other data sources and facilitate more specific case findings pertaining to provincial/territorial harm reduction policy and policymaking. Although we did recruit current and former senior decision-makers in our sample, we did not include any elected officials. Because our sample focused on engaging people knowledgeable about harm reduction policy and efforts to advance it, we did not interview any self-identified opponents of these services. Further research in Canada should devise strategies to identify and recruit those who hold dissenting viewpoints, and people in positions of democratically-elected political authority, to generate additional insight on the impact of formal harm reduction policies and other factors that may influence program and service provision. CHARPP included an analysis of Canadian media reporting on harm reduction, and these data will capture public statements of some of these stakeholders, in the absence of qualitative interview data (Wild et al., 2018). Scholarship that attends specifically to the perspectives of women, Indigenous people, people of color, youth and members of the LGTBQI community—key harm reduction target populations—is also needed. Finally, it should be noted that data collection for this paper was conducted during a 13-month period ending in December 2017. Views on policy developments occurring after this time were not captured. Additionally, because sampling proceeded jurisdiction-by-jurisdiction, policy actor views on events occurring within this window but after recruitment for a given jurisdiction ended, may have been missed.

Despite these limitations, the present study provided the first national overview of policy actors' views on provincial/territorial harm reduction policy in Canada. Our approach may also be relevant for other jurisdictions with similar decentralized governance structures over healthcare and harm reduction policies and programs. Burris (2017) has argued that comparative drug policy analysis "should confine its primary gaze to formalized policies" based on the (reasonable) expectation that "practice will now take place more widely, more thoroughly, more consistently, more effectively" when codified in formal policy (Burris, 2017, p. 129). However, our findings suggest that, at least in Canada, participants in policymaking do not always share this optimism, and highlight a variety of ways in which they navigate variable policy contexts to advance harm reduction outside of formal policy development and implementation.

Declarations of interest

None.

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