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The Discursive Construction of Substance Use and Harm Reduction in Canadian Health Policy

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Abstract

Harm reduction as a philosophy has been widely recognized by healthcare professionals in Canada, yet the topic remains controversial in both political and public discourses. Understanding these discourses will allow health care providers to better respond to political and public concerns, as well as ensuring that services are aligned well with public health needs. This study explored the discursive use of the term “harm reduction” in Canadian health care and nursing policy documents’ contexts by using a Foucauldian framework and Bacchi’s ‘what’s the problem represented to be?’ approach. I propose three discursive themes: self-responsible citizen, evidenced-based practice, and what nurses must do. The findings indicate possibilities for designing favorable and humanistic policies and strategies for people who use substances. This study reveals the problem of how language is an enactment of power over people who use substances and recommends more humanistic policies and empowering language.

Keywords

substance use, harm reduction, Foucault, discourse analysis, governmentality, biopower, nursing, drug policy, Canada

Summary for Lay Audience

This study focuses on the language used in the healthcare system to characterize people who use substances. The presupposition is that language is not unbiased or impartial but rather is social and cultural. As such, oral and written language conveys the marks of human interactions, influential perspectives, and conversations in specific contexts. Using language with entirely overt or covert meanings creates discourses. Discourse analysis allows researchers to find out how language produces, shapes, and reorganizes social practices. With this knowledge, healthcare providers are better able to provide care and reduce unintentional harm to those people they interact who use substances.

Harm reduction as a philosophy has been widely recognized by healthcare professionals in Canada. Various harm reduction facilities are provided throughout the healthcare system, but the topic is still contentious in both political and public discourses. For example, newspaper editorials, as well as Canadian politicians, have continued to assert that harm reduction interventions are not helpful and detract from rehabilitation. Currently, the news of how the opioid crisis has been aggravated by Covid-19 now comes from every corner of Canada. As a solution, Canada needs to integrate broader harm reduction services that include legitimized and safe drug supplies within drug policies.

Nurses are on the forefront of these efforts to integrate harm reduction principles because they function as a bridge between the government and the public. Understanding the discourses related to harm reduction will allow healthcare providers to better respond to political and public concerns. This study explores how the Canadian healthcare and nursing policy document' contexts approach harm reduction and what is hidden or left unsaid. Findings from this study indicate several discourses in policies, such as people who use substances being represented as self-responsible citizens, the emphasis on evidence in practice and policy actions, and the duties of nurses. The findings indicate possibilities for designing supportive, favorable, and humanistic policies and strategies for people who use substances. The discursive practices in these policies construct 'addicts' or 'drug users' and currently contribute to the stigmatization of people who use substances. This study therefore recommends more humanistic policies and empowering language.

Co-Authorship Statement

Associate Professor Dr. Abe Oudshoorn (academic advisor) and Professor Dr. Cheryl Forchuk (committee member) are co-authors of this study based on meeting the four criteria outlined by the International Committee of Medical Journal Editors:

- Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
- Drafting the work or revising it critically for important intellectual content; AND
- Final approval of the version to be published; AND
- Agreement to be accountable for all aspects of the work in ensuring the questions related to the accuracy and integrity of any part of the work are appropriately investigated and resolved.

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Chapter 1

1 Background and Significance

Harm reduction, as a philosophy, has been broadly adopted by healthcare providers in Canada (Canadian Nurses Association [CNA], 2011; Government of Canada, 2018). Several harm reduction services are funded in various areas of the healthcare system such as methadone maintenance treatment, needle exchange programs, condom distribution, and managed alcohol programs (Government of Canada, 2018). Harm reduction approaches are congruent with the registration competencies of nurses in respect to "critical inquiry and evidence-based knowledge to protect" and in "supporting the freedom, dignity, respect, and privacy of individuals" (College and Association of Registered Nurses of Alberta [CARNA], 2018; CNA, 2011). From an ethical perspective, nurse-patient relationships are built on mutual trust and provision of nursing care is to be independent of prejudice and discrimination and based on individual needs of patients (Pressley Byrd & Bartlett, 2019). Such ethical responsibilities also necessitate respecting "patients' decisions" regardless of personal opinions (Pressley Byrd & Bartlett, 2019, p. 1). Risky decisions of patients require nurses to disclose the possibility of self-harm and recommend resources for best outcomes, including risk elimination (Pressley Byrd & Bartlett, 2019; CARNA, 2018). In the context of harm reduction, this can mean mitigating risk without necessarily requiring a shift in the underlying behaviour, which means focusing on harms rather than the drug use itself.

Evidence-based efforts toward harm reduction continue to be contentious in both political and public discourses (Ziegler et al., 2019). In this regard, supervised consumption sites serve as an example of a harm reduction program that has received mixed support within the political realm, approached differently by successive federal governments and by different provincial governments (Ziegler et al., 2019). Newspaper editorials, as well as certain political figures, have continued to assert that harm reduction facilities run counter to "abstinence-based and other drug treatment" strategies (Boyd et al., 2016, p. 127). Indeed, media sources spread the idea that financing for harm reduction initiatives is counterproductive to drug rehabilitation programmes (Boyd et al., 2016). Such

discourses produced by media might aggravate tensions between community residents and people who use substances (PWUSs) or people who use drugs (PWUDs) and thereby create segregationist public policies (Boyd et al., 2016). Major political figures in Canada, such as former Federal Health Minister Tony Clement, who described evidence of safe injection sites as false and expressed that safe injection sites are neither ethical nor helpful for recovery (Collier, 2009) and former Health Minister Rona Ambrose, who misled the public regarding an opioid therapy and expressed that "Our goal must be to take heroin out of the hands of addicts, not put it in their arms", have also created oppositional discourses (Eggertson, 2013; Boyd et al., 2016). This hostility is fuelled by a poor understanding of the value of harm reduction programs and by stigma against PWUDs (Boyd et al., 2016). Influenced by such discourses, announcements of new harm reduction services within the healthcare sector are frequently met with public skepticism, including both petitions and protests (Ziegler et al., 2019). Moreover, the support of municipalities or healthcare authorities is not assured even though the provincial health policy frameworks reinforce these programs (Boyd et al., 2016, p. 128). Therefore, positions taken by healthcare providers are not necessarily reflective of the prevailing political or public perspectives given the constant debate between policymakers, healthcare professionals, and the public regarding supervised consumption sites in Canada (Ziegler et al., 2019).

In this study, I discuss position statements, action plans and policies related to harm reduction through a Foucauldian lens. There are critical issues that make this study timely. The news of how the opioid epidemic has been exacerbated by Covid-19 now comes from every corner of Canada, from Vancouver to Kingston (Park, 2021; Hristova, 2021; Crosier, 2021). Issues such as the increase in toxic supplies in the market, such as fentanyl and carfentanyl, using of drugs alone rather than in groups, or lack of access to housing and healthcare services as a result of the Covid-19 pandemic have led to an overdose crisis in Canada (Park, 2021; Hristova, 2021; Crosier, 2021). It appears that Covid-19 just aggravated "the mass poisoning epidemic" (Tyndall, 2020, p. 1) already happening since 2015, when fentanyl was first introduced into the drug market in North America and prescription drugs became harder to access. This situation reignited discussions about decriminalization and safe supply. Unless a safe supply is provided, as

an antidote, everyone who consumes drugs sold on the street is a potential victim of an overdose (Tyndall, 2020). In addition, Canada currently leans on criminal justice to combat illegal drug consumption and drug markets while also spends vast sum of money to prevent distribution and sell (Boyd et al., 2016). Canada needs to integrate broader harm reduction services that includes decriminalization and safe supply to drug-related policies (Boyd et al., 2016).

Given the principles of harm reduction and their alignment with ethical codes of nursing (CARNA, 2018), understanding the complexities of the discourses related to harm reduction in Canada is also significant and timely. Understanding these discourses will allow health providers to better respond to political and public concerns, as well as ensure that services are integrated well with public health programming. Because, unlike the "traditional writings depict nursing as a powerless profession and an apolitical practice" (Perron et al., 2004, p. 543), nurses function as political actors situated between government authorities and people such as PWUSs (Perron et al., 2004).

Therefore, a critical awareness of the language in Canadian healthcare and drug policy documents, including nursing policy documents and public health guidance documents, is needed in order to gain understanding of how this, at times, controversial approach is integrated into policy in healthcare. Reisigl and Wodak (2009) emphasize that "language is not neutral, transparent and essentialist, but it is historical, cultural and links with social relation" (p. 88). As such, language in texts is not value-free and creates discourses that are affected by human interactions, dominant perspectives, and communication in particular contexts (Pitsoe & Letseka, 2013). Discourse analysis explores language and reveals recurrent patterns in "how text and talk are organised and how social practices occur, constructed and reproduced." (Arribas-Ayllon & Walkerdine, 2010, p. 11).

1.1 Study Purpose

Following a critical discourse analysis methodology, this study explores and describes the discursive use of the term 'harm reduction' as it relates to substance use in a Canadian health and nursing policy context. With a disciplinary focus on the role of nurses in providing health services related to drug use, prioritized sources will include Canadian

healthcare and drug policy documents, nursing policy documents (e.g. competencies, position statements, ethics statements), and public health guidance documents. While the short-term goals are to identify presuppositions that underpin 'the substance use problem' and its reflections on these documents as well as effects on PWUSs, the ultimate goal is to find out opportunities to design humanistic and supportive policies and programs for PWUSs. Given the nurses are significant social actors of power relations between government authorities and citizens (Perron et al., 2004), understanding these discourses ultimately helps in designing policies to support health providers and to better respond to political and public concerns.

1.2 Research Question

Drawing on the discourse theory of Foucault (Foucault, 2000), the research question guiding this study is: how do Canadian health system and nursing policy documents construct the idea of 'harm reduction' as it relates to substance use?

1.3 Declaration of Self

I am a nurse, an international graduate student, a Caucasian, heterosexual, female, and a middle-class person. I am from Turkey and spent twenty-eight years of my life there, half of it in a rural area and half of it in metropolitan cities. While I was aware of many rehabilitation centers for PWUSs in Turkey, I was initially unfamiliar with Canadian approaches, such as safe injection sites, until studying here. Because substance responses in Turkey rarely integrate theory into practice, and focuses on mostly abstinence-only treatments, many harms related to substance use persist and barriers to enhanced well-being in the context of addiction prevent adequate management. In the future, I would like to play a role in introducing a harm reduction philosophy into health services in my country. Initially I was going to observe safe injection sites closely by interviewing stakeholders. Due to COVID-19 pandemic restrictions, I had to change the methodology and focus of the study. In this sense, I decided to start by analyzing language related to harm reduction in policy documents to generate new insights into discourses that can contribute to applying harm reduction strategies. In my opinion, every individual is an

invaluable member of the community who deserves dignity and life, and harm reduction offers a means to better actualize this in nursing practice.

Additionally, I am an outsider to discourses on these documents that I will analyze. I am a person who speaks English as a second language and Canadian nursing policy is unfamiliar to me to date. I have no primary or secondary familial experiences related to substance use and harm reduction. In this sense, I rely on my thesis committee to support me in perceiving insider cues that may not be evident to me.

1.4 Theoretical Framework

This study makes use of a discourse analysis methodology, particularly a Foucauldian approach, and aims to examine the ways in which social issues are constructed through discourses (Foucault, 1982; Freshwater et al., 2010). Within Foucauldian discourse analysis (FDA), discourses function as a web of "situated meanings" (p. 122) created through "language" (p. 121) and "social actions" (p. 121), which then frame perceived realities (Gee & Green, 1998). Moreover, discourses are "sets of statements that construct objects and an array of subject positions [and] these constructions in turn make available certain ways-of-seeing the world and certain ways-of-being in the world" (Willig, 2001, p. 380). From a Foucauldian standpoint, these subject positions generate, perpetuate, and validate those power relations (Willig, 2001).

Looking deeper into the Foucauldian power, Prado (2000) starts with how power (or biopower) cannot be identified, such as "force", "capacity", "domination", or "authority" (p. 68). Rather, Prado (2000) calls attention to the "complex set of relations" that are not intimidating or forceful. Foucault (1982) identifies power as "a set of actions upon other actions" (p. 789) and "is a way in which certain actions modify others" (p. 788). Power is exerted on actions, which means power restricts "actions rather than individuals" (Prado, 2000, p. 71). Consequently, a number of concepts, such as "power (also called bio-power in order to emphasize the important role of biology), resistance, the body, social science, social agents, and the medicalization and clinicalization of social control" are fundamental components of this research and should be taken into account in the process associated with Foucauldian discourse analysis (Powers, 2007, p. 27). Therefore, this

analysis will be particularly attuned to the power internalized within Canadian healthcare policies related to harm reduction and substance use. Discourse analysis invites us to ask critical questions regarding how we speak to, speak about, or speak around the contested issues of substance use.

1.5 Structure of Thesis

This thesis follows an integrated article format. Therefore, Chapter 2 represents a publishable manuscript incorporating all aspects of a research study. Chapter 1 lays out the basic necessity of the study and introduces the approach. Chapter 3 provides recommendations and implications in detail. It is noted that in an integrated article format that is overlap between Chapter 2 content and the content both in Chapter 1 and in Chapter 3.

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Chapter 2

2 Introduction

Harm reduction is both an approach and a series of healthcare interventions. These interventions prioritize "reducing harm from problematic substance use through the provision of specific policies and services" (Poole et al., 2010, p. 2). As a philosophy, harm reduction involves a humanistic approach to drug use by focusing on preventing the negative health and social impacts associated with using drugs, rather than on preventing the use of drugs themselves (Harm Reduction International, 2021). Nurses have been influential in shaping and implementing harm reduction programs around the world, from research to advocacy to implementation (Canadian Nurses Association, 2017). This thesis will explore how harm reduction in the context of substance use is described within Canadian nursing and broader healthcare policy documents.

Harm reduction's advocates, especially those working in political and professional contexts, emphasize its "value neutral" approach to substance use as one of its main benefits and points of appeal to the general public (BC Ministry of Health, 2005, p. 4). By taking a value-neutral, "disease prevention" approach (Keane, 2003, p. 231) to substance use, harm reduction has been significant within public health policy in Canada (Boyd et al., 2016) and elsewhere. Through their positions of authority, medical professionals, researchers, and public health advocates have contributed towards a discursive and political shift whereby drug use is considered a biomedical, rather than a criminal, issue (Roe, 2005; Smith, 2012). This shift is meaningful as the concept 'harm reduction' is not value-neutral and is contested in every way that it is used. Rapley and Jenkins (2010) offer an approach to understanding the way that concepts are contested in their utilization, such as in written documents. Through an examination of language and interpretation of connotations, documents can be truly understood by scholars instead of seeing them as objective, "neutral" (p. 382), and unbiased information (Rapley & Jenkins, 2010). This type of study is called "discourse analysis" and interrogates the construction of distinct realities produced by documents (Rapley & Jenkings, 2010, p. 382). Rapley and Jenkings (2010) also maintain that "Within this approach, language

(written or spoken) is never treated as a neutral, transparent, means of communication, instead, language is understood as performative and functional" (p. 382).

2.1 Literature Review

The purpose of this literature review is to provide a brief overview of discourse analyses on substance use and harm reduction within the existing literature. Google Scholar, PubMed, and Scopus were used to identify articles from 2000 to 2020 that were not limited by geography. The following search terms were used: nurs*, substance use, harm reduction, harm reduction support, discourse analysis, Foucauldian discourse, and critical discourse. Findings from the literature review focus on the following topics: discourses related to substance use, discourses related to harm reduction in particular, how nurses and nursing as a discipline view substance use, and how nurses and the profession of nursing approach harm reduction. This approach moves from literature that is more peripheral to my thesis to literature that is most closely related to my own research question. An ancestry review of articles was also used to identify any relevant studies not found through the search but that occurred in the reference lists of found studies.

2.1.1 Conceptualizing Substance Use

Tupper (2012) argues that, based on the particular context, the term 'drug' has multiple connotations in English language and proposes a table of the "three dominant social constructions of psychoactive substances in modern public and political discourses" (p. 468) in order to situate the term 'drug'. These are:

> "Non-drugs: Use is condoned by the state, promoted by corporations, and permitted a matter of personal choice, such as alcohol, tobacco, and caffeine.
>
> Medicines: Use is promoted by the state and private corporations, but only within a prescribed medical regimen requiring a physician's prescription.
>
> Drugs: Use is generally prohibited, and decision to use criminalized or pathologized as abuse or addiction" (Tupper, 2012, p. 469).

These classifications are based upon the legal status of ‘drugs’ given the distinction between psychoactive substances that are “legal, regulated, and illegal” respectively. The third definition for “drugs” is considered the historically dominant discourse and situates the use of substances as pathological (Bright et al., 2014).

While health researchers note how substances continue to be constructed as toxic, immoral, addictive, and destructive (Room, 2006; Moore, 2008), this discourse is shifting, although inequitably. For example, an examination of Canadian newspaper statements by Haines-Saah et al. (2014) indicated different articulations based on the societal status of ‘users’ such as a surge in normalization of marijuana if used by upper class people or celebrities and demonization among those of the poorer classes (Haines-Saah et al., 2014).

Researchers in Canada and Australia have sought to contribute to shifting perspectives around substances through theoretical constructions. For example, Kiepek et al. (2019) proposed a broader understanding of substance use by applying different theoretical standpoints, such as the concept of pleasure within medical marijuana use, bringing forward ideas that explore positive aspects of substance use, adapting and using various critical analytical methodologies that include non-problematic depictions of substance use. Lancaster et al. (2017, p. 123) elaborated on the concept of “pleasure” within the justification of ‘medicinal marijuana’ use, which broadened the definition of pleasure to include “freedom from pain, enjoyment of life, promotion of wellbeing, the alleviation of suffering, and the dignity borne from compassion”. This perspective both humanizes substance use as well as recognizes the diverse medicinal values of such substances.

Academics have also explored stigmatizing language about substance related practices. According to Tupper (2008), the word ‘abuse’ and its connotations deserve critical examination, explaining “Abuse is a noun that functions as a semantic binary antonym to the noun ‘use’, thus, these two terms ‘use’ and ‘abuse’ delineate mutually exclusive categories for the consumption of psychoactive substances” (p. 229). That is, ‘use’ is framed as good, ‘abuse’ is framed as bad, devious, and sick. The word ‘abuse’ has negative connotations beyond the discussion of substances because it pertains to publicly

unwanted, alienated activity, thereby substances are rarely referred to as being ‘used’ in public discourses; rather, they are referred to as being ‘abused’ (Herzog, 2016). This is notable as a general use of the term ‘substance abuse’ to delineate any substance use constructs all use as problematic. Conversely, shifting from speaking of ‘abuse’ to speaking of ‘use’ removes some of the judgements related to substances (Herzog, 2016).

‘Users’ within substance-related discourses are also conceptualized differently in social and scientific discourses and these constructions are reflected in drug policies. It is noteworthy that the terms PWUSs and PWUDs are used often in the literature and data, though in this thesis PWUSs is the preferred term. In their qualitative study in Barcelona, Spain, Albertín et al. (2011) analyzed the “situated identities” (p. 228) of PWUDs as they envisioned themselves, which are in fact associated with social discourses based on their daily interactions with professional healthcare workers. One of the dominant discourses that constitutes “drug user” in these legal or therapeutic discourses is the consumer as a person who is “cognitively and affectively destructured, weak, marginal, and amoral, compulsive, no self-control, egocentric, passive, and victim of the circumstance of his or her situation” (Albertín et al., 2011, p. 229). Another study by Sibley et al. (2020) in the U.S. examined “the discursive resources” (p.2280) used by PWUDs in social discourses, in other words their “self and other constructions in the addiction” context (p. 2279). The study revealed “three subject positions used reflexively by participants to mark their own affiliation or location within discourses of addiction and recovery”, such as the “victim” who has become a PWUDs as a result of trauma, primary or secondary experiences, the “good Samaritan” who helps others in an overdose case, and lastly a person “motivated for change” who has recovered or is in a treatment course (Sibley et al., 2020, pp. 2281-2284). As is evident through the literature, to be a user of drugs is both stigmatized and contested.

Much of the ways in which substances have been conceptualized and how concepts have been contested plays out through policies within the justice system, in particular the legality of various substances (Herzog, 2016). Those substances deemed illegal are perceived as being more harmful or pathogenic. This is a limited perspective, however, as the harm related to any substance varies significantly related to the context in which it is

consumed, who consumes it, and the quantity and form (Herzog, 2016). As we have seen with shifting laws related to alcohol and cannabis, for example, as substances that have been made illegal, then decriminalized, and some made legal yet again, these conceptualizations are primarily social (Ontario Human Rights Commission [OHRC], 2018; Government of Canada, 2021). For example, cannabis use has been criminalized, medicalized, and normalized all within a single lifespan in Canada (Government of Canada, 2021; Erickson & Fischer, N.D.; Government of Canada, 2020). Research on the criminalization of substance use frequently highlights how social discourses intersect with legal perspectives and the degree of criminalization seen in each locality. These discourses also integrate perceptions on approaches to addressing substance use, including harm reduction.

2.1.2 Discourses Related to Harm Reduction

By embracing the value of personal responsibility, liberalism, a core philosophy within Canadian society, sees those who use substances as self-determining agents (Herzog, 2016). While this accounts for the individualistic blame often placed on PWUSs, it also structures harm reduction as a philosophy wherein personal decisions are valued. Harm reduction perceives 'the users' in a positive manner as it considers consumers to be self-responsible, conscious, and rational decision-makers regarding how they choose to respond to drug-associated harms (Moore, 2008). This understanding challenges traditional discourses of PWUDs as "irrational" and instead provides them the self-determining status bestowed on to other people (Moore, 2008).

Drucker et al. (2008) emphasizes how harm reduction practices, such as promoting safer sex through knowledge about the transmission of HIV, have actually arisen from shifting discourses. By maintaining an individualistic perspective but flipping from blame to choice and responsibility, harm reduction discourses harness the power of language. Campbell and Shaw (2008) similarly highlight the "self-governing" nature of harm reduction discourses. Keane (2003) explores the tensions between morality and harm reduction discourses by touching on good / bad binary while harm reduction takes a pragmatic approach. Pragmatism includes recognizing that "non-medical use of psychoactive or mood-altering substances is a universal phenomenon" and accepting that

"drug use is complex and carries varying degrees of risks [as well as] provides the individual and society with benefits" (Bridgman et al., 2017, p. 5). While Canadian law allows for harm reduction facilities, including recent exemptions for drugs that remain generally illegal, there is still a discursive struggle related to the concepts of deterrence of use versus promotion of use (Wild et al., 2017; Hyshka et al., 2017).

Human rights are also an indispensable aspect of harm reduction philosophy (Elliott et al., 2005). The right to life, liberty, and security of the person in Canada means that health services are provided for everyone. PWUDs are disproportionately members of marginalized groups, including ethnic minorities who experience inequitably high unemployment and low education levels, increasing their vulnerability to drug related harms and criminalization (Ezard, 2001). Therefore, a rights-based approach means providing equitable supports to all people to reduce differential negative health outcomes. Additionally, human rights violations, such as the criminalization of substance users, deters PWUDs from seeking treatment or accessing health services (Erdman, 2012). In Canada, the state is required to provide health services and reduce harms regardless of background, which includes providing medical services, treatments, adequate standards of living, and prevention of diseases (Ezard, 2001; Elliott et al., 2005; Erdman, 2012).

2.1.3 Nurses' Views of Substance Use

People who work in substance use related fields or in healthcare more generally have a role in constructing discourses of harm reduction. According to Foucault (2003) construction of discourses is highly influenced by social power. Institutional actors, such as "police officers, social workers, and nurses", define what is normal and what is pathological, in part in relationship with PWUDs as well as other related social actors, such as drug dealers and family members (Herzog, 2016, p. 107). In discourse analysis, it is recognized that, while social actors such as nurses are influenced by dominant discourses, they also independently either recreate or resist these discourses (Herzog, 2016). Herzog (2016) emphasizes that social constructions can shift in a variety of contexts, and in the case of this study an example being how healthcare settings might take a more positive view to harm reduction than legal actors. While PWUDs can be

framed as offenders in legislative discourses, they can alternatively be seen as patients coping with an illness in the biomedical context (Herzog, 2016).

Hospital settings have been recognized as settings of high social control (Rhodes, 2012; McNeil et al., 2014) wherein discourses, formal and informal policies, and discrimination may create harms. In this regard, how nurses both navigate and assert power is important in constructing healthcare-related discourses of harm reduction. Nurses' thoughts, insights, assumptions, and attitudes affect their approach to providing care to the PWUDs (Brener et al., 2010; van Boekel et al., 2013; Pauly et al., 2015). A qualitative ethnographic study in Canada by Pauly et al. (2015) explored the construction of "culturally safe care" for PWUDs in an urban hospital (N=34) and reveled three types of constructions, including "an individual failing, a criminal activity, and a disease of 'addiction' that impacts accessing health care and pain management" (pp. 125-134). These varying constructions influence the nature of nursing care being provided. Chu and Galang (2013) have noted that negative attitudes of nurses against PWUDs may influence the therapeutic relationship between nurse and patient, leading to poor patient care. In comparison to many other disorders, substance use disorders have been structured as immoral and criminal activity even by nurses: "clients with a substance use disorder are more likely to be perceived by health-care providers as having personal control over their illness and, therefore, are more likely to be held responsible and blamed" (Registered Nurses' Association of Ontario [RNAO], 2015, p. 19). In a qualitative study, a group of twenty Thai nurses constructed substance use not only as immoral and weak but also a risk to the wellness and prosperity of whole nation, depicting PWUDs as a substantial burden to the social system (Chan et al., 2008). This idea of people experiencing an illness as a social burden demonstrates how cultural perspectives can lead to variations in how stigmatized PWUDs are by nurses.

In their cross-sectional survey study of nurses' attitudes towards PWUDs, Ford et al. (2008) found that only 15% of nurses felt fulfilled and satisfied for caring for these patients and only 30% had motivation and desire to care for this patient group (N = 3241, 50% response rate). Additionally, in another cross-sectional survey study by Salameh and Polivka (2020) in the U.S., nurses presented condemnatory attitudes toward mothers of

babies with neonatal abstinence syndrome (N=150). In a different study of nurses in the United Kingdom, Monks et al. (2013) found most of the nurses that they interviewed had negative perceptions of PWUDs (N=29). In Canada, a study by Strike et al. (2020) focusing on "illicit drug use while admitted to hospital and how injected drug users and health care providers describe, respond, and attempt to manage its use" (Pg. 7) noted that, though some health care providers have used a variety of approaches, such as early discharge, strengthened behavioural check, seizing of substances or usage equipment, and cancelling of prescribed medications, others attempted to mitigate the threat of early release and were concerned about keeping these patients in the hospital given the lack of policies with respect to effective support for these patient groups (Strike et al., 2020, p. 8). Stigma is a significant impediment in providing care for PWUDs (Ford, Bammer, & Becker, 2008; Strike et al., 2020; Salameh & Polivka, 2020; Monks, Topping, & Newell, 2013; Chan, 2008; Pauly, 2015) across many studies.

Although there is considerable evidence that indicates health care providers may contribute to structuring negative discourses related to substance use, there are also some studies that have found positive attitudes towards PWUDs or processes to at least improve perceptions. For instance, in their cross-sectional study of physician attitudes and thoughts toward PWUDs in the U.S., Ding et al. (2005) found that increased contact with this population was associated with more positive thoughts towards the population (N=373). A phenomenological study conducted at outside of hospital settings in the U.S. noted that nurses value their role in care related to substance use, but their role is confined while working with other professionals (e.g. social workers) (Abram, 2018).

2.1.4 How Nurses and Nursing Approach Harm Reduction

Harm reduction principles are compatible with the following nursing values: "the delivery of safe, ethical, professional and compassionate nursing care; the promotion of health and well-being; respect for informed decision-making; the protection of dignity; and the pursuit of justice" (Canadian Nurses Association [CNA], 2011, p. 14; Pauly et al., 2007, p. 20). Educating a person to minimize the adverse outcomes of drug use and eschew infection is congruent with ethical principles of nursing and does not mean recommending illicit substance use (Bartlett et al., 2013). Also, including the College and

Association of Registered Nurses of Alberta, several nursing organizations in Canada explicitly support the principles of harm reduction and acknowledge "the need to support members in increasing their understanding and integration of a harm reduction approach into nursing practice since 2012" (CARNA, 2018, p. 1; College of Registered Nurses of British Columbia [CRNBC], 2010; CNA, 2011).

In a cross-sectional survey study conducted in Australia to analyse nurses' perspectives of harm reduction and other strategies and issues related to illegal substance use, Ford (2012) notes that nurses expressed support for needle exchange programs, a common form of public health harm reduction and how they are unwittingly optimistic about the effectiveness of abstinence based services (N= 1,605, 50% response rate). However, perspectives varied across different harm reduction modalities, as nurses demonstrated "significantly lower support for safe consumption sites as well as methadone maintenance programs" (Ford, 2012, p. 23). This shows that conceptualizations of harm reduction programs among nurses not only vary from nurse to nurse, but vary from program to program. This is conceivably related to the degree by which each program has been normalized in both public and professional discourses. That said, Strike et al. (2020) notes that there are growing demands for implementation of harm reduction strategies in hospitals by health providers, but adoption of said programs has been slow. Also, inadequate understanding of harm reduction leads to low approval of harm reduction strategies as Lin and Detels (2011) emphasize in a study conducted to explore the reasons behind the prescription of low dosages of methadone in China.

With methadone users in Sweden, Ekendahl (2011) analyze the discursive construction of methadone maintenance therapy as a way of harm reduction among substance use treatment service providers (N=28) including nurses. Methadone maintenance treatment is described as "therapeutic intervention", as "beyond harm reduction" because it provides another "narcotic drug" yet prevents crime, thereby emphasizing the fine line between "legitimate and illegitimate drug consumption", and as a "pragmatic solution" (Ekendahl, 2011, pp. 430-435).

A discourse analysis conducted in Brazil with primary care nurses examines the discursive narratives that dominate the understanding of nurses about the harm reduction approach (Pereira et al., 2020). While their substance use understanding is still dominated by biomedical and moral approaches that are contradictory to the tenets of harm reduction, the "expanded clinic" approach regarding harm reduction is targeted as diminishing risks and harms associated with drug use, yet most of these risks and harms are physical (Pereira et al., 2020, p. 7).

Nurses have been, and continue to be, the pioneers of harm reduction policies, advocating for programs and delivering harm reduction strategies in Canada. In the face of at times public and political resistance, nurses continue to support harm reduction strategies, seeing value added to public health and the well-being of many Canadians (CNA, 2017).

2.2 Methodology

This study is situated within a critical theoretical perspective. The critical paradigmatic perspective includes research that seeks to examine meanings beyond mere illustration and comprehension (Rose & Glass, 2008). Critical appraisal of knowledge promotes "empowerment and transformation as well as to move beyond the explanation of 'what has been' and currently 'what is' in nursing, to most importantly, enhance the opportunities of 'what could be'" (Rose & Glass, 2008, p. 10). In terms of how we enact the critical paradigm in nursing, Fontana (2004, p. 96) highlights shifting problematic discourses through: "critique, context, politics, emancipatory intent, democratic structure, examining power relationships, dialectic analysis, and reflexivity". The process is starting with "examining power relationships and imbalances within societal structures" (Fontana 2004, p. 97). Seeing PWUSs as a disempowered or marginalized group, a critical paradigmatic perspective motivates the goal for understanding harm reduction discourses to the ultimate end of shifting discourses towards support.

2.2.1 Bio-power and Governmentality

Power is a key concept in critical research and within this study. The work of Foucault on power is the foundation for our theoretical understanding herein. One of the key issues for Foucault (2003) was the methods by which the state governs knowledge statements

and disciplines. According to Foucault (2003), authority seeks to dominate bodies to turn them into a profitable human resource. Perron et al. (2005) note that "bio-power or power over life" is tacit and ubiquitous and is reinforced by the medicalization and marginalisation of any differences (p. 537). It aims to control and govern citizens as well as provides a deeper understanding of policy decisions related to the optimizing, enhancing, and preserving of human strength (Souleymanov & Allman, 2016; Perron et al., 2005). This form of power governs "individuals' bodies" and health, prohibiting divergence from a fixed standard, and also in turn controlling problems related to "the birth rate, the mortality rate, longevity, illness" (Foucault, 2003) and physical and mental health (Souleymanov & Allman, 2016, p. 1433). The concept is particularly pertinent for considering discourses around substance use, which as an act is often situated as a form of deviance. Policies that frame substance use then may be a form of control over differences situated in governing power.

Foucault introduces the concept of 'governmentality' to explain how individuals are subjects and are subjected. This occurs both at the individual level and the population level. Consistent with Bacchi (2009), Holmes and Gastaldo (2002) point out that power networks in governmentality are threefold, "sovereign-discipline-governmentality" and so governing encompasses these three types of power (p. 559). What is important in this consideration is that the power that is used to control those who are considered outside the norm or deviant can be situated in government authority, and be translated through regulations, or can be adopted by individuals in how they attempt to rule themselves to meet norms. Discourses then of substance use can be written into policy, can be enacted by others against those who use substances, or can be internalized as a process of self-management.

In Foucault's own words, governmentality refers to:

> "The ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of

> knowledge political economy, and as its essential technical means apparatuses of security.”. (Foucault, 2000, p. 219)

The term ‘governmentality’ assists us in looking beyond formal government to understand how power is enacted as social control; while government implies a kind of ruling over the self and others, governmentality denotes “how to govern” (Holmes & Gastaldo, 2002, p. 559) and extends beyond formal powers. Regarding healthcare, Souleymanov and Allman (2016) tackle this by focusing on the “subject's government of the self through the practice of becoming responsible for one's own health” (p. 253). Going further, Souleymanov and Allman (2016) explicitly draw the connection between “drug use, the control of bodies, and bio-power and governmentality” (p. 253). As noted earlier, harm reduction embraces the notion of people’s autonomy in respect to those who use substances by supporting them with “education and public health measures” as responsible decision-makers in their own health (Fischer et al., 2004, p. 358). In a way, then, harm reduction is a direct challenge to governmentality and the power of the state to dictate ‘right’ behaviours. Similarly, Roe (2005) argues that harm reduction and “decentralizing power from the state to the local and the individual level” (p. 245) are inextricably tied, thereby emphasizing a move away from the hegemonic control of the state over people (Roe, 2005) including those who use substances.

2.2.2 Foucauldian Discourse Analysis

This study makes use of a discourse analysis methodology, particularly a Foucauldian approach, and aims to examine the ways in which social issues are constructed through discourses (Foucault, 1983; Freshwater et al., 2010). Within Foucauldian discourse analysis (FDA), discourses function as a web of “situated meanings” (p. 122) created through “language” (p. 121) and “social actions” (p. 121), which then frame perceived realities (Gee & Green, 1998). Moreover, discourses are “sets of statements that construct objects and an array of subject positions [and] these constructions in turn make available certain ways-of-seeing the world and certain ways-of-being in the world” (Willig, 2001, p. 380). From a Foucauldian standpoint, these subject positions generate, perpetuate, and validate those power relations (Willig, 2001).

Looking deeper into the Foucauldian power, Prado (2000) starts with how power (or biopower) cannot be identified, such as “force”, “capacity”, “domination”, or “authority” (p. 68). Rather, Prado (2000) calls attention to the “complex set of relations” that are not intimidating or forceful. Foucault (1982) identifies power as “a set of actions upon other actions” (p. 789) and “is a way in which certain actions modify others” (p. 788). Power is exerted on actions, which means power restricts “actions rather than individuals” (Prado, 2000, p. 71). Consequently, a number of concepts, such as “power (also called bio-power in order to emphasize the important role of biology), resistance, the body, social science, social agents, and the medicalization and clinicalization of social control” are fundamental components of this research and should be taken into account in the process associated with Foucauldian discourse analysis (Powers, 2007, p. 27). Therefore, this analysis will be particularly attuned to the power internalized within Canadian healthcare policies related to harm reduction and substance use. Discourse analysis invites us to ask critical questions regarding how we speak to, speak about, or speak around the contested issues of substance use.

2.2.3 Study Design

FDA was deemed the most appropriate methodology since the epistemological position being taken is how Canadian healthcare and drug policy documents, nursing policy documents (e.g., competencies, position statements, ethics statements), and public health guidance documents are all socially constructed and themselves construct discourses on harm reduction. Policies are also a more formalized mode of social power, particularly in how they instruct nurses to practice.

Through discourse analysis, I examined the visible and invisible, organizational and constitutive relationships among power, authority, supremacy, and control as present in the texts, in these case policy documents (Wodak & Meyer, 2001, cited in Turner et al., 2007). Indeed, Graham (2011) emphasizes that “[the] discursive practices within [power] relations [are] a demonstration of how language works to not only produce meaning, but also particular kinds of objects and subjects upon whom and through which particular relations of power are realized (p. 671). In this way, Foucauldian discourse analysis relies on the meanings that language conveys rather than “grammatical / structural” issues

(Graham, 2011, p. 671). Therefore, I considered what the meanings might be within how we structure and speak to policies on harm reduction.

Lupton (1994, p. 308) offers that "language is a form of social practice and that it is conditioned by the social order". The methods for analysing discourse reach "beyond the texts to the context in which they are produced and read" (Lupton, 1994, p. 308). When reading texts, I used an approach developed by Carol Bacchi (2009), "What's the problem represented to be?" (WPR), which I explained in data analysis part.

2.2.4 Sampling Strategy

Overall, the goal of this work was to explore Canadian health policies related to substance use with a focus on harm reduction. Healthcare policy documents from federal, provincial and territorial governments and nursing policy documents were collected between September and December 2020. The intention was to obtain a breadth of discourses on harm reduction as it relates to substance use. All the data was textual and publicly accessible.

2.2.4.1 Inclusion/Exclusion Criteria

Eligibility focused on Canadian healthcare and drug policy documents, nursing policy documents (e.g. position statements, ethics statements), and public health guidance documents, including those at federal, provincial, or regional system levels. Only documents referencing harm reduction and substance use were included. Although there are a number of documents available that make mention of harm reduction, as seen in Table 1 (see Appendix), for data sufficient to conduct the discourse analysis, only those documents were selected that included a focus on harm reduction or some breadth of discussion on the topic. A 10-year timeline was selected for documents given the rapid pace of evolution of the concept and the concept in practice. Documents outside of Canada and not directly related to harm reduction and substance use were excluded. In addition, documents specific to a single healthcare organization, such as a hospital, were excluded.

2.2.5 Data Collection and Management

All documents were accessed from official websites of healthcare policymakers, nursing organizations, or healthcare organizations such as the Canadian Centre on Substance Use and Addiction. Obtaining documents from government sites included both search functions on the sites as well as more general Google searching. Healthcare sections of federal and provincial government websites were also browsed for any substance use related policies. Any policies referenced throughout the literature review have also been noted for inclusion. Provincial nursing association and registration body websites were browsed and searched for any substance use related content across all provinces and territories in Canada. Documents were obtained in May of 2021.

Platt (1981) recommends that, if multiple versions of a policy exist, as happens often with such documents, the newest version must be obtained. Therefore, I chose the newest version of each document. In order to guarantee authenticity, trustworthiness, and undoubtable origin of the documents, I used governmental and regional health system documents that I obtained directly from their websites versus secondary sources that might speak to a policy document but not include the document text itself. The keywords that I used on their search engines were ‘substance use policy, drug use policy, substance abuse policy, illicit substance use and nursing guidelines, public health policy, harm reduction and substance use’.

Table 1 (see Appendix) shows that the documents I collected are related to harm reduction and substance use, directly or indirectly. The data consists of a combination of federal, provincial, territorial, and organizational healthcare documents within the Canadian context. I viewed all the provincial and territorial nursing organizations’ competency documents and practice standards. All provincial and territorial nursing organizations’ competency documents and practice standards require nurses to incorporate harm reduction principles into care plans, except for the Yukon Territory’s. Since these documents mention harm reduction in only one or two sentences, I neither presented them in the table nor analyzed them.

2.2.6 Data Analysis

In this policy analysis, I used an approach developed by Carol Bacchi (2009), "What's the problem represented to be?" (WPR), which offers a stepwise method that interrogates policy origins, content, and implications. Through this analysis, the WPR approach provides a chance to examine and capture the underlying assumptions behind policies. The first question suggests that problems are nestled in the policies intended to mitigate them, and so how a problem is portrayed or constructed is important (Bacchi, 2009). Because how the problem is portrayed has ramifications "for how the issue is thought about and for how the people involved are treated, and are evoked to think about themselves", accordingly this question asks "what is the 'problem' represented to be in a specific policy?" (Bacchi 2009, p. 1). The second question is designed to analyze the deeper connections of 'problem representations' which are "assumptions and / or presuppositions" (Bacchi & Goodwin, 2018, p. 21). In this context, it is vital to recognize "how the problem representation is constructed, or which concepts and binaries does it rely upon?" (Bacchi & Goodwin, 2018, p. 21). The second question is "what presuppositions or assumptions underlie this representation of the 'problem'? (Bacchi, 2009, 4). The third question allows researchers to analyze and trace back the "roots" of problem representations and ask the question "how has this specific problem representation come about?" which includes a type of "Foucauldian genealogy" (Bacchi, 2009, p. 10). The fourth question stimulates critical inquiry by anticipating oppositions to uncover 'unsaids', "silences or unproblematized elements" (Bacchi & Goodwin, 2018, p. 22). To reveal silences, this question asks, "what is left unproblematic in this problem representation and where are the silences?" (Bacchi, 2009, p. 12). The fifth question addresses "the effects of specific problem representation" (Bacchi, 2009, p.15) by examining their "discursive-subjectification-lived effects" (p. 16). This question asks, "What effects are produced by this representation of the problem?" (Bacchi, 2009, p. 15). The sixth question focuses on who can access the specific discourses and media representations by asking "Where is the representation of the 'problem' produced, disseminated, and defended?" (Bacchi, 2009, p. 19). Given the volume of data, in my analysis I particularly focused on questions one, two, four, and briefly five.

2.2.7 Quality Criteria

Greckhamer and Cilesiz (2014) provide guidance regarding the challenges of rigour within discourse analyses. According to the authors, a major challenge for discourse analysts is to study discourses in a rigorous and systematic way that is coherent with a project's "theoretical and epistemological" premises (Greckhamer & Cilesiz, 2014, p. 13). Therefore, coherence is a key goal in providing trustworthiness in FDA (Greckhamer & Cilesiz, 2014). While the reader will be the ultimate judge of coherence, I supported the possibility for coherence by clearly presenting my own subjectivity and presenting it in alignment with both the paradigmatic perspective and the project's methodology.

Rigour is also achieved through transparency, which involves clear and honest descriptions of the analysis process (Freeman et al., 2007; Greckhamer & Cilesiz, 2014). In this discourse analysis, I aimed to provide transparency by communicating the detailed process of interpretations from texts and their discourses and present the decision-making process leading to the results. While reflexivity and presenting subjectivity are essential to transparency (Tracy, 2010), I also articulated the role of my supervisor and advisory committee in guiding the findings. Their involvement also increases rigour through their expert credibility, which is the concept addressed next.

Credibility as a form of rigour may be described as whether findings are trustworthy and believable (Freeman et al., 2007). I followed the advice of Greckhamer and Cilesiz (2014, p. 436) with "what is presented is a transparent commentary of the phenomenon under study, by presenting a detailed description of the research design, implementation and discourses identified within written data collected." As discourse analysis lacks mechanistic analysis methods and is based on interpretations of language in texts, meaningful interpretations contemplating social contexts of statements and exploring connections beyond texts are of the utmost importance (Greckhamer & Cilesiz, 2014).

2.2.8 Overview of the Data

A document search was conducted using the 'search bar' on each governmental and organizational website. Table 1 was constructed to categorize the different types of documents collected. In this data set, 'category' represents my target given the 'harm

reduction content' of the document. To better detail specific harm reduction content, I used four categories: Prolonged discussion of harm reduction (focused or disseminated throughout document), general discussion of harm reduction (equal to or less than a few paragraphs), short discussion of harm reduction (equal to or less than a few sentences), and the documents speak to technical aspects or strategies of harm reduction rather than general philosophies or understandings of harm reduction. I did not analyze any documents about the strategic side of harm reduction, but focused on 15 major documents (seven position statements, two policy documents, one guidance document, three discussion papers, and two information sheets) almost all of which intensively evaluated harm reduction and required the closest scrutiny, and five relatively minor documents (three guidance documents and two action plans) that talked about harm reduction in only a few paragraphs, though not as a main topic, so the data consisted of 20 documents in total. Table 2 addresses discourse themes and the related documents.

In Table 1, British Columbia represents the source of most of the documents. Of the 15 prolonged discussion documents, two documents intensively focus on harm reduction, namely the BC Harm Reduction Strategies and Services Policy and Guidelines which is published by BC Harm Reduction Strategies and Services and Position Statement: Harm Reduction by BC Nurses' Union (BCNU). Four of them generally states harm reduction philosophies, while the rest (nine) incorporates mostly the technical requirements of harm reduction. Alberta provides five major documents consisting of a policy document, a guidance document, and two information sheets published by Alberta Health Services, and a position statement published by College and Association of Registered Nurses of Alberta (CARNA), as well as seven strategic documents. Interestingly, Ontario provides only one document, a guidance document mainly focused on Hepatitis-C prevention, which actually excludes it from the dataset. Similarly, there was one document for Quebec, an act related to cannabis regulation rather than harm reduction, so the documents from Ontario and Quebec were excluded. Most of the documents from Saskatchewan, Newfoundland and Labrador, Nova Scotia, Northwest Territories, Yukon, Nunavut, and the Canadian Centre on Substance Use and Addiction briefly mention harm reduction; however, these documents focus rather on the technical aspects of harm reduction, such as opioid agonist treatment, cannabis regulation, alcohol-related

regulations, naloxone delivery, and safer use of cocaine, and regulations for supervised consumption sites. Also, it is interesting to note that most of the action plans from these jurisdictions barely mention harm reduction, as in fact very little content is allocated for harm reduction, such as Towards Recovery: The Mental Health and Addictions Action Plan for Newfoundland and Labrador (Government of Newfoundland and Labrador, 2015). The majority of the documents analyzed were published by the Canadian Nurses Association (CNA), College and Association of Registered Nurses of Alberta (CARNA), Alberta Health Services, and British Columbia Provincial Health Services Authority, and Government of Prince Edward Island. Lastly, New Brunswick provides one document, which is a position statement on non-medical cannabis use published by the Nurses Association of New Brunswick (NANB), but the content is quite similar to the Harm Reduction for Non-Medical Cannabis Use published by the CNA (2017).

2.3 Findings: Discourses Identified in the Data

Using a Foucauldian framework and Bacchi's 'what's the problem represented to be?' approach, I analyzed the data focused first on discourses of substance use within documents outlining harm reduction policies (Bacchi, 2009). From the analysis I propose three discursive themes: self-responsible citizen, evidenced-based practice, and what nurses must do. I started with interrogating 'the problem' under 'the concept of substance use' and discussed assumptions underlying 'the problem' as well as proposed binaries. The silences and discursive effects of the problem are mentioned under each theme as self- responsible citizen, evidenced-based practice, and what nurses must do.

2.3.1 The Concept of Substance Use

To gain a deeper understanding of the construction of substance use in harm reduction policies, I began with the 'problem' itself by consulting the relevant research to gauge how it defines substance use. Despite the fact that the most predominant substance use theory in the majority of documents is the public health model, it is possible to discern the hallmarks of the disease model as well. The public health model is rooted in the idea of "interaction between the drug, the individual and the environment", which also can be explained by "drug, set, setting" (Zinberg, 1984), that is to say, set corresponds to

personal feelings in a particular context and setting is the environment in which drugs are used (Coomber et al., 2017). Within this model, strong priority is given to equity considerations around determinants of health. While the effects of social and psychological circumstances are explicit in the public health model in inspiring a particular harm reduction philosophy, the medical/biological (biomedical) model employs the disease model to understand drug use (Australian Government Department of Health, 2004). The medical model formally diagnoses drug use according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), where it is called "substance use disorder" (American Psychiatric Association, 2013), which conveys an image of 'diseased or sick' individuals or subjects. To illustrate, consider the main underlying assumption implicit in the Management of Substance Use in Acute Care Settings in Alberta: Guidance Document (Canadian Research Initiative in Substance Misuse [CRISM], 2020) which I propose, based on the document, is that substance use is a biological problem, it is a permanent disease, and it is progressive. This is evidenced in the following excerpt: "Recognize substance use disorders are a chronic medical condition like other chronic diseases..." (CRISM, 2020, p. 17). It is possible to understand that medicalising addiction as a biological disease is a way of viewing patients with what Foucault called the "medical gaze" (Foucault, 1973 cited in Hancock, 2018, p. 443). In a Foucauldian terminology, "medical gaze" corresponds to a lens system that evaluates "patients' bodies as objects of diagnostics, an objectivation, denoting the depersonalisation of the medical object" (Sørensen, 2019, p. 19). The "medical gaze" or "examining power" of the expert is often linked with Foucault's concept of "bio power". The healthcare professional operates as a decision-maker, or even a judge (Foucault, 1973, cited in Hancock, 2018), determining what is usual and what is unusual. Foucault argues that the inaction of the "docile body" is intensified by the involvement of the professional (Foucault, 1979) as he explains "The examination, surrounded by all its documentary techniques, makes each individual a 'case': a case which at one and the same time constitutes an object for a branch of knowledge and a hold for a branch of power." (Foucault, 1979, p. 191).

It is notable that the disease model was advanced and advocated by health providers as superior to former conceptualizations of substance use, particularly the moral model. As

opposed to the more conventional moral model, the disease model was intended to present a different view that is less moralistic, less stigmatizing, and less rooted in blame (Boyd et al., 2016). While the emergence of the disease model has helped to shield PWUSs from undue blame and considers these individuals to be worthy of supported recovery instead, the initial conceptualization individualized substance use and disregarded social and cultural contexts (Boyd et al., 2016). However, a recent review by Heilig et al. (2021) focuses on the contemporary disease model, which emphasizes the undeniable influence of social environment on addiction and proposes that the brain is where this influence is processed. What is clear in the data analyzed is that there remains some tension between the medical model and a broader, public health model of substance use.

That being said, the majority of the documents did approach substance use from the perspective of a public health model and recognize the societal context of drug use. In this regard, the discourses on social determinants of health or social determinants of substance use were common in the data. Social determinants of health in drug use illustrate the impact of socio-economic factors (individual, family, and community level), and inequalities on the delivery of health within society (Spooner & Hetherington, 2004). Primarily, the function of power, especially power over accessibility to social and economic capital, is seen as the critical indicator of health. To this end, the Chief Provincial Public Health Officer Position Statement: Harm Reduction (Chief Provincial Public Health Officer, 2016) explicitly mentions how substance use and its negative consequences systematically differ among populations such as socially or economically marginalized groups as a result of inequalities, which means imbalanced distribution of power. They present this point in the following excerpt:

> Drug and sex related harms are not experienced equally across all populations. Populations that already experience broad, systemic inequalities also tend to experience a greater burden of these harms…the needs of those who are underserved can be addressed effectively to achieve optimal care, reduce gaps in services, and improve health and well-being. (p. 2)

Structural inequities or being a member of a certain group (race, gender, ethnicity) can determine an individual's classification as 'well-served' or 'underserved'. An illustration of this dichotomy also can be seen in the following excerpt from the Psychoactive Substance Use Policy (Alberta Health Services (2020):

> Indigenous people's experiences with the health care system have not always been favourable, contributing to poor health outcomes through unequal care, inequitable access, and ongoing mistrust of inappropriate services. Indigenous people are disproportionately overrepresented in the population prevalence of substance use disorder and have higher rates of adverse effects with substance use. (p. 6)

There are at least two assumptions embedded in this statement. The first is that inequitable power relations in delivery of care can be harmful. The second is that, due to the lack of accessibility to services or certain groups of people, harms related to substance use are borne disproportionately. As noted by Weinstein et al. (2017) "structural inequities produce systematic disadvantages, which lead to inequitable experiences of the social determinants of health" (p. 100). In this regard, the public health model considers structural inequities related to race, class, and social environment, and so enables us to see the broader perspective regarding the roots of substance use and is the next step in constructing the nature of substance use as we emerge from a disease model. CNA also contributed to a public health discourse as they emphasized the impact of social determinants on substance use in both their discussion paper, Harm Reduction and Illicit Substance Use: Implications for Nursing (CNA, 2017) and their position statement, Harm Reduction and Substance Use: Joint Statement (CNA, 2018a). In addition to these documents, also Focus on Harm Reduction for Injection Drug Use in Canadian Prisons: A Supplement to CNA's Harm Reduction Discussion Paper (CNA, 2016), BC Harm Reduction Strategies and Services Policy and Guidelines (BC Harm Reduction Strategies and Services, 2014), and Position Statement on Harm Reduction (BC Nurses' Union [BCNU], 2011) address substance use through a health equity and social justice lens. This is congruent with now long-standing structural perspectives that social and economic variables influence substance use (Spooner & Hetherington, 2004).

2.3.1.1 Binaries

Bacchi (2009) points out the function of binaries or dichotomies in policy analysis to demonstrate the "A/not-A relationship". This helps uncover power in discourses where the "A" group represents the advantaged or superior class and the "not A" group represents those who are marginalized. The aim is "to reveal conceptual logistics that may act to constrain or limit our understanding of an issue" (Bacchi, 2009, p. 7). Since the data consists of a mix of policy and guidance documents related to substance use and harm reduction, there are several dichotomies defining PWUSs in these documents as licit/illicit, good/bad (problematic user/non-problematic or recreational user), and patient/person. Each of these provides consideration as to how PWUSs are constructed as a group outside the social norm.

The implied binary of patient/person was embedded in Psychoactive Substance Use Policy (Alberta Health Services, 2020) and functioned to form implicit meanings of 'substance user' as a problem to be cured in contrast to 'normal/healthy' individuals:

> Patients who use psychoactive substances will have access to low threshold, flexible, and accessible patient-centred services wherever possible, respect for their individual autonomy, and support to set their own goals based on their needs, specific circumstances, abilities, beliefs, and priorities. (p. 2)

In this document, the definition for "patient" is, "residents, clients, and outpatients who receive or have requested health care or services from Alberta Health Services" (p. 8), and in it all PWUSs are deemed as "patients" (Alberta Health Services, 2020). It is notable how the terminology used thus intersects with the higher order conceptualization of substance use as an individual disease or a social public health concern. The explicit assumption in the Psychoactive Substance Use Policy (Alberta Health Services, 2020) is that PWUSs' individual choices are paramount; however, the implicit assumption is that they are still considered "patients" traditionally seen as passive recipients of care. In the Cambridge Dictionary (N.D.), a "patient" is described as "a person who is receiving medical care, especially in a hospital, or who is cared for by a particular doctor or dentist when necessary". The word 'patient' operates to imply not only restricted decision-

making capacity, but also subjugation, medical gaze, surveillance, and control. Such discourses, in essence, posit the idea that PWUSs receive treatment to recover from ailments not of their making. This is notably different than notions of PWUSs as central in defining their own needs and interests, which may include no change in their substance using behaviours.

The dichotomy of licit / illicit drugs is more obvious in cannabis-related discourses. The notion of self-responsibility, given legalization, is strongly emphasized in these discourses, establishing that cannabis is legal as long as it is used 'responsibly'. While nurses should also monitor the health-related risks of cannabis use (Nurses Association of New Brunswick [NANB], 2018, p. 2), the limits of their responsibility are already determined by regulatory mechanisms that dictate:

> While cannabis related activities will soon become legal, rules and regulations will be made to manage this legal environment. Federal, provincial, and municipal authorities will continue to inspect and enforce the new and existing rules that apply to personal, commercial, and public cannabis activities. (Government of Prince Edward Island, 2018, p. 11)

Also, it is possible to find the markers of the disease model, where 'users' fall into the category of 'problematic users' when they have 'cannabis use disorder', even though the documents emphasize that their approach is based on the public health model, as evident in this excerpt:

> The DSM-5 defines cannabis use disorder as "a problematic pattern of cannabis use leading to clinically significant impairment or distress". About nine percent of cannabis users develop this type of dependence. (CNA, 2018b, p. 6)

A similar implicit dichotomy can be seen in the 'problematic use'/ 'recreational use' construct, or in other words 'good' / 'bad' drug use in the Position Statement on Harm Reduction:

> Psychoactive drug use is common in Canadian society and the majority of this use is not problematic. (Winnipeg Regional Health Authority [WRHA], 2016, p. 7)

It seems that whereas the construction of this argument covertly leans on a notion of sociocultural drug use, overtly it relies on an idea of 'recreational user', or in other words non-problematic user, which creates hierarchies between problematic and non-problematic users. Another example, Prince Edward Island Action Plan to Prevent and Mitigate Opioid-related Overdoses and Deaths (Government of Prince Edward Island, 2017), uses binaries of 'use' and 'misuse' while framing substance use as a 'disorder':

> Ultimately, to prevent the harms associated with opioid misuse and opioid use disorder and to promote recovery, interventions affecting the factors which influence problematic drug use and which impact success in recovery are required. (p. 2)

Going further, some documents explained this issue based on a spectrum from "beneficial" to "chronic dependent" and emphasized that, in spite of the risks, the benefits cannot be disregarded (Alberta Health Services, 2020; British Columbia Ministry of Health, 2017a; British Columbia Ministry of Health, 2017b; Alberta Health Services, 2019a). While these documents enable a variety of definitions of substance use 'levels' to then structure what services are provided, the discourse surrounding substance use is notable in constructing some people as being in need of help, regardless of their personal interests in care services. The documents overlook some of the complexities of how substance use can be both problematic and adaptive, often at the same time, or can shift from deleterious to managed given specific contexts. For example, the same drug at similar doses could be harmful for one person and have little effect on another. Yet, most diagnoses do not account for this kind of nuance and instead rely on a stricter definition of problematic based on social expectations rather than the needs and concerns of those involved.

Although all of the documents state 'pragmatism' as one of the main principles of the harm reduction philosophy, the discursive practises in a few documents establish a clearly negative understanding of substance use, such as in the Chief Provincial Public Health Officer Position Statement: Harm Reduction (Chief Provincial Public Health Officer, 2016):

> There are substantial health and social harms associated with psychoactive substance use. Psychoactive substances are often used for coping with physical and/or emotional pain. (p. 2)

Where pragmatism is supposed to mean meeting an individual where they are at and providing whatever level of harm reduction they should choose, there is a strong indication that the right approach is to choose assistance and to reduce use.

2.3.2 Self-responsible Citizen

A discourse related to the self-responsible citizen was dominant throughout the documents. Most (16) of the documents appear to address PWUSs as subjects who are self-directed and who discern the difference between rational and irrational choices in risky situations. Indeed, risk-management skills of PWUSs were depicted in these 16 documents through harm reduction strategies and self-directed activities pertaining to these strategies such as safer environment (safe consumption sites), overdose monitoring (administering naloxone), hygienic injecting (needle distribution), vein care (using sterile supplies), and opioid replacement therapy (methadone maintenance), namely:

- Position Statement: Harm Reduction (BCNU, 2011),
- BC Harm Reduction Strategies and Services Policy and Guidelines (BC Harm Reduction Strategies and Services, 2014),
- Focus on Harm Reduction for Injection Drug Use in Canadian Prisons: A Supplement to CNA's Harm Reduction Discussion Paper Needle Sharing and Substance Use in Prisons (CNA, 2016),
- Chief Provincial Public Health Officer Position Statement: Harm Reduction (Chief Provincial Public Health Officer, 2016),
- Position Statement on Harm Reduction (WRHA, 2016),
- Harm Reduction and Illicit Substance Use: Implications for Nursing (CNA, 2017),
- Integrating a Harm Reduction Approach to Nursing: Practice Advice (College and Association of Registered Nurses of Alberta [CARNA], 2018),

- Harm Reduction and Substance Use: Joint Statement (CNA, 2018a),
- Harm reduction: A Harm Reduction Approach (Alberta Health Services, 2019a),
- Psychoactive Substance Use Policy (Alberta Health Services, 2020),
- Management of Substance Use in Acute Care Settings in Alberta: Guidance Document (CRISM, 2020),
- Provincial Guidelines for Biopsychospiritual Withdrawal Management Services for Adults (British Columbia Ministry of Health, 2017a),
- Provincial Guidelines for Biopsychospiritual Withdrawal Management Services for Youth (British Columbia Ministry of Health, 2017b),
- Improving Health Services for Individuals with Severe Addiction and Mental Illness (British Columbia Ministry of Health, 2013),
- BC Centre for Disease Control Harm Reduction Position Statement: Harm Reduction (British Columbia Centre for Disease Control [BCCDC], 2018),
- Prince Edward Island Action Plan to Prevent and Mitigate Opioid-related Overdoses and Deaths (Government of Prince Edward Island, 2017).

Cannabis related documents such as Harm Reduction for Non-Medical Cannabis Use (CNA, 2018b), Non-Medical Cannabis Use: Position Statement (NANB, 2018), and Cannabis Legalization: A Policy and Legislative Framework for Prince Edward Island (Government of Prince Edward Island, 2018) also imply self responsibility by emphasizing that 'users' are taking their own risks. The notion of managing their own risks amplifies the autonomous subject, free agent, and self-governing understandings in harm reduction as illustrated in the following statement:

> Harm reduction enhances the ability of people who use substances to have increased control over their lives and their health, and allows them to take protective and proactive measures for themselves, their families and their communities. (CRISM, 2020, p. 18)

What is more, by increasing their sense of responsibility, this statement indicates that PWUSs are individuals who are capable of taking care of themselves and their social

environment as well as managing their personal risks. This discourse can be helpful or harmful depending if used to support autonomy or place blame.

Analogies are persuasive strategies to convince us by teaching and comparing obvious similarities with more familiar situations as well as enable us to draw conclusions from past experiences in comparison to current realities (Johnstone, 2018; Schwarz-Plaschg, 2018). Some documents use analogy to illustrate the similarity between harm reduction and daily life risk-management strategies as a part of self-responsibility, such as using seatbelts to decrease the harm of car-crashes and applying sunscreen to prevent sunburns (Chief Provincial Public Health Officer, 2016; BCCDC, 2018). These analogies were notable in that they often compared simple decisions like wearing seatbelts with the far more complex issue of using substances, representing an implied but false congruence.

Six of the documents (BC Harm Reduction Strategies and Services, 2014; Alberta Health Services, 2020; CARNA, 2018; WRHA, 2016; CNA, 2018a; BCCDC, 2018) develop the Foucauldian concepts of self-governing of PWUSs by emphasizing participation in designing policies that affect PWUSs as illustrated in the following text:

> 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. (BC Harm Reduction Strategies and Services, 2014, p. 2).

This is a positive form of PWUSs as self-governing as a space is created for people to empower themselves by guiding service delivery. This particular statement is worthwhile as it acknowledges the necessary input of PWUSs in their own policy interventions. Though hiring PWUSs for such positions can be questioned as dominating bodies and rendering them subjects of disciplinary power while turning them into a productive workforce, taking action in this process encourages those who use substances to speak for their rights and make demands of authority figures.

The discourse of self-governing carries the notion of empowerment for PWUSs as well as their social circles. The following excerpt exemplifies the aim of intentional use of "empower" and "their community" and how consumers embrace and take action within this discourse:

> The best kind of harm reduction program is easily accessible to everyone and *empowers* each person (and *their community*) along with the service provider, to determine the appropriate intervention to address immediate priorities and where possible, long-term goals. (BCNU, 2011, p. 3, emphasis mine)

Such discourses walk a fine balance between creating space for people to empower themselves while at the same time not implying that the person alone has to fix what is often an issue tied to structural inequities. On the negative side, in the Foucauldian model, such discourses generate "self-surveillance", which predominantly puts greater responsibility on PWUSs for decreasing harms related to their substance use, and hence reduces and shifts state responsibility about safer interventions such as providing safe supplies. Indeed, there are silences, or what Bacchi (2009) called "limits" and "[issues are] failed to be problematized" (p. 12), in these self-directedness discourses. These discourses mainly focus on individualizing responsibility:

> Currently there are several harm reduction programs for people who use drugs in PEI, including needle exchange, opioid replacement therapy, education, and peer support, delivered through both government and community organizations. Building on existing services, three priority areas were identified to reduce and mitigate opioid overdoses and deaths: naloxone, harm reduction communications and education, and opioid replacement therapy. (Government of Prince Edward Island, 2017, p. 5)

Another excerpt from the BC Centre for Disease Control's Position Statement: Harm Reduction (BCCDC, 2018) amplifies this notion:

> Needle distribution and safe disposal programs, overdose prevention, response training and supervised consumption services that reduce harms associated with substance use, promote safe use and reduce opioid overdose deaths. (p. 1)

The broader needs of PWUSs, such as housing, stable employment and communication with services (Boyd et al., 2016), are poorly recognized in these documents. Only the CNA discussion document, Harm Reduction and Illicit Substance Use: Implications for Nursing (CNA, 2017) and the Integrating a Harm Reduction Approach to Nursing (CARNA, 2018) acknowledge stable 'housing' as a method of harm reduction and embrace a relatively comprehensive approach that:

> …focuses on a wide range of evidence-based harm reduction strategies such as outreach, overdose prevention, supervised consumption sites, heroin and methadone maintenance therapy, and housing. (CARNA, 2018, p. 1)

While most of the documents refer to safer drug use supplies like naloxone kits, crack use kits, new needles/syringes distribution, 'safe supply' of the substances themselves are not mentioned and so is neither problematized nor supported. Rather than this potential policy approach, individual responsibility is perpetuated as in the excerpt from the Position Statement on Harm Reduction (WRHA, 2016):

> The Statement recognizes that while people make their own health decisions, these decisions are only one factor influencing health outcomes…Increasing the accessibility of safer drug use supplies to individuals and groups who need them. This is consistent with the WRHA's history of providing services to people who use drugs: Winnipeg was one of the first jurisdictions to distribute safer crack use kits. (p. 2)

In another example, the reference to 'supply' is ambiguous:

> Harm reduction interventions may include: Community-based naloxone programs Peer support programs Supply distribution and recovery programs Supervised consumption services Opioid dependency treatments. (Alberta Health Services, 2019a, p. 1)

Ultimately, discourses of responsibility walk the fine line of supporting having voice and having autonomy while also promoting personal responsibility for a complex social issue. The risk of such discourses is putting all the burden of reducing harms on PWUSs and disregarding other social problems, such as stigma and prohibition, that discourage PWUSs from using harm reduction services, thereby affecting the accessibility and acceptability of those services.

2.3.3 The Rhetoric of Evidenced-based Practice

Within the dataset, 'evidence-based' or 'science-based' discourse is used in 15 of the policy and position statement documents namely:

- Position Statement: Harm reduction (BCNU, 2011)
- BC Harm Reduction Strategies and Services Policy and Guidelines (BC Harm Reduction Strategies and Services, 2014)
- Focus on Harm Reduction for Injection Drug Use in Canadian Prisons: A Supplement to CNA's Harm Reduction Discussion Paper Needle Sharing and Substance Use in Prisons (CNA, 2016)
- Chief Provincial Public Health Officer Position Statement: Harm Reduction (Chief Provincial Public Health Officer, 2016)
- Position Statement on Harm Reduction (WRHA, 2016)
- Harm Reduction and Illicit Substance Use: Implications for Nursing (CNA, 2017)
- Harm Reduction for Non-Medical Cannabis Use (CNA, 2018b)
- Non-Medical Cannabis Use (NANB, 2018)
- Integrating a Harm Reduction Approach to Nursing: Practice Advice (CARNA, 2018)
- Harm Reduction and Substance Use: Joint Statement (CNA, 2018a)
- BC Centre for Disease Control Harm Reduction Position Statement: Harm Reduction (BCCDC, 2018)
- Management of Substance Use in Acute Care Settings in Alberta: Guidance Document (CRISM, 2020)

- Provincial Guidelines for Biopsychospiritual Withdrawal Management Services for Adults (British Columbia Ministry of Health, 2017a)
- Provincial Guidelines for Biopsychospiritual Withdrawal Management Services for Youth (British Columbia Ministry of Health (2017b)
- Prince Edward Island Action Plan to Prevent and Mitigate Opioid-related Overdoses and Deaths (Government of Prince Edward Island, 2017).

Where public health concerns exist, evidence-based reasoning should guide to the implementation of policy solutions (European Monitoring Centre for Drugs and Drug Addiction, [EMCDDA], 2010). Presumably, evidence presents an alternative to ideologically motivated policies (EMCDDA, 2010). This is particularly pertinent as the idea of being 'evidence-based' provides legitimacy in western cultures that give high privilege to traditional science. As a relatively new and still in part controversial practice, harm reduction pushes on the idea of evidence to be justified within healthcare. That is, it has to "prove itself" to the doubters so leans heavily on including evidence as proof. In nursing, evidence-based practice refers to any clinical practice that is based on scientific research, and policies and programs should be informed by this "gold standard of knowledge that are best suited to guide decision making" (Parkhurst, 2017, p. 17).

Lancaster (2016) notes that "evidence-based policy" (p. 81) is derived from evidence-based practice, which is based on scientific inquiry. As 'evidence' (e.g. meta-analysis, systematic reviews etc.) is considered the reference and reasoning in nursing interventions as credible and reliable information, "evidence-based approach became de rigueur in healthcare as well as academic and policy circles" (Lancaster, 2016, p. 81). Therefore, the discourse of evidence-based policy ensures that the scope of the problem being handled is "known, measurable, and unambiguous" and that suitable assessment will be able to evaluate the efficacy of policy interventions (Wesselink et al., 2014, p. 340). The following examples demonstrates the emphasis on evidence-based knowledge in harm reduction policies:

> Harm reduction is evidence-informed and has benefits for individuals, families and communities…. Programs, services, and policies should be evidence-based,

> cost-effective, and be adaptable to meet local needs. (British Columbia Centre for Disease Control, 2018, p. 1)
>
> There is substantial empirical evidence to support the benefits of harm reduction strategies in terms of public health and safety. (CNA, 2017, p. 1; CNA, 2016, p. 5)
>
> Peer-reviewed studies have compellingly demonstrated the health, legal and social benefits of harm reduction programs such as Insite: these programs save lives; they are cost effective. (BCNU, 2011, p. 4)

The silences in these discourses can be addressed by Goodyear's (2021) argument which contends the role of evidence-based policies and practices resulting in the production of "one-size-fits-all" policies and devaluation of personal and subjective elements. This is because high quality scientific evidence is considered to be 'randomised controlled trial', 'systematic review' and 'meta-analysis' rather than personal experiences (Parkhurst, 2017, p. 17). While healthcare agencies and other government authorities ultimately decide accessibility and usage of harm-reduction facilities and tools for PWUSs, the "one-size-fits-all" approach does not suit PWUSs as we value human experiences and 'one-size-fits-all approach' is a ubiquitous source of governmentality and power (Goodyear, 2021).

2.3.4 What Nurses Must Do

Through the analysis there was a noted focus around professional roles and responsibilities. The discourse of "professional nursing" was frequently used in the documents, especially in position statements of professional nursing organizations, to refer to what we might consider to be professional knowledge or, in order words, professional power. Herein, I interrogate being a member of a professional discipline and power network from the inside. Being a member of a professional discipline requires following the standards of practice, which are the rules generated by those organizations and associations within that particular discipline. In nursing, professional organizations and associations are significant in creating a dynamic discipline that advances the

knowledge of its members and fortifies society's respect by influencing practices, education, policies, and healthcare standards (Matthews, 2012). Nurses follow these practice standards, guidelines, and position statements to "practice within the legislated scope of practice of the profession" (CARNA, 2013, p. 7). Documents on the scope of practice of the profession are authoritative declarations that guide nurses on how to practice, but do not provide specifications. As an example from Integrating a Harm Reduction Approach to Nursing (CARNA, 2018):

> All regulated members of the College and Association of Registered Nurses of Alberta (CARNA) have a responsibility to provide safe, competent, and ethical care…A harm reduction approach aligns with a nurse's responsibility to use critical inquiry and evidence-informed knowledge to protect and promote an individual's right to autonomy, respect, privacy, and dignity. (p. 1)

College and Association of Registered Nurses of Alberta (2018) even elaborates on the autonomy of registered nurses and nurse practitioners in how they can support a harm reduction approach in nursing practice using certain practices such as prescribing opioid agonist therapy and distributing Naloxone kits (p. 2).

While the standards of practice create a unified nursing practice, nurses also perceive their practices to be shaped by those at the top of the power structure and they are subjected to a number of disciplinary techniques, such as control and observation, to "protect the public". Nurses are not only observed by their colleagues, doctors, and patients, but also, they are responsible to their team managers, supervisors, head nurses, and eventually their professional governing authority (St-Pierre & Holmes, 2008). As explained by St-Pierre and Holmes (2008) "those at the top of the power structure are able to monitor all activities by means of an omnipresent and insidious system of surveillance" (p. 356).

What nurses can do and cannot do may result in limitations. St-Pierre and Holmes (2008) note that "the organization expects nurses to be caring and professional but also subordinate" (p. 354), which makes them feel powerless when they want to provide higher quality of care. Another discursive theme in this context is that authorities or

professional organizations are using ‘professional responsibilities’ intentionally for the express purpose of telling nurses that no matter what they personally think they have to engage in harm reduction practices, thereby there is no open door left for opponents. Particularly, position statements put emphasis on alignment between a harm reduction philosophy driven by kindness and compassion and ethical principals of nursing to make clear the idea of ‘harm reduction should be supported and followed by nurses’ and the professional piece comes up over and over again to convince doubters that it’s not up for debate. Below are a few excerpts as examples from different documents illustrate these assumptions:

> Nursing professional and ethical standards are consistent with the values of harm reduction and require nurses to use the best evidence available in their practice. (CNA, 2017, p. 2; CNA, 2018b, p. 4; NANB, 2018, p. 1)

> The principles of harm reduction are consistent with the primary values in the CNA Code of Ethics for Nurses, particularly nurses’ responsibility (CNA, 2016, p. 5) to provide safe, compassionate, competent and ethical care. Nurses should help advance organizational and governmental harm reduction policies. (CNA, 2018a, p. 3)

> BCNU believes that nurses and other health care providers can offer their wisdom and knowledge to creating a more equitable health care system – a system that approaches the health care needs of persons coping with substance use issues from a perspective of harm reduction – with kindness and compassion. (BCNU, 2011, p. 4)

Another example draws attention to healthcare professionals’ responsibilities on the Alberta Health Services information sheets:

> Harm reduction is founded on kindness, compassion, and caring, and is underpinned by several key principles. These principles are consistent with the concept of social justice, as well as healthcare professionals’ foundational

> responsibilities, values, code of ethics, code of conduct, and standards of practice. (Alberta Health Services, 2019a, p. 1, Alberta Health Services, 2019b, p. 1)

Apart from nursing position statements, healthcare providers' professional responsibilities are also explained in the Psychoactive Substance Use Policy (Alberta Health Services, 2020) and Management of Substance Use in Acute Care Settings in Alberta: Guidance Document (CRISM, 2020). Essentially, professional power is exerted to ensure that nurses are supportive of harm reduction, the discourse being that 'this is what nurses must do'.

Finally, there is a noted silence in policies related to the professional role of nurses. The necessity of harm reduction services is linked to standards of care and supportive evidence. It is notable that these documents lean very little on the idea of concepts such as human rights or rights to life. Rather than appealing to higher order values that underpin the nursing profession, most attention is paid to disciplinary responsibilities. This is a form of enacting power in a hierarchical profession versus appealing to the values of nurses. Presumably, this is perceived as a more effective discourse wherein values related to substance use may not be shared among nurses.

2.4 Discussion and Implications

The aim of this study was to explore and describe the discursive use of the term "harm reduction" as it relates to substance use in a Canadian health and nursing policy context. There are a number of implications regarding policy, education

As evident the findings, having a 'substance/cannabis use disorder' or 'problematic use', turn 'users' into problematic users or potential criminals with the underlying notion that they are engaged in 'bad' drug use and all of its negative connotations, resulting in a punitive approach to substance use. Criminalizing drugs not only creates social justice and equity problems but also leads to deaths, stigmatization, as well as inefficient resource management (Boyd et al., 2016). Recognizing that there are deeper roots to substance use and harms, the findings of this study recommend that further refinement of public health policy needs to focus on health and can be enhanced through both specific

measures, such as ‘safe supply’ (prescribing of substances to address substance use disorders) and broader approaches such as decriminalization. Also, self-responsibility discourses can be disempowering as they put tremendous pressure on PWUSs to solve their own health issues. Moreover, managing their own risks may increase the burden of individual responsibility while neglecting the reality that substance using is a multifaceted social issue, and so individually having to take care of their social environment may lead users to feel more rather than less disempowered. Policies related to harm reduction must balance creating space for empowerment with recognizing that external resources are needed as supports to reduce substance-related harms based on personal preferences.

The findings of this study have implications for nursing education. Considering the evidence-based knowledge in policy, there are notable details in respect to how evidence needs to be taught to students. Putting humanistic values at the center, we need to refine our language through being consciously aware how we think and speak about harm reduction while we teach undergraduate students. Given the role of nurses in power relations between government agents and public (Perron et al., 2004) we should reconceptualize substance use in nursing education to enhance the focus on empowering support and move away from an approach that constructs PWUSs as problematic. Teaching nursing students to be conscious of their own power in relation to care provided with marginalized groups has also utmost importance. Student nurses should be prepared, gain knowledge and awareness regarding practice or interactions with marginalized and vulnerable groups.

As nurses are an integral part of harm reduction in action, the findings who how evidence-based rhetoric performs in a certain sense to set the boundaries of nursing practice. In this case, it can be seen how evidence-based discourse functions in favor of harm reduction practices and ensures that nurses take up care for PWUSs even if they personally have biases against such patients. Practice leaders in nursing can use this approach of ensuring that nurses must practice harm reduction by leaning on professional responsibilities and the direct connection between core principles of nursing and harm reduction philosophy.

The relationship with self-responsibility means that PWUSs can both be involved in delivery of harm reduction services and blamed for failures in service delivery. This opens significant opportunity for research that is participatory in nature looking at refining the policy structure of harm reduction service delivery in health care. This can be supported by knowledge creation such as mapping the power networks in health systems.

2.5 Strength and Limitations

A key strength of this research lies in taking a critical eye to what underlies the language of policy. It is also noteworthy that the methodology of this study, both the Foucauldian approach drawn upon power and governmentality and a step-by-step policy analysis developed by Carol Bacchi (2009), allows us to see how power is embedded in how we speak and how we think about complex health and social issues. Another strength of this study is gleaning data from diverse governmental and organizational sources.

The study also has limitations, especially with regards to my own experience and subjectivity as noted in my self-reflection. In particular, I have limited experience with the Canadian healthcare context as well as no personal experience with addiction. However, my supervisor and advisory committee have supported me in identifying any oversights such as those based on cultural misunderstandings. I have identified some exclusion criteria for the FDA, and specifically excluding policies of single healthcare organizations means that not all nuances of policy language around harm reduction have been captured. However, discipline level discourses, as currently present in foundational nursing guidelines, are likely much more impactful on the broader harm reduction discourse than policies from any one health service. Finally, this work is also limited by its exclusion of the documents focusing on the technical elements of delivering of harm reduction services.

2.6 Conclusion

Using the Foucauldian approach and Bacchi's policy analysis framework, this study has sought to explore the discursive construction of harm reduction in policy documents. This study includes both policies and nursing position statements to focus particularly on the

position of nursing within harm reduction practice. The discursive practices in these policies construct individuals as ‘addicts’ or ‘drug users’ and present a health issue as also criminal, substantially contributing to the stigmatization of PWUSs. In this work, we are reminded yet again that ‘evidence-based practice’ is a powerful discourse that is used to frame the boundaries of nursing care. This can constrain nursing practice, but in this context may do so positively by requiring nurses to accept harm reduction where they may otherwise be personally opposed. Finally, a discourse of self-directedness is present and can either put undo responsibility on PWUSs to solve a broader social challenge or create opportunities for individuals to influence the policies that most affect their lives. This study reveals the complexities of how language creates social and professional power for PWUSs. Ultimately, awareness of these discourses and spaces of power allow nurses to construct an optimal policy context to address the health needs of PWUSs through harm reduction.

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Chapter 3

3 Discussion and Implications

The aim of this study was to explore and describe the discursive use of the term “harm reduction” as it relates to substance use in a Canadian health and nursing policy context. To meet this objective, assumptions underlying ‘problematic representations’ in documents speaking to harm reduction were identified and uncovered. These documents were analyzed with a Foucauldian perspective to unveil how those embedded assumptions framed harm reduction and what effects they produce that impact those implicated in these documents.

3.1 Implications for Policy

Data analysis in this project brought forward the tensions around criminalization of drugs and supply problems as these relate to legal / illegal and responsible / irresponsible binaries. Currently, Canada's principal drug policy, the Controlled Drugs and Substances Act, is mainly centered on a criminal justice strategy (Toronto Public Health, 2018). While government agencies and enforcement authorities argue that drug policy and criminal justice finance are intended to curb greater manufacturing and distribution of illegal drugs, in fact, narcotics data indicate that those made criminal through this approach are mostly street-level sellers consisting of disadvantaged youth (Boyd et al., 2016; Harm reduction TO, N.D.).

As evident the findings, having a ‘substance/cannabis use disorder’ or ‘problematic use’, turn ‘users’ into problematic users or potential criminals with the underlying notion that they are engaged in ‘bad’ drug use and all of its negative connotations, resulting in a punitive approach to substance use. Criminalizing drugs not only creates social justice and equity problems but also leads to deaths, stigmatization, as well as inefficient resource management (Boyd et al., 2016). The health risks of substance use are well established (Boyd et al., 2016; Tyndall, 2020) and these health risks are referred by addressing ‘risk-management skills’ of PWUSs in findings, a health approach is warranted. This means that further refinement of public health policy needs to focus on

health and can be enhanced through both specific measures, such as ‘safe supply’ (prescribing of substances to address substance use disorders) and broader approaches such as decriminalization. As an example, Portugal made a significant change to their drug laws by legalizing all drugs for personal use, and embracing health over punishment in 2001; subsequent to these changes, there was no increase to the rate of people living with substance use disorders (Transform Drug Policy Foundation, 2021; Boyd et al., 2016).

The dichotomies addressed in the findings, such as patient/person, licit/illicit, and good/bad drug use, are particularly related to stigmatization as they predominantly shape the image of drug users in both societal and legal contexts. While associating substance use with an ailment makes it less stigmatizing, using ‘illicit’ substances, or ‘problematic’ use inevitably puts labels on PWUSs in the public eye as well as makes them ‘potential criminals’. In this respect, criminalization and stigmatization interact each other and significantly decrease the accessibility to harm reduction and healthcare services for PWUSs. As noted in the findings, structuring harms as a criminal justice issue constrains public health approaches. At the individual level, fear of incarceration and stigma discourages individuals from seeking treatment (Room & Reuter, 2012). Decriminalization still involves drugs being regulated, as with cannabis more recently in Canada, thereby balancing safe access while reducing intersections with the criminal justice system (Boyd et al., 2016). In this regard, transforming all substance related policies to be fully focused on substance use as a health issue creates a context for policies that also have better outcomes in reducing drug harms.

The narrative of PWUSs as self-responsible citizens was a common theme throughout the project data. Self-responsibility discourses were not limited to harm reduction practices as PWUSs were also social agents having self-responsibility for their social environment and their community. While such discourses may seem empowering at face value, they can also be disempowering as they put tremendous pressure on PWUSs to solve their own health issues. Policies related to harm reduction must balance creating space for empowerment while recognizing that external resources are needed as supports to reduce substance-related harms.

The Foucauldian term ‘governmentality’ is directly connected to these self-responsibility discourses because the notion of governmentality emphasizes “the active consent and willingness of individuals to participate in their own governance” (Huff, 2020). Hache (2007) emphasizes the positive side of ‘empowerment’ is an instrument that activates “individuals’ self-realization” to make them more “self-reliant” (p. 54), which includes why PWUSs should be actively involved in policy design. However, Hache (2007) highlights how self-responsibility discourses in harm reduction often focus on subjects’ “risky” health behaviors, and thereby power operates as an incentive to “make individuals responsible for the duties and (dys)functions of the State while stigmatizing them as irresponsible” (Hache, 2007, p. 55). According to Bacchi (2009), once social standards are accentuated through policy, those on the margins are subjected to “self-surveillance”, or in other words “self-regulation” (p.29) as a form of disempowerment. As reflected in self-directedness discourses, users managing their own risk through using in a safer environment, monitoring overdoses, injecting hygienically, and engaging in vein care all elevate the burden of individual responsibility while neglecting the reality that using is a multifaceted social issue, and so individually having to take care of their social environment may lead users to feel more rather than less disempowered.

3.2 Implications for Education

The findings of this study have implications for nursing education, particularly curriculum components regarding what nurses need to understand to provide care in the context of substance use disorders. In the data, the College and Association of Registered Nurses of Alberta (CARNA) in particular focused on what nurses do and how they provide harm reduction care. The discourses herein highlight the congruency between harm reduction philosophy and nursing core care principles.

Drawing upon the Foucauldian notion of governmentality, Bacchi (2009) examines how ‘knowledge’ and ‘governing’ interact in policy analysis. Bacchi (2009) maintains that “[the] knowledge about whom or what is to be governed” is essential to rule, and therefore rather than focusing on whether the knowledge is true or false, Bacchi (2009) emphasizes “the form of knowledge that are ‘in the true’ and the effects they have on how subjects is organised and governed” (p. 234). In this context, objective knowledge

can be questioned considering "the issue of who is best placed to produce 'knowledges' that will count as 'truth', and how they secure their position/s of influence" (Bacchi, 2009, p.235). According to Foucault, discourses in human sciences are not the outcome of a transparent and neutral analysis, but instead the result of processes of power dynamics vying for control over scientific disciplines within a system (Shiner, 1982). Bacchi (2009) notes Foucault's concern regarding 'truth' and 'scientific discourse' by reciting Foucault's question, which is "What individuals, what groups or classes have access to a particular kind of discourse? How is the relationship institutionalized between the discourse, speakers and its destined to audience?" (Bacchi 2009, p. 235-36).

Wesselink et al. (2014) draw attention to multiple perceptions of "what the evidence says" whereby the interpretation of evidence by "multiple-voices" produces a discourse rather than a policy result. As such, evidence-based knowledge in policy can be thought of as a rhetoric rather than a factual or strict knowledge (Wesselink et al., 2014). Given its present ubiquity in harm reduction and substance use policy, it is possible that while the evidence-based discourse has likely advanced the uptake of harm reduction, it might also constrain, decide, or shape who can talk and what can be said. Holmes and Gagnon (2018) note that "how knowledge is produced and in what context; how scientific claims are made, by whom, and to what end; who the objects and subjects of these forms of knowledge are; and, finally, how these forms of knowledge and the systems that generate them can be destabilized" (p. 4). From this point of view, "knowledge is never neutral, given that it is produced by systems and structures that determine what is considered valid knowledge" (Holmes and Gagnon, 2018, p. 4). In this context, 'objective', 'scientific' evidence is done purposely as this is seen as the best way for one's discourse to 'win' in Western societies. The repetitiveness of "evidence" and "evidence-base" in data can be the reason of trying to win those who are philosophically opposed. Evidence focused on lived experience, participation, and choices could help identify unique needs of PWUSs. Indeed, evidence from qualitative research allows us to hear individual voices of PWUSs, designing better harm reduction services and programs.

Considering the evidence-based knowledge in policy, there are notable details in respect to how evidence needs to be taught to students. Putting humanistic values at the center,

we need to refine our language through being consciously aware how we think and speak about harm reduction while we teach undergraduate students. Sharma et al. (2017, p.5) underline the importance of "de-stigmatization education" for all health practitioners for the starting point to eliminate stigma. Given the role of nurses in power relations between government agents and public (Perron et al., 2004) we should reconceptualize substance use in nursing education to enhance the focus on empowering support and move away from an approach that constructs PWUSs as problematic.

As reflected in 'what nurses must do' discourses, professional authorities in nursing emphasize that nurses have to engage in harm reduction practices because ethical responsibilities of a nurse require to follow harm reduction philosophy. Teaching nursing students to be conscious of their own power in relation to care provided with marginalized groups has also utmost importance. In practice, they are part of power relations, therefore, the way that they exercise power, or their inattention to the language they use might be harmful and destructive. Student nurses should be prepared, gain knowledge and awareness regarding practice or interactions with marginalized and vulnerable groups.

3.3 Implications for Practice

Considering the findings of this study, it can be concluded that clinical guidance documents for hospital settings are needed to ensure dignity of PWUSs is not eroded by nurses' attitudes, skill gaps, and knowledge limitations. As hospital settings are places of contested power (Rhodes, 2012; McNeil et al., 2014) wherein discourses are lived out and authoritative policies may be enacted, such guidance documents could help nurses to prevent harms occurring within the health system against PWUSs. Additionally, these documents may remind nurses of their requirement to deliver non-judgmental practices like harm reduction.

As nurses are an integral part of harm reduction in action, the findings who how evidence-based rhetoric performs in a certain sense to set the boundaries of nursing practice. In this case, it can be seen how evidence-based discourse functions in favor of harm reduction practices and ensures that nurses take up care for PWUSs even if they

personally have biases against such patients. Practice leaders in nursing can use this approach of ensuring that nurses must practice harm reduction by leaning on professional responsibilities and the direct connection between core principles of nursing and harm reduction philosophy.

3.4 Implications for Research

The most complex of the discourses presented herein is that of the self-responsible citizen, which creates both a platform for empowerment and for abandonment. The relationship with self-responsibility means that PWUSs can both be involved in delivery of harm reduction services and blamed for failures in service delivery. This opens significant opportunity for research that is participatory in nature looking at refining the policy structure of harm reduction service delivery in health care. This can be supported by knowledge creation such as mapping the power networks in health systems. Uncovering how nurses may collaborate with PWUSs to enact power and knowledge may allow for tangible ways to move from criminalization to a focus on health. This will create the very evidence to be propelled by the evidence-based discourse. Implementation science research could follow, assessing how policy reforms roll out in real-world environments.

3.5 References

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Appendix

Table 1

Documents related to harm reduction and substance use

Content	Jurisdictions	Year	Document Title	Relevancy
Prolonged discussion of harm reduction (focused or disseminated throughout document)	British Columbia	2011	BC Nurses' Union Harm Reduction: Position Statement	Position statement
	British Columbia	2014	BC Harm Reduction Strategies and Services Policy and Guidelines	Policy document
	Canadian Nurses Association	2016	Focus on Harm Reduction for Injection Drug Use in Canadian Prisons: A Supplement to CNA's Harm Reduction Discussion Paper	Discussion paper
	Manitoba	2016	Chief Provincial Public Health Officer Position Statement: Harm Reduction	Position statement
	Manitoba	2016	Winnipeg Regional Health Authority Position Statement on Harm Reduction	Position statement

	Canadian Nurses Association	2017	Harm Reduction and Illicit Substance Use: Implications for Nursing	Discussion paper
	Canadian Nurses Association	2018	Harm Reduction for Non-Medical Cannabis Use	Discussion paper
	New Brunswick	2018	Non-Medical Cannabis Use	Position statement
	Alberta	2018	Integrating a Harm Reduction Approach to Nursing	Position statement
	Canadian Nurses Association	2018	Harm Reduction and Substance Use: Joint Statement	Position statement
	British Columbia	2018	BC Centre for Disease Control Harm Reduction Position Statement	Position statement
	Alberta	2019	Harm reduction: A Harm Reduction Approach	Information sheet
	Alberta	2019	Harm reduction: Ethics & Harm Reduction	Information sheet
	Alberta	2020	Psychoactive Substance Use Policy	Policy document
	Alberta	2020	Management of Substance Use in Acute Care Settings in Alberta: Guidance Document	Guidance document
General discussion of harm reduction (equal to or less than a few paragraphs)	British Columbia	2017	Provincial Guidelines for Biopsychospiritual Withdrawal Management Services for Adults	Guideline

	British Columbia	2017	Provincial Guidelines for Biopsychospiritual Withdrawal Management Services for Youth	Guideline
	Prince Edward Island	2017	Prince Edward Island Action Plan to Prevent and Mitigate Opioid Overdoses and Deaths	Action plan
Short discussion of harm reduction (equal to or less than a few sentences)	British Columbia	2013	Improving Health Services for Individuals with Severe Addiction and Mental Illness	Action plan
	Prince Edward Island	2018	A Policy and Legislative Framework for Prince Edward Island: Cannabis Legalization	Guidance document
Strategies of harm reduction	British Columbia	2010	Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia	Ten-year action plan
	Saskatchewan	2011	Saskatchewan's HIV Strategy Update	Policy document
	British Columbia	2012	BC Guidance Document for Supervised Injection Services	Guidance document
	Nunavut	2012	A New Approach: Halting the Harm	Action plan
	Ontario	2014	Recommendations for the Public Health Response to Hepatitis C in Ontario	Guidance document

Saskatchewan	2014	Working Together for Change: A 10-Year Mental Health and Addictions Action Plan for Saskatchewan	Action plan
New Foundland and Labrador	2015	Towards Recovery: Action Plan for The Mental Health and Addictions Action Plan for Newfoundland and Labrador	Action plan
New Foundland and Labrador	2016	Opioid Agonist Treatment (OAT)	Information sheet
Nunavut	2016	Taking Steps to Reduce Alcohol-Related Harm in Nunavut	Action plan
Northwest Territories	2016	Backgrounder: Opioid Abuse and Naloxone Availability in the Northwest Territories	Fact sheet
New Foundland and Labrador	2017	Towards Recovery Report Card: The first Six Month	Action plan
Canadian Nurses Association	2017	Fact Check: Dispelling Myths About Supervised Consumption Sites	Fact sheet
Canadian Centre on Substance Use and Addiction	2017	Finding Quality Addiction Care in Canada: Drug and Alcohol Treatment Guide	Guidance document

British Columbia	2017	A Guideline for the Clinical Management of Opioid Use Disorder	Guidance document
British Columbia	2017	Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder	Guidance document
British Columbia	2018	Treatment of Opioid Use Disorder During Pregnancy – Guideline Supplement	Guidance document
Quebec	2018	An Act to constitute the Société québécoise du cannabis, to enact the Cannabis Regulation Act and to amend various highway safety related provisions	An Act
British Columbia	2018	Treatment of Opioid Use Disorder for Youth – Guideline Supplement	Guidance document supplement
Yukon	2018	Yukon's Opioid Action Plan	Action plan
British Columbia	2018	Bag Valve Masks for Overdose Response	Position statement
British Columbia	2018	Retrieval of Used Needles	Position statement
Saskatchewan	2018	Safer Crystal Meth Smoking Brochure	Information sheet
Saskatchewan	2018	Safer Crack Smoking Brochure	Information sheet

Saskatchewan	2018	Safer Ways to Use Cocaine and Crack	Information sheet
British Columbia	2019	Blue Lights in Washrooms	Position statement
British Columbia	2019	Observed Consumption Services	Position statement
British Columbia	2019	The Importance of Harm Reduction	Position statement
Alberta	2019	Reducing Stigma	Information sheet
Alberta	2019	Patient & Family-Centred Care in Harm Reduction	Information sheet
Alberta	2019	Abstinence & Harm Reduction	Information sheet
Alberta	2019	Recovery-Oriented Care	Information sheet
Alberta	2019	Continuity of Care + Harm Reduction = Lives Saved	Information sheet
Prince Edward Island	2019	PEI Chief Public Health Office Strategic Plan 2019-2021	Action plan
Northwest Territories	2019	Mental Wellness and Addictions Recovery Action Plan	Action plan
Canadian Centre on Substance Use and Addiction	2020	Submission to Health Canada consultation to inform proposed new regulations for supervised consumption sites and services	Policy brief

	British Columbia	2021	Toward the Heart	Quick access for harm reduction resources (e.g. a catalogue of supplies, safer drug use, naloxone pilot program, and referrals to other health services.
	Nova Scotia	2021	Nova Scotia's Opioid Use and Overdose Framework	Action plan
	Alberta	N.D.	Supervised Consumption Services Evidence and Services	Fact sheet
Eliminated due to date	Government of Canada	1996	Controlled Drugs and Substances Act (CDSA)	An Act
	British Columbia	2002	Methadone Maintenance Treatment	Guidance document
	British Columbia	2004	Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance use and Addiction	Guidance document

British Columbia	2005	Harm Reduction: A British Columbia Community Guide	Harm reduction guidance document
British Columbia	2006	Following the Evidence: Preventing Harms from Substance Use in BC	Guidance document
British Columbia	2007	Housing & Supports for Adults with Severe Addictions and/or Mental Illness in B.C.	White paper
Nova Scotia	2009	Halifax Regional Municipality Substance Abuse Prevention Policy	Policy document
British Columbia	2009	Prevention of Harms Associated with Substances (Model Core Program Paper)	Evidence review
New Brunswick	2009	Methadone Maintenance Treatment Policies and Procedures	Guidance document
Ontario	2008	RNAO Supports Access to Harm Reducing Health Care Services, including INSITE	Position statement

Table 2

Documents and discourse themes

Document title	Self-responsible citizen	The rhetoric of evidenced - based practice	What nurses must do
BC Harm Reduction Strategies and Services Policy and Guidelines	✓	✓	
BC Nurses' Union Position Statement: Harm reduction	✓	✓	✓
Psychoactive Substance Use Policy	✓		✓
Focus on Harm Reduction for Injection Drug Use in Canadian Prisons: A Supplement to CNA's Harm Reduction Discussion Paper Needle Sharing and Substance Use in Prisons	✓	✓	✓
Harm Reduction: A Harm Reduction Approach	✓		✓
Integrating a Harm Reduction Approach to Nursing	✓	✓	✓
Management of Substance Use in Acute Care Settings in Alberta: Guidance Document	✓	✓	✓
Chief Provincial Public Health Officer Position Statement: Harm Reduction	✓	✓	
Winnipeg Regional Health Authority Position Statement on Harm Reduction	✓	✓	

Harm Reduction and Illicit Substance Use: Implications for Nursing	✓	✓	✓
Harm Reduction for Non-Medical Cannabis Use	✓	✓	✓
Harm Reduction and Substance Use: Joint Statement	✓	✓	✓
Non-Medical Cannabis Use	✓	✓	✓
Cannabis legalization: A policy and legislative framework for Prince Edward Island	✓		
BC Centre for Disease Control Position Statement	✓	✓	
Harm Reduction: Ethics & Harm Reduction			✓
Provincial Guidelines for Biopsychospiritual Withdrawal Management Services for Adults	✓	✓	
Provincial Guidelines for Biopsychospiritual Withdrawal Management Services for Youth	✓	✓	
Prince Edward Island Action Plan to Prevent and Mitigate Opioid-Related Overdoses and Deaths	✓	✓	
Improving Health Services for Individuals with Severe Addiction and Mental Illness	✓		

Note. ✓ Reflects the relevant discourses in documents.

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