
Electronic Thesis and Dissertation Repository

10-5-2021 12:00 PM

An Epidemic Amidst a Pandemic: A Critical Policy Analysis of Supervised Consumption Sites

Vanisa Ezukuse, *The University of Western Ontario*

Supervisor: Oudshoorn, Abram, *The University of Western Ontario*

Co-Supervisor: Lloy, Wylie, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Health and Rehabilitation Sciences

© Vanisa Ezukuse 2021

Follow this and additional works at: <https://ir.lib.uwo.ca/etd>



Part of the Community Health Commons, Comparative and Foreign Law Commons, Comparative Politics Commons, Health Law and Policy Commons, Human Rights Law Commons, Public Affairs, Public Policy and Public Administration Commons, Public Health Commons, Public Health and Community Nursing Commons, and the Social Justice Commons

Recommended Citation

Ezukuse, Vanisa, "An Epidemic Amidst a Pandemic: A Critical Policy Analysis of Supervised Consumption Sites" (2021). *Electronic Thesis and Dissertation Repository*. 8344.
<https://ir.lib.uwo.ca/etd/8344>

This Dissertation/Thesis is brought to you for free and open access by Scholarship@Western. It has been accepted for inclusion in Electronic Thesis and Dissertation Repository by an authorized administrator of Scholarship@Western. For more information, please contact wlsadmin@uwo.ca.

Abstract

This study's primary purpose is to critically appraise current federal and provincial policies regarding supervised consumption sites (SCS), noting intended and unintended consequences; and how these policies could impact SCS users. This study's secondary goal is to compare current policies related to SCS in Alberta, British Columbia, Ontario, and Quebec to provide critical insight and suggestions for ongoing policy development. Carol Bacchi's (2009) "What is the Problem Represented to Be?" framework was applied to the Canadian policy document with a focus on SCS. Four themes are proposed: Public Health versus Criminality, Presumptions versus Assumptions, Policy Unaccountability, and Policy Duality. It is concluded that Canadian SCS federal policy should be more in line with provincial policy documents that framed substance use as a public health issue and the need for a continuum of care. It should encourage a more inclusive and comprehensive strategy that collaborates better with people who use drugs.

Keywords

Supervised consumption sites, opioid overdose crisis, critical policy analysis, substance use comparative analysis, harm reduction strategies, drug policy, provincial drug policy, Ontario consumption site policy, Alberta consumption site policy, Quebec consumption site policy, British Columbia consumption site policy

Summary for Lay Audience

The ongoing rise in substance use and related harms in Canada has been a source of concern, prompting the issue to be labelled a "public health crisis of epidemic proportions." Larger factors like public health and economic policies, socioeconomic and structural contexts like poverty, criminalization, social distress, lack of opportunity, unstable housing, substandard living and working conditions, and microenvironments like social relations, drug accessibility, drug user practice, and substance use problems all work together to contribute to the problem.

The implementation of supervised consumption sites (SCS) is one strategy for dealing with Canada's expanding substance use crisis. SCS is a legally licenced site where people can inject and smoke illegal substances under the supervision of trained staff, as part of a harm reduction policy that recognizes that complete abstinence from substance use is not always a realistic goal. The major goal of this research is to examine current federal and provincial policies on SCS, noting both intended and unforeseen implications, as well as how these regulations may affect SCS users. The secondary purpose of this research is to compare current SCS policies in Alberta, British Columbia, Ontario, and Quebec in order to provide recommendations for future policy formulation. Carol Bacchi's (2009) framework "What is the Problem Represented to Be?" was used to assess three federal and five provincial SCS policies.

The study revealed that Canada's current legal framework falls short in terms of being non-discriminatory, avoiding arbitrary decisions, and ensuring that decisions are based on facts. Canadian SCS federal policy should be more aligned with provincial policy documents that frame substance use as a public health issue and emphasize the need for a continuum of care. For the substance use problem to be successfully addressed, it should support a more inclusive and comprehensive strategy that involves those who use drugs as partners.

Acknowledgments

My master's education and thesis work were supported by several people, all of whom deserve recognition. I consider myself extremely fortunate to have had Dr. Abe Oudshoorn as my primary supervisor, who provided consistent guidance, insight, and mentorship in a patient and courteous manner. It was through him that I learned to approach problems in a new way. He has had an academic and non-academic impact on my life. He has had a significant impact on my future educational goals. Dr. Lloy Wylie, my co-supervisor has been an excellent mentor from the moment of conception to completion of this thesis. As a champion of equitable health, she provided wisdom and unwavering support for this thesis. Dr. Geoff Bardwell, a member of my advisory committee, has continued to challenge my critical thinking and supported my growth as an academic all the way from British Columbia. The opportunity to learn from you all has been a great honour.

My heartfelt thanks go to my family and friends for their unwavering support and encouragement throughout this project. My parents, the Ezukuses, for enlightening me to the flaws in policy documents. Danisa, Biniosa, Joy, and Kenechi for scrutinizing my writing and ensuring that those who are not the intended audience can understand it. In addition, my family and friends who have always supported me emotionally, intellectually and unconditionally. Thank you for all that you have done and continue to do for me.

Table of Contents

Abstract.....	ii
Summary for Lay Audience.....	iii
Acknowledgments.....	iv
Table of Contents.....	v
List of Tables.....	viii
List of Appendices.....	ix
List of Abbreviations.....	x
Chapter 1.....	1
1.1 Background and Significance.....	1
1.1.1 Significance.....	6
1.2 Purpose.....	7
1.3 Research Questions.....	8
1.4 Theoretical Perspective.....	8
1.5 Methodology.....	9
1.5.1 What is the Problem Represented to be?.....	11
1.5.2 Structure of the Thesis.....	13
1.6 References.....	13
Chapter 2.....	24
2.1 Introduction.....	24
2.2 Literature Review.....	25
2.2.1 Analysis of the Impact of Supervised Consumption Sites Policies.....	26
2.2.2 Facilitators and Barriers to Creating Policy for Supervised Consumption Sites.....	31
2.2.3 Analysis of Policies that Limit Supervised Consumption Sites.....	37
2.2.4 Literature Summary.....	38

2.3 Ethical Approval	40
2.4 Methods.....	40
2.4.1 Theoretical Perspective	40
2.4.2 Methodology	41
2.4.3 Data Retrieval and Screening.....	42
2.4.4 Data Management	44
2.4.5 Data Analysis	44
2.4.6 Ensuring Quality	48
2.5 Acknowledgment of Self	49
2.6 Jurisdictional and Legal Overview	49
2.7 Findings.....	50
2.7.1 Problem Representation	51
2.7.2 Presumptions and Assumptions in the Problem Representation.....	55
2.7.3 Discourses Constructed Through Policy Preambles	59
2.7.4 Silences in Policy	61
2.7.5 Potential Effect of Problem Representation (discursive, subjectification, and lived)	66
2.7.6 Production, Dissemination, and Defence of the Problem.....	72
2.7.7 Self- Reflection	73
2.8 Discussion.....	74
2.8.1 Implicit Philosophies represented in Federal SCS Policy	74
2.8.2 Presumed manifest and latent effects of the current Canadian SCS policies	77
2.8.3 Federal Policy Impact on Provincial SCS Policy	79
2.8.4 How do Alberta, British Columbia, Ontario, and Quebec Compare?	80
2.9 Implications.....	84
2.10 Limitations	86

2.11 Conclusion	88
2.12 Reference	91
Chapter 3	102
3.1 Implications for Policy.....	102
3.2 Implications for Research	105
3.3 Implications for Practice	106
3.4 Implications for Education.....	108
3.5 Conclusion	109
3.6 References.....	109
Appendices.....	112
Curriculum Vitae	137

List of Tables

Table 1-Carol Bacchi’s (2009) “What’s the Problem Represented to Be?” Approach	41
Table 2- Matrix for WPR framework for analyzing Canadian federal supervised consumption site policies.....	44
Table 3- Matrix for WPR framework for analyzing Alberta, British Columbia, Ontario, and Quebec supervised consumption site policies.....	46
Table 4- Federal Government Policy Reflections.....	112
Table 5- Provincial Documents reflection	117
Table 6- Matrix filled for WPR framework for analyzing Canadian federal supervised consumption site policies	131
Table 7-Matrix filled for WPR framework for analyzing Alberta, British Columbia, Ontario, and Quebec supervised consumption site policies.....	134

List of Appendices

Table 4- Federal Government Policy Reflections.....	1123
Table 5- Provincial Documents reflection	1178
Table 6- Matrix filled for WPR framework for analyzing Canadian federal supervised consumption site policies	132
Table 7-Matrix filled for WPR framework for analyzing Alberta, British Columbia, Ontario, and Quebec supervised consumption site policies.....	135

List of Abbreviations

SCS- Supervised Consumption Sites

HIV- Human Immunodeficiency Virus

PWUD – People Who Use Drugs

PWID – People Who Inject Drugs

WPR – “What’s the Problem Represented to Be?”

CDSA – Controlled Drugs and Substances Act

UN – United Nations

WHO – World Health Organization

Chapter 1

1.1 Background and Significance

Widespread awareness of the proliferation of substance use-related harms in Canada has accelerated since the turn of the millennium. The continuous rise of substance use-related harms in Canada has been the topic of concern that has led to the issue being termed a public health crisis of "epidemic proportions" (Malkin et al., 2003; Nosyk et al., 2013; Vashishtha et al., 2017). Over the past decade, Canada's opioid-related harm rates have risen, with the death toll increasing to 4395 deaths across Canada in 2020 (January to September), a mortality rate of 16.0 per 100,000 people (Public Health Agency of Canada, 2021). To contextualize this statistic, it is equivalent to 16 individuals dying each day from an opioid overdose. The current COVID-19 pandemic has impacted the overdose crisis with 3351 opioid toxicity deaths occurring between April 2020 to September 2020, a 74% increase from the prior six months, with British Columbia, Alberta, and Ontario accounting for 85% of all opioid toxicity deaths (Public Health Agency of Canada, 2021). Opioid overdose is just the tip of the iceberg in the substance use crisis in terms of harm. According to the National Ambulatory Care Reporting Systems and Hospital Morbidity Database, 70.4 Canadians were hospitalized each day due to opioid-related harm in Canada in 2017 (Belzak & Halverson, 2018; Froot & Paltser, 2019). This matter is not limited to persons who use illegal or illicitly acquired substances; instead, evidence suggests that this is a health and social crisis that affects people in all communities across nations, across all ages, and all socio-economic groups (Belzak & Halverson, 2018; Phillips et al., 2017).

According to Health Canada (2021), the substantial rise of substance-related harms, with the primary focus on opioids, is attributed to many factors, including high rates of opioid prescribing and the introduction of potent synthetic opioids in the illicit substance market, such as fentanyl and carfentanyl. However, utilizing a risk environment framework illustrates how social context affects substance-related harms (Rhodes, 2002; Rhodes, 2009). An emphasis on the risk environment shows the social conditions and locations where harm is generated and minimized. The risk environment can be described as the space in which a variety of factors—social, economic, physical and policy—interact to

increase the likelihood of opioid-related harm (Barry, 2018; Bungay et al., 2010; Fraser, 2011; Hansen, 2017; Rhodes, 2002; Rhodes, 2009). Hence, macro factors such as public health and economic policies, socio-economic and structural contexts such as poverty, criminalization, social distress, lack of opportunity, unstable housing, substandard living and working conditions, and microenvironments like social relations, accessibility to substances, substance user practices, and substance use problems operate synergistically (Boyd et al., 2018; Bungay et al., 2010; Fraser, 2011; Hansen, 2017; Rhodes 2009). The stated factors increase vulnerability to substance-related risks and harms. These risk environment dynamics create disparities that leave populations at higher risk of substance use (Boyd et al., 2018; Rhodes, 2002, Rhodes 2009). For example, in more impoverished and/or smaller communities, the employment market is dominated by manufacturing and service jobs with elevated physical hazards. Over the years, on-the-job injuries can give rise to chronically painful conditions. Combined with a lack of access to harm reduction and appropriate healthcare services, the resulting environment can encourage problematic substance use, potentially resulting in a downward spiral of disability and poverty, which leads to the cyclical perpetuation of substance use (Dasgupta et al., 2018).

The increased importation and manufacturing of highly potent synthetic opioids supplying the illegal market, such as fentanyl and the more potent carfentanil, plays a significant role in the opioid epidemic (Barry, 2018; Do Minh et al., 2018; Fairbairn et al., 2017). Between January and September 2020, fentanyl and its analogues were involved in 82% of accidental apparent opioid toxicity deaths (Public Health Agency of Canada, 2021). Fentanyl is an opioid agonist for treating severe pain, with a potency that is 50 to 100 times that of morphine (Fairbairn et al., 2017). The emergence of illicit fentanyl, mainly when mixed with heroin and counterfeit oxycodone, has resulted in the rapid increase of opioid overdoses (Ciccarone, 2017). Although the expansion of opioid availability may have catalyzed overdose rates, eroded social capital in marginalized communities, accompanied by hopelessness, despair, and many more macro, micro, social, physical, economic and policy factors, all contribute to opioid use disorders and use of other substances in seeking pleasure or relief (National Academies of Science, 2017; Rhode 2002).

The severity of the substance use crisis is not limited to the number of deaths and overdose but includes the spread of serious infections associated with injection substance use, social and mental impairment, and other substance-related harms. Infections play a significant role in morbidity and mortality among substance users, particularly those who inject substances (Ronan & Herzig, 2016). Using substance intravenously contributes to transmitting blood-borne viral infections such as Hepatitis B, Hepatitis C or the human immunodeficiency virus (HIV) via syringe sharing (Ezard, 2001; Morin et al., 2017). Additionally, numerous other physical problems can result from substance injection, including other viral and bacterial infections, abscesses, cutaneous lesions, locomotive disorders, and liver disease (Des Jarlais et al., 1994; Ezard, 2001; Hurley et al., 1997; Portier et al., 2014). Substance use is also associated with adverse health consequences such as respiratory diseases, cardiovascular diseases, cancer, violence, sexual harassment, discrimination within health and social service, gendered and racialized violence (Bardwell et al., 2021; Brook et al., 2009).

As mentioned above, one of the earlier public health concerns that arose from the substance use crisis is the increase in Hepatitis C and HIV. The general population in Canada has seen a decrease in Hepatitis C infection; however, people who use substances intravenously continue to be at increased risk for Hepatitis C infection and HIV by sharing drug preparation and injection materials (Payne et al., 2014). Approximately 68% of the people who inject substances had evidence of a current or past Hepatitis C infection, and upwards of 10% of people who inject substances may be co-infected with HIV and Hepatitis C (Public Health Agency of Canada, 2014). According to 2014 national estimates, the HIV incidence rate was 439 per 100,000 people who inject substances, which is 59 times higher than those who do not inject substances (Public Health Agency of Canada, 2014; Yang et al., 2016). Although the prevalence of HIV in people who use intravenous substances is on the rise in larger Canadian cities, the mobility of people who inject drugs (PWID) and their interactions with other PWID in smaller communities suggest that the problem is not limited to cities (Yang et al., 2016).

The effects of substance use are not limited to physical illness. Over 50% of people who use drugs (PWUD) also have a mental health disorder (Astals et al., 2008; Canadian Centre

on Substance Abuse, 2010). PWUD—the widely accepted, standard terminology to refer to individuals who uses substances—may also experience social issues that affect health, such as homelessness, unemployment, physical and sexual abuse, family and social relationship issues, social exclusion, criminalization and incarceration, and stigma and discrimination in a healthcare setting (Richardson et al., 2013; Wang et al., 2016). Conversely, these social and structural environments are often drivers of substance use and related harms.

The implementation of harm reduction strategies presents a unique, client-centred, and pragmatic solution to Canada's growing substance use issue. Harm reduction refers to strategies grounded in public health and human rights, aiming to reduce substance use's adverse health and social consequences without necessarily decreasing substance consumption (Barry, 2018; McGinty et al., 2018). This approach emphasizes practical rather than idealized goals (Single, 1995). Harm reduction differs from other models that address substance use, in that it does not require individuals to remove their primary coping mechanism of substance use until a new coping mechanism is in place. Harm reduction creates a possible avenue for health promotion, and for some, it is a pathway towards reducing use (Macdonald, 2011). Various harm reduction strategies have gained traction in recent years as substance use, especially prescription opioids, widespread availability and cheaper cost of illegal substances, and potent synthetic opioids, continue to increase mortality (Health Canada, 2021; McGinty et al., 2018). To name a few, substance-related harm reduction initiatives in Canada have included supervised consumption sites (SCS), overdose prevention sites, substance checking services, and overdose reversal kits (naloxone) (Health Canada, 2021). One prominent policy approach used to address Canada's growing national substance use epidemic is the establishment of SCS. This particular approach is the focus of this thesis.

SCS offers a hygienic environment in which pre-obtained substances can be used under trained staff supervision (Kerr et al., 2017; Watson et al., 2013). SCS, by definition, is a legally licenced site where people can inject and smoke otherwise illegal substances under the supervision of qualified personnel, in compliance with a harm reduction strategy that acknowledges that abstinence from substance use is not always a reasonable target

(Hedrich, 2004). Workers from SCS do not directly handle substances or give injections, but they are available to provide sterile injection materials, answer questions about safe injection procedures, provide first aid when appropriate, and control overdoses. SCS – also known as drug consumption facilities, drug consumption rooms, supervised injection facilities (SIF), supervised smoking facilities (SSF), and other applicable terms – are an example of an intervention to improve the health and general well-being of PWUD (Kimber et al., 2003). SCS plays a vital role in a more comprehensive public health approach to drug policy (Russell et al., 2020).

The main goals of SCS includes the reduction of disease transmission, overdose, public illicit substance use, and improving access to health and social services (Kimber, Dolan, & Wodak, 2005). SCS typically aims to provide clean injection equipment, education for safer injecting, an urgent medical response during overdose and health, social and rehabilitation referrals (Broadhead et al., 2002). SCS have decreased the transmission of infections, public substance use, and death due to overdose (Kennedy et al., 2017). A retrospective population-based study done on North America's first medical SCS called Insite, found that, of persons living within 500 m of the SCS (70% of SCS users), overdose deaths decreased from 253 to 165 per 100 000 people per year and the absolute risk difference was 88 deaths per 100 000 persons, per year; 1 overdose death was prevented annually for every 1137 users (Marshall et al., 2011). SCS successfully refer individuals to various external programs, including detoxification and addiction treatment programs (Kerr et al., 2005; Wood et al., 2004, 2006, 2007).

Furthermore, evidence indicates that SCS does not increase crime or promote initiation into injecting (Kerr et al., 2005; Wood et al., 2006), and SCS are cost-effective (Bayoumi & Zaric 2008; Pinkerton, 2010). SCS leads to a reduction in risky substance-related behaviours such as syringe sharing during injection, syringe reuse, and unsafe sexual practices (Bell & Gliberman, 2014; Potier et al., 2014). A rapid review of SCS literature discovered these sites to increase client safety, improve access to overdose care, and provide other nursing services (Caulkins et al., 2019). Abscesses and other injection-related wounds and illnesses are cared for by the nurses and transportation to other health and

social service centres, psychosocial counselling, and referrals to other facilities (Bell & Globerman, 2014).

Given the ongoing challenges with substance use throughout Canada, several municipalities across Canada have been undertaking SCS feasibility research and are developing plans for establishing SCS. There are currently 37 federally sanctioned SCS currently offering services across Canada as of May 2021, with five in Alberta, eight in British Columbia, four in Quebec, nineteen in Ontario, and one in Saskatchewan (Health Canada, 2021; Lingle, 2013; Ng, Sutherland, & Kolber, 2017).

1.1.1 Significance

Recent research on SCS and their associated terms usually involve efficacies, community perspectives, and organizational views. While practices and experiences are essential, further research is needed to investigate the policies surrounding SCS in Canada because, despite the evidence supporting the effectiveness of SCS in reducing the harms associated with the overdose epidemic, Canada has been slow to implement more SCS, and or expand the current ones while the substance-related harm rate continues to increase. The primary focus of this study is to appraise the current Canadian SCS policy landscape. Understanding the intended and the unintended implications offers insight into the implicit philosophies embodied in existing policies on SCS, illuminating whose interest is expressed in the policy. This understanding ensures that SCS have the appropriate policies framing their work that encourage best practices and aid in better health outcomes for people who use drugs (PWUD). SCS is still in the novice policy realm, meaning its policies are fairly new and have room for further development and growth, therefore, cross-comparisons are valuable for provinces participating in SCS programs. Such comparisons allow for mutual learning by analyzing how provinces that bear similarities create policy and change laws around this service to understand parallels and differences that shape SCS best practices. Alberta, British Columbia, Ontario, and Quebec have been chosen as the focus for this comparative critical policy analysis. In 2003, British Columbia became the first province to implement an SCS. It was given a legal exception under the federal Controlled Drugs and Substance Act shortly after its creation, allowing it to function legally. The government of Canada took a significant

step in 2017 by amending CDSA to make it easier to apply for permission to operate SCS (Davidson 2020; Tsang 2020). Despite the passage of this legislation, only five of Canada's thirteen provinces and territories account for all SCS (Health Canada, 2021). The decision-making context surrounding the development of SCS remains complex and requires multi-jurisdictional collaboration to open and operate (Bernstein & Bennet, 2013; Manson-Singer & Allin, 2020). In the Canadian context, the federal government sets criminal laws that apply to all provinces, while provinces are responsible for the delivery of healthcare. SCS is a type of healthcare measure. Four of the five provinces with active SCS have been selected for comparison. Saskatchewan was excluded from the provincial policy comparison because its first legally sanctioned SCS was only recently approved – on March 21, 2021 – while the thesis was already in progress (Health Canada, 2021). Secondly, Saskatchewan was left out because no readily accessible policy documents exist for this critical policy analysis. Alberta, British Columbia, and Ontario are ideal for comparison because they have comparable provincial health policies and the highest burden of substance-related harms, accounting for 85 percent of all opioid toxicity-related deaths between January and September 2020, with British Columbia accounting for 1243, Alberta accounting for 810, and Ontario accounting for 1693 (Public Health Agency of Canada, 2021). The SCS policy of Quebec is included, as it provides a unique policy insight, as social and health services in this province are integrated under one governmental authority. These four provinces also have distinct political climates, which are reflected in their policy documents. Alberta's current ruling party is Conservative, while British Columbia's is New Democratic Party, Ontario is Liberal, and Quebec is the Coalition Avenir Quebec (Ruff & McIntosh, 2020). These four provinces provide a unique perspective on their respective provincial SCS policy environments.

1.2 Purpose

This study's primary purpose was to critically appraise current federal and provincial policies regarding SCS, particularly noting intended and unintended consequences of the policy; and how these policies could impact SCS users. This study's secondary goal was to

compare current policies related to SCS in Alberta, British Columbia, Ontario, and Quebec to provide critical insight and suggestions for ongoing policy development.

1.3 Research Questions

1. What are the implicit philosophies represented in current policies on SCS?
2. What are the presumed manifest and latent effects of the current Canadian SCS policies and how could these impact SCS site users?
3. How do SCS policies in Alberta, British Columbia, Ontario, and Quebec compare?
4. As policy across orders of government is interactive, how do the presumed manifest and latent effects of federal SCS policy impact provincial SCS policies?

1.4 Theoretical Perspective

A variety of critical theorists argue that truth exists as realities shaped by political, gendered, cultural, social, and economic factors (Ford-Gilboe et al., 1995; Weaver & Olson, 2006). Critical theory research includes the process of reflection on how things could be and uses research as a means to take action (Maguire, 1987; Thorne et al., 1999; Weaver & Olson, 2006); this includes theory as praxis to effect transformation (Mill et al., 2001; Weaver & Olson, 2006). This work is informed by three principles of critical theory. The first concerns data collection, analysis, and interpretation. Critical research should connect data to their historical context (Lunn, 2009). The second is the dialectical process critical theorists employ to critique current society (Lunn, 2009; Thorne et al., 1999; Weaver & Olson, 2006). SCS is ideal for dialectical discussion since the surrounding socio-political context is continually changing, evolving, and influenced by trends in politics, economics, and society. The last principle and the primary goal is to change society rather than explain it through a process of reasoning achieved through analyses that identify the potential for an improved future (Lunn, 2009).

Within the realm of critical theory, this study employs critical policy analysis (CPA). CPA involves scrutinizing policy, emphasizing criticality, whereby researchers and

analysts can recognize policy outcomes and processes. CPA illuminates neglected policy elements by evaluating relevant policy descriptions, which necessitate a careful analysis of cultural models, established power connections, and policy patterns (Joo et al., 2010). CPA aims to examine a policy's origins and outcomes while considering social justice and equity. CPA is distinct from other policy analysis perspectives in two main ways: 1) It produces reasonable and comprehensive policy interpretations by considering situational factors and sociocultural factors, and 2) CPA encompasses both an understanding of what is going on and why, as well as recommendations for solutions to the problem, in keeping with critical theory's goal (Troyna, 1994). CPA standards imply both a description and prescription of policy. 'Prescription' means the provision of steps to resolve the problems identified through the analysis process.

Studying policy through a critical framework allows for consideration of the complex social power and equity issues associated with SCS policies. In this study, CPA questioned the current Canadian SCS policies and critically examines their values. CPA in this situation exposed the values underlying policy issues and their proposed solutions (Fischer, 2000; Sullivan, 2007). The critical approach to policy can appraise values and effects that have been silent, meaning they allow for the understanding of manifest and latent effects grounded in evidence, which is the primary purpose of this study. The critique of current policy related to SCS helps identify the potentials for an alternative future for new SCS policies.

1.5 Methodology

Within an overarching critical theoretical lens, this research adopts Carol Bacchi's post-structuralist policy analysis, "What is the Problem Represented to be?" (WPR). Carol Bacchi is an Australian feminist, post-structuralist theorist, policy analyst, and scholar. Bacchi's approach to policy analysis extrapolates from Michel Foucault's (1977) work on 'problematization' and 'thinking problematically.' Foucault defines problematization as:

A set of discursive and non-discursive practices "that makes something enter into the play of the true and the false and constitutes it as an object for thought; whether

under the form of moral reflection, scientific knowledge, or political analysis" (Foucault 1988, p. 257).

Bacchi extends this idea to policy analysis stating that policies “*give shape* to ‘problems’; they do not *address* them” (Bacchi, 2009, p. x, emphasis original). Instead, ‘problems’ are *constituted* and *given meaning* through public policy’s representation of what the problem is (Bacchi, 2016). This approach calls attention to how the ‘problem representations’ implicit within policies give particular meaning to ‘problems’ and, in so doing, carry with them a limited range of solutions (Bacchi, 2009; Bacchi & Eveline, 2010; Barratt et al., 2017). Bacchi’s approach prompts thinking beyond seeking solutions but understanding the nature of the policy problem.

Bacchi’s denoted a key distinction between ‘problem,’ which implies a nature of an issue is fixed and discernible, well-understood, and ‘problematization,’ which describes the ways in which people create policy problems as they make sense of them. By considering the policy through Bacchi’s lens of problematization, we can begin to see the ways the policy generates (and reproduces) categories of social conventions in varying times and context; as such, it reflects the continually changing values in society (Lancaster et al., 2015; Seear & Fraser, 2014). Importantly, this focusing on the nature of problematizations makes it possible to resist dominant problem constructions and imagine how they might be constructed differently based on a different set of circumstances and policy imperatives.

Bacchi (2009) delineates six questions followed by an instruction to examine one’s analytic process’s assumptions instinctually. The six questions are; What is the problem represented to be in a specific policy? What presuppositions and assumptions underlie this representation of the “problem? How has this representation of the problem come about? What is left unproblematic in the problem representation? Where are the silences? What effects (are produced by this representation of the problem? How and where has this representation of the problem been produced, disseminated, and defended? How has it been, or could it be questioned, disrupted, and replaced? The six questions encourage critical scrutiny by probing the assumptions of what the problem is represented to be. It

discourages thinking about the problem in the policy as fixed and determined. This study employs an analysis using the six questions. Bacchi's six questions have been used to examine a range of drug policy issues; for example, this method was used to analyze the effects of laws prohibiting peer distribution of injecting equipment in Australia (see Fraser and Moore, 2011; Lancaster et al., 2015; Lancaster et al., 2011; Lancaster and Ritter, 2014). This developing body of research has started to identify the several ways that drug policies do not merely respond to substance use and addiction but circuitously produce the problem of substance use.

1.5.1 What is the Problem Represented to be?

Bacchi's critical policy analysis approach 'What is the Problem Represented to be?' (WPR) was used. The WPR approach questions the widely held belief that policies solve problems. WPR analyses the ways in which problems are produced and represented in policy (Pienaar & Savic, 2016). For instance, take a policy that promotes rehabilitation and addiction treatment for people who have an opioid use disorder (OUD) as a means to decrease the number of opioid-related harms. The policy implicitly represents the lack of rehabilitation and treatment options for people with OUD and assumes that people with OUD want to stop using opioids. To study this policy, there is a need to critically question how the absence of rehabilitation and treatment options for people with OUD is problematized, the grounds this representation of the "problem" rests upon, and its consequences. Conventional policy analysis focuses on problems as fixed entities within policies (Bacchi, 2009; Bacchi, 2016). To research according to the WPR approach, one starts from the proposed solution meaning the policy, and asks— "if the suggestion is that this form of change or intervention is required, what is the 'problem' represented (constituted) to be?" (Bacchi, 2016, p. 8). Bacchi's WPR approach helps explain why and how policies fail or succeed.

In contrast to traditional approaches to policy analysis that emphasizes problem-solving, WPR focuses on questioning the problem (Bacchi, 2009). This necessitates policy analysts and advocates to reflect on how certain perceptions of issues influence how the problem is handled and how the people involved are treated. In the SCS policy arena, where the notion of "substance issue" is natural, paying attention to the generative

position of policy in creating social problems is a must (Lancaster, Duke & Ritter, 2015). Suppose we are to disrupt the assumption that problems necessarily follow from SCS and expose the counterproductive effects of some harm reduction policies, specifically as it pertains to SCS. In that case, we need to denaturalize the very concept of 'opioid problems' underpinning much of SCS policy (Fischer et al., 2004). Bacchi's approach provides tools to pursue precise analytical thinking mode since it seeks to elucidate the depth of assumption underpinning problem representations and trace how such representations fit within policy interventions (Pienaar & Savic, 2016). Bacchi's WPR approach offers several forms of interrelated questions and analysis that can be followed in order or applied as part of an integrated analysis (Bacchi, 2009, p.48):

Question 1: What is the problem represented to be in a specific policy?

Question 2: What presuppositions—necessary meanings antecedent to an argument—and assumptions (ontological, epistemological) underlie this representation of the "problem" (problem representation)?

Question 3: How has this representation of the problem come about?

Question 4: What is left unproblematic in the problem representation? Where are the silences?

Question 5: What effects (discursive, subjectification, and lived) are produced by this representation of the problem?

Question 6: How and where has this representation of the problem been produced, disseminated, and defended? How has it been, or could it be questioned, disrupted and replaced?

Lastly, Bacchi discusses a seventh step that asks the researcher to apply the questions to one's problem representations.

All the stated questions could be applied to illuminate critical aspects of the policy documents. However, this study focuses on questions 1, 2, 4, and 5. Question 1 acts as the foundation for the analysis. The WPR focuses on deep-seated socio-cultural values

that are often taken for granted despite underpinning the debates, and question 2 sheds light on this matter. Question 4 demands an in-depth analysis of the gaps, consequences, and facilitators in the policy of study. Analyzing the effects or implications of specific problem representations (Question 5) involves considering how they may make it challenging to raise specific issues (Bacchi, 2016). In this way, WPR provides a critical evaluation of the legislative framework, policies, and policy proposals (Bacchi, 2016). Question 3 was addressed briefly but not in detail in this policy analysis because it calls into question the reasons for interventions, such as shifts in social attitudes or attention, changes in government, new knowledge, and new technology that alter social behaviour or make new interventions possible. This subject has already been discussed in many scholarly papers concerning SCS policy (see Baker & McCann, 2018; Hayle, 2015; Hayle, 2018; Ziegler et al., 2019; Zlotorzynska et al., 2013).

1.5.2 Structure of the Thesis

This thesis is organized in a three-chapter Manuscript format. The first chapter provides background information for the research, the second chapter is a complete publishable manuscript, and the third chapter discusses the study implications. As a publishable manuscript, chapter two includes a literature review, information on the study's methodology, findings, discussion, and implications, and therefore necessarily overlaps in part with chapters one and three.

1.6 References

- Astals, M., Domingo-Salvany, A., Buenaventura, C. C., Tato, J., Vazquez, J. M., Martin-Santos, R., & Torrens, M. (2008). Impact of substance dependence and dual diagnosis on the quality of life of heroin users seeking treatment. *Substance use & misuse*, 43(5), 612-632.
- Bacchi, C. (2009). Analysing Policy: Whats the problem represented to be. *Frenchs Forest*.
- Bacchi, C., & Eveline, J. (2010). Approaches to gender mainstreaming: What's the problem represented to be. *Mainstreaming politics: Gendering practices and feminist theory*, 111-138.

- Bacchi, C. (2016). Problematizations in health policy: Questioning how "problems" are constituted in policies. *Sage Open*, 6(2), 2158244016653986.
- Baker, T., & McCann, E. (2018). Beyond failure: The generative effects of unsuccessful proposals for Supervised Drug Consumption Sites (SCS) in Melbourne, Australia. *Urban geography*, 1-19.
- Bardwell, G., Austin, T., Maher, L., & Boyd, J. (2021). Hoots and harm reduction: a qualitative study identifying gaps in overdose prevention among women who smoke drugs. *Harm reduction journal*, 18(1), 1-10.
- Barratt, M. J., Seear, K., & Lancaster, K. (2017). A critical examination of the definition of 'psychoactive effect' in Australian drug legislation. *International Journal of Drug Policy*, 40, 16-25.
- Barry, C. L. (2018). Fentanyl and the evolving opioid epidemic: what strategies should policy makers consider?. *Psychiatric Services*, 69(1), 100-103.
- Bayoumi, A. M., & Zaric, G. S. (2008). The cost-effectiveness of Vancouver's supervised injection facility. *Cmaj*, 179(11), 1143-1151.
- Bell, S., & Globerman, J. (2014). What is the Effectiveness of Supervised Injection Services?. *Ontario HIV Treatment Network*, 89
- Belzak, L., & Halverson, J. (2018). Evidence synthesis-The opioid crisis in Canada: a national perspective. *Health promotion and chronic disease prevention in Canada: research, policy and practice*, 38(6), 224.
- Bernstein, S. E., & Bennett, D. (2013). Zoned Out: "NIMBYism", addiction services and municipal governance in British Columbia. *International Journal of Drug Policy*, 24(6), e61-e65.
- Boyd, J., Collins, A. B., Mayer, S., Maher, L., Kerr, T., & McNeil, R. (2018). Gendered violence and overdose prevention sites: a rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction*, 113(12), 2261-2270.

- Broadhead, R. S., Kerr, T. H., Grund, J. P. C., & Altice, F. L. (2002). Safer injection facilities in North America: their place in public policy and health initiatives. *Journal of Drug Issues*, 32(1), 329-355.
- Brook, J. S., Saar, N. S., Zhang, C., & Brook, D. W. (2009). Psychosocial antecedents and adverse health consequences related to substance use. *American Journal of Public Health*, 99(3), 563-568.
- Bungay, V., Johnson, J. L., Varcoe, C., & Boyd, S. (2010). Women's health and use of crack cocaine in context: Structural and 'everyday' violence. *International Journal of Drug Policy*, 21(4), 321-329.
- Canadian Centre on Substance Use and Addiction. (2010). *Substance Abuse in Canada: Concurrent Disorders* | Canadian Centre on Substance Use and Addiction. Canadian Centre on Substance Abuse (CCSA). <https://www.ccsa.ca/substance-abuse-canada-concurrent-disorders>
- Caulkins, J. P., Pardo, B., & Kilmer, B. (2019). Supervised consumption sites: a nuanced assessment of the causal evidence. *Addiction*, 114(12), 2109-2115.
- Ciccarone, D. (2017). Fentanyl in the US heroin supply: A rapidly changing risk environment. *International Journal of Drug Policy*, 46, 107–111. <https://doi.org/10.1016/j.drugpo.2017.06.010>
- Dasgupta, N., Beletsky, L., & Ciccarone, D. (2018). Opioid crisis: no easy fix to its social and economic determinants. *American journal of public health*, 108(2), 182-186.
- Davidson, N. M. (2020). Fighting Fatality: Insight into British Columbia's Sanctioning of Overdose Prevention Sites. *Health Reform Observer—Observatoire des Réformes de Santé*, 8(2).
- Des Jarlais, D. C., Friedman, S. R., Sotheran, J. L., Wenston, J., Marmor, M., Yancovitz, S. R., ... & Mildvan, D. (1994). Continuity and change within an HIV epidemic: injecting drug users in New York City, 1984 through 1992. *Jama*, 271(2), 121-127.

- Do Minh, T., Chang Vicky, C., Tibebe Semra, T. W., & Ugnat, A. M. (2018). Original quantitative research-Sentinel surveillance of suspected opioid-related poisonings and injuries: trends and context derived from the electronic Canadian Hospitals Injury Reporting and Prevention Program, March 2011 to June 2017. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice*, 38(9), 317.
- Ezard, N. (2001). Public health, human rights and the harm reduction paradigm: from risk reduction to vulnerability reduction. *International Journal of Drug Policy*, 12(3), 207-219.
- Fairbairn, N., Coffin, P. O., & Walley, A. Y. (2017). Naloxone for heroin, prescription opioid, and illicitly made fentanyl overdoses: challenges and innovations responding to a dynamic epidemic. *International Journal of Drug Policy*, 46, 172-179.
- Fischer, B. (2000). Prescriptions, power and politics: the turbulent history of methadone maintenance in Canada. *Journal of public health policy*, 21(2), 187-210
- Fischer, B., Turnbull, S., Poland, B., & Haydon, E. (2004). Drug use, risk and urban order: examining supervised injection sites (SISs) as 'governmentality'. *International Journal of Drug Policy*, 15(5-6), 357-365.
- Ford-Gilboe, M., Campbell, J., & Berman, H. (1995). Stories and numbers: Coexistence without compromise. *Advances in Nursing Science*, 18(1), 14-26.
- Foucault, M. (1977). *Language, counter-memory, practice: Selected essays and interviews*. Cornell University Press.
- Foucault, M. (1988). *Politics, philosophy, culture: Interviews and other writings, 1977-1984*. Routledge.
- Fraser, S. (2011). *The drug effect: Health, crime and society* (pp. 19-34). D. Moore (Ed.). Melbourne: Cambridge University Press.

- Fraser, S., & Moore, D. (2011). Governing through problems: The formulation of policy on amphetamine-type stimulants (ATS) in Australia. *International Journal of Drug Policy*, 22(6), 498-506.
- Frood, J., & Paltser, G. (2019). Types of Opioid Harms in Canadian Hospitals: Comparing Canada and Australia. *Healthcare quarterly (Toronto, Ont.)*, 22(2), 10-12.
- Hansen, H. (2017). Assisted technologies of social reproduction: pharmaceutical prosthesis for gender, race, and class in the white opioid "crisis." *Contemporary Drug Problems*, 44(4), 321-338.
- Hayle, S. (2015). Comparing drug policy windows internationally: Drug consumption room policy making in Canada and England and Wales. *Contemporary Drug Problems*, 42(1), 20-37.
- Hayle, S. (2018). A tale of two Canadian cities: comparing supervised consumption site (SCS) policy making in Toronto and Vancouver. *Drugs: Education, Prevention and Policy*, 25(5), 397-407.
- Health Canada. (2021). *Opioids and the opioid crisis – Get the facts*. Government of Canada. <https://www.canada.ca/en/health-canada/services/opioids/get-the-facts.html>
- Hedrich, D. (2004). *European report on drug consumption rooms* (p. 8). Luxembourg: Office for Official Publications of the European Communities.
- Hurley, S. F., Jolley, D. J., & Kaldor, J. M. (1997). Effectiveness of needle-exchange programmes for prevention of HIV infection. *The Lancet*, 349(9068), 1797-1800.
- Joo, K. P., & Kwon, I. T. (2010). Critical policy analysis: Investigating 'missing' values in the lifelong education system of South Korea.
- Kennedy, M. C., Karamouzian, M., & Kerr, T. (2017). Public health and public order outcomes associated with supervised drug consumption facilities: a systematic review. *Current HIV/AIDS Reports*, 14(5), 161-183.

- Kerr, T., Mitra, S., Kennedy, M. C., & McNeil, R. (2017). Supervised injection facilities in Canada: past, present, and future. *Harm reduction journal*, 14(1), 1-9.
- Kerr, T., Tyndall, M., Li, K., Montaner, J., & Wood, E. (2005). Safer injection facility use and syringe sharing in injection drug users. *The Lancet*, 366(9482), 316-318.
- Kimber, J., Dolan, K., Van Beek, I., Hedrich, D., & Zurhold, H. (2003). Drug consumption facilities: an update since 2000. *Drug and alcohol review*, 22(2), 227-233.
- Kimber, J., Dolan, K., & Wodak, A. (2005). Survey of drug consumption rooms: service delivery and perceived public health and amenity impact. *Drug and alcohol review*, 24(1), 21-24.
- Lancaster, K., Duke, K., & Ritter, A. (2015). Producing the 'problem of drugs': A cross national-comparison of 'recovery' discourse in two Australian and British reports. *International Journal of Drug Policy*, 26(7), 617-625.
- Lancaster, K., Hughes, C. E., Spicer, B., MATTHEW - SIMMONS, F. R. A. N. C. I. S., & Dillon, P. (2011). Illicit drugs and the media: Models of media effects for use in drug policy research. *Drug and Alcohol Review*, 30(4), 397-402.
- Lancaster, K., & Ritter, A. (2014). Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985–2010. *International Journal of Drug Policy*, 25(1), 81-87.
- Lancaster, K., Seear, K., & Treloar, C. (2015). Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. *International Journal of Drug Policy*, 26(12), 1198-1206.
- Lunn, J. (2009). The role of religion, spirituality and faith in development: A critical theory approach. *Third World Quarterly*, 30(5), 937-951.
- Macdonald, A. (2011). Insite or Outside the Law: Examining the place of safe injection sites within the Canadian legal system. *Oñati Socio-Legal Series*, 1(1).

- Maguire, P. (1987). Doing participatory research: A feminist approach.
- Malkin, I., Elliott, R., & McRae, R. (2003). Supervised injection facilities and international law. *Journal of Drug Issues*, 33(3), 539-578.
- Manson-Singer, C., & Allin, S. (2020). Understanding the Policy Context and Conditions Necessary for the Establishment of Supervised Consumption Sites in Canada: A Comparative Analysis of Alberta and Manitoba. *Health Reform Observer—Observatoire des Réformes de Santé*, 8(2).
- Marshall, B. D., Milloy, M. J., Wood, E., Montaner, J. S., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *The Lancet*, 377(9775), 1429-1437.
- McGinty, E. E., Barry, C. L., Stone, E. M., Niederdeppe, J., Kennedy-Hendricks, A., Linden, S., & Sherman, S. G. (2018). Public support for safe consumption sites and syringe services programs to combat the opioid epidemic. *Preventive medicine*, 111, 73-77.
- Mill, J. E., Allen, M. N., & Morrow, R. A. (2001). Critical theory: Critical methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research Archive*.
- Morin, K. A., Eibl, J. K., Franklyn, A. M., & Marsh, D. C. (2017). The opioid crisis: past, present and future policy climate in Ontario, Canada. *Substance abuse treatment, prevention, and policy*, 12(1), 1-7.
- National Academies of Sciences, Engineering, and Medicine. (2017). *Pain management and the opioid epidemic: balancing societal and individual benefits and risks of prescription opioid use*. National Academies Press.
- Nosyk, B., Anglin, M. D., Brissette, S., Kerr, T., Marsh, D. C., Schackman, B. R., ... & Montaner, J. S. (2013). A call for evidence-based medical treatment of opioid dependence in the United States and Canada. *Health affairs*, 32(8), 1462-1469.

- Opioid Overdose Surveillance Task Group (OOSTG) of the Special Advisory Committee on the Epidemic of Opioid Overdoses (SAC). (2021, March). *Opioid- and Stimulant-related Harms in Canada*. Public Health Infobase | Public Health Agency of Canada. <https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/#fn2>
- Payne, E., Totten, S., & Archibald, C. (2014). Hepatitis C: Hepatitis C surveillance in Canada. *Canada Communicable Disease Report*, 40(19), 421.
- Phillips, J. K., Ford, M. A., Bonnie, R. J., & National Academies of Sciences, Engineering, and Medicine. (2017). Trends in opioid use, harms, and treatment. In *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use*. National Academies Press (US).
- Pienaar, K., & Savic, M. (2016). Producing alcohol and other drugs as a policy 'problem': A critical analysis of South Africa's 'National Drug Master Plan' (2013–2017). *International Journal of Drug Policy*, 30, 35-42.
- Pinkerton, S. D. (2010). Is Vancouver Canada's supervised injection facility cost - saving?. *Addiction*, 105(8), 1429-1436.
- Potier, C., Laprévotte, V., Dubois-Arber, F., Cottencin, O., & Rolland, B. (2014). Supervised injection services: what has been demonstrated? A systematic literature review. *Drug and alcohol dependence*, 145, 48-68.
- Public Health Agency of Canada. (2014). *Summary of key findings from I-Track Phase 3 (2010–2012)*. Government of Canada. <https://www.canada.ca/en/public-health/services/hiv-aids/publications/summary-key-findings-i-track-phase-3-2010-2012.html>
- Rhodes, T. (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. *International journal of drug policy*, 13(2), 85-94.

- Rhodes, T. (2009). Risk environments and drug harms: a social science for harm reduction approach.
- Richardson, L., Wood, E., & Kerr, T. (2013). The impact of social, structural and physical environmental factors on transitions into employment among people who inject drugs. *Social science & medicine*, 76, 126-133.
- Ronan, M. V., & Herzig, S. J. (2016). Hospitalizations related to opioid abuse/dependence and associated serious infections increased sharply, 2002–12. *Health Affairs*, 35(5), 832-837.
- Ruff, & McIntosh. (2020, October). *Provincial Government in Canada | The Canadian Encyclopedia*.TheCanadianEncyclopedia.
<https://www.thecanadianencyclopedia.ca/en/article/provincial-government>
- Russell, C., Imtiaz, S., Ali, F., Elton-Marshall, T., & Rehm, J. (2020). 'Small communities, large oversight': The impact of recent legislative changes concerning supervised consumption services on small communities in Ontario, Canada. *International Journal of Drug Policy*, 82, 102822.
- Seear, K., & Fraser, S. (2014). The addict as victim: Producing the 'problem' of addiction in Australian victims of crime compensation laws. *International Journal of Drug Policy*, 25(5), 826-835.
- Single, E. (1995). Defining harm reduction. *Drug and Alcohol Review*, 14(3), 287-290.
- Sullivan, E. L. (2007). *A critical policy analysis: The impact of zero tolerance on out-of-school suspensions and expulsions of students of color in the State of Texas by gender and school level*. Texas A&M University.
- Thorne, S. E., Kirkham, S. R., & Henderson, A. (1999). Ideological implications of paradigm discourse. *Nursing Inquiry*, 6(2), 123-131.
- Troyna, B. (1994). Critical social research and education policy. *British Journal of Educational Studies*, 42(1), 70-84.

- Tsang, J. (2020). Violating the Fundamental Rights to Life, Liberty and Security of the Person: Bill C-2 and its Implications on Supervised Consumption Sites in Canada. *Health Reform Observer—Observatoire des Réformes de Santé*, 8(1).
- Vashishtha, D., Mittal, M. L., & Werb, D. (2017). The North American opioid epidemic: current challenges and a call for treatment as prevention. *Harm reduction journal*, 14(1), 1-6.
- Wang, L., Panagiotoglou, D., Min, J. E., DeBeck, K., Milloy, M., Kerr, T., Hayashi, K., & Nosyk, B. (2016). Inability to access health and social services associated with mental health among people who inject drugs in a Canadian setting. *Drug and Alcohol Dependence*, 168, 22–29. <https://doi.org/10.1016/j.drugalcdep.2016.08.631>
- Watson, T. M., Strike, C., Kolla, G., Penn, R., Jairam, J., Hopkins, S., ... & Bayoumi, A. M. (2013). Design considerations for supervised consumption facilities (SCFs): preferences for facilities where people can inject and smoke drugs. *International Journal of Drug Policy*, 24(2), 156-163.
- Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of advanced nursing*, 53(4), 459-469.
- Wood, E., Kerr, T., Small, W., Li, K., Marsh, D. C., Montaner, J. S., & Tyndall, M. W. (2004). Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *Cmaj*, 171(7), 731-734.
- Wood, E., Tyndall, M. W., Lai, C., Montaner, J. S., & Kerr, T. (2006a). Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. *Substance abuse treatment, prevention, and policy*, 1(1), 1-4.
- Wood, E., Tyndall, M. W., Zhang, R., Stoltz, J. A., Lai, C., Montaner, J. S., & Kerr, T. (2006b). Attendance at supervised injecting facilities and use of detoxification services. *New England Journal of Medicine*, 354(23), 2512-2514.

- Wood, E., Tyndall, M. W., Zhang, R., Montaner, J. S., & Kerr, T. (2007). Rate of detoxification service use and its impact among a cohort of supervised injecting facility users. *Addiction*, *102*(6), 916-919.
- Yang, Q., Ogunnaike-Cooke, S., & Halverson, J. (2016). Estimated national HIV incidence rates among key populations in Canada, 2014 [abstract EPH35]. In *Proceedings from the 25th Annual Canadian Conference on HIV/AIDS Research (CAHR)* (pp. 12-15).
- Ziegler, B. R., Wray, A. J., & Luginaah, I. (2019). The ever-changing narrative: Supervised injection site policy making in Ontario, Canada. *International Journal of Drug Policy*, *74*, 98-111.
- Zlotorzynska, M., Wood, E., Montaner, J. S., & Kerr, T. (2013). Supervised injection sites: Prejudice should not trump evidence of benefit. *CMAJ*, *185*(15), 1303-1304.

Chapter 2

2.1 Introduction

The continuous rise of substance use and related harms in Canada has been the topic of concern that has led to the issue being termed a public health crisis of "epidemic proportions" (Malkin et al., 2003; Nosyk et al., 2013; Vashishtha et al., 2017). According to Health Canada (2021), the substantial rise of opioid-related harms is attributed to many factors, including high rates of opioid prescribing and the introduction of potent synthetic opioids in the illicit drug market, such as fentanyl and carfentanil. However, utilizing a risk environment framework brings to light the correlation in how macro factors such as public health and economic policies, socio-economic and structural contexts such as poverty, criminalization, social distress, lack of opportunity, unstable housing, substandard living and working conditions, and micro environments like social relations, accessibility to substances, substance user practices, and substance use problems operate synergistically (Boyd et al., 2018; Bungay et al., 2010; Fraser, 2011; Hansen, 2017; Rhodes 2009).

The implementation of harm reduction strategies presents a unique, client-centred, and pragmatic solution to Canada's growing substance use issue. Harm reduction refers to strategies that aim to reduce substance use's adverse health and social consequences without necessarily decreasing substance consumption (Barry, 2018; McGinty et al., 2018). One policy approach used to address Canada's growing national substance use epidemic is the establishment of supervised consumption sites (SCS). SCS, by definition, are legally licenced sites where people can inject and smoke illegal substances under the supervision of qualified personnel, in compliance with a harm reduction strategy that acknowledges that abstinence from substance use is not always a reasonable target (Hedrich, 2004). The main goals of SCS include the reduction of disease transmission, overdose, public illicit substance use, and improving access to health and social services (Kimber, Dolan, & Wodak, 2005).

Despite the evidence supporting the effectiveness of SCS in reducing the harms associated with substance use, Canada has been slow to implement more SCS, or expand

the current ones; additionally, the substance-related harm rate continues to increase. This study's primary purpose is to critically appraise current federal and provincial policies regarding SCS, particularly noting intended and unintended consequences; and how these policies could impact SCS users. This study's secondary goal is to compare current policies related to SCS in Alberta, British Columbia, Ontario, and Quebec to provide critical insight and suggestions for ongoing policy development.

2.2 Literature Review

This literature review explores what knowledge is currently available on the central concept of this study, which is the appraisal of policies around SCS and provincial policy comparison. Several articles have evaluated the impact of SCS on people who used substances. Articles have also explored the influence of SCS on the local environment and communities' opinions on the sites. However, gaps in knowledge and content on SCS policies remain. Literature was reviewed for themes related to SCS policies in Canada and any policy analysis or policy comparison. Published literature from CINAHL, Scopus, Nursing and Allied Health (Proquest), and APA PsycInfo (ProQuest) databases were searched. The following key terms and Boolean phrases; "Policy" AND ("analysis" OR "compara*") AND ("Supervised injection site" OR "Supervised consumption site" OR "drug consumption room" OR "Overdose prevention *" OR "supervised injecting facilit*"). Articles were included if they were 1) full-text, 2) written documents, 3) written in English, 4) published within the last fifteen years, and 5) included content applicable to SCS (or terminology related to the same concept), related policies, and any analysis done on the subject matter. The date range was selected to ensure the breadth of the search on the topic since there is limited research on safe consumption site policies. This date range also helped identify research that reflected the most recent developments contextualized to the current SCS policies. Articles were excluded if they were not peer-reviewed, or not written documents, meaning audiovisual and digital recordings or opinion pieces and calls to action. Articles were also excluded if the topic was not related to policy in an SCS or a related harm reduction strategy. Articles that concentrated on the analysis of policies in supervised consumption/injection services and overdose prevention services—a substance use harm reduction strategy—were included.

The search terms were applied in each of the four databases. The results were refined with the inclusion and exclusion criteria, and the results were as follows: CINAHL returned four results, Scopus had seven results, Nursing and Allied Health Database (ProQuest) returned fifty-six, and APA PsycInfo (ProQuest) returned five results. The results were first assessed by topic for relevance to policy in SCS (and its related terms). Abstracts of relevant titles were reviewed in more detail to ascertain significance. Full-text articles were read in their entirety if the abstracts met the inclusion and exclusion criteria. Four articles were suggested to the writer by the thesis advisory committee members. A total of 15 articles were ultimately incorporated into this literature review and organized into three descriptive categories: 'analysis of the impact of supervised consumption site policies,' 'facilitators and barriers to creating policy for supervised consumption site,' and 'analysis of policies that limit supervised consumption sites.'

2.2.1 Analysis of the Impact of Supervised Consumption Sites Policies

Comprehending the impact of policies requires a deep examination of the policy and its manifest and latent effects. Manifest effects refer to the deliberate, intended or known functions or dysfunctions, in this case, regarding policy. Latent effects are the unintended or hidden functions or dysfunctions. This descriptive category reflects one of the principals aims of the dissertation: to understand the intended and unintentional implications and their potential impact on SCS users. Russell et al. (2020) analyzed how the recent changes to SCS policy and legislature affect small communities in Ontario, Canada. Ontario underwent a change in government following the provincial election in 2018. The government changed from a Liberal government that advocated for policies that promote harm-reduction to a Conservative government that declared opposition to SCS (Loriggio, 2018). The new Conservative provincial government replaced SCS regulations with a "streamlined" model that brought about new administrative funding and approval requirements and a limit on the number of sites allowed (Russell et al., 2020). The impact of this specific change is what was analyzed in this article. The initial assessment for this policy change revealed that although examining the existing sites, current evidence, and engagement with representatives from different sectors was

conducted, the decision was primarily based on prioritization and a shift in focus from the harm reduction paradigm to treatment and rehabilitation. (Russell et al., 2020). The author concluded that this policy presents a definite substantial oversight and latent dysfunction that will have lasting negative results. Many small communities throughout Ontario have been suffering harm related to opioid use at rates that exceed those of larger communities. To buttress this statement, in 2017, the rate of opioid overdose hospitalization rates in smaller areas doubled those in Canada's largest area, with communities that contained populations between 50,000 and 99,000 people experiencing some of the highest rates (Canadian Institutes for Health Information, 2018; Russell et al., 2020). For example, the city of Brantford (containing population: 102,000) had an age-adjusted rate of opioid-related hospitalizations of 52.8/100,000 population, and the rate in an even smaller city of Belleville (population: 50,720) was 48.4/100,000; this is in stark contrast to the rates for the province as a whole (population: 14.57 million; rate: 14.8/100,000), as well as for larger cities such as Ottawa (population: 994,837; rate: 10.3/100,000) or Toronto (population: 2.93 million; rate: 7.9/100,000) (Canadian Institutes for Health Information, 2018; Russell et al., 2020). In Ontario, the change in political parties has resulted in a policy that disproportionately impacts many smaller communities from implementing SCS programs. Though the communities are small, SCS implementation remains needed (Russell et al., 2020).

Another analysis of the impact of SCS policies was outlined in Small et al. (2011), who conducted a review into how macro-level contextual policies and regulations influence how SCS are run, as well as how they affect access to and coverage of consumption facilities. The authors analyzed the federal Controlled Drugs and Substances Act (CDSA) and specifically section 56. Section 56 is one of the policies undertaken to reduce the criminal liability related to operating Insite—Canada's first SCS—including legal and administrative agreements (involving health, government, and law enforcement agencies) (Small et al., 2011). Section 56 allows the federal government to authorize an exception from some of the requirements of the CDSA for the medical or scientific purpose of generating knowledge, or if it is otherwise in the public's interest (Elliott et al., 2002; Health Canada, 2002; Small et al., 2011). The new policy allowed Insite's legal sanctioning, but it also subjected the site to a rigorous scientific evaluation of the

facility's health and social impacts (Small et al., 2011). Analysis of this policy revealed that the way the structure of the policy had been employed severely restricts the establishment of SCS to operating as part of a scientific assessment instead of a broader scale, public health intervention. This restriction puts less emphasis on the vulnerable and marginalized population the SCS ought to serve and more focus on reducing risks and liability to institutions and their staff (Fischer et al., 2004; Small et al., 2011). For instance, the guidelines as of 2011 prohibited assisted injections within SCS, in spite of the documented evidence on the harms stemming from this lack of support and the presence of unique strategies that would address civil and criminal concerns from assisted injection within SCS (Pearshouse & Elliott, 2007; Small et al., 2011). Small et al. (2011) notes that optimizing the operation of SCS in Canada will need public policy changes beyond the health sector; an amendment to policy in the legal framework would also be necessary. For example, Canadian SCS can benefit from the permission of assisted injection (Pearshouse & Elliott, 2007). Such an amendment would mean a modification of the present policy framework that legislates SCS and a change to the Canadian civil and criminal law to address the liabilities of offering assisted injections (Small et al., 2011). The evaluation goes on to make recommendations to mediate some prominent issues resulting from inadequate policies, including making amendments to the policy to allow an increase in the injection spaces and the formation of more SCS to mediate the barriers set by reduced access to the injecting rooms. The authors suggest that the current SCS policy focuses on reducing liability to institutional bodies rather than protecting and reducing the barriers experienced by the vulnerable population of people who use drugs (PWUD) and wish to use SCS.

Bardwell et al. (2020) investigated clients' lived experiences with integrated SCS, including the model's strengths and pitfalls, as well as the implementation contexts that shape SCS uptake, in order to evaluate the effectiveness of SCS integrated within community health centres (CHC), and how the design and operation may affect PWUD uptake. The results brought to light the influence of SCS policy on implementation. While SCS users benefit from the integrated systems, such as access to other services and amenities, certain SCS policies impact CHC use. These policies affect spatial layouts, operating hours, a lack of privacy, and assisted injection or drug sharing legality. Many

study participants suggested that the SCS within the CHC should be open 24 hours a day, including weekends. The current spatial orientation of the CHC does not allow for privacy/anonymity for those who visit the SCS site (Bardwell et al., 2020). Non-SCS CHC clients regularly sat and socialized in the foyers, seated directly in front of the SCS entrance points. Bardwell et al. (2020) describe various studies that described how spatial contexts could create risks and challenges for PWUD (Bardwell et al., 2020). The legislation that does not allow assisted injection or substance sharing restricts some clients from common substance use practices that exist outside of SCS (Bardwell et al., 2020; Kerr et al., 2017; McNeil et al., 2014). This literature examines how multiple policies, including hours of operation and waiting areas (CHC policies), inhibit the uptake of services and how SCS policy limits PWUD agency. Through observations and a semi-structured interview with end-users of the SCS integrated with CHC, it educates on the unintended consequences of existing SCS policies. However, this literature does not examine the specific policy document in question. Instead, it focuses on people's experiences and how existing policies shapes and limits access to SCS and other health-related services for PWUD.

Like the previous article, Urbanik and Greene (2021) investigated the barriers to SCS access for SCS users and non-SCS users and how those barriers are consistent among groups. The findings include information on both operational policies and contextual barriers. The outcome demonstrates how SCS access barriers (SCS rules of use, boot time limits) and physical structure constraints (limited booths), recipient providers (allowing others to jump the line), and patient factors (not wanting or being able to wait) have been shaped and operated within an organizational context (Urbanik & Greene, 2021). For PWUD, waiting times for booths have been some of the most common barriers in SCS users and non-SCS users to access SCS. Participants indicated that the varying waiting times discouraged access to the SCS (Urbanik & Greene, 2021). Prohibitions for injection assistance consistently also exclude some PWUD from SCS access (Urbanik & Greene, 2021). With the disproportionate concentration of women, disabled users and long-term substance users' need for injection assistance, such constraints might unfairly target these people, exacerbating existing PWUD risks and harmful disparities (McNeil et al., 2014; Urbanik & Greene, 2021). Understanding the

impact of the current SCS policy on accessing the sites is imperative to inform best practices, policies, and programme development to enhance the SCS' use and address better PWUD's needs. Urbanik & Greene (2021) suggest ways to remediate the situation, such as decreasing wait times through additional booths and increased staffing may encourage PWUDs otherwise dissuaded from using SCS due to symptoms of withdrawal or impatience for access to services. It may increase SCS uptake to allow customers extra time for safe injection without asking them to leave or re-enter the long lineup. The SCS could have a positive effect if such policy changes are implemented. This study examines the impact of SCS policy by identifying barriers to SCS. However, it does not discuss the visible effects of SCS policy or intentionally analyze specific SCS policy from a federal or provincial governing body.

Legal experts have remarked that since SCS represents a healthcare program targeting PWUD, the federal government is by law required to abolish legal and policy barriers to the operation of SCS under the Canadian Charter of Rights and Freedoms (Elliott et al., 2002; Small et al., 2011). A legal case in the Supreme Court of British Columbia challenged the federal government's authority to restrict the operation of Canadian SCS, arguing that access to SCS as a healthcare program is warranted under the Charter. The supreme court judge involved determined that the CDSA cannot take priority over the Charter and proceeded to grant Insite an exemption to the CDSA that pertained to the establishment of the site and instructed the federal government to make the necessary modifications to CDSA in order to inclusive to the operation of Insite (Pitfield, 2008; Small, 2008; Small et al., 2011). This ruling favours the promotion of risk reduction by impacting the CDSA policy to more readily accommodate SCS.

Aside from the impact on small communities and the operationalization of SCS, the SCS policy and regulation enforced by police impacts the use of SCS by PWUD and calls to question the policy's effectiveness around SCS. A study by Bardwell et al. (2019) that examined the implementation policies of newly established SCS in Toronto and the impact that policing has on the accessibility to the site by PWUD noted the disconnect between policing goals and those of SCS policy. The article used qualitative interviews, ethnographic observation, and policy analysis to demonstrate that accessing SCS and the

client experience surrounding SCS is dependent on structural barriers (e.g., criminalization, policing), which can impact future SCS programming. As SCS policy currently stands, the author suggests it is incomplete as it does not encompass, nor does it offer supporting documents, on how law enforcement enforces the laws around SCS or SCS users. Specifically the author suggests that the police should not exist in close proximity to SCS.

Policy related to healthcare responses to substance use is highly political. To this point, policies are sometimes influenced by ideological stances and political rhetoric. Some provincial governments have supported and realized the expansion and upsurge of these harm reduction programs and have experienced positive results. Like Ontario and Alberta, other provincial governments have intermittently vehemently opposed SCS, which has directly impacted the scale-up or continuation of these programs (Russell et al., 2020; Ziegler et al., 2019). Regardless, the SCS policy and legislative amendment's impact presents a multifaceted issue that calls for further analysis into the matter. The current literature that analyses SCS policy is related to only a subsection of the relevant policy documents and discusses the current SCS policy's latent effect. Although the literature expands knowledge and understanding, further analysis is needed to understand the policy documents themselves and their intent. Such analysis will enable dialectic analysis that reveals other latent effects of SCS policy not identified in the current literature.

2.2.2 Facilitators and Barriers to Creating Policy for Supervised Consumption Sites

SCS have received considerable scholarly attention over the last decade as more cities open sites. Within this, a small body of literature examines the policies particular to SCS. The literature on policy explores the socio-political conditions that explain the creation of legal SCS. The focus of the academic literature of SCS policymaking in Canada is principally on the conditions that facilitated the opening of Insite or barriers to SCS establishment in other cities. Two articles reviewed explored how various actors in current society act as facilitators and barriers to SCS policy. Ziegler et al. (2019) use the province of Ontario to describe the narratives constructed by three different, unofficial

coalitions. The ‘supervised injection site (SIS) coalition’ comprises the Liberal government, medical professionals, and people who use substances; the ‘law and order coalition’ comprises the Conservative government and law enforcement; and the ‘crisis coalition’ encompasses the courts, media, and the public. Ziegler et al. (2019) describe how these coalitions use varying narratives to function as barriers or facilitators to the policymaking process that allows for SCS formation. The authors found that the law and order coalition narrative tends to leverage scientific uncertainty and fear about substance use as a barrier against policies that protect SCS. The SIS coalition, who are proponents of SCS, argues that plenty of evidence reveals the SCS model protects communities and reduces harm; this coalition uses a narrative of endangerment from externalities to garner support (Ziegler et al., 2019). The law and order coalition claims the SCS model promotes increased crime and social disorder. Ziegler et al. (2019) mention that such a narrative is becoming the leading rationale for blocking the SCS model while advocating for a rehabilitation and treatment framework that evokes the global trend of "law and order" politics. The conflicting media narratives further reinforce the law and order coalition's narrative about evidence, harm, and social disorder concerning the SCS model. The crisis coalition narrative is well summarized in the research of Atkinson et al. (2019). They conducted a critical analysis of how conflicting international news media influence policies on SCS. They go on to argue that the manner in which SCS is represented in the media frames how the public views the substance use issues and influences political discourse (Atkinson et al., 2019; Forsyth, 2001; Lancaster et al., 2011; Orsini, 2017; Stevens & Zampini, 2018). Both articles reviewed offered focused responses to how different coalition narratives and news media function as barriers or facilitators to the policymaking process that allows for SCS formation.

Two articles selected in this literature review conducted a comparative analysis of the policymaking process. Hayle (2018) examined policy papers, government documents, scientific reports, newspaper articles and secondary literature to identify and explain some of the significant barriers to the municipal council's support of SCS between 2003 and 2016. Vancouver, British Columbia, is home to North America's first SCS called Insite, which opened in 2003. While Toronto, Ontario, the most populous Canadian city with a similar opioid crisis as Vancouver, only recently established an SCS in 2017.

Hayle (2018) compares circumstances and procedures in Toronto (Ontario) to those of Vancouver (British Columbia), where SCS have received city council support since 2001. The authors reported that evidence of SCS effectiveness was available to lead politicians in both cities. However, the interpretation of the presented evidence differed between Toronto and Vancouver. Media attention played a significant role as the authors suggest that activists fighting for SCS in Toronto were not as successful at earning media attention to their cause as those in Vancouver. Implying that, due to the absence of media attention, the support for SCS to be used by PWUD was less apparent to politicians in Toronto than it has been to politicians in Vancouver (Hayle, 2018). Aside from the influence of media and political opinions, further analysis of political documents revealed that: 1) most citizens in Vancouver support SCS, and until 2016, the opinions of Torontonians were more mixed, and 2) in Vancouver, both police officers and police chiefs publicly supported SCS, while police chiefs and police officers continually opposed SCS in Toronto up until 2016 (Hayle, 2018). According to the authors, the facilitators of SCS policy that aligned appropriately are the political interpretation of scientific data, media supports favouring SCS by its activists, community support, and law enforcement's public support. Toronto's barriers stemmed from the misalignment of media, politics, research interpretation, and the public approval that allowed Toronto's council to endorse SCS.

The other comparative analysis article was also conducted by Hayle (2015). This article was an international drug policymaking process comparison between Canada, England, and Wales. The comparing and contrasting of policymaking processes between 1997 and 2015 provide insights into why Canada approved the opening of a lawful SCS in 2003 and why Britain has not done so. The articles refer to three streams that needed to align to make conditions constructive for the government to approve the establishment of SCS: 1) the problem stream, 2) the policy stream, and 3) the political stream. The problem stream is when a systemic issue directs the decision-maker's attention to what the problem objectively appears to be (Hayle, 2015; Kingdon et al., 1984). The policy stream refers to implementable alternative solutions (Hayle, 2015). The political stream refers to the circumstances and willingness of the decision-makers to seize opportunities for policy change and make changes to the policy. (Hayle, 2015; Kingdon, 1984). The article

discusses how the Vancouver healthcare emergency (problem stream), SCS policy proposals (policy stream), public concern over the quality of Canadian healthcare (the political stream), and the provincial and municipal government's stronghold on central Canadian voters (political stream) occurred simultaneously, aligning to make conditions advantageous for the government to approve the establishment of Insite (Hayle, 2015). For the countries being compared—England and Wales—the three streams did not align, thereby causing a barrier to the development of policy that would support the creation of SCS. According to Hayle (2015), some examples from the political streams that did not align were public mood and political climate. Canadian provincial and municipal governments collected a lot of data from public surveys, town halls, and polls to ascertain if a large populace opposed or supported the SCS, whereas, in England and Wales, no clear data were collected, so public mood towards SCS could not be discerned. The political climate in the Canadian context at the time showed concern for healthcare and social programming, not a crime, but in the comparing nations, the government's focus was to be tough on crime. Though opportunities opened in some streams for SCS (problem and policy), the misalignment from the political stream led to the government being unable to establish SCS (Hayle, 2015).

The social and political issues related to the creation of supervised consumption rooms in France and the role of public opinion polling in policymaking were examined by Jauffret-Roustide et al. (2013). The authors present the findings of various polls and scientific studies on the social acceptability of consumption rooms and their impact on the French debate. The EROPP survey, or Study on Representations, Opinions, and Perceptions of Psychoactive Drugs survey, was designed to assess people's attitudes toward substances in general (including heroin, cocaine, and cannabis) (Jauffret-Roustide et al., 2013). The items and phrasing of queries in this questionnaire elicited thoughts about the societal dangers of substances. As a result, the study's design reflects the social debate on substance and injection risks. In contrast, the Knowledge, Attitudes, Beliefs and Practices (KABP) survey considered HIV or Hepatitis B and C as the issue of supervised consumption areas, and the design of the study thus reflects the debate on social measures to reduce risks. The conditions that lead to a favourable or unfavourable response/opinion on a sensitive question, such as the implementation of supervised drug consumption

rooms, are inextricably linked to the questionnaire topic, the wording of the questions asked, and the placement of questions in the questionnaire (Jauffret-Roustide et al., 2013; Matthew-Simmons, Love, & Ritter, 2008). Paris, Strasbourg, Bordeaux, and Marseilles announced plans to introduce consumption rooms in their communities; however, due to local elections and public sensitivity about the subject, this measure was removed from their political agenda (Jauffret-Roustide et al., 2013). The public's fear of an increased presence of substance users in areas where such rooms would be set up, as well as the public's fear that such a measure would send the message that substance use and injecting are acceptable practices, were driving France's reluctance to implement supervised drug consumption rooms (Jauffret-Roustide et al., 2013). Public opinion hampered the harm reduction strategy, which necessitated policy change. According to the author, a public health response to substance dependency should always be guided by public health requirements, international literature, and evidence (Jauffret-Roustide et al., 2013). These would facilitate a positive response to SCS policymaking since they reflect the best practice, and public opinion can be swayed depending on the phrasing.

Watson et al. (2018) sought to learn more about SCS-police relationships in international jurisdictions with long-standing and newer SCS. Five key contributors to cooperative SCS-police relationships were discovered through communication and interviews with SCS managers and police liaisons in multiple countries. As facilitators for SCS policy implementation, these key contributors included: early engagement and dialogues, supportive police chiefs, dedicated police liaisons, negotiated boundary agreements, and regular face-to-face contact (Watson et al., 2018). Participants in the study unanimously agreed that SCS-police dialogues should begin as early as possible, ideally during the preliminary stages or well before the new SCS opens. Many participants saw having supportive municipal police chiefs as essential to working SCS-police relationships, both initially and in the long run because these high-ranking officers can issue orders to officers on how to interact with the SCS and its users. The current study suggests that investing effort in nurturing SCS-police connections on the ground and in a less structured and ongoing way may have a significant and more long-term public health value than designing and implementing formal training curricula to police (Watson et al., 2018). Watson et al. (2018) recognize that relationships with the SCS and police really

can shift with changes in legislation, government priorities, local leadership, and community issues over time. The policing around SCS can, depending on the narrative, be a barrier or a facilitator for PWID's access to and use of SCS (Watson et al., 2018). It can influence the implementation of current policies and can contribute to SCS policymaking negatively and positively.

The last article reviewed on facilitators and barriers to supervised consumption sites' policymaking process scrutinizes the unsuccessful and successful policy proposals in Melbourne, Australia. Baker & McCann (2018) focus on the generative effects of a deterred attempt to establish Melbourne's SCS model. The authors recognize that policies can fail from innate errors within the policy. However, the unsuccessful attempts at moving policy forward can generate allied proposals, offer constructive lessons and experiences in different policy actors' careers, and create meaningful local and global connections (Baker & McCann, 2018). The policy review stressed the political dynamics of policy mobilization, policymaking, policy failure, policy reform, and the continuing political fight to adapt the public health system to the well-being of PWUD. These processes include an ideological debate between various interests and coalitions to determine the best future for a place and its inhabitants (Baker & McCann, 2018).

The most recent and relevant literature on the policymaking process appears to be more focused on the critical socio-political aspects of achieving equitable harm reduction policies. The current literature speaks to how sites were opened, or not, the impact of public opinions and policing relationships or the politics around their openings. After a comprehensive search on the topic, the current research does not sufficiently discuss the complete content of policies that frame SCS. Complete content in this context refers to the specific policies from a federal, provincial, or municipal governing body. The research is limited in its discussion of current SCS policies, particularly since the exacerbation of the overdose epidemic; the studies presented in this section of the literature review do not analyze the policies' manifest and latent effects. The articles refer to peripheral discourse that impacts the formation of policymaking, but there remains a gap in knowledge as to how the facilitators and barriers to SCS led to the creation or revoking of specific federal or provincial policies, or how the environment surrounding

the making of policy connects to a critical understanding of harm reduction strategies. Understanding this gap can clarify the rationale behind existing policies, thus leading to a better understanding by a government body of the purpose of specific SCS policies.

2.2.3 Analysis of Policies that Limit Supervised Consumption Sites

The last theme in the SCS policy literature is the consideration of policies that particularly limit the implementation or increase of SCS. Zlotorzynska et al. (2013) analyze the tabling of Bill C-65 in Canada and how it threatens the evidence-based and public health practice of SCS. Bill C-65 is also known as the Respect for Communities Act. This Bill presents numerous new requirements to be completed by supervised consumption facilities before being approved and exempted from the Controlled Drugs and Substances Act. This legislation authorizes the federal Minister of Health to decide whether to approve a facility's application for exemption. Furthermore, it declares that the Minister should only issue an exemption in "exceptional circumstances." There is a need for police and community support as part of the application process, and the Bill allows the Minister to obtain input directly from the public on any proposed SCS (Zlotorzynska et al., 2013). Zlotorzynska et al. (2013) explain how holistic this Bill C-65 appears to be but, upon analysis, reveals the onerous burdens on applicants to such a degree that it is deemed unlikely that any new facilities will be approved; additionally, the Bill could result in the closure of current SCS. It is noted in the analysis that the voices of opponents to harm reduction are elevated above proponents who speak to the evidence showing that SCS saves lives. Zlotorzynska et al. (2013) argue that the passage of Bill C-65 into law would only fortify the objective of the National Anti-Drug Strategy that appears to ignore harm reduction in the face of robust scientific evidence. Zlotorzynska et al. (2013) reason the Bill should not be legitimized unless revised to be inclusive of evidence-based drug policy that protects the health and human rights of PWUD. Local health officials should be authorized to make evidence-based decisions about what interventions are offered to people who inject drugs rather than this regulatory power being solely afforded to the health minister.

Another report by the Canadian HIV/AIDS Legal Network also critiques Bill C-65, calling it an irresponsible initiative that ignores the extensive evidence that such health

services are needed and valuable and the human rights of Canadians with addictions (Ka Hon Chu, 2013). To clarify the inadequacies of Bill C-65, the study discusses policies such as the Ontario Public Health Standards 2008, the Canadian Charter of Rights and Freedoms, and the International Covenant on Economic, Social, and Cultural Rights. The Ontario Public Health Standards, 2008, mention the need for "a range of harm reduction programme delivery models, which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction techniques in response to local surveillance," (p. 35). The International Covenant on Economic, Social and Cultural Rights (Covenant) states that the right to "enjoyment of the highest attainable standard of physical and mental health" requires Canada "to take steps..., including particularly the adoption of legislative measures" that are necessary for, among other things, "the prevention, treatment and control of epidemic ... diseases" and the "creation of conditions which would assure access to all medical services and medical attention in the event of sickness." (United Nations, 1966; Ka Hon Chu, 2013, p. 4). PWUD have a right to needed healthcare services just like all other Canadians. However, the author concludes that Bill C-65 intentionally, unethically, and unconstitutionally undermines their rights and is an "impermissible retrogressive measure taken by the federal government concerning the right to health" (Ka Hon Chu, 2013, p.5). This literature highlights how politically motivated policy can remarkably reduce the implementation of a given program.

2.2.4 Literature Summary

There is a range of literature focusing on SCS and their effectiveness, how the policies came into action, all of which are valuable information to understanding the narrative that led to, and the intent of the current SCS policies. However, the information is minimal on the appraisal of federal or provincial policies, particularly any provincial policy comparison. This comparison allows for mutual learning by analyzing how provinces that bear similarities create policy and change laws around this service to understand parallels and differences that shape SCS best practices. Policymaking processes in Canada, England, and Wales between 1997 and 2015 were compared, with the specific purpose of providing insights into why Canada approved the opening of a lawful SCS in 2003 and

the reason Britain has not done so. A comparative historical analysis of circumstances in two cities explained the more than decade-long time-lag between Toronto and Vancouver. Research that analyzed SCS policies discussed several barriers to implementation. Legal obstacles, an expectation of low public tolerance, fear of the political repercussions of enforcing the controversial strategy, inadequate police support, concerns about the consistency of the evidence base, related costs, the risk of low-level street substance trafficking near SCS sites, and a general lack of government prioritization of drug policy are all barriers to adoption (Atkinson et al., 2019; Baker & McCann, 2018; Bardwell et al., 2020; Bardwell et al., 2019; Hayle, 2015; Hayle, 2018; Jauffrett-Roustide et al., 2013; Ka Hon Chu, 2013; Lloyd et al., 2017; Russell et al., 2020; Small et al., 2011; Urbanik & Greene, 2021; Watson et al., 2018; Ziegler et al., 2019; Zlotorzynska et al., 2013). Adverse widespread news media reporting has also been highlighted as a critical influencing factor (Atkinson et al., 2019; Ziegler et al., 2019).

The articles reviewed on the analysis of the impact of SCS policies present relevant and thought-provoking insights into the policies of SCS, such as the social and political events surrounding the opening or maintenance of SCS site and the impact of the SCS policies have on small communities. However, no actual examination of SCS policy documents was conducted except for Small et al. (2011), who conducted a direct analysis of specific policies and noted their consequences. Still, the study analysis was brief and was only focused on policy's operational impacts. In this case, operational impact refers to the effect that the day-to-day organization and operations of SCS have on on-site users. The most recent and relevant literature on the policymaking process focuses more on socio-political aspects to attaining equitable harm reduction policies. The available literature that analyses SCS policy is related to only a subsection of the policy and discusses the current SCS policy's latent effect. Although the literature expands knowledge and understanding, the research does not discuss current SCS policies in-depth, nor does it analyze the policies' manifest and latent effects. The literature reviewed under this theme analyses a bill related to the SCS policy. However, an in-depth investigation of SCS policy is needed now as much has changed in the last ten years, and there is a need for current analysis as drug policies and trends change. There were no cross-national comparisons that identified clear elements of effective policies or offered

solutions to policy gaps based on legislation existing in a comparable province. Consequently, there remains a paucity of research exploring in-depth variations in SCS policy within Canada.

This thesis seeks to contribute to substance policy scholarship in three ways. First, it introduces more analytic data on SCS policy to strengthen knowledge and understanding of harm reduction politics. Second, this paper expands knowledge and understanding of the current SCS policies by critically appraising policy and noting the intended and unintended consequences within the Canadian context. Third, this study contributes to Canadian substance policy scholarship by comparing the current policy surrounding SCS in Alberta, British Columbia, Ontario, and Quebec.

2.3 Ethical Approval

This critical policy analysis did not require ethical approval from The University of Western Ontario Research Ethics Board since there were no human participants. However, this study was conducted keeping in mind critical ethical codes such as honesty and integrity, openness, respect for intellectual property, and responsible publication. Honesty and integrity refer to honesty in the research methods, data, and results, meaning the process taken was as described. Openness signifies being prepared to share data and results and to do so with the intention of furthering knowledge. Respect for intellectual property means never plagiarizing others' works; this consideration is met by ensuring proper referencing is conducted. Lastly, the responsible publication is similar to integrity, meaning that the research intention is to advance the state of research and knowledge.

2.4 Methods

2.4.1 Theoretical Perspective

This study is informed by critical policy analysis (CPA), which involves scrutinizing policy, emphasizing criticality, whereby researchers and analysts can recognize policy outcomes and processes. CPA elucidates the undervalued policy dimensions by analyzing pertinent policy descriptions that entail a close examination of cultural models, embedded power relationships, and policy patterns (Joo et al., 2010). CPA aims to examine a

policy's origins and outcomes while considering social justice and equity. CPA standards imply both a description and prescription of policy. The critical approach to policy can appraise values and effects that have been silent, meaning they allow for the understanding of manifest and latent effects grounded in evidence, which is the primary purpose of this study.

2.4.2 Methodology

This study applies Carol Bacchi's post-structuralist policy analysis framework, "What is the Problem Represented to Be?" (WPR), as the overarching critical theoretical lens. This method focuses on how the 'problem representations' implicit in policies provide particular meaning to 'problem' and, as a result, carry a restricted range of solutions with them (Bacchi, 2009; Bacchi & Eveline, 2010; Barratt et al., 2017). Bacchi's method encourages thinking beyond seeking solutions but understanding the nature of the policy problem. The WPR approach calls the commonly accepted notion that policies address issues into question. WPR analyses the manner in which problems are generated using six questions (Table 1) (Pienaar & Savic, 2016). This study focuses on questions 1, 2, 4, and 5.

Table 1-Carol Bacchi's (2009) "What's the Problem Represented to Be?" Approach

<p>Question 1: What is the problem (e.g., of "gender inequality", "drug use/abuse", "economic development", "global warming", "childhood obesity", "irregular migration", etc.) represented to be in a specific policy or policies?</p>
<p>Question 2: What deep-seated presuppositions or assumptions (conceptual logics) underlie this representation of the "problem" (problem representation)?</p>
<p>Question 3: How has this representation of the "problem" come about?</p>
<p>Question 4: What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be conceptualized differently?</p>

Question 5: What effects (discursive, subjectification, lived) are produced by this representation of the “problem”?

Question 6: How and where has this representation of the “problem” been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?

Step 7: Apply this list of questions to your own problem representations.

2.4.3 Data Retrieval and Screening

This CPA of SCS used documents as empirical data. The data is comprised of known/available federal and provincial policy documents on SCS. Policy documents were gathered from the years 2000-2021. The range was chosen for analysis because it includes the vast majority of official discussions surrounding SCS as can be traced in Canada, and it includes the most updated policies existing to date. This temporal criterion also allows analysis to be manageable across the four provinces as it ensures documents reflect policies produced across different governments at the federal and provincial levels.

Document retrieval methods were refined through an iterative search and screening process that includes systematic and purposive components. An iterative search was used to generate a collection of policy texts to explore what documents regarding SCS were federally or provincially issued, and where these documents could be found. The literature review identified several of these policy texts. As the document retrieval proceeded, the starting inclusion and exclusion parameters noted below were refined. The search then became specific to the known existing policies that were currently active, as SCS implementation is governed by particular policy documents. The search was limited to documents published and issued by a federal or provincial government or their delegated health authorities. Government documents were retrieved using search engines accessible on the individual government's websites. For finding the policies, Boolean searches were also conducted by entering different search vocabularies into the Google search engine, allowing for retrieval of publicly available federal and provincial policy documents related to SCS (including all related terms). Keyword search terms were

included—but were not limited to— “policy(ies)”, "Bill C-2", “CDSA”, “Ontario/Quebec/British Columbia/ Alberta” and “supervised/safe consumption sites/facilities/rooms/houses” and “policy(ies)”, "opioid use disorder", "Bill C-37", "harm/risk reduction/minimization", "safe/clean injection/injecting sites/rooms/houses/facilities", and "supervised consumption sites/facilities/rooms/houses”. Thesis committee members also provided recommendations as to who best to contact for a copy of the provincially issued SCS policies that were difficult to find or not readily available online.

All relevant policy documents that were retrieved using these search terms were collected and reviewed at the title level, and their issuing governmental body. Those congruent with the research purpose were given a full review. Pertinent documents were defined as SCS policy texts that are: 1) issued by and representing a provincial, territorial, or federal government, 2) issued by and representing a provincial, territorial, or federal delegated health authority, 3) addressed harm reduction services and interventions, defined as supervised/safe injection/consumption, or 4) produced as either a stand-alone harm reduction policy related to SCS or as part of a strategy document guiding services for substance use, addiction, mental health, and prevention of blood-borne or sexually transmitted infections (Hyshka et al., 2017; Ritter & Berends, 2016). Documents were excluded if they described services at the municipal level and a government or health authority authored document focused on healthcare worker's best practice guidelines. This aspect was excluded because the analysis focuses on provincial and federal policies, not municipal policies, or provider-level harm reduction practices.

Following the preliminary search, purposive searches for progress updates or status reports were conducted on all selected policy documents. Before analysis, a recency review was done. The policy document retrieved were categorized as current and included in the analysis if 1) the policy is in effect as of 2021; and 2) the document is the most current and there is no newer version with the same focus (Hyshka et al., 2017).

2.4.4 Data Management

The qualitative data collected was managed using NVivo 12 software for coding the data into themes and subthemes for analysis. This study employed abductive and deductive coding instruments, meaning coding schemes was derived before and during the data analysis. First, each policy document was coded based on the 6 WPR questions (See Table 2 and Table 3) with special attention to questions 1, 2, 4, and 5 then, as different themes were proposed throughout the policy analysis, new codes were created and used.

2.4.5 Data Analysis

The Bacchi WPR questions guided the data analysis phase and involved the deductive coding of documents. When unexpected or aberrant findings were encountered, abductive coding was applied, and the nuanced piece evolved to accommodate these data as the research progressed. This analysis aims to keep with the CPA's goal, which is to produce a comprehensive interpretation of policy; the WPR approach asks questions tailored to ensuring the goal of CPA is accomplished. The WPR approach also guided the provincial comparative analysis. The policy documents were described and then analyzed. The data were examined following the coding framework demonstrated in Table 2 for the Canadian federal SCS policy. Table 3 was used as a coding system for the analysis and comparison of provincial policy. Tables 2 and 3, shown below, are merely reference guides, meaning that the number of policy documents stated in the table can be more or less than the numbers represented in the table. Although all six WPR questions were answered, significant emphasis was placed on questions 1, 2, 4, and 5.

Table 2- *Matrix for WPR framework for analyzing Canadian federal supervised consumption site policies*

WPR Questions	Federal			
	Policy 1	Policy 2	Policy 3	Policy 4
Question 1: What is the problem represented to be				

in a specific policy?				
Question 2: What presuppositions –necessary meanings antecedent to an argument—and assumptions (ontological, epistemological) underlie this representation of the "problem" (problem representation)?				
Question 3: How has this representation of the problem come about?				
Question 4: What is left unproblematic in the problem representation? Where are the silences?				
Question 5: What effects (discursive, subjectification, and lived) are produced by this representation of the problem?				
Question 6: How and where has this representation of the problem				

WPR Questions	Alberta		British Columbia		Ontario		Quebec	
	Policy 1	Policy 2	Policy 3	Policy 4	Policy 5	Policy 6	Policy 7	Policy 8
and defended? How has it been, or could it be questioned, disrupted, and replaced?								

The first part of the analysis involved a brief review of the documents to become familiar with the policies' nature. The second stage involved a more thorough analysis of the content and answering the WPR questions. Answering the questions revealed thematic patterns pertinent to SCS policy discourses. No predefined themes or categories were utilized to ensure that the central discourse-related themes are proposed directly from the data (Hayle, 2018). After thorough analysis, the implication section suggests steps to resolve the analysis's problem in keeping with the CPA aim.

2.4.6 Ensuring Quality

Trustworthiness describes the amount of confidence in the data and analysis used to ensure a study's quality (Polit & Beck, 2017). There are many ways of defining trustworthiness; this study focuses on reflexivity and sustained feedback (Korstjens & Moser, 2018).

2.4.6.1 Trustworthiness

Reflexivity traditionally refers to the continuous process of critical self-reflection about oneself as a researcher and considering how personal bias affects the research (Korstjens & Moser, 2018). McCabe & Holmes (2009) expands on the usefulness of reflexivity, explaining that it is not limited to being a method to control researcher bias, but it is also

a mechanism for understanding new depth in research; it informs both the research process and the one conducting the research. As a CPA researcher, the author had to be continuously reflective. During the thesis proposal, the writer made an initial declaration of self and potential biases. The thesis supervisors allowed the author to have a self-critical account of the research process by discussing the research project's logistics, methodological decisions, and rationales with them. A brief recording the researcher's reflections of their values, interests, and insightful information about the self was shared with the thesis advisory committee (Nowell et al., 2017; Tobin & Begley, 2004). In keeping with McCabe & Holmes (2009), although the WPR questions appear to be fixed, the writer was open to explore the new questions that arise when analyzing policy documents.

2.4.6.2 Sustained Feedback

The writer of this thesis ensured the quality of study through ongoing reviews from the advisory committees inclusive of supervisors and an external committee member. The committee answered questions, critiqued writing, and thought processes, offered suggestions, and made continued edits throughout the analysis and the thesis writing process.

2.5 Acknowledgment of Self

This section is included with the thesis as a part of the intuitive process to put forth the author's personal belief that ingrained within policies exist firm institutional legislation (be it purposefully or unintentionally) designed to oppress marginalized populations. This declaration is an acknowledgment of this personal belief in advance of the policy analysis.

2.6 Jurisdictional and Legal Overview

The Canadian government is divided into three orders, as well as Indigenous governments, each of which may be involved in the implementation of SCS. SCS requires a federal exemption under section 56.1 of the Controlled Drugs and Substances Act (CDSA) to operate. The CDSA defines requirements that SCS applicants must

achieve in order to be given this exemption. The provincial government is responsible for healthcare services and related legislation. SCS is considered a healthcare intervention, therefore each province has the authority to make its own decisions regarding SCS as a healthcare service. Following the federal exemption, SCS applicants are presented with provincial criteria that must be met. The municipal government then has its regulations that govern sectors like local police and zoning, which might have an impact on the implementation of SCS. All three orders of government must then approve some component of implementation for SCS to be delivered. The legal intricacies, jurisdictions, and criminal law at the federal level are not considered in this thesis.

2.7 Findings

Bacchi's WPR approach was applied on the Federal level to Bill C-2 and C-37, whose reforms shape sections 55, 56, 56.1, and 56.2 of the Controlled Drugs and Substances Act (CDSA), which deal with the federal exemption of SCS. The SCS policy documents of Alberta, British Columbia, Ontario, and Quebec were also examined using the WPR approach. The focus of analysis is on the chosen policies as it directly details the legal obligation for the application and operation of SCS. This investigation delves into the implicit philosophies, inherent assumptions, silences, and effects on SCS users represented in current Canadian policies on SCS. Since the legislation reflects a society's ever-changing values, the current research provides vital insight and proposals for ongoing policy reform.

According to Bacchi (2009), the WPR methodology can be used systematically or as an integrated analysis. The current study takes both approaches, employing all the questions while also focusing on a few specific questions to delve deeper. Using questions 1, 2, 4, and 5 of the WPR approach as a guide, this research investigates how the problem of substance use is represented in the CDSA and other provincial policy documents, as well as the assumptions, silences, and impacts caused by this representation of the problem. When these questions were applied, four themes are proposed from the text, each of which applies to a different question in the WPR framework: (1) Public Health vs Criminality (2) Presumptions vs Assumptions, (3) Unaccountability in Policy, and (4)

Duality of Policy. Following a thorough examination of these proposed themes, the author provides critical self-reflection in compliance with Step 7 of the WPR process.

2.7.1 Problem Representation

The WPR approach applied to this research begins with a legislative policy intervention and works backwards in order to reveal how the issue is being conceptualized. For federal documents analyzed herein, CDSA Section 56.1 speaks directly to the obligations of service that SCS is bound to meet; Bill C-2 (Respect for Communities Act, 2015), as well as Bill C-37 (An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts, 2017), has shaped the details in Section 56.1. The problem for this thesis is the issue of substance use, so examining SCS policy shed light on how the CDSA conceptualizes substance use.

2.7.1.1 Federal

Three federal policy documents –CDSA, Bill C-37 and Bill C-2—were analyzed and coded, questioning “*what is the problem represented to be?*” in each of these specific policies in order to clarify the problem representation inherent within these policies. At first glance, all three federal SCS policy analyzed appears to reflect coherence with harm reduction by showing concern for both the health and safety of SCS users and the community at large. Bill C-2 (2015) acknowledges its objectives as protecting public health and public safety (p.1). The problem represented from this statement is that substance use is a public health issue. However, upon further analysis of the federal SCS policy documents, a common theme arose, wherein substance use and related SCS are presented as a criminal issue.

SCS is a healthcare-based harm reduction strategy that reflects the acute nature of Canada's current substance use crisis. The SCS policy that demands “evidence, if any, of any variation in crime rates in the vicinity of the site during the period beginning on the day on which the first exemption was granted under subsection” (Bill C-2, 2015, p. 13) has a degree of a presumption that SCS services may be connected to increased criminality. This legislative statement pulls away from the initial intent of public health and places emphasis on crime. The CDSA, Bill C-2, and Bill C-37 all influence the

application and continued operation of SCS by asking SCS applicants to provide a “description of the potential impacts of the proposed activities at the site on public safety, including the following: information, if any, on crime and public nuisance in the vicinity of the site and information on crime and public nuisance in the municipalities in which supervised consumption sites are located” (Bill C-2, 2015, p. 9). The problem representation as a criminal issue goes beyond noting the crime rate. Currently, without an exemption from the provisions of the CDSA, users and operators of SCS are exposed to the risk of criminal prosecution for certain drug offences—possession—under the CDSA. Prospective SCS operators are constrained by the need to apply on a case-by-case basis for a section 56.1 exemption under the CDSA (issued for a “medical purpose”) as the principal avenue for protecting SCS clients and providers from potential criminal prosecution. Inherently, this exemption does two things: 1) It acknowledges an SCS as a healthcare intervention, while simultaneously 2) problematizes SCS as an avenue for criminal activity. This problematization of SCS as an avenue for crime is further noted in the SCS application policy that requires key staff members to provide

A document issued by a Canadian police force in relation to each person referred to in paragraph (w), stating whether, in the 10 years before the day on which the application is made, in respect of a designated drug offence or a designated criminal offence, the person was (i) convicted as an adult, (ii) convicted as a young person in ordinary court, as those terms were defined in subsection 2(1) of the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985, immediately before that Act was repealed, or (iii) a young person who received an adult sentence, as those terms are defined in subsection 2(1) of the Youth Criminal Justice Act (Bill C-2, 2015, p. 12).

A further subtext of criminalization is seen in regulations around SCS staffing. Many research studies suggest that having staff and volunteers who have a personal history of substance use working in substance use services allows for knowledge sharing, the building of trust, and forming of meaningful relationships; this is valued by clients and coworkers and contributes to compassionate and non-judgmental work environments and insights that would otherwise be absent in an SCS (Austin & Boyd, 2021; Collins et al.,

2020). Significantly, involving people with lived experience with substance use has resulted in increased diversity within harm reduction and substance dependence treatment interventions, with socially and economically marginalized women and Indigenous PWUD playing a particularly prominent role in emerging programming (Austin & Boyd, 2021; Collins et al., 2020). Unfortunately, the policy representation as crime limits those who have this wealth of experience to help PWUD in their harm reduction journey through the use of SCS, by reducing the ability of these individuals to become key staff members if their previous lifestyle led to a run-in with the law. Instead, this policy prioritizes the perceived prevention of criminality over the positive health impact that those with lived experiences of substance use could offer. Fortunately, these individuals can still impact PWUD by taking on other roles in SCS.

It is also notable that embedded in federal SCS policy is the conceptualization of the problem as a need for rehabilitation. This representation is noted in the policy that requires, “A description of the drug treatment services available at the site, if any, for persons who would use the site” (Bill C-2, 2015, p. 8) and that SCS “may offer a person using the site alternative pharmaceutical therapy before that person consumes a controlled substance that is obtained in a manner not authorized under this Act” (*Controlled Drugs and Substances Act*, 2019, p. 54). Problematization of the substance use crisis in Canada as a need for rehabilitation under the SCS policy goes against the definition and intent of SCS, which is a harm reduction strategy that aims to reduce substance use's adverse health and social consequences without necessarily decreasing substance consumption (Barry, 2018; McGinty et al., 2018). The main goals of SCS include the reduction of disease transmission, overdose, public illicit substance use, and improving access to health and social services (Kimber, Dolan, & Wodak, 2005). Although rehabilitation referrals are included as a part of the health service any individual may request, structuring the problem as a need for rehabilitation shifts focus from reducing substance-related harms to prioritizing treatment.

2.7.1.2 Provincial

The Province of Alberta mentions that “Supervised consumption services are part of the addiction and mental health service continuum, and service providers are required to help

clients in accessing other resources along the continuum of treatment and recovery services” (Alberta Ministry of Health, 2021, p. 7). At first glance, this policy assertion portrays the problem as a lack of continuity of care, implying that the substance use issue extends beyond addiction and mental health services and that it can be applied across the spectrum of health services, rather than being limited to the prevention of bloodborne pathogens. Other aspects of health should be considered as well. However, the latter part of the policy statement shows that the problem is portrayed as a shortage of treatment services; this interpretation is supported by the statement, “Employees are available to respond to people in medical distress and connect people to services like treatment within a recovery-oriented system of care. It is important that these services exist within a broad continuum of services that can support Albertans on their path to recovery” (Alberta Ministry of Health, 2021, p. 5). A recovery-oriented system is further defined in the Alberta policy as, “...a coordinated network of community-based services and supports that is person-centred and builds on the strengths and resilience of individuals, families, and communities to achieve a life free of illicit drugs and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems or mental health issues.” (Alberta Ministry of Health, 2021, p. 5). While this recovery-oriented method is outlined here, it problematizes substance use as a lack of continuity of care services and eliminates one of the objectives of harm reduction by presenting SCS goals as a substance-free existence. The other three provinces represent substance use as a need for harm reduction and as public health and social issue. British Columbia Ministry of Health (2012) and Ministère de la Santé et des Services Sociaux (2013) explicitly discuss the problem representation by mentioning that the problematic substance use is a significant public health and social issue. The Ministry of Health and Long-Term Care in Ontario (2018) takes it further in this problematization by mandating that “Consumption and Treatment Services (CTS) must provide integrated, wrap-around services that connect clients who use drugs to primary care, treatment, and other health and social services” (p. 3). Despite the shared problem representation across all four provinces, the influence of the federal policy on what the problem is represented to be can be noted in the provincial policy documents. The federal conceptualization that imposes itself on provincial policy is the view of illicit substance use as a criminal issue.

Such representation imposes that “Local promoters should describe the local situation regarding certain aspects of the public safety related to injection drug use and provide existing information, based on research as well as health and law enforcement statistics relating to following items: (1) Public disorder and criminality linked to drug consumption (e.g. feeling of safety in the sector, number of violations of municipal regulations concerning public order, drug trafficking” (Ministère de la Santé et des Services Sociaux, 2013, p. 6). The provincial policy initially represented the problem of substance use as one of public health and harm reduction; however, the federal policy does impose the presumption of criminal activity in SCS, and this idea is mandated to be included in provincial policy in order to attain exemption to operate as federally sanctioned.

2.7.2 Presumptions and Assumptions in the Problem Representation

WPR question 2 asks *what presuppositions –necessary meanings antecedent to an argument—and assumptions (ontological, epistemological) underlie this representation of the "problem" (problem representation)?* It calls for a reflection on the underlying presumptions and assumptions that contribute to the problem representation. To correctly analyze policy based on this query, it becomes essential to distinguish between presumptions and assumptions. Presumptions refer to taking something as accurate based on a reasonable amount of evidence or confidence-backed reasoning, while an assumption is taking something as true with little to no evidence (Editors of Merriam-Webster, 2019).

2.7.2.1 Federal

Thus far, it has been proposed that the federal SCS policy has represented substance use as a criminal issue and that those accessing services need rehabilitation. This section reviews the underlying presumptions in the problem representation and common assumptions made throughout the federal policy documents.

Bill C-2 mentions, “Whereas the money that is used to purchase controlled substances that are obtained from illicit sources often originates from criminal activity such as theft,

and that money, in turn, often funds organized crime in our communities” (p. 1). This statement acknowledges that the federal policymakers and governing body presume PWUD and, therefore, SCS users purposefully contribute to reducing public safety in communities by engaging in the procurement of illicit substances for use in SCS. With this presumption, it is no surprise that SCS policy document represents the problem as a criminal issue, and the SCS application and continued operation require extensive research on SCS “impact on criminal activity” (Bill C-2, 2015, p.13; Bill C-37, 2017, p. 42; CDSA, 2019, p. 55). The policy statement at the beginning of the paragraph presumes that PWUD and SCS users continue to perpetrate crimes by purchasing substances with money obtained illegally. While current evidence suggests that PWUD use money from criminalized activities to purchase substances, especially in specific communities living in poverty with few options for employment due to social issues such as stigma and a lack of training/opportunities, the evidence does not show that PWUD criminal activity increases with the presence of SCS (Jaffe et al., 2021). It is worth debating why this activity is important in the first place and how it relates to SCS as a health intervention. The phrasing of this policy statement presumes that criminal activity results from the use of substances. Further inclusion of this statement in the SCS policy document assumes that SCS services may be connected to increased criminality, so SCS poses a public safety issue for the communities that apply to engage in this harm reduction strategy.

Another problem representation again noted in the policy analysis is the conceptualization of substance use as a need for rehabilitation. The statements, “A description of the substance treatment services available at the site, if any, for persons who would use the site” (Bill C-2, 2015, p. 8) and that SCS “may offer a person using the site alternative pharmaceutical therapy before that person consumes a controlled substance that is obtained in a manner not authorized under this Act” (CDSA, 2019, p. 56) makes two assumptions: 1) It assumes that the primary intent of SCS is rehabilitation, and 2) it presumes that PWUD and SCS users want to stop using substances. SCS remains a harm reduction strategy, as stated throughout this analysis. An assumption can be made that SCS users are reasonably aware of the benefits of using SCS—overdose prevention, clean injection equipment, education for safer injecting, and health and social referrals or access—hence, the use SCS to allow for safer use of substances, as opposed

to using SCS to necessarily reduce or stop use. It is worth acknowledging that given that SCS users may use the sites for a number of reasons, the ambiguous use of the term "may" implies that this statement is not required, and may be construed as offering PWUD the choice of alternative therapy or illegal substance use.

Across all three policy documents analyzed there exists a common statement “The Minister may, on any terms and conditions that the Minister considers necessary, exempt from the application of all or any of the provisions of this Act or the regulations any person or class of persons or any controlled substance or precursor or any class of either of them if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest” (Bill C-2, 2015, p. 5; Bill C-37, 2017, p. 43-44; CDSA, 2019 p. 55). This statement makes the fundamental assumption that the Minister—who is the sole approver for the application and opening of SCS—opinions are evidence-based and guided by reasonability as opposed to being politically motivated, biased, or prejudiced. Another statement with the similar assumption in all three federal policy document demand, “expressions of community support or opposition” and, “a summary of the opinions of those groups on the proposed activities at the site” for the application for approval for SCS (Bill C-2, 2015, p. 10; Bill C-37, 2017, p. 44; CDSA, 2019, p. 55). It assumes that opening a community dialogue on the stigmatized issue of substance use will have some inherent value. As the policy statement calls for hearing group opinions, it implicitly expects or assumes that opinions of community groups will be fair, logic-based, and unbiased towards an intervention for this highly marginalized and stigmatized group, PWUD. Mandating the inclusion of the community groups' opinions in the decision-making process for SCS allows room for prejudice and stigma to impact the health outcomes of PWUD.

2.7.2.2 Provincial

Provincial policies share assumptions and presumptions similar to those discussed in the federal analysis. The first being a degree of a presumption that disorder, and crime go on in and around SCS. “The organization should describe the potential impact of the SIS on public safety, including (where available through health or law enforcement research and statistics) estimates of public disorder and crime” (British Columbia Ministry of Health,

2012, p. 3). The Ministry of Health and Long-Term Care in Ontario (2018) specifically asks for “the number of times security staff addressed a security event in the immediate perimeter of the CTS” (p. 17). Another British Columbian policy document goes on to mention that “Public order and safety may be put at risk by open drug use in communities” (British Columbia Ministry of Health, 2005, p.2). This statement assumes that having SCS where PWUD can use substances openly under supervision will lead to public disorder and compromise the community's safety. The policy assumes that open substance use may go up in the community and that criminal activity related to substance use might also increase in the community before the emergence of SCS as a harm reduction in that community. In a related manner, Alberta's policy reads that “Community engagement policies must demonstrate a relationship with local law enforcement and plans to mitigate public safety concerns in an ongoing way.” (Alberta Ministry of Health, 2021, p. 6). According to a study, a strong relationship with local police enforcement is critical to SCS effectiveness (See Strike et al., 2020). Given that SCS users utilize prohibited substances, it is reasonable to assume that criminal activity does occur in the vicinity of the facility. However, there is still an assumption that the implementation of SCS would increase criminal activity in some way. It should be reiterated that SCS is only used in situations when there is a considerable amount of substance use already present. The province of Quebec shares a similar presumption about public use by mentioning that “additional measures must be taken to prevent people from injecting drugs in public places (parks, alleys, public toilets)” (Ministère de la Santé et des Services Sociaux, 2013, p. 6). It is presumed that PWUD mostly use substances in public areas, however research shows the contrary, and SCS integration in the community has been shown to reduce public injecting (Wood et al., 2004).

Another shared assumption between federal and provincial is the presumption that PWUD wants to stop using substances. Presumptions are obvious in the statement “The Vancouver site has been found to attract younger drug user ...this provides an important opportunity to link this hard to reach the group with ...addiction treatment services” (British Columbia Ministry of Health, 2005, p.11). Ontario makes a similar assumption about PWUD in the policy statement that mandates “Onsite or defined pathways to addictions treatment services” (Ontario Ministry of Health and Long-Term Care, 2018, p.

3). Alberta made a similar statement “On-site or defined pathways to addiction treatment and recovery-oriented services, including mental health supports” (Alberta Ministry of Health, 2021, p. 5). The Alberta policy statement does exhibit a dual nature, on the one hand it acknowledges that substance use is connected with need for mental health support. However, it also presumes and emphasizes treatment, which is a different philosophy than harm reduction, which has no requirement for decreasing or stopping use. Also, worth noting in the Ministry of Health and Long-Term Care in Ontario policy document is the implicit assumption that there will be continued friction between SCS and the community. This is evident in the statement “CTS operators will be required to support ongoing community engagement and liaison initiatives to address local community and neighbourhood concerns on an ongoing basis” (Ministry of Health and Long-Term Care, 2018, p.4). Alberta Mental Health Services Act make a similar presumption that community support constantly changes but takes it further by making it grounds for dismissing SCS.

2.7.3 Discourses Constructed Through Policy Preambles

WPR next asks *How has this representation of the problem come about?* Question 3 can be considered a historical analysis, as the researcher interrogates how this problem representation emerged. This question has two primary objectives: to reflect on historical developments and to recognize that problem representations exist and change over time and space, under changing influences. This subject has been discussed in many papers concerning SCS policy (see Baker & McCann, 2018; Hayle, 2015; Hayle, 2018; Ziegler et al., 2019; Zlotorzynska et al., 2013). The preamble sections of federal policy documents provide insight into the changes that led to policy change and are analyzed to address this question.

2.7.3.1 Federal

The first legally sanctioned site—Insite—was permitted to operate after being granted a federal exemption under section 56.1 of the CDSA (Dooling and Rachlis 2010). Section 56.1 allowed the Minister to grant an exemption if, “the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest” (CDSA, 2019, p. 54).

This policy statement acknowledges SCS as a healthcare intervention that benefited members of the community. In 2015, the Conservative-led Government of Canada introduced Bill C-2 in response to the Supreme Court of Canada ruling that favoured the sanctioning of SCS. This Bill acknowledged that substance use and its production impacts Canadians, and the harm related to substance use is an issue in the nation: “Whereas the diversion of controlled substances and precursors, as those terms are defined in the Act, which is frequently used in the production of illicit drugs, is a worldwide problem with significant impacts on Canada” and “Whereas the negative consequences associated with the use of illicit substances can have significant impacts on vulnerable subsets of the Canadian population” (Bill C-2, 2015, p. 1 - 2). However, Bill C-2 meant that onerous criteria were created that sites were obligated to adhere to, in order to be considered for federal exemption evident by the statement, “And whereas an exemption from the application of the Act and its regulations for certain activities concerning controlled substances that are obtained from illicit sources should only be granted in exceptional circumstances and after the applicant has addressed **rigorous criteria**” (Bill C-2, 2015, p. 2). The 'rigorous criteria' imposed by Bill C-2 accomplishes two objectives. 1) It explicitly concedes that opening SCS should be challenging and then goes on to make it so, and 2) it offers justification for the problematic portrayal of SCS as a conduit for criminal activity. The objectives imply that, because the goal was to make it difficult for SCS to open, the problem had to be portrayed in a way that concerned everyone and piqued the public's interest. After the Liberal Party formed the government, Canada introduced Bill C-37, *An Act to amend the Controlled Drugs and Substances Act* and to make related amendments to other Acts in 2017, which came to be with the intent of reducing the number of criteria that sites needed to meet to be granted a federal exemption. The intentions were clearly stated in the policy statement “This enactment amends the Controlled Drugs and Substances Act to, among other things, (a) simplify the process of applying for an exemption that would allow certain activities to take place at an SCS, as well as the process of applying for subsequent exemptions” (Bill C-37, 2017, p. ii). This suggests that the policy came to be to simplify the process of operating. The present CDSA is framed by the discourse between Bill C-2 and Bill C-37, which was influenced by two opposing political parties (Conservative versus Liberal). The CDSA

looks to be more equitable than the explicit aim of Bill C-2, yet it retains the underlying intent of Bill C-2 in the policy framing and problem representations.

2.7.3.2 Provincial

The Ontario Ministry of Health and Long-Term Care (2018, p. 3) policy states that “In October 2018, Ontario’s Deputy Premier and Minister of Health and Long-term Care announced a new program to help people who are struggling with addiction receive healthcare and other supports”. This statement describes the intent of initiating SCS in the province of Ontario, and this aim is reflected in the problem representation of substance use as a public health concern. Quebec followed suit. Alberta portrayed the problem as a need for a continuum of treatment and recovery-oriented services, and this portrayal was inspired by and is reinforced by the Mental Health Service Act, which states that “A policy or procedure referred to in subsection (1) must meet the requirements, if any, set out in the Recovery-oriented Overdose Prevention Services Guide.” (Alberta Mental Health Services Protection, 2021, p. 3). It refers to the province's recommendations, which are very recovery-oriented, so much so that it is reflected in the policy name.

2.7.4 Silences in Policy

Question 4 of the WPR policy analysis method requires an in-depth analysis of the gaps, consequences, and facilitators in the policy of study. It acknowledges the limitations of problematizations through a careful analysis of the gaps and silences left by representations. Thus far, within the problem representation, presumptions, assumptions, and becoming of current policy there exist some silences and gaps, but this question seeks to make explicit that which was previously subtle.

2.7.4.1 Federal

The previous question noted problem representation in the policy statement, which allows for federal exemption only “in exceptional circumstances and after the applicant has addressed rigorous criteria” (Bill C-2, 2015, p. 2). This use of the particular word “rigorous” in this statement must be looked into further to understand the implicit meaning and silences. Rigorous, by popular definition, refers to doing something

carefully and with much attention to detail; in simpler terms, it means being extreme, strict, complex, and demanding (Merriam-Webster, 2021; Oxford University Press, 2021). The policy statement noted above acknowledges that the application and opening of SCS ought to be problematic. What is silenced here is the acknowledgment that the application criteria to be met are demanding and extreme, hence why it lays out incredibly detailed and tedious criteria for SCS application.

The federal SCS policies analyzed use a significant amount of vague terminology, which is open to interpretation by the decision-maker. According to Bill C-2 (2015), the Minister can require “any other information [he/she] considers relevant to the consideration of the application” (p. 12). Additionally, “The Minister *may* consider an application for an exemption for a medical purpose under subsection” (Bill C-2, 2015, p. 5; Bill C-37, 2017, p. 43; CDSA, 2019, p. 55). What is silenced in this statement is the use of vague verbiage like “may” and “consideration” in federal SCS policy proposes no indication of what level of information, research, opposition, or support would result in an application being accepted or denied and, no timeline for a decision once the required information is submitted. In fact, under the current legislation, the Minister is not required to view any SCS application despite meeting the “rigorous” application criteria. Federal SCS policy, as it stands, employs vague wording to give the Minister and Governor-General authority over the health of the highly stigmatised PWUD community. “The Governor in Council may make regulations for carrying out the purposes and provisions of this Act, including the regulation of the medical, scientific and industrial applications and distribution of controlled substances and precursors and the enforcement of this Act” (Bill C-2, 2015, p. 4; Bill C-37, 2017, p. 38; CDSA, 2019, p. 49). Here, what is implicit is the suggestion that the Governor in council can solely redefine regulation and terms that regulate SCS without any obligation to indicate the level of information or research that went into such decision. Bill C-37 tries to remedy this by mandating that, “After making a decision under subsection (1), the Minister shall, in writing, make the decision public and, if the decision is a refusal, include the reasons for it” (Bill C-37, 2017, p. 44; CDSA, 2019, p. 56). However, the silence remains as the Minister’s reasoning is public only after the decision is made. There still is no obligation for the Minister to re-review the application after the reasoning for rejections has been

mediated. The Minister continues to have unilateral veto power. The ambiguity in policy wording appears to provide statutory language to defend site denial decisions if challenged.

2.7.4.2 Provincial

Across all policy documents analyzed in this study is the shared statement or mentioning that, “The organization should describe the potential impact of the SIS on public safety, including (where available through health or law enforcement research and statistics) estimates of (1) public disorder and crime; (2) public injection; and (3) inappropriately discarded injection or other drug-related litter” (British Columbia Ministry of Health, 2012, p.3; Ministère de la Santé et des Services Sociaux, 2013, p. 6). What is silenced here is the obligation that the SCS applicants and operators have to meet based on the mandate set by the federal government. This policy appears to have trickled down to provincial policy because of the federal problematization of substance use as a criminal issue. The province must support this notion by mandating the SCS service provider to be on the watch for criminal behaviour on the site at all times and to report it should it occur.

In Ontario’s policy document, several silences were noted throughout the policy document. First, the statement that “CTS will not be concentrated in one area or neighbourhood, and proximity to childcare centers, parks and/or schools (including post-secondary institutions) will be considered” (Ontario Ministry of Health and Long-Term Care, 2018, p. 4). The silence here is the implicit bias and institutionalized stigma that the province has towards PWUD. This bias suggests that SCS can be in the community but not a part of the community, not in the same way other healthcare interventions are. The consideration of where the SCS is located to a degree suggests that it should be hidden, including removal from any public spaces. Second, the vague terms used in the federal policy can be noted in the statement, “Applicants who meet the provincial program criteria, and receive an exemption from Health Canada to establish a supervised consumption service (SCS), may be considered by the ministry for provincial CTS funding” (Ontario Ministry of Health and Long-Term Care, 2018, p.4). This statement provides the opportunity for the provincial government to be absolved of responsibility of funding SCS by implying that even after all necessary exemptions and approval to run

SCS, the province is not mandated to fund the site. Further, the province of Ontario strongly encourages SCS to be a wrap-around service. However, it will not fund said services. “Only Full-Time Equivalent employees (FTEs) and supplies directly associated with the consumption service, post-consumption space, referrals, and/or addressing community concerns will be eligible for funding. The program funding will not cover direct costs of wrap-around services” (Ontario Ministry of Health and Long-Term Care, 2018, p.12). The silence here is that SCS can refer PWUD to services they need and will benefit from; however, the services often cannot be used related to cost. This policy fails to see PWUD holistically by not seeing the intersection between health and financial cost. Lastly, legislation states that “The ministry will identify communities demonstrating a need for CTS based on the following: (1) Mortality data: (a) Number of opioid-related deaths (i.e., cases) (b) Rate of opioid-related deaths” (Ontario Ministry of Health and Long-Term Care, 2018, p.6). This statement suggests to a certain degree that unless we see a result of death or extreme harm, a harm reduction strategy cannot be placed in the community.

In British Columbia, SCS policy places some emphasis on public safety, and it goes on to make assumptions that SCS will encourage open substance use, which will lead to civil disorder and compromise safety. However, the policy statement “Public order and safety may be put at risk by open drug use in communities” (British Columbia Ministry of Health, 2005, p.2) silences the notion that SCS is established in communities that need it. This means that SCS exist in communities that already have public substance use, purchasing of illicit substance, and harms related to substance use on PWUD.

The Province of Quebec policy has a silence or subtly that can be considered a positive one that other policy documents—provincial and federal—have been unable to offer SCS. “Once the positive response has been received from the Minister of Health of Canada, the MSSS (Ministère de la Santé et des Services Sociaux) and the agency can then give their approval to the implementation of the project and give it the appropriate support” (Ministère de la Santé et des Services Sociaux, Quebec, 2013, p.10). This policy is the first of its kind to offer certainty that, pending approval from the federal government, the ministry will support the SCS. Other provinces must receive approval

from three levels of government (Federal, Provincial, and municipality) and even still, the vague terminology does not guarantee support. Quebec offers support as long as federal standards are met.

Three major silences have been identified in Alberta's SCS policy. First, the Alberta SCS policy contains a "Good Neighbour" policy, which stipulates "in addition to demonstrating rigorous community consultation and engagement regarding the site. Good neighbour agreements will support the successful integration of a site with the surrounding neighbourhood and community as a whole. Good neighbour agreements must include the following: interested parties signing on to the agreement (e.g., local businesses, community associations and nearby residents within a minimum 200-metre radius); the responsibilities and commitments of each party, including the service provided" (Alberta Ministry of Health, 2021, p. 6). The wording of this regulation makes it sound quite fair since it states that SCS candidates must respect the community. What is left unsaid is that even if applicants complete all required duties and respond to or address community concerns, members of the community are not compelled to sign the agreement. This appears to be unjust because the supply of healthcare might be subject to the whims of neighbourhood organizations and groups within a 200-meter radius.

Second, the text that says "Nearby detox, addiction treatment, and social assistance agencies" is silent (Alberta Ministry of Health, 2021, p. 19). The policy statement does not elaborate on what "nearby" means. If nearby means within a local region, the issue here is that smaller or remote towns without detoxes that have a need for SCS may be unable to adopt SCS due to a lack of nearby detox facilities. If it is considered to imply the closest, the distance does not matter. Clarity would be beneficial in this situation.

Finally, the provincial policy that says "For the purpose of ensuring that this Regulation is reviewed for ongoing relevancy and necessity, with the option that it may be repassed in its present or an amended form following a review, this Regulation expires on June 30, 2026" (Alberta Mental Health Services Protection, 2021, p. 6) ensures that policy is continually evaluated. Mandated continuous evaluation of policy can be useful in enhancing policy to favour PWUD. However this timetable could be a concern as the structure does imply that certain incorrect policies can go unchecked or unaltered until 2026.

2.7.5 Potential Effect of Problem Representation (discursive, subjectification, and lived)

The next question asks *What effects (discursive, subjectification, and lived) are produced by this representation of the problem?* The term ‘effects’ does not refer to its traditional meaning of evaluation or measurement of outcomes; instead, it means being attuned to the consequences of particular problem representations for power relations (Bacchi, 2009, p. 15; Bacchi, 2016). Bacchi identifies three main ‘effects’ of problem representation: discursive, subjectification and lived effects. Discursive refers to how problem representations delimit what can be thought or said; it contributes to constructing the fundamental ways we perceive and understand issues, rather than just symbolizing an existing issue (Bacchi, 2009, Bacchi and Eveline, 2010). Subjectification is how kinds of political subjects and subject positions are discursively produced, and it is how people are positioned in a problem (Bacchi, 2009, Bacchi and Eveline, 2010). Finally, lived effect means the actual, material repercussions and impact in people's lives (Bacchi, 2009, Bacchi and Eveline, 2010). Question 5 calls for a critical examination of the effects of problem representations, which often benefit some groups and harm others.

2.7.5.1 Discursive

An application for an exemption under subsection (1) shall include information, submitted in the form and manner determined by the Minister, regarding the intended public health benefits of the site and information, if any, related to (a) the impact of the site on crime rates; (b) the local conditions indicating a need for the site; (c) the administrative structure in place to support the site; (d) the resources available to support the maintenance of the site; and (e) expressions of community support or opposition (Bill C-37, 2017, p. 44; CDSA, 2019, p. 55).

The policy stated above is a federal SCS policy that shows the intent of the legislative and governing bodies to understand the benefit of what an SCS can offer by mandating “information...regarding the intended public health benefits of the site.” The statement lists five criteria that have now become requirements for the application and subsequent opening of SCS if approved. The duality of the criteria is apparent when viewed under a

critical lens. “Impact of the site on crime rate” this criterion reflects the concern that the policy has for the public safety of the community members. As stated in previous questions, it also problematizes the current substance crisis as a criminal issue by prioritizing the rate of crime associated with SCS. This statement does assume links to criminal activity occurs at the sites and acknowledges that it ought to be tracked. In addition, it shifts the focus from curbing the substance use crisis by reducing harm related to substance use to criminal activity that may or may not occur at the SCS site. It bears no relation to the tenant of harm reduction.

The second criteria, “the local conditions indicating a need for the site,” provides the opportunity in the SCS application process to provide hard evidence and data on the realities of the substance crisis in the communities that SCS will be opening in. It reflects a favourable policy that uses evidence to guide application decisions. Alberta’s Ministry of Health SCS policy uses this criterion to change how we perceive or understand the issue of substance use thus far in policy by making the explicit statement that, “on-site or defined pathways to a variety of wrap-around services including but not limited to primary care, housing and other social supports” (Alberta Ministry of Health, 2021, p. 5). This statement takes a holistic look at PWUD and encourages viewing this marginalized group beyond substance use and instead see how multiple factors come into play that perpetuate the current substance use crisis. Similarly, the province of Quebec understands the role of social determinants of health in substance use and it offers “SIS is part of an integrated offer of healthcare and social services” (Ministère de la Santé et des Services Sociaux, Quebec, 2013, p.8). Ontario attempts to have a holistic approach to SCS policy for PWUD, but the duality of policy that holds no government body accountable is revealed again, “Applicants may provide additional optional services based on capacity and local conditions. These should be described in the application. Please note that optional services may require approval from Health Canada and/or the ministry based on the type of service” (Ontario Ministry of Health and Long-Term Care, 2018, p.7). This statement allows for flexibility and opportunity to tailor care to the needs of PWUD, but the ambiguity comes into play where the services are not mandated to be approved by the governing body.

The third criteria, “The administrative structure in place to support the site” on the one hand, appears to show concern for SCS and its users by requesting a structure that serves the population best. On the other hand, it has been previously required in policy that key staff have no criminal record in the last ten years, bringing the problematic conceptualization of substance use and SCS as a criminal issue again and limiting the hiring of experienced staff as PWUD allies. Also, this statement does not detail what exactly is meant by “administrative structure” does this include hours of operation? Staffing protocol? Eligibility criteria for site use? Procedure for managing site narcotics and pharmaceutical interventions? The administrative structure is left to the interpretation of the SCS applicant. Further, it offers no guidance on how best to serve the PWUD regarding any listed structures. This statement does not require the SCS users and PWUD to be a part of the administrative structure process. However, as the users of SCS, the PWUD would be able to understand the needs of the population better and help put forth ideas and structures that would best serve the needs of the intended population.

“The resources available to support the maintenance of the site” refers to the financial resource of the SCS. The legislation suggests having a budget and securing funds or a commitment to funding SCS; however, with the framing of the SCS policy, there is currently no indication of what level of information, research, opposition, or support would result in an application being accepted or denied. The lack of certainty in current policy poses a burden when convincing an organization or community to commit to funding an SCS. This can, in turn, impede the opening of SCS because, without resources, this criterion will not be met and therefore gives the Minister grounds for rejecting an application.

The last criteria, “expressions of community support or opposition,” pose much duality regarding who benefits and who loses from the problem representation. The statement allows everyone in a community to input a health intervention that only impacts a specific population subset. It allows SCS proponents, allies and advocate, a forum to voice the benefit of the SCS, use evidence to address and debunk stigma and prejudice that member of the community may have against SCS. Consequently, it also gives free rein for opinions lead by unfounded fears, biases, and personal prejudice to be not only

voiced but impact the marginalized PWUD group health and welfare. This policy statement does not require the concerns and oppositions to be backed by evidence or discussed logically. The duality of policy seen in the federal analysis is also present in the provincial policy document, and this discursively contributes to the construction of the fundamental ways we perceive and understand issues. The Ontario policy statement: “CTS operators will be required to support ongoing community engagement and liaison initiatives to address local community and neighbourhood concerns on an ongoing basis” on the one hand, allows for continuous engagement with the community to share insight on SCS, PWUD and offers an opportunity to destigmatize PWUD (Ontario Ministry of Health and Long-Term Care, 2018, p.4). However, the policy’s phrasing separates the local community from the SCS operators and SCS users.

2.7.5.2 Subjectification

The subjectification effect calls into question how policy positions people. Asking for information on the “impact of crime rate” poses a degree of an assumption that PWUD is thought about as a group of individuals who conduct or partake in criminal activity and not a marginalized group seeking a health intervention to reduce harm related to substance use disorder. Conversely, the Quebec provincial policy statement that mandates “local promoters to show how the supervised injection service: (1) is part of a continuum of services related to the use of psychoactive substances and the misdeeds that result from it; (2) respects the principle of “low entry threshold”; (3) is adapted to the gender, culture and demography of the target population” positions PWUD as a priority, by focusing on continuity of care (Ministère de la Santé et des Services Sociaux, 2013, p.5). It also sees PWUD as marginalized in the community, but this insinuation encourages culturally competent care by insisting on adapting care and services to different populations within PWUD.

The remaining criteria in the federal policy (b) to (e) (Bill C-37, 2017, p. 44; CDSA, 2019, p. 55), allows PWUD to be a part of the community since it demands understanding of substance use and substance use disorder from the perspective of PWUD. It sheds light on how this population's health is impacted. However, if members of the community who oppose SCS position PWUD as criminals or not part of the

community related to the transient nature of the group, then these criteria could pose a burden that negatively impacts the health of PWUD. None of the criteria explicitly create opportunities to hear the thoughts of PWUD, implicitly positioning this population in policy as unable to partake in the discussions that impact their health. Provincial policies have this same duality in how they position PWUD for example, British Columbia's policy notes "Emergency, transitional and supportive housing must be available for people who continue to use drugs, as well as those who are in recovery. Other supports needed to help people reintegrate into the community include low threshold mental health and addictions services, assertive community outreach, life and work skills training and supportive employment" (British Columbia Ministry of Health, 2005, p.16). This statement does have that duality of policy where, on the one hand, it acknowledges that PWUD are not part of the community or are excluded from their local community, while, fostering the reintegration of PWUD into their community by examining this group in its entirety, noting the social-economic challenges they encounter, and ensuring that the limitations are addressed. Ontario positions PWUD in policy as a part of the substance use solution by encouraging their involvement in SCS staffing and operational details evident by the statements: "Proposed hours should be based on local context and consultation with community stakeholders, local community groups, and persons with lived experience... The staffing model must include peers/persons with lived experience" (Ontario Ministry of Health and Long-Term Care, 2018, p.7-8). This statement fosters inclusivity and respects that PWUD do know what works best for them, services they wish to see and can contribute to their health outcomes. It empowers PWUD to be involved in the decision makings of SCS, which the PWUD population will frequent.

2.7.5.3 Lived: Real Effects on Real People

The actual effects on real people in each of the previously listed federal criteria's are that; "Impact of crime rate" informs the community to remain conscious of criminal activity in the area surrounding SCS and in SCS. It may also be used to demonstrate to the public that an SCS does not affect crime rates. "The local conditions indicating a need for the site" allows people to understand facts of what is going on in their community and how SCS could mediate the problem. "Expressions of community support or opposition"

offers a platform for PWUD in the community to share their story, their lived experience with substance use and its related harms. It can also serve to perpetuate the prejudice of PWUD and further marginalization of this group. This stigma can obstruct access to a harm reduction approach for PWUD and create various hurdles to PWUD obtaining and utilizing health and social services. This statement demonstrates how community resistance or support imposed by federal policy constrains provincial policy and pushes policymakers to acknowledge it, “Applicants will require evidence of support by local stakeholders, including residents. Community consultation is a requirement of the federal CDSA exemption application and does not have to be carried out separately for the Ontario program application, provided the consultation meets federal requirements” (Ontario Ministry of Health and Long-Term Care, 2018, p. 10- 11). The Alberta policy approach takes it one step further and mentions that “A director may consider the following criteria when issuing or refusing to issue, amend or renew a license for the provision of supervised consumption services: (a) community support for the services” (Alberta Mental Health Services Protection, 2021, p. 3). This policy allows community opinion and lack of support to shut down or prevent the implementation of SCS — a health service — in Alberta. This policy affects PWUD by allowing room for prejudicial opinions to influence the decision of SCS, same as in the federal policy. Having a potentially lifesaving and harm reducing health intervention like SCS depends on public opinion does not bode well for this highly stigmatized and marginalized group.

The policy statements at the provincial level have a direct and practical influence on the lives of PWUD. According to Alberta’s SCS policy, “Service providers must have in place policies that demonstrate clearly defined referral pathways to treatment and recovery services and, where possible, minimize barriers to accessing detox and treatment programs” (Alberta Ministry of Health, 2021, p. 7). This regulation may benefit individuals who seek treatment, but it is unclear if others who do not seek treatment or do not desire to stop using the site will be able to continue to use it. It appears to prioritise therapy above possible alternative interventions for PWUD. The current Ontario provincial policy appears inclusive by ensuring “the facility meets municipal bylaws and provincial regulations for accessibility” (Ontario Ministry of Health and Long-Term Care, 2018, p.9).

2.7.6 Production, Dissemination, and Defence of the Problem

Finally, question 6 of the WPR method suggests an analysis of how a particular problem representation is conveyed to the public. This question necessitates considering how a particular representation becomes dominant (Bacchi, 2009; Bletsas & Beasley, 2012).

Evidence from all the other questions clarifies how the problem of representation became dominant in the policy. Bill C-2 states that “if, in the opinion of the Minister, the exemption is necessary for a medical, law enforcement” (Bill C-2, 2015, p. 8).

Throughout federal policy documents, substance use is conceptualized as a criminal issue, and it has been reflected in the acknowledgement of the bias (see Bill C-2, 2015, p. 10; Bill C-37, 2017, p. 44; CDSA, 2019, p. 55) and presumptions made based on the conceptualized issue. This problematization has been perpetuated in policy by the use of vague terminology and statutory language to defend negative or lack of decisions (see Bill C-2, 2015, p. 5; Bill C-37, 2017, p. 43; CDSA, 2019, p. 55) superfluous requirements (see Bill C-2, 2015, p. 2) and the provision of opportunity for public opposition (Bill C-2, 2015, p. 10; Bill C-37, 2017, p. 44; CDSA, 2019, p. 55) all the while framing issue as a “public safety issue.” Fortunately, these policies have been questioned by SCS advocates and reformed in part by Bill C-37, which reduces in part the vagueness regarding the role that the Minister plays by ensuring transparency and accountability (Bill C-37, 2017). Nonetheless, this problem and its conceptualization remain, and the discussion section will offer a further interpretation of what has been learnt concerning federal policy.

Most provincial policy documents have problematized substance use as a need for harm reduction or public health intervention, while Alberta conceptualized substance use as a need for a recovery-oriented system. According to the policy documents, this problem representation has become dominant for three main reasons: the first is the “ongoing community engagement and liaison initiatives to address local community and neighbourhood concerns on an ongoing basis” (Ontario Ministry of Health and Long-Term Care, 2018, p.11), which allows ongoing education to members of the community and provides a safe environment perspective sharing, as well as, for prejudices to be mentioned and then destigmatized or broken down. The second is related to “Close involvement with members of the local media is important to ensure the public receives

accurate information” (British Columbia Ministry of Health, 2005, p. 11). This statement confirms that the media play a significant role in how the public perceived an issue. Finally, Alberta defends the problem representation as an avenue for PWUD to live substance free, betterment of mental health, and quality of life by phrasing the SCS process as “a coordinated network of community-based services and supports that is person centered and builds on the strengths and resilience of individuals, families, and communities to achieve a life free of illicit drugs and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems or mental health issues” (Alberta Ministry of Health, 2021, p. 5).

2.7.7 Self- Reflection

A complete study of problematization necessarily includes reflection on the self. The researcher's position in a WPR analysis comes with a set of beliefs, assumptions, and intentions that influence the study of problem representations. In light of this, self-problematization is built into the WPR approach – Bacchi encourages the applications of all questions to one’s own biases (Bacchi, 2009). A WPR analysis “radicalizes our sense of the contingency of our dearest biases and most accepted necessities, thereby opening up a space for change” (Flynn, 2005, p. 33). In this sense, applying a critical lens to one’s thoughts lays the foundation for reflection and growth, and the WPR approach moves from a series of declarations to an exercise in critical reflexivity (Bacchi & Goodwin, 2016).

I applied Bacchi’s WPR approach to my problem representations at this last point in the analysis. Bacchi stipulates that the Act of self-problematization is critical, given that everyone is uniquely situated in history and culture. This Act of reflexivity problematizes our thought processes and shifts the WPR approach beyond observation into a rigorous activity in thought (Bacchi, 2012; Bacchi & Goodwin, 2016). In reflecting on the six questions, I am aware that my lens of analysis is shaped by the construction of substance use, SCS, and harm reduction that I have developed in my studies, research, and discussion with SCS users and PWUD. As a Health Promotion student, I am encouraged to approach problems holistically and empathetically, considering outcomes across several variables. As such, my construction of a substance use crisis, SCS, and harm

reduction are from a healthcare standpoint, and I perceive it as it ought to be wholesome and inclusive and aligns with the notion that in order have a healthy community, marginalized groups health ought to be prioritized without neglecting the needs of the rest of the community. This disparity in policy and the author's sense of health may have led to a negative assessment of the policy and beliefs that these policy papers are not founded on research. As the writer is aware, some of the SCS research has influenced policy at both the federal and provincial levels. As a result, SCS policy is influenced not only by politics or preconceived notions, but also by evidence-based conclusions and recommendations. This schema draws my attention to Bacchi's WPR approach – I am interested in how the implicit philosophies in policy affect SCS users. I must also be aware and critical of my position in the neoliberal context. I do not face similar barriers to care as the persons I write about, though I strive to understand their situation. For PWUD and SCS users, the constitution of “SCS” and “substance use crisis” in legislation is inherently different from the general population. Further, my position as a Canadian carries a great deal of privilege that I must be aware of. As a citizen of a wealthy country with a well-funded public health system, I can critically analyze health and policy provision and access from a relatively comfortable vantage point.

2.8 Discussion

This study sought to appraise the current Canadian SCS policy landscape to understand its intended and unintended consequences. In doing so, it provides insight into the implicit philosophies embodied in existing policies on SCS, illuminating whose interest is expressed in the policy. The secondary goal of this study is to compare current policies regarding SCS in Alberta, British Columbia, Ontario, and Quebec to provide critical insight and suggestions for ongoing policy development.

2.8.1 Implicit Philosophies represented in Federal SCS Policy

Federal and provincial policy documents present competing discourses of public health versus criminality. As it currently stands, without an exemption from the provisions of the CDSA, users and operators of SCS are exposed to the risk of criminal prosecution for certain substance related offences—possession, trafficking—under the CDSA. The very

nature of seeking an exemption to operate criminalizes and stigmatizes people using the health service. It inherently problematizes SCS as an avenue for criminal activity. The problematization of substance use as a criminal issue in federal policy comes as no surprise. The major objective of the CDSA, which contains a set of prohibitions and punishments, is to establish a framework for the regulation of substances that might change mental processes and may cause harm to a person or society when diverted to an illicit market (Health Canada, 2015). According to the CDSA (2019), chemicals that are classified as controlled substances have the power to be used in illegal acts, so, the CDSA provides law enforcement authorities with the power to take action against unlawful activity involving such substances when those substances are scheduled under the CDSA (Health Canada, 2015). Most problems discussed in the CDSA are criminal in nature because they are related to illegal substances and activities. SCS is a health intervention, but because its federal policy is included in the CDSA, it is problematized as a crime, as are the majority of the issues in the CDSA. This problematization of SCS as an avenue for crime is further noted in the SCS application policy that requires key staff members to provide extensive criminal scrutiny, so much so that it may limit those who have personal experience with substance use from being key staff members and using their wealth of experience to help PWUD in their harm reduction journeys through the use of SCS. Instead, this policy prioritizes the perceived prevention of criminality over the positive health impact that the staff could offer. SCS in federal policy—which in turn affect provincial policy—appears to be linked to increased "criminality," and it has been suggested that service providers operating SCS may have to justify their delivery of these health services by demonstrating that they not only provide health benefits but also reduce crime. SCS, on the other hand, are health services, whether they are stand-alone sites that only provide this service or are integrated into other health services that reach PWUD. The goal of SCS is not to reduce crime, but its continued operation is contingent on doing so. Expecting or requiring an SCS to reduce crime rates is not logical since no other health clinic or hospital is required. Currently, in Canada, if the crime statistics were to rise around a healthcare service, it would not warrant the facility's closure because the health impact of shutting down the facility is prioritized. The same reasoning should be applied to SCS. Using crime statistics to evaluate healthcare is not a suitable

benchmark or consideration. On the other hand, the Quebec, Ontario and British Columbia's provincial policy document tries to shift the focus away from crime and back to its initial intent of harm reduction and betterment of public health by positioning its harm reduction on a continuum of care, acknowledging prioritizing treatment.

Another implicit philosophy in policy documents reviewed conceptualizes substance users as needing rehabilitation, or a recovery-oriented pathway. Federal policies assume that the primary intent of SCS is rehabilitation, and it assumes that PWUD and SCS users want to stop using substances. The premise of harm reduction in this context of substance use is to reduce substance use's adverse health and social consequences without necessarily decreasing drug consumption (Barry, 2018; McGinty et al., 2018). SCS remains a harm reduction strategy and should be used to allow for safer use of substances instead of being used to stop substance use. Imposing rehabilitation can deter PWUD from using this harm reduction strategy. The following implicit philosophy represented in SCS policy is the assumption that the "opinions" of the Minister—who is the sole approver for the application and opening of SCS—are evidence-based and guided by reasonability instead of being politically motivated, biased, or prejudice. This sentiment also extends to the community groups. SCS policy document assumes that opinions of community groups will be fair, logic-based, and unbiased towards an intervention for this highly marginalized and stigmatized group, PWUD. It assumes that opening a community dialogue on the stigmatized substance use issue will have some inherent value. It fails to recognize that mandating the inclusion of the community groups' opinions in the decision-making process for SCS allows room for prejudice and stigma to impact the health outcomes of PWUD. An unmanaged or ill-managed public dialogue will only cause further harm to this already vulnerable population.

The SCS policies analyzed use a significant amount of vague terminology, which is open to interpretation by the decision-maker. What is silenced in these policies is that the use of vague verbiage like "may" and "consideration" in SCS policy offers no indication of what level of information, research, opposition, or support would result in an application being accepted or denied and no timeline for a decision once the required information is submitted. In fact, under the current federal legislation, the Minister is not required to

view SCS applications despite meeting the “rigorous” application criteria. Federal SCS policy uses ambiguous terms to put so much power in regards to the health outcomes of the highly stigmatized PWUD population in the hands of the Minister and Governor in council. The ambiguity in policy wording appears to provide statutory language to defend adverse decisions if challenged.

Current SCS policies do have the potential to decrease the decision-making power of the federal health minister by only permitting the Minister to consider granting exemptions under “exceptional circumstances;” while also increasing control held by the Minister versus other health services that do not require any federal approval or oversight. It is worth noting that provinces have the authority to curtail this, declare public health crises, and establish locations on their own. The term "exceptional circumstances" is subjective to the Minister, and how it is interpreted can limit or strengthen the Minister's decision-making power. For example, if Canada's substance use crisis subsides as a result of a multi-pronged system that includes more SCS, one Minister may consider closing the current SCS because the crisis has waned and is no longer an exceptional situation (decreased power), whereas another Minister may insist on keeping it open because it has the potential to keep the crisis at bay (increased power). Canadian SCS policy creates a process that has many opportunities for stigma, discrimination and political posturing and calculation, rather than decisions based solely on the evidence of health needs and benefits. SCS policy currently allows for unnecessary subjective biases to enter a decision-making process and put the lives of Canadians, both those who do and do not inject substances, at risk. The policy environment of SCS has created a series of barriers under the guise of a regulation process through consultations and criteria to make SCS implementation difficult.

2.8.2 Presumed manifest and latent effects of the current Canadian SCS policies

The manifest and latent effect of SCS policy can be noted in the duality of policy. Federal policy list five criteria that have now become requirements for the application and subsequent opening of SCS. The first criteria, “Impact of the site on crime rate,” has the manifest effect that reflects the concern that the policy has for the community members'

public safety. It can even prove that no connection exists between crime rate and SCS presence. However, the latent effect problematized the current substance crisis as a criminal issue by prioritizing the rate of crime associated with SCS. This statement does assume links to increased criminal activity occurring at the sites and acknowledges that criminality in the vicinity should then be tracked. In addition, it poses a degree of an assumption that PWUD are a group of individuals who conduct or partake in criminal activity and not as a marginalized group seeking a health intervention. As the use of illicit substances is by the definition of 'illicit' illegal, it is no surprise that criminal conduct is presumed in SCS. The fundamental objective of SCS, however, should be reiterated: harm reduction and health intervention, in which PWUD are allowed to use substances safely and under supervision. As a result, SCS fundamental essence is harm reduction in order to improve health. SCS policy therefore should be focused on health rather than crime. Considering federally sanctioned SCS is exempt from criminal prosecution, using an unlawful substance in SCS is not a crime, and therefore should not be affiliated with criminal activity. Furthermore, SCS feasibility studies conducted prior to the establishment of a SCS typically reveal that a significant number of PWUD in the region where SCS can be implemented are using illicit substances. Since criminal behaviour already exists as a result of illicit substance usage, the introduction of SCS as a health intervention cannot and should not be anticipated to have an influence on crime.

“The local conditions indicating a need for the site” has the intended effect of providing hard evidence and data on the realities of the substance use-related harms in the communities that SCS will be opening in. It reflects a favourable policy that uses evidence to guide application decisions. It provides the opportunity to take a holistic look at PWUD and encourages viewing this marginalized group beyond substance use and instead see how multiple factors come into play that perpetuate the current substance use crisis. It allows PWUD to think of themselves as a part of the community since it demands an understanding of substance use and substance use disorder from the perspective of PWUD. It sheds light on how this population's health is impacted. It allows people to understand what is going on in their community and how SCS could mediate the problem.

The last criteria, “expressions of community support or opposition,” shows duality regarding who benefits and loses from the problem representation. The statement allows everyone in a community to provide input into a health intervention that only impacts a specific subset of the population. At the same time, it allows SCS proponents, allies, and advocates a forum to voice the benefits of SCS. It permits continuous engagement with the community to share insight on SCS, its use evidence to address and debunk stigma and prejudice that members of the community may have against SCS, it offers a platform for PWUD in the community to share their story, their lived experience with substance use and its related harms. Consequently, it also gives free rein for opinions led by unfounded fears, biases, and personal prejudice to be not only voiced but impact the marginalized PWUD group health and welfare by posing multiple barriers to accessing and utilizing health and social services in the PWUD population. This policy statement does not require the concerns and oppositions to be backed by evidence or discussed logically, and it unjustly permits other stakeholders (for example, business associations) to have a tangible impact in the existence of services that they may or may not ever use themselves.

2.8.3 Federal Policy Impact on Provincial SCS Policy

Federal and provincial policies are interactive. Knowing this, the decisions made at the federal level appear to impact end-users. Despite the provincial government's intentions to focus on the problematization of substance use as a need for harm reduction and public health, the mandate set by the federal movement perpetuates the conceptualization of the problem as a criminal issue, by continuing to assume that SCS fosters increased criminal activity resulting in the expectation and subsequent monitoring of crime. However, with thought and knowing that end-users can influence policy changes, the question ‘Who began seeing this problem of substance use as an avenue for criminal activity first?’ arises. Perhaps it stems from the reasoning that the CDSA main purpose is to describe crime and its penalty. It could be as a result of noticing crimes in the non-federally sanctioned site or other similar harm reduction initiatives, to the point where community members wanted assurance that it would not happen again, which led to informing the federal policy. Maybe that is why the community opinion is also needed? Regardless,

many studies have shown that currently, SCS does not negatively impact the crime rate (See Freeman et al., 2005; Kennedy et al., 2017; Snowball et al., 2010; Wood et al., 2006). The provincial policy initially represented the problem of substance use as one of public health, a need for a continuum of care, recovery-oriented pathway, and harm reduction; however, the federal policy does impose the presumption of criminal activity in SCS, and this idea is mandated to be included in provincial policy in order to attain exemption to operate as federally sanctioned. The provinces must support this conceptualization by constantly being on the lookout for criminal activity on the site and reporting it should any occur. Aside from criminal activity, federal and provincial policy share similar vague terminology that absolves the Minister and health ministries from being obligated to implement SCS.

2.8.4 How do Alberta, British Columbia, Ontario, and Quebec Compare?

Providers in British Columbia are the pioneers in North America for SCS. It would stand to reason that they have knowledge and experience to offer other provinces. The Province with the official policy document for SCS that best reflects a healthcare focus is British Columbia. Alberta's document was made in 2021, Ontario's was 2018, Quebec 2013, British Columbia is currently undergoing revisions and is likely to change, but their most recent is 2012. Alberta's policy is the most recent and, therefore ought to have been the most in line with the constantly changing healthcare climate. Alberta conceptualizes substance use as a concern that should be met with a continuum of care and recovery oriented pathway. In contrast, other provinces focused on seeing the matter as just a public health or social issue. Notably, the Quebec healthcare system is combined with social services, and as such, their policies also address the importance of following up on SCS users' other needs like housing and employment.

British Columbia's provincial policymakers have conceptualized harm reduction as an approach for broadly addressing health, social, and economic harms associated with substances since 2003. This longstanding approach to harm reduction across provincial and regional documents suggests a shared understanding of harm reduction guided by the four-pillars approach, which highlights a balance of substance use prevention, treatment,

law enforcement, and harm reduction, as a means to depart from punitive approaches to substance use (Cohen & Csete, 2006). Despite acknowledging harm reduction's applicability to health, social, and economic harms, sanctioned interventions primarily focus on health harms. The policy document proposes activities to address social harms such as stigma and discrimination. British Columbia distinguished itself from other provinces by stressing the use of media to disseminate evidence-based information about the ongoing substance use crisis. The incumbent New Democratic Party of British Columbia is currently the governing political party. A government spokesperson emphasized the Premier's support for SCS as an essential element in managing the substance use crisis (Froese, 2019). As British Columbia revises its provincial SCS policy, the support should be reflected in a more efficient policy for SCS users.

Earlier this year, the provincial government of Alberta issued new rules for the operation of supervised consumption facilities. A quality standard for SCS was introduced in Alberta, making it the first jurisdiction in Canada to do so. United Conservative Party (UCP), the governing party, issued a policy statement outlining a new set of requirements that an SCS must now satisfy in order to be licensed. Standardized data collection, personnel credentials and training as well as good neighbour agreements and ensuring that things like providing enough washrooms for their customers and cleaning up needles and other substance paraphernalia are all part of the new operating plan. The new standards require SCS to keep track of known referral results for each client and to provide support to SCS users. These modifications appear to be aimed at continuing to decrease harm to people who use drugs (PWUD) while also improving access to treatment and recovery resources, as well as reducing social disorder that is presumed near such institutions. The *Mental Health Services Act of Alberta* gives broad guidance and a few specific implementation recommendations, rather it mostly refers to the Recovery-Oriented Overdose Prevention Guide created by the ministry of health as its new policy document related to SCS. Throughout the Recovery-Oriented policy statement, a harm reduction philosophy is implicitly acknowledged, but treatment is the named fundamental pillar of the provincial approach to substance use. The policy statement in Alberta comprehensively focuses on substance use as a multifaceted problem that requires a continuum of care. Irrespective of the fact that it came from a

conservative administration that has historically constructed obstacles and undertaken actions against SCS, the policy statement nevertheless appears to be fair, but it assumes treatment and recovery are the only good outcomes (See. Alberta Mental Health Services Protection, 2021; Loriggio, 2018; Russell et al., 2020; Urbanik & Greene, 2021). Although Alberta's SCS policy appears to be health-focused and supportive, there appears to be a disconnect between policy and practice, based on media responses and the current study. Despite the health-related wording, a number of Alberta SCS have lately been closed. There is a misalignment between political authority and motive and the documents that organize service delivery in this way. Some of the issues that emerge are due to the wording of the same policy. The present policy, which reflects political power, places a significant focus on abstinence-based treatment programmes as an addiction strategy (Castillo et al., 2021). According to the policy, there are “documented referral pathways to treatment and recovery services” (Alberta Ministry of Health, 2021, p. 7). This documentation would need the presentation of a government-issued personal health number by SCS users before they are able to access the SCS. However, some marginalized PWUD, particularly those experiencing homelessness or insecure housing, may not have these numbers for a variety of reasons, including having forgotten or lost them, or never having had them at all. To remedy this, the government's new guidance suggests that both the customer SCS user and the service provider contact the government in order to acquire or recover access. The policy document also includes a link to another government website that lists the types of documents that can help a person obtain healthcare coverage in the province, such as pay stubs, social insurance numbers, bank statements, and baptism certificates, which these marginalized groups may not be able to provide; this may discourage PWUD from utilizing SCS and its associated services (Alberta Health Service, 2021; Castillo et al., 2021). Harm reduction initiatives should meet individuals where they are, and this required documentation may represent an additional barrier to health. Alberta should try to keep some of the positive foundations of the policy, like ensuring continuity of care but remove some of the demands it makes for a healthcare intervention such as requiring identification, and the over-focus on treatment, and focus rather on harm reduction. As the current policy (both Alberta Ministry of Health and the *Alberta Mental Health Protection Act*) have briefly

discussed harm reduction measures, but no explicit mention of harm reduction as its intent, which fundamentally is the role of SCS—a harm reduction strategy for reducing substance use related harms.

The Ontario SCS policy appears to be the most internally contradicting of the provincial policies, possibly as a result of the considerable political instability that accompanied the previous election. The current Premier of Ontario expressed his disapproval with SCS, and his administration went on to eliminate SCS and its financing, while the Minister of Health in Ontario recognized its benefits (CBC News, 2019; Loriggio, 2018 April 20). In terms of the opposing policies, on the one hand, it reflects a comprehensive understanding of harm reduction principles and promotes incorporating harm reduction into the operational standards of public health delivery across the province. On the other hand, it offers no accountability for the provincial Ministry regarding meeting the needs of SCS. One policy statement could mention the importance of having a holistic approach, but it offers no direction on funding or means to ensure this holistic approach is implemented. Ontario is also the only province to mandate a continuous ongoing dialogue between SCS operators and site users and the community in which the SCS is located. As mentioned throughout the findings and discussion, this could pose a burden or an avenue for understanding depending on how the dialogue is managed. Another positive regarding Ontario's provincial policy is the emphasis placed on involving members of the PWUD population in the decision-making process of SCS. It fosters inclusivity and respects that PWUD do know what works best for them, services they wish to see and can contribute to their health outcomes. The document does mandate boards of health to ensure access to SCS and harm reduction programs, delivery models, and strategies.

Overall, Quebec's provincial document is very well coordinated and presents a cohesive policy framework. The document was produced considering the broader policy context, building on previous work in similar areas, and demonstrating an effort to cover areas in need of new policy rather than producing redundant policy documents. Quebec has an integrated harm reduction in its approach to substance use. The province consistently acknowledges that harm reduction can be applied to the general population and some

populations disproportionately affected by drug-related harms. Quebec was the first of the provincial policy document to offer certainty that, pending approval from the federal government, the Ministry will support the SCS. The integrated Ministry of health and social service allows for an integrated approach to harm reduction.

SCS as a harm reduction intervention is strongly supported by evidence and has become even more necessary during this global pandemic given the high incidence of overdose death and related harms in 2020 (Public Health Agency of Canada, 2021). Although public support for SCS has seen an upward trend, unfavourable public opinion, political motives and attitudes towards substance use and PWUD influence policy and limit implementation and expansion of current SCS services. Even though conceptualizing substance use and the need for harm reduction through a continuum of care, or holistic approach for PWUD, may help overcome stigma and misconceptions about PWUD and SCS. SCS is a harm reduction strategy whose ethos to substance use is “meeting people where they are at” in order to improve overall health. The policy makers of these provinces could work together, to note how policy has positively impacted SCS user and revise their provincial policies to be even more client centered around PWUD, form more equitable and appropriate policies that prioritize the people at risk of being in the most harm related to substance use.

2.9 Implications

This study has policy, research, practice, and educational implications. By erecting hurdles to the implementation and growth of SCS, current federal and provincial SCS legislation has hampered PWUD access to harm reduction programmes and other health and social services offered through the SCS referral programme. The current SCS policy landscape acts as an indirect impediment by creating barriers to the establishment and maintenance of sites. This critical policy analysis discovered that the Canadian SCS policy's intentions appear to align with current research; nevertheless, policy statements have unintended weaknesses that might obstruct SCS and PWUD. The decreased harm reduction services could increase or impose further barriers to entering the care continuum for clients who would otherwise be referred to health and social services at the point of care (Health Canada 2021).

In terms of implications for practice, if policymakers are willing to destigmatize PWUD, they may have a more significant role in effecting system-level reform. This is not to say that policymakers are deliberately hostile or that they make negative assumptions on purpose or even consciously, but rather that this is one of the unintended consequences of policy formulations that locates the cause for the 'problem' on PWUD as opposed to systemic. As Bacchi (2009) points out, the policy's conceptual logic and assumptions are deeply embedded, necessitating close examination for their potential to marginalize, stigmatize, or simply undercut the interests of people the policy is intended to help. Despite the scarcity of resources and research advocating for stronger SCS policy, this study gives significant insight into future policy changes by highlighting present shortcomings. When and if policy changes are made, more study on SCS policy implementation should be done to verify that policy statements and best practices are consistent. The study of policy implementation can also be done prior to policy change. This can be done by ensuring that the new fairer SCS policy has an accountability structure that holds the federal, provincial, and municipal government, and SCS service providers accountable for delivering care in a fair and equitable manner. SCS provision should include more favourable, fair policies are guiding site development and operation. This means focusing on health interventions, removing barriers to development, and providing protection against closure due to political perspectives versus health needs. This paper can also help SCS applicants and key stakeholders understand the current SCS policy.

The ramifications for education can be discovered in the details of this CPA, which uncovers implicit philosophies buried in policy documents. Considering nearly every proposed policy has an unintended impact on health, it is becoming increasingly vital for health experts, including PWUD, to be included in the process. Healthcare and public-health systems all over the world are governed by health-policy frameworks. These health policies have a significant and direct impact on population health, health outcomes, health inequalities, health equity, and health workers' environmental, socio-cultural, and industrial contexts. Healthcare professionals have a Hippocratic responsibility to participate in health policy formulation to enhance people's health worldwide. This covers the well-being of drug users. This thesis has looked at SCS policy

documents and broken down how they may impact PWUD. This study serves as a starting point for understanding SCS policy, allowing health professionals working in SCS or with PWUD to assess how their SCS are implemented and advocate for greater implementation of the policy where it is missing, as well as better policies to address implementation gaps. For individuals working with PWUD, this thesis has brought to light some of the stigmas that they face, and it should inspire healthcare professionals to be more deliberate in their care and analyze their own biases toward PWUD. This evaluation of health policy, laws, and regulations is also critical to understanding how to develop health policy to benefit public health and will broaden the knowledge of nurses and other health professionals about the complex workings of health systems. This study may also be used to enlighten policy analysts, activists, and the general public about the gaps in SCS policy and the manifest and latent impacts of the existing policy, as it reveals policy silences. Furthermore, while it was not the aim, adequate evidence in favour of SCS was supplied throughout the study, which community members can use to better understand the topic and the role that they play in ensuring better health outcomes for PWUD.

This thesis acknowledges that SCS is simply one tool that may be used to confront the substance use crisis in Canada and that they are not, nor should they be, the sole measure to combat the epidemic. Drug testing programmes, naloxone distribution, safer supply programs and referral services, for example, can all help to address the opioid crisis (Iysins et al., 2020; King, 2015; Manson-Singer & Allin, 2020). SCS, on the other hand, is an essential component of a harm reduction strategy that prioritizes the health, well-being, and safety of PWUDs. This research gives much-needed insight into the legislation that exists in order for SCS to be implemented.

2.10 Limitations

This critical policy analysis does have some inherent limitations. For one, a fully comprehensive understanding of SCS policy in Canada requires an exhaustive, intimate knowledge of Canadian judicial system, laws, policy formation, and how it affects the creation of SCS policies at all orders of government, including federal, provincial and municipal orders, especially in cities with multiple SCS. However, this research limited

its focus to national and provincial policies and does not take into account legal complexities and jurisdictions and criminal law at the federal level. An exploration into SCS policies in Canada and its provinces SCS (or related terminology) might conceivably add some knowledge value to the comparative analysis body. However, there is also an added complexity as different provinces and municipalities have less comparable health and social systems and socio-economic contexts. This thesis offers an important starting point in the provincial comparative analyses of SCS policy in Alberta, British Columbia, Ontario, and Quebec. Also, the availability of official SCS Policy documents from the governing health or legislative body is scarce across all four provinces analyzed. Another issue is that current policies are assumed to shape practice; while this is true in certain cases, what goes into practice in terms of organization-level policy and practice is often not the same. As a result, some SCS may be able to get away with infringing on provincial regulations. Another limitation is that SCS federal policy, which informs provincial policy, is written in CDSA, which is intrinsically criminal justice oriented. As a result, adopting an SCS policy in the Federal Health Act or a related Act might help SCS and its users by ensuring that the language is less crime focused.

Since the writer did not explicitly interact with SCS users and PWUD, the lived impacts in Bacchi's question 5 are limited because this was a document analysis. Looking at policy implementation from the perspectives of SCS users, direct service personnel, and management might be a potential route for future study. This could include speaking with SCS users and investigating how existing federal and provincial SCS regulations affect their day-to-day access and use of services (including SCS, health and social). SCS employees can share their knowledge of the policies' impacts. This article analyzed current supervised consumption regulations in Alberta, British Columbia, Ontario, and Quebec in order to give critical insight and ideas for continued policy development. Further studies might look at international policy comparisons with nations with comparable profiles to Canada to develop improved SCS policy.

Implicit in a qualitative study is subjectivity. In the analysis and interpretative portion of this critical policy analysis, personal views may affect the content explored within SCS policy. The researcher acknowledges personal beliefs through reflection. The thesis

committee and co-supervisor's involvement allowed other perspectives to be brought to the thesis process, including interpretations and findings.

2.11 Conclusion

This thesis conducted a critical, poststructuralist analysis of Canada's current SCS policy, identifying the ways in which it constitutes the 'problem of substance use'. This study's purpose was to critically appraise current federal and provincial policies regarding SCS, noting intended and unintended consequences and compare current policies related to SCS in Alberta, British Columbia, Ontario, and Quebec to provide critical insight and suggestions for ongoing policy development.

Implicit philosophies in policy evolve into barriers to opening SCS as part of a public health emergency response. While the present version of the CDSA reduces certain legislative hurdles to operating SCS, changes are required to respond to the overdose crises and other substance use-related harms more quickly and broadly. To begin, the very nature of seeking an exemption to operate harm reduction services criminalizes and stigmatizes people using the health service. It inherently problematizes SCS as an avenue for increased criminal activity. The goal of SCS is not to reduce crime, but its continued operation is contingent on doing so. Expecting or requiring an SCS to reduce crime rates is not logical since no other health clinic or hospital is required to do so. Provincial policy documents have the potential to focus on the intent of harm reduction and betterment of public health by positioning harm reduction on a continuum of care and acknowledging treatment as just one outcome. Federal policies currently assume that the primary intent of SCS is rehabilitation, and assume that PWUD and SCS users want to stop using substances. The premise of harm reduction in this context of substance use is to reduce substance use's adverse health and social consequences without necessarily decreasing substance consumption. The need for SCS establishment to consult the broader community (e.g., police, business associations, etc.) for implementation assumes that opinions of community groups will be fair, logic-based, and unbiased towards an intervention for this highly marginalized and stigmatized group. It also reflects attitudes irrespective of whether good or bad. It fails to recognize that mandating the inclusion of

the community groups' opinions in the decision-making process for SCS allows room for prejudice and stigma to impact the health outcomes of PWUD.

The SCS policies analyzed use a significant amount of vague terminology, which is open to interpretation by decision-makers. What is silenced in these policies is that the use of vague language like “may” and “consideration” in SCS policy offers no indication of what level of information, research, opposition, or support would result in an application being accepted or denied and no timeline for a decision once the required information is submitted. Canadian SCS policy creates a process that has opportunities for stigma, discrimination and political posturing and calculation, rather than decisions based solely on the evidence of health needs and benefits. SCS policy currently allows for unnecessary subjective biases to enter a decision-making process and put the lives of Canadians, particularly PWUD, at risk. The policy environment of SCS has created a series of barriers under the guise of a regulation process through consultations and criteria to make SCS implementation difficult.

The presumed manifest and latent effects of the current Canadian SCS policies reflect the five main criteria for SCS application. The first criteria, “Impact of the site on crime rate,” has the manifest effect that reflects the concern that the policy has for the community members' public safety, but the latent effect assumes links to increased criminal activity occurring at the sites. “The local conditions indicating a need for the site” has the intended effect of reflecting a favourable policy that uses evidence to guide application decisions. “Expressions of community support or opposition,” allows everyone in a community to provide input into a health intervention that only impacts a specific subset of the population. At the same time, it allows SCS proponents, allies, and advocates a forum to voice the benefits of SCS. It permits continuous engagement with the community to share insight on SCS, its use of evidence to address and debunk stigma and prejudice that members.

This study found federal and provincial policies to be interactive in that the decisions made at the federal level appear to impact end-users. Despite some provincial government’s intentions to focus on the problematization of substance use as a need for

harm reduction, continuum of care, rehabilitation, social issue and public health, the mandate set by the federal government perpetuates the conceptualization of the problem as a criminal issue, by continuing to assume that SCS fosters criminal activity resulting in the expectation and subsequent monitoring of crime. British Columbia set itself apart from other provinces by emphasizing media use to help spread evidence-based information on the ongoing substance use epidemic. Ontario SCS policy appears to be the most contrasting of the provincial policies, perhaps influenced by the significant political change in the Ontario government at the last election. On the one hand, it reflects a comprehensive understanding of harm reduction principles and promotes incorporating harm reduction into the operational standards of public health delivery across the province. On the other hand, it offers no accountability for the provincial Ministry regarding meeting the needs of SCS. Quebec was the first of the provincial policy documents to offer certainty that, pending approval from the federal government, the Ministry will support the SCS. The integrated Ministry of health and social services allows for an integrated approach to harm reduction. Alberta has a Recovery-Oriented policy document where harm reduction philosophy is implicitly acknowledged, but treatment is the fundamental pillar of the provincial approach to substance use. These provinces could work together to revise their provincial policies to be even more client-centered around PWUD, in order to form more equitable and appropriate policies that prioritize the people at risk of being in the most harm related to substance use.

This study revealed both consistency and variability in provincial and federal policy frameworks. Canadian SCS federal policy should be more in line with provincial policy documents that framed substance use as a public health issue and the need for a continuum of care. It should encourage a more inclusive and comprehensive strategy that collaborates with PWUD to address the substance use issue adequately. Given our present public health crisis, the only condition needed is that the applicant establishes the need for an SCS. Despite the increasing evidence of the effectiveness of SCS as a harm reduction approach to problematic substance use, current policy in Canada could benefit from revisions at the provincial and federal levels.

2.12 Reference

- Alberta Health Services. (2021). *FAQs AHS ID Program*.
<https://www.albertahealthservices.ca/about/Page13447.aspx>
- Alberta Mental Health Services Protection. (2021). *Alberta Regulation 114/2021 Mental Health Services Protection Act*. Province of Alberta.
<https://www.canlii.org/en/ab/laws/regu/alta-reg-114-2021/latest/alta-reg-114-2021.html>
- Alberta Ministry of Health. (2021). *Recovery-oriented overdose prevention services guide - Recovery-oriented overdose prevention services guide - Open Government*. Government of Alberta. <https://open.alberta.ca/dataset/recovery-oriented-overdose-prevention-services-guide/resource/159b4628-1a23-4a74-b8df-56e5d647d8aa>
- Atkinson, A. M., McAuley, A., Trayner, K. M. A., & Sumnall, H. R. (2019). 'We are still obsessed by this idea of abstinence': A critical analysis of UK news media representations of proposals to introduce drug consumption rooms in Glasgow, UK. *International Journal of Drug Policy*, 68, 62-74.
- Austin, T., & Boyd, J. (2021). Having a voice and saving lives: a qualitative survey on employment impacts of people with lived experience of drug use working in harm reduction. *Harm reduction journal*, 18(1), 1-12.
- Bacchi, C. (2009). Analysing Policy: Whats the problem represented to be. *Frenchs Forest*.
- Bacchi, C., & Eveline, J. (2010). Approaches to gender mainstreaming: What's the problem represented to be. *Mainstreaming politics: Gendering practices and feminist theory*, 111-138.
- Baker, T., & McCann, E. (2018). Beyond failure: The generative effects of unsuccessful proposals for Supervised Drug Consumption Sites (SCS) in Melbourne, Australia. *Urban geography*, 1-19.
- Bardwell, G., Strike, C., Altenberg, J., Barnaby, L., & Kerr, T. (2019). Implementation contexts and the impact of policing on access to supervised consumption services in Toronto, Canada: a qualitative comparative analysis. *Harm reduction journal*, 16(1), 1-9.

- Bardwell, G., Strike, C., Mitra, S., Scheim, A., Barnaby, L., Altenberg, J., & Kerr, T. (2020). "That's a double-edged sword": Exploring the integration of supervised consumption services within community health centres in Toronto, Canada. *Health & place*, *61*, 102245.
- Bardwell, G., Austin, T., Maher, L., & Boyd, J. (2021). Hoots and harm reduction: a qualitative study identifying gaps in overdose prevention among women who smoke drugs. *Harm reduction journal*, *18*(1), 1-10.
- Barratt, M. J., Seear, K., & Lancaster, K. (2017). A critical examination of the definition of 'psychoactive effect' in Australian drug legislation. *International Journal of Drug Policy*, *40*, 16-25.
- Barry, C. L. (2018). Fentanyl and the evolving opioid epidemic: what strategies should policy makers consider?. *Psychiatric Services*, *69*(1), 100-103.
- Boyd, J., Collins, A. B., Mayer, S., Maher, L., Kerr, T., & McNeil, R. (2018). Gendered violence and overdose prevention sites: a rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction*, *113*(12), 2261-2270
- British Columbia Ministry of Health. (2005). *Harm Reduction: A British Columbia Community Guide*. Library and Archives Canada Cataloguing in Publication Data. <https://www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf>
- British Columbia Ministry of Health. (2012). *GUIDANCE DOCUMENT SUPERVISED INJECTION SERVICES*. <https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/guidance-document-for-sis-in-bc.pdf>
- Bungay, V., Johnson, J. L., Varcoe, C., & Boyd, S. (2010). Women's health and use of crack cocaine in context: Structural and 'everyday' violence. *International Journal of Drug Policy*, *21*(4), 321-329
- Canadian Institutes for Health Information. (2018). *Opioid-Related Harms in Canada / CIHI*. Canadian Institutes for Health Information (CIHI). <https://www.cihi.ca/en/opioid-related-harms-in-canada>
- Castillo, T., Chowdhery, S., & Peele, S. (2021, June 10). Alberta Government's New Rules Set SCS Up to Fail, Advocates Say. *Filter*. <https://filtermag.org/alberta-consumption-site-rules/>

- CIHI. Ottawa(ON): 2017. Opioid-related harms in Canada: chartbook, September 2017. Available from: <https://www.cihi.ca/sites/default/files/document/opioid-harms-chart-book-en.pdf>.
- CBC News. (2019). “Unacceptable”: Toronto board of health chair slams province for supervised injection site cuts. <https://www.cbc.ca/news/canada/toronto/ontario-overdose-prevention-strategy-2019-1.5076869>
- Cohen, J., & Csete, J. (2006). As strong as the weakest pillar: Harm reduction, law enforcement and human rights. *International Journal of Drug Policy*, 17(2), 101–103. <https://doi.org/10.1016/j.drugpo.2005.07.005>
- Collins, A. B., McNeil, R., Czechaczak, S., & Boyd, J. (2020). “That’s what I’m supposed to do at work”: gendered labor, self-care, and overdose risk among women who use drugs in Vancouver, Canada. *Critical Public Health*, 1-10.
- Controlled Drugs and Substances Act*. (2019, September 19). Justice Laws Website. <https://laws-lois.justice.gc.ca/eng/acts/c-38.8/FullText.html>
- Dooling, K., & Rachlis, M. (2010). Vancouver’s supervised injection facility challenges Canada’s drug laws. *Cmaj*, 182(13), 1440-1444. <https://doi.org/10.1503/cmaj.100032>
- Dooling, K., & Rachlis, M. (2010). Vancouver’s supervised injection facility challenges Canada’s drug laws. *Canadian Medical Association Journal*, 182(13), 1440–1444. <https://doi.org/10.1503/cmaj.100032>
- Editors of Merriam-Webster. (2019, June 25). *Assume vs. Presume: Are They Synonyms?* The Merriam-Webster.Com Dictionary. <https://www.merriam-webster.com/words-at-play/assume-vs-presume>
- Elliott, R., Malkin, I., & Gold, J. (2002). *Establishing safe injection facilities in Canada: Legal and ethical issues*. Canadian HIV/AIDS Legal Network= Réseau juridique canadien VIH-SIDA.
- Fischer, B. (2000). Prescriptions, power and politics: the turbulent history of methadone maintenance in Canada. *Journal of public health policy*, 21(2), 187-210
- Fischer, B., & Argento, E. (2012). Prescription opioid related misuse, harms, diversion and interventions in Canada: a review. *Pain physician*, 15(3 Suppl), ES191.

- Fischer, B., Turnbull, S., Poland, B., & Haydon, E. (2004). Drug use, risk and urban order: examining supervised injection sites (SISs) as 'governmentality'. *International Journal of Drug Policy*, 15(5-6), 357-365.
- Forsyth, A. J. (2001). Distorted? A quantitative exploration of drug fatality reports in the popular press. *International Journal of Drug Policy*, 12(5-6), 435-453.
- Ford-Gilboe, M., Campbell, J., & Berman, H. (1995). Stories and numbers: Coexistence without compromise. *Advances in Nursing Science*, 18(1), 14-26.
- Foucault, M. (1977). *Language, counter-memory, practice: Selected essays and interviews*. Cornell University Press.
- Fraser, S. (2011). *The drug effect: Health, crime and society* (pp. 19-34). D. Moore (Ed.). Melbourne: Cambridge University Press.
- Freeman, K., Jones, C. G., Weatherburn, D. J., Rutter, S., Spooner, C. J., & Donnelly, N. (2005). The impact of the Sydney medically supervised injecting centre (MSIC) on crime. *Drug and Alcohol Review*, 24(2), 173-184.
- Froese, I. (2019). *Consumption sites save lives, B.C. government says after Manitoba premier points to "unintended consequences."* CBC News. <https://www.cbc.ca/news/canada/manitoba/safe-injection-sites-manitoba-mischaracterized-misunderstand-1.5093170>
- Government Bill (House of Commons) C-2 (41–2) - Royal Assent - Respect for Communities Act - Parliament of Canada.* (2015, June 18). PARLIAMENT OF CANADA. <https://www.parl.ca/DocumentViewer/en/41-2/bill/C-2/royal-assent/page-4>
- Government Bill (House of Commons) C-37 (42–1) - Royal Assent - An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts - Parliament of Canada.* (2017, May 18). PARLIAMENT OF CANADA. <https://www.parl.ca/DocumentViewer/en/42-1/bill/c-37/royal-assent>
- Hansen, H. (2017). Assisted technologies of social reproduction: pharmaceutical prosthesis for gender, race, and class in the white opioid "crisis." *Contemporary Drug Problems*, 44(4), 321-338.

- Hayle, S. (2015). Comparing drug policy windows internationally: Drug consumption room policy making in Canada and England and Wales. *Contemporary Drug Problems*, 42(1), 20-37.
- Hayle, S. (2018). A tale of two Canadian cities: comparing supervised consumption site (SCS) policy making in Toronto and Vancouver. *Drugs: Education, Prevention and Policy*, 25(5), 397-407.
- Health Canada. (2002). *Application for an exemption under Section 56 of the Controlled Drugs and Substances Act for a scientific purpose for a pilot supervised injection site*. Ottawa, ON, Canada: Office of Drug Strategy and Controlled Substances Programme. Retrieved from [http://www.cdnaiids.ca/web/mailouts.nsf/1937f4d80b2408c685256aa0055ae02/da6097909fcbc99c85256ccd005daaae/\\$FILE/SIS%20guidance%20jan2nd.rtf](http://www.cdnaiids.ca/web/mailouts.nsf/1937f4d80b2408c685256aa0055ae02/da6097909fcbc99c85256ccd005daaae/$FILE/SIS%20guidance%20jan2nd.rtf)
- Health Canada. (2015). *Frequently Asked Questions - Narcotic Control Regulations - Canada.ca*. Government of Canada. <https://www.canada.ca/en/health-canada/corporate/about-health-canada/legislation-guidelines/acts-regulations/frequently-asked-questions-narcotic-control-regulations.html>
- Health Canada. (2021). *Opioids and the opioid crisis – Get the facts*. Government of Canada. <https://www.canada.ca/en/health-canada/services/opioids/get-the-facts.html>
- Hedrich, D. (2004). *European report on drug consumption rooms* (p. 8). Luxembourg: Office for Official Publications of the European Communities.
- Hyshka, E., Anderson-Baron, J., Karekezi, K., Belle-Isle, L., Elliott, R., Pauly, B., ... & Hathaway, A. (2017). Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm reduction journal*, 14(1), 50.
- Ivsins, A., Boyd, J., Beletsky, L., & McNeil, R. (2020). Tackling the overdose crisis: the role of safe supply. *International Journal of Drug Policy*, 80, 102769.
- Jaffe, K., Nosova, E., Maher, L., Hayashi, K., Milloy, M. J., & Richardson, L. (2021). Income generation and the patterning of substance use: A gender-based

- analysis. *Drug and Alcohol Dependence*, 226, 108862.
<https://doi.org/10.1016/j.drugalcdep.2021.108862>
- Jauffret-Roustide, M., Pedrono, G., & Beltzer, N. (2013). Supervised consumption rooms: the French Paradox. *Int J Drug Policy*, 24(6), 628-30.
- Joo, K. P., & Kwon, I. T. (2010). Critical policy analysis: Investigating 'missing' values in the lifelong education system of South Korea
- Ka Hon Chu, S. (2013). Brief to the Toronto Board of Health regarding Supervised Injection Services in Toronto. *Human Rights Documents Online*.
 doi:10.1163/2210-7975_hrd-9902-2016012
- Kennedy, M. C., Karamouzian, M., & Kerr, T. (2017). Public health and public order outcomes associated with supervised drug consumption facilities: a systematic review. *Current HIV/AIDS Reports*, 14(5), 161-183.
- Kerr, T., Mitra, S., Kennedy, M. C., & McNeil, R. (2017). Supervised injection facilities in Canada: past, present, and future. *Harm reduction journal*, 14(1), 1-9.
- Kimber, J., Dolan, K., Van Beek, I., Hedrich, D., & Zurhold, H. (2003). Drug consumption facilities: an update since 2000. *Drug and alcohol review*, 22(2), 227-233.
- Kimber, J., Dolan, K., & Wodak, A. (2005). Survey of drug consumption rooms: service delivery and perceived public health and amenity impact. *Drug and alcohol review*, 24(1), 21-24.
- King, L. A. (2015). Facilitate recreational drug testing to help save lives. *Pharm J*, 294, 176-177.
- Kingdon, J. W., & Stano, E. (1984). *Agendas, alternatives, and public policies* (Vol. 45, pp. 165-169). Boston: Little, Brown.
- Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, 24(1), 120-124.
- Lancaster, K., Hughes, C. E., Spicer, B., MATTHEW-SIMMONS, F. R. A. N. C. I. S., & Dillon, P. (2011). Illicit drugs and the media: Models of media effects for use in drug policy research. *Drug and Alcohol Review*, 30(4), 397-402.

- Lancaster, K., Seear, K., & Treloar, C. (2015). Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. *International Journal of Drug Policy*, 26(12), 1198-1206.
- Lloyd, C., Stöver, H., Zurhold, H., & Hunt, N. (2017). Similar problems, divergent responses: drug consumption room policies in the UK and Germany. *Journal of Substance Use*, 22(1), 66-70.
- Loriggio, P. (2018, April 20). Doug Ford says he's 'dead against' safe injection sites. Retrieved August 1, 2020, from <https://toronto.ctvnews.ca/ontario-election-2018/doug-ford-says-he-s-dead-against-safe-injection-sites-1.3894717>
- Malkin, I., Elliott, R., & McRae, R. (2003). Supervised injection facilities and international law. *Journal of Drug Issues*, 33(3), 539-578.
- Manson-Singer, C., & Allin, S. (2020). Understanding the Policy Context and Conditions Necessary for the Establishment of Supervised Consumption Sites in Canada: A Comparative Analysis of Alberta and Manitoba. *Health Reform Observer - Observatoire Des Réformes de Santé*, 8(2). <https://doi.org/10.13162/hros.v8i2.4114>
- Matthew-Simmons, F., Love, S., & Ritter, A. (2008). *A review of Australian public opinion surveys on illicit drugs*. Sydney, Australia: National Drug and Alcohol Research Centre
- McCabe, J. L., & Holmes, D. (2009). Reflexivity, critical qualitative research, and emancipation: A Foucauldian perspective. *Journal of advanced nursing*, 65(7), 1518-1526.w
- McGinty, E. E., Barry, C. L., Stone, E. M., Niederdeppe, J., Kennedy-Hendricks, A., Linden, S., & Sherman, S. G. (2018). Public support for safe consumption sites and syringe services programs to combat the opioid epidemic. *Preventive medicine*, 111, 73-77.
- McNeil, R., Small, W., Lampkin, H., Shannon, K., & Kerr, T. (2014). "People knew they could come here to get help": an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption room in a Canadian setting. *AIDS and Behavior*, 18(3), 473-485.

- Merriam-Webster. (2021). *rigorous*. The Merriam-Webster.Com Dictionary.
<https://www.merriam-webster.com/dictionary/rigorous#other-words>
- Ministère de la Santé et des Services Sociaux. (2013). *Balises pour les établissements de santé et de services sociaux et les organismes communautaires désirant offrir des services d'injection supervisée aux personnes qui font usage de drogues par injection* (No. 978-2-550-67652-2). Bibliothèque et Archives nationales du Québec. <https://publications.msss.gouv.qc.ca/msss/fichiers/2013/13-313-01W.pdf>
- Ontario Ministry of Health and Long-Term Care. (2018, October). *CONSUMPTION AND TREATMENT SERVICES: APPLICATION GUIDE*.
https://health.gov.on.ca/en/pro/programs/opioids/docs/CTS_application_guide_en.pdf
- Nosyk, B., Anglin, M. D., Brissette, S., Kerr, T., Marsh, D. C., Schackman, B. R., ... & Montaner, J. S. (2013). A call for evidence-based medical treatment of opioid dependence in the United States and Canada. *Health affairs*, 32(8), 1462-1469.
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International journal of qualitative methods*, 16(1), 1609406917733847
- OPHA (Ontario Public Health Association) (2008). *Ontario Public Health Standards 2008*. Toronto: Ontario Public Health Association.
- Orsini, M. M. (2017). Frame analysis of drug narratives in network news coverage. *Contemporary drug problems*, 44(3), 189-211
- Oxford University Press. (2021). *rigorous adjective - Definition, pictures, pronunciation and usage notes | Oxford Advanced Learner's Dictionary at OxfordLearnersDictionaries.com*. Oxford Learner Dictionaries.
<https://www.oxfordlearnersdictionaries.com/us/definition/english/rigorous?q=rigorous>
- Pearshouse, R., & Elliott, R. (2007). A helping hand: Legal issues related to assisted injection at supervised injection facilities. Toronto, ON, Canada: Canadian HIV/AIDS Legal Network

- Pienaar, K., & Savic, M. (2016). Producing alcohol and other drugs as a policy 'problem': A critical analysis of South Africa's 'National Drug Master Plan' (2013–2017). *International Journal of Drug Policy*, 30, 35-42.
- Pitfield, T. H. M. J. (2008). PHS Community Services Society v. Attorney General of Canada, 2008 BCSC 661. The Supreme Court of British Columbia.
- Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice*, (10th ed.). Philadelphia, PA: Wolters Kluwer.
- Rhodes, T. (2009). Risk environments and drug harms: a social science for harm reduction approach.
- Ritter, A., & Berends, L. (2016). Twenty years of (non) reform in Victorian alcohol and other drug treatment policy. *Drug and Alcohol Review*, 35(3), 250-254.
- Russell, C., Imtiaz, S., Ali, F., Elton-Marshall, T., & Rehm, J. (2020). 'Small communities, large oversight': The impact of recent legislative changes concerning supervised consumption services on small communities in Ontario, Canada. *International Journal of Drug Policy*, 82, 102822.
- Small, D. (2008). Fighting addiction's death row: British Columbia Supreme Court Justice Ian Pitfield shows a measure of legal courage. *Harm reduction journal*, 5(1), 1-16.
- Small, W., Shoveller, J., Moore, D., Tyndall, M., Wood, E., & Kerr, T. (2011). Injection drug users' access to a supervised injection facility in Vancouver, Canada: the influence of operating policies and local drug culture. *Qualitative health research*, 21(6), 743-756.
- Snowball, L., Burgess, M., & Fitzgerald, J. (2010). Trends in property and illicit drug crime around the Medically Supervised Injecting Centre in Kings Cross: an update.
- Stevens, A., & Zampini, G. F. (2018). Drug policy constellations: A Habermasian approach for understanding English drug policy. *International Journal of Drug Policy*, 57, 61-71.
- Strike, C., Watson, T. M., Altenberg, J., Barnaby, L., Bayoumi, A. M., Challacombe, L., ... & Wright, A. (2020). Challenges, Skepticism, and Recommendations from

- Police about Working in Collaboration with Supervised Consumption Services. *Substance Use & Misuse*, 55(12), 1919-1924.
- Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of advanced nursing*, 48(4), 388-396.
- United Nations. (1966). International covenant on economic, social and cultural rights. *Treaty Series*, 933, 3-12.
- Urbanik, M. M., & Greene, C. (2021). Operational and contextual barriers to accessing supervised consumption services in two Canadian cities. *International Journal of Drug Policy*, 88, 102991
- Vashishtha, D., Mittal, M. L., & Werb, D. (2017). The North American opioid epidemic: current challenges and a call for treatment as prevention. *Harm reduction journal*, 14(1), 1-6.
- Watson, T. M., Bayoumi, A. M., Hopkins, S., Wright, A., Naraine, R., Khorasheh, T., ... & Strike, C. (2018). Creating and sustaining cooperative relationships between supervised injection services and police: A qualitative interview study of international stakeholders. *International Journal of Drug Policy*, 61, 1-6.
- Watson, T. M., Strike, C., Kolla, G., Penn, R., Jairam, J., Hopkins, S., ... & Bayoumi, A. M. (2013). Design considerations for supervised consumption facilities (SCFs): preferences for facilities where people can inject and smoke drugs. *International Journal of Drug Policy*, 24(2), 156-163
- Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of advanced nursing*, 53(4), 459-469
- Wood, E., Kerr, T., Small, W., Li, K., Marsh, D. C., Montaner, J. S., & Tyndall, M. W. (2004). Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *Canadian Medical Association Journal*, 171(7), 731-734. <https://doi.org/10.1503/cmaj.1040774>
- Wood, E., Tyndall, M. W., Lai, C., Montaner, J. S., & Kerr, T. (2006). Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. *Substance abuse treatment, prevention, and policy*, 1(1), 1-4.

- Ziegler, B. R., Wray, A. J., & Luginaah, I. (2019). The ever-changing narrative: Supervised injection site policy making in Ontario, Canada. *International Journal of Drug Policy*, 74, 98-111.
- Zlotorzynska, M., Wood, E., Montaner, J. S., & Kerr, T. (2013). Supervised injection sites: Prejudice should not trump evidence of benefit. *CMAJ*, 185(15), 1303-1304.

Chapter 3

3.1 Implications for Policy

By erecting hurdles to the implementation and growth of SCS, current federal and provincial SCS legislation has hampered people who use drugs (PWUD) access to harm reduction programmes and other health and social services offered through SCS referral programmes. The current SCS policy landscape acts as an indirect impediment by creating barriers to the establishment and maintenance of sites. This critical policy analysis discovered that the Canadian SCS policy's intentions appear to align with current research; nevertheless, policy statements have unintended weaknesses that might obstruct SCS and PWUD. The decreased harm reduction services could increase or impose further barriers to entering the care continuum for clients who would otherwise be referred to health and social services at the point of care (Health Canada 2021).

The problematization of substance use as a criminal issue in federal policy is a reoccurring theme in this study. SCS federal policy, which informs provincial policy, is written in Controlled Drugs and Drugs Act (CDSA), which is intrinsically criminal justice oriented. The major objective of the CDSA, which contains a set of prohibitions and punishments, is to establish a framework for the regulation of substances that might change mental processes and may cause harm to a person or society when diverted to an illicit market (Health Canada, 2015). According to the CDSA (2019), chemicals that are classified as controlled substances have the power to be used in illegal acts, so, the CDSA provides law enforcement authorities with the power to take action against unlawful activity involving such substances when those substances are scheduled under the CDSA (Health Canada, 2015). Since the CDSA centres around illegal activities, the majority of the problems discussed in the CDSA are related to crime and SCS, albeit a health intervention is no different. As a result, adopting an SCS policy in the health related federal policy document might help SCS and its users by ensuring that the language is less crime-focused.

In spite of the overarching concerns, it is noted that there are mixed barriers and opportunities within existing policies. For example, a strength noted in federal Bill C-2 is that it moves beyond the criminalization of substances and creates an opportunity for exemptions for healthcare delivery; it also has the potential to incorporate positive community perspectives. It also creates a regulatory process that allowed for informed decision-making from the federal Minister of Health. The shortcomings of Bill C-2 were many. First, it fails to recognize that SCS creates a safe environment for harm reduction workers to provide care and makes these safe spaces harder to access (Kazatchkine et al., 2016; Tsang, 2020). Bill C-2 creates a process wherein there is significant misinformation and stigma against injection-substance users to enter the planning process, through the community perspective. The rigorous criteria have made it difficult to develop new SCS or maintain existing SCS, potentially ultimately contributing to unsafe injection practices. Bill C-2 disproportionately considers “opinions” around access to critical health services. It effectively gives certain authorities—federal minister—unilateral veto power in the implementation of supervised consumption services, and it does not provide sufficient certainty or protection against arbitrariness. Lastly, this Bill C-2 imposed 26 tiers of necessary criteria on an already stigmatized and marginalized community, requiring numerous reports to be evaluated for section 56.1 exemption applications. The 26th condition was an open-ended provision that permitted the federal minister of health to add more preconditions.

Bill C-37 intended to streamline and simplify the application and renewal process for communities who wish to open SCS while ensuring that community consultation continues to be an integral part of the process. It accomplished this by allowing the review of the application to begin without a complete application, so long as basic info, community consultation and policies and procedures are included. It aimed to reduce the application criteria from 26 to 5, which aligned with the five factors set out by the Supreme Court of Canada in *Canada v. PHS Community Services Society*. It also tried to impose accountability and transparency on the government by instructing the decisions on applications to be made public, including reasons for refusals. Even though this Bill simplified the process, it remains a bureaucratic hindrance in the way of timely access to evidence-based healthcare services that can help avert diseases, injuries, and death. As a

result, the existing CDSA framework for seeking an exemption should have a more straightforward set of options, and there are three ways to do so.

First, because healthcare delivery is a provincial responsibility, in addition to the federal minister of health's ability to grant exceptions, the provincial or territorial health minister or chief public health officer (since substance use is a public health concern) should have the authority to grant an exemption for the operation of SCS, at least for a period until the application is approved. In this approach, urgent health services can be provided while the application is being completed and SCS applicants await a federal response.

Provinces can currently only open non-sanctioned SCS when the province declares a public health emergency; however, the state of emergency should not be required in order to establish a health intervention for a growing public health problem (CDSA, 2019; Pauly et al., 2020). Secondly, due to the lack of evidence to support the association between SCS and an increase in criminality, the crime rate exemption should be removed from the criteria because SCS is a health service, and it is illogical to expect that SCS will reduce crime and provide health services to PWUD at the same time. Finally, while working with local communities, government agencies, and local police can help improve the facility's acceptance and thus its operation, making their input a legal requirement for receiving or even applying for an exemption is unjustified and excessive, and it should be removed as one of its criteria. The fact that SCS are intended to help PWUD appears to be the sole justification for such special treatment with a more stringent standard. Local opposition to the introduction of SCS is likely to be based on misunderstandings, fear, and false preconceptions about substances, PWUD, and harm reduction programmes.

Alberta currently prioritises abstinence-based treatment programmes as an addiction strategy in its government policy. The province might gain from Ontario, Quebec, and British Columbia, which all recognise the necessity of having a rehabilitation pathway, but it is not the basis of their SCS policy, but rather another option accessible should PWUD wish to pursue it. While British Columbia's SCS policy is being rewritten, the province could benefit from reading Quebec's policy, which outlines activities to mitigate social problems. Ontario policy holds no one responsible for how the SCS is implemented, and it might benefit from Quebec policy, which was the first of the

provincial policy documents to state that the Ministry will support the SCS pending federal approval. The integrated Ministry of Health and Social Services in Quebec provides for a harm reduction strategy that is comprehensive. This integration ensures that politicians consider the wider picture of health when setting policy. Ontario, whose SCS implementation necessitates active participation of PWUD, fostering inclusivity and respect for PWUD, could benefit all jurisdictions. Alberta's policy, which requires SCS service providers to maintain track of referral processes and pathways for SCS users, could help all provinces.

3.2 Implications for Research

Future research can expand on this document analysis by partnering with future SCS applicants and monitoring the process from genesis through SCS establishment to see how policies are applied. It would give further insight into how policies affect the creation of SCS from the applicant's and PWUD community's perspectives. Another option for the study is to interview SCS users to learn about their facilitators and barriers to using the service. SCS employees can share their understanding of the policies' implications and discuss how the implementation of organisational SCS policies may reflect or contradict provincial or federal policies, as well as the frictions between these two in how services are delivered. Another area of research for which this study laid the groundwork is the public perception of SCS. Policy analysis by the federal and provincial governments reveals the importance of community members' and associations' views on SCS. The policy assumes a degree of fairness or balance in the community's opinions on SCS. This study contends that this assumption may be incorrect. In fact, the Pivot Legal Society secured a legal precedent in Alberta in 2019 that any evaluation of detrimental affects on the local community should be secondary and discretionary (Kim, 2019). So, research involving members of the community with established SCS and those whose communities may benefit from SCS to determine what these opinions are and whether it is fair to include them as a requirement for SCS implementation could aid policymakers in positively revising this current criterion for SCS establishment. Further research might broaden this provincial comparison by examining international policy comparisons with nations with comparable features to Canada in order to generate better SCS policies. A

review of social policies that influence substance use can be useful in informing good, equitable policy changes that go beyond SCS policy. Local communities' challenges with SCS might potentially be shown through a policy study that incorporates municipal bylaws and the SCS. An exploratory study on the interplay of current policies and political activities might potentially reveal gaps in policy implementation. It could also shed light on why the province of Alberta has closed several SCS. Many other investigations may be built upon the foundation of this research.

3.3 Implications for Practice

In terms of implications for practice, if policymakers are willing to destigmatize PWUD, they may have a more significant role in effecting system-level reform. This is not to say that policymakers are deliberately hostile or that they make negative assumptions on purpose or even consciously, but rather that this is one of the unintended consequences of policy formulations that locates the cause for the 'problem' on PWUD as opposed to systemic. As Bacchi (2009) points out, the policy's conceptual logic and assumptions are deeply embedded, necessitating close examination for their potential to marginalize, stigmatize, or simply undercut the interests of people the policy is intended to help. Despite the scarcity of resources and research advocating for stronger SCS policy, this study gives significant insight into future policy changes by highlighting present shortcomings. When and if policy changes are made, more study on SCS policy implementation should be done to verify that policy statements and best practices are consistent. This can be done by ensuring that the new fairer SCS policy has an accountability structure that holds the federal, provincial, and municipal government, and SCS service providers, accountable for delivering care in a fair and equitable manner. This can be accomplished by inspecting and reviewing SCS on a yearly or bi-annual basis. The review board must include prior or current SCS users who can clarify what best practises are expected from a SCS user's standpoint. The review must include opportunity for comments from current SCS users, and investigations into the cause of deficient areas should be conducted; if lacking areas are the consequence of legislation at any governmental level, then the issue should be escalated to the appropriate governing body. SCS provision should include more favourable, fair policies are guiding site

development and operation. This means focusing on health interventions, removing barriers to development, and providing protection against closure due to political perspectives versus health needs. This paper can also help SCS applicants and key stakeholders understand the current SCS policy.

For more than a decade, the healthcare agenda has been concentrated on person-centered and holistic care (Eklund et al., 2019; Ekman et al., 2011; Holmström & Röing, 2010). A person-centered approach to care centres on the individual, their context, history, family, and individual strengths and limitations (Eklund et al., 2019). It also entails a transition from perceiving the patient as a passive recipient of healthcare to one in which the patient is an active participant in their own treatment and decision-making. One of the SCS policy shortcomings is not including SCS users as active participants in the SCS healthcare intervention. To have a bigger impact on system change, health professionals would need to be better equipped to engage in policy advocacy. Understanding present policies, in this case concerning SCS, is the first step toward achieving this. This study should be used to teach health professionals about policy barriers that affect PWUD, as well as a resource for health professionals who want to advocate for a better understanding of PWUD in the community and more equitable policy reforms.

Healthcare professionals also have a responsibility—according to the Hippocratic oath—to encourage good health, by taking on the role of health promoters. Health promotion for policy entails identifying and overcoming barriers to the adoption of healthy public policies in non-health sectors (World Health Organization, 2021). The overall goal is for policymakers to create agency for PWUD to make healthier decisions. Health promotion aids personal and societal growth by offering information, health education, life skills enhancement and a safe environment free from harm and conducive for growth. By doing so, it expands people's ability to exert greater control over their health and environments, and to make choices conducive to health. Understanding the implicit philosophies contained in existing SCS policy as health professionals should offer a knowledge basis about PWUD and how to advocate for their better health. This understanding and advocacy will have an impact on policy and, ideally, offer PWUD greater control over their health. This paper can also help SCS applicants and key stakeholders traverse the

SCS policy and application system by providing a means to understand the current SCS policy.

3.4 Implications for Education

The ramifications for education can be discovered in the details of this critical policy analysis, which uncovers implicit philosophies buried in policy documents. Considering nearly every proposed policy may have an unintended impact on health, it is becoming increasingly vital for health experts to be included in the process. Healthcare and public health systems all over the world are governed by health-policy frameworks. These health policies have a significant and direct impact on population health, health outcomes, health inequalities, health equity, and health workers' environmental, socio-cultural, and industrial contexts. Healthcare professional, ought to participate in health policy formulation to enhance people's health worldwide. This covers the well-being of substance users. This thesis has looked at SCS policy documents and broken down how they may impact PWUD. This study serves as a starting point for understanding SCS policy, allowing health professionals working in SCS or with PWUD to assess how their SCS are implemented and advocate for greater implementation of the policy where it is missing, as well as better policies to address implementation gaps. For individuals working with PWUD, this thesis has highlighted some of the stigmas that they face, and it should inspire healthcare professionals to be more deliberate in their care and analyze their own biases toward PWUD. This evaluation of health policy, laws, and regulations is also critical to understanding how to develop health policy to benefit public health and will broaden the knowledge of nurses and other health professionals about the complex workings of health systems. This study may also be used to enlighten policy analysts, activists, and the general public about the gaps in SCS policy and the manifest and latent impacts of the existing policy, as it reveals policy silences. Furthermore, while it was not the aim, adequate evidence in favour of SCS was supplied throughout the study, which community members can use to better understand the topic and the role that they play in ensuring better health outcomes for PWUD.

3.5 Conclusion

This study revealed both consistency and variability in provincial and federal policy frameworks. Canadian SCS federal policy should be more in line with provincial policy documents that framed substance use as a public health issue and the need for a continuum of care. SCS as a harm reduction intervention is strongly supported by evidence and has become even more necessary during this global pandemic given the high incidence of overdose death and related harms in 2020. Although public support for SCS has seen an upward trend, unfavourable public opinion, political motives and attitudes towards substance use and PWUD influence policy and limit implementation and expansion of current SCS services. Even though conceptualizing substance use and the need for harm reduction through a continuum of care, or holistic approach for PWUD, may help overcome stigma and misconceptions about PWUD and SCS. SCS is a harm reduction strategy whose ethos to substance use is “meeting people where they are at” in order to improve overall health. Provinces could work together to revise their provincial policies to be even more person-centered around PWUD. This could be accomplished by engaging and communicating with PWUD and learning what they believe they need to reduce harm and improve their health; then incorporating these discussions into policy statements and ensuring that they are operationally enforced. Provinces should collaborate to form more equitable and appropriate policies that prioritize the people at risk of being in the most harm related to substance use.

3.6 References

- Bacchi, C. (2009). *Analysing Policy: Whats the problem represented to be. Frenchs Forest.*
- Controlled Drugs and Substances Act.* (2019, September 19). Justice Laws Website. <https://laws-lois.justice.gc.ca/eng/acts/c-38.8/FullText.html>
- Eklund, J. H., Holmström, I. K., Kumlin, T., Kaminsky, E., Skoglund, K., Högländer, J., ... & Meranius, M. S. (2019). “Same same or different?” A review of reviews of

person-centered and patient-centered care. *Patient Education and Counseling*, 102(1), 3-11.

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., ... & Sunnerhagen, K. S. (2011). Person-centered care—ready for prime time. *European journal of cardiovascular nursing*, 10(4), 248-251.

Health Canada. (2021). *Opioids and the opioid crisis – Get the facts - Canada.ca*. Canada.Ca. <https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/get-the-facts.html>

Holmström, I., & Röing, M. (2010). The relation between patient-centeredness and patient empowerment: a discussion on concepts. *Patient education and counseling*, 79(2), 167-172.

Kazatchkine, C., Elliott, R., & MacPherson, D. (2014). An injection of reason: Critical analysis of Bill C-2 (Q&A). *Canadian HIV/AIDS Legal network and Canadian Drug Policy Coalition (23 October 2014) online*: < <http://www.aidslaw.ca/site/an-injection-of-reason-critical-analysis-of-bill-c-2>.

Kim, P. (2019). *Pivot Legal Society and Canadian Drug Policy Coalition successfully defend supervised consumption at Federal Court of Canada*. Pivot Legal Society. https://www.pivotlegal.org/pivot_legal_society_and_canadian_drug_policy_coalition_successfully_defend_supervised_consumption_at_federal_court_of_canada

Pauly, B., Wallace, B., Pagan, F., Phillips, J., Wilson, M., Hobbs, H., & Connolly, J. (2020). Impact of overdose prevention sites during a public health emergency in Victoria, Canada. *PloS one*, 15(5), e0229208.

Supreme Court of Canada (2011). *Canada (Attorney General) v PHS Community Services Society*. *Const. F.*, 20, 41.

Tsang, J. (2020). Violating the Fundamental Rights to Life, Liberty and Security of the Person: Bill C-2 and its Implications on Supervised Consumption Sites in Canada. *Health Reform Observer—Observatoire des Réformes de Santé*, 8(1).

World Health Organization. (2021). *Health Promotion*. World Health Organization (WHO). <https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference/action>

Appendices

Table 4- *Federal Government Policy Reflections*

REFLECTIONS	QUOTES FROM FEDERAL POLICY DOCUMENTS
Question 1- Problem Representation	
Both health and safety are presented as the concerns	“Are the protection of public health and the protection of public safety;” (Bill C-2, 2015, p.1)
The text acknowledges the two different intents of addressing substance use	“Dual role of prohibiting certain activities associated with harmful substances and allowing access to those substances for legitimate medical, scientific and industrial purposes” (Bill C-2, 2015, p.1)
A degree of a presumption that SCS services may be connected to increased criminality	“Evidence, if any, of any variation in crime rates in the vicinity of the site during the period beginning on the day on which the first exemption was” (Bill C-2, 2015, p. 13)
A degree of a presumption that SCS services may be connected to increased criminality. Suggests to a certain degree that PWUD (past of present) with convictions cannot be key staff.	“A document issued by a Canadian police force in relation to each person referred to in paragraph (w), stating whether, in the 10 years before the day on which the application is made, in respect of a designated drug offence or a designated criminal offence, the person was (i) convicted as an adult, (ii) convicted as a young person in ordinary court, as those terms were defined in subsection 2(1) of the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985, immediately before that Act was repealed, or (iii) a young person who received an adult sentence, as those terms are defined in subsection 2(1) of the Youth Criminal Justice Act” (Bill C-2, 2015, p. 12).
Suggests rehabilitation as a standard, not harm reduction	“Description of the drug treatment services available at the site, if any, for persons who would use the site” (Bill C-2, 2015, p. 8)

<p>Acknowledges SCS as a potential avenue for crime and its problem is a public safety issue.</p>	<p>“Description of the potential impacts of the proposed activities at the site on public safety, including the following: information, if any, on crime and public nuisance in the vicinity of the site and information on crime and public nuisance in the municipalities in which supervised consumption sites are located,” (Bill C-2, 2015, p. 9).</p>
<p>Poses problem as insufficient rehabilitation opportunities for PWUD</p>	<p>“May offer a person using the site alternative pharmaceutical therapy before that person consumes a controlled substance that is obtained in a manner not authorized under this Act.” (<i>Controlled Drugs and Substances Act</i>, 2019, p. 54).</p>
<p>Question 2 - Presumptions</p>	
<p>A degree of the presumption that SCS services may be connected to increased criminality</p>	<p>“Evidence, if any, of any variation in crime rates in the vicinity of the site during the period beginning on the day on which the first exemption was” (Bill C-2, 2015, p. 13). “A document issued by a Canadian police force in relation to each person referred to in paragraph (w), stating whether, in the 10 years before the day on which the application is made, in respect of a designated drug offence or a designated criminal offence, the person was (i) convicted as an adult, (ii) convicted as a young person in ordinary court, as those terms were defined in subsection 2(1) of the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985, immediately before that Act was repealed, or (iii) a young person who received an adult sentence, as those terms are defined in subsection 2(1) of the Youth Criminal Justice Act (Bill C-2, 2015, p. 12). “Impact on criminal activity” (Bill C-2, 2015, P.13; Bill C-37, 2017, p. 42; CDSA, 2019, p. 55). “a letter from the head of the police force that is responsible for providing policing services to the municipality in which the site would be located that outlines his or her opinion on the proposed activities at the site, including any concerns with respect to public safety and security;” (Bill C-2, 2015, p.8)</p>

<p>Acknowledgment of government thought that PWUD & SCS users perpetrate crime with money made from an illicit source. Criminal activity often results from the use of illicit substances. Acknowledges SCS as a potential avenue for crime and its problem is a public safety issue.</p>	<p>“Whereas the money that is used to purchase controlled substances that are obtained from illicit sources often originates from criminal activity such as theft, and that money, in turn, often funds organized crime in our communities” (Bill C-2, 2015, p. 1)</p>
<p>A degree of the presumption that SCS is meant for rehabilitation or that PWUD and SCS users want to stop substance use</p>	<p>“Description of the drug treatment services available at the site, if any, for persons who would use the site” (Bill C-2, 2015, p. 8) “provides information about access to drug treatment services, if any, that are available in the province for persons who would use the site” (Bill C-2, 2015, p. 8) “may offer a person using the site alternative pharmaceutical therapy before that person consumes a controlled substance that is obtained in a manner not authorized under this Act.” (CDSA, 2019, p.55)</p>
<p>A presumption that ministers' “opinion” will be evidence-based or reasonable.</p>	<p>“The Minister may, on any terms and conditions that the Minister considers necessary, exempt from the application of all or any of the provisions of this Act or the regulations any person or class of persons or any controlled substance or precursor or any class of either of them if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.” (Bill C-2, 2015, p. 5; Bill C-37, 2017, p. 43-44; CDSA, 2019 p. 55)</p>
<p>Assumes reasonability or fairness, unbiased opinions of community members</p>	<p>“expressions of community support or opposition” Bill C-2, 2015, p. 10; Bill C-37, 2017, p. 44; CDSA, 2019, p. 55)</p>
<p>Question 3- Discourse Constructed Through Policy Preambles</p>	
<p>Acknowledgement that substance use and production impact Canadians</p>	<p>“Whereas the diversion of controlled substances and precursors, as those terms are defined in the Act, which is frequently used in the production of illicit drugs, is a worldwide problem with significant impacts on Canada” (Bill C-2, 2015, p. 2).</p>
<p>Acknowledgement that substance use and production impact Canadians. Acknowledgement that harm related to</p>	<p>“Whereas the negative consequences associated with the use of illicit substances can have significant impacts on vulnerable</p>

substance use is a problematic issue in the nation. A mandate from the superior court	subsets of the Canadian population;” (Bill C-2, 2015, p. 2).
To simplify the process of operating and having an exemption for SCS. - C-37 In an effort to simplify the process of operating and having an exemption for SCS.	“simplify the process of applying for an exemption that would allow certain activities to take place at a supervised consumption site, as well as the process of applying for subsequent exemptions;” (Bill C-37, 2017, p. ii).
Question 4- Silences	
Acknowledgment that the application/opening of SCS ought to be hard	“And whereas an exemption from the application of the Act and its regulations for certain activities in relation to controlled substances that are obtained from illicit sources should only be granted in exceptional circumstances and after the applicant has addressed rigorous criteria;” (Bill C-2, 2015, p. 2).
Assume reasonability of the inspector (2), the vagueness of this law allows for the unintended effect to deter people from the use by asking and demanding cooperation from PWUD for info regarding access to the illegal substance	“The owner or other person in charge of a place entered by an inspector under subsection (1), (1.1) or (1.2) and every person found there shall give the inspector all reasonable assistance in that person’s power and provide the inspector with any information that the inspector may reasonably require.” Subsection 31(5) (Bill C-2, 2015, p. 3).
Suggests that Governor in council can solely redefine terms that allow for exemption	“(1.2) The Governor in Council may make regulations for carrying out the purposes of section 56.1, including (a) defining terms for the purposes of that section; (b) amending the definitions that are set out in subsection 56.1(1)” (CDSA, 2019, p. 52).
The unilateral veto power of the Minister. the Bill does not indicate what level of information, research, opposition, or support would result in an application being accepted or denied	“The Minister may consider an application for an exemption for a medical purpose under subsection (2) that would allow certain activities to continue to take place at an existing supervised consumption site only after, in addition to the information referred to in paragraphs (3)(a) to (z.1),” (Bill C-2, 2015, p.13)
Minister reasoning is made only after the fact. SCS users are not involved in the decision-making process, hold ministry accountable but only after the fact	“After making a decision under subsection (1), the Minister shall, in writing, make the decision public and, 35 if the decision is a

	refusal, include the reasons for it.” (Bill C-37, 2017, p.44; CDSA, 2019, p. 55).
Questions 5- Effects	
SCS still may or may not be considered, as no law demands attention to the SCS application by the Minister. There is an issue with the word may.	“The Minister may consider an application for an exemption for a medical purpose under subsection (2) that would allow certain activities to continue to take place at an existing supervised consumption site only after, in addition to the information referred to in paragraphs (3)(a) to (z.1)” (Bill C-2, 2015, p.13)
Discursive: Benefits: Community organization prejudiced against PWUD. (the fact that it is open also makes it possible for PWUD to potentially band together, but their transient nature, does not allow for this. Looses: PWUD Subjectification: PWUD is thought about as not a part of the community, no policy that needs to hear the users Lived: the opportunity for further stigma.	“An application for an exemption under subsection (1) shall include information, submitted in the form and manner determined by the Minister, regarding the intended public health benefits of the site and information, if any, related to (a) the impact of the site on crime rates; (b) the local conditions indicating a need for the site; (c) the administrative structure in place to support the site; (d) the resources available to support the maintenance of the site; and (e) expressions of community support or opposition” (Bill C-37, 2017, p.44; CDSA, 2019, p. 55).
SCS still may or may not be considered, as no law demands attention to the SCS application by the Minister. There is an issue with the word may.	“The Minister may, on any terms and conditions that the Minister considers necessary, exempt from the application of all or any of the provisions of this Act or the regulations any person or class of persons or any controlled substance or precursor or any class of either of them if, in the opinion of the Minister, the exemption is necessary for a medical or scientific” (Bill C-37, 2017, p.43-44)
positive policy- allow for updated evidence-based learning.	“An application for an exemption under subsection (1) that would allow certain activities to continue to take place at a supervised consumption site shall include any update to the information provided to the Minister since the previous exemption was granted, including any information related to the public health impacts of the activities at the site.” (Bill C-37, 2017, p.44)
Can swing both ways to impact SCS users. The policy does not mandate the Minister to consider the comments.	“The Minister may give notice, in the form and manner determined by the Minister, of any application for an exemption under

	subsection (1). The notice shall indicate the period of time — not less than 45 days or more than 90 days — in which members of the public may provide the Minister with comments.” (Bill C-2, 201, p. 14)
Question 6 – Production, Dissemination and Defence	
Opinions of the local government allow for non-evidence-based, and feared opinions from those who have little to no understanding of the SCS purpose or knowledge and experience of the users	“Letter from the local government of the municipality in which the site would be located that outlines its opinion on the proposed activities at the site, including any concerns with respect to public health or safety;” (Bill C-37, 2017, p.44; CDSA, 2019, p. 55).
The statement acknowledges the production of the problem as a law enforcement or medical issue	“if, in the opinion of the Minister, the exemption is necessary for a medical, law enforcement” (Bill C-2, 2015, p. 8).

Table 5- Provincial Documents reflection

REFLECTIONS	QUOTES FROM PROVINCIAL POLICY DOCUMENTS
Question 1- Problem Representation	
Problem representation as a need for harm reduction, treatment here appears to be used holistically, not cure seeking	“Consumption and Treatment Services (CTS) will provide integrated, wrap-around services that connect clients who use drugs to primary care, treatment, and other health and social services.” (Ontario Ministry of Health and Long-Term Care, 2018, p. 3)
Reflect problem representation as public safety and concern for the community and public safety.	“The new program will also include requirements to address community concerns and ensure ongoing community engagement and liaison where CTS is established.” (Ontario Ministry of Health and Long-Term Care, 2018, p.3)
The problem as public health and public safety	“Problematic substance use is a significant public health and social issue. Injection drug use, in particular, is associated with risk of blood-borne pathogen transmission (such as HIV and Hepatitis C), death from unintentional drug overdose, and public disorder.” (British Columbia Ministry of Health, 2012, p.1)

The problem as public health and social issue	“SCFs serve an important function by providing immediate response to overdoses, increasing use of health and social services, and reducing the problems associated with public consumption of drugs” (British Columbia Ministry of Health, 2005, p.11)
Problem representation as lack of inappropriate harm reduction strategy	“Conduct a detailed needs assessment to determine the level of unmet need for harm reduction services. Communities should take advantage of existing data sources, such as health, education, and police sources, and encourage the data holders to help collect the data necessary to support the development, implementation, assessment, and evaluation of a comprehensive harm reduction strategy” (British Columbia Ministry of Health, 2005, p.14)
Problem representation as public health	“Public order and safety may be put at risk by open drug use in communities. Without coordinated action, public health systems can become overburdened with problems arising from the spread of HIV, Hepatitis and other diseases related to drug use, particularly injection drug use.” (British Columbia Ministry of Health, 2005, p.2)
Acknowledges conceptualization of substance use as a public health issue as well as public disorder	“Problematic drug use has profound consequences that affect not only consumers and their families, but also the entire population, in terms of public health. In particular, injection drug use can be linked to deaths from unintentional overdose, with the risk of transmitting infections through the blood (such as HIV and the Hepatitis C virus) or certain public disorder problems” (Ministère de la Santé et des Services sociaux, Quebec, 2013, p. 1)
Acknowledges the belief that a level of criminal activity occurs at SCS. Conceptualization as a crime. But is it a trickle-down effect from federal policy?	“Local promoters should describe the local situation regarding certain aspects of the public safety related to injection drug use and provide existing information, based on research as well

	<p>as health and law enforcement statistics relating to following items: (1) public disorder and criminality linked to drug consumption (e.g., feeling of safety in the sector, number of violations of municipal regulations concerning public order, drug trafficking); (2) injecting drugs in public” (Ministère de la Santé et des Services sociaux, Quebec, 2013, p. 6)</p>
<p>The “continuum of care” is Alberta’s perspective of harm reduction as a strategy that can be applied across the spectrum of health services, rather than an approach contained to the prevention of bloodborne pathogens. According to this policy, harm reduction interventions can be used beyond addiction and mental health services, in areas such as primary care and acute care. Problem represented as a need for services that require recovery system and a lack of access to treatment and care services</p>	<p>Employees are available to respond to people in medical distress and connect people to services like treatment within a recovery-oriented system of care (Alberta Ministry of Health, 2021, p. 5) “It is important that these services exist within a broad continuum of services that can support Albertans on their path to recovery.” (Alberta Ministry of Health, 2021, p. 5) “Supervised consumption services are part of the addiction and mental health service continuum and service providers are expected to support clients to access other services along the continuum of treatment and recovery services.” (Alberta Ministry of Health, 2021, p. 7)</p>
<p>While this recovery-oriented system is being defined here it problematizes a substance use as a lack of continuity of care services and removes the intentions or harm reduction by expressing the goals as a life free from illicit drugs.</p>	<p>“A recovery-oriented system of care is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve a life free of illicit drugs and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems or mental health issues.” (Alberta Ministry of Health, 2021, p. 5)</p>
<p>This Act refers to the Recovery-Oriented Overdose prevention service guidance on how SCS ought to be run, however the being a mental health act one would assume guidance with a focus here on mental health would be here, but this referral to the guide mean it does not problematize substance use</p>	<p>“A policy or procedure referred to in subsection (1) must meet the requirements, if any, set out in the Recovery-oriented Overdose Prevention Services Guide” (Alberta Mental Health Services Protection, 2021, p. 3)</p>

as a mental health issue, but a lack of recovery programs	
Question 2 - presumptions	
The assumption that SCS users want rehabilitation	“Onsite or defined pathways to addictions treatment services” (Ontario Ministry of Health and Long-Term Care, 2018, p. 3)
The assumption that there will be continued friction.	“CTS operators will be required to support ongoing community engagement and liaison initiatives to address local community and neighborhood concerns on an ongoing basis” (Ontario Ministry of Health and Long-Term Care, 2018, p.4)
Assumes the reasonability of these stakeholders. Why do businesses and police be involved with whether a health service is open or not?	“At a minimum, the following stakeholders should be consulted on the CTS: Local businesses and/or business associations; Local citizens and/or community groups; Local municipality. Police and other emergency services; Public health (local board of health); and Persons with lived experience. Applicants may include additional stakeholders in their consultation process.” (Ontario Ministry of Health and Long-Term Care, 2018, p.11)
Presume PWUD and SCS users are unified or gather in a particular area. There is evidence that does support this.	“Applicants must also demonstrate how the CTS is: Strategically located (i.e., walking distance from where open drug use is known to occur); Easily accessible by public transit.” (Ministry of Health and Long-Term Care, 2018, p.13)
The assumption of criminal activity or crime in SCS is evident in this statement that trickles down from federal policy, it assumes that there will be police called to intervene and crime occurring in the immediate vicinity.	“# of times security staff addressed a security event in the immediate perimeter of the CTS” (Ontario Ministry of Health and Long-Term Care, 2018, p.17) “As part of the monitoring and reporting requirements, CTS will be required to report on the following indicators every month” (Ontario Ministry of Health and Long-Term Care, 2018, p.17)

<p>A degree of the assumption that disorder, crime and goes on in SCS.</p>	<p>“The organization should describe the potential impact of the SIS on public safety, including (where available through health or law enforcement research and statistics) estimates of · public disorder and crime; · public injection; and · inappropriately discarded injection or other drug-related litter” (British Columbia Ministry of Health, 2012, p. 3)</p>
<p>The assumption that younger drug users want treatment</p>	<p>“The Vancouver site has also been found to attract younger drug users who have an elevated risk of HIV infection and overdose.³⁹ This provides an important opportunity to link this hard-to-reach group with health care and addiction treatment services.” (British Columbia Ministry of Health, 2005, p.11)</p>
<p>The assumption that SCS equates to public disorder and compromised community safety, assumes that open drug use does not already exist in the community, and that crime existed before the emergency of SCS as harm reduction.</p>	<p>“Public order and safety may be put at risk by open drug use in communities. Without coordinated action, public health systems can become overburdened with problems arising from the spread of HIV, Hepatitis and other diseases related to drug use, particularly injection drug use.” (British Columbia Ministry of Health, 2005, p.2)</p>
<p>The presumption is that PWUD mostly use in public spaces. PWUD are not being treated with respect or human dignity</p>	<p>“improving current services with regard to harm reduction by taking additional measures to prevent people from injecting drugs in public places (parks, alleys, public toilets)” ((Ministère de la Santé et des Services sociaux, Quebec, 2013, p.2, p. 6)</p>
<p>Degree of assumption that PWUD wish to stop using substances</p>	<p>“It is important that these services exist within a broad continuum of services that can support Albertans on their path to recovery.” (Alberta Ministry of Health, 2021, p. 5) (Alberta Ministry of Health, 2021, p. 5)</p>
<p>Duality, Alberta policy is the first to acknowledge that substance use is connected with need for mental health support. However, it also presumes and</p>	<p>“On-site or defined pathways to addiction treatment and recovery-oriented services, including mental</p>

emphasized treatment which imposes on harm reduction that is based on the not necessarily decreasing or stopping use.	health supports.” (Alberta Ministry of Health, 2021, p. 5)
A lot of policies mention the public safety and worry about the public use surrounding the SCS. Alberta mandates and hold SCS accountable for monitoring and handling this issue. It does assume however that SCS users will be using and discarding consumption supplies, around SCS.	“monitoring for and removing discarded consumption supplies (e.g., needles and other drug use equipment) from public spaces surrounding the site” (Alberta Ministry of Health, 2021, p. 5)
While evidence suggest that a good relationship with local law enforcement can be very crucial to the effectiveness of SCS. Since the use of the illegal substance is used in SCS, it is understandable that one can presume that public safety and criminal activity maybe performed around the site. However there remains an assumption that the introduction of SCS will somehow increase criminal activity. It appears they have forgotten that SCS is where there already exists how high amount of PWUD.	“Community engagement policies must demonstrate a relationship with local law enforcement and plans to mitigate public safety concerns in an ongoing way.” (Alberta Ministry of Health, 2021, p. 6)
Presumes that community support constantly changes.	“A director may consider the following criteria when issuing or refusing to issue, amend or renew a licence for the provision of supervised consumption services: (a) community support for the services;” (Alberta Mental Health Services Protection, 2021, p. 2)
Question 3 - discourse constructed through policy preambles	
Introduction to the purpose of the site	“In October 2018, Ontario’s Deputy Premier and Minister of Health and Long-term Care announced a new program to help people who are struggling with addiction receive healthcare and other supports.” (Ontario Ministry of Health and Long-Term Care, 2018, p.3)
Intentions of the document to ensure harm reduction are the focus of SCS	“This document was developed by the Ministry of Health to provide guidance to health authorities and organizations seeking to offer supervised injection services as part of a comprehensive health system response to non-medical injection and other potentially harmful

	substance use in BC. This document outlines the broad subject areas which the Ministry recommends should be addressed by agencies considering the establishment of SIS.” (British Columbia Ministry of Health, 2012, p.1)
Quebec minister acknowledging the province could benefit from harm reduction.	“Following this judgment, the then Minister of Health and Social Services, Mr. Yves Bolduc, expressed his intention to welcome SIS projects in Quebec by taking into account the criteria dictated by the Supreme Court.” (Ministère de la Santé et des Services sociaux, Quebec, 2013, p.3)
Intention is navigating the existing licensing policy	“This purpose of this guide is to support current or future providers of supervised consumption services in Alberta to understand and meet certain licensing requirements set out by the Government of Alberta under the Mental Health Services Protection Act and Mental Health Services Protection Regulation (collectively referred to in this guide as MHSPA).” (Alberta Ministry of Health, 2021, p. 4)
The problem representation of recovery or treatment focused came from the acknowledgement that the intention of the policy and goal of SCS in Alberta is a recovery oriented.	Employees are available to respond to people in medical distress and connect people to services like treatment within a recovery-oriented system of care (Alberta Ministry of Health, 2021, p. 5)
Hold SCS responsible for ensuring follow up and continued care for PWUD. Mandating a policy that hold the provincial government and SCS service providers accountable to the continued care of the SCS users	“a commitment that referral processes are tracked for each client, including known outcomes of referrals” (Alberta Ministry of Health, 2021, P. 7). “Service providers must have policies and procedures in place respecting the collection and use of each client’s personal health number (PHN). This ensures clients can be easily referred to a continuum of services within the healthcare system.” (Alberta Ministry of Health, 2021, p. 12).
It does not any specific instructions on how provincial policy related to SCS but refers to the guide outlined by the province on	“A policy or procedure referred to in subsection (1) must meet the requirements, if any, set out in the Recovery-oriented Overdose Prevention

how this this given, and guide is very recovery oriented.	Services Guide.” (Alberta Mental Health Services Protection, 2021, p. 3)
Question 4 - silences	
The implicit bias is that SCS can be in a community but not a part of the community. A shame that needs to be hidden	“CTS will not be concentrated in one area or neighborhood, and proximity to childcare centers, parks and/or schools (including postsecondary institutions) will be considered” (Ontario Ministry of Health and Long-Term Care, 2018, p.4)
Vague terminology, additional provincial criteria place, in addition to federal, and could still not receive funding for the site	“Applicants which meet the provincial program criteria and receive an exemption from Health Canada to establish a supervised consumption service (SCS), may be considered by the ministry for provincial CTS funding.” (Ontario Ministry of Health and Long-Term Care, 2018, p.4)
This infers to a certain degree that unless we see a result of the worst-case scenario (death), a harm reduction strategy cannot be placed.	“The ministry will identify communities demonstrating need for CTS based on the following: · Mortality data: Number of opioid-related deaths (i.e., cases), Rate of opioid-related deaths” (Ontario Ministry of Health and Long-Term Care, 2018, p.6)
Another level of government to go through for a health intervention.	“Must obtain and submit local municipal council support (i.e., council resolution) endorsing the CTS” (Ontario Ministry of Health and Long-Term Care, 2018, p.12)
Health interventions depend on public opinion on the matter. Does not bode well for this already marginalized group.	“Should submit other evidence of support for the CTS.” (Ontario Ministry of Health and Long-Term Care, 2018, p.12)
The provincial government will not cover the cost attend any of the wrap-around services, meaning SCS can refer you to what you need, but PWUD is not encouraged to use the service referred to them because of cost issues.	“Only Full-Time Equivalent employees (FTEs) and supplies directly associated with the consumption service, post consumption space, referrals, and/or addressing community concerns will be eligible for funding. The program funding will not cover direct costs of wrap-around services.” (Ontario Ministry of Health and Long-Term Care, 2018, p.14)
The crime is positively silenced	“The organization should include information relevant to the geographic region, neighbourhood or targeted

	<p>patient and client population to be served by the SIS, such as: · number and scope of other drug-related support services; · number of injection drug-related deaths and hospitalizations in the region (e.g., overdose, endocarditis, abscesses); · rates of communicable disease (e.g., HIV, Hepatitis C); · number of interactions between outreach health professionals (e.g., street nurses, Assertive Community Treatment team members) and people who engage in injection or other non-medical drug use; · estimates of local rates of drug dependence or other problematic substance use; and · clinical or patient-focused rationale to provide SIS, including if applicable, risk management for SIS as continuity of care.” (British Columbia Ministry of Health, 2012, p.3)</p>
<p>To problematized substance use as a crime, it neglects that SCS is established in the community with a need for it, meaning substance use already exists.</p>	<p>“Public order and safety may be put at risk by open drug use in communities.” (British Columbia Ministry of Health, 2005, p.2)</p>
<p>To problematized substance use as a crime, it neglects that SCS is established in the community with a need for it, meaning substance use already exists. How the imposed federal policy and its problematization as substance use as a criminal issue, puts the province in a box where they are mandated to support the idea as per policy by watching for a crime.</p>	<p>“The organization should describe the potential impact of the SIS on public safety, including (where available through health or law enforcement research and statistics) estimates of: · public disorder and crime; · public injection; and · inappropriately discarded injection or other drug-related litter” (British Columbia, 2012, p.3; Ministère de la Santé et des Services sociaux, Quebec, 2013, p. 6)</p>
<p>Offers a little certainty that if health Canada is approved, the ministry will be supporting the SIS if approved by Health Canada. Reduced the amount of hurdle to climb from 4 levels of government (federal, provincial, regional. Municipality) to just the federal government. As long as all criteria are met.</p>	<p>“Once the positive response has been received from the Minister of Health of Canada, the MSSS and the agency can then give their approval to the implementation of the project and give it the appropriate support” (Ministère de la Santé et des Services sociaux, Quebec, 2013, p.10)</p>
<p>Strong community opinion and involvement in a healthcare measure. The framing of this</p>	<p>“in addition to demonstrating rigorous community consultation and</p>

<p>policy allows it to sound very reasonable, in that worded in a way that means SCS applicants respect of the communities however, what is silenced here is that should applicants, perform all the necessary tasks, and answer or address concerns of the community, members of the community are still not obligated to sign the agreement. Which appears to be unfair, as the provision of a healthcare measure could hang on the whims of the community associations and groups within a 200m radius.</p>	<p>engagement regarding the site. Good neighbour agreements will support the successful integration of a site with the surrounding neighbourhood and community as a whole. Good neighbour agreements must include the following:</p> <ul style="list-style-type: none"> • interested parties signing on to the agreement (e.g., local businesses, community associations and nearby residents within a minimum 200-metre radius) • the responsibilities and commitments of each party, including the service provide” (Alberta Ministry of Health, 2021, p. 6)
<p>Doesn't not appear to define what nearby implies. If nearby is taken to mean as intent within the area, it silences here is the that small or isolated communities without detoxes who do experience a need for SCS because they do not have nearby detox services. It taken to mean the nearest, then the distance is relevant. Clarity in this would be helpful.</p>	<p>“Nearby detox, addiction treatment and social service agencies” (Alberta Ministry of Health, 2021, p. 19)</p>
<p>Ensures that policy is constantly reviewed, it could benefit the PWUD, and continue to improve on policy, however the timeline could be an issue, does this mean that some inappropriate policies can go unchecked or unchanged until 2026.</p>	<p>“For the purpose of ensuring that this Regulation is reviewed for ongoing relevancy and necessity, with the option that it may be repassed in its present or an amended form following a review, this Regulation expires on June 30, 2026.” (Alberta Mental Health Services Protection, 2021, p. 6)</p>
<p>Question 5 - Effects</p>	
<p>Duality, continuous engagement with the community to share insight on SCS use and opportunity to destigmatize PWUD. It separated SCS from the community by framing the policy, it separates the CTS operator from the local community.</p>	<p>“CTS operators will be required to support ongoing community engagement and liaison initiatives to address local community and neighbourhood concerns on an ongoing basis” (Ontario Ministry of Health and Long-Term Care, 2018, p.4)</p>
<p>Appears to reflect the intentions of SCS and harm reduction, care for the community, reduction of bias through education of the public. Details of mandate certain standards of the SCS site, and holds them accountable to the intent of the SCS</p>	<p>“The applicant must demonstrate an ability to provide the following services: Supervised consumption (injection, intranasal, oral) and overdose prevention services, Onsite or defined pathways to:</p> <ul style="list-style-type: none"> o Addictions treatment services o Mental health services

	<p>Primary care services o Social services (e.g. housing, food, employment, other), Harm reduction services: Education (on harm reduction, safe drug use practices, safe disposal of equipment), First aid/wound care o Distribution and disposal of harm reduction supplies o Provision of naloxone and oxygen, Removal of inappropriately discarded harm reduction supplies (e.g. potentially contaminated needles and other drug use equipment) surrounding the CTS area using appropriate equipment (i.e. needle resistant safety gloves), The CTS program does not include supervised inhalation services.”(Ontario Ministry of Health and Long-Term Care, 2018, p.6-7)</p>
<p>Allows for the flexibility and opportunity to tailor care to needs, but then goes back to ambiguity where services are not mandated to be approved</p>	<p>“Applicants may provide additional optional services based on capacity and local conditions. These should be described in the application. Please note optional services may require approval from Health Canada and/or the ministry based on the type of service.” (Ontario Ministry of Health and Long-Term Care, 2018, p.7)</p>
<p>Involves people all members of the community including PWUD on how a service should be delivered, however, it considers the opinion of people who are not directly affected site, introduced the opportunity for bias and stigma to be perpetuated.</p>	<p>“Preference will be given to sites that offer consistent hours of operation, seven (7) days per week. Proposed hours should be based on local context and consultation with community stakeholders, local community groups, and persons with lived experience.” (Ontario Ministry of Health and Long-Term Care, 2018, p.7)</p>
<p>Sees the benefit of including PWUD in modelling how SCS ought to be decided. Fosters inclusivity, optimizes benefits of the site to PWUD</p>	<p>“The staffing model must include peers / persons with lived experience “(Ontario Ministry of Health and Long-Term Care, 2018, p.8)</p>
<p>Inclusive to those who experience accessibility issues</p>	<p>“Verify the facility meets municipal bylaws and provincial regulations for accessibility” (Ontario Ministry of Health and Long-Term Care, 2018, p.9)</p>
<p>Constrained by federal SCS, this federal policy trickles down to impact users by</p>	<p>“Applicants will require evidence of support by local stakeholders, including</p>

<p>allowing room for prejudiced opinions to influence of decision of SCS. Health intervention depends on public opinion on the matter. Does not bode well for this already marginalized group.</p>	<p>residents.” (Ontario Ministry of Health and Long-Term Care, 2018, p.10). “community consultation is a requirement of the federal CDSA exemption application and does not have to be carried out separately for the Ontario program application, provided the consultation meets provincial requirements.” (Ontario Ministry of Health and Long-Term Care, 2018, p.11)</p>
<p>This flexibility allows for SCS applicant and proponent to be creative in what they offer as evidence to support the SCS</p>	<p>“Should submit other evidence of support for the CTS.” (Ontario Ministry of Health and Long-Term Care, 2018, p.12)</p>
<p>Great for inclusion and accessibility. Encourage competent care</p>	<p>“Applicants must verify the CTS is compliant with the Accessibility for Ontarians with Disabilities Act. Applicants must also demonstrate how the services offered are culturally, demographically, and gender appropriate.” (Ontario Ministry of Health and Long-Term Care, 2018, p.13)</p>
<p>Trying to ensure continuity of care for PWUD. Hold SCS accountable to the policy standards.</p>	<p>“To ensure that the CTS programs are efficacious and are achieving provincial objectives, each CTS provider will need to complete an annual report, subject to the criteria provided by the ministry. The ministry will also complete an evaluation of all provincially funded CTS operations.” (Ontario Ministry of Health and Long-Term Care, 2018, p.18)</p>
<p>Trying to ensure continuity of care for PWUD. All very relevant evidence for SCS, a fantastic example of a reasonable SCS requirement.</p>	<p>“The organization should include information relevant to the geographic region, neighbourhood or targeted patient and client population to be served by the SIS, such as: number and scope of other drug-related support services; number of injection drug-related deaths and hospitalizations in the region (e.g., overdose, endocarditis, abscesses); rates of communicable disease (e.g., HIV, Hepatitis C); number of interactions between outreach health</p>

	professionals (e.g., street nurses, Assertive Community Treatment team members) and people who engage in injection or other non-medical drug use; estimates of local rates of drug dependence or other problematic substance use; and clinical or patient-focused rationale to provide SIS, including if applicable, risk management for SIS as continuity of care.” (British Columbia Ministry of Health, 2012, p.2)
A holistic look at PWUD	“Specifically, how the services: are part of a continuum of response to substance use and its related harms;” (British Columbia Ministry of Health, 2012, p.3)
Embraces PWUD as a part of the community rather than shunning but encouraging welcoming. Sees PWUD holistically to ensure the social-economic barrier that impacts substance use is addressed in housing	“Emergency, transitional and supportive housing must be available for people who continue to use drugs, as well as those who are in recovery. Other supports needed to help people reintegrate into the community include low threshold mental health and addictions services, assertive community outreach, life and work skills training and supportive employment” (British Columbia Ministry of Health, 2005, p.16)
A holistic look at PWUD	“where the SIS is part of an integrated offer of healthcare and social services” (Ministère de la Santé et des Services sociaux, Quebec, 2013, p.8)
Prioritizes continuity of care and encouraging culturally competent care by insisting adaptation to different populous	“Local promoters must show how the supervised injection service: is part of a continuum of services related to the use of psychoactive substances and the misdeeds that result from it; respects the principle of “low entry threshold; is adapted to the gender, culture and demography of the target population” (Ministère de la Santé et des Services sociaux, Quebec, 2013, p.5)
Holistic look at the social factors that does impact substance use, allowing for a holistic approach to the substance use problem.	“on-site or defined pathways to a variety of wrap-around services including but not limited to primary care, housing and

	other social supports.” (Alberta Ministry of Health, 2021, P. 5)
Positive effect for those who choose to seek treatment, however it is not clear if people may still use the site should they not choose treatment, or should they not wish to stop using.	“Service providers must have in place policies that demonstrate clearly defined referral pathways to treatment and recovery services and, where possible, minimize barriers to accessing detox and treatment programs.” (Alberta Ministry of Health, 2021, p. 7)
This is could prove to be a strong community support system, where they can review the role, they all played and discuss how best to continue to positively impact the lives of PWUD and help curb the substance use issue in the community. However, it can also be a platform where people stereotypes and prejudice against PWUD can impact positive SCS implementation.	“The service provider’s policies respecting community engagement must outline ongoing commitments to engage, at a minimum once a year, with local government, first responder organizations (local police, fire department, Emergency Medical Services), the local business community and persons with lived experience who use the site.” (Alberta Ministry of Health, 2021, p. 6) “concerns raised by stakeholder groups and how any concerns will be addressed Different consultation requirements may apply to sites established on an urgent basis.” (Alberta Ministry of Health, 2021, p. 6)
Encouraging better access to health services - good effect	“partnerships with treatment providers to reduce barriers, such as wait times, when possible, for clients accessing services” (Alberta Ministry of Health, 2021, p. 7)
Ensured better safety for PWUD	“ongoing training for overdose response and other medical emergencies” (Alberta Ministry of Health, 2021, p. 10)
SCS is a health service that community opinion and lack of support can shut down.	“A director may consider the following criteria when issuing or refusing to issue, amend or renew a licence for the provision of supervised consumption services: (a) community support for the services;” (Alberta Mental Health Services Protection, 2021, p. 3)
Ensures that policy is constantly reviewed, it could benefit the PWUD, and continue to improve on policy, however the timeline could be an issue, does this mean that some	“For the purpose of ensuring that this Regulation is reviewed for ongoing relevancy and necessity, with the option that it may be repassed in its present or an amended form following a review,

inappropriate policies can go unchecked or unchanged until 2026.	this Regulation expires on June 30, 2026.” (Alberta Mental Health Services Protection, 2021, p. 6)
Question 6 – Production, Dissemination and Defence	
Problem representation of public safety produced in this policy that is obligated to follow federal guidelines and demands opinion of potentially prejudiced people to have a say in the lives of PWUD.	“community consultation is a requirement of the federal CDSA exemption application and does not have to be carried out separately for the Ontario program application, provided the consultation meets provincial requirements.” (Ontario Ministry of Health and Long-Term Care, 2018, p.11)
The role media plays in putting public perception	“Close involvement with members of the local media is important to ensure the public receives accurate information.” (British Columbia Ministry of Health, 2005, p. 11)
Problem representation defended as an avenue for PWUD to live substance free, betterment of mental health, and quality of life.	“A recovery-oriented system of care is a coordinated network of community-based services and supports that is person centered and builds on the strengths and resilience of individuals, families, and communities to achieve a life free of illicit drugs and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems or mental health issues.” (Alberta Ministry of Health, 2021, p. 5)

Table 6- Matrix filled for WPR framework for analyzing Canadian federal supervised consumption site policies

WPR Questions	Bill C-2	Bill C-37	CDSA
Question 1: What is the problem represented to be	Crime and social issue (public nuisance) that needs approval from law enforcement and community. Cost	Crime and cost issue	Crime issue. “substance abuse” needing a cure

in a specific policy?	problem. “Substance abuse” requires rehabilitation. Not health service, or public health, not harm reduction		
Question 2: What presuppositions –necessary meanings antecedent to an argument—and assumptions (ontological, epistemological) underlie this representation of the "problem" (problem representation)?	SCS users and PWUD perpetrate crime with money made from an illicit source. PWUD and SCS users want to be “cured” from substance use. Large reasonability of the Minister. Criminal activity often results from the use of illicit substances	Assume the reasonability of the Minister, and community. Criminal activity goes on in SCS	Medical purpose, not a harm reduction. Assumes reasonability or fairness, unbiased opinions of community members
Question 3: How has this representation of the problem come about?	Acknowledgement that harm related to substance use is a problematic issue in the nation	In an effort to simplify the process of operating and having an exemption for SCS.	Acknowledgement that harm related to substance use is a problematic issue in the nation. The mandate from the superior court
Question 4: What is left unproblematic in the problem representation? Where are the silences?	The unilateral veto power of the Minister. the Bill does not indicate what level of information, research, opposition, or support would result in an application being accepted or denied. Harm reduction is silenced	Easier renewals. Harm reduction is still silenced. Opinions” that are not necessarily based on any evidence are unjustifiable requirements. The fact that supervised consumption services are meant to serve people who use drugs seems to be the only reason for such exceptional	The unilateral veto power of the Minister. the Bill does not indicate what level of information, research, opposition, or support would result in an application being accepted or denied. Harm reduction is silenced

		treatment with a more burdensome standard.	
Question 5: What effects (discursive, subjectification, and lived) are produced by this representation of the problem?	<p>Discursive: Benefits: Community organization prejudiced against PWUD. (the fact that it is open also makes it possible for PWUD to potentially band together, but their transient nature, does not allow for this.</p> <p>Looses: PWUD</p> <p>Subjectification: PWUD is thought about as not a part of the community, no policy that needs to hear the users</p> <p>Lived: Stigma reduced access to harm reduction. Increased substance-related harm, substance-related overdoses</p>	<p>Discursive: Benefits: Community organization prejudiced against PWUD. (the fact that it is open also makes it possible for PWUD to potentially band together, but their transient nature, does not allow for this.</p> <p>Looses: PWUD</p> <p>Subjectification: PWUD is thought about as not a part of the community, no policy</p> <p>Lived: Stigma reduced access to harm reduction. Increased substance-related harm, substance-related overdoses</p>	<p>Discursive: Benefits: Community organization prejudiced against (opposition) PWUD. (the fact that it is open also makes it possible for PWUD to potentially band together, but their transient nature, does not allow for this.</p> <p>Looses: PWUD, community organizations that support</p> <p>Subjectification: PWUD is thought about as not a part of the community, with no policy ensuring their inclusion. Comment made after the fact and no policy that insists it is taken into consideration to impact verdict on site.</p> <p>Lived: Stigma reduced access to harm reduction. Increased substance-related harm, substance-related overdoses</p>
Question 6: How and where has this representation of the problem been produced, disseminated, and defended?	<p>The vagueness of the Minister's roles needs to be questioned. Seen as a public safety issue and not public health issue from</p> <p>Disseminated by providing an unjust</p>	<p>unwarranted to base determinations on whether to grant an exemption to a proposed SCS based on "the impact of such a</p>	<p>Crime focus, including the role of the inspector, proposes so much power and turns people away from SCS. The vagueness of the Minister's role</p>

How has it been, or could it be questioned, disrupted, and replaced?	opportunity for public opposition	facility on crime rates	is also present. Disseminated by the allowance of people opinions that may or may not be informed
--	-----------------------------------	-------------------------	---

Table 7-Matrix filled for WPR framework for analyzing Alberta, British Columbia, Ontario, and Quebec supervised consumption site policies

WPR Questions	Alberta		British Columbia		Ontario	Quebec
	Alberta Ministry of Health (2021)	Alberta Mental Health Services Protection (2021)	British Columbia Ministry of Health. (2012).	British Columbia Ministry of Health. (2005).	Ministry of Health and Long-Term Care. (2018)	Ministère de la Santé et des Services Sociaux. (2013)
Question 1: What is the problem represented to be in a specific policy?	A lack of continuum of care	A lack of recovery programs	Public health and social issues The imposed problematization of SCS as a criminal activity	Public health and social issues The imposed problematization of SCS as a criminal activity	Lack of/need for harm reduction Public health The imposed problematization of SCS as a criminal activity	public health and social issues The imposed problematization of SCS as a criminal activity
Question 2: What presuppositions – necessary meanings antecedent to an argument—and assumptions (ontological, epistemological)	Degree of assumption that PWUD wish to stop using substances. SCS will lead to increased	Presumes that community support constantly changes.	Need for treatment	SCS and public disorder	SCS and public disorder Forcing of treatment services	SCS can decrease public use

gical) underlie this representation of the "problem" (problem representation)?	criminal activity					
Question 3: How has this representation of the problem come about?	The intention of the policy and goal of SCS in Alberta is a recovery oriented.	Mental health Act demanding a follow of the very recovery oriented guide	Influence of media and framing harm reduction	Influence of media and framing harm reduction	Public health concern	Public health concern
Question 4: What is left unproblematic in the problem representation? Where are the silences?	Good neighbour policy that should applicants, perform all the necessary tasks, and answer or address concerns of the community, members of the community are still not obligated to sign	Ensure policy is constantly reviewed, however the timeline could be an issue, does this mean that some inappropriate policies can go unchecked or unchanged until 2026	SCS and encouraging drug use	SCS exist in communities that already have public drug use	SCS can be in the community but not a part of the community SCS not in public spaces No mandate to fund SCS	This policy is the first of its kind to offer certainty that, pending approval from the federal government, the ministry will support the SCS

	the agreement.					
Question 5: What effects (discursive, subjectification, and lived) are produced by this representation of the problem?	Holistic look at the social factors that does impact substance use. Ensured better safety for PWUD	Ensures that policy is constantly reviewed, it could benefit the PWUD. SCS is a health service that community opinion and lack of support can shut down.	Acknowledges that PWUD are not part of the community or are excluded from their local community. it encourages the reintroduction of PWUD back into their community		An integrated approach to SCS policy for PWUD, but no accountability Community bias opportunity fosters inclusivity and respects that PWUD do know what works best for them, services they wish to see and can contribute to their health outcomes. considerate and inclusive	The holistic approach to SCS policy for PWUD
Question 6: How and where has this representation of the problem been produced, disseminated, and defended? How has it been, or could it be questioned,	Problem representation defended as an avenue for PWUD to live substance free, betterment of mental health, and		Role of the media	media	ongoing education to members of the community	

disrupted, and replaced?	quality of life.					
--------------------------------	---------------------	--	--	--	--	--

Curriculum Vitae

Name: Vanisa Ezukuse

**Post-secondary
Education and
Degrees:** McGill University
Montreal, Quebec, Canada
2013-2017- BScN- Bachelor of Science in Nursing

The University of Western Ontario
London, Ontario, Canada
2019-Present MScN -Master of Science in Health and
Rehabilitation Science (Health Promotion Stream)

**Related Work
Experience** Teaching Assistant, Health Science
The University of Western Ontario
Sept 2019- Dec 2019

Research Assistant, Arthur Labatt School of Nursing
The University of Western Ontario
Jan 2020 – May 2020

Publications and Conference:

Ezukuse, V. (2021, May 31). *Factors Influencing Access and Utilization of Health*

Service Among Substance Using Homeless Youth: A Scoping Review [Powerpoint Presentation]. Legacy Virtual Research Conference: Honouring our Past, Creating our Future: Transforming Education, Services, Systems and Policies that Impact Health, London, Ontario.

Oudshoorn, A., Benbow, S., Esses, V., Baker, L., Annor, B., Coplan, I., ... & Ezukuse, V. (2020). Homelessness prevention for refugees: Results from an analysis of pathways to shelter. *European Journal on Homelessness*, 14(2), 189.