HIV LEGAL NETWORK
RÉSEAU JURIDIQUE VIH

SCALING UP SUPERVISED CONSUMPTION SERVICES:

WHAT HAS CHANGED IN CANADA?

A 2024 addendum to the HIV Legal Network's 2019 report:
Overdue for a change: Scaling up supervised consumption services in Canada.

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The HIV Legal Network works on the land now called Canada, which is located on treaty lands, stolen lands, and unceded territories of Indigenous groups and communities who have respected and cared for this land since time immemorial. We work to address the ongoing injustices and resulting health inequities faced by Indigenous Peoples that contribute to the disproportionate impact of the HIV epidemic on Indigenous communities. We are committed to learning to work in solidarity and to dismantling and decolonizing practices and institutions to respect Indigenous Peoples and Indigenous ways of knowing and being.

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KEY FINDINGS

PROGRESS

- Expansion of Supervised Consumption Services (SCS) in Canada since 2019, including in five additional provinces. In November 2023, SCS are available in British Columbia, **Yukon,** Alberta, **Saskatchewan, Manitoba,** Ontario, Quebec, **Nova Scotia,** and **New Brunswick.***
- Greater diversity of services is now available in Canada (e.g. drug checking, peer-assisted injection).
- The application process to obtain an exemption at the federal level to operate SCS has been streamlined since our last report.
- Additional pathways to apply for exemptions for temporary Urgent Public Health Sites have been put in place during the COVID-19 pandemic.

* *Added emphasis on provinces that did not have SCS at the time of our initial report.*

REMAINING BARRIERS

- Barriers at provincial levels, including overly stringent conditions for SCS implementation and funding, impede the scaling-up of SCS in Canada.
- General cuts in social services negatively impact SCS operations, staff, and clients.
- SCS providers encounter important challenges to recruit, retain, and ensure well-being of SCS staff.
- Insufficient funding is available to implement SCS, including to fund staff.
- SCS remain highly vulnerable to the political context at all levels of government.

KEY RECOMMENDATIONS:

- Federal, provincial/territorial, and municipal authorities must increase access to a diversity of SCS, including supervised inhalation services, culturally safe services, and youth- and women-centred SCS.
- Federal authorities must expand the scope of SCS exemptions to include protections for employed peer workers and nurses to offer assisted injection and provincial nursing colleges must provide guidance to nurses to offer this assistance.
- The federal government must take measures to remove case-by-case exemptions for SCS, including through the decriminalization of activities related to personal drug use.
- Provincial/territorial authorities must not impose unnecessary or overly stringent conditions for licensing or funding SCS.
- Federal and provincial/territorial authorities must urgently improve and sustain uninterrupted funding for SCS.
- Federal, provincial/territorial, and municipal authorities must increase support for comprehensive, diverse, and innovative programs that address the toxicity of the unregulated drug supply, including through safe supply, and other programs to meet the diverse needs of people who use drugs, including those related to mental health, treatment to manage substance use, housing, food security, and other social determinants of health.
- Additional research is needed to document existing and needed SCS models across the country, and their adaptation to local contexts.

BACKGROUND

Supervised consumption services (SCS) are evidence-based health services that provide a safe, hygienic environment where people can use drugs under the supervision of trained staff or volunteers. SCS, which include low-threshold and/or temporary services (often designated as Overdose Preventions Services or OPS), have a wide range of benefits. They prevent accidental overdoses and overdose (or toxic drug) deaths,[1] reduce the spread of blood-borne infections such as HIV and hepatitis C through harm reduction education and supplies, and contribute to improved health outcomes by linking clients to health and social services (including treatment and peer-based services).[2] Moreover, they reduce public use and discarded drug use equipment. Many SCS also provide access to health care onsite, including primary care (e.g. immunization, contraception, screening, and testing for sexually transmitted and blood-borne infections, etc.) and wound care as well as safe supply prescribing in some cases. Some SCS offer additional services and supports, such as drug checking and peer-assisted injection. Women-friendly SCS can also provide a refuge from violence that women experience in the streets.[3] SCS are a vital component of a comprehensive public health approach to reducing the harms that may be associated with drug use, particularly in the context of a toxic drug supply and among the most structurally vulnerable people who use drugs.[4]

In Canada, the expansion of SCS has been repeatedly hindered by legislative and political barriers at all levels of government. To operate SCS without risk of criminal prosecution, prospective organizations are required to apply for a federal exemption from prohibitions under Canada's *Controlled Drugs and Substances Act* (CDSA); without such an exemption, clients and staff members could risk criminal charges for possession (or possibly trafficking) in some circumstances.[5] For funding, providers mostly rely on support from provincial authorities. For many years, barriers at the federal level made it impossible to obtain an exemption and open new SCS in Canada. Despite the streamlining of the federal exemption process since 2016, SCS implementation remains challenging especially because new barriers have arisen at provincial and municipal levels in localities where governments do not support harm reduction and/or oppose SCS more specifically.

SCS implementation in Canada has been marked by a long series of steps forwards and backwards as one level government removes barriers and another imposes new restrictions. In this context, people who use drugs, service providers, health professionals, researchers, and activists must continue to work tirelessly to push for the implementation of these lifesaving services, advocate for legal and policy changes, preserve threatened gains, adapt to the evolving drug poisoning epidemic in Canada, and find creative solutions to address scarce funding and changes in governments' approaches to SCS.

Despite these hurdles, some progress has been made in the implementation of SCS in Canada. This progress is often overlooked because of the dramatic toll of the drug poisoning crisis on our communities.

In a report released in 2019, the HIV Legal Network explored the state of SCS in Canada in the previous year, described and analyzed legal and policy developments related to SCS implementation since their first inception, identified barriers and facilitators faced by current and future SCS operators, and formulated a series of recommendations primarily targeting the Government of Canada.[6]

In this new report, we provide an updated picture of SCS in Canada, assessing the implementation of our 2019 recommendations and highlighting the most pressing issues, including emerging threats, currently faced by SCS providers in the hope that it can inform the way forward.

In 2020, 40 of the 130 supervised consumption services in the world were in Canada according to Harm Reduction International.[7] *

***This figure does not account for SCS operating without a federal exemption in Canada under section 56.1 of the CDSA. More info below on the wide range of SCS operating in Canada.**

CONTEXT

SCS expansion in Canada is linked to the exponential number of toxic drug deaths and harm (hereinafter "drug poisoning crisis" or "overdose crisis") experienced in Canada over the past seven years.[8] One response to this crisis, driven by a poisoned supply of opioids and stimulants, has been increased access to SCS. Since our first report in 2019, the crisis has continued to worsen.[9] Between April 2020 and March 2022, 15,134 people died of an overdose, compared to 7,906 between April 2018 and March 2020.[10] The years following our first report were marked by the emergence of COVID-19, which severely affected people who use drugs, who were exposed to an increasingly toxic and unpredictable drug supply and faced feelings of isolation, stress, and anxiety in a context of diminished availability and accessibility of services.[11] Physical distancing and isolation requirements meant more people used unregulated drugs alone. They also increased vulnerabilities of people experiencing homelessness and living within alternative housing (i.e. hotels, rooming houses, and shelters/supportive living).[12] Circumstances forced service providers, health professionals, and policymakers to rethink access to SCS and ultimately led to new models (as well as legal pathways to open SCS) in an attempt to address a dramatic increase of overdose-related deaths during the pandemic.[13] However, efforts have been insufficient as a total of 3,970 new apparent opioid toxicity deaths occurred between January and June 2023.[14] This is an average of 22 deaths per day. In 2023, the toxicity and unpredictability of the drug supply remains a major driver of the illicit drug poisoning crisis in Canada.[15]

METHOD

Data for this new report were drawn from available published literature as well as a series of 11 interviews with SCS providers as well as a person who uses drugs, a lawyer, a researcher, and Health Canada representatives. Interviews were conducted by phone between May and September 2023 and recorded for accuracy. Respondents were from B.C., Yukon, Alberta, Manitoba, Ontario, Quebec, and Nova Scotia. Questions focused on positive changes identified in the past four years in relation to SCS as well as remaining challenges and gaps that need to be addressed to facilitate SCS implementation and mitigate the drug poisoning crisis. A three-member advisory committee reviewed the work plan and provided input during the drafting of the report.

SUPERVISED CONSUMPTION SERVICES

In this report, the term "supervised consumption services" (SCS) designates services offering supervised consumption of drugs (usually pre-obtained illicit drugs but it may also include prescription of safe supply medications) by trained volunteers and staff in a safe and hygienic environment. As noted above, our definition of SCS is purposefully broad to encompass multiple forms of supervised consumption services, including low-threshold and/or temporary services (often designated as Overdose Preventions Services or OPS), as well as more comprehensive/long-term supervised consumption services. The terminology used to designate SCS in Canada also varies depending on their legal status.

- "Supervised consumption sites" designate services that operate under an exemption issued by the federal Minister of Health for a "medical purpose" under section 56.1 of the CDSA.
- Temporary "urgent public health needs sites" are services operating under an exemption pursuant to section 56(1) of the CDSA issued by Health Canada "in the public interest."
- Overdose prevention sites are services authorized by provincial governments, and, in some cases, are unsanctioned sites that operate without official authorization or exemption.[16] For instance, in British Columbia, OPS operate legally through a 2016 Provincial Ministerial Order related to the public health overdose emergency.[17]

We will refer to "supervised consumption sites," "urgent public health needs sites (UPHN)," or "overdose prevention sites," where necessary to be specific. Otherwise, we will use the generic expression of "supervised consumption services" (SCS) encompassing multiple models of services.

In February 2024, **45 supervised consumption sites** across the country hold a valid exemption under section 56.1 of the CDSA with 39 currently offering supervised consumption services to the public — compared to 28 when we released our first report in 2019 (and two in 2016).[18] Federally exempted SCS are available in British Columbia, Alberta, Quebec, Ontario, and Saskatchewan. In addition to supervised consumption sites, several temporary "**urgent public health need sites"** operate in Canada, including in provinces where "supervised consumption sites" are not available such as Manitoba, Yukon, New Brunswick, and Nova Scotia.[19] In British Columbia, more than 40 additional "**overdose prevention sites**" are operating across the province.[20] It is also important to acknowledge that several overdose prevention sites in Canada continue to operate without a federal exemption, thus risking criminal prosecution. **Unsanctioned overdose prevention sites** led by people who use drugs have played a major role in the implementation of low-threshold access to SCS in Canada, filling gaps in the absence of governmental action and pushing for a wide range of SCS models, including low-threshold OPS.[21]

Finally, SCS also operate in Canada outside fixed (or mobile) sites in ways that do not necessarily require a specific exemption. For instance, SCS may be done **virtually** through phone or web applications, typically by peers with lived experience.[22]

In British Columbia, **Episodic Overdose Prevention Service (E-OPS)** refers to "provider-witnessed consumption of substances for the purpose of preventing or responding to drug poisoning delivered outside of established sites (e.g. SCS and OPS). E-OPS may operate in inpatient units, emergency departments, long-term care facilities, clinics, community-based settings, housing, emergency shelters, outreach, etc. This service is facilitated by a (peer/service/health) provider

trained in overdose response and equipped with supplies to respond to an overdose (e.g. take-home naloxone kit).[23] In British Columbia, currently, E-OPS are legally protected through the 2016 Ministerial Order and a province-wide Health Canada exemption from the CDSA for personal possession of limited quantities of specific drugs.[24]

SCS have also been provided by harm reduction workers in "**satellite sites**" referring to "informal harm reduction hubs operating out of the homes of people who use drugs."[25] Most often, these sites operate informally but, in Toronto (Ontario), two community health centres have developed satellite site programming to distribute harm reduction supplies and naloxone and to respond to overdoses in private homes and residential settings.[26] Satellite workers provide services from their homes. Satellite workers have also been recruited among shelter residents. Satellite workers may offer witnessed consumption to some people, though not necessarily, and receive some protection against prosecution for simple drug possession because of changes made to the CDSA in 2022 (see below).[27]

"To end the overdose crisis, we need to multiply efforts and find innovative ways of responding. In places that have been able to scale up supervised consumption and overdose prevention sites, we're confronted with the reality that these measures alone are not enough, and that we've hit a ceiling in terms of how many people they can protect. We need to reflect on different models — witnessed use, shelter-based sites, safer supply programs — and new ways of responding to ensure no one is left behind."[28]

(Harm Reduction Satellite Sites Guide, Toronto, Ontario)

LEGAL AND POLICY CHANGES

Since 2019, incremental legal and policy developments at the federal level have contributed to an expansion of SCS across Canada and more diversity in models. At the same time, this progress is overshadowed by new barriers erected at the provincial and local levels as well as the vulnerability of SCS to any political changes.

FEDERAL LEVEL

Because (most) SCS need a specific exemption from Health Canada to operate without risk of prosecution, facilitating the exemption process has been at the centre of advocacy efforts to increase access to SCS in Canada. A primary recommendation in our 2019 report was for the Government of Canada to grant a *class exemption* protecting clients and staff, including volunteers, from prosecution for drug possession or for activities (such as drug sharing or assisted injection) that may amount to trafficking when accessing or providing SCS that meet the minimum required conditions. Such an exemption could be granted "in the public interest" under section 56 of the CDSA or through regulation under section 55.

The purpose of this recommendation was to significantly ease implementation by removing the need for potential SCS providers to apply for an exemption on a case-by-case basis. It was also meant to "depoliticize" SCS by acknowledging that these services are legitimate evidence-based health services that should be protected from prosecution without having to rely on the discretion of the ministry of Health to provide site-specific exemptions. In October 2020, Health Canada organized a virtual meeting with SCS providers to inform the development of new regulations for SCS in Canada. Following the consultation, Health Canada decided not to proceed with new regulations but instead took some incremental steps to facilitate and accelerate SCS implementation and to authorize additional services and practices at SCS.

Health Canada's exemption process under section 56.1 of the CDSA

At the federal level, exemptions for SCS are provided under section 56.1. of the CDSA — a specific legal regime for SCS exemptions to be granted by Health Canada for "a medical purpose."[29] In our 2019 report, SCS providers reported that the application process had been streamlined to some extent (including through law reform) and that communication with Health Canada had improved tremendously in recent years.[30] Despite this progress, SCS providers maintained that the application process remained overly burdensome and created unjustified hurdles for organizations seeking to open new SCS. Respondents at the time described many of the criteria and requirements in law or policies to apply for an exemption as problematic or irrelevant[31] and urged Health Canada to take greater leadership in permitting and supporting diverse and innovative models of SCS.

What has changed?

The application process for section 56.1 exemptions has not fundamentally changed since our previous report.[32] However, according to respondents, Health Canada's attitude towards SCS seems to have become more flexible as the toxic drug supply and overdose crises continue. For example, Health Canada usually conducts site visits before granting an exemption. But in some circumstances (and it is not uncommon) an organization wanting to implement an SCS would need an exemption to access (provincial) funding to make renovations that are necessary to be able to offer the service. In these cases, Health Canada has approved an application before their site visit, issued a conditional exemption, and conducted their site visit after renovations have been completed and before the site opening to the public.[33]

Health Canada has also changed their approach to the duration of exemptions. Exemptions can now be granted for much longer periods as recommended in our 2019 report. The Government of Canada website indicates that three-year exemptions are common, with some even being renewed for five years.[34] According to Health Canada, several elements are taken into consideration when determining the duration of exemptions, including compliance history, reporting history, and the duration of confirmed funding. Should service providers wish to continue operating their SCS beyond the expiry date of the exemption, they must apply for a subsequent exemption. According to respondents, the application process for a subsequent exemption is usually much simpler.

Additionally, respondents indicated that community consultations were no longer overly onerous, reflecting a change from findings in our previous report, where respondents identified the mandatory community consultation requirement as an important barrier.[35] For this report, several respondents described organizing tours at their SCS to engage with local stakeholders rather than having to conduct townhall meetings, for example. Best practices have also now been identified to meet Health Canada's community consultations requirement and can help future SCS providers better navigate this process.[36]

Overall, the federal exemption process was no longer perceived by respondents as a major barrier, especially for stakeholders that had previously undergone the application process. This was more evident in cases where provincial and municipal governments enacted their own regulatory barriers, which were experienced as particularly onerous compared to Health Canada exemptions. However, the current application process may still be overwhelming for others, especially smaller organizations that have very little capacity or are new to the process. SCS providers and advocates maintain that the exemption process should be less complicated and nimble enough to respond to immediate needs and constantly changing drug supply.[37] In this regard, the *Urgent Public Health Needs exemption* by the federal government, discussed in the next section, has been seen as a welcome development.

Moreover, there is no guarantee that current practices and documented progress will remain the same if a new federal government comes into power. SCS are highly politicized, making exemptions particularly dependent on the political context. There are insufficient safeguards in the law or in existing regulations to prevent Health Canada from abandoning their current flexible approach and restoring previous practices that made it difficult and extremely time consuming to obtain an exemption.[38]

> *"The current federal government has moved a long way expediting the process… (but) again, there is this element of exceptionalism in the way that we are addressing SCS where it should just be: do you have a need in your community? Ok, then move forward."*
>
> **(Project respondent — Researcher)**

Class exemptions under section 56 (1) of the CDSA and Urgent Public Health Needs Sites

As described in the previous report, Health Canada began issuing class exemptions "in the public interest" under section 56(1) of the CDSA in 2017 to allow provincial and territorial governments to implement OPS without going through Health Canada's site-specific exemption process.[39] At the time, provinces and territories had to request this exemption.[40] Once the exemption was granted, those governments could regulate OPS and applications for new services would be directed to them rather than the federal government.

What has changed?

In response to the COVID-19 pandemic and continuing toxic drug supply and overdose crises, Health Canada issued a class exemption to all provinces and territories under section 56(1) of the CDSA in April 2020.[41] Although the name of the sites changed from "emergency overdose prevention sites" to "urgent public health need sites" (UPHNS), the goal of the exemption remained the provision of SCS on a temporary basis in an area with urgent need. Under this class exemption approach, each provincial or territorial Minister of Health may decide whether to implement the class exemption or not. If they decide to implement the exemption, SCS providers can go directly to their provincial or territorial government to set up a UPHNS without first having to apply for a Health Canada exemption.

Importantly, if a provincial or territorial Minister decides not to implement the class exemption or rejects a UPHNS application, organizations that want to open a (temporary and urgently needed) SCS can apply directly to Health Canada for a site-specific UPHNS exemption. In practice, Health Canada will always encourage such organizations to reach out first to their provincial and territorial government.

As they are meant to address an urgent need and to be temporary, applications for UPHNS are shorter and less time consuming.[42] Health Canada also prioritizes these applications for review, resulting in shorter wait times. If a site is urgently needed but would also need to be in place for a longer period, Health Canada has allowed organizations to open a UPHNS while an application for a longer-term SCS exemption is prepared. The fact that they can apply directly to Health Canada for an exemption allows SCS providers to benefit from this process even where provincial authorities may not be supportive. While specifically meant to address urgent needs arising from COVID 19, this class exemption has effectively provided new pathways for expedited implementation of (temporary) SCS through provincial/territorial authorities or through Health Canada. By issuing this class exemption, Health Canada recognized the need to go beyond section 56.1 and use other legal tools to expand access to SCS.

Based on the data available, at least 18 UPHNS exist across Canada in Yukon, Saskatchewan, Alberta, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.[43] Some provinces have used UPHNS to authorize ad hoc activities such as drug checking at festivals.[44] These services are intended to be temporary, so this number is likely to fluctuate. The UPHNS class exemption has been renewed multiple times and is currently set to expire in September 2025.[45]

Operational guidance and support for SCS

Operational Guidance for Supervised Consumption Services was released in July 2023.[46] The need for more guidance (and flexibility) from the federal government to increase the diversity of allowed services and activities was identified in our previous report — especially for new services such as inhalation services. Lack of guidance forced organizations wanting to open an SCS and public health officials to dedicate considerable time looking for information. Additionally, a national community of practice gathering approximately 50 organizations that operate SCS in Canada was launched and continues to be spearheaded by the Dr. Peter Centre. Knowledge exchange between SCS providers has proved central in advancing SCS policies and practices in Canada.

Decriminalization of activities related to personal drug use

As described in our 2019 report, decriminalizing activities related to personal drug use would effectively end the SCS exceptional regime as there would be no need for an exemption from criminal prosecution to protect both SCS staff *and* clients — allowing SCS to operate in a similar fashion to other harm reduction services. This is why it was our primary recommendation to the federal government.

What has changed?

Since 2019, some (geographically limited) developments have occurred. In January 2023, British Columbia secured a CDSA exemption from Health Canada to decriminalize possession of up to a cumulative 2.5 grams total of opioids, crack or powder cocaine, methamphetamine, or ecstasy by people over the age of 18.[47] This pilot exemption will last three years, until January 2026. However, some advocates have suggested that a 2.5-gram limit is too low to meet the needs of many people who use drugs.[48] Moreover, a bill was introduced at the time of writing of the present report to ban drug use in many public places and authorize police to confiscate people's drugs and to arrest them if they do not comply with direction to stop consuming or to leave a public place, thus contributing to the continuous criminalization of people who use drugs.[49] On December 31, 2023, the Supreme Court of British Columbia ordered that the legislation be paused until March 31, 2024, saying "irreparable harm will be caused if the act comes into force."[50]

Calls for decriminalization have continued outside British Columbia as well. The City of Toronto's application for municipal-level decriminalization has been under review by Health Canada for two years.[51] First submitted in January 2022, Toronto's full application with specific details of the requested exemption was submitted in March 2023, seeking an exemption effectively decriminalizing personal possession of *all* unregulated drugs in the CDSA, including for youth.[52] If granted, this exemption would be more far-reaching than the British Columbia pilot exemption. Other municipalities, including Montreal (Quebec) and Edmonton (Alberta), have also expressed interest in pursuing decriminalization.[53]

Although it has stopped short of decriminalizing simple drug possession, the federal government has taken steps to reduce such prosecutions. In August 2020, the Public Prosecution Service of Canada (PPSC) released new **prosecutorial guidelines for simple possession offences** under s. 4(1) of the CDSA. These guidelines instruct Crown attorneys to prosecute for these offences only in the "most serious" circumstances, including where the safety of children is at risk, an individual was operating a vehicle or is otherwise a risk to public safety, the offence took place in a prison or jail, the individual is a police or peace officer, or there is a connection to other CDSA offences. The guidelines apply to the PPSC, which is responsible for prosecuting all CDSA drug offences except in Quebec and New Brunswick, where the PPSC prosecutes only drug offences investigated by the RCMP.[54]

In November 2022, the government went one step further adopting **Bill C-5 (*An Act to amend the Criminal Code and the Controlled Drugs and Substances Act*).**[55] The new legislation *requires* that peace officers and prosecutors (including in Quebec[56] and New Brunswick) consider alternatives to laying or proceeding with criminal charges for *simple possession of drugs,* recognizing that "problematic substance use should be addressed primarily as a health and social issue," although their failure to do so does not invalidate any subsequent charges laid against the individual for the offence. Of particular relevance to SCS implementation, the law provides that it is not an offence for "social workers, medical professionals, or other service provider in the community" where they come into possession of drugs in the course of their duties and who intend to lawfully dispose of those drugs within a reasonable period of time — meaning they are automatically protected against prosecution for drug possession (i.e. without having to apply for a specific exemption) if they possess drugs *in the course of their duties* and intend to lawfully dispose of those drugs within a reasonable period of time. Of note, this does not extend to people who use drugs (e.g. SCS clients) and use in their presence, absent a federal exemption.

Assessing our recommendations for a streamlined exemption process

In our 2019 report, and based on information shared by respondents, we recommended that if a case-by-case exemption process was to be (unnecessarily) maintained, the federal government should take measures to further streamline the current application requirements and process. In particular, we recommended that:

Additional pathways are necessary to allow expedited exemptions issued either by provincial/territorial or local health authorities, or by the federal minister simply on the basis of such a request from such authorities.	✅ For UPHNS
Community consultations should not be required to provide an exemption.	✅ For UPHNS[57]
Securing funding should not be a precondition for a federal exemption.	Applicants must describe their financial plan and sources of funding.[58] Some sites have received a federal exemption while waiting for provincial funding approval but are not operating due to lack of alternative funding.[59]
Organizations should be permitted to submit joint applications and to open satellite sites without having to apply for a new exemption.	The application form allows for joint applications, but SCS exemptions remain site-specific and are considered on a case-by-case basis.[60]
To better accommodate the needs of individual communities, greater flexibility is needed to encourage and authorize a wide range of service models and an ability to adapt to changing contexts.	✅
Exemptions should be granted for more than one year.	✅

PROVINCIAL AND TERRITORIAL LEVEL

According to Health Canada, between January and June 2023, "most (89%) of the accidental apparent opioid toxicity deaths in Canada occurred in British Columbia, Alberta, and Ontario. Elevated mortality rates have also been observed in other areas with smaller population sizes."[61] While our initial report focused on federal barriers to SCS, it also highlighted disparities between provinces/territories and municipalities in their approaches to SCS. Additionally, it identified barriers emerging at a provincial level including in provinces hardest hit by the illicit drug poisoning crisis, such as Ontario and Alberta. Over the past four years, provincial barriers have become a primary concern for SCS providers in several provinces.

Provincial and territorial governments can control the implementation of SCS in multiple ways. In Canada, provinces have jurisdiction over the provision of health services. This also means that provinces are largely responsible for the funding of health services, including SCS. Given the level of power that provinces and territories have over health services, politics and ideology espoused by these governments play a critical role in the availability of harm reduction services in a given area. Thus, the experiences of service providers will differ greatly across the country depending on their provincial or territorial government's support for harm reduction. Provincial control over SCS may also be protective if a new federal government is less amenable to harm reduction. In British Columbia, for example, the provincial government was able to implement OPS without any federal exemptions because of its declaration of a public health emergency in 2016. Provincial and territorial governments have also chosen to regulate SCS in different ways. The following sections highlight legal and policy developments in Ontario, Alberta, and Manitoba that have raised concerns as to their impact on SCS implementation at a provincial level.

Ontario

As detailed in the 2019 report, a new provincial government overhauled Ontario's SCS after it came to power in June 2018. All provincially funded SCS and OPS became Consumption and Treatment Services (CTS) and existing sites/services were forced to reapply for provincial funding and needed to obtain a federal exemption under section 56.1 of the CDSA *as a pre-condition to provincial funding* (something that was no longer necessary for OPS under the previous provincial government).[62] As indicated in the new CTS designation, treatment, rather than harm reduction, became the focus. The CTS application process has remained the same since its inception in 2018.[63] Years later, it is evident that the CTS model has created barriers to scaling up SCS in Ontario.

The CTS model introduced additional conditions over and above what Health Canada requires for supervised consumption sites. It also prohibits inhalation services, which are urgently needed in Ontario.[64] Moreover, the province announced in 2018 that it would only fund 21 CTS across the province and that funding cap is still in effect.[65] These barriers have disproportionately affected rural communities in Ontario, which research shows have been hardest hit by the drug poisoning crisis.[66] Compared to larger urban centers, prospective SCS providers in smaller communities face heightened lack of capacity to implement onerous CTS requirements and increased risks of public opposition.[67] While numerous rural areas are potentially in need of SCS, the funding cap creates a situation where they have no chance of getting a site funded.[68] It has also reinforced geographical inequalities in access to services within the province with only one site in Northern Ontario (Thunder Bay) operating with provincial funding.[69]

As described by one of the respondents, one positive aspect of the CTS model is that it is better funded than the OPS model briefly introduced under the previous provincial government. However, wait times for CTS funding decisions have been unacceptably long. SCS providers in Barrie have been waiting for more than two years to receive funding approval since they submitted their application in October 2021.[70] In Peterborough, it took more than four years of efforts by community members, social services, and policy makers to establish a SCS. In addition to the duration of the wait, Peterborough faced great difficulties finding a location for the site (a pre-condition to apply for a federal exemption and provincial funding approval).[71]

As of February 2024, 17 CTS sites were in operation and five were still awaiting approvals.[72] At least one of the five proposed CTS will not be approved based on the funding cap. In the fall of 2023, the Ontario government also announced it was pausing approving new CTS in the province pending a review of all existing sites after a bystander was shot near a CTS in Toronto and died. While the province's Associate Minister of Mental Health and Addictions specified that the province is not looking to shut down any of Ontario's 17 CTS because they "know that there is some benefit to them because (they)'ve seen the outcomes,"[73] the decision to pause applications has already forced at least one site to close because they could not continue operating without provincial funding[74] and others are at risk of following.[75]

Because the CTS model is not a sanctioning (licensing) model, sites that hold a federal exemption may still operate outside of the CTS framework in Ontario. As a result, several SCS (including low-threshold OPS) have been operating outside the CTS scheme based on private donations or other alternative funding.[76] In Sudbury, where an SCS has been waiting for more than two years to receive provincial funding approval, the Spot has operated an OPS with temporary municipal funding but that funding ended up expiring.[77] Casey House, a sub-acute hospital in Toronto that supports patients living with or at higher risk of contracting HIV through inpatient and outpatient day programs, also operates an OPS without provincial funding. This has allowed Casey House to operate an inhalation room, which is not allowed at provincially funded CTS.[78] The initial investment and operating costs related to that service are covered by hospital donors. Nevertheless, this funding model is undoubtedly not achievable or sustainable for all organizations. Relying on private donations or financial support from municipalities to fund SCS is a great source of insecurity for implementers and has already forced some vital services to shut down.

Alberta

SCS have also been stifled in Alberta following a change in government. In 2019, a new provincial government came into power that prioritizes an abstinence-based approach to drug use at the expense of harm reduction programs, reversing progress made under the previous government to expand harm reduction services.[79] The number of overdose-related deaths remains high in the province, with Alberta having the second highest rate of overdose deaths in Canada.[80] Among a series of multiple blows to SCS in Alberta was an announcement in 2019 that the Alberta government would freeze funding pending a review of evidence of SCS.[81] In March 2020, it published a controversial report on the socioeconomic outcomes of SCS in the province.[82] The report, which reviewed only the potential social and economic impacts of SCS without considering the overall health benefits of services on people who use drugs, indicated that crime increased in the immediate vicinity of SCS sites (except in Edmonton) and reported other concerns related to public order raised by local residents. Researchers have criticized this report for being biased and methodologically unsound and have denounced the harms it caused.[83] In September 2020, the ARCHES SCS in Lethbridge, which was at the time the "busiest SCS in North America"[84] with an average of 500 visits per day, lost its provincial funding. Loss of funding was attributed to alleged mismanagement of funds although there was no attempt to address those allegations at the time and no charges were laid after an investigation found all funds were accounted for.[85] The ARCHES site also provided the only supervised inhalation service in the province. The site was replaced by a mobile OPS operated by Alberta Health Services, with a three-person capacity and no supervised inhalation services. Through interviews with community members that use substances, research found that Lethbridge's SCS closure negatively affected people who use drugs.[86] People reported being more reticent to access OPS services due to the unsafe location, lack of inhalation services, and lack of other social supports that used to be offered at ARCHES. Participants also reported seeing more people dying from overdose since the Lethbridge SCS closed.[87] In 2021, the government also announced the closure of Calgary's SCS and closed one site in Edmonton, further jeopardizing access to SCS in the province.[88] More recently in Red Deer, the government stopped funding the community organization that runs the OPS and handed over operations to Alberta Health Services, which switched to mobile services.[89] (At the time of writing the site was at risk of closure due to pressure from a municipal councilor.[90])

In additional efforts to control SCS in Alberta, the government established stringent licensing requirements in 2021[91] under the *Mental Health Services Protection Act* and *Mental Health Services Protection Regulations* (which also regulate "Narcotic Transition Services" and "Psychedelic Drug Treatment Services). SCS implementers must now meet *Recovery-oriented Supervised Consumption Services Standards* to obtain a license to operate in Alberta.[92] Without a license, SCS are not allowed to operate even with private funding.

The licensing process imposed by the government of Alberta is much more onerous than the federal exemption process and risks discouraging potential SCS providers. As one respondent described: "We feel under a microscope." Notably, standards set by the province require a long list of written policies and procedures to be established and implemented on site. The renewal of licensing also takes place annually, compared to the longer exemptions provided by the federal government. Further, compliance with government standards requires licensed providers to submit monthly reports, which must include a plethora of information, including the number of visits to the site, a record of which drugs were used at the site and in what proportions, referrals to other services, and additional qualitative information. In particular, the standards oblige service providers to ask people who use the site to provide their personal health number at intake (and if clients do not have a personal health number, service providers must, with the client's agreement, assist them in obtaining one).[93] Service providers denounced this unjustifiable requirement that risks deterring people from using the site. As described by respondents, clients have been reluctant to provide personal health numbers and service providers feel this is undermining efforts to create trusting relationships with clients. Moms Stop the Harm and the Lethbridge Overdose Prevention Society took the matter to court seeking an injunction to suspend the application of

that requirement, but their application was denied.[94] Additionally, while our previous report pointed out how community consultation could pose major barriers to SCS implementation, standards set in Alberta not only require community consultation but the creation of a "Good Neighbour Agreement" signed by all local businesses, community associations, and nearby residents within a minimum 200-metre radius around the site. Service providers must also engage, at least annually, with local government, first responder organizations (including police), the local business community, and people with lived experience that use the site and maintain records of all engagement activities including letters of support from local law enforcement. Together, these represent a formidable administrative burden on already over-stretched and burned-out implementers who must address multiple overdoses inside and outside their sites everyday (including increasing inhalation-related overdoses outside SCS, according to respondents). The model was also established to facilitate complaints against SCS. A striking illustration of that is the section of the Minister of Health's website related to SCS, which does not include any information on SCS that could contribute to public education about these sites, but instead provides detailed information on how concerns and complaints can be brought forward and addressed.[95]

The government, which was re-elected as a majority government in May 2023, has continued to take a hard stance on drug use, including through coercive measures, such as a proposed bill that would allow family members, police officers, or doctors to seek a court order for forced treatment of people who use substances in violation of their human rights and contrary to evidence-based practices.[96]

Manitoba

Manitoba has been in an illicit drug poisoning crisis due to a toxic drug supply since 2016. In 2021, the province had a record number of 407 deaths — an increase from 372 in 2020.[97] Manitoba has also seen a spike in HIV cases with a rate of new cases that is three times higher than the national average.[98] There is currently only one mobile OPS operating in Manitoba under an Urgent Public Health Needs exemption from Health Canada. This OPS was launched without any provincial or municipal funding.[99]

Despite this context, and following Alberta's example, the previous government of Manitoba introduced Bill C-33 in March 2023. Bill C-33 aimed at regulating the provision of addiction services in Manitoba including SCS. Under the Bill, such services would only operate if they were granted a license. Moreover, service providers would still need to apply for a federal exemption meaning they would have to duplicate efforts to obtain the right to open SCS. The bill ultimately died on the order paper and in October 2023, the opposition won the provincial election, making it unlikely for Bill C-33 to be reintroduced. In fact, representatives of the new government expressed support for SCS and committed to open at least one site in Manitoba.[100]

A DIVERSITY OF MODELS AND SERVICES

One recommendation included in our previous report was to increase diversification of SCS to address the diverse needs of people who use drugs and local conditions. Fortunately, the diversity of SCS available has increased. As described earlier in this report, there are now many different models of SCS operating in different provinces including comprehensive supervised consumption sites, low-threshold OPS, supervised consumption services integrated into multi-service community agencies,[101] health facilities[102] or treatment centres, mobile OPS and SCS,[103] OPS primarily staffed by people with lived experience of drug use, e-OPS, unsanctioned sites operating in tents, and satellite sites. Sites providing services exclusively to women-identifying clients and non-binary people are slowly emerging, including in shelters. No youth-specific SCS exist and minors are often excluded from SCS and other harm reduction services due to age restrictions and parent/guardian consent requirements.[104] Efforts are also necessary to create culturally safe SCS, including for Indigenous people.[105]

The wide diversity of SCS models across the country has yet to be documented and more research is recommended to increase understanding of how SCS can adapt to local contexts and local needs. In addition to legal and policy developments described above, contextual circumstances, including the COVID-19 pandemic, have been important factors propelling changes in SCS models in Canada. 2020 was marked by the expansion of SCS in COVID shelters and hotels as well as in housing facilities[106] (at least in B.C., Alberta, Ontario, and Quebec). Specific guidance was developed at a national level to support people who use drugs in shelter settings during the COVID-19 pandemic.[107] Such expansion, however, was also concomitant to the emergence of new barriers that limited access to SCS during the pandemic. Evaluations of SCS during COVID-19 demonstrate a decrease in visits to SCS due notably to service closure, reductions in operating hours, capacity restrictions and related increases in waiting times, as well as fear of being exposed to COVID-19 while attending SCS.[108]

Services available at SCS have also diversified since our last report. Access to drug checking, for example, has significantly expanded. Drug checking is "a service that employs various technologies (e.g. testing strips, spectrometry) to provide information about the composition and/or purity of illegal drugs."[109] It can help people adapt their consumption based on test results and provide information about substances that are circulating on the unregulated drug market. In July 2023, 29 SCS were providing drug checking as part of their service models.[110] The UPHNS federal class exemption has also been used by provinces to authorize drug checking at festivals. One respondent directly connected the expansion of drug checking services in Canada (and in Quebec more particularly) to a simplified exemption process in relation to drug checking. Funding, however, remains a barrier to the implementation of drug checking in SCS, as the most accurate and precise tests are expensive.[111]

In 2020, peer assistance was added to the list of authorized services that prospective SCS operators can include in their applications for a federal exemption.[112] Peer assistance refers to "one person providing assistance to another in the course of preparing and consuming drugs."[113] As of February 2024, 29 supervised consumption sites (out of 39 currently offering services) were authorized to permit peer assistance with injection.[114] This represents important progress from the pilot program in place at the time of our previous report. Important limits to assisted injection/consumption remain, as SCS staff (including nurses or peers on shift) cannot administer drugs to clients. Only other clients and friends can help administer drugs. This create barriers to SCS access for clients who need direct help with injecting.[115] It also prevents staff, including nurses, from meeting clients where they are. As described in a recent report, "when working with clients who live with a disability, clients who experience withdrawal symptoms or have a history of injection-related anxiety, and clients with difficult or limited access to veins, nurses encounter situations in which not being able to provide direct assistance with

the injection itself results in the client having to leave to seek help somewhere else."[116]

As described in our previous report, drug sharing and splitting for personal use is another element respondents said should be authorized at SCS. Splitting and sharing means acquiring, separating, and/or transferring drugs between individuals — a common practice among people who use drugs.[117] Following consultations with Health Canada in 2020, a national civil society working group was formed to address barriers related to drug sharing and splitting. In 2021, the working group developed a survey to collect SCS providers' and clients' perspectives on drug sharing and splitting restrictions. Respondents highlighted that those restrictions forced people to exchange and/or prepare their drugs outside SCS, exposing them to criminalization, and created barriers to accessing SCS.[118] The working group then developed a protocol for splitting and sharing at SCS. Community advocacy paid off as Health Canada now provides exemptions for splitting and sharing for personal use on sites.[119]

Another major development that has occurred since our last report is the development of safer supply programs in some jurisdictions in Canada, including with federal funding. Health Canada defines safer supply as "providing prescribed medications as a safer alternative to the toxic illegal drug supply to people who are at high risk of overdose."[120] Vancouver's first program distributing hydromorphone tablets was launched at the Molson Overdose Prevention Site and Learning Lab in January 2019. Other safer supply programs linked to SCS exist in Toronto and Thunder Bay.[121] Increased support for and expanded access to a diversity of safer supply options remain urgently needed in Canada.[122]

As already identified in our 2019 report, SCS providers exchange experiences, procedure books, and practical information about SCS operations. Community stakeholder support and partnership continue to be essential to the expansion of SCS and innovative programming in Canada.

REMAINING CHALLENGES AND PRESSING ISSUES

ADAPTING SERVICES TO EVOLVING DRUG CONSUMPTION

In conversations with respondents across Canada, a consistent throughline was clear: there is an urgent need for inhalation in SCS. Inhalation now accounts for more overdose deaths than injection in the provinces the most affected by the drug poisoning crisis (British Columbia, Alberta, and Ontario). Inhalation-related deaths outnumbered injection-related ones by more than double in Ontario from March to December 2020. In British Columbia from 2017 to 2021, 44 percent of opioid-related deaths had evidence of inhalation only, while 23 percent had evidence of injection only.[123]

This data represents a shift from earlier years when injection was the mode of consumption most often seen in overdoses, leading harm reduction advocates and governmental authorities to call for services to address overdoses by inhalation.[124] In the Yukon, for example, the Blood Ties Four Directions Centre would not have opened their SCS without an authorization to offer inhalation services. They knew from their experience working in the community and from the lived experience of members of their SCS advisory group that no one would have visited a site offering supervised injection only. This is confirmed by their data showing that 94 percent of the visits to their site is for smoking while only 6 percent of the visits are related to injection.[125] Where SCS do not offer access to inhalation rooms, staff may be accidently exposed to smoke when people use bathrooms for smoking, making the need for dedicated and ventilated space for smoking even more necessary. Washrooms in health and social services agencies and shelters are frequent sites for drug consumption.[126]

Indoor inhalation services have been slow to open in British Columbia, despite the province's pressing need for them. Smoking legislation, occupational health and safety legislation, and funding exigencies for new ventilation systems have been identified as major barriers to implementation. Given these challenges, most supervised inhalation occurs informally, typically outdoors or in tents. However, a promising development occurred in May 2023 in Vancouver, as its city council voted to lift the indoor smoking ban for SCS for two years.[127] This will allow SCS to include smoking booths in their sites for the first time, although outdoor sites will continue to be preferred. There is currently one indoor inhalation room, along with 16 "indoor-outdoor hybrid" locations, in the province.[128] One SCS provides indoor inhalation services in Saskatchewan[129] and the same in Ontario.[130] In Quebec, indoor inhalation services should be soon available in Montreal.[131]

Respondents who were able to include inhalation rooms in their sites provided some valuable insight. First, provincial or municipal smoking legislation assumed to be major barriers to *indoor* inhalation supervised consumption services were in fact determined not to apply to sites in Toronto (Ontario) and Whitehorse (Yukon). Local authorities (i.e. the Ministry of Health in Ontario and the municipality of Whitehorse) confirmed that indoor smoking legislation and municipal smoking bans apply to cannabis and tobacco smoke only; smoking other substances indoors does not contravene those laws. A similar experience had been previously described in Alberta.[132]

Health Canada does not impose any specific restrictions around inhalation services. However, they require SCS applicants to ensure their services comply with provincial legislation and municipal bylaws on smoking and on occupational safety. Determining how this plays out in practice can pose challenges for SCS operators as well as for provincial and territorial health authorities given the lack of data on the effects of secondhand fumes from illicit substances and lack of guidance on ventilation specific to SCS inhalation rooms (although specific guidance could also create barriers if standards are set

too high). In that regard, respondents shared early anecdotal evidence from these sites that the fumes created from smoking are very limited and do not require the sophisticated ventilation systems initially expected and used. There is a possibility that less expensive ventilation methods may be sufficient to reduce health and safety risks, lowering the investment needed for future SCS to implement indoor inhalation services.

INSUFFICIENT RESOURCES FOR SCS AND OTHER SOCIAL SERVICES

Lack of social services

Respondents from different provinces said they have witnessed the destruction of social services for people experiencing homelessness and other precarious situations over years, and this has created an excessive burden on SCS. Respondents described the stress experienced by staff during COVID-19 at a time when SCS were the only places where people could go and there were no other services (e.g. food banks and drop-in shelters) to which they could refer their clients to address their most pressing needs. As they observed, services have not fully resumed and SCS continue to fill the void for people who experience homelessness or are struggling with mental illness or drug use. SCS staff are now expected to find shelter beds and treatment programs for clients. Research on OPS staff in Toronto described how one of the most difficult and frustrating aspects of their job was spending hours on the phone trying to find a shelter bed or drug treatment for people in a context where there is a total dearth of available services.[133] OPS are staffed for monitoring and responding to OPS — not to provide case management or secure housing. Yet, some OPS offer additional services like food and clothing because these services are no longer being offered in the community and clients need them. Cuts in social support not only add to the burden of SCS workers but also expose SCS to increased risk of unjustified criticism as the drug poisoning crisis persists. Although crucial, SCS cannot be expected to address all determinants of health of people who use drugs and are only one of the many necessary interventions to address the poisoning crisis.[134]

> *"The belief [was] that supervised consumption services or overdose prevention sites were the only answer and that they were also going to magically address poverty and houselessness and crime around the area, and then when they failed to meet those expectations, it opened the door for critical commentary that we should abandon this approach, that it has not done what it was designed to do. But they were never designed to do those things… the answer is, a continuum of options available to people that acknowledges the unique characteristics of every person who uses drugs and the varying circumstances they may arrive accessing services."*
>
> (Respondent, B.C.)

Recruitment and other staff challenges

Staff recruitment, retention, and wellness are major challenges that were frequently raised by respondents. Workload, working conditions, hours of operations (including night shifts for some services), mental distress, and trauma have important impact on SCS staff. Yet, resources for personnel remain limited and do not necessarily reflect the evolution of the drug poisoning crisis. As described by a respondent, for example, their staff model has remained unchanged since they opened their site despite a dramatic spike in the number of overdoses on site and outside their site (due to inhalation and lack of dedicated space for smoking). Another respondent indicated that they only have two staff to supervise consumption although multiple overdoses sometimes happen at the same time. Staff shortage, turnover, and lack of experience in harm reduction among some new staff, all create significant barriers to SCS expansion and diversification. This is particularly true for SCS that rely on nurses or other regulated care providers for which there is significant shortage in Canada.

"We are always trying to just keep our head above water… It is very tiring. The staff are traum[atized] right out… They are giving CPR. Probably normal to see eight overdoses in a day. It is a lot for staff. Lot of mental injury and burnouts happening because of that."

(Respondent from Alberta)

Limited funding

For many SCS providers, uncertainties around funding exacerbate difficulties of recruiting and retaining staff. It is a source of anxiety and can be a major organizational challenge, affecting service delivery for SCS. As described in a study of OPS in Toronto, "efforts to keep the programs operating required balancing service delivery with the considerable time and human resource demands dedicated to securing funding and developing contingency plans if the sites were to close."[135] In Sudbury (Ontario), the OPS lost a nurse and a social worker because of uncertain funding and the risk of closure.[136] In Saskatchewan, Prairie Harm Reduction has asked unsuccessfully for government funding for its supervised consumption site for the past four years and now fears closure.[137] Funding was brought up by all respondents in all regions as a significant barrier to service availability, let alone scale-up of services. Because funding is largely dependent on provincial authorities, implementing and maintaining SCS in provinces where the government does not support them is especially challenging. Providers have been obliged to find alternative solutions to support their services including crowdfunding, private donations, merchandise sales, or municipal funding — demonstrating the important role municipalities can play to support access to SCS.

POLITICS, LAW ENFORCEMENT, AND COMMUNITY ACCEPTANCE

Several respondents pointed to greater community acceptance and "normalization" of SCS in Canada, as illustrated by their expansion in several provinces. However, community acceptance varies from one place to another, and the situation remains volatile. As illustrated in Alberta, opposition from local businesses and fears that SCS may create public disorder remain common concerns that may be used politically to limit access to services despite evidence that SCS do not fuel crime or public disorder in their surrounding communities.[138] Law enforcement presence on site or during overdoses have also been described by respondents as major barriers to services.

Overall, respondents agreed that SCS remain extremely vulnerable to the political context. They were particularly concerned that changes in the federal government could have major negative repercussions on access to SCS in Canada. In that regard, our recommendations from 2019 to depoliticize SCS by removing the requirement for site-specific exemptions and decriminalizing activities related to personal drug use remain relevant.

KEY RECOMMENDATIONS

Although progress has been made to facilitate the scale-up of SCS in Canada, most of the recommendations laid out in our 2019 report remain valid. Here are key recommendations that we wish to highlight in 2024:

- Federal, provincial/territorial, and municipal authorities must increase access to a diversity of SCS, including supervised inhalation services, culturally safe services, and youth- and women-centred SCS.
- Federal authorities must expand the scope of SCS exemptions to include protections for employed peer workers and nurses to offer assisted injection and provincial nursing colleges must provide guidance to nurses to offer this assistance.
- The federal government must take measures to remove case-by-case exemptions for SCS, including through the decriminalization of activities related to personal drug use.
- Provincial/territorial authorities must not impose unnecessary stringent conditions for licensing or funding SCS.
- Federal and provincial/territorial authorities must urgently improve and sustain uninterrupted funding for SCS.
- Federal, provincial/territorial, and municipal authorities must increase support for comprehensive, diverse, and innovative programs that address the toxicity of the unregulated drug supply, including through safe supply, and other programs to meet the diverse needs of people who use drugs, including those related to mental health, treatment to manage substance use, housing, food security, and other social determinants of health.
- Additional research is needed to document existing and needed SCS models across the country, and their adaptation to local contexts.

ANNEX: 2019 RECOMMENDATIONS

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

1. Decriminalization

The federal government should decriminalize activities related to personal drug use.

2. Class exemption for SCS clients and providers

In the interim, before necessary decriminalization, the federal government should grant a class exemption protecting clients and staff, including volunteers, from prosecution for drug possession or for activities (such as drug sharing or assisted injection) that may amount to "trafficking" when accessing or providing SCS that meet minimum required conditions.

3. A streamlined process for SCS exemption applications

If the federal government insists on unnecessarily maintaining a case-by-case SCS exemption process, it should take measures to further streamline the current application requirements and process.

4. Other measures the federal government should adopt to support SCS expansion

- Federal funds should be made available to support SCS, including in provinces and territories where authorities are reluctant to fund these life-saving services.
- The federal government should work with provincial, territorial, and municipal governments to ensure they commit to facilitate the scale-up of SCS where needed, including through immediate and sustained operational funding for SCS.
- Greater support should be made available to service providers, especially grassroots, peer-led organizations who are well positioned to provide SCS but may not have the financial or human resources necessary to apply for an exemption or implement SCS meeting the minimum criteria.

RECOMMENDATIONS TO PROVINCIAL, TERRITORIAL, AND MUNICIPAL AUTHORITIES:

- Provincial and territorial authorities should provide immediate and sustained operational funding for SCS in their province or territory.
- Provincial and territorial authorities should not impose conditions for SCS implementation that are not required for other health services. In particular, provincial and territorial authorities should not create exceptional hurdles for service providers to receive funding to provide a wide range of supervised consumption services. Provincial guidance related to SCS should be amended accordingly.
- Municipal authorities should not impede the establishment of SCS through the enactment of by-laws.

ENDNOTES

1 In Canada, overdose related deaths are driven by toxic/poisoned drugs (opioids and stimulants). See B. Fischer, "The continuous opioid death crisis in Canada: changing characteristics and implications for path options forward," *The Lancet Regional Health* 14 (2023): 100437.

2 For an overview of SCS benefits, see M. C. Kennedy, M. Karamouzian, and T. Kerr, "Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review," *Current HIV/AIDS Reports* 14(5) (2017): pp. 161–83. https://pubmed.ncbi.nlm.nih.gov/28875422/.

3 N. Fairbairn, "Seeking refuge from violence in street-based drug scenes: Women's experiences in North America's first supervised injection facility," *Social Science & Medicine* 67 (2008): pp. 817–823.

4 See e.g. E. Wood, et al., "Do supervised injecting facilities attract higher-risk injection drug users?," *American Journal of Preventative Medicine* 29(2) (2005): pp. 126–30. https://pubmed.ncbi.nlm.nih.gov/16005809/.

5 Some protection for staff now also exists under section 10.7, *An Act to amend the Criminal Code and the Controlled Drugs and Substances Act*, S.C. 2022, c. 15.

6 A. Foreman-Mackey and C. Kazatchkine, *Overdue for a change: scaling-up supervised consumption services in Canada*, Canadian HIV/AIDS Legal Network, 2019.

7 Harm Reduction International, *Global State of Harm Reduction*, London: Harm Reduction International, 2020.

8 B. Fischer, M. Pang, and M. Tyndall, "The opioid death crisis in Canada: crucial lessons for public health," *Lancet Public Health* 4(2) (2019): e81-e82. doi: 10.1016/S2468-2667(18)30232-9.

9 Federal, provincial, and territorial Special Advisory Committee on the Epidemic of Opioid Overdoses, *Opioid- and Stimulant-related Harms in Canada*, Ottawa: Public Health Agency of Canada, December 2023. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/.

10 Special Advisory Committee on the Epidemic of Opioid Overdoses, *Opioid and Stimulant-related Harms in Canada*, Ottawa: Public Health Agency of Canada, September 2022.

11 Health Canada, Public Health Agency of Canada, and U.S. Department of Health and Human Services, *Canada-U.S. Joint White Paper: Substance Use and Harms During the COVID-19 Pandemic and Approaches to Federal Surveillance and Response*, Ottawa, Ontario; Washington, D.C.: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, 2022.

12 In Ontario and during the pandemic in 2020, the number of opioid-related deaths among people experiencing homelessness more than doubled. Thirty percent of deaths that occurred in hotels, motels, or inns occurred in those that were identified by the investigating coroner as being designated to provide COVID-19 physical distancing shelter or isolation services. T. Gomes et al., *Changing circumstances surrounding opioid-related deaths in Ontario during the COVID-19 pandemic*, Ontario: Public Health Ontario, 2022. https://odprn.ca/wp-content/uploads/2021/05/Changing-Circumstances-Surrounding-Opioid-Related-Deaths.pdf.

13 See e.g. E. Hyshka et al., *Supporting people who use substances in shelter settings during the COVID-19 pandemic: National Rapid Guidance*, Edmonton, Alberta: Canadian Research Initiative in Substance Misuse; September 19, 2022. https://crism.ca/wp-content/uploads/2023/01/CRISM-COVID-19-Shelter-Doc_V2-1.pdf; T. Gomes et al., *supra* note 12.

14 Federal, provincial, and territorial Special Advisory Committee on the Epidemic of Opioid Overdoses, *supra* note 9.

15 Of all accidental apparent opioid toxicity deaths in early 2023 (January-June), 84 percent involved fentanyl. This percentage has increased by 47 percent since 2016 when national surveillance began but appears to have stabilized in recent years. Of all accidental apparent opioid toxicity deaths in 2023 (January-June), 80 percent involved opioids that were only non-pharmaceutical. This percentage has increased by 21 percent since 2018 when national surveillance began but appears to have stabilized in recent years. *Ibid.*

16 Canadian Research Initiative in Substance Misuse (CRISM), *National Operational Guidance for the Implementation of Supervised Consumption Services*. Edmonton, Alberta: Canadian Research Initiative in Substance Misuse, July 17, 2023.

17 Vancouver Coastal Health, *Overdose Prevention Site Manual 2022*, 2023. http://www.vch.ca/en/media/13086.

18 Health Canada, "Supervised consumption sites: Status of applications," December 12, 2023. www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html.

19 Health Canada, interview, September 2023; See also, A.-E. Prentice and R. Hempel, "Manitoba's first formal overdose prevention site launches in Winnipeg" *Global News*, October 30, 2022; "ReFix," *Direction180*, Nova Scotia. https://direction180.ca/our-parterships/; "Nos services," *Ensemble Moncton*, New Brunswick. https://ensemblegm.ca/fr/services/.

20 A. Kulkarni, "Why calls are growing in B.C. to fund more overdose prevention sites," *CBC News*, March 11, 2023. www.cbc.ca/news/canada/british-columbia/overdose-prevention-sites-bc-1.6775263.

21 A. Foreman-Mackey and C. Kazatchkine, *supra* note 6.

22 See "Two years later, Lifeguard App continues to save lives," BC Emergency Health Services, May 17, 2022; See also, the *National Overdose Response Service (NORS)*, www.nors.ca or the Brave App, www.brave.coop/about.

23 BC Centre for Disease Control (BCCDC), British Columbia Ministry of Mental Health and Addictions, and Provincial Health Services Authority, *Provincial Episodic Overdose Prevention Service (eOPS) Protocol*, 2023.

24 Health Canada has granted an exemption from section 4(1) of the Controlled Drugs and Substances Act to the Province of B.C. This is effective from January 31, 2023 to January 31, 2026. Under this exemption, adults (18 years and older) in B.C. are not arrested or charged for possessing up to 2.5 grams cumulatively of opioids, crack/cocaine, methamphetamine, and MDMA. See *Ibid* at p. 8; See also Health Canada, "Subsection 56(1) class exemption for adults in the province of British Columbia to possess small amounts of opioids, cocaine, methamphetamine and MDMA," September 14, 2023. www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/exemption-personal-possession-small-amounts-certain-illegal-drugs-british-columbia/subsection-56-1-class-exemplтion-adults-18-years-age-older.html.

25 L. Michaud and R. Thomas, *Harm Reduction Satellite Sites. A Guide for Operating Harm Reduction Hubs from the Homes of People Who Use Drugs*. Toronto: Parkdale Queen West Community Health Centre & South Riverdale Community Health Centre, 2020.

26 Evaluation of satellite programs show that they tend to reach higher rates of women and racialized people who use drugs. *Ibid.*

27 This CDSA amendment makes an exception for a "social worker, medical professional or other service provider in the community" who comes into possession of a substance in the course of their duties and intends to lawfully dispose of it within a reasonable period. *An Act to amend the Criminal Code and the Controlled Drugs and Substances Act,* SC, 2022, c 15, s 10.7.

28 L. Michaud and R. Thomas, *supra* note 25, p. 5.

29 This specific regime was established in 2015 by the previous federal government and amended in 2017 by the current government.

30 In 2017, the government (still in power to date) repealed the *Respect for Communities Act* and replaced it with *Bill C-37 (An Act to amend the CDSA*), which came into force in May 2017. Bill C-37 did not remove section 56.1 of the CDSA but replaced previous onerous legislative requirements with simpler, streamlined requirements. The number of approved supervised consumption sites in Canada rose rapidly to 24 within the first five months the legislation was in effect.

31 Under section 56.1 of the CDSA, applicants must provide information regarding the intended public health benefits of a future SCS and, if any, information related to 1) the impact of the site on crime rates, 2) the local conditions indicating a need for the site, 3) the administrative structure in place to support the site, 4) the resources available to support the maintenance of the site, and 5) expressions of community support or opposition.

32 The current government amended Section 56.1, creating a specific legal regime for SCS exemption, in 2017, and it has remained unchanged since then. Health Canada's guidance and forms to apply for an exemption were updated in July 2021 to include the possibility of proposing drug splitting and peer assistance services at SCS.

33 Dr. Peter Centre, *UPHNS Community of Practice HUB: Application process for UPHNS vs. SCS*., online webinar, November 24, 2020.

34 Health Canada, *supra* note 18.

35 As described in recently developed national guidance for SCS, "Health Canada does not provide any specific requirements regarding what the required community consultation and engagement must entail (i.e., it can consist of anything prospective operators deem meaningful for capturing opinions regarding the proposed site). Health Canada typically expects that consultation and engagement be broader than engaging only with prospective SCS participants, and include unbiased reporting of the feedback received, and for all feedback to be treated equally." See Canadian Research Initiative in Substance Misuse (CRISM), *supra* note 16 at pp. 66-67.

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