**QUESTIONNAIRE**

**Contact Details**

Please provide your contact details in case we need to contact you in connection with this questionnaire. Note that this is optional.

|  |  |
| --- | --- |
|  | [ ]  Member State [ ]  Observer State[x]  Other (please specify)Civil Society – Canadian Drug Policy Coalition (CDPC) (www.drugpolicy.ca) |
| Name of StateName of Survey Respondent | CanadaNicholas Boyce, Senior Policy Analyst, CDPC |
| Email | nicholas\_boyce@sfu.ca |

**Background**

Within the framework of Human Rights Council resolution 51/21, the Special Rapporteur on the highest attainable standard of physical and mental health has identified health equity as a strategic priority, ranging from the underlying determinants of health to the need to eliminate structural and systemic barriers in accessing health care services, goods, and facilities, particularly among persons living under vulnerable or marginalised circumstances. In compliance with her mandate and in line with these priorities, the Special Rapporteur on the right to health has decided to devote her next thematic report to the Human Rights Council, to be held in June 2024 to the theme of “Drug policies and responses: a right to health framework on harm reduction”.

**Objectives of the report**

All persons are entitled to the enjoyment of the highest attainable standard of physical and mental health, which includes the underlying determinants of health and timely and appropriate health care. In the present report, the Special Rapporteur intends to explore the ways in which harm reduction intersects with the enjoyment of right to health and related human rights. Relying on the frameworks of the social and commercial,[[1]](#footnote-1) determinants of health, the Special Rapporteur will examine the laws, policies, and practices that give rise to the need for harm reduction, as well as the laws, policies, and practices that take a harm reduction approach, aiming to address the negative health, social, and legal outcomes in various contexts.

Harm reduction has been primarily developed in the context of drug use, including needle and syringe programs, supervised injection and drug use facilities, opioid substitution therapy, overdose prevention, and community outreach programs, as well as access to legal assistance, social services, housing, and adequate food. However, in this report, the Special Rapporteur will take a broadened view of harm reduction to examine how this approach can intersect with the right to health and related human rights in other realms, including but not limited to sex work, abortion, and safe sex.

The Special Rapporteur also intends consider harm reduction as key public health interventions for populations that are often stigmatised and discriminated against. She will explore how the laws, policies, and practices that give rise to the need for harm reduction can disproportionately impact certain people, such as those in situations of homelessness or poverty, persons who use drugs, sex workers, women, children, LGBTIQ+ persons, persons with disabilities, persons who are incarcerated or detained, migrants, Indigenous Peoples, Black persons, persons living with HIV or hepatitis, and persons living in rural areas. Taking an anti-coloniality and anti-racism approach, the Special Rapporteur will explore how in some contexts criminalisation and stigmatisation can serve as a legacy of colonialism and slavery.

**Definitions**

Most commonly, harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.[[2]](#footnote-2) For the purposes of this report, the Special Rapporteur defines harm reduction in a broader sense, including the policies, programmes, and practices that aim to minimise the negative health, social, and legal impacts associated with various behaviours and related policies and laws, as exemplified above.

**Questionnaire**

The questionnaire can be downloaded below in English (original language), French and Spanish (unofficial translations). Responses can address some of the questions or all of them, as feasible or preferred.

* Download the questionnaire (WORD): English | Français | Español

# How and where to submit inputs

Inputs may be sent by e-mail by 15 November 2023.

|  |  |
| --- | --- |
| **E-mail address** | ohchr-srhealth@un.org |
| **E-mail subject line** | Contribution to HRC report - SR right to health |
| **Word limit** | 500 words per question |
| **File formats** | Word and PDF |
| **Accepted languages** | English, French, Spanish |

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# Treatment of inputs/comments received

# Please note that all responses will be published on the official webpage of the mandate of the Special Rapporteur by default.

# Key Questions

*You can choose to answer all or some of the questions below. (500 words limit per question).*

Inputs may be sent by e-mail **by 15 November 2023**.

1. **While the concept of harm reduction has traditionally been applied to drug use, the Special Rapporteur is taking a broadened approach to harm reduction. What types of harm reduction policies, programmes, and practices are in place in your community, and what is their purpose or aim? How successful have they been at achieving that aim? Please provide data, as possible.**

Harm reduction can sometimes be explained but other concepts, for example: seatbelts in cars; sunscreen lotion; mask wearing and vaccinations; condom use during sex; etc.

However, a critical distinction is that harm reduction, as it applies to drug use, is a response to harms primarily caused by existing legal and social frameworks. Drug use harms are more often the result of laws and policies, rather than the drugs themselves. Harm reduction can be about specific physiological risk due to the pharmacology, route of administration, or setting of drug use, but is also about broader bio-psychosocial determinants of health, and can be viewed through a social justice lens, with an aim to create a more just and equitable society, especially through legal reform of historically colonial, racist and classist drug laws. Harm reduction can be thought of a practical set of strategies, programs and policies, but at its essence, it is a philosophical approach to drug use that centres and prioritises personal autonomy, public health, human rights, social equity, and environmental justice.

While there is substantial evidence of myriad benefits and positive results of harm reduction initiatives, in Canada, the scale and pace of drug harm reduction program and service implementation has not been significant enough or rapid enough. Positive benefits are often outpaced by the rapidly changing and increasing toxic unregulated drug crisis, especially in the context of intersecting housing and poverty crises. Unfortunately, this has created a public and often politicized perception that harm reduction efforts are failing, or even contributing to harms.

**Further reading:**

**The continuous opioid death crisis in Canada: changing characteristics and implications for path options forward,** The Lancet Regional Health - Americas Volume 19, March 2023, 100437<https://doi.org/10.1016/j.lana.2023.100437>

1. **How do legal frameworks affect the harm reduction policies, programmes, and practices (whether related to drug use or otherwise) that are available in your community, country, or region? Are there laws or policies that either facilitate or serve as a barrier to adopting or implementing certain harm reduction policies, programmes, and practices? Aside from legal and regulatory barriers, are there other obstacles in place? Please provide specific examples.**

**Barriers – Prohibition laws; jurisdictional issues; stigma**

International drug control conventions and federal drug laws in Canada that prohibit and criminalize drugs, frame drug use as immoral and criminal behaviour, which then shapes individual and societal understanding, values, negative attitudes, and stigma towards drugs and people who use drugs, further affecting public and political priorities, policies, and responses.

In Canada, there are also jurisdictional barriers to implementing some harm reduction initiatives. In Canada, drugs are controlled at the federal level under the [*Controlled Drugs and Substances Act* (CDSA)](https://laws-lois.justice.gc.ca/eng/acts/c-38.8/). However, healthcare is a provincial or territorial responsibility, and there are further challenges at the municipal level where the enactment of by-laws or lack of community of political support can present barriers.

As an example, in the province of British Columbia, a province notably historically more progressive than other jurisdictions in Canada, health service delivery in the form of Overdose Prevention or Supervised Consumption Sites (OPS / SCS) is consistently marred by a lack of capacity and support from local governments and Regional Health Authorities (RHA). Although municipalities and RHA have been instructed to enable the opening and operating of SCS under a 2016 Ministerial Order, significant resistance to these services has occurred at the local level throughout the province. These services have sometimes been promised and received funding from an RHA, only to meet interference from municipalities. As examples: [the City of Surrey cancelling the Surrey Newton Union of Drug Users (SNUDU) business license](https://www.surreynowleader.com/news/drug-users-group-fights-city-of-surreys-discriminatory-cancellation-of-business-licence-2986415) (April 2, 2022) - SNUDU offered an indoor SCS and related services to its members; a [news article](https://vancouverisland.ctvnews.ca/nanaimo-drug-consumption-site-deemed-nuisance-by-council-1.6236266) about the City of Nanaimo declaring a SCS operated by the Nanaimo Area Network of Drug Users (NANDU) a “nuisance property,” (Jan. 18, 2023); [an article](https://www.cbc.ca/news/canada/british-columbia/nelson-inhalation-site-public0-consultation-1.6842604) about Interior Health Authority delaying the opening of the first supervised inhalation site in Nelson after “backlash” from local residents (May 12, 2023).

Municipalities throughout the province have also passed, or have publicly considered passing, bylaws prohibiting public drug consumption. Moreover, the unavailability of harm reduction services is now being compounded by [decreased access to safer supply](https://www.cbc.ca/news/canada/british-columbia/bc-drop-prescribed-safe-supply-1.6973560) across the province, meaning that people who were at far lesser risk of fatal drug interaction because they were consuming pharmaceutical grade drugs by prescription or through a compassion club - are now more likely to be accessing the unregulated drug market. The province’s [most recent data](https://news.gov.bc.ca/factsheets/escalated-drug-poisoning-response-actions-1) on safe supply states that as of August 2023, 4,465 people were prescribed safer supply opioid medications. In March of 2023, over 5,000 people were prescribed safer supply.

**Other barriers**

**The “goldfish bowl”: a qualitative study of the effects of heightened surveillance on people who use drugs in a rural and coastal Canadian setting,** Harm Reduction Journal (2022) 19:136 <https://doi.org/10.1186/s12954-022-00725-2> Findings illustrate the unique experiences faced by PWUD in a rural and coastal setting. The “gold- fish bowl” effect in this rural community created heightened social and structural surveillance of PWUD, which led to a variety of negative consequences. There is a clear need for interventions to address the larger contextual drivers affecting people who use drugs in rural settings, including decriminalization and peer-led anti-stigma strategies, in order to improve the lives of PWUD.

**Growing political backlash toward harm reduction and increasing political rhetoric about involuntary, coercive, or mandated drug treatment,** CDPC submission to the United Nations High Commissioner for Human Rights ([LINK](https://drugpolicy.ca/about/publication/submission-to-the-united-nations-high-commissioner-for-human-rights/))

**Flawed reports can harm: the case of supervised consumption services in Alberta,** Can J Public Health. 2023 Nov 6. <http://doi.org/10.17269/s41997-023-00825-x>

Abstract: Supervised consumption services have been scaled up within Canada and internationally as an ethical imperative in the context of a public health emergency. A large body of peer-reviewed evidence demonstrates that these services prevent poisoning deaths, reduce infectious disease transmission risk behaviour, and facilitate clients’ connections to other health and social services. In 2019, the Alberta government commissioned a review of the socioeconomic impacts of seven supervised consumption services in the province. The report is formatted to appear as an objective, scientifically credible evaluation of these services; however, it is fundamentally methodologically flawed, with a high risk of biases that critically undermine its authors’ assessment of the scientific evidence. The report’s findings have been used to justify decisions that jeopardize the health and well-being of people who use drugs both in Canada and internationally. Governments must ensure that future assessments of supervised consumption services and other public health measures to address drug poisoning deaths are scientifically sound and methodologically rigorous. Health policy must be based on the best available evidence, protect the right of structurally vulnerable populations to access healthcare, and not be contingent on favourable public opinion or prevailing political ideology.

1. **How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use? Please provide disaggregated data, including but not limited to gender, age, race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.**

In Canada, drugs are controlled at the federal level under the [*Controlled Drugs and Substances Act* (CDSA)](https://laws-lois.justice.gc.ca/eng/acts/c-38.8/). Under the Act, there can be a “[Section 56 exemption](https://laws-lois.justice.gc.ca/eng/acts/c-38.8/page-7.html)”. Under Section 56(1), “the Minister [of Health] 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.”

Primarily Section 56 exemptions have been used to allow for decriminalized spaces such as Overdose Prevention Sites (OPS) and Supervised Consumption Sites (SCS), where people are exempt from the possession of controlled substances, allowing them to use drugs on site, to be attended to by healthcare workers in the event of overdose, and to get connected to a range of health and social supports.

Section 56 also allows for geographical or population-based exemptions. On January 31, 2023, the province of British Columbian became the first jurisdiction in Canada to implement a drug decriminalization policy after receiving a three-year [Exemption Order issued by Health Canada](https://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-exempltion-adults-18-years-age-older.html) to remove criminal penalties for adults (aged 18 and older) who possess up to a total of 2.5 grams of certain controlled substances for personal use (Decriminalization Pilot).

The purposes of the Decriminalization Pilot are to reduce interactions between people who use drugs (PWUD) and the criminal-legal system, including interactions with police; reduce stigma associated with illegal drug use; and reduce the barriers that PWUD experience when attempting to access health and social services. In [announcing the Decriminalization Pilot](https://news.gov.bc.ca/releases/2022MMHA0029-000850), the Minister of Mental Health and Addictions explained that, “[s]ubstance use is a public health issue, not a criminal one...By decriminalizing people who use drugs, we will break down the stigma that stops people from accessing life-saving support and services.”

Early data suggest that the Decriminalization Pilot is having a positive effect in line with the policy purposes of decriminalization. During the first six months of the Decriminalization Pilot, possession offenses (defined as “a police encounter involving personal possession of controlled substances listed in the exemption”) dropped 76% in BC compared to the previous four-year average during the same period - [Data Snapshot](https://www2.gov.bc.ca/assets/gov/health/mental-health/building_a_mental_health_and_substance_use_system_of_care_snapshot.pdf), BC Ministry of Mental Health and Addictions (September 2023). As well, the provincial government has publicly acknowledged that public drug use has not increased since its Decriminalization Pilot began.

NOTE: As of November 08, 2023, [provincial legislation](https://www.ubcm.ca/about-ubcm/latest-news/legislation-introduced-regulating-public-use-illicit-drugs#:~:text=With%20the%20new%20provincial%20legislation,of%20a%20bus%20stop%3B%20and) criminalized public drug consumption, despite previous legislation mentioned above that decriminalized drug possession. This new law, in effect, criminalizes poor and unhoused people.

**Further Reading:**

B.C.'s ban on drug use in public spaces is unconstitutional, lawsuit claims

<https://bc.ctvnews.ca/b-c-s-ban-on-drug-use-in-public-spaces-is-unconstitutional-lawsuit-claims-1.6642349>

**General drug use data sources:**

**Canadian Alcohol and Drugs Survey (CADS): summary of results for 2019**

<https://www.canada.ca/en/health-canada/services/canadian-alcohol-drugs-survey/2019-summary.html>

**Canadian Drug Trends -** Canadian Centre on Substance Use and Addiction

* Includes summaries of various specific substances.

<https://www.ccsa.ca/canadian-drug-trends>

1. **Beyond reducing the adverse health, social, and legal consequences of drug use, what other areas can benefit from harm reduction policies, programmes, and practices in furtherance of the right to health and related human rights? Examples may include, but are not limited to, the decriminalisation of sex work, the decriminalization of abortion, and safe sex programmes.**

**Public Space and Homelessness**

As noted in CDPC’s *Submission to the United Nations Office of the High Commissioner on Human Rights’ study on the decriminalization of homelessness and extreme poverty* ([LINK](https://drugpolicy.ca/about/publication/submission-to-the-united-nations-office-of-the-high-commissioner-on-human-rights-study-on-the-decriminalization-of-homelessness-and-extreme-poverty/)):

Prohibitions on necessities of life such as sheltering, panhandling, urinating and defecating in public exist all over Canada. In Canada, most public space is regulated through municipal bylaws and other provincial, territorial or federal land use legislation such as highway, fisheries and railway acts. Municipal bylaws, in particular, frequently criminalize activities related to drug use that occur at the intersection of poverty and homelessness such as the possession and distribution of harm reduction equipment (e.g. sterile syringes), in addition to other activities such as sleeping outdoors, erecting a temporary shelter, panhandling, and other life sustaining activities. Yet due to the increasing drug toxicity of the unregulated market, public space may be the safest place to use drugs to ensure proximity to others and access to emergency health care, outreach services, and harm reduction support in the event of a drug poisoning. For example, the distribution of harm reduction equipment on public land is a necessary healthcare service that reduces transmission of blood-borne illness and life-threatening infections, as well as provides community connections and other social supports for people living in public space. For people without housing and living in poverty, public space may be their only option.

Efforts to implement the right to adequate housing and the decriminalization of offences associated with poverty and homelessness must incorporate public health and human rights-based drug policy such as the full decriminalization of drug possession and street-based selling and trading, equitable access to safe regulated supply programs, harm reduction equipment and services such as supervised consumption sites, and evidence-based and voluntary treatment that aligns with people’s needs, aspirations and informed consent.

**Decriminalizing Compassion Clubs**

In Canada, grassroots civil society organizations of people who use drugs have made efforts to decriminalize compassion clubs, which Compassion clubs could provide a non-prescription safer supply of quality-controlled drugs to its membership under a cooperative model. The decriminalization of compassion clubs would likewise decrease criminal sanctions for street-level selling/trading, serve as a stabilizing factor in the lives of people who use drugs and decrease the need to generate income through other criminalized and policed activities such as sex work and panhandling by enabling members to acquire safer supply at a lower price point. Unfortunately, these efforts to obtain legal protections have not succeeded to date. For example, in B.C., the Drug User Liberation Front (DULF), a volunteer-operated coalition, submitted an application for a formal exemption under CDSA to decriminalize the distribution and possession of drugs for the purposes of delivering quality-controlled safe supply to its membership. Despite the federal government’s denial of this request, the group continued to deliver a lifesaving supply of drugs purchased on the “black market” and tested for safety under a compassion club membership model without amnesty from the federal government. People accessing the DULF compassion club were safer from the possibility of fatal overdose, have the stability of regularly accessing safe supply from a reliable and safe source and have a decreased need to engage in survival income generation that is often criminalized and policed due to the cooperative model of compassion clubs and the subsequent lower price point for safer supply– not because DULF’s activities have been officially decriminalized, but rather because police have not enforced the law against them to date.”

Note: in November 2023, the founders of DULF were arrested. Further readings:

* <https://www.cbc.ca/news/canada/british-columbia/drug-user-liberation-front-harm-reduction-vancouver-bc-police-arrests-1.7009019>
* <https://www.drugdatadecoded.ca/p/vancouver-police-arrest-dulf-organizers>
* <https://drugpolicy.ca/when-law-and-policy-is-unjust-communities-have-no-choice-but-to-act/>

**Further Reading**

**Compassion Club and Fulfillment Centre Report** Drug User Liberation Front (DULF) (2023) ([LINK](https://www.dulf.ca/_files/ugd/fe034c_8bcdebbbf9a3432a897800b0904c4c91.pdf))

**Heroin and the illegal drug overdose death epidemic: A history of missed opportunities and resistance**

International Journal of Drug Policy, Volume 91, May 2021, <https://doi.org/10.1016/j.drugpo.2020.102938>

**Heroin Compassion Clubs**, British Columbia Centre on Substance Use (2019)

<https://www.bccsu.ca/wp-content/uploads/2019/02/Report-Heroin-Compassion-Clubs.pdf>

A cooperative model to reduce opioid overdose deaths & disrupt organized crime’s role in fentanyl, money laundering & housing unaffordability

**British Columbia Coroners Service Death Review Panel: An urgent response to a continuing crisis (2023)**

<https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/an_urgent_response_to_a_continuing_crisis_report.pdf>

1. **What type of harm reduction policies, programmes, and practices, as well as mental health and other support (e.g., housing, legal, social, educational, and economic), are available for people who use drugs in the community, institutions, or detention facilities? Please share examples of the impact of criminalisation, discrimination, stereotypes and stigma on the different groups of the population e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).**

**Housing and Shelters**

In September 2023, CDPC and Pivot Legal Society made a submission to the United Nations Office of the High Commissioner on Human Rights’ study on the decriminalization of homelessness and extreme poverty. This submission outlines how public space bylaws disproportionately target unhoused and housing insecure people who use drugs through criminalizing life sustaining activities, including the possession and consumption of drugs in public space.

<https://drugpolicy.ca/about/publication/submission-to-the-united-nations-office-of-the-high-commissioner-on-human-rights-study-on-the-decriminalization-of-homelessness-and-extreme-poverty/>

**Of note in the report: Policies in housing and shelter organizations discriminate against and endanger the safety of people who use drugs.** Emergency shelters that are specifically intended to alleviate the need to sleep, wash, defecate or perform other hygienic activities in public places are often inaccessible to people who use drugs – meaning that people who use drugs are more likely to resort to using public spaces out of necessity. For example, shelter policies such as mandatory abstinence, prohibitions on carrying harm reduction equipment or drugs, curfews that don’t allow people to exit/re-enter the shelter for people who need to use drugs regularly to stave off painful and potentially dangerous withdrawal, and banishment policies that limit access to these essential services for any infraction of shelter policy all create access barriers for people who use drugs.

The [Pan Canadian Women’s and Housing and Homelessness Survey](https://womenshomelessness.ca/wp-content/uploads/EN-Pan-Canadian-Womens-Housing-Homelessness-Survey-FINAL-28-Sept-2021.pdf) demonstrates that people who use drugs were banned from shelters at a rate 3 times greater than those who did not use drugs

The [Guidance Document for Harm Reduction in Shelter Programs: A Ten Point Plan](https://www.toronto.ca/wp-content/uploads/2021/06/9633-10PointShelterHarmReduction210528AODA.pdf) was developed by The Works (Toronto Public Health) to provide a plan for the design and implementation of successful shelter-based harm reduction programs. The guidance document recommends ten areas of harm reduction programming for implementation across emergency shelters

[SisterSpace](https://atira.bc.ca/what-we-do/program/sisterspace/) is a women-only overdose prevention site that is located on the main floor of a gender-specific low-barrier supportive co-housing program.

[RainCity](https://www.raincityhousing.org/social-impact/innovations/) housing programs provide a peer witnessing intervention model where residents who use drugs are connected to peer residents who provide support, education, and overdose prevention and response services.

**Prisons**

Canada does not have robust harm reduction in prisons. **Points of Perspective: research report on the federal prison needle exchange program in Canada**, November 24, 2022, [HIV Legal Network](https://www.hivlegalnetwork.ca/site/points-of-perspective-research-report-on-the-federal-prison-needle-exchange-program-in-canada/?lang=en)

In 2018, Correction Services Canada introduced a “Prison Needle Exchange Program” (PNEP) and committed to scaling this up across all federal prisons. But in 2022, the program only exists in nine federal prisons and has been heavily criticized for its inaccessibility. Four years after its implementation, *Points of Perspective* seeks to explore barriers to accessing the PNEP and builds on the [On Point: Recommendations for Prison-based Needle and Syringe Programs in Canada](https://www.hivlegalnetwork.ca/site/on-point-recommendations-for-prison-based-needle-and-syringe-programs-in-canada/?lang=en) report released in 2016 by Toronto Metropolitan University, the HIV Legal Network, and PASAN.

**Limited positive developments in prisons:** [Naloxone distribution on release](https://www.cadth.ca/funding-and-management-naloxone-programs-canada-0#:~:text=Nasal%20spray%20naloxone%20kits%20are,at%20risk%20of%20opioid%20overdose)

All Correctional Services Canada inmates being released to the community or transitioned to community supervision are eligible for the naloxone, **Funding and Management of Naloxone Programs in Canada,** Canada’s Drug and Health Technology Agency**,**January 26, 2023

**Rural communities**

**Barriers and facilitators to opioid agonist therapy in rural and remote communities in Canada: an integrative review,** Subst Abuse Treat Prev Policy **17**, 62 (2022). <https://doi.org/10.1186/s13011-022-00463-5>
People living in rural and remote communities in Canada are often disproportionately impacted by opioid use disorder. When compared to urban centres, rural and remote populations face additional barriers to treatment, including geographical distance as well as chronic shortages of health care professionals. This integrative review of the literature was conducted to explore the facilitators and barriers of OAT in rural and remote Canadian communities.

**African, Caribbean, and Black communities**

**“They're causing more harm than good”: a qualitative study exploring racism in harm reduction through the experiences of racialized people who use drugs,** Harm Reduct J 19, 96 (2022). <https://doi.org/10.1186/s12954-022-00672-y>

Findings suggest that structural and institutional racism are prevalent in Harm Reduction services within the Greater Toronto and Hamilton areas of Canada, in the form of colour-blind policies and practices that fail to address the intersectional nature of the drug policy crisis. There is a need for local Harm Reducion organizations to critically reflect and act on their practices and policies, working with communities to become more equitable, inclusive, and accessible spaces for all people who use drugs.

1. **Are there alternative measures to institutionalisation or detention? For example, are there outpatient or inpatient facilities available in your country for people using drugs? Please provide additional details (are they compulsory, voluntary; number available in urban and rural areas; entity in charge; type of support provided and type of staff working in these facilities/centres)?**

n/a

1. **Please provide examples of harm reduction policies, programmes, and practices adopted or implemented with international cooperation or through foreign assistance in your country, as well as their impact on different groups within the population. What types of challenges can arise from reliance on foreign assistance? Please also provide examples focusing on the need for, and impact of, harm reduction policies, programmes, and practices on different groups of the population (e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).**

n/a

1. **Are there programmes of research and innovation related to harm reduction from a right to health perspective (e.g., needle and syringe programmes, supervised injection and drug use facilities, opioid substitution therapy, and others beyond the area of drug use), including outreach and education programmes, in your community, country, or region? Please provide good practices and examples.**

**Safe Supply**

Safer supply programs are an approach to addressing the emergency unregulated toxic drug crisis. People are provided with pharmaceutical grade substances as an alternative to the volatile and increasingly toxic unregulated supply. Working from a harm reduction approach that puts the needs and goals of people who use drugs at the forefront and improving access to non-stigmatizing healthcare and social services for people who use drugs [prescribed safer supply](https://www.nss-aps.ca/pss-faq) reduces overdose risk and improves the health and wellness of people who use drugs.

**Safer Supply Evaluations:** <https://www.nss-aps.ca/safer-supply-evaluations>

**Further Readings:**

**“Safer Drug Supply” Measures in Canada to Reduce the Drug Overdose Fatality Toll: Clarifying Concepts, Practices and Evidence Within a Public Health Intervention Framework, *Journal of Studies on Alcohol and Drugs, 84*(6), 801–807 (2023),** <https://www.jsad.com/doi/full/10.15288/jsad.23-00195>

Abstract: Safer supply initiatives provide users with prescribed, pharmaceutical-grade drug supply with the aim of reducing overdose and death risks. These measures have been criticized but also misconstrued from several angles, e.g., as representing inadequate medical or even unethical and harmful practice. Related concerns regarding “diversion” have been raised. In this Perspective, we briefly address some of these issues and clarify selected issues of elementary concepts, practices, and evidence related to safer supply measures within a public health–oriented intervention framework. These measures are also discussed in reference to other, comparable types of public health–oriented emergency health or survival care standards, while considering the extreme contexts of an ongoing, acute drug death crisis in Canada.

**Peer-led safer supply and opioid agonist treatment medication distribution: a case study from rural British Columbia,** Harm Reduction Journal (2023) 20:156 <https://doi.org/10.1186/s12954-023-00883-x>

Conclusions: This peer-led intervention is a promising approach to engaging people who remain disconnected from health services in care in a rural community. This model could be adapted to other settings to support patient contact with the health system and medication access and continuity, with the ultimate goal of reducing overdose risk.

**“Innovating Beyond Exclusively Medicalized Approaches” Policy Brief and Recommendations,** Canadian Civil Society Advancing Safe Supply Working Group (2023) ([LINK](https://drugpolicy.ca/about/publication/innovating-beyond-exclusively-medicalized-approaches-policy-brief-and-recommendations/))This policy brief from a coalition of national, provincial, territorial and regional stakeholders with expertise in drug use, policy, research, and medical and non-medical models of safe supply, articulates the limitations of, and the harms of over-emphasizing, medicalized models for safe supply, and proposes recommendations for advancing non-medicalized models for the supply, distribution, and access to safer alternatives to the increasingly toxic unregulated drug supply.

**Harm Reduction for People Who Smoke Drugs**

**A review of supervised inhalation services in Canada, Ontario HIV Treatment Network, Rapid Response Service | #171, July 2022**

<https://www.ohtn.on.ca/wp-content/uploads/2022/07/RR171_supervised-inhalation_July212022.pdf>

**Casey House Hospital opens first indoor supervised inhalation space for substance use in Ontario, Canada, November 16, 2022,**

<https://caseyhouse.ca/commentary/casey-house-opens-first-indoor-supervised-inhalation-space-for-substance-use/>

**Commentary: Dreams Do Come True: The Realization of Harm Reduction Interventions in Urban and Rural Settings for People Who Smoke Drugs,** Journal of Studies on Alcohol and Drugs, 83(4), 625–627 (2022) <https://doi.org/10.15288/jsad.2022.83.625>

1. See: [www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health](http://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health) [↑](#footnote-ref-1)
2. See also: <https://undocs.org/Home/Mobile?FinalSymbol=A%2F65%2F255&Language=E&DeviceType=Desktop&LangRequested=False>, para. 50. [↑](#footnote-ref-2)