



# National Operational Guidance for the Implementation of Supervised Consumption Services



**CRISM-ICRAS**

Canadian Research Initiative  
in Substance Misuse

Initiative Canadienne de  
Recherche en Abus de Substance



**CIHR IRSC**

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We respectfully acknowledge the sovereignty, lands, histories, languages, knowledge systems, and cultures of First Nations, Métis, and Inuit nations. In particular, the work to complete this guidance document was hosted on Treaty 6 territory, a traditional gathering place for diverse Indigenous Peoples including the Cree, Blackfoot, Métis, Nakota Sioux, Iroquois, Dene, Ojibway/Saulteaux/Anishinaabe, Inuit, and many others.

## About the Canadian Research Initiative in Substance Misuse

Funded by the Canadian Institutes of Health Research (CIHR), the Canadian Research Initiative in Substance Misuse (CRISM) is a national research consortium focused on substance use disorders, comprising five large interdisciplinary regional teams (nodes) representing British Columbia, the Prairie Provinces, Ontario, Quebec, and Atlantic. Each CRISM node is an expert network of research scientists, service providers, policy makers, community leaders, and people with lived/living experience of substance use. CRISM's mission is to translate the best scientific evidence into clinical practice and policy change. More information about CRISM can be found at: <https://crism.ca>.

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## Detailed Summary - Disclosure of Interests (DOI) for CRISM National Operational Guidance for the Implementation of Supervised Consumption Services

In accordance with the Guidelines International Network's Principles for Disclosure of Interests and Management of Conflicts<sup>1</sup>, authorship committee members and external reviewers were asked to disclose all sources and amounts of direct and indirect (i.e., research support) remuneration from industry, for-profit enterprises, and other entities that could potentially introduce real or perceived risk of bias. In addition, authorship committee members and external reviewers were asked to report indirect sources of bias, such as academic advancement, clinical revenue, and professional or public standing that could potentially influence interpretation of research evidence and formulation of recommendations.

Of the 24 authorship committee members and external reviewers, 17 (71%) acknowledged potential direct conflicts of interest. There were no authorship committee members or external reviewers with commercial interests. On review, potential conflicts of interest were not deemed to be of sufficient weight or relevance to warrant exclusion from the guidance committee.

Most (18, 75%) authorship committee members and external reviewers disclosed potential indirect sources of bias (e.g., advisory board and committee membership, involvement with SCS programs and regulations, substance use organizations or programs, research interests). Of these, 9 acknowledged that they have publicly stated support for SCS. In order to mitigate the risk of bias while maximizing the contributions of members in their respective areas of expertise, authorship committee members and external reviewers were reminded to consider any influential factors or sources of bias during the review process. Authors and reviewers contributed to review of sections related to their areas of expertise as well as the overarching guideline content to ensure that a broad range of clinical and academic specializations was adequately represented.

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<sup>1</sup> Schünemann HJ, Al-Ansary LA, Forland F, et al. Guidelines international network: principles for disclosure of interests and management of conflicts in guidelines. *Ann Intern Med.* 2015;163(7):548-553.

guidance on implementing and operating supervised consumption sites that is national in scope and aligns with current federal policy; however, the authors of the BCCSU guidance document do not necessarily endorse all of the guidance provided in the current document. We also gratefully acknowledge the assistance of Dr. Denise Adams (CRISM Prairies Node Manager), Ethan Candler, Soo Chan Carusone, Andre Ceranto, Sean LeBlanc, Anna Markov, Daniel O'Brien, and Dr. Katherine Rudzinski in the writing and preparation of this document.

## Disclaimer for Health Care Providers

The recommendations in this guidance document represent the view of the National Operational Guidance Document Review Committee, arrived at after careful consideration of the available scientific evidence and external expert peer review. The application of the guidance contained in this document does not override the responsibility of health care professionals to make decisions appropriate to the needs, preferences, and values of an individual patient, in consultation with that patient (and their guardian[s] or family members, when appropriate), and, when appropriate, external experts (e.g., specialty consultation). When exercising clinical judgment in supervising drug consumption, health care professionals are expected to take this guidance document fully into account while upholding their duties to adhere to the fundamental principles and values of their relevant codes of ethics. Nothing in this guidance document should be interpreted in a way that would be inconsistent with compliance with those duties.

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## Abbreviations

**ARCHES:** AIDS Outreach Community Harm Reduction Education Support

**BCCSU:** British Columbia Centre on Substance Use

**CAC:** Community Advisory/Liaison Committee

**CAPUD:** Canadian Association of People who Use Drugs

**CDSA:** Controlled Drug and Substances Act

**CIHR:** Canadian Institutes of Health Research

**CRISM:** Canadian Research Initiative in Substance Misuse

**EMS:** Emergency Medical Services

**HCV:** Hepatitis C Virus

**HIV:** Human Immunodeficiency Virus

**iOAT:** Injectable Opioid Agonist Treatment

**2SLGBTQIA+:** 2-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or questioning, Intersex, Asexual, plus

**MOPS:** Molson Overdose Prevention Site

**NORS:** National Overdose Response Service

**OAT:** Opioid Agonist Treatment

**OPS:** Overdose Prevention Site

**PHNs:** Personal Health Numbers

**RAH:** Royal Alexandra Hospital

**RPIC:** Responsible Person in Charge

**RV:** Recreational Vehicle

**SCS:** Supervised Consumption Site

**SRCHC:** South Riverdale Community Health Centre

**UPHNS:** Urgent Public Health Needs Site

## Definitions

This document is designed to provide national, evidence-informed, national operational guidance to plan, develop, implement, and evaluate federally exempted supervised consumption sites in Canada. Although this guidance document does not specifically address the operation of other supervised consumption models, information herein may be relevant for planning such services. See below for our definition of each service type and other terms used throughout the document.

Service types (see Figure 1. SCS, UPHNS, and OPS service types according to their exemption status)	
<b>Overdose prevention site (OPS)</b>	Authorized by provincial governments or operating without official authorization (i.e., operating illegally). <i>NB: Outside of the current document, this term is sometimes used informally to refer to Urgent Public Health Need Sites</i>
<b>Supervised consumption service(s)</b>	Refers to a range of supervised consumption models (including urgent public health need sites, overdose prevention sites, virtual models, and services available in other countries outside of Canada’s authorization system). This term is used as a comprehensive, umbrella term to capture the full range of consumption service models available globally.
<b>Supervised consumption site (SCS)</b>	Supervised consumption services specifically exempted under section 56.1 of the Canadian <i>Controlled Drug and Substances Act</i> by Health Canada.
<b>Urgent public health need site (UPHNS)</b>	Services exempted under subsection 56(1) of the Canadian <i>Controlled Drug and Substances Act</i> via site-specific exemptions from Health Canada, or provincial/territorial Ministers of Health (or their delegates) under provincial/territorial class exemptions.

Other terms	
<b>Consumption</b>	Any route of drug use currently authorized within supervised consumption services (i.e., injection, inhalation, oral, intranasal), unless otherwise specified.
<b>Drug/substance</b>	“[A] controlled substance or precursor that is obtained in a manner not authorized under [the <i>Controlled Drug and Substances Act</i> ]” (1) (p.54).
<b>Drug poisoning(s)</b>	Acute toxicity resulting from the consumption of a drug or combination of drugs, either unintentionally or intentionally (sometimes referred to as overdose).
<b>Participant(s)</b>	People attending supervised consumption services to consume drugs and/or use services (e.g., clients, service users).
<b>People who use drugs</b>	People who use currently illegal drugs (e.g., criminally prohibited substances or the misuse of prescription medications).

# Key Points of this Document

- Supervised consumption services are evidence-based and provide a safer environment where people can consume drugs with sterile equipment, access supportive services, and be monitored by trained staff who provide education on harm reduction and emergency medical care for drug poisonings.
- 
- The purpose of this guidance document is to support organizations in Canada proposing new (or operating existing) supervised consumption sites by providing practical guidance for supervised consumption site planning, development, implementation, and quality improvement.
- 
- Supervised consumption sites are federally authorized under section 56.1 of the Canadian *Controlled Drugs and Substances Act*, which protects staff and participants against criminal charges due to activities with illegal drugs. This document is designed to help prospective operators meet the current federal regulatory requirements for implementing and operating a supervised consumption site in Canada. Guidance provided herein does not indicate an endorsement of current federal regulatory requirements.
- 
- Supervised consumption sites are one of several types of supervised consumption services, an umbrella term that also includes urgent public health need sites (exempted under subsection 56(1) of the Canadian *Controlled Drugs and Substances Act*, via a provincial/territorial class exemption or a site-specific federal exemption) and overdose prevention sites (authorized by provincial governments or operating without official authorization), both of which are outside the scope of this document.
- 
- Supervised consumption site operators are required to secure their own funding (typically from provincial/territorial governments, or from municipal or private sources).
-

- **As of July 2023, there are 38 supervised consumption sites operating in Canada and several urgent public health need sites and overdose prevention sites, although the exact number of these types of supervised consumption services are unknown.**
- 

- **High quality supervised consumption site service provision requires that people who use drugs directly inform planning, implementation, operation, and evaluation activities.**
- 

- **A harm reduction philosophy of care, including relational practice, cultural safety, and trauma-informed care, should be at the forefront of all service design and delivery where attempts are made to reduce health, social, and economic harms associated with drug use.**
- 

- **Perspective operators are required to gather and submit several pieces of information to Health Canada when applying for a supervised consumption site, including outlining the applicant information, a description of proposed site, a description of local conditions, policies and procedures, personnel, community consultation report, and a financial plan.**
- 

- **In addition to requirements outlined by Health Canada, there may be additional provincial/territorial requirements that need to be addressed but are beyond the scope of this document.**
- 

- **There are multiple models for supervised consumption sites including: fixed stand-alone models (distinct facility that is dedicated to providing supervised consumption site); integrated models (part of a larger facility such as a hospital or a health care centre); and mobile outreach models (modified vans that travel to high traffic areas for people who use drugs).**
- 

- **Design and delivery of supervised consumption site services should consider populations experiencing specific social and structural inequities, including people who identify as women, 2SLGBTQIA+ (2-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or questioning,**

Intersex, Asexual, plus), youth and young adults, and people who are First Nations, Inuit, or Métis.

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- Incorporating non-injection drug use, assisted consumption, splitting and sharing as well as integrating drug checking services, drug use treatment, and safer supply programs will maximize uptake and impact of supervised consumption site
- 

- Local conditions (i.e., the context of drug use and services for people who use drugs) should be assessed and incorporated into the design of supervised consumption sites, which can be done by collaborating with local groups of people who use drugs and conducting community consultations, the latter being required by Health Canada.
- 

- A variety of policies and procedures are required or recommended to protect the safety of supervised consumption site staff and participants, including outlining codes of conduct/rights and responsibilities for participants and staff, eligibility and user agreements, pre- and post-consumption procedures, conflict management, refusal of service protocols, and drug poisoning response protocols.
- 

- Hiring people with lived/living experience of substance use within supervised consumption sites can increase accessibility and service quality.
- 

- Reporting aggregate demographic and supervised consumption site program statistics is required by Health Canada and may also be required by provincial/territorial governments or funders. It is important to collect the least possible amount of personal information from supervised consumption site participants to avoid deterring those who feel more comfortable using these services anonymously.
- 

- While not mandated by Health Canada, evaluation activities can be conducted internally to ensure operational goals are being met, that the service is participant-centered, and that opportunities for service improvement are identified.

# 1.0 About this Document

## 1.1 Purpose and Scope

Relatively few resources provide detailed guidance to support the planning and implementation of supervised consumption services in Canada. Existing publicly available documents are specific to unique legislative, regulatory, and policy contexts of individual provinces, health regions, or organizations, and are not entirely generalizable to other settings. As a result, community-based organizations, frontline health and harm reduction workers, and public health officials have had to dedicate considerable time and attention to *ad hoc* consultations and informal information sharing networks that connect prospective supervised consumption service operators with existing ones. While this type of cross-provincial/territorial collaboration has been a hallmark of Canada's harm reduction community and an important factor in advancing these practices nationally, it takes time away from operating services and developing additional community-based programs or services. A lack of formal operational guidance also undermines the sustained operation and ongoing optimization of existing supervised consumption services, and hinders development and implementation of new supervised consumption services in parts of Canada (e.g., smaller urban centers, rural settings, some provinces/territories) where service providers and health officials face additional challenges for planning and implementing harm reduction interventions (e.g., may have fewer resources, may not be connected with operators elsewhere, may have extensive constraints of regulations imposed on the services). Therefore, national, evidence-informed operational guidance on the implementation of supervised consumption services is urgently needed to support ongoing scale up, sustainability, and optimization of these interventions in Canada. This document includes resources designed to assist prospective operators by providing practical guidance for supervised consumption service planning, development, implementation, and quality improvement activities. In the longer term, this resource may support further expansion of supervised consumption services across Canada, encourage standardization across new supervised consumption service models while still accommodating flexibility according to community needs, facilitate research and evaluation in this area, and increase opportunities to establish supervised consumption service best practices.

For the purposes of this document, supervised consumption sites (SCS) are considered services that provide space for people to consume illegal substances and be monitored by trained staff who provide education on harm reduction and emergency medical care for drug poisonings and are federally-exempted under section 56.1 of the Canadian *Controlled Drug and Substances Act* (CDSA). Illegal substance refers to “a controlled substance or precursor that is obtained in a manner not authorized under [the CDSA]” (1) (p.54). ‘Consumption’ refers to any route of illegal drug

consumption currently authorized within SCS (i.e., injection, inhalation, oral, intranasal), unless otherwise specified. Although this guidance document does not specifically address the operation of urgent public health need sites (UPHNS) and overdose prevention sites (OPS), some of the information herein may be relevant for planning such services (see **9.0 Other supervised consumption service types** for more information on UPHNS and OPS).

We developed this guidance document to provide an overview of the rationale for, and evidence supporting, SCS as well as guidance on implementation, operation, and evaluation of SCS. The document is organized to reflect the current process in Canada for securing a federal section 56.1 exemption under the CDSA to operate a SCS. Each of the following sections address topics and information designed to be helpful in preparing the requisite sections of Health Canada's SCS application form. Specifically, this document includes information to assist prospective SCS operators in:

1. Articulating the rationale and evidence for implementing SCS;
2. Centering the needs and voices of people who use drugs;
3. Planning SCS service models;
4. Assessing and describing local conditions;
5. Developing SCS policies and procedures;
6. Planning human resource requirements;
7. Developing a financial plan; and
8. Conducting evaluation and reporting activities.

It is important to note that this document is limited to addressing Health Canada's requirements. There may be additional provincial/territorial requirements that prospective SCS operators are required to address that are beyond the scope of this document. Furthermore, this document and any guidance provided herein should not be construed as an endorsement of any or all of Health Canada's legislative and policy requirements for SCS. This document is designed to help operators meet the current federal regulatory framework and does not necessarily indicate support for the requirements by the authors or any of the external reviewers.

This document is designed to provide general guidance for implementing and operating SCS; see *Supporting people who use substances in shelter settings during the COVID-19 pandemic* for guidance tailored to emergency shelter operators (2), and *Harm reduction worker safety during the COVID-19 global pandemic* for guidance tailored to harm reduction workers (3).



## 1.2 Development Process

The Canadian Research Initiative in Substance Misuse (CRISM) convened a SCS operational guidance document committee from across the five CRISM nodes (British Columbia, Prairies, Ontario, Quebec, and Atlantic) to develop a national operational guidance document on SCS. This committee includes people who have directly participated in efforts to establish SCS in Canada, and represents academic, healthcare, policy, and lived/living experience perspectives.

We acknowledge and are greatly indebted to the British Columbia Centre on Substance Use (BCCSU)'s *Supervised consumption services: Operational Guidance* publication (4), which was developed and reviewed by experts from that province. In creating the present national document, we built directly upon the BCCSU's previous work, with the aim of providing updated guidance on implementing and operating SCS that is national in scope and accounts for recent federal policy changes. Specifically, our authorship committee reviewed the BCCSU document and identified areas for revision based on new research, and changes to the federal SCS legislative and policy requirements and exemption application process. The draft document was then circulated to the committee for comments and feedback before undergoing review from other key stakeholders internal and external to CRISM. This document is current as of its publication date and will be periodically updated to reflect changing practice and any future shifts in federal policy and regulations.

## 1.3 Intended Audience

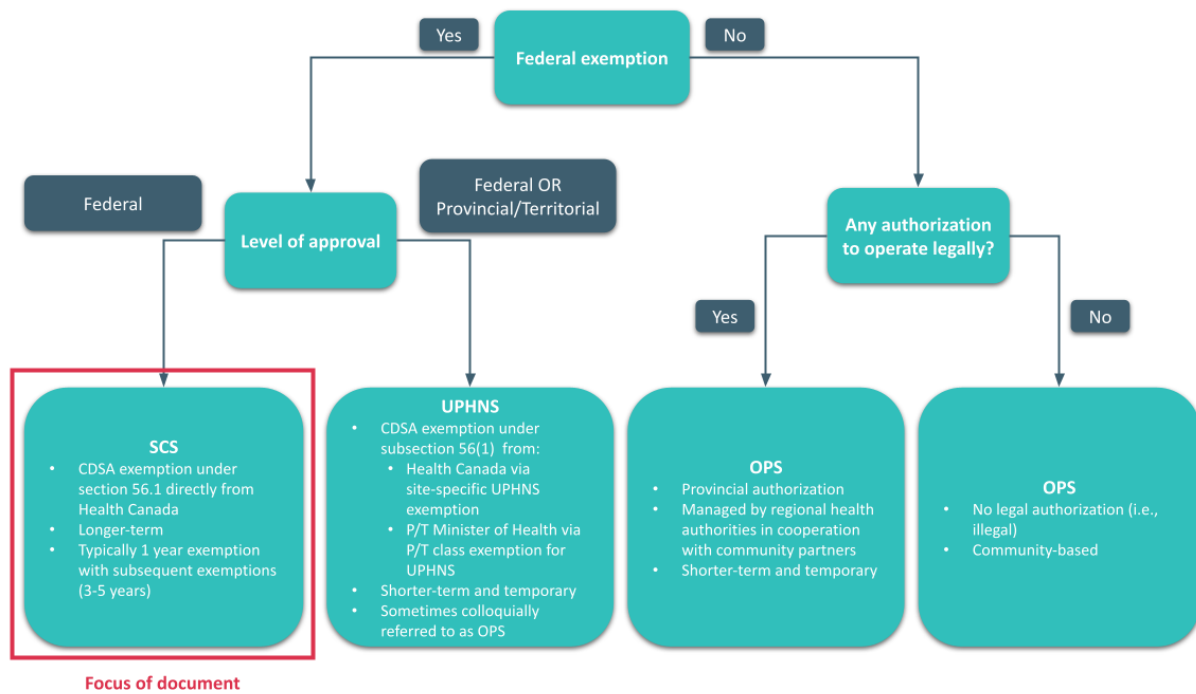
This document is intended to be a tool for those working to implement SCS, which may include policymakers, clinical and operational leads in health authorities, healthcare and social service organizations and providers, advocates, community non-profits, drug user organizations, and others who want guidance on how to plan, implement, or evaluate SCS in Canada. New or existing SCS operators may also find this document helpful for planning program changes and conducting quality improvement activities or evaluation activities.

## 1.4 Background

SCS provide a safer environment in which people can consume drugs with sterile equipment, access supportive services, and be monitored by trained staff without the risk of arrest for activities with illegal drugs. SCS are part of a range of services for addressing drug-related harms associated with the increasingly toxic illegal drug supply, including needle/syringe distribution programs, and complementary drug treatment programs, such as withdrawal management, pharmacotherapy, and psychosocial counselling (5). Many SCS also incorporate connections to other health and social services, as requested by participants. There are different ways to assess need, plan, design and

implement SCS, and many issues to consider with respect to the target population, existing network of services for people who use drugs, and resources available, including funding, space, and staff. SCS range considerably in size, structure, and staffing.

As shown in Figure 1, SCS are authorized by a section 56.1 exemption, UPHNS are authorized under a subsection 56(1) class exemption or a site-specific exemption, and OPS are authorized through provinces or have no legal authorization. This document focuses only on SCS federally-exempted under section 56.1 of the Canadian CDSA. While outside the scope of this document, additional information on UPHNS and OPS can be found in **9.0 Other supervised consumption service types**.



**Figure 1.** SCS, UPHNS, and OPS service types according to their authorization status.

### 1.4.a A brief historical overview

According to 2020 data compiled by Harm Reduction International, there are currently over 130 supervised consumption services operating in 12 countries around the world (6). The first legally exempted supervised consumption service was established in 1986 in Berne, Switzerland. High rates of human immunodeficiency virus (HIV) transmission, increases in drug-related deaths, growing public drug scenes, and the rise of harm reduction principles as viable alternatives to abstinence-based strategies resulted in the establishment of early supervised consumption services (7).

In Canada, growing interest in supervised consumption services and delays in government action on HIV and drug poisonings in Vancouver led to the opening of non-exempted supervised consumption service. Two OPS, “The Back Alley” which opened in 1995 and “327 Carrall Street” which opened in April 2003, were operated by people who use drugs and local activists before being closed by police enforcement. A third OPS, known as “The Hair Salon,” was quietly built in 2003 and operated by the Portland Hotel Society while waiting for government approval, and would later become Insite (8). The Dr. Peter Centre in Vancouver’s West End began offering supervised consumption services at their facility in 2002 but did not receive a formal federal SCS exemption until 2016. In September 2003, Insite opened as the first federally exempted SCS in Canada as a three-year pilot project before receiving ongoing operational support.

The federal government did not approve any additional SCS until 2016, after passing Bill-C 37 in an attempt to streamline and simplify the SCS application process. Between February and October 2017, new SCS received federal exemptions in Quebec, Ontario, Alberta, and British Columbia. Thus far, SCS in Canada have largely been implemented in urban settings, though feasibility and acceptability studies on implementing supervised consumption services in additional communities indicate high levels of willingness to use these services among people who use drugs in both urban (10–12) and rural (13) settings.

As of July 2023, there are 38 exempted SCS operating in Canada. For a current list of exempted SCS maintained by Health Canada please see:

- [Health Canada - Supervised Consumption Sites: Status of Applications](#) (9)

### **1.4.b State of knowledge**

Available epidemiological data on supervised consumption service participants suggest that these facilities attract structurally vulnerable members of substance-using populations (i.e., people experiencing homelessness or housing insecurity, people who use drugs in public (14–16)). Structurally vulnerable people are more likely to experience drug poisonings, inject drugs daily, and be exposed to high-risk drug use environments, suggesting that these facilities have been successful in attracting and providing services for individuals who are marginalized and frequently excluded from existing health and ancillary services (5). Research shows that many supervised consumption service participants report experiencing challenges finding a vein, history of injection-related infections, and lack of knowledge of safer consumption practices (17,18). Supervised consumption services typically address these issues by offering education on safer consumption practices, access to sterile supplies, and a safer environment for drug consumption (19).

Numerous studies have demonstrated positive impacts of SCS on the morbidity and mortality of people who use drugs. This finding is supported by a recent systematic review of research

examining public health outcomes of supervised consumption services, which found consistent international evidence to suggest that supervised consumption services are effective in reducing risk of drug poisoning-related harms (20). For example, research from Australia indicated a 68% decrease in calls for ambulances in the vicinity of the supervised consumption service during its operational hours (18), while in Germany, the opening of multiple supervised consumption services in major cities was found to decrease drug-related deaths (21). In Vancouver, researchers observed a 35% decline in drug poisoning deaths in the area around Insite after the service opened compared to only a 9% reduction in other areas of the city (22). Additionally, there have been no drug poisoning-related deaths ever reported within supervised consumption services (20). Regular supervised consumption service use has also been associated with receipt of safer consumption education (5,23) and has been associated with other positive changes in drug use practices among people who use drugs, including a reduction in syringe reuse, public injecting, and improper disposal of syringes and other injection-related litter (17,20,24,24,25). The evaluation of Insite in Vancouver determined that frequent SCS users were 70% less likely to share used syringes (26), thus reducing transmission of HIV (27,28) and other viral and bacterial infections. The impact of supervised consumption services on infectious disease transmission risk is further supported by modelling studies, which suggest supervised consumption services reduce HIV and hepatitis C virus (HCV) transmission rates (27,29,30).

Frequent supervised consumption service use and contact with supervised consumption service staff specializing in substance use has also been associated with an increase in referrals to substance use treatment centres, initiation of withdrawal management programs (31), and initiation of methadone treatment and other addiction treatment services (15,31–34). In Vancouver, among SCS participants, regular SCS use has been associated with an approximate 70% increased likelihood of enrolling in withdrawal programs (35) and a 30% increased likelihood of initiating any form of addiction treatment, as well as subsequent declines in frequency of injection drug use after initiating treatment (32). Qualitative research conducted at the Dr. Peter Centre found that the integrated supervised consumption program influenced participants' access to care "by building more trusting relationships with staff and facilitating engagement in a broader array of support services, including safer injection education and care for injection-related infections" (36) (p.640). Another study found that Dr. Peter Centre participants were 58% less likely to leave hospital against medical advice, suggesting that the integration of supervised consumption services within the Dr. Peter Centre may have helped individuals stay in the hospital located across the street from the Dr. Peter Centre (37).

Evidence has not shown that supervised consumption services encourage more people to start using drugs or prolong the length of time someone uses drugs (5). Supervised consumption services often serve people who use their drugs in public locations (14,16). Despite concerns about other negative neighbourhood impacts of supervised consumption services, seven studies have found that supervised consumption services are associated with sustained reductions in public drug use

and/or publicly discarded consumption supplies (24,25,38–42). During the first year after opening Insite in Vancouver, crime rates remained stable (35) and showed a significant, stable decrease almost two years after opening in the neighbourhood where the SCS is located (43). The opening of Insite was not associated with an increase in initiation of injection drug use (44). Evidence from a non-exempted supervised consumption service in an urban city in the United States supports this finding, which demonstrates the role of supervised consumption services in promoting safer drug use practices and reducing public substance use (45). Evidence shows that people who use drugs are often not willing to travel long distances (e.g., more than 10 blocks, more than 1 kilometer) to access a SCS (46,47). Therefore, it is recommended by stakeholder groups in Canada such as public residents and businesses, municipal officials, and people who use drugs that supervised consumption services are implemented in neighbourhoods accessible to existing populations of people who use drugs to optimize their impacts on public health and public safety (47,48).

SCS have also been found to be highly cost-effective. Several studies have evaluated the cost-savings of existing SCS in British Columbia (27,28,30,49,50). Although the degree by which these sites save money are varied (i.e., between \$200,000 and \$6,000,000 annually), the studies agree that overall, supervised consumption services are cost-saving (20). However, these studies have considered only a limited number of potential outcomes (e.g., savings associated with HIV infections prevented), and future cost-effectiveness studies could consider a broader set of outcomes. Additional analyses have examined the potential cost-savings of SCS if implemented in other Canadian cities, including Saskatoon, Montreal, Toronto, and Ottawa (49,51–55).

# 2.0 Guiding Principles

## 2.1 Centering the Perspectives of People Who Use Drugs

High quality SCS service provision can only be achieved when the perspectives of people who use drugs directly inform planning, implementation and evaluation activities. Emerging work suggests that some people who use drugs may prefer to use drugs at locations other than a supervised consumption services for many reasons (e.g., they prefer to consume via a route that is not permitted in the site, they prefer to use drugs in private locations like their own or a friend’s home, they feel supervised consumption services are too crowded, they are unaware of supervised consumption service operating hours) (56). Some of these reasons, such as SCS policies and practices, could be addressed with greater involvement of people who use drugs in the planning, implementation and evaluation of SCS (56). People who use drugs are best positioned to identify characteristics of SCS models that will be most likely to attract and retain their peers, and have the networks and expertise required to connect with hard-to-reach members of the population (57,58). In line with the ethos of ‘nothing about us without us,’ many have argued that there is an ethical imperative to include people who use drugs—especially those who have been historically criminalized, stigmatized, structurally disadvantaged, and excluded from mainstream healthcare services— in policy and service design and implementation. Many supervised consumption services in Canada and internationally have been designed with, led by, and/or employ people with lived/living experience of substance use (59,60). It is also important to include people who use drugs in the design and ongoing evaluation of SCS to ensure the service can adapt to and meet the evolving needs of participants. Equitable inclusion in evaluation could include ongoing participant feedback through an advisory board of staff with lived/living experience of substance use and SCS participants, suggestion boxes, informal surveys, staff communication, and periodic meetings depending on the interest of participants. Review and include the information collected from these evaluation processes in SCS operations and policies as appropriate.

A concern among people who use drugs who work in harm reduction services is their lack of equal treatment and compensation compared to other employees who don’t have lived/living experience (61). *Peerology*, a guide on engaging people who use drugs published by the Canadian AIDS Society in 2015, details 11 recommendations to improve the quality of inclusion of people who use drugs in policy, research, and healthcare decisions (62). An abridged version of their recommendations is outlined below:

- 1) Give us the means: “If you want us to participate in your discussions and decisions on services and other concerns, you have to allow us to do so.” Support people who use drugs

with the necessary material, resources, guidelines, and preparation to participate fully in meetings and project teams.

- 2) Include us in an equitable way: “There is nothing more frustrating than having the impression that we are there as tokens and that our opinion is not sought, not listened to and not taken seriously.” Explain goals, make space for all voices to be heard, listen well, and consider what is said and do not be dismissive towards participating people who use drugs.
- 3) Keep it simple: “If you want people who use drugs to participate in committees and other settings, it is important to not complicate matters more than they already are.” Keep meetings short, informal and to the point. Take breaks during meetings and set predetermined end times.
- 4) Adapt to our life conditions: “We often live in precarious conditions (for example, poverty, unstable housing, health issues, etc.), so if you want to include us, you must change your common way of doing things. Consider using the phone instead of using e-mail to communicate with us since it is not always easy for us to access the internet.” Tailor your approach to accommodate the needs of people who use drugs as collaborators.
- 5) Inviting two of us is better: “For many reasons, it may happen that we cannot attend a meeting we had committed to going to. That is why you should avoid giving all the information and all the responsibilities to only one person. Having two of us attend meetings together will make us feel more at ease with other participants.” Inviting more than one person who uses drugs to participate in a project or a meeting helps keep the work manageable, provides an alternate if someone is unable to attend, and can help people feel more comfortable participating.
- 6) Emphasize good deeds: “It is always good to know that what we did was appreciated and that it is worth continuing to be involved.” Highlight accomplishments, achievements, and successes of including people who use drugs in planning processes.
- 7) Take action: “It is nice to get together, to share information and ideas, to find solutions to our problems, but if those meetings are not followed up by actions, we lose interest and that discourages us from getting involved.” Ensure that meetings are followed by concrete actions designed to implement the suggestions discussed during the meetings.
- 8) Thoroughly train allies to understand and support our inclusion: “We want people who work with us to be aware of our problems and continue to support our mandates.” Ensure all members of the team have the appropriate knowledge and training to engage people who use drugs equitably and comprehensively.
- 9) Recognize our expertise: “We are experts of our reality and lived experience, and that is why we are asked to participate in committees and meetings and why we want to be invited.” Enable people who use drugs to take on leadership opportunities, or engage them in decision-making, as they are the experts who know the realities better than anyone else.
- 10) Compensate us for our time: “We are the experts, but we often are the only ones around a table who are not paid.” Compensate people who use drugs for their participation in the

engagement to demonstrate the value they provide. When inviting people who use drugs to an engagement, it is important to discuss expectations regarding their duties (time requirements and role expectations), the timing of their compensation, and their preferred payment method (e.g., cash) prior to their commitment (63). Research fair and equitable compensation according to your local context and provide that to each person who uses drugs who you engage. In addition, cover any other costs related to participating in the engagement (e.g., transportation, accommodation, meals, etc.) by the organization rather than expecting reimbursement of personal payments for these costs, and avoid credit card imprints at hotels.

- 11) Support organizations of people who use drugs to support inclusion: “To support the inclusion of people who use drugs, it must be acknowledged that there are organizations of people who use drugs across Canada that have a mandate of inclusion.” Recognize the different drug user groups that exist, along with their capacity to organize and lead new initiatives. When seeking to involve people who use drugs in an engagement, extend invitations to the leadership of these groups to allow them to nominate a representative for the collaboration.

For more information on centering the perspectives of people who use drugs, please see the following resources:

- [Canadian Drug Policy Coalition & Canadian Association of People who Use Drugs - Hear Us, See Us, Respect Us: Respecting the Expertise of People who Use Drugs](#) (64)

## 2.2 Practicing a Harm Reduction Philosophy of Care

Supervised consumption services were originally developed by people who use drugs as a strategy for creating safer environments and supporting one another. As these services grew in number, spread, and evolved they have focused on attracting structurally vulnerable people who use drugs (65) —subpopulations of people who use drugs who are at increased risk of harm due to social, physical, political and economic aspects of their environment who are more likely to engage in public drug use (66,67). As a result, supervised consumption services often serve participants who may be unstably housed or homeless, living in poverty, and have past experiences of trauma, racism, discrimination, and violence (68,69). Further, many SCS participants are likely to have had previous negative experiences with health services and systems and evidence shows that people who use drugs are often stigmatized, judged, and shamed by healthcare professionals when seeking care (70–72). Close attention to philosophy of care within SCS is thus critically important for ensuring optimal experiences for people who use drugs and recognizing and mitigating the negative impacts of structural vulnerability amongst participants.



In addition, it is important to reflect on the fact that many SCS participants or staff may be living with grief and loss from the current and ongoing drug poisoning emergency. When interacting with SCS participants or staff, being sensitive to and/or directly acknowledging this grief and loss is beneficial. Furthermore, services should have debriefing protocols in place in the event of a drug poisoning or other emotionally difficult event within the SCS or community. These protocols could include regular team-based debriefing meetings, one-on-one debriefing as needed, or providing information on available mental health supports (e.g., provincial/territorial and/or national mental health supports) including support specific to certain populations (e.g., Indigenous people, youth).

## **2.2.a Harm reduction**

SCS are part of an evidence-based harm reduction approach to substance use that attempts to reduce health, social and economic harms associated with substance use while also acknowledging that such harms are largely the product of prohibition, criminalization, and other adverse socio-political contexts (e.g., colonization, racialization, poverty) (73). It moves beyond an individual risk reduction perspective to focus on creating safer physical and social environments for people who use drugs through implementing programs tailored to local needs, and advocating for broader policy changes that reduce the risk of negative health and social outcomes.

While there is no universally accepted definition of harm reduction, many harm reduction approaches and practices are underpinned by common principles and goals (74):

### **Principles**

- Respecting human rights: treating people who use drugs with dignity, respect, and compassion;
- Commitment to evidence: ensuring harm reduction programs and services are informed by a strong body of evidence;
- Commitment to social justice: equitably including people who use drugs in the design, implementation, and evaluation of programs that serve them, and ensuring discrimination based on race, gender, socioeconomic status, etc. does not exclude people who use drugs from health and social services; and
- Avoiding stigma: accepting people who use drugs as they are without judgement and stigmatizing language.

### **Goals**

- Keeping people alive and encouraging positive change: the most urgent priority is keeping people who use drugs alive and then reinforcing positive changes, no matter how small;
- Reducing harms from drug laws and policies: challenging laws, policies, and law enforcement practices that contribute to drug-related harm; and

- Offering alternative approaches to abstinence-only treatment: ensuring abstinence from drug use is not imposed nor regarded as the only option.

One example of a harm reduction definition in the Canadian context is provided below:

*Harm reduction is a comprehensive, just, and science-based approach to substance use. The principles can also apply to activities such as sex work. It represents policies, strategies, and services, which aim to assist people who use legal and illegal psychoactive drugs to live safer and healthier lives. All substances have both positive and negative effects, and substance use may affect one's health and legal vulnerability. Most people who use drugs do not experience problems, but in some circumstances, substance use can become problematic. Harm reduction recognizes that people use drugs for many reasons. Reduction of substance use and/or abstinence is not required in order to receive respect, compassion or services. Harm reduction enhances the ability of people who use drugs to have increased control over their lives and their health, and allows them to take protective and proactive measures for themselves, their families and their communities (adapted from Streetworks Edmonton (75)).*

For more information on the fundamentals of harm reduction, please see the following resources:

- [CATIE - Harm Reduction Fundamentals: A toolkit for service providers](#) (76)

## **2.2.b Relational practice, cultural safety, and trauma-informed care**

Other key concepts for guiding staff working in SCS settings include relational practice, cultural safety, and trauma-informed care. Relational practice is the respectful, compassionate, and ethical partnership between a health care provider and their patient (77), and it encompasses many important aspects of care including harm reduction, patient- and relationship-centered care, cultural safety, and trauma-informed practice.

Cultural safety was originally developed to provide more respectful care to New Zealand's Indigenous Peoples (e.g., Māori) to address racial inequities (78,79). Within the Canadian context, cultural safety has been particularly relevant for understanding the impact of historical and ongoing colonization and systemic oppression influencing Indigenous Peoples' (e.g., First Nations, Métis, Inuit) access to health and social care and overall health status (78,80). This model of care acknowledges the importance of how structural violence and histories of trauma, including the legacy of colonization, impact the lives of people who use drugs and other marginalized populations (195). Cultural safety is intended to address inequities for people who experience discrimination or marginalization in healthcare settings (82,83), as well as ensure that spaces are physically, socially, emotionally, culturally, and spiritually safe (70,84). Cultural safety is ultimately defined by the

people who experience it, not those who provide it; however, for people who use drugs, culturally-safe care often:

- Facilitates their engagement and participation in shaping the care they and their peers receive;
- Recognizes that their health, experiences, priorities, and health care are influenced by histories and policies that criminalize drug use;
- Considers how their past histories of trauma and violence, layers of stigma, and disadvantage affect their ability to engage with providers and care plans;
- Emphasizes trust as a priority outcome; and
- Requires a culture of safety and respect where they are valued and seen as deserving of care (85,86).

Adopting principles of cultural safety within SCS will aid staff in developing relationships with people who use the site. Examples of cultural safety practices that can be provided in SCS are presented below (73,85):

- Being aware and sensitive to cultural practices and customs of SCS participants;
- Critically examining how one's own power, privilege, beliefs, values, biases, and assumptions can impact therapeutic relationships;
- Reflecting on the structures, discourses, and assumptions that frame delivery of SCS services. This includes acknowledging that individuals are part of the legacy of trauma and violence experienced by marginalized groups as a result of actions (potentially even those well intended) of service providers, health care professionals, and others;
- Understanding the history of drug policy and of those who use the SCS (e.g., experiences using the healthcare system, histories of trauma and violence);
- Acknowledging that the power in patient-provider relationships is skewed in favour of the service provider and facilitate an environment where the SCS participant has the power to say when they feel that an encounter is safe or unsafe;
- Adopting a social justice and/or anti-oppression lens to address structural factors that create and exacerbate harms associated with drug use;
- Actively informing SCS staff members of these efforts, and be open to being held accountable for actions or inactions, even if they are well intended; and
- Acknowledging that SCS participants who are Indigenous require special consideration. This includes working directly with Elders, knowledge keepers, and traditional supports within the community and SCS to build relationships and trust as well as to recognize how Indigenous Peoples define and understand cultural safety themselves (see **3.3.a Considerations for key populations**).

Moreover, it is essential to ensure appropriate and adequate cultural safety training and periodic re-training for all SCS staff to promote adoption of these practices. At a minimum, training should meet the following three learning outcomes:

- Reflect on their own, often unconsciously held, attitudes and beliefs about others;
- Examine the ways in which history, social relations, and politics continue to shape people's responses, needs, access, and health; and
- Demonstrate flexibility in how they relate with others, especially those that differ from themselves (71,87).

It is critical that culturally safe care is provided in tandem with trauma-informed practice. Trauma-informed practice specifically recognizes the need to respond to an individual's intersecting experiences of trauma, mental health, and substance use (88,89). Principles of trauma-informed practice that can be implemented within SCS include (89):

- Awareness of trauma: building awareness among SCS staff of the high prevalence of trauma experiences, the impact of trauma on development, adaptation of survival and coping mechanisms, and the interconnected relationship between trauma, substance use, mental health, and physical health;
- Safety and trustworthiness: establishing safety and trustworthiness through physical, emotional, and cultural safety such as through welcoming intake procedures, adapting the physical SCS space to be less threatening, clear information about the intentions and processes of the SCS, and attending to staff burnout and self-care;
- Focus on choice, collaboration, and connection: creating safer environments that facilitates self-determination, dignity, and personal care for SCS participants through open communication, equalizing power imbalances, providing choices, and working collaboratively;
- Strengths based and skill building: helping SCS participants to identify their strengths and develop resilience and coping skills by emphasizing skills to acknowledge calmness, centering, and triggers; and
- SCS participants who are Indigenous require special consideration, as this population has been disproportionately impacted by historical and intergenerational trauma and colonization (see **3.3.a Considerations for key populations**).

By encompassing the principles above, disclosure of trauma is not necessary. The SCS should be an environment where SCS participants do not experience initial trauma, further trauma, or re-traumatization. SCS participants are trusted to know their own needs and encouraged to make their own decisions about those needs.

In cases where trauma is disclosed, trauma-specific services that directly address trauma available either onsite or through referrals need to be available. Trauma recovery options can include specialized counselling such as trauma-focused cognitive behavioural therapy, stress inoculation, exposure therapy, psychotherapy, eye movement desensitization and reprocessing, and healing and empowerment (89).

For more information on cultural safety and trauma-informed practice, please see the following resources:

- [Canadian Public Health Association - Do you Ensure Programs and Services are Culturally Relevant and Culturally Safe?](#) (90)
- [EQUIP Health Care - Research to Equip Health Care of Equity](#) (91)
- [National Collaborating Centre for Aboriginal Health - Cultural Safety Collection](#) (92)
- [Northern Health Indigenous Health - Cultural Safety](#) (83)

# 3.0 Planning of SCS Service Models

## 3.1 Section 56.1 SCS Exemption Information

To legally operate a SCS in Canada, operators must be granted an exemption from Health Canada to protect staff and SCS participants against criminal charges due to activities with illegal substances within the site. Obtaining a SCS exemption requires prospective operators to complete an application that presents information pertaining to five broad criteria. SCS approved under this process are typically granted a one-year exemption that is renewable. Subsequent exemptions (i.e., renewals) may be granted for up to five years, depending on the availability of funding, the operators' record of compliance, and whether Health Canada has any concerns about the service's operations.

The present document is not intended to be a step-by-step guide to the exemption process or the Health Canada legislative and policy requirements. Rather, the topics covered here may help prospective SCS operators engage in higher-level discussions about the rationale, goals, and design of a SCS, which will ultimately aid people in drafting an exemption application. To assist prospective operators in gaining a general understanding of the level of information and resources required to assemble a successful application, a high-level explanation of the current Health Canada exemption process is described below. For further information, please refer to Health Canada's detailed guidance for section 56.1 SCS exemption applicants available on their website (93).

### 3.1.a Application process

In determining SCS exemption applications, the following five broad criteria outlined in legislation must be considered prior to granting an exemption under the CDSA (94) (p.2):

- 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."

Health Canada's SCS exemption application process collects information pertaining to these five criteria. Applicants are required to address these criteria in their submissions and meet any other

additional requirements set out by Health Canada. As of this writing, the SCS application form (July 2021 edition) is organized into multiple sections, including (94):

- 1) Applicant information (contact information; if applicable, organization and current services provided);
- 2) Proposed site description (proposed services and hours of operation; site floor plan);
- 3) Local conditions (description of target population; drug-related poisonings and deaths; health and safety impacts; other factors such as crime rates);
- 4) Policies, procedures, and security (roles and responsibilities of staff and training; sharps and biohazardous material disposal; rules regarding assisted consumption and drug splitting/sharing; addressing unidentified substances, as well as loss or theft of unidentified substances; security; record management);
- 5) Personnel (Responsible Person in Charge [RPIC]; with a recent criminal record check (i.e., issued within 1 year of SCS application submission) in addition to all education, volunteer, and work experience for the last 10 years (including a criminal record check for any experience outside of Canada, if applicable));
- 6) Consultation report and letter of opinion (consultation report and related documents; measures to address concerns; see **4.1.a Community consultation and engagement best practice** for more information);
- 7) Financial plan (statements or audits; confirmed and/or committed funding; budget proposal);
- 8) Renewal (if applicable); and
- 9) Applicant statement (certifying completeness and accuracy of information).

Health Canada requires a site visit prior to a SCS opening to the public to ensure that the site is set up with a configuration, and policies, and procedures that would enable the proposed service to operate in compliance with a SCS exemption, if granted. Site visits will vary significantly based on the type of SCS described in the exemption application (e.g., inhalation, mobile, single room, whole floor, etc.). Please note that detailed information on these areas are requirements for a federal exemption. If you have questions or want a copy of the SCS application form, contact the Exemptions Section of the Office of Controlled Substances at Health Canada ([exemption@hc-sc.gc.ca](mailto:exemption@hc-sc.gc.ca)) for more information.

## 3.2 Service Models

SCS are often accessed by structurally vulnerable populations of people who use drugs (e.g., those experiencing poverty, homelessness, colonization, unemployment, racialization, sexism, criminalization, and other inequities). These factors are often the underlying cause of poor health in people who use drugs and exacerbate risks and harms associated with drug use (95,96). SCS provide a valuable opportunity to address these factors by providing a crucial point of connection with health and social services (34,97).

There are many ways to design and implement a SCS. The type, range, and scope of services offered depends on the SCS participant population's characteristics and needs, existing local services, and resources available to establish a facility.

The basic physical components of an SCS often include:

- 1) A reception area that is distinct from the area where illegal drugs are consumed, where potential users of the SCS can learn about the service and its operation, and wait for access to the consumption area;
- 2) A dedicated drug consumption area reflecting the route(s) of consumption offered in the SCS that is equipped with sterile consumption equipment and a receptacle for the disposal of used equipment. This area is often closed off from the rest of the facility, if space and resources allow; and
- 3) A common area for drug poisoning response, after care, or monitoring where SCS participants rest, interact with health and social workers and employees with lived experience, and receive referral, education, and counselling resources as appropriate.

A SCS may also provide access to a range of additional services, either on-site or via referrals to other service providers, including those outlined below (note that this list has been adapted from a document developed by the European Monitoring Centre for Drugs and Drug Addiction (98)).

- Distribution of drug consumption supplies, such as syringes, needles, tourniquets, wipes, cookers, pipes, screens for use at, and outside of, the site;
- Health education, including harm reduction strategies for drug-use and safer consumption techniques;
- Take-home naloxone and drug poisoning prevention training;
- Drug checking services
- Drug use-related medical care (e.g., wound care, vein care, abscess management);
- Peer support programs;
- Drug treatment programs (e.g., withdrawal management, opioid agonist treatment, counselling);
- Residential services (e.g., overnight or day shelters);
- Primary and preventative healthcare (e.g., chronic illness management, immunization, sexually transmitted infection screening, screening and treatment for other communicable diseases such as HIV and HCV, wound care);
- Social work support (e.g., assistance securing income, housing, or addressing other needs);
- Mental health care;
- Women's health services;
- Off-site outreach;



- Employment opportunities, programs, and/or counselling;
- Legal support;
- Identification services;
- Recreational activities;
- Education counselling;
- Meals, snacks, coffee/tea;
- Phone/Internet access;
- Showers and/or laundry;
- Lockers;
- Postal addresses;
- Low-barrier or supportive housing; and/or
- Recovery housing.

The type, scale, and scope of services offered depends on the needs of the SCS participant population, existing services available in the area, and overall budget and capacity of the facility. While establishing referral pathways, partnerships may be the most efficient way to integrate health and social services in SCS with limited capacity. Including these supports directly in SCS may address existing difficulties maintaining continuity of care between SCS and community resources for people who use drugs and are structurally vulnerable (34). Assisting SCS participants with basic necessities (e.g., food, clothing, laundry/shower services) (99) also requires specific attention.

Consideration of the needs of the SCS participant population and the capacity of the facility are important when determining the SCS hours of operation. To reduce potential harms, such as using substances in unsafe locations or in public during the closed hours of a SCS (100), longer hours of operation are ideal. Any changes to SCS hours of operation (e.g., limited staffing, temporary closures, limited services, changes in regular hours) need to be clearly communicated to participants so that alternatives can be offered, as well as to maintain trusting relationships between SCS staff and participants. Examples of clear communication of this information to existing and prospective SCS participants (e.g., those from out of town, first time participants) include social media; partner organizations; posters, flyers, and postcards; and a 24-hour program contact number or voicemail that can be easily updated with this information. SCS may wish to delegate communication tasks to a designated staff member to ensure consistency and reliability of communication regarding changes to the service. If a SCS is closed for longer than 24 hours, exemption holders are required to notify Health Canada within 48 hours.

In general, there are three different SCS models that currently operate in Canada: stand-alone models, integrated models, and mobile outreach models. These models are used to classify differences in *design* aspects, such as location, physical layout, and availability of co-located services. There are variations between each type of model in terms of the size of the facility, weekly number of participant visits to the SCS, number of staff, hours of operation, and the number and

types of ancillary services offered. There may also be differences between programs of the same model type, such as different participant populations served by mobile outreach SCS. Although Health Canada allows for flexibility in designing SCS to fit local context on a case-by-case basis, descriptions of the standard models currently in operation are provided below. Please see case examples referred to under each model below for additional details.

### **3.2.a Physical SCS environment**

The external and internal physical environments of a SCS, irrespective of the model, can influence the willingness of people who use drugs to access the service, as well as their experience, satisfaction, privacy, and safety. For example, many SCS stakeholders prefer a nondescript facility to preserve anonymity of participants entering and exiting the facility (47). Likewise, if an integrated SCS is co-located with other healthcare services, some people who use drugs may feel uncomfortable accessing the service if there is a risk that they could be seen by someone they know (e.g., a healthcare provider, neighbour, friend) who is not aware they use drugs (101). Other aspects of the physical SCS environment that could be considered include:

- Presence and location of security cameras (102);
- Locations of entrances and exits (101);
- SCS layout features, including adequate space for drug poisoning response (e.g., CPR, multiple drug poisonings) and post-consumption areas (e.g., hang out spaces, those recovering from drug poisoning);
- SCS participant flow, including accessibility for participants with disabilities (e.g., wheelchairs, walkers);
- Visibility of SCS participants from the outside (e.g., placement of windows, access procedures); and
- Additional considerations as appropriate (e.g., service animal/pet considerations).

Ongoing consultations with people who use drugs and local stakeholders regarding the physical SCS environment are an important way to ensure that the space meets the needs of SCS participants and other community members. The availability of funding and resources to clean and maintain the exterior of the SCS may align with some community ‘clean and safe’ programs and support positive community relations. SCS are not a one size fits all approach, and each site needs to be tailored to meet the specific needs of the community it serves.

### **3.2.b Stand-alone model**

Also called a “specialized model,” the stand-alone SCS model is a distinct facility whose primary goal is to provide supervised consumption services. A stand-alone SCS is typically located in a high traffic

area for people who use drugs and in close proximity to local drug scenes and other services serving people who use drugs. This type of facility may be connected to other additional services, such as showers, refreshments, meals, primary care services, counselling, temporary housing (i.e., shelter) and referrals to external services. However, the majority of the facility's staff time and resources are dedicated to the operations of the SCS. This type of facility may be closely connected to other local service organizations for people who use drugs via established referral pathways.

Because stand-alone SCS primarily serve people who use drugs, the facility's services can be specifically catered to their needs. Also, it has been suggested that a stand-alone SCS may better reach participants who actively avoid, are marginalized from, or do not seek out other health care services (103). Accordingly, this form of SCS is best utilized in settings with large and more concentrated populations of people who use drugs, including settings with established drug scenes.

### **Example of a stand-alone SCS – Insite**

Insite is located on East Hastings Street in Vancouver's Downtown Eastside neighbourhood. A large proportion of people who use drugs in Vancouver live in the Downtown Eastside (104). People who use drugs in this area face homelessness, poverty, unemployment, mental health concerns, and violence. Insite opened in 2003 as a pilot project and was the first federally exempted SCS in Canada. People who use drugs in Insite are more likely to be homeless or precariously housed, to inject drugs in public, to inject drugs daily, and to have recently had a non-fatal drug poisoning; Insite has thus been successful in engaging high-risk people who inject drugs in harm reduction services through SCS (14).

Insite's staff consists of nurses, counsellors, mental health workers, and employees with lived/living experience of substance use. There are 13 consumption booths in Insite. Currently, Insite is authorized to permit injection, intranasal, and oral drug consumption (9).

While Insite is a stand-alone facility, it is also part of the PHS Community Services Society, a network of services (e.g., Community Managed Alcohol Program, Community Transitional Care Team, Douglas Street Community Supportive Recovery Program, PHS Food Program, Indigenous Health Services) in the immediate geographic area (105). In particular, Insite exists in the same building as Onsite, which has a withdrawal management facility consisting of 12 rooms with private bathrooms, and a transitional housing program with 18 units. Insite is also part of a referral network that consists of two community health centres, a hospital, rehabilitation centre, assertive community treatment, opioid agonist treatment (OAT), and support services for women.

During a 14-month period from March 10, 2004 to April 30, 2005, over 4,700 individuals registered at Insite and over 2,000 referrals were made, with over one third of referrals for substance use counselling (106). Based on the most recent Insite user statistics from Vancouver Coastal Health,

5,111 unique individuals visited Insite over 170,000 times in 2019, with an average number of 312 daily visits to the injection room (107). During this same year, 1,314 drug poisonings were treated at the facility, none of which were fatal (107).

Insite is an example of a more medicalized model of SCS provision (e.g., employing health care professionals, not necessarily accounting for the social or pleasurable aspects of drug use). A recent study showed that medicalization of Insite may deter some people from accessing the service, and many people who use drugs are receptive to less medicalized, peer-run SCS (108).

### **3.2.c Integrated model**

Globally, integrated facilities are the most common type of supervised consumption service (98). In the integrated model, SCS are part of larger facilities that typically serve people who use drugs and/or those who are homeless or unstably housed. Under this model, the SCS functions as one of several different interlinked services that address the needs of the target SCS participant population. Integrated facilities can offer an array of different services, including health and medical care, social services, and harm reduction services. Some integrated facilities aim to serve as a “one-stop-shop” for participants, while others provide more limited services to participants. Examples of facilities with an integrated SCS include hospitals, residential buildings, primary care clinics, and drop-in services (109–111). Regardless of the extent of available services, it is important to clearly demarcate spaces where drug use can take place within the facility and where it cannot, so that program participants who are not using the SCS (i.e., those who may be trying to reduce or avoid illegal drug use) can easily avoid these areas (112). It is also important to align facility and SCS policies by establishing clear plans and procedures between the SCS and the facility in which it is integrated. This may include protocols outlining what to do in cases where drug use may be found outside of the SCS (e.g., procedures for connecting the person to SCS staff, walking them to the SCS to see the space, and/or providing supplies, naloxone, etc.) as well as response protocols in the event of a drug poisoning event outside the SCS space.

Taking a harm reduction approach and providing SCS within acute care settings has the potential to reduce the identified risks and harms related to drug use among people who use drugs who require acute care (70,101). Canadian research suggests that a significant portion of people who inject drugs continue to inject while hospitalized (113). Most hospitals operate under written or unwritten abstinence-based policies and do not allow non-medical drug use or related equipment on their premises. This has resulted in people who use drugs engaging in high-risk substance use on or off hospital grounds (such as using drugs alone in a locked bathroom), avoiding accessing hospitals, and leaving hospital against medical advice (68). Integrating a SCS within a network of services offered within the same facility allows participants to access a spectrum of care without having to travel

outside of the facility premises, thereby helping to prevent loss to care, decrease barriers in access to care, and ensure continuity of care.

SCS models integrated into hospitals can be implemented in acute care or sub-acute care facilities, and can be open to patients only, or both patients and community members. People who use drugs have shown willingness to access supervised consumption services in a hospital (37). At the time of writing, only one acute care hospital in Canada, Royal Alexandra Hospital (RAH) in Edmonton, has implemented a SCS as defined in this document. However, Casey House (a specialized sub-acute care hospital for people living with, or at risk of, HIV) in Toronto operates an inpatient SCS, and St. Paul's Hospital in Vancouver operates an OPS.

Additionally, SCS may be a potentially important strategy for reducing drug poisoning fatalities in residential buildings where a significant proportion of tenants use drugs. Epidemiological data from some Canadian provinces indicate that most people who die of drug poisoning do so in a private residence (114,115). Relevant housing environments may include overnight shelters, transitional housing, or permanent supportive housing facilities. Ensuring these service models are tailored to the needs of all residents, including women and other subpopulations specifically vulnerable to substance-related harm (69), is particularly important.

Integrated SCS may more easily provide wrap-around care for SCS participants who face complex health and social challenges. However, potential trade-offs for this model may include challenges ensuring privacy and anonymity of SCS participants (especially if the host facility serves the general public or a broader population than people who use drugs), physical space constraints, and limitations on operating hours (112).

### **Example of a SCS integrated into a hospital – Royal Alexandra Hospital**

The RAH SCS is a patient-only facility located inside the hospital that is open 22 hours a day, 7 days a week (109). The RAH is located in a socioeconomically disadvantaged health services catchment and the facility sees the largest number of presentations for mental health and substance use disorders in the province. The SCS was opened in April 2018 to improve patient and staff safety and reduce the risk of drug poisonings occurring on hospital grounds (116).

The SCS is staffed by nurses, and contains a waiting area, two consumption rooms (with two booths each), and a post-consumption area (117). Currently, the RAH SCS is authorized to include injection, intranasal, and oral drug consumption (9). The RAH SCS is a clinical space, but efforts have been made to make it more inviting for patients (e.g., patient artwork decorates the walls; a television and nutrition are provided). All patients who have access to the SCS have the opportunity to receive wraparound services from the hospital's full-service, multidisciplinary addiction medicine consultation team.



Photo credit: Dong et al., 2020 (109).

### **Example of a SCS integrated into a housing program - Fred Victor**

Fred Victor is a charitable organization that provides a variety of programs and services to support people experiencing low-income or homelessness at 20+ different sites in Toronto (118,119).

In February 2018, Fred Victor opened a SCS at the Fred Victor housing and transitional housing program site as an evidence-based response to the growing drug poisoning crisis (120) to “save lives, connect people to other health services and to support the local community through this crisis” (120) (p.4). The SCS is currently authorized to include injection, intranasal, and oral drug consumption (9). This location also offers a variety of other services such as mental health and justice support; a restaurant and clothing room; gardening, arts and open house drop-in; and drug and alcohol withdrawal management (119,120). Fred victor clients already accessing the site's services and new clients access the SCS (119).

### **Example of a SCS integrated into a health centre – South Riverdale Community Health Centre**

The South Riverdale SCS is integrated into the South Riverdale Community Health Centre (SRCHC) in Toronto. This integrated facility offers additional community services such as senior’s wellness, women’s health screening, social work programs, primary health care, and other harm reduction programming in addition to the SCS (121). This program, named the “keepSIX” SCS, opened its doors on November 27, 2017, and was Canada’s first community health centre-embedded SCS (122).

keepSIX is located on the first floor of the SRCHC, beside the harm reduction drop-in office (123). The SCS contains an intake area, a consumption room with three standard booths and one large booth (to accommodate more than one person or people with mobility devices), and a post-consumption room (123). Currently, the SCS is authorized to include injection, intranasal, and oral drug consumption (9).

keepSIX mirrors the operational hours of the rest of the community health centre from Monday to Friday. In approximately its first year of operation, keepSIX reversed 8 drug poisonings in 2,800

consumption episodes from 400 unique visitors (124). keepSIX is staffed by nurses, health promoters, and employees with lived/living experience of substance use. The name of the site means “got your back” and is an homage to Raffi Balian, founder of SRCHC’s COUNTERfit harm reduction program (established 20 years ago) and lifelong advocate for people who use drugs (124).

### **3.2.d Mobile SCS outreach model**

A mobile outreach model of SCS may be useful if the local population of people who use drugs is not centralized in a particular location but rather dispersed across a large geographic area. Mobile SCS may also be desirable and complimentary in settings where stand-alone or integrated SCS programs already exist but are out of reach for some people who use drugs. Mobile SCS consist of modified vans or buses that contain consumption booths and can be moved to locations where services for people who use drugs may be limited and drug use occurs. In some jurisdictions, mobile facilities have been shown to be more socially acceptable for local stakeholders, such as police, policymakers, and neighbourhood business associations, than a fixed site (125).

Due to their smaller capacity, mobile facilities can typically see fewer SCS participants per day compared to larger fixed-site facilities. However, mobile facilities can require similar levels of staffing as larger fixed-site facilities, resulting in higher cost per participant than fixed-site facilities (126).

A study examining mobile SCS in Kelowna and Kamloops recently reported on the strengths and weaknesses of this model. While study participants were generally satisfied with access to services and physical safety of the mobile SCS, many reported being dissatisfied with the size constraints of the unit, and had concerns about weather-related events making service provision difficult or impossible (i.e., winter weather conditions causing cancelled shifts, high summer temperatures making the inside of the SCS uncomfortably warm) (127).

Operators intending to apply for a mobile SCS exemption need to include the following in their application:

- Description of the mobile unit (van, trailer, camper, or recreational vehicle/motorhome, etc.);
- Address of where the mobile SCS would be parked outside of operating hours (94);
- Route plan (i.e., neighbourhood(s) and/or specific address(es) of stop(s) and/or the geographic range of operation) (94);
- Confirmation that illegal substances will not be stored in the vehicle overnight (i.e., transferred to, and stored in, a fixed location until picked up by police, or driven to police); and

- For each stop, confirmation of support from the owner(s) of the property (i.e., municipal government if stopping on public property and/or landlord if stopping on private property).

### **Example of a mobile SCS - Kelowna**

In July 2017, Health Canada approved the application for a mobile SCS in Kelowna. The service was housed in a retrofitted recreational vehicle (RV), which parked at two fixed locations (downtown and Rutland area) in Kelowna from Tuesday to Saturday in four-hour shifts (127). The RV contained two booths and additional space used as a waiting room (128). People who used this mobile SCS could only inject - other forms of consumption were not permitted. From June 2017 to July 2018, the service reported having over 26,000 visits and reversing 47 drug poisonings (128). In addition to supervising injections and responding to drug poisonings, staff of the SCS provided naloxone kits, nursing care, and referrals to medical and social services (128).

## **3.3 Other Considerations for Service Provision**

There are many potential opportunities to expand the operation and scope of SCS. This includes focusing on the specific needs of key populations (e.g., people who identify as women, 2SLGBTQIA+ [2-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or questioning, Intersex, Asexual, plus], youth and young adults, Indigenous Peoples); accommodating non-injection drug use and injection in high-risk areas (e.g., jugular vein, groin); offering assisted consumption and splitting and sharing of drugs; and integrating drug checking services and/or safer supply programs (129,130). Each of these ideas for expansion is discussed in further detail below. See section **2.2 Practicing a harm reduction philosophy of care** for guidance on service provision using harm reduction, relational practice, and cultural safety approaches.

However, it is also important to note that the three SCS models outlined above limit services to people who can travel to the SCS, whose consumption practices are accommodated within the SCS, and who are not deterred from SCS due to the stigma associated with illegal substance use. Virtual supervised consumption services (e.g., phone or web applications which monitor substance use and are typically staffed by people with lived/living experience (131,132)) expand and address these gaps in service delivery by monitoring participants' level of responsiveness and activating local emergency services as needed. For example, the National Overdose Response Service (NORS) offers both telephone and application based drug poisoning prevention support across Canada and the United States. However, virtual supervised consumption service models are out of scope of this document. For additional reading on virtual supervised consumption services, including other virtual supervised consumption service programs such as The Brave App and the Lifeguard App, see the following resources:

- [The Brave Co-Op - The Brave App](#) (132)



- [Bristowe et al. - Virtual Overdose Response for People Who Use Opioids Alone: Protocol for a Feasibility and Clinical Trial Study](#) (131)
- [Grenfell Ministries et al. - National Overdose Response Service \(NORS\)](#) (133)
- [Lifeguard Digital Health - Lifeguard Digital Health](#) (134)

### 3.3.a Considerations for key populations

We use the term ‘key populations’ to refer to groups who—due to specific social and structural inequities—are more likely to experience substance-related harm. A growing body of literature (135–138) documents the importance of accounting for diverse and unique needs of key populations in supervised consumption service planning and implementation as one way to reduce access barriers and promote health equity for various subpopulations of people who use drugs. Below we outline emerging evidence and practice related to the inclusion of key populations within SCS models of care.

#### People who identify as women

People who identify as women and use drugs face unique and intersecting sets of challenges and dangers resulting from gendered power relations, criminalization, and violence. In Vancouver’s Downtown Eastside, people who identify as women and inject drugs who are under the age of 30 are 54 times more likely to die prematurely when compared to the Canadian non-drug-injecting population of the same age, most frequently via homicide (139,140). Compounding these health inequities, people who identify as women and use drugs experience high rates of homelessness, everyday violence (e.g., victimization and sexual abuse), criminalization, and barriers to accessing harm reduction, health, and social services (141–143).

People who identify as women are more likely than men to seek assistance from another person when injecting, which places them at an increased risk for HIV, HCV, drug poisoning, and other drug-related harms (144–146). Research suggests that this tendency to seek assistance with obtaining, preparing, and injecting results from unequal power relationships, a lack of knowledge of how to inject, and gendered power-relations with substance-using male sexual partners (142,147,148). Reliance on a male sexual partner for drug injection can expose people who identify as women to intimate partner violence, including physical, sexual, emotional, and financial abuse, as well as elevated risk for HIV infection (142,144,149). However, prohibiting assisted consumption in SCS does not stop these dynamics. Accommodation of assisted consumption is critical to increasing SCS access among women who use drugs who would otherwise avoid SCS (150). It is imperative that people who identify as women and need help with administering their drugs be allowed to receive that help, either from SCS staff or their own helper to avoid gendered power relations. See **3.3.c Assisted consumption** for more information.

Healthcare access barriers and stigma are especially amplified for people who identify as women and are pregnant and/or parenting (151,152). For example, fear and the possibility of child apprehension (e.g., Canadian child welfare system involvement) discourage pregnant or parenting women who use drugs from openly seeking support for substance use, including accessing SCS (153–155). This is concerning, as consuming drugs alone and in public spaces can expose people who identify as women to violent victimization, and often interferes with their ability to protect their health (142). This may be especially true in the context of illegal drug markets that are saturated with illegal fentanyl and analogues which can produce rapid onset of severe intoxication (150). People who identify as women and use drugs in public spaces also report being subject to hassling or “grinding” by men for money and drugs (149).

Despite the unique vulnerabilities experienced by people who identify as women and use drugs in Canada and internationally, most substance use services are tailored to target and serve men who use drugs (156). Consistent with this, SCS tend to be male-dominated spaces. While mixed-gender supervised consumption services allow people who identify as women to avoid risks associated with using drugs in public (149), the ongoing presence of gendered violence and power dynamics in these spaces discourages women from accessing these services (150,157–160). As such, mixed-gender supervised consumption services can perpetuate gender disparities in substance use related risks and everyday violence (150,160). People who identify as women and access women-only supervised consumption services have reported feeling more comfortable, relaxed, and safe in comparison to experiences at mixed-gender SCS (157). People who identify as women also cite high levels of trust in staff, allowing them to speak openly. As a result, women report being more willing to accept offers of help in women-only supervised consumption services (7). SCS only for people who identify as women available overnight were identified as particularly beneficial for people who identify as women and use drugs and engage in sex work as there are limited safe spaces available during those times (160). To our knowledge, there are currently only two supervised consumption services serving only people who identify as women worldwide: Ragazza located in Germany, and SisterSpace in Vancouver (161). Two other supervised consumption services, one in Switzerland (7) and one in Toronto (162) also offer women-only consumption services for limited hours each week. A model serving only people who identify as women was also opened for a brief period in Mexico (163).

Beyond implementing SCS models for people who identify as women, SCS operators can also support people who identify as women and consume illegal drugs by:

- Offering space/hours at the facility dedicated to people who identify as women (however, this is less ideal than a dedicated women-only SCS, as staff would have to deny access to men during these hours which would increase their risks of harm, and men may still be around the SCS during the women-only hours);

- Providing accommodations within the SCS to help maintain privacy of people who identify as women and are unable to inject themselves, want to inject in intimate areas, and/or are pregnant;
- Providing safer consumption and other targeted harm reduction education for people who identify as women;
- Providing women’s health services, such as reproductive and sexual health services, and referrals to women specific health and support services in the area;
- Establishing gender equity and gendered violence policies in the facility (e.g., explicit rules on, and consequences for, discrimination and violence against people who identify as women within SCS), including staff training and codes of conduct for SCS participants;
- Offering tools and resources for violence prevention (e.g., bad date sheets); and
- Providing harm reduction and support services run by people who identify as women.

## **2SLGBTQIA+**

2SLGBTQIA+ are at greater risk for earlier substance use initiation and have higher rates of substance use compared to their heterosexual counterparts (164–167). 2SLGBTQIA+ individuals experience extreme stigmatization and discrimination across their life spans and are often targets of violence (e.g., sexual and physical assault, harassment, hate crimes) (168,169). As a result, 2SLGBTQIA+ Canadians are more than twice as likely than heterosexual Canadians to use drugs to cope with emotional, physical, and sexual abuse (170). However, 2SLGBTQIA+ people also use substances as part of social and community life (171). Substance use patterns by 2SLGBTQIA+ people can vary from those observed in the general population. For example, drug use, particularly methamphetamine use, within sexualized contexts may be more common amongst 2SLGBTQIA+ people (167,172). 2SLGBTQIA+ people may also use drugs more frequently through non-injection routes of consumption (173,174).

Despite the high prevalence of substance use among 2SLGBTQIA+ individuals, few access supervised consumption services or feel confident that they can access supervised consumption services if they need to (167). Safe spaces for 2SLGBTQIA+ remain an ongoing challenge in harm reduction and there are currently no known SCS tailored specifically towards this group of people who use drugs.

SCS operators can better support 2SLGBTQIA+ people who use drugs by:

- Providing tailored harm reduction education and interventions for using drugs in sexual contexts;
- Providing tailored harm reduction education and interventions for methamphetamine use;
- Ensuring access to inhalation and intranasal drug use supplies; and
- Employing 2SLGBTQIA+ staff.

## **Youth and young adults**

In Canada and around the world, youth who are below the age of majority (<18 or 19) or age of consent for healthcare (as stipulated by each province and territory (175)) are often excluded from SCS and other harm reduction services due to age restrictions and parent/guardian consent requirements (176,177). This is concerning, because SCS facilities have the potential to reduce the harms of ongoing drug use among youth and provide connections to health and social support. Several expert bodies in Canada have recommended including underage youth in supervised consumption services and other harm reduction services, including the BCCSU, the British Columbia representative for Children and Youth, and the Office of the Child and Youth Advocate Alberta (177–179). Similarly, the World Health Organization and Harm Reduction International recommend removing age restrictions and parent/guardian consent requirements for harm reduction services to increase accessibility (6,180). Other calls to action include opposing abstinence based approaches, ensuring confidentiality (e.g., communicating with participants on what information - if any - can be shared with family members, caregivers, other staff, etc.) and implementing harm reduction services led by youth themselves (181). Importantly, Health Canada does not specify age limitations or parent/guardian consent requirements for people accessing an SCS.

In general, we recommend avoiding policies that prevent SCS access among youth because they may exclude a population that is highly vulnerable to substance use-related harms. Such harms are elevated among structurally vulnerable youth, such as those who have left their family due to conflict, who live in poverty, who are unstably housed, or who live and work in the streets (182). These social-structural conditions can lead to an array of risk behaviors among youth, including injection drug use, risky sexual practices, survival sex work, syringe sharing, and consumption of drugs in public spaces such as parks or alleyways (183,184). Consequently, structurally vulnerable youth experience an elevated risk of HIV or HCV infection (185–188), drug poisoning (189), and premature mortality (139,190).

Additionally, prior research has consistently shown that youth and young adults (aged 18-30) are more likely to engage in riskier injection practices compared to older, more experienced people who inject drugs (180,183,191–193). Given their relative inexperience with injecting, young people often lack knowledge of safe injection practices (193–195). They are also more likely to receive assistance with injection from close friends, peers, or sexual partners, which may involve sharing of injection equipment (196). As a result, young people experience a disproportionate burden of HIV and HCV infection compared to older people who use drugs (197–199). Young people may also lack knowledge of factors that increase drug poisoning risk, such as polysubstance use (192). SCS and other harm reduction services can reduce substance use-related harms among young people by educating them about safer consumption practices and drug poisoning prevention (196).

SCS can also help address various barriers to accessing health and social services that youth who use drugs face. These barriers include difficulty establishing and maintaining trust with authority figures and institutions (200–202). This distrust may be related to prior institutional trauma, such as government care or incarceration (203,204). Youth may have also been previously victimized or exploited by their caregivers, which can contribute to mistrust of adults in general (205). Other barriers include experiences of stigma and discrimination from service providers, fear of police or other government agency involvement, a lack of personal identification or fixed address, lack of knowledge of services, and long waitlists for programs (200,202,203,206,207).

Engaging youth through SCS can help build positive relationships with a population who may otherwise be unlikely to engage in health and social services (177). Ethnographic work with structurally vulnerable young people (aged 14-26) has demonstrated how harm reduction-oriented services can facilitate establishing meaningful relationships with service staff, which can be a valued source of social support (177). Additionally, previous research with youth (aged 14-26) in Vancouver found that SCS uptake was greatest among youth with high risk of drug poisoning and infection of HIV or HCV, such as those who injected drugs daily, injected in public, and who lived or spent time in the Downtown Eastside neighborhood surrounding the SCS (208). A similar study found youth who inject drugs who were homeless, injected in public, had loaned needles or experienced a drug poisoning in the last six months were more likely to access SCS (24). These results suggest that SCS can provide an important point of contact with vulnerable youth who may otherwise be hard to reach with conventional public health efforts and addiction treatment services (208).

While SCS have the potential to reach populations of marginalized young people, several obstacles have been identified that contribute to lower use of harm reduction services among youth compared to older adults (180,191,193,209). Young people who use drugs are often uncomfortable accessing harm reduction services that are primarily used by older individuals (184,202,209–211). Some may also be reluctant to access harm reduction services given the stigma attached to these interventions (183,184). Additionally, there are several developmental issues that can make engaging young people in harm reduction services challenging, including negative experiences with authority, general suspicion of those in helper roles, and high valuing of self-reliance and protection of autonomy (209). Structural barriers include the location of most programs in urban centers, which are often far from neighborhoods in which many young people reside and use drugs (184). As well, often inexperienced drug users have few social networks of people who use drugs and are poorly connected to harm reduction in their communities (184).

These obstacles to harm reduction service uptake have spurred calls to develop more youth-oriented services, including SCS (177,180,184,209). The development of such services needs to meaningfully involve young people who use drugs in the planning, design, implementation, and evaluation of services (180,209). In previous consultations, youth have called for youth-oriented SCS to be integrated within other services where youth congregate, such as drop-in centers, shelters,

and youth community centers (177). Additionally, youth have indicated that having young peers in harm reduction roles can increase engagement and offer valued guidance and mentorship (177,180,209). Youth-oriented SCS models are a promising intervention that may help increase uptake in the future. However, given the potential for SCS to help mitigate some of the risks associated with drug use, it is important to have policies in place to include youth within current SCS models such as:

- *Conditions for access to the SCS for minors.* SCS facilities are appropriate for youth who have a history of drug use. Provide SCS access to youth who report drug use and intend to consume pre-obtained drugs. For youth who do not meet the above criteria, provide access to resources that more appropriately meet their level of need (e.g., developing safety plans, promoting the use of monitoring services such as NORS);
- *Youth intake protocols if granted access to the SCS.* As indicated by their assessment, provide expedited referrals to primary health care, addiction medicine services, shelter, and mental health services;
- *Protocols consistent with provincial/territorial guidelines for suspicion of youth in need of protection.* For youth under 18 who are at immediate risk of harm other than substance use, a report to children’s services may be appropriate.
  - For more information on provincial and territorial child protection regulations see (212);
- *Confidentiality.* For youth under 18, ensure that SCS participants are aware of their rights to confidentiality and that any limits of confidentiality due to mandatory reporting responsibilities are made clear (180). Low-barrier registration processes (e.g., anonymous, not asking for ID; see **8.1.a Government issued identification and personal health numbers**) may also support youth accessing SCS;
- *Safer consumption education for inexperienced youth.* Offer to teach young SCS participants safer consumption techniques and provide information on drug poisoning prevention and response (192,213); and
- *Involving young peers where possible.* Youth have also indicated that having peers with lived experience involved in harm reduction and support services may improve engagement and offer valued mentorship and support (177,180,209).

## **Indigenous Peoples**

In Canada, Indigenous Peoples (First Nations, Inuit, or Métis) experience disproportionate rates of substance use disorders, substance-related harm and criminalization, unstable housing, and homelessness (214). The increased structural vulnerability of Indigenous Peoples directly reflects the legacy of colonization and intergenerational trauma inflicted by the residential school system, as well as contemporary systemic and systematic discrimination and socioeconomic marginalization (215,216). There is an urgent need for the core involvement of Indigenous Peoples in the

development and implementation of substance use services and programs (217). To this end, it is imperative that Indigenous Peoples are at the forefront of decisions on implementing SCS and determining whether SCS are valuable to their communities, to avoid perpetuating colonial practices of setting up services that these communities may not want or need. Outlined below are overarching principles to consider when designing and operating SCS with and for Indigenous Peoples. (Note that this list has been adapted from the *BC First Nations and Aboriginal People's Mental Wellness and Substance Use 10 Year Plan* (218)).

- Recognize that culture, traditions, and language are the foundation to healthy individuals, families, and communities;
- Support approaches that ensure Indigenous Peoples receive safe and effective care from health providers;
- Find ways to address travel and funding barriers that make it hard for Indigenous Peoples to access substance use programs and services;
- Build and strengthen capacity among Indigenous communities;
- Make sure that services and programs are kept local, when possible;
- Support broad, collaborative multi-system approaches that consider social and economic determinants of health;
- Build and strengthen partnerships among Indigenous communities, the regional, provincial, and federal systems and non-governmental organizations, including improved coordination and leveraging of innovations and resources;
- Make sure that health and human service providers work in a manner that is culturally safe and respects individual customs, values, and beliefs;
- Recognize that the social determinants of health have a key role in mental wellness and empower communities and leadership to address these determinants through inter-sectoral collaboration and action;
- Encourage approaches that are based in and build on individual, family, community, and cultural strengths;
- Reduce stigma against Indigenous Peoples who use substances; and
- Recognize that responses to addiction and substance use can be gender specific. This includes men and women, and 2SLGBTQIA+ individuals. Programs and supports may need to be modified to support this population.

In the context of harm reduction service provision, it is imperative that culturally appropriate care is available (219). Indigenous harm reduction services aim to address a broader range of harms by including harms associated with colonization (220,221), and are underpinned by the following principles (219):

- Decolonizing services (e.g., providing trauma-informed care in SCS);

- Indigenizing services (e.g., supporting Indigenous-led development of cultural services for SCS participants);
- Providing holistic services (e.g., working with SCS participants to address poverty);
- Providing inclusive services (e.g., ensuring everyone is comfortable using the SCS, regardless of their ethnicity, age, gender, or sexual orientation); and
- Providing innovative and evidence-based services (e.g., integrating Indigenous healing practices into SCS).

For more information on Indigenous harm reduction, please see the following:

- [First Nations Health Authority - Fact Sheet: Indigenous Harm Reduction Principles and Practices](#) (222)

Indigenous harm reduction practice within existing SCS is often limited to referrals to external organizations (223). However, integrating culturally safe care has been associated with improvements in health outcomes in other health and social service settings (221,224). Therefore, it is important to integrate Indigenous harm reduction practices within SCS as much as possible.

### **3.3.b Considerations for non-injection drug use**

Internationally, a recent scoping review identified 48 supervised consumption services that reported accommodating people who use drugs by non-injection routes of administration, most of which were in Germany (225). Most SCS in Canada have received federal approval to monitor the consumption of drugs via intranasal, oral, and inhalation routes of administration. When possible, it is important to plan, implement, and evaluate SCS catering to non-injection routes of administration.

#### **Drug consumption by inhalation or smoking**

While the majority of SCS in Canada have exemptions that support intranasal and oral routes of consumption, as of April 12, 2022, only two federally exempted SCS have ever been able to offer supervised inhalation services (9) (one in Lethbridge, which closed in August 2020 due to funding challenges - see example below - (136), and one in Saskatoon, which began operating on October 1, 2020). Several OPS, however, do offer inhalation services outside the purview of the federal government. Barriers to offering inhalation services may include physical space and adequate ventilation (225), which may require costly installation or retrofits. Utilizing outdoor areas for inhalation has also been practiced in the absence of ventilated rooms (225). However, local non-smoking laws may be an additional barrier to implementing supervised inhalation services. For example, operators of a Toronto SCS are unable to open their inhalation booth due to Ontario's



smoke-free laws, despite the fact that a large portion of their participants would prefer to consume via inhalation over injection (226).

People who use drugs via inhalation are at risk of experiencing drug poisonings and other drug related harms. A recent report on drug poisoning deaths in Alberta in 2017 indicated that amongst 653 opioid-related poisoning deaths, 23% were related to either inhalation or intranasal use (smoking and snorting, respectively) (227). In Ontario, at least 33.7% of opioid-related poisoning deaths were due to inhalation between March 16 and December 31, 2020 (228). In addition, data from populations of people who smoke drugs indicate high rates of pipe-sharing (229), which is associated with an increased risk of HCV transmission (230,231). Compared to people who only inject drugs, injecting and inhaling drugs is associated with increased risk of HIV seroconversion (232).

Feasibility and needs assessment studies on non-injection routes of consumption support the potential public health impacts of inhalation rooms (46,233–237). Participants who attended an unsanctioned supervised consumption service for inhalation in Vancouver indicated that it minimized structural and drug-related violence among people who smoke drugs and helped address stigma related to smoking drugs in public areas (238). In addition to providing harm reduction services for people who smoke drugs, modelling studies suggest supervised inhalation services may be cost-effective for preventing substance-related harm (29). There is also evidence to suggest that supervised consumption services can help reduce public drug use and pipe sharing (239), and provision of sterile inhalation supplies (i.e., glass pipes, rubber tubing, foil) within these services can help promote smoking over injecting (240). While many European jurisdictions have implemented supervised inhalation services, these facilities have not yet been well-studied to date (237). More research is needed to establish the effectiveness of supervised inhalation programs for reducing substance-related harm (237). The current lack of supervised inhalation spaces presents a barrier to the successful evaluation of these services, and challenges service providers' abilities to offer the full scope of harm reduction and substance use treatment and other supports to all people who use drugs. When designing and implementing supervised consumption services, integrating supervised inhalation services, including the provision of sterile inhalation supplies, is particularly important in settings where a significant portion of people who use drugs do so via inhalation (241–243).

### **Example of a SCS offering supervised inhalation/smoking: Lethbridge's AIDS Outreach Community Harm Reduction Education Support**

The first Canadian SCS to allow four modes of consumption (inhalation, injection, intranasal, and oral) operated in Lethbridge (136) between February 28, 2018 and August 31, 2020. Lethbridge is a mid-sized city (population of approximately 100,000 people), and is the fourth largest city in Alberta (244). In order to operate, the AIDS Outreach Community Harm Reduction Education Support (ARCHES) SCS needed to comply with federal, provincial, and municipal smoking legislation (136). In

addition, the SCS operators worked with Alberta Labour and followed Canada's occupational health and safety regulations to ensure their operations were up to code (e.g., ensuring proper ventilation) (136).

The ARCHES SCS was located in a large building offering many other health and social services, and was open 24 hours each day (245). The consumption room contained 13 injection booths and two inhalation rooms (246). Each room could accommodate multiple people inhaling their drugs at once, and were separated to allow the consumption of different drugs without cross-contamination (136). Each SCS participant was permitted to spend up to 45 minutes in the consumption area (246). The SCS also included a space for post-use monitoring, as well as education, nursing care, and referrals to other services.

In the event of a drug poisoning, observing staff pressed a button near the observation station, and the air inside the inhalation room was rapidly ventilated and replaced with fresh air. The staff member was then able to enter the room and tend to the drug poisoning as necessary (136). Between January 1 and March 31 2020, the facility had 60,098 visits, an average of 439 unique participants per month, and reported attending to 320 drug poisonings requiring medical attention (e.g., oxygen, naloxone) (247). The high number of visits led many to claim ARCHES as Canada's busiest SCS, and possibly even one of the busiest supervised consumption services in North America (248,249).

For more examples and information on supervised consumption services supervising inhalation/smoking see the following resources:

- [Gehring et al. - The State of Science on Including Inhalation within Supervised Consumption Services: A Scoping Review of Academic and Grey Literature](#) (237)
- [Lem et al. - Inhalation Room Prototype Design](#) (250)
- [Speed et al. - To What Extent do Supervised Drug Consumption Services Incorporate Non-Injection Routes of Administration? A Systematic Scoping Review Documenting Existing Facilities](#) (225)

### **Rectal drug consumption**

Rectal drug consumption is another route of consumption used by people who use drugs which generally involves instilling dissolved drugs into the rectum to experience psychoactive effects (251,252). This practice is not currently permitted in SCS under Health Canada exemptions; however, Health Canada assesses each application on a case-by-case basis, and interested SCS may want to include rectal drug consumption in their exemption applications for consideration as some SCS participants may be interested in, or currently engaged in this practice. Offering rectal consumption harm reduction education and supplies to participants as needed will help SCS

operators reach participants who are interested in this practice if it is not permitted within their SCS.

Specific considerations for rectal consumption in SCS include:

- Maintaining privacy of participants;
- Provision of supplies such as needleless syringes and lube; and
- Providing specific harm reduction education.

Further resources on rectal drug consumption:

- [ACToronto - Booty Bumping](#) (251)
- [MAX Ottawa - Do the Bump. The Booty Bump That Is](#) (252)

### **3.3.c Assisted consumption**

Until 2020, peer- (clients/participants who use drugs) assistance (i.e., assisted drug consumption) was not permitted in federally exempted SCS, and provider- (nurse or other staff members) assistance was not permitted at the time of this publication. Health Canada cites two reasons for this omission: 1) lack of legal protection for the person helping if harm were to come to the person being assisted, and 2) lack of professional guidance for nurses to administer illegal drugs (137). However, banning peer- or provider-assisted consumption creates a barrier to SCS access for people requiring assistance consuming drugs (144); requiring assistance, particularly with injection, is associated with increased substance-related harm (68,135,137) that is exacerbated when excluded from SCS. Increased risk behaviours (e.g., being forced to inject themselves, seeking assistance outside the SCS) are unable to be monitored or mitigated when people requiring assistance are excluded from SCS (253). Specifically, repeated unsuccessful self-injection attempts can lead to vein damage, and bacteria from the skin or other surfaces may be deposited in a person's blood and tissue. As a result, abscesses, sepsis, endocarditis, and other severe bacterial infections may occur (254), which can lead to lengthy treatment with intravenous antibiotics, disability, and death. Other harms experienced by people requiring assistance include increased vulnerability to theft of drugs, missed injections, and drug poisoning (255), as well as increased risk of syringe-sharing, street or partner-related violence, physical, economic, and emotional abuse, and exploitation (137,256). People who require but are unable to access assisted consumption often leave SCS to seek assistance elsewhere, and therefore do not access the health and social supports provided by SCS (258). This especially disadvantages vulnerable subpopulations of people who use drugs, including women reliant on men to inject them (68), people with disabilities who cannot inject themselves (137), people who do not know how to inject safely, and people who are in active withdrawal (258).

## Peer-assistance

In 2018, Health Canada implemented a peer-assistance pilot study of select SCS. Participating SCS were required to apply specifically for an updated exemption to participate in the pilot study, and submitted monthly reports to Health Canada indicating data elements such as the frequency of visits in which peer assistance was requested, the reason cited for requesting assistance, basic demographic information of SCS participants requesting assistance, and referrals to health, social, or treatment services. In 2020, peer-assistance was added to the list of authorized services that prospective SCS operators can include in their applications, and as of April 12, 2022, 25 SCS in Canada are actively offering this service (9). Supervised consumption services in Canada offering peer-assistance have successfully engaged and reduced harms among structurally vulnerable higher-risk subpopulations of people who use drugs (e.g., women, those experiencing structural violence and/or unstable or lack of housing) (68,135,253,259).

Health Canada states that SCS applications intending to include peer-assistance must include and adhere to the following policies and procedures (94):

- Staff cannot administer illegal substances to participants while on shift (including staff peer support workers);
- Participants wanting to receive peer-assistance must be given harm reduction education about routes of consumption other than injection (e.g., inhalation, oral, intranasal) permitted in the SCS prior to allowing peer-assistance;
- If lack of knowledge is the barrier to self-consumption, staff must give guidance on how to self-consume, whereas if the barrier to self-consumption is a physical disability, limitation, or other condition (permanent or temporary), staff should provide physical supports to allow the participant to self-consume;
- If staff cannot support self-consumption, informed consent and a liability disclaimer need to be discussed with the participant requiring assistance and their designated peer (including potential criminal liability associated with peer-assistance);
- Staff must discuss the basics of safer consumption (e.g., sterile supplies, hand-washing, angle of needle insertion, bevel up, etc.) with the designated peer and;
- If the designated peer plans to self-consume at the SCS within the same visit, they must assist the other participant first.

SCS operators intending to offer this service might also consider developing additional policies or documents, similar to those used in the pilot study (253), which address the following:

- Specialized data collection tools to ensure timely reporting on this practice (e.g., age, gender, reason for assistance, successful/unsuccessful assistance); and
- Staff protocols that clarify:

- the process for identifying and accommodating requests for peer-assistance,
- procedures for preventing syringe sharing between the designated injector and person being injected, and
- procedures to prevent exploitation or coercion of vulnerable individuals who cannot self-inject.

### **Provider-assistance**

Despite recent success in allowing peer-assistance in SCS, provider-assistance has yet to be approved. While providers are able to indirectly assist participants to self-consume (e.g., helping find a vein, stabilizing syringe while the participant inserts the needle, removing the tourniquet, adjusting the angle of the syringe, removing the syringe in cases of drug poisonings), SCS providers, including peer support workers, cannot: 1) administer illegal drugs directly into SCS participants; 2) insert needles into participants' skin; and 3) depress the needle plunger.

In Vancouver, a peer-run, non-exempted OPS allowed trained volunteers to inject OPS participants who requested support. While these volunteers potentially faced legal risks involved in injecting others, including criminal charges (68,260), they still elected to help participants in need. In a qualitative study of this service, participants reported that volunteer-assistance within the OPS helped minimize common health risks associated with self-injection or peer-assistance occurring outside the service (e.g., blood-borne disease transmission by minimizing receptive syringe sharing and unhygienic conditions), and helped people who need help injecting to avoid drug scene violence (68).

Nurse-assistance has been implemented in some European supervised consumption services (137). However, there remains a number of legal and regulatory hurdles preventing nurse- or provider-assistance within federally-regulated SCS in Canada. Legislative reform and/or regulation and policy change is required to facilitate formal implementation and evaluation of this practice within SCS in Canada (137).

While people with lived or living experience of substance use employed as SCS staff cannot provide peer-assistance while on shift, they can provide peer-assistance off-shift when they are using the SCS as a registered participant or as a designated "peer". See **3.3.c Assisted consumption** for more information.

### **3.3.d Splitting and sharing drugs**

Splitting and sharing of drugs (i.e., "dividing a portion of illegal substances between clients, before or after drugs are prepared for consumption") (94) (p.12) has historically not been permitted in federally exempted SCS as it was considered "trafficking" (261). This restriction has been

documented as a barrier to accessing supervised consumption services for people who use drugs (262,263), and disproportionately impacts women and youth (198).

In July 2020, Health Canada began consultations with supervised consumption service operators to prioritize changes to policies related to splitting and sharing. A national working group formed through the Canadian Association of People who Use Drugs (CAPUD) and the SCS/OPS Service Providers UPHNS Community of Practice to highlight the impact of excluding splitting and sharing and suggest pathways towards policy change (264). The first initiative this group undertook was the development and distribution of a survey for individuals who work at or access supervised consumption services for personal drug use. The survey demonstrated that 92% of respondents were in favour of allowing splitting and sharing, with 61% believing there should be no limitations around amounts shared (265).

The survey results also highlighted harms generated through restrictions to splitting and sharing, with 62% of (n=140) respondents who have worked in a supervised consumption service reporting negative impacts as a direct result of restrictions. Among the top three reported impacts, 87% reported clients needing to exchange substances outside the supervised consumption service (potentially increasing vulnerability to violence or arrest), 68% reported clients needing to prepare their doses outside the supervised consumption service (potentially under unsafe or unsterile conditions), and 64% reported participants leaving the supervised consumption service and not returning.

Through the efforts and findings of the national working group, Health Canada updated the policy regarding drug splitting and sharing within SCS in July 2021. Applicants are now eligible to apply for drug splitting and sharing as an exempted service offered at SCS. Current federally exempted SCS can submit an amendment application to include this service (see reference (266) for a protocol template).

The new Health Canada policy (94) (p.12) states that:

- Staff cannot split or share drugs for SCS participants while on shift;
- Splitting and sharing can only involve SCS participants;
- Each SCS participant participating in splitting or sharing drugs must be consuming the drugs at the SCS during their visit;
- Splitting and sharing must take place under staff supervision in the consumption area;
- Splitting and sharing must not include exchanges for goods, services, or financial compensation; and
- Drug dealing remains prohibited.

For SCS who already have an exemption and would like to be authorized to add splitting and sharing to their available services, it is important to reflect this change in other relevant policies and procedures (e.g., in the Code of Conduct: “clients must remain in possession of their own drugs at all times, except if engaging in drug splitting/sharing [and assisted consumption, if applicable] as per the applicable policies and procedures”).

For a protocol template to incorporate splitting and sharing in SCS, please see the following:

- [Ranger et al. - Splitting & Sharing in OPS/SCS Protocol Template](#) (266)

### **3.3.e Drug checking**

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. Depending on the method employed, drug checking can detect the presence of various psychoactive substances (e.g., fentanyl, benzodiazepine) and cutting agents in a sample (267). Drug checking can provide people who use drugs with information about potential drug poisoning risk and what substances are circulating in the local illegal drug supply, improve the ability to respond to drug poisonings, and increase awareness about drug poisoning risk (267–269).

Emerging evidence suggests that use of drug checking technologies may promote safer drug use practices. For example, one study from the United States found that 43% of survey participants who used fentanyl test strips on their own (outside the context of supervised consumption services) reported changes in drug use behaviour (270). The most commonly reported behaviour changes were using less drugs than usual and performing a test shot (i.e., injecting a small amount at first to gauge potency) (270). A recent study (268) conducted at Vancouver’s Insite showed that SCS participants accessed drug checking services in 1% of visits to the facility during the study period, and fentanyl was detected in drug samples in 80% of these 1121 visits. Furthermore, following a fentanyl-positive pre-consumption drug check, this study reported that 36% of participants indicated they planned to reduce their dose and 11% said they planned to dispose of their drugs. However, recent qualitative research from Vancouver examined perspectives of people who use drugs on a variety of drug checking technologies. Participants reported low willingness to use drug checking services due to not wanting to give up a portion of their drugs for testing, the time it takes to get results, the low accuracy of the tests, and their limited recourse if their sample came back positive for fentanyl (269).

Before implementing drug checking into a SCS, the benefits and limitations of drug checking technologies should be considered. Spectrometry is considered the gold standard due to its accuracy and precision, however equipment and operational costs associated with this technology

are high (271). Test strips may be a more cost-effective and lower-barrier option, but provide less information about the content of drugs and are less valid in detecting synthetic opioids (271). It is also important to consult with people who use drugs to assess the acceptability and feasibility of implementing this innovation in SCS settings. For example, a feasibility study in a Canadian setting found that people who use drugs prioritized confidentiality, accuracy, and usefulness of information (e.g., amount of contamination and effects of contaminants) when considering drug checking services (272). As of July 2023, 29 SCS in Canada provide drug checking as part of their service models (9).

### **3.3.f Integrating substance use treatment and safer supply programs within SCS**

SCS have been shown to increase uptake of substance use treatment, including withdrawal management services and addiction treatment, among people who use drugs who access the SCS facilities (31,32).

Service providers at SCS should be able to inform SCS participants about available substance use treatment options and assess SCS participants for willingness to access treatment. Importantly, honouring the needs and priorities of SCS participants is required to ensure person-centered care. SCS could either provide on-site treatment programs for substance use or establish strong referral pathways in their local area (where available) that SCS participants can access if they choose to, including:

- Addiction medicine specialist consultation;
- OAT;
- Addiction counselling;
- Ambulatory or outpatient substance use treatment programs;
- Inpatient and residential treatment programs;
- Recovery-oriented services including peer-support programs and other resources;
- Where indicated, withdrawal management programs that provide linkages to substance use treatment;
- Where relevant:
  - Youth-focused ambulatory and residential substance use treatment services,
  - Women-only ambulatory and residential substance use treatment services,
  - Indigenous ambulatory and residential substance use treatment services; and
- Housing (both harm reduction and abstinence-oriented models).

Additionally, link SCS participants to a family physician or integrated primary health care teams whenever possible. It is critical that conversations regarding substance use treatment with SCS



participants follow culturally safe and trauma-informed principles (see **2.2.b Relational practice, cultural safety, and trauma-informed care**).

### **Treatment - oral and injectable OAT**

OAT is medication-based treatment for people with opioid use disorder. OAT involves taking oral opioid agonists such as methadone, buprenorphine/naloxone (Suboxone), or slow-release morphine (Kadian) (273). In Canada, methadone or buprenorphine/naloxone are the most commonly available forms of OAT (274) and evidence suggests that both medications are equally effective (275,276). However, current Canadian clinical guidance recommends buprenorphine/naloxone as the first-line treatment given its advantages over methadone (e.g., reduced risk of fatal drug poisoning, less adverse reactions and drug-drug interactions, flexible take-home dosing) (274). Methadone is recommended to be considered for individuals responding poorly to buprenorphine/naloxone or with a preference for methadone, and slow-release morphine should be considered when both buprenorphine/naloxone and methadone are ineffective or contraindicated (274). However, concerns regarding limited effectiveness of OAT within the current toxic illegal drug supply (e.g., fentanyl) have some prescribers calling for induction protocol updates to achieve therapeutic doses more quickly in order to increase engagement and retention in OAT (277).

Injectable opioid agonist treatment (iOAT) is an evidence-based, cost-effective medical treatment for people with opioid use disorder who do not adequately benefit from oral OAT (278). In Canada, iOAT programs dispense injectable liquid hydromorphone or liquid diacetylmorphine. Both drugs have effectively the same clinical benefits (279,280); however, hydromorphone has been shown to have fewer side effects (oversedation or seizures) and is currently more readily available in Canada than diacetylmorphine. In a clinical trial comparing iOAT and methadone among a cohort of patients who had not previously benefited from methadone, those receiving iOAT showed higher treatment retention (88% vs 54% on methadone), reduced criminal activity and illegal drug use, and improved health and social functioning (279,281). Current Canadian clinical guidance recommends individuals self-administer iOAT medications via intravenous, intramuscular, or subcutaneous injection under the supervision of qualified health professionals (278).

In Canada, the integration of OAT within SCS is relatively common (282,283) and a few SCS have begun integrating iOAT programs within their service models. For example, Ottawa Inner City Health's managed opioid program has integrated iOAT within the context of supportive housing and a SCS (284), the RAH in Edmonton and the Dr. Peter Centre in Vancouver have also initiated participants on iOAT within their SCS (109,285). These facilities demonstrate that integrating iOAT within a SCS is feasible. However, there are a number of factors related to physical space, pharmacy access, and staffing that need to be considered (285).

If interested in integrating oral or injectable OAT within your own facility, consult the CRISM iOAT clinical guidelines (278) and operational guidance document of opioid use disorder (273) for detailed information on implementing these services.

### **Example of an iOAT program embedded within a SCS – Royal Alexandra Hospital**

The RAH's SCS in Edmonton supports an iOAT program for inpatients to access during their hospital stay, which began in-hospital in October 2018. Patients are evaluated for eligibility for iOAT by the hospital's addiction medicine consultation service. If eligible, patients attend the SCS at a predetermined appointment time (up to 3 times a day) and are provided pre-filled syringes of hydromorphone according to their individualized treatment plan. Patients inject under observation by a nurse in the SCS, which is required to reduce potential for diversion. Injection into the groin or neck is prohibited, and the patient must be able to self-inject. Patients remain in the site for 15-30 minutes post-injection for monitoring for drug poisoning or other adverse events. The SCS communicates with the community iOAT program to ensure successful bridging of patients, post-discharge.

The Albertan government announced that all provincial iOAT programs would close in March 2020 as they were ceasing funding for the programs (286). This prompted a legal battle (287) and the suspension of iOAT at the RAH SCS for both new and existing patients. In March 2021, the government announced it would continue to fund iOAT (288), and the RAH SCS resumed their iOAT program, but only to existing clients.

### **Safer supply**

In Canada, efforts to address the national drug poisoning emergency – which is largely being driven by an increasingly toxic illegal drug supply – have led to the development of 'safer supply' programs in some jurisdictions. Safer supply programs aim to provide people who use drugs with pharmaceutical-grade alternatives in known doses in an effort to reduce drug poisoning risk and other negative health outcomes (284). Safer supply programs were also developed as a potential strategy to address some of the current limitations of traditional agonist treatment programs, such as: high drug costs and limited availability of injectable formulations, rigid dosing requirements and missed dose protocol, urine drug screens, titration and home doses ('carries') limitations, and patient preference for preparing and injecting tablets (e.g., oral hydromorphone) rather than receiving pre-compounded syringes or oral medications (289–291). However, hydromorphone tablets have not been approved for injection use in Canada (292). In addition, while evidence supports the benefits of safer supply programs, some research indicates potential unintended harms, particularly when supplying oral tablets that people later crush up and inject (284). For example, this research suggests that injecting oral medications can increase the risk of skin and soft

tissue injuries, circulatory problems, and infections compared to pharmaceutical-grade liquid formulations (284).

It is also worth noting that safer supply programs are not considered treatment, and they allow participants to determine when (and often where) they consume drugs (293). Pilots of a variety of safer supply programs (involving various medications and both observed and unobserved dosing) are ongoing in Canada.

People with lived/living experience should be consulted when designing and implementing safer supply programs. There are many potential strategies for implementing access to pharmaceutical alternatives to illegal drugs within and outside of SCS settings. However, it is important that safer supply programs within SCS do not take away from requirements for participants using drugs from the illegal drug supply (e.g., ensure adequate room to respond to drug poisonings), who are at higher risk of drug poisoning and other harms associated with using drugs of unknown quality and toxicity.

Operators interested in theoretical and emerging safer supply models may wish to consult the following resources for more information:

- [BCCSU - Heroin Compassion Clubs](#) (294)
- [BCCSU - Risk Mitigation in the Context of Dual Public Health Emergencies](#) (295)
- [CAPUD - Safe Supply Concept Document](#) (296)
- [CRISM - Injectable Opioid Agonist Treatment National Clinical Guidance](#) (278)
- [CRISM - Injectable Opioid Agonist Treatment National Operational Guidance](#) (297)
- [CRISM - Medications and Other Clinical Approaches to Support Physical Distancing for People who use Substances During the COVID-19 Pandemic: National Rapid Guidance](#) (298)
- [Hales et al. - Safer Opioid Supply Programs \(SOS\): A Harm Reduction Informed Guiding Document for Primary Care Teams-April 2020 update](#) (299)
- [Health Canada - Toolkit for Substance Use and Addictions Programs Applicants](#) (284)
- [Young et al. - Characterizing Safer Supply Prescribing of Immediate Release Hydromorphone for Individuals with Opioid Use Disorder Across Ontario, Canada](#) (300)

### **Example of a safer supply program embedded within a supervised consumption service - Molson Overdose Prevention Site**

The Portland Hotel Community Services Society is piloting a hydromorphone tablet dispensing safer supply program at the Molson Overdose Prevention Site (MOPS) in Vancouver. In the MOPS program, people are dispensed 8 mg crushed hydromorphone tablets which they consume under the supervision of MOPS staff up to five times per day, with one hour minimum between doses (284,290,291,301). Participants prepare and consume the dispensed medication by their preferred

route of administration (of those allowed within MOPS). While outcomes research on the MOPS safer supply program is currently ongoing, preliminary qualitative research has documented a high willingness to access the program among structurally vulnerable people who use drugs (291), as well as self-reported decreases in the use of illegal opioids and engagement in criminalized income generating activities (291).

### **Treatment and safer supply for stimulant use**

Stimulant use and its associated harms have risen drastically in North America in recent years, yet have received significantly less attention than opioid-related harms (302). Unlike opioid use disorder, there is a lack of medication treatments available for stimulant use disorder (303). However, there is some evidence to suggest that the psychostimulants methylphenidate and dextroamphetamine may be appropriate treatments for methamphetamine use disorder (304,305). For people who use stimulants and opioids, iOAT programs have been able to help participants self-manage their stimulant use and promote improvements in their health and social wellbeing (306), and SCS offering iOAT programs therefore present an opportunity to engage with individuals using stimulants. Safer supply for stimulant use disorder is also limited (305).

### **Treatment and safer supply for inhaled drug use**

There is also an increasing drug poisoning risk for people who use drugs through inhalation (307), however available OAT and safer supply options cannot be smoked. In SCS where safer supply programs are provided, be mindful of the dynamics between participants who are and are not able to access a safer, more stable supply of substances and continue to advocate for the availability of safer alternatives that meet the needs of people who use drugs. It is important to provide appropriate services and supports to meet the needs of participants using stimulants (e.g., evidence-based psychosocial interventions) and/or inhalation (e.g., integrating inhalation into SCS, safer use education, sterile smoking supplies; see **3.3.b Considerations for non-injection drug use**).

### **3.3.g People who inject into high-risk areas on the body**

Injecting into the neck, armpit, hand, and groin present higher risk of harm than injecting into the arm. These areas are harder to see and veins in these areas are often larger, increasing risk of damage, serious circulatory problems, and life-threatening infections (308). Despite these risks, people who inject drugs use these alternative injecting sites for many reasons. For example, some people inject into the groin or neck because all other viable veins have been exhausted or choose to inject in the groin because it is convenient or considered a ‘sure shot’ (309,310). While some SCS have internal policies restricting what areas of the body injection is permitted, feasibility studies show that people who use drugs oppose rules prohibiting neck and groin injections (311,312) and Health Canada does not have specific rules on what areas of the body injection is permitted. It is

therefore important for SCS to be inclusive of participants who wish to inject into these high-risk areas. Tailored SCS services or resources for this group of people who inject drugs should include:

- Assisting groin and neck injectors to find other viable injecting locations, if they choose;
- Providing safer use education on high-risk injecting sites;
- Determine clear protocols when permitting assisted consumption (see **3.3.c Assisted consumption**); and
- Accommodations to help maintain privacy of participants injecting in intimate areas.

### 3.4 Security and the Safety of SCS Participants and Workers

As with any health service, it is important to ensure the safety and security of all participants, staff, and the service itself.

Drug poisonings can occur anywhere in a SCS (e.g., bathrooms, waiting rooms, consumption room). Therefore, proper visibility and monitoring of SCS participants at all times is critical to preventing drug poisoning deaths. Further, occasionally untreated mental health issues, adverse reactions to stimulants, withdrawal, or chaotic circumstances may lead to behavioural concerns for some participants. Such behaviours may place staff and other SCS participants at risk. While ensuring that services are as accessible as possible, the facility layout, staffing, training, and protocols need to minimize potential security issues and maximize safety.

Health Canada requires that the main doors of the SCS lock, site policies and procedures clearly indicate who is responsible for the distribution of security access control (e.g., keys, fobs), and a system is in place for recording entry and exit of SCS participants and visitors from the consumption area (313). While there are no other required physical or security specifications, consideration of the following features could be included in the planning process of SCS:

- Secure entrances and exits that ensure the ability to manage SCS participant flow (i.e., ideally all rooms would have two potential exits);
- Adequate lighting in all areas;
- Open layout for the drug consumption area with open sight lines so that all SCS participants and staff are always visible, and there is adequate space for drug poisoning response. If a person requires a privacy screen for injections in sensitive areas, preserve a sight line as much as possible;
- Video monitoring of entrances, exits, and drug consumption area (or a private/closed off consumption area) if appropriate (e.g., security, pandemic responses [e.g., to support physical distancing]) and in accordance with local privacy legislation/guidelines and the local community of people who use drugs;

- Use of mirrors in any areas not directly visible, including drug consumption booths, to monitor SCS participant activity and level of consciousness;
- Adequate ventilation to prevent second hand exposure to drugs that are heated prior to consumption and/or inhaled drugs if applicable;
- Personal protective equipment and infection control measures, such as gloves, aprons, gowns, masks, eye goggles, and sharps containers (please see your regional Occupational Health and Safety policies and procedures);
- Maintaining a minimum staff-to-client ratio to accommodate medically and physically safe environments, and SCS participant load;
- Ability to access back-up staff or security personnel, as necessary;
- Contingency plans in circumstances where SCS participants are refused service (see **5.6 Refusal of service**);
- Clear protocols outlining in what circumstances police are or are not allowed on site (e.g., when de-escalation procedures are unable to remove the threat of violence); and
- Clear protocols outlining the recording of serious incidents (e.g., serious occurrence and serious adverse events reporting), and how to monitor actions taken in response to incidents to prevent and/or mitigate further incidents.

Make SCS participants aware of the security features and any codes of conduct during their initial screening intake and emphasize that these features help to ensure the safety of both SCS participants and staff. Demonstration of adequate site security may also help to increase the confidence and buy-in of local stakeholders, such as police, policy makers, and community groups and partners.

Early consideration of insurance and liability matters are also important. Some new SCS operators have identified securing appropriate liability insurance as being a barrier to opening a site. SCS that are hosted by an organization or have support from the provincial/territorial government may be able to secure insurance through these channels, but the extent of liability insurance needs to be determined in consultation with the host organization. Some sites require a waiver of release from liability to be signed by SCS participants before using the site.

### **3.4.a Safer washrooms**

Even when implementing SCS, it is imperative that operators acknowledge that drug use may occur in washrooms (314). Making SCS washrooms safer to prevent drug poisonings or other substance use related harms within the washroom stalls or area is required (314). Below, we outline staff actions and physical components of the washrooms for consideration when designing safer washrooms.

### **Staff actions to create safer washrooms**

- Always being aware of when the washroom is in use, and knowing how to gain entry to a locked washroom in the event of an emergency;
- Develop protocols for regular washroom check-ins, including how frequently staff should check in with a participant in the washroom and at what point should staff enter the washroom (to maintain participant privacy, check-ins should only include knocking on the door/speaking through the door and staff should not enter the washroom unless an emergency is suspected);
- Develop protocols for responding to an emergency in the washroom;
- Ensure SCS participants are aware of safer washroom protocols and practices (e.g., by posting the protocols in the washroom); and
- Be mindful of where sharps may be placed or discarded and be careful of these areas when cleaning the washroom.

### **Physical components of a safer washroom**

- Install accessible and tamper-proof sharps containers inside the washroom;
- Ensure washrooms have adequate lighting;
- Maintain emergency response supplies (e.g., naloxone, oxygen, etc.) in or near washrooms;
- Ensure staff are able to open washrooms doors in the event they need to respond to an emergency (e.g., installing doors which unlock after a fixed period of time) and that staff are always aware when washrooms are in use (e.g., installing washroom doors that leave a space between the bottom of the door and floor that is small enough to not compromise participants' privacy but large enough that staff can tell if the washroom is in use or if a participant has fallen (315));
- Ensure all washroom doors are outward facing (in the event someone falls down, they cannot block staff from entering and responding);
- Install anti-motion sensors (e.g., sensors which sound an alarm or other signal upon detection of no motion for a period of time) (316);
- Install an intercom system to allow communication between participants and staff (315);
- Provide a flat space (e.g., counter space, table) for people to place their belongings;
- Install an emergency call bell that is accessible from the ground in the event the participant has fallen (e.g., attached to a string) (315);
- Ensure there is sufficient space between the walls and toilet (e.g., to prevent someone from falling and getting stuck in the event they lose consciousness); and
- Consider the advantages and disadvantages of designing single occupant or multi-stall washrooms (e.g., single occupant washrooms offer more privacy for SCS participants but

may lead to a delayed response during a check-in if no one is around to immediately witness the emergency) (315).

Operators wishing for more information on safer washrooms can consult the following resources:

- [Buchheit et al. - “Opening the door to somebody who has a chance.” – The experiences and perceptions of public safety personnel towards a public restroom overdose prevention alarm system](#) (317)
- [Migliardi - Safer Washroom Evaluation](#) (314)
- [University of Victoria - The Safer Bathroom Toolkit](#) (318)
- [Vancouver Coastal Health - Overdose Prevention & Response in Washrooms: Recommendations for Service Providers](#) (315)



# 4.0 Description of Local Conditions

## 4.1 Determining Need

Health Canada requires prospective operators requesting a SCS exemption to share information on local conditions in the community that can be used to identify unmet health needs. Therefore, prior to planning or designing a SCS, it is important to assess and understand the local context of drug use and services for people who use drugs. As part of this process, operators should consider the following questions (in addition to the other factors discussed in the document):

- Who is the target SCS participant population? How large is this group?
- What are the needs of local people who use drugs?
  - What are the drug use trends of the target SCS participant population (e.g., type of substances, frequency of substances, mode of consumption)?
  - What is the current rate of drug poisoning deaths? What is the current rate of Emergency Medical Services (EMS) calls for drug poisonings? What is the quality of the current illegal drug supply?
  - Is there evidence of under-addressed drug-related harms (e.g., injection-related infections, rates of HIV or HCV)?
  - Are many local people who use drugs consuming drugs in public or semi-public spaces (e.g., restrooms)? Is there a concern about improperly disposed syringes or other drug use equipment in the area?
  - Are there specific (sub) groups of people who use drugs who do not access existing services or referrals? What are the barriers/challenges that these program participants face in accessing these services or referrals?
- Are local people who use drugs willing to use a SCS?
- What is the optimal design and distribution of SCS to meet local needs?
- What other key stakeholders need to be consulted to ensure the program's success?

All kinds of data are acceptable but when available, quantitative descriptions are considered to be higher quality than qualitative for the purposes of securing a SCS exemption. The Local Conditions section in Health Canada's application is also where prospective operators may elaborate on local crime rates or trends, and the expected impact of a SCS on community or neighbourhood crime. When indicated, applicants are expected to identify mitigation strategies to address possible negative impacts of SCS on public safety, such as measures to ensure the appropriate disposal of

used drug use equipment outside the SCS premises. These measures could be related to the physical building or property (e.g., sharps disposal boxes), the neighbourhood (e.g., public contact information dispersed to community associations, outreach staff connecting with participants), or municipal services (e.g., outreach or syringe disposal teams in the community).

SCS feasibility assessments in the local context may be useful to answer these questions. It is possible to conduct a small-scale assessment on limited budget and time. To ensure adequate engagement of people with lived/living experience of drug use, involve local people who use drugs in the planning and execution of such feasibility work, as has been done successfully in the past (46,319). A feasibility assessment can help strengthen operators' rationale for opening a SCS and past research has shown that expressed willingness to use a SCS predicts future use of a SCS (320). Such work may also shed light on issues that operators have not anticipated. For instance, the operators may discover that local people who use drugs are not interested in consuming drugs under the supervision of trained staff, but are open to carrying naloxone (medication used to reverse an opioid poisoning). This finding can help operators better channel their resources into developing and/or expanding community-based naloxone training programs or other services. If there is a local drug users' group, it may be an excellent community partner for designing and conducting this feasibility assessment. Please see **2.1 Centering the perspectives of people who use drugs** for details on best practices for involving people who use substances in the SCS feasibility assessments.

#### **4.1.a Community consultation and engagement best practices**

Community consultation requirements may challenge efforts to establish SCS (125). However, Health Canada requires evidence of consultation as part of the SCS exemption application process, but 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. Relevant stakeholders will vary according to local context and the SCS model proposed, but could include community partners and other health and social service providers, nearby businesses, police, neighbourhood associations, and residents. During consultation, it is imperative to communicate the public health benefits of SCS and that the goal is to identify potential issues or concerns and strategies to mitigate them.

Common issues identified by stakeholders that could be addressed during community consultation include the goals and functions of SCS (e.g., drug poisoning prevention, safety, reduction of public drug consumption, provision of harm reduction education); concerns regarding the location, rules and regulations of the SCS; and suggestions for change (321). The following are examples of

community engagement and consultation actions that can be undertaken to meet Health Canada's requirements and successfully integrate the SCS into public health and health care services as well as the broader community:

- Create a Community Advisory/Liaison Committee (CAC) to provide an opportunity for ongoing communication and collaborative problem-solving on issues or misunderstandings that may arise related to SCS operations. The CAC could consist of key stakeholders, which may include representatives of key staff at proposed location, local Business Improvement Association or Chamber of Commerce, local police department, local health and social service organizations, local hospitals, local businesses, local housing complexes, local Indigenous organizations, communities, and nations, local residents, advocacy groups for people who use drugs, and/or groups of people who use drugs, as appropriate. Which stakeholders to include depends on the unique context and goals of the proposed SCS. It is important to recognize that who is invited to participate in the CAC will affect the quality of trust people who use drugs invest in the SCS.
- Develop a tour plan for the proposed location, including a walkthrough of proposed service locations, such as the waiting area, consumption area, and post-consumption area. May also consider developing a sketch of the location's proposed SCS space (if area bears some additional description). Invite key stakeholders and media to tour the space.
- Develop Frequently Asked Questions sheets and other informational resources, which may include background information on SCS, the demonstrated need for SCS in the area, the proposed SCS model, the timeline for the SCS, the anticipated benefits of implementing the SCS and how they meet the vision for the neighbourhood, and common myths associated with SCS. Provide resources in a variety of different mediums (e.g., hard copies, websites, mailed flyers, telephone hotline) to ensure diverse and equitable distribution and access to the information.
- Prevent the development of anticipated issues such as discarded needles and syringes by organizing the distribution of sharps containers and cleaning up of drug use supplies in the neighbourhood. This can be aided through risk and needs assessments.
- Offer harm reduction education sessions with neighbouring agencies, residents, and interested groups in the community.
- Start small (e.g., one-on-one meetings, focus groups) and increase efforts and capacity (e.g., community workshops, open houses, education forums, online surveys, information sessions, door-to-door canvassing) to ensure concerns can be addressed before wider dissemination.
- Keep engagement with the community open after the SCS is implemented (e.g., including a telephone number, email, and/or comment box on the SCS website for feedback).

The consultation report submitted to Health Canada needs to describe all activities undertaken, all comments and feedback received, and measures taken or in progress to address any concerns.

Note that letters of opinion from a provincial or territorial Minister of Health are considered but not required for SCS exemption applications to Health Canada. While community concerns may not change even with ample consultation, it is important that service access and health benefits are prioritized throughout the design, implementation, and operation of SCS (322).

According to Health Canada, the exemption application can be submitted for review prior to the completion of the community consultation and the police record check for the RPIC. Considering the length of time the approvals can take, it is advised to submit the application prior to completing and submitting the community consultations and police record check, as these tasks can require a large amount of time.

## 4.2 Defining Overall SCS Goals

Once the local context is understood, define the overall goals, targets, and outcomes for implementing a SCS. The goals and outcomes need to be in line with local service needs (with the input of people who use drugs in the area and communities affected by drug use), as well as achievable with available resources. Undertaking this conceptual work can help operators clearly establish a rationale for the facility, map the range, scope and scale of services they will offer, and more effectively channel their resources.

In relation to their target SCS participant population, operators may consider any number of the following potential goals:

- To reduce rates of drug poisoning-related harms (e.g., ambulance calls, hospitalizations, deaths);
- To reduce rates of drug-related transmission of blood-borne infections among people who use drugs (i.e., HIV and HCV);
- To decrease the rates of acute health complications that are related to injection drug use (e.g., soft tissue infections, infective endocarditis or myocarditis);
- To improve uptake of, and access to, health and social services among people who use drugs;
- To improve knowledge and uptake of, and access to, harm reduction practices and services amongst people who use drugs;
- To improve knowledge and uptake of, and access to, drug treatment services, including a range of OAT programs (including iOAT) and recovery-oriented programs amongst people who use drugs;
- To reduce drug use in public or semi-public spaces, including inappropriately discarded drug use equipment and related litter;
- To facilitate social inclusion and connection among people who use drugs; and

- To combat stigma.

Keep in mind that the goals and aims of their facility may change over time, in accordance with funding and staffing, as well as changes in the needs of the SCS participants, local service networks, and local drug scene.

# 5.0 Policies and Procedures

## 5.1 General Policy Documents to Consider

It is important for operators to establish clear procedural protocols and policies regarding SCS, as well as the role of each staff member who is authorized to provide supervision and/or clinical support in these spaces. Health Canada's SCS website provides further guidance to support prospective operators in the drafting of their site-specific policies and procedures. Health Canada requires the following policies to be included with SCS applications:

- Roles and responsibilities of staff members, including training requirements (e.g., RPIC, alternate-RPIC, training logs, etc.);
- Response to unidentified substances left behind on premises (i.e., methods of containment, storage, record keeping, preventing their loss or theft, and notification of local police department for removal), including record-keeping and reporting forms;
- Security measures to minimize risks to health, safety, and security of all persons at the site (e.g., entry/exit log; Code of Conduct; floor plan showing physical security features, exits, etc.); and
- Procedures for drug checking, assisted consumption, and splitting/sharing of drugs (if applicable).

The following policies and procedures are not required for application submission but attestation that they exist and are operational is required on the form:

- Disposal of sharps and biohazardous materials (including how it is removed from the premises); and
- Consideration of provincial or territorial government guidance on establishing a SCS, if any.

Typically, protocols and policies also address the following:

- Participant inclusion criteria, intake, registration, and assessment for acute toxicity and specific health care needs, such as vein care, abscess management, sepsis from soft tissue injuries, and other symptoms;
- Drug consumption room(s) procedures, including provision of equipment;
- Needlestick injury protocol;
- Safer consumption and harm reduction education;
- Provision of naloxone and associated training;

- Post-consumption care procedures (e.g., assessment for signs/symptoms of soft tissue injury and medical emergencies);
- Treatment/clinical room procedures for abscesses, cellulitis, vein care, infection, and other healthcare needs;
- Drug poisoning response;
- Responding to pregnant, breastfeeding, under-age, overtly aggressive or intoxicated participants, and SCS participants who are on OAT or consuming alcohol concurrent to drug use;
- Cleaning protocols and infection prevention and control measures;
- Staff use of SCS to consume illegal substances on or off shift; and
- How to respond to emergency situations (e.g., weapons, bomb threats, emergency evacuation plans).

The protocols and policies may involve step-by-step procedures, documentation (e.g., charts, or electronic records), and referral pathways within the facility or outside the facility if the service is in another organization.

### **5.1.a Notifying Health Canada of changes to procedures and policies**

SCS operators are required to notify Health Canada (by emailing [exemption@hc-sc.gc.ca](mailto:exemption@hc-sc.gc.ca)) if:

- There is a death at the SCS related to activities involving illegal substances (notification must occur within 24 hours of the death);
- The SCS was closed for longer than 24 hours (notification must occur within 48 hours of closure);
- The SCS no longer provides drug checking services, or allows peer assistance or drug splitting/sharing, as applicable (notification must occur within 48 hours of this change); and
- There are any changes to security measures or procedures or policies that could lead to an increased risk of public safety and security (notification must occur within 10 working days of the effective date of the changes, and include a description of the revised security measures and a copy of the revised procedures and policies).

## **5.2 Code of Conduct/Rights and Responsibilities**

In order to ensure safety of SCS participants and staff, establish a code of conduct or “house rules” that outline the rights and responsibilities of SCS participants and staff. It is recommended that operators develop the code/rights and responsibilities in consultation with SCS participants to ensure that people who use drugs are active participants in their own harm reduction practices and to build rapport between the facility and local people who use drugs. Developing these policies with

people who use drugs may also help to avoid potential harms, such as being banned from the service, and helps ensure that such policies do not seem external or arbitrary. Codes/rules need to be clearly communicated to SCS participants; common methods of communication include verbal or written acknowledgement during the registration process and posters clearly posted in the SCS. Codes/rules that are required by federal exemption guidelines include:

- Restricting drug consumption to specifically designated areas of the SCS;
- Specifying which routes of administration are and are not allowed at the SCS (e.g., injection, oral, inhalation, intranasal, rectal);
- Prohibiting selling or trading drugs on site;
- Requiring participants to maintain possession of their own drugs at all times, unless engaging in assisted consumption and/or drug splitting and sharing (if either are applicable to the SCS);
- Prohibiting staff from providing illegal drugs to SCS participants; and
- Prohibiting staff from taking control or possession of illegal drugs at any time, other than in instances of drug checking conducted by staff or drugs left behind (where drugs must be stored in a locked cabinet and local police department to be notified and asked to remove the substance).

In addition to those required by federal exemption guidelines, the following code/rules may be useful:

- Prohibiting staff from providing SCS participants information on where or how to obtain illegal drugs;
- Depending on the individual context and capacity of the SCS, as well as SCS participant needs, the amount of time SCS participants can use drug consumption rooms/booths in one sitting may be applied (e.g., 30-45 minutes);
- Prohibiting loud or offensive language and threatening or intimidating staff and other SCS participants;
- Requiring SCS participants to clean up their consumption area after using in the consumption space and to dispose of used materials in designated disposal receptacles;
- Encouraging SCS participants to help keep the facility clean;
- Reminding SCS participants and staff that SCS participants are entitled to non-judgmental service from staff and a clean, peaceful environment in which to consume drugs; and
- Reminding SCS participants and staff that staff reserve the right to refuse service if the SCS participant does not meet the eligibility criteria (see **5.6 Refusal of service**) or does not adhere to house code/rules.



## 5.3 Eligibility and User Agreement

The first interaction with new SCS participants is an opportunity to establish rapport and trust with SCS participants within a welcoming environment. Appropriate forms and written protocols (e.g., user agreements and consent forms) for intake procedures for first time participants to an SCS could include:

- Screening for eligibility (according to site policies);
- Informing the SCS participant about services offered and hours of operation, and introducing the SCS participant to SCS staff (as appropriate);
- Informing the SCS participant about expectations, rules, and protocols for using SCS (see **5.2 Code of conduct/rights and responsibilities** for examples);
- Informing the SCS participant about their rights and responsibilities when using SCS (see **5.2 Code of conduct/rights and responsibilities** for examples);
- Informing the SCS participant about any data collection for monitoring, evaluation or research purposes, as well as appropriate ethical considerations; and
- Assessing the SCS participant for any need for specific physical care, their knowledge of harm reduction techniques and ability to apply these to drug use, as well as their knowledge of harm reduction services

## 5.4 Pre and Post-Consumption Procedures

Clearly map out the SCS participant's footpath when accessing the SCS. For each of the steps listed below, it is important to consider where the step will take place in the facility, which (and how many) staff members will be involved, what the staff's responsibilities and roles are, and what the appropriate procedures and protocols (including documentation) are:

- Intake/assessment and waiting area;
- Drug consumption room(s);
- Harm reduction/safer consumption education;
- Disposal of drug consumption equipment;
- Treatment room (for basic nursing/medical care and responding to drug poisoning); and
- Post-consumption area.

In addition to consumption-specific procedures, consider the appropriate staff member to provide ancillary services, such as counselling, peer support, and referrals, and the number of hours they will be available, based on the needs of SCS participants

## 5.5 Conflict Management

There may be instances where SCS staff are required to respond to a crisis situation and/or aggressive behaviour by a SCS participant. Each situation will be unique and all facility staff need to be trained in crisis management and de-escalation techniques, as well as relational practice, cultural safety, and trauma-informed care (see **2.2.b Relational practice, cultural safety, and trauma-informed care**) to ensure the safety of all SCS participants and staff.

## 5.6 Refusal of Service

SCS are often a safe space for people who use drugs and conflict is typically resolved without incident; however, SCS may reserve the right and obligation to refuse service if the staff deems that drug consumption will potentially put the SCS participant in danger to themselves or others, if the SCS participant does not adhere to the code of conduct or house rules, if the facility is full, or for other reasons pre-determined by the facility operators. Only refuse services in exceptional circumstances and prioritize the prevention of invoking this policy as much as possible. The intent of refusal of service should be used to balance the rights, safety, and wellbeing of the individual being refused service with other SCS participants, staff, and the community at large.

If a SCS must refuse service, ensure that this is done in a low barrier manner. This means instituting a refusal of service process that is uncomplicated (e.g., minimizing the need for paperwork) and is non-punitive. Refused participants should be made aware of other options for safer drug consumption.

Take a culturally-safe and trauma-informed approach to harm reduction to ensure that structures (e.g., policies and laws) that inform drug-related harms are not being upheld (88) (see **2.2.b Relational practice, cultural safety, and trauma-informed care**). Developing a trusting relationship with the participant may mitigate the need to refuse service due to behaviour.

When designing SCS facilities, be mindful of the demand for services in the local area to minimize refusal due to operational constraints (88) (i.e., site capacity, mode of consumption). Ensure policies support access of the most structurally vulnerable SCS participants (e.g., those who need assisted consumption, youth, women) rather than limit access due to their unique needs (see **3.3.a Considerations for key populations**).

Refusal of service policies should:

- Be established in partnership with people with lived/living experience;
- Be applied consistently for all SCS participants, across all SCS staff;
- Employ a culturally-safe and trauma-informed approach to refusing service;

- Outline a clear procedure that indicates why, when, and how a participant would be asked to leave, as well as the steps to regaining access;
  - Facilities may wish to pre-develop an individual behaviour plan mutually with some participants as a form of shared decision making, which may include identified positive behaviours, challenging behaviours, specific date of return, participant feedback, overview of the participant’s needs, and options to increase their safety while away from the facility. Clearly communicate this plan to all staff;
- Determine the length of refusal through shared-decision making with the SCS participant;
- Give participants the ability to appeal their refusal of services and the length of time they are being refused the service;
- Be clearly outlined and communicated to all participants and staff (see **5.2 Code of conduct/rights and responsibilities**); and
- Include tracking and analyzing data on refusal of services (e.g., monitoring rates, shifts, times of the month) to understand, monitor, and tailor refusal of service policies to minimize the impact of these policies.

## 5.7 Drug Poisonings

Given the unregulated drug supply, SCS operators must have clear, predetermined protocols and policies to deal with potential drug poisonings. These protocols and policies will need to meet local legal or regulatory requirements, and therefore may differ between jurisdictions. The protocols and policies should be living documents and developed by individuals well versed on SCS operations. These could address:

- Staff education and training including,
  - Keeping up to date with current local drug trends,
  - Complex drug poisoning response training such as in the case of combined benzodiazepine and opioid use, or medical complications (e.g., fentanyl-induced muscle rigidity, cocaine-induced psychosis);
- Drug poisoning response equipment (e.g., personal protective equipment, bag-valve-mask, oxygen tank and tubing) and equipment maintenance (e.g., checking for expiry dates, filling oxygen tank);
- Drug poisoning intervention procedures;
- Assessment procedures;
- Manual ventilation;
- Drug poisoning reversal and medication administration policies, and medical directives (i.e., oxygen, naloxone hydrochloride);
- Responding to cardiac and/or respiratory arrest;
- Responding to a stimulant poisoning;

- Procedures for transferring care to paramedics and emergency departments, including when to call EMS or police services, what specific information to provide to dispatchers, and how to prepare for their arrival on site; and
- Be trauma-informed, and acknowledge and minimize the effects of opioid withdrawal.

Ensure that all staff members are sufficiently trained to provide responses to drug poisonings. Protocols and policies should also be developed for other medical emergencies (e.g., seizures, strokes, heart attacks).

# 6.0 Personnel

## 6.1 Staffing Models

Operators will need to consider the number and type of staff who are involved in providing SCS, in accordance with the services offered, the facility's budget and capacity (i.e., the number of consumption booths and the number of people attending at one time), and scope of practice and regulations outlined by professional bodies. Although many SCS employ nurses or other healthcare professionals, there is no requirement to include healthcare workers in the SCS staffing model. For all staff, outline the roles and responsibilities, workplace safety protocols, policies, and procedures regarding the following:

- Minimum staffing levels, skill-sets, competencies, and training required to carry out duties while maintaining a safe environment, supporting job satisfaction, and preventing burn-out;
- Clear guidance on principles, resources, and structures for delivering evidence-based SCS;
- Clear guidance for health professionals regarding scope of practice and competence to be used as part of the SCS from appropriate professional regulatory bodies/colleges for physicians, social workers, nurses and other regulated health professionals,
  - Operators may also consult the International Consensus Statement on the Role of Nurses in Supervised Consumption Sites (73). This 2019 statement included input from 17 experts from 10 countries with SCS. The document was created with the intention that it would inform decision-makers and employers about the role of nurses in SCS;
- Adherence to relevant legislation and regulations as applicable (e.g., provincial Health Professions Acts, Hospital Acts, Public Health Acts, etc.);
- Health and safety for SCS participants and staff (e.g., non-violent crisis intervention, universal precautions for blood-borne pathogens, needle stick injuries);
- Compliance with regional Occupational Health and Safety policies and procedures and emergency and/or disaster (e.g., fire, bomb threat, earthquake) preparedness and response;
- Compliance with other relevant regional, provincial, federal policies and/or legislation;
- Cultural safety (78,101), attention to social determinants of health, and reduction of stigma; and
- When designing the staffing model for a SCS, balance budgetary concerns with SCS participant safety and risk management, particularly in relation to possible drug poisoning events and other emergencies.

Though staffing models will change based on objectives and target population, typically people involved in the operation of a SCS may include some combination of nurses (e.g., registered nurse, licensed practical nurse), social workers, paramedics, harm reduction/outreach or peer support workers, mental health workers, counsellors, physicians, and volunteers.

Hiring people with lived/living experience of substance use into these staffing roles is standard. Employees with lived/living experience have specifically been identified as important within SCS, with past feasibility work indicating that most people who use drugs prefer having employees with lived/living experience present within supervised consumption services (319), and that their involvement increases feelings of comfort among people who use drugs (59). Employees with lived/living experience can engage with SCS participants to provide education, relationship building, and support, and other health and social services depending on their training. Though some staff may have lived/living experience, position titles should be reflective of their duties and not solely their lived/living experience to avoid class distinction between ‘professional’ and ‘peer’ role. In addition, it is important to provide an opportunity for staff with lived/living experience to shape their own title, as some may prefer a ‘peer’ title while others may not. It is also important to ensure equitable working conditions and equitable compensation for employees with lived/living experience, including providing equivalent pay and benefits (including physical and mental health supports), full-time equivalent positions, and advancement opportunities as provided for ‘professional’ employees.

Federal policies do not require the presence of licensed healthcare professionals to operate a SCS. If the employees supervising consumption are not regulated health professionals, such as harm reduction or outreach workers, Health Canada requires details outlining extra training that will be provided to these personnel, including drug poisoning response training. Nurses or other healthcare professionals may also staff the site to provide emergency care, injection-related skin and wound care, conduct pre-and post-consumption assessments, and initiate referrals to other health and social services where appropriate. Also, where appropriate, engage Indigenous Elders, traditional healers, and liaisons at various levels of service and care delivery, including the design of the SCS. All providers in the SCS site should receive training in basic health and safety for SCS participants and staff.

There is a large variety in staffing models in existing SCS, depending on community needs, and the size and resources of the SCS. Determine your staffing model based on what works best for the local context (e.g., the size of the SCS and the operators’ goals and desired outcomes), including number of staff, staff hours, and staffing mix.

## 6.2 Staff Training, Retention, and Safety

Like other healthcare settings, SCS can be challenging environments to work in and it is important to pay special attention to staff training, retention, and safety. Also, at times, the demanding nature of SCS work and ongoing precarious funding can contribute to difficulties with staff retention.

Staff training can be resource intensive; however, it is important to implement a thorough training program and staff supports to ensure the wellbeing and safety of staff and increase retention. Further, operators may consider the following supports (note that this list has been adapted from a document developed by the Dr. Peter AIDS Foundation (323)):

- 1) Implementing processes and protocols to support the emotional wellbeing of SCS staff:
  - a. Regular debriefing and individual meetings to help support resiliency, especially after emergency or stressful situations,
  - b. Use emergency situations as learning and education tools for staff,
  - c. Having counselors on site as needed;
- 2) Providing capacity building opportunities to support staff skill sets:
  - a. Employing people with lived/living experience of substance use can help to destigmatize staff-SCS participant interactions and conversations around drug use as well as ease staff responsibilities,
    - i. Support and training are particularly important for medical staff who may not have as much experience working in community-based settings; and
- 3) Additional training/capacity building for staff with lived/living experience:
  - a. Clearly communicate the roles, responsibilities and expectations of all staff,
  - b. Ensure support is available (e.g., regular meetings and check-ins), and
  - c. Have additional conversations about boundary setting and confidentiality with staff with living experience who may have a dual role of SCS staff and SCS participant, and/or may have existing relationships with SCS participants, particularly those staff who do not have experience working in formal organizations or services.

# 7.0 Funding Sources

Although the Federal Government is responsible for exempting SCS under the CDSA, it does not currently provide funding to support implementation or ongoing operations. In Canada, SCS operators are required to secure their own funding, typically from provincial/territorial governments, municipal governments, health authorities and/or from private sources (e.g., private donations). The government will not approve a SCS without a description of the financial plan and funding that will be in place. Suggested attachments include:

- Financial statements or audits for the organization(s) applying;
- Documentation confirming sources of funds (private and/or public);
- Confirmation of funding commitments; and
- Budget proposals, including proof of financial support.



# 8.0 Reporting and Evaluating

## 8.1 Collecting Data to Fulfill Health Canada and Funder Reporting Requirements

Reporting aggregate demographic and SCS program statistics may be required by Health Canada, provincial/territorial governments, and/or funders. Health Canada requires that all data be maintained on site for the duration of the exemption and be available upon request. Internally, SCS operators may choose to use these reports for monitoring and quality improvement; operators can assess these trends to modify their services to meet the needs of SCS participants. However, the usefulness of these reports depends on the resources available for data collection and analysis, and will vary between different sites. It is, however, important to collect the least possible amount of personal information from SCS participants.

Health Canada and funders will identify their data reporting requirements, which may be standard to a given jurisdiction or unique to each SCS. Common data elements currently collected and typically reported monthly by existing SCS include:

Visit Level Data	
Data Element	Notes
Date of visit	
Time of visit	
SCS participant identifier	Identifiers are anonymous and may be constructed by using participant initials or handle and date of birth. Using these may help SCS participants remember their identifier more easily (see <b>8.1.a Government issued identification and personal health numbers</b> ).
SCS participant's first name or handle	This is the name that the SCS participant prefers to be called by staff in the SCS.
Drug(s) consumed during visit	SCS participants may consume more than one drug per visit.

Route(s) of consumption	Current options include intranasal, oral, inhalation, and/or injection, depending on the routes included in the section 56.1 exemption. SCS participants may use more than one method per visit.
Reason why SCS participant did not consume	Include reasoning why the SCS participant did not consume drugs during the visit if applicable (e.g., could not find a vein, wait time too long, etc.)
Drug poisonings	Include information about the event and response: drug poisoning type (e.g., opioid, stimulant); drug that precipitated the poisoning; typical or atypical presentation of the drug poisoning; poisoning response (e.g., oxygen or naloxone (including amount) provided, other treatment); whether EMS was called, if they responded, and whether they transferred the SCS participant to the hospital; whether the drug poisoning was fatal or non-fatal; whether any other medical emergencies occurred.
Non-drug poisoning intervention	Include what drug(s) the participant consumed; whether the SCS participant required monitoring or oxygen administration (without experiencing a drug poisoning); whether any other interventions were provided to the SCS participant.
Other medical emergency	Include what medical emergency occurred; what interventions were provided to the SCS participant (e.g., oxygen); whether EMS was called; whether EMS responded to the emergency; whether EMS transferred the SCS participant to the hospital.
Services provided to SCS participant	Include what staff provided to the SCS participant (e.g., harm reduction education, addiction counselling, snacks, first aid, etc.)
Internal and external referrals provided to SCS participant	Include any connections to other service providers that staff provided to the SCS participant (e.g., iOAT, addiction counselling, community physician, etc.). These service providers can be within the SCS, in the same building as the SCS (if integrated), or off-site.

Law enforcement	Include whether police were called to address a situation.
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\* NOTE: For each of these data elements, classify nonresponses or missing data as Unknown or Other. Also, Health Canada or a funder may request that the data be categorized by day, week, month, or unique SCS participant (e.g., How many first-time participants attended the SCS this past month?).

**Other visit-level site-specific data that other SCS have collected, as applicable:**

<b>Other Visit Level Data</b>	
<b>Data Element</b>	<b>Notes</b>
Peer assistance	At the minimum, report peer-assisted consumption as a subset of the total number of consumption episodes. SCS may also choose to separately report all data elements for peer-assisted consumption vs. non-peer-assisted consumption.
Drug checking	Capture: <ul style="list-style-type: none"> <li>i) the number of drug checks performed,</li> <li>ii) the results of the drug check (was the drug what the SCS participant thought it was?), and</li> <li>iii) did the check influence the SCS participant's behaviour (did they change anything about their consumption?)</li> </ul>
Splitting and sharing	At the minimum, report splitting and sharing as a subset of the total number of consumption episodes. SCS may also choose to separately report all data elements for splitting and sharing vs. no splitting and sharing.

\* NOTE: For each of these data elements, classify nonresponses or missing data as Unknown or Other.

The following SCS participant-level data could be collected upon first visit and updated as necessary to ensure that the space is welcoming and culturally safe for those who use it:

<b>SCS Participant Level Data</b>	
<b>Data Element</b>	<b>Notes</b>
Age	Age upon first visit will suffice, there is no need to track change in age.
Gender	e.g., “Do you identify as male, female, or other?” or “Do you identify with the 2SLGBTQIA+ community?”
Ethnicity (see the Canadian Institute for Health Information’s guidance document on standards for ethnicity-based data collection (325))	e.g., “Do you identify as Indigenous, white, etc.?”

\* NOTE: For each of these data elements, classify nonresponses or missing data as Unknown or Other. Some of these questions may be sensitive and may need to be modified as appropriate.

### **8.1.a Government issued identification and personal health numbers**

Many people who use drugs prefer to use supervised consumption services anonymously and oppose registration policies (47,325–328). Participants are not required by Health Canada to verify their identity as a condition of accessing SCS under a section 56.1 exemption. In order to protect participant anonymity and privacy, use non-identifiable participant user names and pseudonyms (e.g., participant handles). Asking for, or requiring, government-issued identification or personal health numbers (PHNs) is widely-recognized as a major barrier to care for people who use drugs (312). People who use drugs are often skeptical of the legal protection provided by supervised consumption services and report fears that accessing supervised consumption services will lead to interdiction from police (102,329–332). This causes apprehension about sharing identifiable information with SCS service providers out of fear that this information may be disclosed to police or other officials without their knowledge or consent. Under provincial law, hospitals in Alberta can only deliver clinical care to registered patients. As a result, the RAH SCS records PHNs to confirm patient registration. However, hospital patients in this setting cite this requirement as a major barrier that deters a subset of patients from accessing the SCS (329).

In September 2021, the government of Alberta stipulated that SCS be required to collect PHNs at all SCS, arguing that collecting PHNs is standard practice for health services (333). While this prompted an emergency injunction application to be filed and the regulation delayed until January 2022, the

Court of Queen’s Bench of Alberta (334) and later the Alberta Court of Appeal (335) upheld the decision to collect PHNs. In February 2022, the government of Alberta delayed the requirement again until April 2022 to be in compliance with the Health Information Act (333). Plans to continue challenging the policy in court are ongoing (325).

The new regulation and legal proceedings in Alberta have raised human rights concerns and calls for SCS not to require government issued identification or PHNs. It is crucial that SCS do not require government issued identification or PHNs, unless legally required to under their respective jurisdictions. Even if refusal to provide PHN or other identification does not result in exclusion from SCS, simply asking for PHNs is likely to heighten concerns that SCS staff are collaborating with police or that police are accessing SCS records, and will likely deter people who use drugs from accessing these services. Prior research has documented that many people who use drugs are unwilling to engage in other life-saving health services due to fears that it could potentially lead to their arrest and incarceration (326,327).

## 8.2 Data to Collect to Facilitate the Provision of SCS Services

Operators may consider collecting additional program data that Health Canada or funders will not routinely ask to be included in their reports. This information can be helpful for ensuring the safety of SCS participants and facilitate staff in providing personalized care for each participant. Potential data elements that may be useful for SCS provision include:

<b>Visit Level Data (<u>NOT</u> for reporting)</b>	
<b>Data Element</b>	<b>Notes</b>
When was the last time you used?	Ask at the beginning of each visit.
What did you use?	Ask at the beginning of each visit.
What drugs do you plan to use today?	Ask at the beginning of each visit.
Have you experienced drug poisoning since you last visited?	e.g., “Have you experienced drug poisoning in the last 24 hours? ”
Have you recently had a break in use?	e.g., “Have you recently gotten out of jail or been in detox or the hospital?”

Other data elements that may facilitate staff in identifying potential resources that may be useful to the SCS participant include:

<b>Visit or SCS Participant Level Data (NOT for reporting)</b>	
<b>Data Element</b>	<b>Notes</b>
Housing status	Is the SCS participant unstably housed, couch-surfing, etc.?
Health history and current health issues	
Indigenous status	Is the SCS participant eligible for certain services for those who identify as Indigenous or registered Indigenous Peoples?
Treatment history	Has the SCS participant ever accessed detox, treatment, support groups, etc.?
Goals of attendance	Does the SCS participant have any particular goals staff can help them achieve? (iOAT, detox, inpatient treatment, outpatient treatment, etc.)

### 8.3 Data Collection Platforms and Systems

Various data collection systems are used within SCS across Canada. Specialized data collection platforms allow staff to record and save SCS data to a database in real time. These platforms can be developed in-house by the SCS operators or purchased from an external vendor. Host data on a secure server within Canada to protect SCS participant privacy. If electronic data capture platforms are not feasible, Excel, MS Access, and other database software may serve as a lower cost, if less functional, alternative. If data is recorded on paper, consider entering that data into a secure computer or online database as soon as possible.

When exploring which data collection system to use, there are several issues to consider. If the SCS has several separate rooms and staff throughout the space, recording data for a SCS participant at different times throughout the visit, operators may consider using a computer platform that can be accessed by multiple people at the same time. However, if the SCS space is small and there is only

one location where data is recorded, an Excel sheet on one computer or a paper document may be sufficient.

It is also important to consider how the data will be used and who will require access to it. If the data are to be used internally, identify the program's needs and use them to decide on a data collection system that aligns with the delivery of the program. For example, consider whether the data will be used for government reporting, operational communication between staff, case management or to track client outcomes. If the data are to be used for external comparison to other areas (e.g., sites, cities, provinces), it is important to clearly define medical terms and interventions for comparisons, and to ensure the data collection system being used aligns with the data collection system being used by other SCS.

## 8.4 Program Evaluation

While Health Canada has specific reporting requirements for SCS, they do not mandate that sites carry out or report evaluation activities. However, for SCS operators with the resources to undertake a program evaluation, it can help ensure that operational goals are being met, that the service is client-centered, and provide opportunities for the development of best practices and optimization of the service. Further, program evaluations often yield useful information for communicating with various stakeholders about the SCS and its impacts on participants and communities.

Evaluation activities can be conducted internally, in partnership with academics, or through third party credentialed evaluators. Decide as soon as possible who will be conducting the evaluation based on available resources, including financial and human resources. Some existing SCS have made their evaluation frameworks publicly available (328) which may facilitate internal evaluations. Other SCS operators may wish to connect with their nearest post-secondary institution or with existing academic partners to develop an evaluation plan. Consult with professional associations such as the Canadian Evaluation Society (336) if you are interested in working with a third-party credentialed evaluator or looking to develop in-house expertise.

SCS are being implemented in many different settings and contexts across Canada, and a service model that is effective in one location or setting may or may not produce the same positive outcomes in another. Ongoing evaluation allows service providers to continue to tailor SCS to meet the needs of people who use drugs in their local communities. Given the rapid scale up of SCS in Canada, program evaluations are also helpful for documenting the evolution of novel service models and practice innovations, and for sharing this information with others providing services for people who use drugs. Further, some provincial governments and other SCS funders may require SCS operators to engage in evaluation activities as a condition of receiving financial support.

There are many potential methods and approaches for evaluating SCS. Two types of program evaluation designs that may be helpful are outcome evaluations and process evaluations. Each design type serves a distinct purpose, although a combination of these designs is beneficial whenever feasible. Outcome evaluations assess the extent to which a program is achieving its aims by measuring its effects on participants' short, medium, and/or long-term outcomes. Some outcome evaluations may also seek to measure whether SCS are having any impact on the broader community. Some examples of commonly measured outcomes in SCS evaluations include:

- Changes to SCS participants' substance use behaviours (e.g., syringe sharing and reuse, improper syringe disposal);
- Changes to SCS participants' drug poisoning death rates;
- Changes to referrals and/or connections to health and social services, and SCS participants' uptake or utilization of these services;
- Changes in public consumption surrounding the site; and
- Changes in prevalence of improperly discarded drug-related litter surrounding the site.

Some outcomes evaluations also seek to measure whether observed benefits justify the costs of implementation to assess whether SCS are cost-effective.

Process evaluations aim to understand if a program has been implemented as designed, how it operates, and who used the program. Understanding how a program operates is crucial to interpreting outcome evaluation results (e.g., How were specific outcomes achieved? Why were other outcomes not achieved?). Process evaluations can assist with monitoring and adjusting implementation as needed to ensure program fidelity and quality; capturing and incorporating SCS participants' and other stakeholders' feedback into program modifications and enhancements; ensuring that the target population is being reached and that there are no undue barriers to access; and monitoring and mitigating contextual factors which may impact program effectiveness. Some examples of what might be examined in a SCS process evaluation are provided below:

- SCS participants' perspectives on the service;
- Staff perspectives on the service;
- Service outputs (e.g., number of visits, unique visitors, drug poisoning reversals, referrals, episodes of care); and
- How closely the service being provided matches with the model of care that was initially proposed.

Findings from process evaluations can help SCS operators understand what components of their SCS helped or hindered achieving certain participant or community outcomes, and identify potential areas for quality improvement or further service expansion.



Regardless of the type of evaluation, PHNs are not required to meaningfully evaluate SCS (see **8.1.a Government issued identification and personal health numbers**). For evaluations where administrative data linkage to health records would be helpful (e.g., for measuring uptake into other health services that collect PHN), it is both feasible and ethical to make participant enrollment (and requisite collection of PHN) voluntary through an opt-in process that does not ask all SCS participants for identification upfront.

For more information on supervised consumption service program evaluations see:

- [Belackova et al. - Drug Consumption Rooms: A Systematic Review of Evaluation Methodologies](#) (337)
- [Ontario HIV Treatment Network - A Review of Structural, Process, and Outcome Measures for Supervised Consumption Services](#) (338)

It is important to note that most of the outcome and process evaluation examples provided above are primarily driven by supervised consumption service stakeholders (e.g., funders) and operators, and/or the public. Involving SCS program participants in the design, implementation, and interpretation of program evaluations is required to ensure SCS are client-centered (62,339).

# 9.0 Other Supervised Consumption Service Types

## 9.1 Urgent Public Health Need Sites

UPHNS are designed to be temporary and operate within a limited time horizon and scope (341). There are two mechanisms to apply for an exemption to operate a UPHNS under subsection 56(1) of the CDSA: 1) site-specific exemption directly through Health Canada; and 2) class exemption through provinces and territories. Health Canada (as of this writing) has issued class exemptions to provinces and territories to authorize UPHNS directly (or delegate this authority to municipalities within their jurisdiction) until September 30, 2025 (341). The decision to implement this class exemption and/or approve UPHNS applications under a provincial/territorial class exemption is at the discretion of that province or territory's Minister of Health or a delegated municipality. For more information on operating UPHNS, contact the UPHNS Community of Practice (342).

### 9.1.a Determining whether to apply for SCS or UPHNS exemption

When deciding whether to operate an SCS or UPHNS, important considerations include the urgency, timeline, and long-term plans for the site. Applicants intending to operate an SCS at a specific location for multiple years or indefinitely are generally expected to seek a regular SCS exemption through Health Canada. A UPHNS is better suited to address emergent public health needs, is less expensive to run, and takes less time to implement than an SCS (343,344). Additionally, Health Canada has indicated that applications for site-specific UPHNS exemptions will typically be approved faster than for SCS due to the urgent nature of community needs and that applications for UPHNS require less information than SCS exemption applications. An organization could initially apply to operate a UPHNS (whether applying directly to Health Canada for a site-specific UPHNS exemption or requesting approval from their provincial/territorial Minister of Health for a class exemption) in order to establish an operational site quickly, after which the organization could apply to Health Canada for an SCS exemption to transition the service from a UPHNS into a SCS. This option allows for faster approval of operational service provision compared to applying for a SCS exemption first. Alternatively, Health Canada will also consider granting applicants an interim exemption to operate a temporary SCS while an authorized permanent SCS is undergoing construction or renovations (e.g., operating a SCS within a trailer or other temporary structure, while a permanent fixed site is being constructed).

It is important to consider if a SCS or a UPHNS exemption would most effectively serve the needs of the community in which it is to be located, by assessing the following factors:

- 1) Are you intending to respond to an emergent public health need (i.e., recent spike in drug poisoning deaths or HIV incidence) or a longer standing issue?
- 2) What is already known about the local population, their preferences, and needs?
- 3) What is known about the feasibility of implementing a SCS compared to a UPHNS (i.e., community and political opposition or support)?
- 4) What are the financial resources that are available to implement and operate a SCS or a UPHNS?
- 5) What is the proposed timeline of the project?

Some differences in applying for a site-specific UPHNS exemption vs a SCS through Health Canada are provided below:

- UPHNS exemption applications do not require a submitted site floor plan;
- UPHNS exemption applications only require attestation of policies and procedures and do not require applicants to supply written documentation as part of their application materials;
- UPHNS exemption applications do not require a criminal record check for the RPIC; and
- UPHNS exemption applications do not require community consultation.

For more information about the exemption process and to receive an application form, visit the Health Canada webpage: [Subsection 56\(1\) class exemption in relation to urgent public health need sites in the provinces and territories](#). If a particular provincial/territorial Minister of Health is not using their class exemption to set up UPHNS, an organization may apply directly to Health Canada by contacting [exemption@hc-sc.gc.ca](mailto:exemption@hc-sc.gc.ca) and requesting a copy of the UPHNS application form.

## 9.2 Overdose Prevention Sites

OPS operate without federal exemption, either: 1) under provincial ministerial order in response to a public health emergency (262); or 2) in the absence of official approval from any level of government (345). For example, the province of British Columbia, through a provincial ministerial order, directed its health authorities to establish OPS as an emergency response to the drug poisoning emergency and operators in that province have not sought formal federal exemptions for most of these OPS.

Qualitative research suggests that non-exempted OPS are lower-barrier or easier-to-access than more formal SCS or UPHNS (346). Non-exempted OPS were originally developed as a community-based initiative in response to rising drug poisoning deaths and bureaucratic barriers securing a

federal exemption (346). As a result, non-exempted OPS have been successful in preventing drug poisoning-related deaths, especially among people who use drugs whose needs and preferences cannot be accommodated within the current federal regulatory structure (59,135,346).

Please see **Figure 1. SCS, UPHNS, and OPS service types according to their exemption status** and the **Definitions** section of this document for more information. For guidance on how to open a UPHNS/OPS or general information about these service models, see the following resources:

- [CAPUD - This Tent Saves Lives](#) (48)
- [Irvine et al. - Modelling the Combined Impact of Interventions in Averting Deaths During a Synthetic-Opioid Overdose Epidemic](#) (347)
- [Pauly et al. - Impact of Overdose Prevention Sites During a Public Health Emergency in Victoria, Canada](#) (344)
- [PIVOT Legal Society - SCS and OPS in Canada Map](#) (348)
- [Wallace, Pagan, and Pauly - The Implementation of Overdose Prevention Sites as a Novel and Nimble Response During an Illegal Drug Overdose Public Health Emergency](#) (262)

# 10.0 Further Reading and Resources

- [BCCSU - Supervised Consumption Services: Operational Guidance](#) (4)
- [Canadian Centre on Substance Use and Addiction - Supervised Consumption Sites – Injection Drug Use: A Bibliography](#) (349)
- [Canadian HIV/AIDS Legal Network - Overdue for a Change: Scaling Up Supervised Consumption Services in Canada](#) (346)
- [Canadian Nurses Association - Harm Reduction & Illicit Substance Use: Implications for Nursing](#) (350)
- [Dr. Peter AIDS Foundation - Community of Practice Programs](#) (351)
- [European Monitoring Centre for Drugs and Drug Addiction - Perspectives on Drugs: Drug Consumption Rooms: An Overview of Provision and Evidence](#) (98)
- [Gagnon et al. - International Consensus Statement on the Role of Nurses in Supervised Consumption Sites](#) (352)
- [Giacomazzo et al. - Lessons Learned from Supervised Consumption and Overdose Prevention Sites in Canada](#) (353)
- [Hedrich - European Report on Drug Consumption Rooms](#) (354)
- [HIV Legal Network - Gendering the Scene: Women, Gender-Diverse People, and Harm Reduction in Canada](#) (355)
- [Rudzinski et al - Twelve Characteristics of Client-Centred Supervised Consumption Services \(SCS\): A Toolkit for Service Design, Delivery and Evaluation](#) (356)
- [International Network of Drug Consumption Rooms - Map of Locations](#) (357)
- [Registered Nurses Association of Ontario - Implementing Supervised Injection Services](#) (88)
- [Schaffer, Stover, and Weichert - Drug Consumption Rooms in Europe: Models, Best Practice and Challenges](#) (358)
- [Toronto Drug Strategy's Supervised Injection Services Working Group - Supervised Injection Services Toolkit](#) (359)
- [Woods - Drug Consumption Rooms in Europe: Organisational Overview](#) (360)

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