

# HARD TIME FOR HARM REDUCTION

## SAVING SUPERVISED CONSUMPTION SITES



On February 12, 2026, the HIV Legal Network hosted the first of two webinars focused on current threats to harm reduction in Canada. The webinar, *Hard Time for Harm Reduction: Saving Supervised Consumption Sites*, was a 90-minute virtual event that brought together frontline workers, community organizers, advocates, researchers, and elected officials. Together, they examined growing legal and political barriers facing supervised consumption services (SCS) across the country, ongoing advocacy efforts, and ways to get involved. One message underscored the entire webinar: SCS are in crisis, but there are significant efforts underway to protect harm reduction in this country. This summary report provides an overview of the discussion.

## OPENING REMARKS

**Cécile Kazatchkine**, Senior Policy Analyst at the HIV Legal Network, opened the webinar by providing an overview of SCS. She explained that SCS — including overdose prevention sites (OPS) and temporary urgent public health need sites (UPHNS) — are evidence-based health services that provide safe and hygienic spaces where individuals can use drugs under the supervision of trained staff or volunteers. These services prevent fatal overdoses, reduce infectious disease transmission, and connect people to primary care, wound care, and social support.

She described the exceptional legal framework that apply to SCS in Canada. SCS providers must obtain a federal exemption to operate without staff and clients risking prosecution for possession or trafficking under the *Controlled Drugs and Substances Act*. Provincial governments are usually the ones responsible for funding SCS.

Cécile then emphasized that, after a few years of expansion,<sup>[1]</sup> SCS are currently in crisis. Some provincial governments have increasingly imposed legislative and funding barriers. In Ontario and Alberta, many sites have closed following the introduction of restrictive policies. She framed the webinar as an urgent opportunity to assess both the legal landscape and strategies for resistance.

## PRESENTATIONS

### **Impact of changes to supervised consumption site service provision in Ontario**

*Dr. Gillian Kolla – Assistant Professor of Population Health and Applied Health Sciences at Memorial University of Newfoundland's Faculty of Medicine.*

Dr. Gillian Kolla presented research conducted in Ontario following the passage of the *Community Care and Recovery Act* (CCRA) in December 2024 and the closure of multiple SCS in the province. The legislation prohibits SCS from operating within 200 metres of schools or childcare facilities and requires that municipalities obtain provincial approval before applying for or supporting a federal exemption.<sup>[2]</sup> This restriction was adopted hastily, without meaningful consideration of community needs for SCS or how many kinds of essential health, social, and educational services are delivered in close proximity due to the density of urban settings, ultimately resulting in the removal of this essential healthcare from communities.

By the end of March 2025, nine SCS had closed because of CCRA and provincial funding policies. Two additional sites and four Urgent Public Health Needs sites located in shelters later closed in 2025. There are currently no operating sites in Northern Ontario where overdose mortality is approximately double that of Southern Ontario and where a significant proportion of the population is Indigenous. The province was warned internally that the legislation carried a high risk of violating the *Canadian Charter of Rights and Freedoms* (“Charter”) and would likely increase emergency department visits, deaths from overdose, and public drug use.

Over 100 clients and frontline workers were interviewed before and after in five cities. They reported:

- an increase in people using alone in public spaces such as alleys, parks, bathrooms, and parking lots as well as in hidden spaces;
- more frequent overdoses in public and hidden spaces which increases pressure on paramedics who are forced to intervene in difficult conditions;
- an increase in deaths following the closure of sites — especially among clients who were using these services regularly before their closure;
- the loss of access to low barrier health and social services;
- the loss of community space in a context of increased policing and surveillance around former SCS locations, contributing to the displacement of people to hidden spaces with increased risks of fatal overdoses; and
- a growing sense of abandonment and moral distress among clients and staff due to the loss of critical services.<sup>[3]</sup>

Gillian stressed that SCS function as broader community hubs that offer connection, dignity, and safety. Their closures represent not just a loss of overdose prevention but a dismantling of community infrastructure. Further, she raised concerns about the province’s replacement

of SCS with HART hubs, as there has been a lack of transparency, consultation, and design for success. Ultimately, Gillian observed that the harms following closures are consistent with decades of evidence: removing harm reduction services increases overdose deaths and public health burdens.

## **Litigating the right to supervised consumption services.**

*Sandra Ka Hon Chu – Co-Executive Director of the HIV Legal Network*

Sandra outlined legal responses to emerging legal and policy restrictions to SCS across the country using two case studies.

The first focused on an Ontario constitutional challenge to the CCRA. In response, The Neighbourhood Group Community Services (TNG) — a social agency that operates a SCS in downtown Toronto — and two individuals — Katharine Resendes and Jean-Pierre Aubry Forgues — relying on SCS in Toronto and Kitchener challenged the law in court. They asked the Ontario Superior Court to rule that the CCRA violates the Charter, or that it is otherwise unconstitutional because it intrudes on Canada’s exclusive power to authorize SCS.

The Applicants argued that the CCRA violates Section 7 of the Charter, which guarantees the right to life, liberty, and security of the person, because closing the SCS would increase the risk of overdose death; force people to use drugs in an unsafe way; force people to consume outside SCS thus exposing them to a higher risk of criminalization; and expose people to a higher risk of infectious disease and other harms to their health. The Applicants also argued the CCRA violates section 15 of the Charter by discriminating against those with substance use disorder (which is recognized as a “disability” in law), with disadvantages that are even more pronounced for women, unhoused people, Indigenous people, racialized people, and those with mental health and physical disabilities. The issue of provincial funding for SCS was not brought before the Court.

In March 2025, the Court ordered an injunction exempting all existing SCSs from the 200 metre rule until 30 days after the release of the final decision:<sup>[4]</sup> As the Court concluded:

*“It is foreseeable that many more will overdose, and some of those will die... Death and disease that would have been prevented will now not be prevented, because those who would have used an SCS will now consume drugs in less safe settings. The other health and social services provided by SCSs and for which SCSs are a gateway will no longer be accessed at the same rate. Given the number of users that are affected by substance use disorder, homelessness, and other marginalized characteristics, the impact will be felt by the most vulnerable.”*

TNG’s site was able to keep its doors open because of the injunction as they do not rely on provincial funding. Of note, the injunction does not cover the CCRA’s requirement for municipally operated or supported sites to obtain provincial approval, and sites in Toronto, Peel, and Ottawa were forced to close as a result. Further, the injunction has no impact on provincial funding. At the time of the webinar, a final decision in the Ontario Charter challenge was still pending.

The second case study was about the Red Deer Overdose Prevention Site (OPS) in Alberta, which was shut down in March 2025 by the provincial government. Aaron Brown, a client of the Red Deer OPS, challenged Alberta’s decision, arguing that it breached his Charter rights. In Mr. Brown’s words:

*“I would be dead without the Red Deer OPS and the supervised consumption services it offers. ... I will likely acquire other diseases and infections through street sourced opioid use and be hospitalized and lose the social and economic supports that I have, including housing. ... It will essentially be a death sentence for me and the many others who use the facility.”*

The Alberta court released its decision in August 2025, concluding among other things that Brown’s risk of injury and death did not arise “solely” from Alberta’s decision to reallocate funding to “recovery-based alternatives.”<sup>[5]</sup> The Court also repeatedly referenced these alternative services and minimized the harms of the loss of OPS. This was despite Aaron Brown describing in clear terms how the existing services could not replace the benefits provided by OPS. The Court also stressed that there is no “constitutional right requiring the government ... to continue offering health services.”

This decision is being appealed, and a hearing will occur in May 2026.

Sandra concluded by stating that these closures are all part of a growing movement against people who use drugs, with the aim to erode and ultimately wipe out harm reduction services which people who use drugs have fought so hard to establish.

## **Panel discussion**

*Moderated by Beeta Senedjani from the Canadian Drug Policy Coalition*

### **New legislation and community mobilization in Quebec**

**Sandhia Vadlamudy**, Executive Director of l’Association des intervenants en dépendance du Québec (AIDQ), described recent mobilization efforts in Quebec in response to regressive drug policy proposals. Bill 103, adopted in November 2025, imposes minimum distance requirements and enhanced ministerial discretion for SCS in Quebec.<sup>[6]</sup> Sandhia characterized the law as part of a broader shift towards conservatism that contradicts Quebec’s support and commitment towards harm reduction. Civil society mobilized rapidly in response, forming a coalition of approximately 30 organizations to oppose the proposed legislation, issuing press releases, and submitting a joint brief to the provincial government. Further, more than 150 organizations signed an open letter defending SCS and denouncing the bill.

Advocates met with government representatives as well as representatives from all different political parties. They also participated in consultations with parliamentarians to oppose the legislation. Recognizing that a full repeal was unlikely, the coalition proposed amendments. Many of their proposed modifications were incorporated into the final legislation including protections for existing sites and limits on ministerial discretion.

While advocates remain dissatisfied with the law's passage, this example of collaboration can be used as motivation to build coalitions and effect legislative change. She emphasized collective action, flexibility, and centring harm reduction as key solutions to combatting the attacks on SCS.

### **Access to SCS in British Columbia (BC) including supervised inhalation services**

**Corey Ranger**, Clinical Director at AVI Health & Community Services, discussed the growing mismatch of drug consumption patterns and available SCS models. Specifically, the significant gap in SCS in BC, particularly for inhalation services. As of January 2026, the BC Centre for Disease Control reported 41 OPS/SCS sites with witnessed consumption, but only 25 with witnessed inhalation.<sup>[7]</sup> This means that less than two-thirds of sites offer inhalation services despite smoking accounting for a significant proportion (73%) of overdose deaths.<sup>[8]</sup>

Corey described stagnation and regression surrounding access to inhalation services in BC. Expansion has plateaued, new sites have been paused, and political attention has shifted toward treatment and recovery beds rather than harm reduction. Corey described how this regression has been driven by a coordinated attack on harm reduction across Canada, rooted in mis- and disinformation, especially false claims about second-hand fentanyl exposure at inhalation services. Despite the absence of evidence, this moral panic has shaped policy, labour relations, community opposition, and even BC's return to criminalization. The closure of the Thomas Donaghy OPS in January 2026 is a prime example of political pressure overriding evidence-based needs.

Corey emphasized that while operational knowledge is extensive, what is lacking is political will. He urges advocates to counter fear-based narratives and reaffirm the humanity of people who use drugs.

### **Grassroots organizing**

**Marina Classen** from Harm Reduction Advocacy Collective spoke about community responses to increasing rhetoric against drug users and harm reduction in policy, within communities, and in some media. HRAC is a Toronto-based grassroots collective made up of people who use drugs, harm reduction workers, and allies organizing to protect harm reduction and fight for drug user liberation as well as the liberation of all oppressed peoples. The collective is led by people who use drugs with an emphasis on coalition-building to mobilize and build power. It recognizes the importance of mutual aid, political education, and local organizing. HRAC organizes weekly meetings, direct action, and political education. The collective has grown in their momentum and mobilization in response to the attacks on and defunding of SCS.

Marina emphasized that harm reduction originated as a community movement rooted in ways of survival, joy, and solidarity. Specifically, they credited queer, Indigenous, and Black communities in creating and shaping these practices and underlined the importance of relying on one another rather than state institutions. They described how harm reduction

never belonged to the state or even to public health and the medical field in the first place. Harm reduction is a movement by people who use drugs and people who are criminalized. It is a movement rooted in the teachings of marginalized community — how can we support each other when the State neglects us? — and that harm reduction cannot be extinguished by defunding alone.

She encouraged participants to join their movement, insisting on the need for a strong, large, and well-coordinated movement against increased conservatism in order to win back health services. Marina also invited participants to contribute to demystifying stigma and publicly supporting harm reduction in the media, in your community, and with policy makers as well as to being kind and showing care to people who use drugs, especially those who are unhoused and are using or standing outside because they have nowhere else to go.

In conclusion, Marina pointed out that barriers to SCS are experienced at all levels of government, including at the federal level, and called for the removal of political blocks, including the requirement for federal exemptions, that prevent the expansion of SCS in Canada.

## **Political Strategy**

**MPP Robin Lennox**, is a family physician in Hamilton as well as the Official Opposition's Shadow Minister for Mental Health and Addictions and Primary Care and an advocate for public health. Robin was involved in the first OPS that opened in Hamilton and the second Urgent Public Health Need site that opened in the city; she described her experience and the site closures as her motivation for entering politics. Robin characterized CCRA as a strategic mechanism to close sites indirectly. She noted that policymakers remain unmoved on the support of harm reduction despite overwhelming medical evidence and cost-benefit analysis.

For this reason, Robin emphasized the power of human stories in advocacy. She also described the need for a massive and well-coordinated rallying in support of harm reduction to out-organize those who oppose SCS.

She underscored the importance of breaking silos and building coalitions across areas of organizing including climate justice movements and other sectors to support each other's fights and unite forces. Local conversations including with neighbors, co-workers, and friends are essential. Public safety has been weaponized to close sites, but we need to talk about how SCS are public safety measures that make everyone safer.

## QUESTIONS AND ANSWERS

In the Q&A portion of the webinar, participants were able to engage directly with speakers, who addressed questions, comments, and concerns. Many of the speakers both in the panel and the Q&A foregrounded the fact that drug policy and attacks on harm reduction disproportionately affect Indigenous communities, women, migrants, sex workers, and unhoused individuals. Meaningful advocacy must reflect these intersections to be effective in combating the systems of power that marginalize all people who use drugs.

Several speakers discussed strategies for rallying in support of harm reduction. Building “unlikely,” “unusual,” or “necessary” alliances, coalitions, and community power including with tenants’ groups, parents’ groups, workers’ groups, 2SLGBT+ groups, migrant groups, and the climate change movement was singled out as central to sustaining harm reduction and uniting forces around common grounds. Speakers also discussed the importance of widening engagement with policy makers by reaching out to the Minister of Public Safety and the Minister of Justice and not just people in charge of public health.

In relation to barriers experienced at the federal level because of exemptions, speakers explained how local politicians can and must engage with their federal counterparts in their own party to coordinate and pair respective advocacy efforts and ensure that dual levels of barriers are not put on local organizations. They also insisted on the need to call on the federal government for more leadership and support efforts to resist judicial review brought against Health Canada in relation to one of their exemptions because it could have a ripple effect across the country and influence their practice.

Regarding the role of evidence in advocacy, speakers acknowledged how stigma and discrimination mean that opponents put aside our best evidence in order to stick to a moralistic space. There is ample evidence of the benefits of harm reduction, including economic benefits, but we are in a crisis of empathy and a crisis of inability to centre the needs of some of our most vulnerable community members. It is easier for policy makers to lean into stigmatization of people who use drugs than to fix the destruction of the health care system and the housing crisis. In response, it is essential to re-centre care and concern, and work to reduce stigma and discrimination. Speakers highlighted the importance of describing SCS as one service that is part of a continuum of many interventions that help people to take care of themselves and flourish as well as to bring forward the powerful voice of people who use and can speak to their experience at SCS and touch the broader public. It is essential for the broader population to understand that harm reduction is not just about programming: it is about principles and practices rooted in love. Speakers also discussed how essential it is to understand opposition narratives and identify connection points to engage in constructive dialogues.

Finally, voting and protesting are critical methods to show public disapproval with policymakers and force change. The transformation of government policy ultimately requires changing who holds decision-making power.

## CONCLUSION

*Hard Times for Harm Reduction: Saving Supervised Consumption Sites* underscored the power of speaking out in support of SCS and harm reduction as well as the importance of broad coalition building recentring care and empathy as well as evidence as the foundations of policy decisions on access to care.

View the webinar and find associated materials [here](#).

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## REFERENCES

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