2024 Harm Reduction Client Survey Report

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Provincial Health Services Authority

BC Centre for Disease Control
Provincial Health Services Authority

Acknowledgements

Data entry: Genica Manuel, Niveda Palanivel, Samarth Srivastava

Data cleaning, analysis, and interpretation: Mieke Fraser, Lisa Liu, Kara Loewen, Chloé Xavier, Christie Wall, Katie Fajber, Brooke Kinniburgh, Alexis Crabtree

Project management: Katie Fajber and Laura Moore

Professionals for Ethical Engagement of Peers (PEEP): Kurt Lock (Operations coordinator), Charlene Burmeister (PWLLE stakeholder engagement lead), Paul Choisil, Dylan Griffith, Beth Haywood, Iesha Henderson, William (Billy) Morrison, Jenny McDougall, Cheri Newman, Marnie Scow, Kali Sedgemore, Jennifer Speck, and Amber Streukens.

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British Columbia Centre for Disease Control (BCCDC), Harm Reduction and Substance Use Services.

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Land Acknowledgement

We acknowledge the Title and Rights of BC First Nations who have cared for and nurtured the lands and waters for all time, including the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh Úxwumixw (Squamish Nation), and səl̓ílwətaʔ (Tsleil-Waututh Nation) on whose unceded, occupied, and ancestral territory BCCDC is located — and whose relationships with the land continue to this day. As a provincial organization, we also recognize and acknowledge the inherent Title and Rights of BC First Nations whose territories stretch to every inch of the lands colonially known as "British Columbia."

Rights Acknowledgement

We also recognize that BC is also home to many First Nations, Inuit, and Métis people from homelands elsewhere in Canada and have distinct rights, including rights to health which are upheld in international, national, and provincial law.

Thee Eat – Truth

BCCDC is working to address the consequences of colonial policies which have had lasting effects on all First Nations, Inuit, and Métis Peoples living in the province. Consistent with the Coast Salish teaching of *Thee Eat* (truth) gifted to PHSA by Coast Salish Knowledge Keeper Siem Te'ta-in, we recognize that ongoing settler colonialism in BC undermines the inherent Title and Rights of BC First Nations and Indigenous Peoples who live in BC. The In Plain Sight report found widespread systemic racism against Indigenous people in health care; this stereotyping, discrimination and prejudice results in a range of negative impacts, harm, and even death. The data shown in this report we're sharing reflect people who access harm reduction sites in British Columbia. In 2024, nearly half (48%) of harm reduction client survey (HRCS) participants self-identified as First Nations, Inuit, or Métis. This reflects both the characteristics of people who use the harm reduction sites that participated in the 2024 survey, as well as the ongoing and disproportionate impact of the toxic drug poisoning crisis on Indigenous and First Nations people in BC. Information provided by Indigenous respondents is included in these results, but we do not present specific (stratified) results for First Nations or Métis participants. As part of BCCDC's commitment to uphold a distinctions-based approach to Indigenous data sovereignty, self-determination, and respectful use of data for all Indigenous Peoples who live in BC, data for First Nations respondents are shared with the First Nations Health Authority, and data for Métis respondents are shared with Métis Nation BC. For information on the First Nations Health Authority's approach to harm reduction and the toxic drug crisis, please see their website FNHA Harm Reduction and the Toxic Drug Crisis. For information on public health surveillance indicators pertaining to Métis Peoples in BC, please see: Taanishi kiiya? Miiyayow Métis saantii pi miyooayaan didaan - BC Métis Public Health Surveillance Program–Baseline Report, 2021. Currently, there is no designated organization or pathway to respectfully share Inuit-specific data in BC.

Introduction

Key findings

Respondent demographics

- Many HRCS respondents were men, heterosexual, underhoused, and unemployed.
- Surveying clients of harm reduction sites gives insight into people who visit these sites, but not into all people who use substances across the province.

Substance use

- Most respondents used substances every day and many used substances alone or in public at some point in the last 30 days.
- Respondents used both regulated and unregulated substances in the past 30 days. The most commonly used substances were crystal meth, tobacco, 'down', cocaine, cannabis, and alcohol.
- Nearly half of respondents used both opioids and stimulants.
- Some respondents used opioid, stimulant, or benzodiazepine medications that were not prescribed to them.

How people use substances

- Smoking (inhalation) was by far the most common way that people used substances, although many people both smoked and injected substances. It was rare for people to only inject substances.
- Smoking was the most common way that people used crystal meth, 'down', and cocaine.

Safer smoking

- Most respondents reported smoking in risky ways, like sharing pipes and using cracked pipes.
- 1 in 4 respondents could not get the amount or type of smoking supplies they asked for, which could lead to sharing pipes or using broken supplies.

Overdose experience and naloxone possession

- 1 in 3 respondents experienced an opioid overdose and 82% witnessed an opioid overdose in their community in the last 6 months.
- 19% of respondents who witnessed an overdose said 9-1-1 was not called.
- Three quarters of respondents had a naloxone kit. More respondents had injectable naloxone kits than nasal naloxone kits.

Use of harm reduction, health care, and substance use services

- 60% of respondents were connected to a regular health care provider, and most (86%) were comfortable discussing substance use with that provider.
- Respondents used many types of harm reduction services. The most common included picking up smoking supplies (79%), using outreach services (62%), and picking up naloxone (57%). Many reported the ways that community members are support each other, like having someone watch when they use drugs to respond to an overdose (63%) or getting support from peer workers (53%).

Prescribed alternatives

- Over 40% of respondents said they received a prescribed alternative in the last 6 months, the majority being opioid alternatives. Respondents may have different opinions than prescribers and policy makers about which medications count as prescribed alternatives.
- Almost 30% of those who received a prescribed alternative had their medication stopped or reduced. Hydromorphone – the most dispensed prescribed alternative – was also the medication most commonly stopped or reduced.

Overdose prevention site or supervised consumption site use

- 67% of respondents used substances at overdose prevention services or supervised consumption site (OPS/SCS) in the last 6 months. The most common way people used substances at OPS/SCS was smoking (85%), followed by injection (39%).
- Additionally, 53% of respondents regularly picked up harm reduction supplies at OPS/SCS, 36% received supportive socialization, and 24% connected to other supports.
- Respondents reported barriers to using OPS/SCS services, including site operating issues, sites being too far away, and not having spaces to smoke substances.

Barriers to health and social services

- Half of respondents said they hesitated to seek health or social services, and a quarter did not go to the service because of their hesitation. They hesitated for many reasons, including having bad experiences in the past, worrying about discrimination, and disclosing their substance use.
- Half of respondents were worried about going to the emergency department and 57% were afraid of going into withdrawal when being admitted to hospital.
- Approximately 33-41% of respondents did not feel welcome in public and community services and spaces, which can influence feelings of safety, well-being, and willingness to seek life-saving services and supports.

Experiences with law enforcement

- Over half of respondents (59%) had at least one interaction with police in the last 3 months. Less than half (34%) of respondents said they were treated with respect by police.
- The most common types of interactions with police were being asked to move to another location, being asked for name or ID to check release conditions, and being intimidated or harassed.

Awareness of decriminalization policy

- Although 78% of respondents said they were aware of the decriminalization policy, respondents were less aware of the details of the policy and how it applied in different situations.

Improving the lives of people who use substances

- Respondents were navigating simultaneous crises – the toxic drug supply, lack of housing, and unaffordable cost of living – while also caring for their loved ones and seeking belonging and community.

Context

The Substance Use System of Care in British Columbia

The substance use system of care in British Columbia (BC) spans prevention and education, screening and early intervention, substance use treatment, and long term supports. Harm reduction includes policies, programs, and practices that help minimize the negative health, legal, and social impacts of substance use. It is a key part of the continuum of care because it can support people at any point in their substance use journey – whether they are using substances, not using substances, or somewhere in between. Harm reduction includes evidence-based health and social services such as overdose prevention and response, distributing sterile substance use equipment, sharing information on safer substance use, overdose prevention services and supervised consumption sites, drug checking, and more. These services help people to make informed choices about substance use and reduce the risk of blood borne infections and drug poisoning (overdose). Through relationship-building and referrals, harm reduction also connects people who use substances to other health and social services. The Harm Reduction Client Survey (HRCS) asks people about their substance use and experiences using harm reduction services in BC.

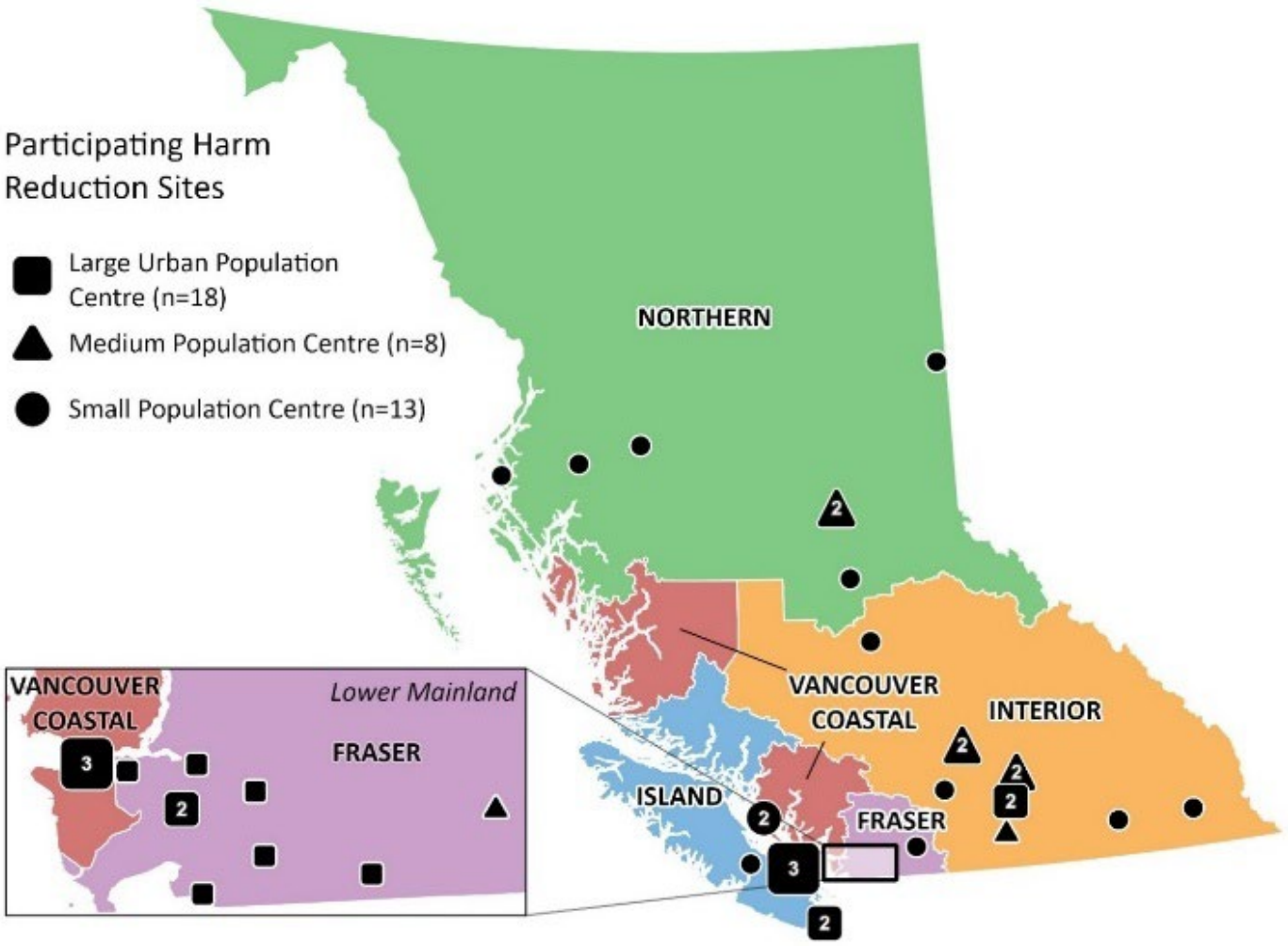
Figure 1. The Substance Use System of Care in BC

Overview of the Harm Reduction Client Survey

First administered in 2012, the Harm Reduction Client Survey (HRCS) is a periodic survey of PWUS who access selected harm reduction sites in BC. It is intended to support rapid information gathering on the health of people who use substances and to improve provincial harm reduction supply programs. A comprehensive history of the HRCS is available here. The BCCDC's Harm Reduction Client Survey website includes the survey tools and results, organized by year.

In 2024, 56 sites were invited and 39 sites participated in the HRCS. Participating sites were located across BC (Interior: 11 sites, Fraser: 10 sites, Vancouver Coastal: 5 sites, Island: 6 sites, Northern: 7 sites) and in small (13), medium (8), and large (18) population centres (Figure 2). Fraser Health and Vancouver Coastal Health were under sampled compared to the BC population (-15% and -6%, respectively), whereas Northern Health and Interior Health were oversampled compared to the BC population (+11% and +9%, respectively) (1). Of the 39 sites that participated in 2024, a little more than half (56%) offered observed consumption services. There were 622 responses included in the analysis after removing responses from people who did not meet the eligibility criteria of the survey (those who reported using only cannabis, alcohol, or tobacco, or were under 19 years of age). Data was collected between September 23 and November 22, 2024, about 20 months after decriminalization began, and 5 months after an amendment which limited the public places that were covered under decriminalization.

Figure 2. Location of participating harm reduction sites (N = 39)



The results shared here represent the perspectives of respondents in the 2024 HRCS. While these results cannot be generalized to the experiences of all PWUS in BC, they may be generalizable to PWUS who access harm reduction supply distribution sites.

Decriminalization in British Columbia

In June 2022, the Province of British Columbia (BC) was granted a three-year exemption to the federal *Controlled Drugs and Substances Act.* It allowed people to carry up to 2.5 grams of opioids, methamphetamine, cocaine, and MDMA for personal use. The exemption started on January 31, 2023 as a three-year pilot and has been amended twice since implementation. The province did not request a renewal of the exemption, and it ended February 1, 2026. A timeline on the BCCDC website shows when provincial and federal changes were made and the timing of the HRCS (2). Survey design and analysis are particularly challenging in this rapidly evolving policy environment.

Objective

This report gives a high-level comprehensive summary of findings from the 2024 HRCS. Embedded in this report are quotations from members of Professionals for the Ethical Engagement of Peers (PEEP) that provide additional context and insight from people with lived and living experience of substance use.

Additional reports and infographics using data from the 2024 HRCS are available on the BCCDC website. For more detailed analysis on topics related to decriminalization, also refer to the following knowledge updates:

- Awareness and knowledge of decriminalization among people who use substances: Harm Reduction Client Survey 2024 (3)
- Interactions with law enforcement: Harm Reduction Client Survey 2024 (4)
- Hesitance in accessing services: Harm Reduction Client Survey 2024 (5)
- Overdose Prevention and Supervised Consumption Sites and public substance use among individuals who use substances: Findings from the Harm Reduction Client Survey 2024 (6)

Results

Respondent demographics

The sociodemographic characteristics of HRCS respondents are shown in Table 1. Most respondents were 30 years of age or older (89%), heterosexual (85%), and unemployed (84%). Many respondents were male (64%), were unsheltered or lived in shelters (58%), and did not have a cell phone (49%). It is important to consider the characteristics of HRCS respondents when interpreting the results because this data does not include every type of PWUS.

Who is missed in this survey?

"We know that this survey's intent is to capture harm reduction clients; not all people who use substances. Policy makers have a responsibility to seek additional information from groups of people that this survey does not include (like youth and less marginalized people who use substances)."

-PEEP member

Table 1. Sociodemographic characteristics of respondents (N = 622)

Characteristic	N	n (%)[†]
Health authority	622	
Interior		154 (25%)
Fraser		149 (24%)
Vancouver Coastal		109 (18%)
Island		104 (17%)
Northern		106 (17%)
Community size (2021 Census Population Centre)	622	
Large Urban Population Centre		292 (47%)
Medium Population Centre		122 (20%)
Small Population Centre		208 (33%)
Age group	618	
19 to 29		68 (11%)
30 to 39		189 (31%)
40 to 49		196 (32%)
50 or older		165 (27%)
Missing		4
Gender	615	
Man		392 (64%)
Woman		216 (35%)
Non-binary / Gender expansive		7 (1%)
Missing		7

Characteristic	N	n (%)[†]
Sexual orientation	598	
Heterosexual or straight		506 (85%)
LGBQA+[§]		92 (15%)
Missing		24
Employment and volunteer work	587	
Yes (full- or part-time)		95 (16%)
No		492 (84%)
Missing		35
Type of current residence	591	
Private or band-owned residence		81 (14%)
Temporary or transitional residence[‡]		146 (25%)
Shelter		120 (20%)
Unsheltered homeless[*]		227 (38%)
Other		17 (3%)
Missing		31
Cell phone access	605	
Yes, I have a calling/texting plan and data plan		103 (17%)
Yes, I have prepaid minutes		116 (19%)
Yes, I have calling/texting plan and no data plan		34 (6%)
Yes, but I have no minutes or monthly plan		55 (9%)
No		297 (49%)
Missing		17

[†] *Column percentages are calculated based on the number of respondents who answered each question, excluding unknown responses.*

[§] *Lesbian, gay, bisexual/pansexual, queer/questioning, asexual, or other sexual orientation (LGBQA+)*

[‡] *Includes hotels/motels, rooming houses, single room occupancy (SRO), social/supportive housing.*

[*] *Includes houseless, couch surf, tent, encampment, in a vehicle, no fixed address.*

Key findings

- Many HRCS respondents were men, heterosexual, underhoused, and unemployed.
- Surveying clients of harm reduction sites gives insight into people who visit these sites, but not into all people who use substances across the province.

Substance use

Frequency

Most respondents used substances every day (83%). Using substances alone was common, with 57% of respondents reporting using alone every day and another 24% using alone a few times a week (Table 2). The risk of overdose death is higher when people use substances alone because there is no one there to call for help in case of an overdose.

What is in the drugs?

"Due to the increasingly toxic unregulated supply, people often do not know for sure what substances they are taking."

-PEEP member

Daily use of substances in public settings was shared by 44% of respondents, and another 23% used substances in public a few times a week. People used substances in public for many reasons including not having a private place to go, wanting to socialize with friends, and not having an OPS/SCS nearby – especially one where you could smoke. Some people also reported feeling safer using substances in public because someone may be able to see and respond in case an overdose occurs. These reasons are explored in more detail in a separate knowledge update.

Table 2. Frequency of substance use in the last 30 days (N = 622)

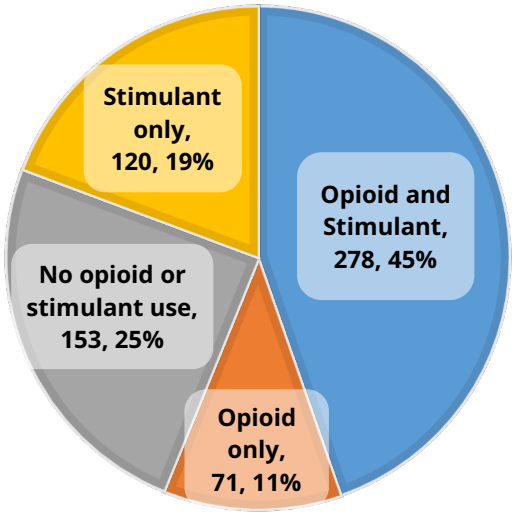
In the last 30 days, how often did you…	N[†]	Every day	A few times a week	A few times a month or less	Did not use substances (in this way)	Missing
Use substances	600	497 (83%)	70 (12%)	33 (6%)	0 (0%)	22
Use substances alone	565	321 (57%)	134 (24%)	64 (11%)	46 (8%)	57
Use substances in public	553	244 (44%)	129 (23%)	101 (18%)	79 (14%)	69

[†] Row percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).

Types of substances used

Stimulants were the most common type of substances used (64%), followed by opioids (56%); one quarter of respondents did not use either in the last three days (Table 3). It was very common for respondents to use both opioids and stimulants (45%), with smaller proportions using only stimulants (19%) or only opioids (11%). For harm reduction services to work well, they need to meet the needs of people who use opioids, stimulants, or both.

Table 3. Types of substances used in the last 3 days (N = 622)



Substance type	n (%)
Opioids[†]	**349 (56%)**
Stimulants[§]	**398 (64%)**

[†] Opioids include 'down', fentanyl (illicit or prescribed), heroin, Methadone, Buprenorphine or buprenorphine naloxone, Morphine, Hydromorphone, Oxycodone, and Diacetylmorphine.
[§] Stimulants include crystal meth, crack or powder cocaine, Ritalin, Dexedrine, and Adderall.

Most common substances used

HRCS respondents used both regulated and unregulated substances in the month before the survey. In the last 30 days, most respondents used crystal meth (70%), tobacco (69%), or 'down' (60%), followed by cocaine (50%), cannabis (46%), and alcohol (37%). These same substances were also the ones most used in the last 3 days (Table 4).

What is 'down'?

In BC, a colloquial term for illicit opioids is 'down'. Down can refer to fentanyl, heroin, or other unknown opioids (7). Recently in BC, down is most commonly fentanyl.

Among substances that may be prescribed, benzodiazepines (14%) and methadone (11%) were most common to be used in the last 3 days. The proportion of respondents who had a prescription for the substance they were taking was highly variable; however, this finding should be interpreted with caution. We could not distinguish people who didn't answer from people that did not have a prescription; low proportions of respondents with a prescription may reflect people without a prescription, incomplete responses, or both.

Table 4. Substances used in the last 30 days, 3 days, and prescription status (N = 622)

Substance[†]	N[§]	Used in last 30 days	Used in last 3 days	Have a prescription[‡]
Crystal meth / methamphetamine	617	430 (70%)	324 (53%)	-
Tobacco	618	427 (69%)	335 (54%)	-
'Down'	620	371 (60%)	308 (50%)	-
Crack or powder cocaine	622	313 (50%)	196 (32%)	-
Cannabis	621	288 (46%)	187 (30%)	5 (3%)
Alcohol	621	231 (37%)	137 (22%)	-
Benzodiazepines[*]	621	142 (23%)	85 (14%)	13 (15%)
Hydromorphone (Dilaudid)	620	114 (18%)	55 (9%)	31 (56%)
Methadone	622	110 (18%)	71 (11%)	52 (73%)
Other psychedelics	621	108 (17%)	25 (4%)	-
Morphine (Kadian, M-Eslon)	622	101 (16%)	54 (9%)	28 (52%)
Fentanyl (prescribed)	621	86 (14%)	58 (9%)	10 (17%)
Illicit alcohol	622	68 (11%)	32 (5%)	-

[†] *Substances in shaded rows are unregulated/illicit, whereas substances in unshaded rows are regulated or may be prescribed. Substances used by less than 10% of respondents in the last 30 days are not shown.*

[§] *Based on the question format, we cannot distinguish respondents who did not use the substance from those who did not answer. Denominator excludes only responses that were conflicting or illegible.*

[‡] *Among respondents that reported using the substance in the last 3 days. Based on the question format, we cannot distinguish respondents who did not have a prescription from those who did not answer. Reported only for substances that may be prescribed. Interpret results with caution.*

[*] *Responses may include those who use 'benzodope' or 'benzo down'.*

Key findings

- Most respondents used substances every day and many used substances alone or in public at some point in the last 30 days.
- Respondents used both regulated and unregulated substances in the past 30 days. The most commonly used substances were crystal meth, tobacco, 'down', cocaine, cannabis, and alcohol.
- Nearly half of respondents used both opioids and stimulants. Some respondents used opioid, stimulant, or benzodiazepine medications that were not prescribed to them.

How people use substances

Smoking (inhalation) was by far the most common way that people use substances; 94% of respondents reported smoking in the last 6 months compared to 38% who injected substances. Many people (38%) both smoked and injected substances (Table 5).

Table 5. How people used substances in the last 6 months (N = 622)

	N[†]	n (%)
Injection vs. smoking (last 6 months)	598	
Smoking only		336 (56%)
Injection and smoking		225 (38%)
Injection only		3 (1%)
Neither		34 (6%)
Missing		24
Injected any substance (last 6 months)	602	
Yes		231 (38%)
No		371 (62%)
Missing		20
Smoked any substance (last 6 months)	602	
Yes		565 (94%)
No		37 (6%)
Missing		20

[†] *Column percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

Smoking was the most common way people used substances overall, but mode of use differed by substance. Most respondents who used 'down', crystal meth, or cocaine in the last 3 days smoked these substances (84% to 92%, Table 6). Nearly one-third of people who used 'down' and crystal meth reported injecting. More than half of respondents who used other unregulated substances (e.g., MDMA, other psychedelics, and other drugs) swallowed these drugs, and less than 30% of respondents smoked them.

Table 6. How people used selected substances (N = 622)

Substance	N[†]	Smoke	Inject	Snort	Swallow
'Down'	308	283 (92%)	89 (29%)	29 (9%)	14 (5%)
Crystal meth / methamphetamine	324	286 (88%)	96 (30%)	57 (18%)	25 (8%)
Crack or powder cocaine	196	165 (84%)	17 (9%)	23 (12%)	7 (4%)
Other (MDMA, Psychedelics, and other)	45	10 (22%)	2 (4%)	2 (4%)	25 (56%)

[†] *Among respondents who used the substance in the last 3 days. Not all respondents completed the mode of use portion of the question. Respondents can select multiple modes of use. Mode of use was only collected for unregulated or illicit substances.*

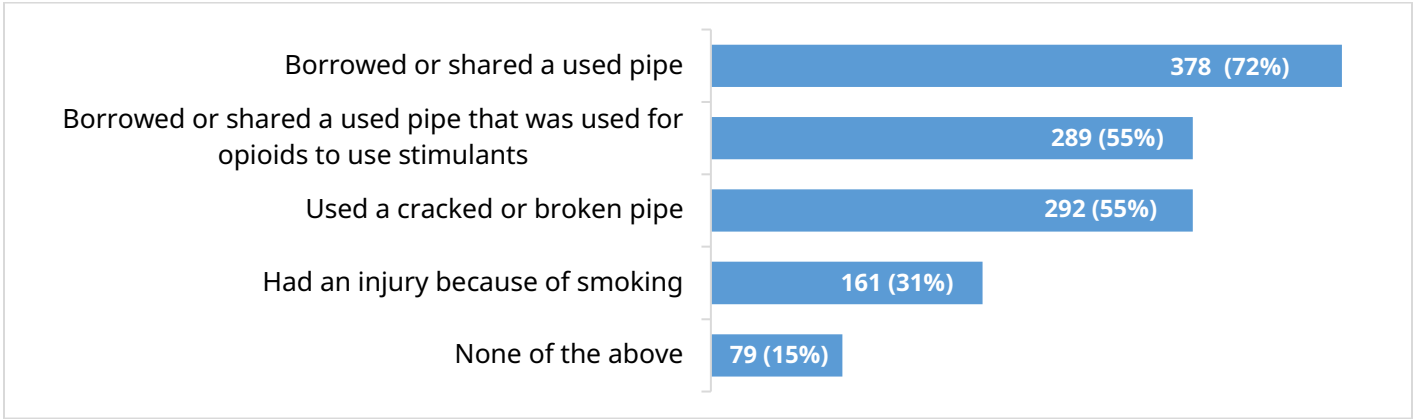
Key findings

- Smoking (inhalation) was by far the most common way that people used substances, although many people both smoked and injected substances. It was rare for people to only inject substances.
- Smoking was the most common way that people used crystal meth, 'down', and cocaine.

Safer smoking

Smoking substances comes with risks that are different from other ways of using substances. Some risks are related to sharing pipes: pipes previously used to smoke opioids can increase the risk of overdose for someone without a tolerance to opioids, and sharing pipes can also transmit communicable diseases. In addition, using cracked or broken glassware can cause injuries. Many of these risky behaviours were common among survey respondents: 72% of respondents reported sharing pipes, 55% said they shared pipes that had been used to smoke opioids to smoke stimulants, 55% used a cracked or broken pipe, and 31% reported having an injury caused by a pipe. (Figure 3).

Figure 3. Smoking risks among respondents who smoked substances (N = 527)



Just over a quarter of respondents could not get smoking supplies from a harm reduction supply distribution site (Table 7) There are several reasons why supplies may not have been available, including having already received the daily limit or the site not stocking the desired item. The supplies respondents most often said they could not get were bubble pipes (23%) and straight pipes (15%) – these supplies are part of the provincial harm reduction program and demand is known to exceed availability. Additionally, 10% of respondents reported being unable to get hammer pipes – this type of pipe is offered by some sites but is not part of the provincial program. Some respondents could not get other supplies offered by the harm reduction program (i.e., mouthpiece/tubing, foil, push sticks, and brass screens); however, these types of supplies are always available for sites to order from BCCDC with no volume limits or recent availability shortages. It is unclear if respondents were unable to get these supplies from sites when they asked, if they were able to get the supplies but didn't have them on hand when they needed them, if they had trouble getting to the site to pick up supplies or if respondents misunderstood the question in another way. An evaluation of safer smoking harm reduction supplies is in progress and will be posted on the BCCDC website.

Table 7. Barriers to accessing safer smoking supplies (N = 565)

	N	n (%)
Could not get smoking supplies at harm reduction site when asked.	518[†]	
Yes		138 (27%)
No		380 (73%)
Missing		47
If yes, what supplies were you unable to get?[§]	518[†]	
Any type of supply		134 (26%)
Bubble pipes[‡]		121 (23%)
Straight pipes[‡]		79 (15%)
Mouthpiece/tubing		62 (12%)
Foil		59 (11%)
Hammer pipes[*]		54 (10%)
Push sticks		51 (10%)
Brass screens		44 (8%)
Missing		4

[†] *Column percentages are among the respondents that smoked substances in the last 6 months, only respondents who answered the question are included in the denominator above (missing/unknown/illegible responses are excluded from denominator).*

[§] *Respondents can select multiple responses to the question (Check all that apply).*

[‡] *The demand for these supplies is higher than what is available for sites to order.*

[*] *Not part of the provincial supply program*

Key findings

- Most respondents reported smoking in risky ways, like sharing pipes and using cracked pipes.
- 1 in 4 respondents could not get the amount or type of smoking supplies they asked for, which could lead to sharing pipes or using broken supplies.

Overdose experience and naloxone possession

One third (34%) of respondents experienced an opioid overdose in the last 6 months and most respondents also witnessed an opioid overdose (82%). Among those who witnessed an overdose, 911 was called 77% of the time and more than half (56%) of these overdoses happened outdoors (Table 8). PWUS may use substances in public as a safety measure because it increases the chance that someone will be able to respond if they overdose (6).

Table 8. Overdose experiences in the last 6 months (N = 622)

Experience	N	Yes	No	Don't know	Missing
Had an accidental opioid / 'down' overdose	572[†]	192 (34%)	365 (64%)	15 (3%)	50
Had an accidental stimulant overdose	554[†]	82 (15%)	446 (81%)	26 (5%)	68
Been present when someone else had an accidental opioid / 'down' overdose	588[†]	483 (82%)	101 (17%)	4 (1%)	34
Did anyone call 911 at the last overdose you witnessed	467[§]	359 (77%)	91 (19%)	17 (4%)	16
Where did the most recent overdose you witnessed occur?[‡]	459[§]		**Location**		24
Outdoors			256 (56%)		
Housing space			57 (12%)		
A harm reduction site			47 (10%)		
A public building			25 (5%)		
Other/multiple locations			74 (16%)		

[†] *Row percentages are calculated based on the respondents who answered each question, may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

[§] *Among respondents that witnessed an opioid overdose in the last 6 months. Only respondents who answered the question are included in the denominator above (missing/unknown/illegible responses are excluded from denominator).*

[‡] *Some respondents provided multiple locations - results should be interpreted with caution.*

What is the Good Samaritan Drug Overdose Act (GSDOA)?

To encourage people at an overdose event to seek emergency medical care by reducing concerns around police arrests, the GSDOA offers legal protection for charges and conditions related to the simple possession of drugs at the scene of an overdose event. This protection applies to the person who overdosed, the person who contacts 9-1-1, and bystanders.

Three quarters of respondents had a naloxone kit and another 12% wanted a kit. Among respondents with a kit, 96% had injectable naloxone, 29% had nasal naloxone, and 25% had both injectable and nasal naloxone (Table 9). At the time of data collection, injectable naloxone was widely available for free through the provincial Take Home Naloxone program at locations including harm reduction sites, community agencies, and participating pharmacies. Nasal naloxone was free for people with First Nations Health Benefits, but others could buy it at pharmacies for about $75 to $80 for two doses (8). A nasal naloxone pilot program with limited supply was announced on November 1, 2024, near the end of the survey collection period.

Table 9. Naloxone possession (N = 622)

	N	n (%)
Do you have a Naloxone kit	566[†]	
Yes		431 (76%)
No, but I want one		66 (12%)
No, I don't want one		69 (12%)
Missing		56
Type of Naloxone kit	420[§]	
Injectable only		297 (71%)
Nasal only		16 (4%)
Both		107 (25%)
Missing		11

[†] *Column percentages are calculated based on the respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

[§] *Among respondents that had a naloxone kit. Only respondents who answered the question are included in the denominator above (missing/unknown/illegible responses are excluded from denominator).*

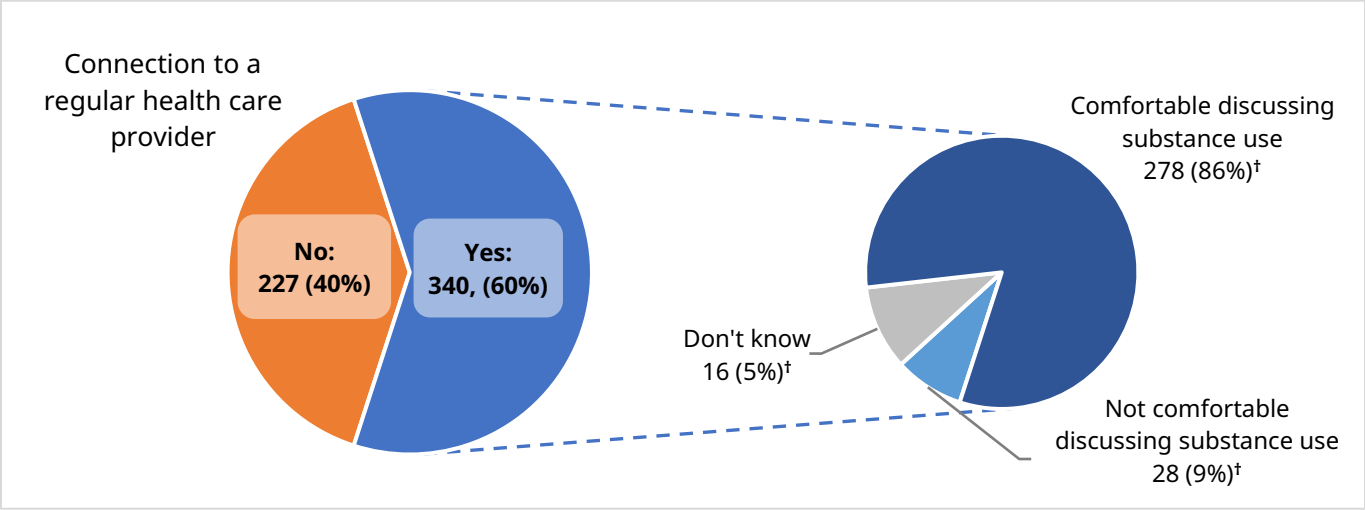
Key findings

- 1 in 3 respondents experienced an opioid overdose and 82% witnessed an opioid overdose in their community in the last 6 months.
- 19% of respondents who witnessed an overdose said 9-1-1 was not called.
- Three quarters of respondents had a naloxone kit. More respondents had injectable naloxone kits than nasal naloxone kits.

Use of harm reduction, health care, and substance use services

Access to basic health care as well as referrals to other services in BC are enhanced by being connected to a regular health care provider. Only 60% of respondents reported they were connected to a regular health care provider, compared to 79% of all BC residents in 2024 (9). Of those with a regular provider, 86% felt comfortable discussing their substance use with that provider (Figure 4). The survey did not ask what type of health care provider the respondent was referring to in their response to these questions – a regular provider could be a usual walk-in clinic, a primary care provider, or a substance use care provider. The consistency of relationships and comprehensiveness of services may vary by the type of clinic or provider people visit.

Figure 4. Connection to regular health care provider (N = 622) and comfort discussing your substance use with that provider (N = 322)



† *Among respondents that were connected to a regular health care provider. Only respondents who answered the question are included in the denominator above (missing/unknown/illegible responses are excluded from denominator).*

Respondents used many different services and supports in the last 6 months, not just those available at harm reduction supply sites. The most common were smoking supplies (79%), witnessed consumption in community (63%), outreach workers (62%), naloxone (57%), and peer support (53%, Table 10). Harm reduction strategies like witnessed consumption in community (i.e., peer witnessing) and peer support demonstrate how PWUS help each other reduce risks when using substances. It is important to note that the services listed may not be available in every community.

Table 10. Use of harm reduction services and supports (N = 622)

Which services or supports have you accessed and/or used in the last 6 months? Check all that apply.	n (%) (N=605[†])
Smoking/inhalation supplies	480 (79%)
Witnessed consumption in community[§]	380 (63%)
Outreach workers	374 (62%)
Naloxone[‡]	345 (57%)
Peer support	319 (53%)
OPS/SCS site[*]	292 (48%)
Injection supplies	233 (39%)
Safer sex supplies	205 (34%)
In-person drug checking	171 (28%)
Provider-witnessed consumption	149 (25%)
Drug user organization	145 (24%)
Counselling	145 (24%)
Opioid agonist treatment	144 (24%)
Take-home drug checking strips	133 (22%)
Prescribed alternatives[††]	129 (21%)
Harm reduction supplies from a vending machine	106 (18%)
Treatment center	85 (14%)
Drug alerts	54 (9%)
Virtual overdose prevention services	42 (7%)
Other[§§]	39 (6%)
Mail-in drug checking	37 (6%)
Harm reduction supplies ordered online	34 (6%)
None of the above	22 (4%)
Missing	17

† *Column percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator). Not all harm reduction service options are shown in table.*

[§] *For example peer witnessed consumption, or having a buddy watch when using substances.*

[‡] *Proportion reported differs from the respondents who reported owning a naloxone kit. It is unclear if some people interpreted this question as having naloxone used on you vs. carrying naloxone.*

[*] *Proportion reported differs from the respondents who reported using OPS/SCS in a different question. It is unclear why these questions elicited different results.*

[††] *Proportion reported differs from the respondents who reported receiving prescribed alternatives in a separate section. Interpret results with caution.*

[§§] *Responses included food/hygiene services, family/friends, and other specialized health and mental health services.*

Key findings

- 60% of respondents were connected to a regular health care provider, and most (86%) were comfortable discussing substance use with that provider.
- Respondents used many types of harm reduction services. The most common included picking up smoking supplies (79%), using outreach services (62%), and picking up naloxone (57%). Many reported the ways that community members are support each other, like having someone watch when they use drugs to respond to an overdose (63%) or getting support from peer workers (53%).

Prescribed alternatives

Understanding people's experiences with prescribed alternatives (PA) to the toxic drug supply is a priority in BC; however, after reviewing the prescriptions people said had been discontinued, it was clear that many respondents were describing their experience with opioid agonist treatment (OAT) or other medications. Because we did not ask the name of the medication(s) that people received as prescribed alternatives, we cannot be certain that those medications are included in the provincial definition of prescribed alternatives (10). This limits how much we can conclude from these results.

Do PWUS know what "prescribed alternatives" are?

> "People are often confused with the alternative medication options that are available including the difference between OAT and PA. Prescribers who are not familiar with PA are often reluctant to prescribe them, which only increases the barriers that PWUS face when attempting to access these medications."
>
> -PEEP member

More than two-fifths of respondents said they received any PA in the last 6 months (Table 11). Most respondents received opioid PA, while stimulant PA and benzodiazepine PA were reported less often. Among the 216 respondents that received opioid PA, 18% were also prescribed stimulant PA and 15% were also prescribed benzodiazepine PA. Many respondents who received stimulant or benzodiazepine PA also received opioid PA (67% and 73%, respectively).

Table 11. Prescribed alternatives (N = 622)

Receipt of a prescribed alternative	N[†]	Yes	No	Unsure	Missing
Any prescribed alternative	**587**	**245 (42%)**			**35**
Opioid prescribed alternative	580	216 (37%)	338 (58%)	26 (4%)	42
Also received stimulant[§]	216	39 (18%)			
Also received benzodiazepine[§]	216	32 (15%)			
Stimulant prescribed alternative	556	58 (10%)	466 (84%)	32 (6%)	66
Also received opioid[§]	58	39 (67%)			
Benzodiazepine prescribed alternative	546	44 (8%)	478 (88%)	24 (4%)	76
Also received opioid[§]	44	32 (73%)			

[†] *Row percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

[§] *Among respondents that answered yes to receiving any prescribed alternative.*

More than one-quarter of respondents who received PA in the last 6 months said their prescription was stopped for at least 3 days or the dosage reduced when they didn't want it to be (Table 12).

Table 12. Deprescribing among respondents who received PA in the last 6 months (N = 245)

Deprescribing experience	N[†]	Yes	No	Missing, OAT or non-PA[§]
Prescription was stopped (at least 3 days when you did not want it to be)	162	44 (27%)	118 (73%)	83
Prescription was reduced (when you did not want it to be)	193	52 (27%)	141 (73%)	52

[†] *Row percentages are reported among respondents that said they **received** any type of prescribed alternative in the last 6 months. Respondents whose response did not include at least one medication that can be prescribed as PA are excluded.*

[§] *Respondents commonly reported deprescribing of OAT and non-PA medications – these are excluded from the denominator. Use with caution, distinctions between PA and OAT medications may not be clear to survey respondents.*

Hydromorphone was the PA medication most often stopped (66%) or reduced (56%). Hydromorphone was also the most commonly dispensed PA and was dispensed to 83% (3,059/3,665) of all people receiving opioid PA in December 2024 (11). When asked why they thought their medication was stopped or reduced, respondents thought it was their prescriber's decision (33%), they missed appointments (33%), or they missed pharmacy pick ups (33%). It is important to note that 33% of those who said their prescription was stopped and 21% of those who said their prescription was

reduced either did not specify which medication changed or listed a medication that was not considered PA (e.g. methadone, buprenorphine, or psychiatric medications).

Key findings

- Over 40% of respondents said they received a prescribed alternative in the last 6 months, the majority being opioid alternatives. Respondents may have different opinions than prescribers and policy makers about which medications count as prescribed alternatives.
- Almost 30% of those who received a prescribed alternative had their medication stopped or reduced. Hydromorphone – the most dispensed prescribed alternative – was also the medication most commonly stopped or reduced.

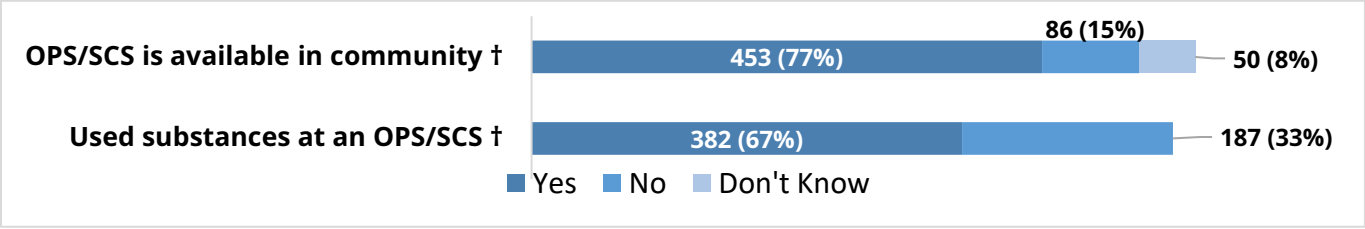
Overdose prevention site and supervised consumption site use

In 2024, 77% of respondents said that overdose prevention service sites (OPS) and/or supervised consumption sites (SCS) were available in their community, and 67% of respondents used substances at these sites in the past 6 months (Figure 5). Most respondents who used substances at OPS/SCS smoked (85%), while 39% injected substances (Figure 6).

Inhalation OPS/SCS are not available everywhere

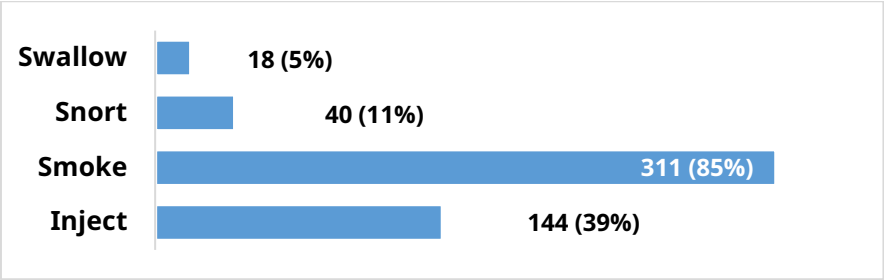
> "Inhalation-specific OPS/SCS are not available in all communities across the province. In addition to smaller communities not having as many services (if any), people are often reluctant to use sites because of the higher chances of being recognized as a substance user."
>
> -PEEP member

Figure 5. Availability and use of OPS/SCS in the last 6 months (N = 622)



† Calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).

Figure 6. Mode of substance use at OPS/SCS in the last 6 months (N = 368) [†]



[†]*Among respondents that used substances at OPS/SCS in the last 6 months. Only respondents who answered the question are included in the denominator above (missing/ unknown/illegible responses are excluded from denominator). Respondents can select multiple responses to the question (Check all that apply).*

Many respondents used a variety of services at OPS/SCS sites, not just observed consumption. Only 34% of respondents said they had not used other services or supports at an OPS/SCS in the last 6 months (Table 13). This shows that OPS/SCS are important places for connecting people to other supports, referrals, and social connections.

Table 13. Use of other services at OPS/SCS (N = 622)

	N	n (%)
Did you access any other services or supports at an OPS/SCS?[§]	549[†]	
No		188 (34%)
Picked up harm reduction supplies		291 (53%)
I got support from or socialized with others		195 (36%)
Connected to social services (e.g., income assistance, housing, employment)		130 (24%)
Wound care/health care		127 (23%)
I got a referral[‡]		37 (7%)
Other[*]		26 (5%)
Missing		73

[†] *Column percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

[§] *Percentages here are among all respondents, unlike the OPS/SCS knowledge update which calculates percentages among those who reported using another service.*

[‡] *Examples included physical or mental health care, detox/treatment, and social services. Respondents may have different definitions of what constitutes a referral, and/or may have selected the connection to social services option instead.*

[*] *Other services included receiving necessities (food, clothes, phone, bus tickets), community information and general assistance, and as a place of employment.*

The top barriers to using an OPS/SCS were operating issues, such as overcrowding, limited opening hours, long wait times, not enough booths available inside, and no wheelchair ramps (Table 14). Other barriers reported were sites or services being too far away or not available, and lack of inhalation (smoking) services. Showing identification would make 21% of respondents less likely to use services at an OPS/SCS. Identification is not currently required at OPS/SCS.

Table 14. Barriers to observed consumption at an OPS/SCS (N = 622)

	N	n (%)
Barriers to using drugs at an OPS/SCS in the last 6 months[§]	418[†]	
I had no difficulties accessing an OPS/SCS		154 (37%)
Site / service operating issues		134 (32%)
Site / services not available or too far away		82 (20%)
No inhalation services available		75 (18%)
Worry about police taking substances away while travelling		67 (16%)
Too many site rules		59 (14%)
Confidentiality / privacy concerns		43 (10%)
I do not feel safe		42 (10%)
The services are not culturally safe		19 (5%)
Something else		2 (0%)
Does not apply, I did not try to access OPS/SCS[§]		92
Missing		112
How would a requirement to provide personal information change your use of OPS/SCS?	579[†]	
I would be more likely to access the OPS/SCS		81 (14%)
It would not change my use of the OPS/SCS		257 (44%)
I would be less likely to access the OPS/SCS		119 (21%)
Unsure		122 (21%)
Missing		43

[†] *Column percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

[§] *Denominator excludes respondents who did not try to access OPS/SCS and missing/unknown/illegible responses. Barriers to OPS/SCS are also reported in a separate knowledge update with different frequencies. Percentages may differ because here they are reported among all respondents, while in the other report they are represented among respondents who reported any type of barrier.*

For more information on OPS/SCS, see the posted knowledge update which covers this topic in detail.

Key findings

- 67% of respondents used substances at overdose prevention services or supervised consumption site (OPS/SCS) in the last 6 months. The most common way people used substances at OPS/SCS was smoking (85%), followed by injection (39%).
- Additionally, 53% of respondents regularly picked up harm reduction supplies at OPS/SCS, 36% received supportive socialization, and 24% connected to other supports.
- Respondents reported barriers to using OPS/SCS services, including site operating issues, sites being too far away, and not having spaces to smoke substances.

Barriers to health and social services

Half of respondents said they hesitated (delayed or avoided) accessing health and social services. When people do not access services, it can directly increase their risk of overdose and experiencing medical complications from treatable conditions. It also reduces opportunities for service providers to build trust and connect people to primary care, housing, and treatment. Among people who hesitated, half usually did not go to the service, and half hesitated but went anyway.

Stigma and discrimination harm PWUS

> "Persistent and widespread discrimination of PWUS leads to internalized stigma, which has real and clear impacts in how often they seek care, leading to health inequities."
>
> -PEEP member

The most common reasons for hesitating were fear of being discriminated against by staff (40%) and having a bad experience accessing services in the past (39%). Respondents said they hesitated because they worried about discrimination related to their substance use, housing situation, and race or ethnicity. When asked who they worried might find out about their substance use, the most common groups were friends, family, and people in their community. The least common groups were employers, Indigenous leaders (elders), and health care providers. These details are outlined in a separate knowledge update.

Table 15. Barriers to accessing health and social services in the last 6 months (N = 622)

	N	n (%)
Have you hesitated before accessing health and social services?	536[†]	
I hesitated but usually went anyway		140 (26%)
I hesitated and did not access the service		134 (25%)
I did not hesitate to access the services I need		262 (49%)
Missing		86
If you hesitated to access health and social services, what were the reasons?	272[§]	
None. I did not hesitate to access the services that I need.		18 (7%)
Worried about discrimination from staff		108 (40%)
Had a bad experience accessing services in the past		107 (39%)
Worried about interacting with police		77 (28%)
Not sure where to go		75 (28%)
Worried that someone would find out that I use substances		74 (27%)
The services were not available or too far away		72 (26%)
Did not feel the services were culturally safe		36 (13%)
Something else[‡]		35 (13%)
Missing		2

[†] *Total survey sample is 622 respondents. The proportions above exclude missing responses.*

[§] *Among respondents that hesitated to use health and social services. Denominator excludes missing responses.*

[‡] *Examples included being scared/anxious or mistrusting providers, health-related reasons, situational circumstances, and other unique reasons.*

Approximately 33-41% of respondents said they did not feel welcome in public and community services and spaces (Table 16). Feeling unwelcome can affect a person's sense of safety and wellbeing and can make them less likely to seek life-saving services and supports.

Table 16. Comfort using emergency services and in community settings (N = 622)

Statement	N[†]	Agree n (%)	Neutral n (%)	Disagree n (%)	Missing
I feel worried about calling 911 when someone has an overdose	576	139 (24%)	92 (16%)	345 (60%)	46
I do not want to go to the emergency department when I need medical care	576	287 (50%)	106 (18%)	183 (32%)	46
I feel worried about going through withdrawal if admitted to hospital	575	330 (57%)	74 (13%)	171 (30%)	47
I feel worried about interacting with law enforcement	573	310 (54%)	100 (17%)	163 (28%)	49
I feel welcome in outdoor public spaces[§]	574	246 (43%)	137 (24%)	191 (33%)	48
I feel welcome using public services[‡]	576	249 (43%)	112 (19%)	215 (37%)	46
I feel welcome in most local businesses	571	240 (42%)	99 (17%)	232 (41%)	51

[†] *Row percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

[§] *e.g., sidewalks, parks, and beaches*

[‡] *e.g., libraries, community centres, and public restrooms*

For more information on hesitancy accessing services, see a separate knowledge update found on the BCCDC website.

Key findings

- Half of respondents said they hesitated to seek health or social services, and a quarter did not go to the service because of their hesitation. They hesitated for many reasons, including having bad experiences in the past, worrying about discrimination, and disclosing their substance use.
- Half of respondents were worried about going to the emergency department and 57% were afraid of going into withdrawal when being admitted to hospital.
- Approximately 33-41% of respondents did not feel welcome in public and community services and spaces, which can influence feelings of safety, well-being, and willingness to seek life-saving services and supports.

Experiences with law enforcement

Over half (59%) of respondents had contact with law enforcement at least once in the last 3 months (Table 17). The most common types of interactions were being asked to move somewhere else (65%), being asked for their name or ID to check release conditions (54%), and being intimidated or verbally harassed (49%). Only 34% of respondents felt they were treated with respect by law enforcement during their most recent interaction (Table 17). More details on experiences with law enforcement topics can be found in a knowledge update posted to the BCCDC website.

> See research on qualitative reflections of PWUS on law enforcement during decriminalization:
>
> Drug decriminalization in British Columbia: A qualitative study with people who use drugs. Phase 2 research report (12)

Table 17. Interactions with law enforcement in the last 3 months (N = 622)

	N	n (%)
Interaction with law enforcement (last 3 months)	556[†]	
Yes		330 (59%)
No		226 (41%)
Missing		66
What happened in the interaction?	314[§]	
I was asked to move to another location		204 (65%)
I was asked for my ID / name was run through the system or checked release conditions		169 (54%)
I was intimidated or harassed verbally		154 (49%)
I was asked to stop using substances in public spaces		133 (42%)
I was asked if I was okay / police did a wellness or health check		127 (40%)
I was put in jail or a sobering cell		103 (33%)
I was arrested for something else[‡]		89 (28%)
I had my non-prescription or illegal substances taken away		86 (27%)
I had my rigs, pipes, or harm reduction supplies taken away		80 (25%)
I was harassed physically or sexually		71 (23%)
I was provided with information about health or harm reduction services		46 (15%)
I was arrested for drug possession		38 (12%)
I had my prescribed substances taken away		33 (11%)
I was arrested for selling drugs/trafficking		20 (6%)

Continued next page

	N	n (%)
Other*		31 (10%)
Missing		16
The last time I interacted with police I was treated with respect.	537†	
Agree		182 (34%)
Neutral		128 (24%)
Disagree		227 (42%)
Missing		85

† *Column percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

§ *Among respondents that had a law enforcement interaction in the last 3 months. Only respondents who answered the question are included in the denominator above (missing/unknown/illegible responses are excluded from denominator).*

‡ *Most common 'other arrest' reasons included assault, warrant/violation of conditions, theft/breaking and entering, and minor offences.*

* *Most common 'other' interactions included being questioned, being taken to detox or a healthcare service, and being detained.*

A detailed analysis of law enforcement topics, including experiences of drug seizures, is available in a separate knowledge update posted to the BCCDC website.

Key findings

- Over half of respondents (59%) had at least one interaction with police in the last 3 months. Less than half (34%) of respondents said they were treated with respect by police.
- The most common types of interactions with police were being asked to move to another location, being asked for name or ID to check release conditions, and being intimidated or harassed.

Awareness of decriminalization policy

The decriminalization policy has been amended twice since it was first implemented (September 2023 and May 2024). The HRCS included questions to see whether respondents knew about the policy in general, and whether they understood the situations when the policy applies. Most respondents were aware of the policy in general (78%), but many did not understand the details about it how it is applied in different scenarios.

See the separate knowledge update for more details.

Table 18. Awareness of decriminalization (N = 622)

	N	n (%)
Did you know that, since January 31, 2023, British Columbia has a decriminalization policy?	555[†]	
Yes		433 (78%)
No		122 (22%)
Missing		67

[†] *Column percentages are calculated based on the number of respondents who answered each question, so may be lower than the total number of survey participants (missing/unknown/illegible responses are excluded from denominator).*

Key takeaway

- Although 78% of respondents said they were aware of the decriminalization policy, respondents were less aware of the details of the policy and how it applied in different situations.

Improving the lives of people who use substances

At the end of the 2024 HRCS, respondents were asked the open-ended question: "What is one thing that would improve your life right now?". Their answers show that many people are not getting their basic needs met. The most common response was a need for housing, with many respondents further qualifying that they needed housing that was affordable, independent, stable, and/or safe. Access to basic needs (i.e., housing, showers, bathrooms, food) were frequently mentioned, as were access to a variety of health care and harm reduction services (i.e., counselling, Opioid Agonist Treatment or OAT, prescribed alternatives, detox services). The need for more money and stable income was another dominant theme, as was the desire for employment or return to work, because of the high cost of living. The desire to reconnect with family was also commonly noted, regardless of where people were at in their substance use journey. Although the written responses were short and not able to give much context, they showed many unmet needs and the complexity of people's lives.

Notably, many respondents mentioned their relationship with substances: some expressed a desire to not use substances, others indicated wanting to use less, and others expressed needing access to substances to stay well. The diverse goals and motivations of PWUS in relation to their substance use are evident and serve as a reminder of why harm reduction is important for meeting people where they are at. Respondents also described experiencing stigma and discrimination from the general

public, service providers, law enforcement and businesses. This underscores the underlying discrimination that PWUS are often forced to navigate while obtaining their basic needs and accessing services. Many respondents named a feeling that would improve their life; stability and safety were the most common sentiments expressed.

Together, these results showcase the complex and full lives of PWUS. Respondents of the 2024 HRCS are navigating simultaneous crises – the toxic drug supply, lack of housing and an increasingly unaffordable cost of living – while also caring for loved ones and seeking belonging and community. We have summarized the responses to this question here to give a more wholistic view of the priorities and challenges that PWUS face.

Key findings

- Respondents were navigating simultaneous crises – the toxic drug supply, lack of housing, and unaffordable cost of living – while also caring for their loved ones and seeking belonging and community.

Use of Harm Reduction Client Survey data

The HRCS gives unique and valuable insights into the current experiences of PWUS with harm reduction services and other topics related to the toxic drug supply. These results can help us understand the experiences and perspectives of people using harm reduction sites and can inform program planning, improvements, and policy, together with other data sources. The findings demonstrate the benefits of harm reduction sites as a community hub for peer and health support services, as well as some barriers and challenges that exist for PWUS to navigate the current systems. We hope that public service and public health leaders can continue the work of destigmatizing these systems to meet PWUS where they are at in their journey. These findings should be interpreted in combination with the other evaluations and reflections of PWUS.

Limitations

- Participants in the 2024 HRCS are a convenience sample of clients who visited a participating harm reduction supply distribution site in BC. Results from this survey are impacted by selection bias and our results may not be a fair representation of all PWUS.
- Participants in the HRCS are anonymous and different site locations may participate each year. Comparisons of results from different survey years should be interpreted with caution.
- Although results from the HRCS provide some insights into the experiences of PWUS during decriminalization, they must be interpreted alongside other quantitative and qualitative sources of information to fully understand the impacts of decriminalization.
- Survey responses are self-reported, and the accuracy of responses cannot be assessed. Many sites had someone available to support people to complete the survey; however, the presence of a support person may have affected how respondents answered. BCCDC continues to look for new ways to support individuals completing the survey and help them provide honest responses that can be used to improve services and supports for people who use harm reduction services.
- Results related to use and possession of decriminalized substances in amounts over 2.5 grams are not included as they were determined to be unreliable due to ambiguity in question wording. Feedback from PEEP advisory group also reflected that the results are not reflective of drug possession patterns across BC. For results on this topic, see the 2023 Knowledge Update: Changes in usage, possession, and the supply of substances post-decriminalization in British Columbia: Harm Reduction Client Survey 2023 (13).

References

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Appendix

Methods

For the 2024 HRCS cycle, the survey tool was revised to reflect changes in the harm reduction and policy landscape, as well as the feedback from sites and experiences with analysis and interpretation of the 2023 survey. Revisions and updates were made in consultation with partners to ensure question clarity and appropriateness. The 2024 survey has been approved by the UBC Behavioural Research Ethics Board (UBC REB# H23-02685).

BCCDC partnered with its existing peer advisory group, Professionals for Ethical Engagement of Peers (PEEP), who were willing and able to provide multiple rounds of feedback on the HRCS questionnaire, support identification of implausible and possibly invalid responses, and ensure data interpretation reflected the lived experience of people who use substances. We are grateful to PEEP for sharing their time and expertise with us.

Survey responses were collected digitally or on paper and stored in REDCap electronic data capture tools hosted at The BC Children's Hospital Research Institute. Data was then extracted and analysed using R and R studio (14,15). Using tidyverse and the gtsummary package, frequency tables were created for inclusion in this report (16,17).

After the survey dataset was extracted from REDCap and processed in using R and RStudio, ineligible respondents were removed, written “other” responses were recategorized if appropriate, formatting and factoring were applied to the responses, and aggregated and derived variables generated. In addition, enforcement of analysis logic was applied including removing “does not apply” and “prefer not to say” responses from denominators, and enforcing the question universe definitions based on prior responses. Once data cleaning and processing was completed an analysis ready dataset was created.

Racial and ethnic self-identification, including Indigenous identity, are currently not included in public reporting. We are trying to ensure that the data that we release will not cause harm to any vulnerable groups. We are actively working with Indigenous serving organizations to provide the HRCS data with ethnicity stratifications as a start in respecting OCAP and data sovereignty for First Nations and Métis peoples.

When groups contain less than 20 respondents, they were not further broken down based on other responses due to concern of unstable rates. A footnote will indicate which group (row) was removed due to low response count.

Due to the nature of the survey, there are often missing/blank and illegible responses included in the paper surveys. In addition, some responses were marked as “prefer not to say”. These were all considered non-responses and are documented for internal reference. These types of missing responses were removed from the question-specific denominators. Questions with missingness of ≥20% were also reviewed to identify whether the question could be improved for future surveys.