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Access to health and harm reduction services during drug decriminalization in British Columbia, Canada: a mixed-method study

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Abstract

Background On January 31st 2023, the Canadian province of British Columbia temporarily decriminalized the personal possession of certain illegal drugs up to 2.5 g, cumulatively, for adults. A stated aim of this policy directive was to reduce the stigmatization of people who use drugs and increase access to health and harm reduction services. The aim of this study was to capture the prevalence and nature of potential barriers to such services under drug decriminalization.

Methods We employed a mixed-methods study design, triangulating survey data from harm reduction service users in 2022 ($n=503$) and 2023 ($n=433$) alongside qualitative interviews with people who use drugs in British Columbia ($n=78$) collected in 2023. Qualitative and quantitative findings were analysed convergently.

Results Findings across both datasets suggest that reported barriers to health and harm reduction services persisted during British Columbia's decriminalization pilot. Quantitative and qualitative data reflecting these barriers are presented in parallel under four themes: (1) stigma and fear of substance use disclosure, (2) stigma and access to services, (3) service-specific barriers, and (4) police-related barriers.

Conclusion Decriminalization alone may be insufficient to address and/or mitigate the barriers that continue to constrain people who use drugs' access to care. If the policy goal is to reduce barriers to health and harm reduction services, additional structural and institutional supports may be required.

Highlights

- Barriers to accessing health and harm reduction services persisted during BC's decriminalization pilot.
- Perceived stigma limited access to health and harm reduction services.
- Inhalation services remain limited at observed consumption sites across BC.
- Despite the legal reform, policing practices discouraged health service attendance.
- Decriminalization alone may be insufficient in eliminating service barriers.

Keywords Drug decriminalization, Harm reduction, Health services, Barriers, Stigma, Police, Mixed-methods

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Introduction

On May 31st 2022, Health Canada approved a temporary federal exemption to the Controlled Drugs and Substances Act for a three-year period in the province of British Columbia (BC), Canada. Enacted on January 31st 2023 and in effect until January 31, 2026, this novel policy decriminalized the personal possession of certain drugs (opioids, power and crack cocaine, MDMA, and methamphetamine) for adults over the age of 18, permitting possession up to 2.5 g (cumulative) for personal use with no legal grounds or police authority for arrest, seizure, fines, or mandatory treatment [1]. Additionally, police were directed to distribute information about accessing harm reduction and recovery services in the form of a resource card to support connections to care. In September 2023, the exemption was amended to prohibit possession in child-focused spaces and in close proximity to them, including schools, playgrounds, parks, and childcare facilities [2]. In May 2024, this prohibition was further expanded to apply to most public spaces (excluding private residences, designated health facilities and to people who are unhoused and lawfully sheltering), effectively reinstating police authority to seize drugs and make arrests for possession of any amount of illegal drugs in public.

One aim of decriminalization, amongst others, was to reduce "barriers and stigma that prevent people from accessing life-saving supports and services" [1]. Although broad in its framing, in implementing decriminalization, policymakers recognized the protective factors associated with health and harm reduction service engagement for people at risk of overdose. Highlighting this understanding was Health Canada's explicit requirement for BC to make concurrent investments in health, harm reduction, drug treatment and social services during the pilot phase [2]. Extensive evidence links engagement with a range of health and harm reduction interventions including supervised consumption and overdose prevention sites (SCS/OPS), opioid agonist treatment, primary and hospital care pre- and post-overdose and community mental health services to reduced rates of mortality amongst people at risk of overdose [3–11].

Before decriminalization, between September 2016 and January 2023, more than 14,000 suspected drug deaths were recorded in BC [12]. Drug-related fatalities in BC represented approximately 32% of all overdose deaths nationally despite only 13.8% of the national population residing in the province [13]. Since the declaration of a provincial public health emergency related to increases in overdose deaths in 2016, BC has expanded the implementation of early intervention and prevention programs (e.g., integrated child and youth teams, the delivery of harm reduction services (e.g., observed consumption sites, opioid substitution programs, naloxone access, drug checking services etc.) and the expansion of community and residential drug treatment services [2]. However, research conducted in jurisdictions and policy periods where the possession and use of drugs remain criminalized has documented barriers arising from the criminal legal status of drugs and police interactions, particularly in relation to the ability of people who use drugs to access health and harm reduction services [14–16].

Systematic reviews highlight the multitude of potential social (e.g., stigma from family, community or health workers), structural (e.g., criminalization, restrictive service models, geographical inaccessibility of services) and individual barriers (e.g., low health literacy, low self-esteem, privacy concerns) to accessing health and harm reduction services [17–25]. In these studies, the direct (e.g., fear of arrest) and indirect (e.g., reinforcement of social stigma in health settings) impacts of criminalization consistently emerge. Prior scholarship, such as Sheehan et al. [26], commonly differentiates between internalized stigma (the internal acceptance of negative stereotypes), public stigma (negative attitudes, stereotyping, and discriminatory behaviours enacted by others), and structural stigma (the embedding of stigma within laws, policies, and institutional practices that systematically disadvantage marginalized groups) [26]. In this paper, stigma is understood as a multi-scalar social process through which people who use drugs are devalued, blamed, or excluded, shaping both self-perception and interactions with individuals and institutions [27].

These barriers, including stigma are not experienced uniformly. Structural vulnerability – shaped by intersections of poverty, racialization, indigeneity, gender, disability, and housing precarity – profoundly influence how people who use drugs encounter health and harm reduction systems. For many, criminalization interacts with these structural factors to deepen social exclusion and restrict access to lifesaving services. Without explicit attention to these inequities, reforms such as decriminalization risk reproducing or even exacerbating existing disparities in service access and health outcomes. Recognizing that those most likely to benefit from harm reduction interventions are also often those least able to access them underlines the need for equity-focused evaluation of drug policy reforms. In this paper, we address these questions through an equity-attentive mixed-methods approach that situates quantitative findings within qualitative accounts of lived experience, rather than through quantitative stratification or subgroup comparisons.

A foundational premise of BC's decriminalization pilot was that reducing criminal penalties and removing the threat of legal punishment would enable individuals to seek out supports [1]. More specifically, the policy aimed to reduce the multifaceted manifestations of social stigma in the lives of people who use drugs, including a

reluctance to seek out health, social, housing and drug treatment support due to actual and perceived mistreatment or discrimination within these settings [22, 27–34]. Before the implementation of this temporary policy, research specific to BC highlighted related harms, including: (1) police presence around health and harm reduction services can increase overdose risk by dissuading service access due to fear of police apprehension [14, 15, 35], (2) fear of criminalization increases likelihood of isolated drug use, exacerbating overdose risk [36] and (3) people who use drugs perceive and experience criminal drug laws as a primary driver of social stigma, both broadly in society and specifically within health and other institutional settings [27, 37, 38], again, dissuading and limiting access to services key in overdose prevention and risk mitigation.

Initial research on the impact and implementation of drug decriminalization in BC has documented changes in drug crime and opioid and stimulant harm [39], levels of awareness and knowledge of drug decriminalization amongst people who use drugs [40], policy perspectives of police [41, 42] and qualitative experiences of stigma and police interactions [43–46]. While these studies have highlighted short-term impacts, the perceived barriers to health and harm reduction services during the drug decriminalization pilot in BC remain underexplored. Given decriminalization's stated goal of reducing these barriers, there is a unique opportunity to study how people who use drugs experience access to services during the policy period.

Methods

Mixed methods study design

The current study utilizes a convergent mixed methods design using two distinct and independently collected datasets to examine the impact of decriminalization on access to health and harm reduction services in BC amongst people who use drugs: [1] a quantitative, multi-year survey at harm reduction sites conducted by the BC Centre for Disease Control and [2] qualitative interviews conducted by researchers at Simon Fraser University. Although collected separately, the two components were designed to be complementary. Research teams collaborated during the development phase to review and refine the study aims and data collection tools (survey, question guide) to promote alignment and comparability across datasets. Following separate analyses, the teams engaged in a collaborative interpretation process to compare findings and highlight areas of convergence, divergence, and expansion across the datasets. Through this integrated approach, we embed qualitative findings alongside the quantitative results to explain and provide connections – thereby enriching the understanding and interpretation of outcomes and patterns. Data collection took place during a period of policy transition, marked by evolving bylaws and proposed amendments to decriminalization. The first amendment, prohibiting possession in child-focused spaces, was introduced during the study period, while further amendments to expand prohibitions to most public spaces occurred after data collection ended. As such, the findings reflect experiences during a time of heightened uncertainty, public debate, and legislative change.

Quantitative methods

The Harm Reduction Client Survey (2022 UBC REB#H07-00570; 2023 UBC REB#H23-02685) is a cross-sectional, quantitative survey administered at selected harm reduction sites across BC. The survey aim is to gather information on the health of people accessing the sites and improve the services offered to them. In 2022 and 2023, the survey included questions relevant to BC's decriminalization policy, as well as substance use and social and demographic characteristics of respondents (see supplementary materials for both the 2022 and 2023 surveys). The research team collaborated with an advisory group of people with lived and/living experience of substance use through regular meetings to develop survey questions and interpret survey findings to ensure appropriate contextualization of the data.

The paper-based survey is self-administered and anonymous. Staff at harm reduction sites recruited participants, collected verbal consent and answered any questions from participants. Eligible survey respondents were 19 years or older and reported use of unregulated substances within the last six months. See Table 1 for survey participant demographic characteristics. Survey respondents received a $20 honorarium for completing the survey. The 2022 survey dataset includes 503 eligible respondents across 29 harm reduction sites collected between November 2022 and January 2023, *before* implementation of decriminalization. The 2023 survey dataset includes 433 eligible respondents at 23 harm reduction sites collected between December 2023 and March 2024, *after* decriminalization came into effect and after it was amended to exclude specific child-focussed spaces [47].

The survey responses were entered in REDCap electronic data capture tools hosted at the BC Children's Hospital Research Institute and data were extracted, cleaned, and analysed in R (version 4.3.1) at the BC Centre for Disease Control. Frequency tables were created for the purpose of data exploration in addition to the tables included in this report. Descriptive and bivariate tables were generated for questions that related to hesitation to attend services, police interactions, experiences in the community and use of observed consumption sites (OPS/SCS). Proportions provided are based on the total number of valid responses to each question, and differ from

Table 1 Characteristics of Harm Reduction Client Survey respondents 2022 ($n=503$) and 2023 ($n=433$)

Characteristic	2023		2022	
	Overall*	*n* (%)	Overall*	*n* (%)
Age, in years	419	19–75 (avg = 43)	490	19–71 (avg = 42)
Health Authority (survey site)	433		503	
Interior (IH)		69 (16%)		139 (28%)
Fraser (FH)		89 (21%)		102 (20%)
Vancouver Coastal (VCH)		77 (18%)		53 (11%)
Island (ISLH)		89 (21%)		104 (21%)
Northern (NH)		109 (25%)		105 (21%)
Community size (2021 Census Population Centre)	433		503	
Small Population Centre		186 (43%)		171 (34%)
Medium Population Centre		55 (13%)		164 (33%)
Large Urban Population Centre		192 (44%)		168 (33%)
Type of current residence**	398		485	
Private or band owned residence		84 (21%)		120 (25%)
In a temporary or transitional residence		108 (27%)		111 (23%)
Shelter		79 (20%)		98 (20%)
Unsheltered homeless		127 (32%)		150 (31%)
Gender	425		477	
Man		267 (63%)		293 (61%)
Woman		142 (33%)		179 (38%)
Nonbinary / Gender expansive		16 (4%)		5 (1%)
Employment	409		481	
Yes (full or part time)		84 (21%)		110 (23%)
No		325 (79%)		371 (77%)
Frequency of substance use in the last 30 days	416		478	
Every day		334 (80%)		339 (71%)
A few times a week		49 (12%)		82 (17%)
A few times a month or less		33 (8%)		57 (12%)
Injection drug use, last 6 months	413		489	
Yes		193 (47%)		189 (39%)
No		220 (53%)		300 (61%)
Inhalation drug use, last 6 months	408		487	
Yes		371 (91%)		429 (88%)
No		37 (9%)		58 (12%)
OPS/SCS use, last 6 months	408		487	
Yes		263 (64%)		239 (49%)
No		145 (36%)		248 (51%)

*n (column %), Missing, illegible, prefer not to say responses are excluded. Each variable may have a slightly different (lower) denominator based on survey respondents that completed the question

** 'Temporary or transitional residence' includes hotels/motels, rooming houses, single room occupancy (SRO), social/supportive housing. 'Unsheltered homeless' includes houseless, couch surf, tent, encampment, in a vehicle, no fixed address. One additional residence category ("Other") included fewer than 20 respondents and is not shown to protect confidentiality; these respondents are included in the total denominator

the total respondents when questions were unanswered or if respondent indicated "prefer not to say". Results from the 2022 and 2023 Harm Reduction Client Survey are presented side-by-side when the same question was asked across surveys. Statistical comparisons between survey years were not conducted due to changes in questions between years and because the independence of samples was uncertain – the survey was anonymous and some sites participated in both years. General comparisons between years offer insight into the experiences of survey respondents (also see the limitations section for details).

Qualitative methods

The qualitative component of the current study draws on interview data collected as part of the broader 'Decriminalization in British Columbia' project, a multi-year qualitative investigation into the impacts of BC's drug decriminalization policy on people who use drugs. The current analysis focuses exclusively on one-on-one interviews with people who use drugs conducted between

August 2023 and January 2024 – during the first year of the decriminalization pilot. One study objective was to understand how decriminalization has impacted access to health and harm reduction services, with particular attention to reported structural and interpersonal barriers and facilitators. This approach foregrounds the experiences, perspectives, and concerns of people who use drugs as they navigate services in a shifting legal environment.

Table 2 Characteristics of qualitative interview participants ($n = 78$)*

Age, in years	18–71 (avg = 38)
Gender	
Cisgender woman	37 (47.4%)
Cisgender man	37 (47.4%)
Gender expansive	3 (3.8%)
No response	1 (1.3%)
Living Situation	
Private residence, alone or with others	54 (69.2%)
No regular place to stay	13 (16.7%)
Other residence	11 (14.1%)
Health Authority	
Interior (IH)	15 (19.2%)
Fraser(FH)	13 (16.7%)
Vancouver Coastal (VCH)	23 (29.5%)
Island (ISLH)	17 (21.8%)
Northern (NH)	10 (12.8%)
Years Living in BC	
16 + years	47 (60.3%)
6–15 years	16 (20.5%)
0–5 years	14 (17.9%)
No response	1 (1.3%)
Illicit Drugs Used (within the past 30 days)	
Cocaine	29 (37.2%)
MDMA	26 (33.3%)
Methamphetamine	25 (32.1%)
Fentanyl	22 (28.2%)
Crack Cocaine	14 (17.9%)
Heroin	8 (10.3%)
Other illicit drugs	49 (62.8%)
Use of Harm Reduction Services	
Never	21 (26.9%)
Less than once a month	22 (28.2%)
A few times a month	8 (10.3%)
Once a week or more	10 (12.8%)
Daily	15 (19.2%)
No response	2 (2.6%)
Personal yearly income	
$0–19,000	29 (37.2%)
$20,000-$39,999	25 (32.1%)
$40,000-$59,999	9 (11.5%)
$60,000-$79,000	7 (9.0%)
$80,000-$99,999	5 (6.4%)
$100,000+	2 (2.6%)
No response	1 (1.3%)

* *n* (column %). Denominator includes missing and non responses

Eligible participants were adults (19 years or older) residing in BC who reported regular use (defined as weekly use for the past six months) of one or more of the drugs outlined in the decriminalization model (opioids, methamphetamine, cocaine, and MDMA). Participants were recruited through a multi-modal strategy designed to maximize reach and ensure the inclusion of diverse voices across BC. Recruitment was led, in part, by the same community advisory board that supported the Harm Reduction Client Survey. The board was composed of individuals with lived or living experience of drug use from diverse communities, including urban and rural/remote settings. Board members aided recruitment by leveraging peer networks and offering guidance on recruitment strategies that prioritized cultural relevance, accessibility, and relational trust. Recruitment was supplemented by the dissemination of study information through online platforms. Snowball sampling was also employed to extend reach within social networks. This layered recruitment approach was intended to reach a broad cross-section of people who use drugs, including those who may not be closely connected to formal services or peer organizations. See Table 2 for qualitative interview participant demographic characteristics.

Participants provided informed consent prior to the interview commencing. Interviews were semi-structured and conducted by phone or on Zoom, based on participant preference (in-person interviews were offered but were not taken up by any participants). The interview guide was developed collaboratively with the research team and underwent multiple revisions informed by existing literature, evolving features of the decriminalization model, and insights from early interviews. The community advisory board reviewed and provided feedback on multiple iterations of the interview guide which contributed to the refinement of questions prior to data collection. Although the interview guide covered a range of topics related to drug use, decriminalization, policing, and service access, the current study draws specifically on participants' narratives regarding their ability to access or navigate health and harm reduction services during the decriminalization period. Questions relevant to this analysis include: *"Can you tell me about a time recently when you tried to or did access health and social supports, such as going to the doctor, seeing a counsellor, seeking harm reduction services, or treatment programs?"* or *"How do you think decriminalization has impacted access to harm reduction services for others in your community?".* The qualitative interviews were conducted by the second and third author who are both PhD candidates with substantial experience in qualitative research who served as research co-ordinators for this project (and

previous phases of the broader decriminalization study). In addition to conducting interviews, the second author led involvement with the community advisory board throughout the project, which facilitated relationships with community partners and interview participants. Together, the interviewers' sustained involvement in the research program and prior qualitative data collection supported rapport building and trust during interviews.

We used thematic analysis [48] to examine the effects of drug decriminalization on health and harm reduction among people who use drugs. Data management and coding were carried out using NVivo 12 (QSR International, 2024), allowing for systematic organization and analysis of interview transcripts. Initial codes were generated inductively and discussions amongst the research team guided the development and refinement of themes. The broader social and policy context in BC was considered throughout the analysis, particularly in relation to decriminalization and the implementation on the ground. Themes were not developed in a linear fashion, but rather were developed through an ongoing process of returning to the data, reflecting on meaning, and engaging in dialogue as a research team. This recursive approach allowed us to remain attentive to the depth and nuance of the data, while situating narratives within broader structural and policy landscapes.

All interviews were audio recorded, transcribed verbatim, and de-identified to protect participant confidentiality. Ethics approval for the qualitative study was granted by Simon Fraser University's Office of Research Ethics (#30001251). The research was conducted in accordance with the Declaration of Helsinki, ensuring voluntary informed consent, confidentiality, and participant wellbeing.

Results

Findings across the quantitative and qualitative data sets provided insights on a range of factors that impact access to health and harm reduction services in the context of drug decriminalization. We have organized these factors under four themes: (1) stigma and fear of substance use disclosure, (2) stigma and access to health and harm reduction services, (3) service-specific barriers and (4) police-related barriers to health and harm reduction services.

1) Stigma and fear of disclosure

Despite the introduction of BC's decriminalization pilot, many participants in the survey and interviews reported that they experienced stigma and fear of disclosure. In the 2023 Harm Reduction Client Survey (see Table 3), 39% ($n = 159$) of survey respondents worried about people finding out they used substances (indicated worry about one or multiple groups of people). The qualitative data echo and complement this finding, wherein participants recounted instances of stigma within service environments and broader community contexts when being identified as someone who accesses such services. Some participants shared how these feelings led to avoiding harm reduction services specifically, not because of a lack of availability, but due to fears of being identified as a harm reduction client (and therefore someone who uses drugs) by other community members:

> *They [harm reduction services] should be in everybody's area … where people feel safe to access them, because I think a lot of people right now are going to avoid that area like the plague. Because again, it is all these neighbours who just can't wait to take a picture of somebody who is at their most vulnerable and put it on social media and say that they don't want this in their area, right. So I think even though there are a lot of overdose prevention services available, are people really going to use them when it is so visible to everybody else when they're using them? (Participant 5, VCH).*

As highlighted by this participant, concerns about visibility, community surveillance, and fear of being identified as a harm reduction client – and the ensuing stigma – was an important driver of service avoidance. Several interviewees described the potential social and professional consequences of being identified as a harm reduction client, including fear of job loss or reputational harm:

> *It's always going to be hard to access those services unless there's some kind of policies in place about job protection, other stuff like that where people feel safe, where they're not putting themselves at risk. Because this is a really expensive city to live in and, you know, we got to pay rent. (Participant 24, VCH)*

Being recognized as a harm reduction client was described as particularly problematic for participants employed in care or social service sectors, where disclosure of drug use could jeopardize professional standing. Maintaining a distance between personal services and one's professional life was seen as critical: *I'm, like, scared of the crossover being a drug user and a social worker. And I wouldn't want to be found out.* (Participant 20, IH). Some participants noted that stigma was amplified by the geography of services. Locations associated with marginalized neighbourhoods, such as Vancouver's Downtown Eastside, were described as highly stigmatized. For some, the mere act of accessing services in these areas marked them with negative assumptions:

Table 3 Harm Reduction Client Survey responses for access harm reduction services, 2022 and 2023

Characteristic	2023 *n* (%)*	2022 *n* (%) **
Hesitant to access services due to site/service-related barrier:	*N* = 402	*N* = 491
Any hesitance site/service-related barrier	201 (50%)	-
Site is in my red zone / an area that violates my conditions of release	14 (3%)	19 (4%)
Worry about police taking my drugs away	55 (14%)	59 (12%)
Site/service operating issues (limited hours, long waits, no wheelchair ramps)	78 (19%)	-
Services not available in my community or too far away	58 (14%)	-
Trying to avoid another client(s) of the service	55 (14%)	-
Don't like the organization that provides the service	29 (7%)	-
Don't like staff providing the service	40 (10%)	-
Other	20 (5%)	-
Does not apply to me	201 (50%)	-
Worry about the following people finding out you use substances	*N* = 406	*N* = 491
Any group ^	159 (39%)	130 (26%)
Family services (I am a parent or caregiver) ^	56 (14%)	36 (7%)
Health care provider ^	40 (10%)	33 (7%)
Friends or family ^	104 (26%)	57 (12%)
Police/parole/probation officer ^	51 (13%)	60 (12%)
My employer ^	44 (11%)	34 (7%)
None of the above ^	247 (61%)	-
Worry you will be treated badly when accessing services due to	*N* = 399	*N* = 491
Any stigmatized identity	263 (66%)	-
Substance use	223 (56%)	-
Housing situation	173 (43%)	-
Race or ethnicity	53 (13%)	52 (11%)
Sex or gender	32 (8%)	30 (6%)
Sexual orientation	30 (8%)	17 (3%)
None of the above	136 (34%)	-

* *n* (column %). Denominator excludes missing, illegible, and prefer not to say responses. The 2023 questions included in this table are respondents that answered each of three questions:

• "Have any of the following things made you hesitant to access services you need to be healthy?" (*n* = 402)

• "Do you worry about these people finding out that you use substances?" (*n* = 406)

• "Do you worry you will be treated badly when accessing services because of your…" (*n* = 399)

** *n* (column %). Denominator excludes missing, illegible, and prefer not to say responses. The 2022 comparison include respondents that answered a single question:

• "In the last six months, have any of the following things made you hesitant to access services you need to be healthy?" (*n* = 491).

• The 2022 question had fewer response options; there is not a comparable 2022 value for many rows, including the derived "any hesitance site barrier" or "any stigmatized identity".

^ In 2022 this response was asked as resulting in to hesitating to access services, while in 2023 it was asked in general if the respondent worried about these people/groups finding out they use substances. Values are not directly comparable between survey years.

> *I've been seeing that some of them they're, like, on Hastings close to Main [Downtown Eastside] and that area's sketchy. And I don't know, like, that was, like, my first neighbourhood and I'm not– never been afraid of that. But it's not like enjoyable to be there. So– and it's, like, I feel like if you go to one of these centres it's, like, I feel like they will judge you as a junky because the location is there. (Participant 12, VCH)*

Reluctance to access harm reduction services stemmed not only from fears of discrimination but also from the visibility of services and the risk of being identified as someone who uses drugs could jeopardize social standing, employment, and professional identity.

2) Stigma and access to health services

Perceived stigma (see Table 3) was equally reported in the survey data where 66% (*n* = 263) feared mistreatment when accessing services due to one or more stigmatized identity, 56% (*n* = 223) due to their substance use, 43% (*n* = 173) due to their housing situation and 13% (*n* = 53) due to their race or ethnicity. One consequence of anticipated or perceived stigma was that 10% (*n* = 40) of survey respondents worried about disclosing their substance use to their health care provider and 51% (*n* = 200) agreed with the statement that they avoid or delay going to an emergency department when they need medical care. Exploring the root of these fears – namely, judgement and mistreatment – interview participants described

tangible shifts in treatment by healthcare staff following the disclosure of their drug use:

> *It's very difficult to get in [to see a doctor] and nine times out of ten the minute you say you use drugs… You're just treated like crap. The way they treat you changes. (Participant 19, ISLH).*

A narrative that arose with interviewees who reported past stigmatizing experiences was that it occurred at the very first point of contact with healthcare services. These experiences were particularly apparent through participants' reflections on their own experiences as relatively different from people who do not use drugs:

> *Emergency room waits are horrible…I have never really had very good healthcare experiences…I feel judged. It is like, literally they are just cold all of a sudden and…they just want nothing to do with you. I have seen somebody in line in front of me get offered all these…resources and then my turn and I just get…basically brushed off. The difference in care is insane. There is such a difference. (Participant 69, IH)*

Whilst perceived mistreatment by healthcare staff was often conceptualized as being associated with one's substance use, equally reflected in both datasets were perceptions that this mistreatment intersected with experiences of discrimination based on other visible markers of marginalisation such as race or housing status:

> *The last time with them [healthcare provider] I had a health issue and they denied that I've had it, which is making it worse […] I see that as discrimination alone in there, my being Aboriginal, being a drug user, it is awful, it has been a year and three months and I've not been getting any help. (Participant 63, IH)*

Negative experiences of stigma functioned as a barrier to healthcare access. Reflecting on these experiences, some participants felt the implementation of the decriminalization policy, rather than reducing negative attitudes from healthcare professionals, exacerbated stigma:

> *I feel like there's been an increase in the stigma and the way that you get treated by healthcare professionals since decriminalization rather than the other. Which is obviously a goal of decriminalization, right. So I feel like it's not working. (Participant 54, VCH)*

Experiences of stigma and/or perceived mistreatment or discrimination within healthcare settings act as barriers to people seeking out and subsequently continuing to engage with such services. Again, survey data reinforced that people who use drugs had concerns around disclosure, and discriminatory treatment within healthcare settings during the decriminalization pilot. Together, these findings demonstrate a persistence of the social mechanisms of such barriers amid the first year of the decriminalization pilot.

3) Service-specific barriers

Participants identified a range of service-specific barriers that limited access to health and harm reduction supports (see Table 3). Although decriminalization was intended to reduce barriers to service access, these barriers were shaped less by the decriminalization policy itself, and more by provincial service coverage, service design, funding allocation, and site-specific operational factors - including long wait times for services, geographic and operational inaccessibility, and limited availability of overdose prevention services for people who do not inject drugs. Participants consistently described these barriers as persisting unchanged during the decriminalization period. These challenges limited service access and were reflected in the survey data: 50% ($n = 201$) of respondents reported hesitance in accessing a health or harm reduction service due to any site-related barrier, 19% of survey respondents ($n = 78$) reported hesitance due to site or service operating issues (e.g., limited hours, long wait times or inaccessible infrastructure) and 14% ($n = 58$) noted that services were not available in their community or too far away as a limiting factor.

Several participants noted the difficulties associated with accessing publicly funded drug treatment during the decriminalization pilot. Although private treatment options exist, the high cost rendered them unattainable for most and resulted in participants describing long wait times for provincially funded care:

> *More money should be spent into treatment, cause right now I am actually on a waiting list to get into treatment…I am in a pretty good place though, mentally and physically. But it is still tough, really tough for me to get in and I have connections through recovery. And I am already waiting 47 days…to get into treatment and I am still quite a ways away. There is a lack of provincially funded beds…you can get in easy if you have $15,000-$20,000 a month. But as someone who has been using for almost a year again…I have lost my construction company…I have lost my place to live and burned through all of*

my finances. So, $15,000-$20,000 is just not feasible. (Participant 48, VCH)

This quote underscores the inequities between those who can afford private care and those reliant on an under-resourced public system. For many, wait times meant missed opportunities for recovery and/or harm reduction. Participants frequently contrasted the stated goals of decriminalization with their ongoing difficulties accessing treatment, pointing to persistent structural gaps in timely, affordable, and culturally appropriate bed-based treatment options despite the policy reform. Recognizing the ongoing difficulties with drug treatment access, participants questioned the pilot's broader impact on health and harm reduction access:

It is interesting to know that is what they're looking at as a measure of success for decriminalization and I wonder if people have felt a difference in the way that they access healthcare as a result. I certainly haven't. (Participant 54, VCH)

Despite the province's stated intention to scale up services alongside decriminalization, participants reported geographic disparities, particularly in rural and remote areas. Limited availability of overdose prevention services outside major urban centres was perceived to create significant risks for people using drugs alone, without supervision, or access to emergency care:

I've discussed it [decriminalization] with a couple of friends and they've brought up the same kind of worry that some of the younger, newer into the scene [individuals], that they're a little more worried that they might go without the support of having an OPS in the area. So, they make bigger purchases and then they want to use alone…they financially can't share or they don't want to, or don't want to get robbed, or they don't have a safe place to go… decrim is the right direction but with a lot of things missing. Like OPS funding for smaller communities. (Participant 41, IH)

Even within the same city, participants believed that harm reduction services were concentrated in specific areas or neighbourhoods; even though most understood the need and utility of having such services easily accessible in a single area, they also called for more evenly distribution across regions, something several participants had expected decriminalization to address:

[People who use drugs] live everywhere. They're not all just [in the Downtown Eastside]. And it's, like, sure, we need systems and programs in [the Downtown Eastside]. But you also need programs other places. (Participant 6, VCH)

Limited geographical coverage undermined some people's desire and intentions to access specific harm reduction services (observed consumption sites and OAT) - an outcome participants expressed disappointment about given the implementation of decriminalization. Public health efforts were undermined through this limited geographical coverage (e.g., driving larger purchases and/or encouraging isolated drug use). Survey data showed that 23% ($n = 45$) of participants noted that SCS/OPS were not available in their community or too far away as a limiting factor. In response to service gaps, some interview participants described travelling long distances to access appropriate health and harm reduction services during the decriminalization pilot:

I am on the OAT program and the two doctors here, they're impossible. So I have to travel an hour and a half to go to Nelson to deal with the doctor there that is willing and has been working with me for the past month. (Participant 67, IH)

Such travel requirements pose significant burdens, especially for individuals managing unstable housing, employment, or withdrawal symptoms. Additionally, amongst people who reported a difficulty accessing an SCS/OPS 39% of survey respondents ($n = 77$) reported that inhalation/smoking was not locally available to them and that this was a barrier to them using a supervised consumption services (Table 4). Interview participants similarly articulated a need for observed consumption services that support people who smoke, snort or consume their drugs through other modes:

If you are homeless and you are a drug user and you just picked up or something, where are you supposed to really do them, right? I know there are some safe injection sites, but what if you don't inject? (Participant 69, ISLH)

Frustration regarding the lack of inhalation facilities was common amongst interview participants. Some also discussed limited service hours, which often failed to accommodate the needs of people who use drugs at night or outside typical business hours, an occurrence participants noted had not shifted following decriminalization:

I have been advocating since 2016 to have an overdose prevention site open 24 h a day…drug use doesn't stop at one o'clock because an overdose prevention site is closed. (Participant 52, VCH)

Table 4 Difficulties experienced accessing OPS/SCS. Harm Reduction Client Survey 2023

Experience of difficulties at OPS/SCS	*n* (%)*
Did you experience difficulties? (*n* = 379)	
I did not have difficulties	180 (47%)
Experienced at least one difficulty accessing OPS/SCS	199 (53%)
Reasons for difficulty using substances at an OPS/SCS (*n* = 200)	
Inhalation/smoking is not available	77 (39%)
Site/service operating issues	76 (38%)
Sites/services not available in my community or too far away	45 (23%)
There are too many rules I have to follow	38 (19%)
I haven't felt safe using at an OPS/SCS (e.g., from other clients, from dealers, etc.)	35 (18%)
I have confidentiality / privacy concerns	30 (15%)
Something else	16 (8%)

* *n* (column %). Denominator excludes missing, illegible, and prefer not to say responses

Table 5 Harm Reduction Client Survey responses to statements about feeling worried about accessing services and feeling welcome in community settings, Harm Reduction Client Survey 2023**

Statement	Overall *N* = 433*	Agree *n* (%)^	Neutral *n* (%)^	Disagree *n* (%)^
I feel worried about calling 9-1-1 when someone has an overdose	393	94 (24%)	50 (13%)	249 (63%)
I do not want to go to the emergency department when I need medical care	393	200 (51%)	60 (15%)	133 (34%)
I feel worried about interacting with law enforcement	395	236 (60%)	59 (15%)	100 (25%)
I feel welcome in outdoor public spaces (sidewalks, parks, and beaches)	388	189 (49%)	73 (19%)	126 (32%)
I feel welcome using public services (libraries, community centres, and public restrooms)	402	213 (53%)	56 (14%)	133 (33%)
I feel welcome in most local businesses	401	171 (43%)	75 (19%)	155 (39%)

*Missing, illegible, and prefer not to say responses are not included in the proportions reported for each response

** No comparable questions in 2022 survey

^ *n* (row %)

Participants emphasized that limited hours of operation restricted the effectiveness of harm reduction services as they fail to align with the schedules of people who use drugs as a diverse population. This was seen as particularly true for those who worked during traditional working hours:

> *A lot of people work. If these places– especially in smaller communities, they're only open during the day. You can't go after work and obtain a naloxone kit or needles or whatever you need, right? (Participant 31, IH)*

Limited service hours did not reflect individuals' daily consumption patterns, illuminating gaps in providing lifesaving services when people needed them in a way that also allowed them to balance other life and work demands. Several participants also had limited information about the availability and accessibility of harm reduction services, suggesting that service visibility and access remained unchanged during the decriminalization period. Some expressed unique challenges in accessing such information, underscoring the structural barriers that some people who use drugs face:

> *I wouldn't be able to tell you what hours they're [harm reduction services] open. And if I can't tell you what hours they're open and I have access to the Internet and a cell phone.... (Participant 5, VCH)*

While many of the service-specific barriers described here existed prior to the decriminalization pilot, participants consistently discussed these barriers in relation to this policy and its stated intention to reduce barriers to care. Rather than experiencing meaningful improvements in access, participants described these constraints as persisting largely unchanged during the first year of implementation, underscoring a perceived gap between policy intent and lived experience.

4) Police-related barriers to health and harm reduction service access

Findings from both datasets indicated that even in the context of decriminalization, policing was a barrier to accessing health and harm reduction services. Quantitative findings indicate that 60% (*n* = 236) of respondents worried about interacting with police (Table 5). In addition, 14% (*n* = 55) of survey respondents reported concern for accessing services due to fear that police would confiscate their drugs and 13% (*n* = 51) expressed that

Table 6 Details of police interactions in the last 3 months among respondents with recent law enforcement encounter. Harm Reduction Client Survey 2022 and 2023

Details of police interaction	2023**	2022**
	N **= 233**	***N*** **= 235**
Intimidated or harassed verbally, physically, or sexually*	115 (49%)	--
Asked for ID / ran name through the system, checked release conditions	113 (48%)	116 (49%)
Arrested for any reason^	74 (32%)	94 (40%)
Arrested for drug possession^	7 (3%)	27 (12%)
Arrested for a reason other than drug possession^	52 (22%)	88 (37%)
Did a wellness or health check / asked if you were okay	70 (30%)	59 (25%)
Took away rigs or pipes	60 (26%)	72 (31%)
Took away drugs not prescribed, including illegal drugs	59 (25%)	65 (28%)
Took away prescribed drugs	36 (15%)	22 (9%)
Provided information about health or harm reduction services	32 (14%)	18 (8%)
Confiscation or destruction of belongings	6 (3%)	4 (2%)

* The response option "Intimidated or harassed verbally, physically" was added for 2023 as it was a common free-text response in 2022. A small number of respondents wrote in that they were sexually harassed or assaulted by law enforcement, and these responses were grouped with verbal and physical intimidation or harassment for analysis

** *n* (column %). Denominator excludes missing, illegible, and prefer not to say responses

^ In 2022, there were three response options about arrests: arrested for personal possession, arrested for selling drugs, or arrested for other reasons. In 2023, respondents were asked if they were arrested and to specify the reason for arrest in a free text response

they worried about police finding out that they use substances (Table 3).

The qualitative data offers insights into the nature of law enforcement experiences that may be influencing hesitancy. First, many participants talked about their experiences with recent drug seizures. Although personal possession up to 2.5 g was decriminalised, 25% ($n = 59$) of survey respondents who had police contact in the last 3 months reported that they had substances (of any kind) taken away during street-level encounters (see Table 6). Participants described seizures that occurred without arrest, contributing to perceptions that police were circumventing the decriminalization policy:

> *They're not charging them with possession, they just pull you aside, search you, take your dope, put them in their pocket, and let you go. (Participant 73, VCH)*

Encounters resulting in the seizure of medications prescribed to the individual, a category of drugs explicitly protected within the decriminalization framework, were also reported. This was equally reflected in the survey data with 15% ($n = 36$) of respondents who had a recent police interaction reported having their prescribed substances taken away (see Table 6). The location of negative police encounters was impactful in dissuading people who use drugs to access harm reduction facilities:

> *Sure, they [police] are [seizing drugs], yeah…I would see it outside the overdose prevention sites all of the time (Participant 52, VCH).*

Reports of drugs being confiscated without arrest – particularly when quantities were under the decriminalized threshold – reflected a potential disconnect between policy on paper and police practices on the ground. Another participant said:

> *I have witnessed it with my own eyes…police stamping on people's pipes and just doing really provoking and enticing people to the point where they can arrest them, and search them, and find the drugs. (Participant 54, VCH)*

Police actions were not only perceived as punitive but also as arbitrary, discretionary, and ultimately in conflict with the stated public health goals of decriminalization. The survey data supported these descriptions of negative police interactions. When asked if participants agreed or disagreed (or were neutral) with the statement '*The last time I interacted with law enforcement I was treated with respect*', 44% ($n = 141$) of survey respondents disagreed. When asked about the nature of their most recent police interaction, 49% ($n = 115$) reported being intimidated or harassed (verbally, physically or sexually) and 26% ($n = 60$) reported having harm reduction supplies and equipment taken away (Table 6). Interview data substantiated these reports, with participants recounting police encounters and presence around harm reduction facilities that impacted people who use drugs' access to services:

> *Clients that I work with [are] still having those negative experiences [with police]. When I work…at [anonymized OPS]…there is still a huge police presence…*

on the block which deters people from coming to the site. (Participant 24, VCH)

Survey data affirmed that by maintaining a presence around harm reduction sites, police were directly dissuading some individuals from accessing these services; 14% ($n = 55$) reported worrying about police taking their drugs away and 13% ($n = 51$) reported police taking substances away was a barrier to SCS/OPS use. Coupled with the widespread accounts of police seizures of drugs and equipment and recent police encounters among people who use drugs, policing practices induced fear of the potential apprehension of drugs for some potential users of these services.

Participants across both datasets also reported on access to health information cards from law enforcement. Only 14% ($n = 32$) of survey respondents who had a recent interaction with police reported that they were provided with information about health or harm reduction services from police (Table 6). Qualitative accounts suggest that the effectiveness of police efforts to distribute health resource cards may be undermined by their perceptions of law enforcement. As one participant explained, people who use drugs were sceptical of both the intention of the officer and the legitimacy of the health services listed:

I don't see how they [officers] could be offering useful resources that anyone would be interested in actually pursuing. There is such a level of suspicion... towards the police and I really don't see how anyone would be eager and willing and interested to follow up with anything that police offered. (Participant 53, VCH)

Participants showed clear apprehension towards police-involved public health efforts. This skepticism extended even to the services themselves, with some participants noting they would reject harm reduction services solely because they were associated with police:

If a cop came to me and told me, like, hey, this is a harm reduction location, I wouldn't trust it. Even if I knew it was for real, I wouldn't trust it. It is not something that I would think is trustworthy coming from them [police] (Participant 73, VCH).

The transference of mistrust of police to health services demonstrates the profound and enduring impact of policing on health and harm reduction services – an engrained attitude present even in the context of decriminalization. The fundamental lack of trust and response to police undermined the potential of decriminalization to achieve its goal of promoting people who use drugs' access to health and harm reduction services.

Discussion

The experiences and perceptions of people who use drugs across both datasets revealed persistent barriers to health and harm reduction services during BC's drug decriminalization pilot. These findings suggest that a central aim of the policy - to reduce stigma and increase health and harm reduction service access [49] - was only partially realized. Although this aim was concurrently supported through increased investments into services [2], participants reported that key barriers, fear of substance use disclosure, stigma when accessing harm reduction services, service-specific barriers and police-related barriers both persisted and also manifested in new or altered forms. Our findings suggest that decriminalization reform alone may be limited in its ability to meaningfully achieve its intended aims, particularly in the absence of more widespread structural and institutional changes that support and promote health outcomes. It is equally important to consider these findings within the broader socio-political context in which the pilot unfolded, particularly as public and political scrutiny intensified toward the end of the study period. Although decriminalization has been theorized and framed as a macro intervention which would reduce stigma towards people who use drugs [27, 50, 51], participants in this study reported ongoing experiences of stigma and mistreatment within both healthcare and harm reduction settings. Notably, some participants linked these experiences directly to their identity as people who use drugs and reported avoiding services – including emergency care and SCS/OPS - due to anticipated or actual discrimination. Participant accounts further revealed how substance use stigma intersects with other marginalized identities, including poverty, homelessness, and racialization, which aligns with broader literature on the intersectional nature of health-related discrimination [29, 34, 52, 53]. Several participants perceived an intensification of negative treatment during the decriminalization period which suggests that changes in legal status alone may be insufficient, or counterproductive, to shift entrenched societal views. While causality cannot be established, these accounts point to potential mechanisms through which decriminalization may fail to reduce and may even exacerbate stigma in the short term. Toward the end of the study period, decriminalization was increasingly framed in public and political discourse as contributing to visible public drug use, disorder, and overdose deaths, despite limited empirical evidence to support such claims. This discursive framing may have shaped public attitudes, institutional responses, and service environments, and may help to contextualize participants' reports of heightened stigma and hostility. Participants from a recent study by Ali et al. [45] described feeling blamed for a perceived increase in public drug use and public disorder, suggesting that

decriminalization may have heightened animosity or hostility among some service providers or the public towards people who use drugs. Substantiating these beliefs, a recent study by Imtiaz et al. [54] examining public attitudes towards the pilot found that a majority of participants (n = 1,202) disagreed that decriminalization will reduce overdoses (55%) and drug-related crimes (50%). Supported by our findings, this research suggests that the social conditions necessary for stigma reduction may not have been in place during the early implementation of the pilot. Both sustained investments and time to shift deeply engrained social constructs may be required to undo the effects of decades of prohibition and deeply embedded stigma towards people who use drugs, particularly at a system level. Stigma reduction therefore may be better realized as a longer term impact of future decriminalization efforts. These findings reinforce calls for targeted, evidence-based, institutional and context-specific anti-stigma training within health and harm reduction settings in order to maximize the health equity impact of such reforms [55]. Interventions such as anti-stigma training led by people with lived and living experience, mandatory trauma and equity-oriented care training for health and harm reduction providers, and organizational accountability mechanisms that address discriminatory practices at the service level towards patients/clients who use drugs could be considered [56–59]. Prior research has shown that such interventions can reduce stigmatizing attitudes among healthcare providers and improve patient-provider relationships as well as service engagement among people who use drugs [55, 60, 61].

Our study suggests that barriers related to the services themselves are present amid the legal changes implemented through the decriminalization pilot. Our study suggests that practical constraints, such long wait times, unaffordable private care and treatment, inadequate rural coverage, and insufficient operating hours, shaped access. These findings illuminated a duality of barriers, suggesting that both stigma and material barriers operate in tandem rather than as competing explanations. The tension between stigma and practical barriers are particularly evident when considering the realm of consumption spaces currently available in BC. For example, many of the available consumption sites in BC continue to prioritize injection-based drug use, despite the fact that inhalation has become the dominant mode of drug consumption in BC [62, 63]. Participants in our study echoed this as a concern. The prioritization of people who inject drugs [64, 65] continues to exacerbate overdose risk across social contexts [65–68] and may limit the realization of the policy's intended benefits. Whilst prior research has evidenced the need for harm reduction services that explicitly accommodate non-injection use, particularly smoking, and for the expansion of these services to underserved rural communities [64], there are also significant barriers to implementing inhalation spaces. These can include high costs of retrofitting existing OPS/SCS, provincial funding requirements and complex occupational safety regulations related to safe and proper ventilation mechanisms [69]. Nevertheless, with harm reduction facilities functioning as critical "inclusion health interventions" [70] which support access to other auxiliary health and social services, undervaluing the importance of engaging people who smoke drugs simultaneously reduces the health equity potential of the decriminalization pilot.

Reflected extensively in the literature prior to decriminalization, street-level policing practices can significantly hinder access to harm reduction services [15, 71–77]. This prior evidence raises concerns about the ongoing evidence of policing among participants across both data sources. Our findings also support those of Russell et al. [44] that policing practices continued to disrupt harm reduction access during this period. Indeed, a quarter of participants with recent police contact reported drug seizures (including below the legal threshold), while others described detailed accounts of harassment and intimidation in the vicinity of harm reduction facilities. The seizure of drugs – even when within the legal threshold – points to significant implementation gaps and suggests a lack of clarity, training, or willingness among officers to adhere to the new legal framework. Participants' descriptions of these interactions – as arbitrary, punitive, and contradictory to public health goals – signal a critical disconnect between policy intent and practice. Extensive research highlights how seizure practices drive isolated drug use, riskier consumption practices and service avoidance, all contributors towards heightened overdose mortality risk [35, 78–80]. In this context, the May 2024 amendment, which substantially restricted where decriminalization applies in public spaces, can be understood as a policy response to mounting public concern and political pressure rather than as a resolution to the structural issues identified by participants. These findings challenge the assumption that legal reform will necessarily result in the complete elimination of law enforcement in the lives of people who use drugs, in particular those who are most susceptible to overdose. Our findings and others highlight that the enduring discretionary power of law enforcement and the structural entrenchment of policing in the lives of marginalized communities in particular by reinforcing or perpetuating inequities for people who use drugs [44, 81].

Moreover, efforts to leverage police in decriminalization as a public health intervention – through initiatives such as the distribution of health resource cards – were largely perceived among interview participants as ineffective or even counterproductive. This finding is in

contrast to recent research on the topic [44] and raises critical questions about the appropriateness and effectiveness of involving law enforcement in the delivery of health-focused drug policies. Practically, without structural accountability mechanisms and community-led oversight, attempts to integrate police into mechanisms of health promotion risk undermining health and harm reduction services themselves.

Policy recommendations

Together the persistence of these four primary barriers - fear of substance use disclosure, stigma when accessing harm reduction services, service-specific and police-related barriers - suggest that macro legal reforms cannot be disentangled from the social, health, housing and policing institutions which are so closely weaved into the lives of people who use drugs. Although investments into such systems coupled onto the decriminalization pilot, our findings suggest that potential barriers adjacent to and potentially unaffected by the legal reform may persist. Additionally, participants (particularly 2023 survey respondents) commonly reported concerns about family or friends finding out that they used substances, highlighting social and relational stigma, reputational harm, and perceived surveillance as key upstream barriers to service access. Even in the absence of stigmatizing encounters with providers, the fear of social exposure may prevent individuals from accessing services altogether. Recognizing and addressing these concerns should be seen as key to realizing the initially stated provincial aims of increasing access and reducing barriers to health and harm reduction services [1].

With these findings in mind, we suggest three recommendations. Firstly, anti-stigma training and accountability mechanisms for health and harm reduction staff should be implemented to reduce negative experiences within services and drive engagement. Secondly, recognizing inhalation as the dominant mode of drug consumption in BC as well as the temporal dynamics of drug use, where possible, harm reduction services (e.g., SCS/OPS) should extend their opening hours and include safe inhalation services, in particular by allocating dedicated funding for such services in rural communities with populations at risk of overdose [82]. Thirdly, efforts to reduce encounters between police and people who use drugs need to be a priority in and around harm reduction facilities. Drug seizures, including the confiscation of prescribed medications and harm reduction equipment, should be strictly limited through clear legislative and organizational directives rather than left to individual officer discretion. Particularly as discretionary appeals to 'public safety' have historically enabled police overreach and the disproportionate targeting of structurally marginalized people who use drugs. Although harm reduction policing training has been conceptualized [83, 84] and has shown positive results in some international contexts [85–87], it is important to note that evidence on the effectiveness of such training interventions on the nature of street-level encounters is currently limited [88]. This limitation underscores the need for structural approaches beyond training, including clear provincial or municipal policy guidance, mechanisms for monitoring police practices, and consequences for non-compliance. Given the prevalence of negative police interactions experienced by people who use drugs, robust oversight structures specific to interactions with marginalized groups should be enacted, for example through civilian-led oversight bodies [89], public health–police governance agreements (e.g., memorandums of understanding) [90, 91], or independent complaint and review processes that meaningfully include people who use drugs [92].

Limitations

This study has several limitations. Firstly, with regards to the harm reduction client survey, respondents are a convenience sample of clients who visited a participating harm reduction supply distribution site in BC. These results are not generalizable to the broader population of people who use drugs in the province and their diverse experiences. Selection bias may have influenced the results as participation was limited to individuals who chose to engage with harm reduction services and agreed to complete the survey. Responses are also 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 survey respondents answered. Finally, the scope of this project was to evaluate short term impacts of the decriminalization policy, in particular how access to health and harm reduction services was experienced. This outcome however may be longer term impact that may not yet be fully realized within the first year of the pilot. With regards to the harm reduction client survey data, although demographic information was collected, we did not report participant ethnicity of the surveys to promote confidentiality and respect Indigenous data governance. These demographics are not central to our findings. Readers should be cautious when considering the generalizability of our findings across diverse racial and ethnic groups.

Conclusion

Barriers to health and harm reduction services highlighted through the experiences and perceptions of people who use drugs during BC's drug decriminalization pilot suggest that a central aim of the policy may be only partially realized. Despite explicit policy aims of increasing service access, both within our quantitative and qualitative data, participants reported barriers which not only endured but took different forms and meaning during this period.

These barriers included experiences of stigma and mistreatment within health and harm reduction settings, limitations in service provision and design and policing practices that continued to disrupt service access through drug seizures and harassment, in particular in the vicinity of harm reduction sites. Taken together, these findings suggest that legal reform alone may not be sufficient to meaningfully fully transform access to health and harm reduction services.

Abbreviations

BC	British Columbia
SCS	Supervized Consumption Site
OPS	Overdose Prevention Site
IH	Interior Health
FH	Fraser Health
VCH	Vancouver Coastal Health
IH	Island Health
NH	Northern Health

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Data availability
Data and materials are not publicly available however may be available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
The study received approval from Simon Fraser University's Office of Research Ethics (#30001251). All participants provided informed consent to participate in this study. The research was conducted in accordance with the Declaration of Helsinki, ensuring voluntary informed consent, confidentiality, and participant wellbeing.

Consent for publication
N/A.

Competing interests
The authors declare no competing interests.

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