PRESCRIBED ALTERNATIVES PROGRAMS: EMERGING EVIDENCE

National Safer Supply
Community of Practice

Prescribed Safer Supply Programs: Emerging Evidence

Contents

What are prescribed alternatives?

Prescribed alternatives (also referred to as prescribed safer supply) are a medicalized model of safe supply. Safe supply refers to regulated pharmaceutical drugs of known content, quantity, quality, and potency that provide the mind/body altering properties of drugs that are currently only available through illegal markets and not available through traditional opioid agonist therapies (CAPUD, 2019). Prescribed alternatives involve the routine clinical practice of off-label prescribing – in this case, the prescribing, dispensing, and administration of prescription medications as alternatives to the poisoned drug supply (British Columbia Office of the Provincial Health Officer, 2023).

> *"Pharmaceutical alternatives to the illegal drug supply are promising interventions to reduce mortality in people with opioid use disorder."* (Slaunwhite *et al*., 2024)

Objectives and scope of this document

This document is a brief summary of the current evidence about prescribed alternatives programs for lay audiences, political briefings, and the media. It draws on findings from peer-reviewed research articles and commentaries, as well as program evaluation reports of prescribed safer supply programs in Canada. It looks at evidence relating to the period between 2020 and 2025, when Health Canada Substance Use and Addiction Program (SUAP) funded pilot projects across the country and when BC implemented Risk Mitigation Guidance to support social distancing during COVID-19 and also reduce risks associated with withdrawal and drug toxicity from unregulated substances. Published literature on one community-based (non-prescriber) program is also included. For a more in-depth review of the evidence, please see ODPRN's (2023) Safer Opioid Supply: A Rapid Review of the Evidence.

Context and Implementation

A toxic and volatile unregulated drug supply

The appearance of fentanyl and harmful contaminants in the unregulated drug supply in recent years has made the illegal drug supply increasingly unpredictable and toxic (British Columbia Office of the Provincial Health Officer, 2023). As a result, there were 50,928 opioid toxicity related deaths in Canada between January 2016 and September 2024 (Special Advisory Committee, 2025). Fentanyl is overwhelmingly responsible for drug-related deaths in Canada, contributing to 89% of drug-related deaths in Ontario and 86% of drug-related deaths in BC in 2021 (British Columbia Coroners Service, 2023; Gomes, Murray *et al.*, 2022).

> *"...the fastest way to reduce deaths is to reduce dependence on the unregulated toxic drug supply for people who use drugs. This requires creating access to a*

quality-controlled, regulated supply of drugs for people at risk of dying." (British Columbia Coroners Service Death Review Panel, 2023)

The implementation of safer supply has varied across prescribers, communities and provinces. Starting in 2020, Health Canada temporarily funded 25 pilot programs across the country which prescribed alternatives to people at high risk of toxicity (i.e., overdose) and harms from the toxic unregulated drug supply. This marked a rapid expansion of prescribed safer supply programs in Canada until 2023, when politicization of safer supply (and harm reduction, more broadly) began to dampen prescriber willingness to offer daily-dispensed take-home medications. Virtual care providers in pharmacy-settings appear to be filling the gap following the ending of SUAP funding programs.

Program Implementation

Implementation of safer supply programs has occurred in distinct and varying contexts, with an effort to target local populations rather than trying to use a "one size fits all" approach (Haines and O'Byrne, 2023; Nafeh *et al.,* 2025). The most common settings for prescribed alternatives are community health settings, such as community health centres and primary care clinics, and onsite pharmacies (Glegg *et al.*, 2022). There are also unfunded programs and individual health care providers who prescribe alternatives.

Access to safer supply is continuously shaped by stigma and criminalization of substance use, and participants have cited the challenges of getting to the clinic, obtaining information about safer supply, and accessing a prescriber (Urbanoski *et al*., 2024). In BC, prescribing was more common among prescribers who were in urban areas, were nurse practitioners (compared to physicians), had more experience treating substance use disorder, and had experience prescribing opioid agonist therapy (Pauly *et al.*,2024). Prescribers indicate the importance of implementation guidance, funding and support at organizational and provincial levels (Pauly *et al*., 2024).

Prescribed Models

Prescribed models involve a licensed provider prescribing drugs on the provincial drug formulary to a person in their care to reduce harms of the toxic drug supply. This is the most common model of providing safer supply and has been implemented in several models:

- Prescribed safer supply programs with wraparound services.
- Outreach-focused programs.
- Individuals prescribing safer supply through their current clinical practice.

"Regardless of the model of service provision, any model of care for providing safer supply needs to be conceptualized, designed, and must function using a harm reduction, trauma-informed, and culturally-sensitive lens." (Karamouzian *et al.*, 2023)

Non-Prescribed Models

In Vancouver, an unsanctioned compassion club and fulfillment center operated from 2022-2023 (Nyx & Kalicum, 2024). Evaluation results show reductions in overdoses, police interactions, hospitalizations, and experiences of violence (Drug User Liberation front, 2023; Kalicum *et al*., 2024). Additionally, the compassion club model facilitated feelings of safety and autonomy among individuals while also strengthening social bonds and building community (Bowles *et al*., 2024). Program participants reported reduced unregulated drug use, risk of overdose, and engagement in criminal activity; and recommended longer operating hours and expanded substance options (Kalicum *et al.,* 2025*).*

Importantly, operations of this compassion club came to an abrupt end in October 2024 following a raid of the club and the homes of the two compassion club founders (Nyx & Kalicum, 2024*).*

Public Perception

A study in Alberta and Saskatchewan found that a majority of respondents supported provincial government efforts to expand prescribed alternatives (Morris *et al*., 2023). Public perception of prescribed alternatives varies across geographies, sociodemographics, and personality traits, suggesting opportunities for public health messaging (Thornton *et al.,* 2023). Although the study did not address prescribed alternatives specifically, a 2025 Canadian survey of 1500 people found that 53% support harm reduction and 19% are opposed (CATIE, 2025). Further, the study found that one third of respondents were only familiar with the term ‘harm reduction’ and had little understanding of what it involved, demonstrating the need to improve public understanding. Similarly, public understanding about prescribed alternatives and its role on the spectrum of substance use health care needs to be strengthened.

Who can access prescribed alternatives?

Around 5% of adults around the world use illegal drugs, and nearly 90% of them are occasional or recreational users (Schlag, 2020). Anyone who uses substances procured from the illegal, unregulated drug supply – either recreationally or routinely – needs access to a safer supply. Safer supply has mainly been accessible through medicalized programs (i.e., “prescribed alternatives”) due to the current legislative and regulatory context in Canada.

However, prescribed alternatives programs have very limited capacity. One program estimated 6000 people in their region would benefit from prescribed alternatives, but they are only able to serve 300 people (McMurchy & Palmer, 2022). Prescribed alternatives programs have prioritised those who are at the highest risk of death from overdose (Young *et al*., 2022), who are experiencing serious medical complications from their drug use (Gomes, Kolla, McCormack *et al*., 2022; Haines, Tefoglou, & O'Byrne, 2022; McMurchy & Palmer, 2022; Selfridge *et al*., 2020), and who are marginalized from health care services, including traditional opioid agonist therapies (ESCODI, 2022). Some programs have prioritized serving Indigenous and racialized populations as part of their equity-oriented approach (McCall *et al*., 2024; M*usa et al*., 2025)

> *"Not all people who use opioids are interested in treatment, nor is conventional treatment suitable for all people who use opioids"* (Ivsins *et al.*, 2020a).

Prescribed alternatives programs are not accessible to those who use opioids recreationally (British Columbia Centre on Substance Use, 2024; British Columbia Office of the Provincial Health Officer, 2023). Typical prescribed alternatives program inclusion criteria include DSM V defined opioid use disorder and previous unsuccessful experience with methadone, buprenorphine or SROM, or disinterest in methadone, buprenorphine, or SROM (Hales *et al.*, 2020). Individual prescribed alternatives programs add criteria such as a history of overdose and high risk of overdose, complications related to injection drug use (infections, etc.), and social factors such as being unhoused[1] or precariously housed, being disengaged from health care and social services, or being involved in crime or sex work. Typically, programs have provided access to care to people whose needs have not been met through traditional addictions medicine or primary care settings. Compared to those in methadone programs, prescribed alternatives clients have significantly more health complexities, including higher rates of HIV, hepatitis C, and prior serious infections and opioid toxicities (Gomes *et al.*, 2025).

Participants in prescribed alternative programs have different goals including reducing unregulated substance use, abstinence, stopping injection drug use and stabilizing their health, housing, and/or employment (Ivsins *et al.,* 2024) and their goals may evolve other time, as participants stabilize on the program (Sparkes *et al*., 2024). Retention rates in prescribed alternatives programs are very high (Atkinson *et al.*, 2023; McMurchy & Palmer, 2022; Kolla *et al.*, 2022; Gomes *et al*.; 2025; Haines, Tefoglou, & O'Byrne, 2022; ESCODI, 2022; Selfridge *et al.*, 2022). Access or referral to prescribed alternatives may be supported by engagement with other harm reduction services (overdose prevention site, drug checking) (Palis *et al., 2024).*

What does the evidence show?

Initiators of prescribed alternatives programs in Canada have drawn on the extensive literature on international OAT studies, European Heroin Assisted Treatment (HAT) studies (e.g., Poulter *et al.*, 2024) and Canadian iOAT studies. There are many research and evaluation studies of prescribed alternatives programs underway. Ongoing research and evaluation is required, including longitudinal studies to monitor changes in access to and delivery of prescribed alternatives in the country, determine which models are most effective, and identify the impact of programs on the health, well-being and safety of individuals and communities.

> *"Evidence supports prescribed alternatives as a critical option on the continuum of treatment and harm reduction services for people who have not been successful with traditional approaches to care and who are at high risk of drug poisoning. Safer supply is one intervention that can disrupt cycles of problematic substance use while upholding autonomy of people who use drugs."* (Haines & O'Byrne, 2024*)*

[1] A 2024 study found that homelessness had a causal impact on drug- and alcohol-related mortality (Bradford & Lozano-Rojas, 2024)

Key findings from prescribed alternatives program research and evaluations:

- **Reduced risk of death and/or overdose:** Both drug-related deaths and deaths from any cause among people receiving prescribed alternatives were rare (Gomes, Kolla, McCormack *et al.*, 2022; Young *et al.*, 2022) and they had fewer overdoses (Atkinson *et al.,* 2023; AVI, 2025; Bardwell *et al.*, 2023; ESCODI, 2022; Haines, Tefoglou, & O'Byrne, 2022; Haines *et al.*, 2023b; Haines *et al*., 2024; Hardill and King, 2024; Henderson, *et al.,* 2024; Kalicum *et al.*, 2024; Kalicum, *et al., 2025;* Lew *et al.,* 2022; Musa *et al., 2025;* McNeil *et al.*, 2022; Perri *et al.*, 2023a; Schmidt *et al*., 2023; Schmidt *et al.,* 2024, Selfridge *et al.*, 2020; Slaunwhite *et al.*, 2024; Sparkes *et al., 2024*).
- **Reduced use of drugs from the unregulated street supply** (thereby reducing overdose risk) and, in some cases, reducing drug use overall or ceasing the use of drugs by injection (Atkinson *et al.,* 2023; AVI, 2025; Bardwell *et al.*, 2023; ESCODI, 2022; Haines, Tefoglu, & O'Byrne, 2023; Haines, Tefoglou, & O'Byrne, 2022; Haines *et al*., 2023b; Haines *et al.*, 2024; Haines & O'Byrne, 2025; Hardill and King, 2024; Henderson *et al.,* 2024; Ivsins *et al*., 2020b; Kalicum 2023; Kalicum *et al., 2025;* Kolla *et al.*, 2022; Kolla & Fajber, 2023; Marris and King, 2024; McNeil *et al.*, 2022; Musa *et al., 2025;* Norton *et al.,* 2024; Schmidt *et al.,* 2024; Selfridge *et al.*, 2020; Sparkes *et al., 2024*).
- **Engagement and retention in programs and care:** People experienced increased access to health and social services, including primary care, COVID-19 quarantine, OAT, counselling, and housing support; and improved relationships with providers (Atkinson *et al.,* 2023; AVI, 2025; Brothers *et al.*, 2022; Haines & O'Byrne, 2023; Haines, Tefoglu, & O'Byrne, 2023; Haines & O'Byrne, 2025; Hardill and King, 2024; Hong, Brar & Fairbairn, 2022; Kalicum 2023; Kolla *et al.*, 2022; McMurchy & Palmer, 2022; Min *et al.,* 2024; Musa, *et al., 2025;* Perri *et al*., 2023a; Schmidt *et al*., 2023; Schmidt *et al.,* 2024; Selfridge et *al.*, 2020; Selfridge *et al.,* 2022; Socias *et al.*, 2023; Sparkes e*t al.,* 2024).
- **Improvements in physical and mental health:** People experienced improved chronic and/or infectious disease management, medication adherence, pain management, sleep, nutrition, and energy level (Atkinson *et al*., 2023; AVI, 2025; Gomes *et al.*, 2022; Haines & O'Byrne, 2023; Haines, Tefoglou, & O'Byrne, 2022; Ivsins *et al*., 2021; Isvins *et al.,* 2024; Klaire *et al.*, 2022; Kolla *et al.*, 2022; Kolla & Fajber, 2023; Ledlie *et al*., 2024; Marris and King, 2024; McMurchy & Palmer, 2022; Musa *et al., 2025;* Norton *et al.,* 2024; Perri *et al.*, 2023a; Schmidt *et al.,* 2024; Selfridge *et al.*, 2020; Sparkes *et al., 2024*).
- **Fewer emergency department visits and hospitalizations:** People had significantly fewer Emergency Department visits and inpatient hospital admissions after entering the prescribed alternatives program compared to the year prior, with no change in these outcomes among a matched group unexposed to prescribed alternatives in the same time period (Gomes *et al.*, 2022).
- **Decrease in hospitalizations for infectious complications:** In the year after beginning a prescribed alternatives program, there was a significant decrease in hospitalizations for infectious complications among prescribed alternatives program clients; hospitalizations dropped from 26 in the year before program entry to 13 in the year following entry to a prescribed alternatives program (Gomes *et al.*, 2022). There was no

change in these outcomes among a matched group unexposed to prescribed alternatives in the same time period (Gomes *et al.*, 2022). Increasing infection rates overall among people who inject drugs since 2016 align with the shifts in the unregulated drug market towards non-prescription fentanyl (Gomes *et al.*, 2021). Many clients credited prescribed alternatives programs for reducing the frequency at which they injected, providing an alternative to injecting fentanyl, and allowing them to stop injecting by providing safer supply medications that are dosed properly and can be taken orally (Gagnon *et al.*, 2023).

- **Improved control over drug use and withdrawal management.** The flexibility and autonomy of prescribed alternatives programs, coupled with certainty about dose strength, enabled participants to avoid withdrawal symptoms and manage pain (Bardwell *et al.*, 2023; Haines & O'Byrne, 2023; Henderson *et al.,* 2024; Ivsins *et al.*, 2020b; Isvins *et al.,* 2024; Marris and King, 2024; McNeil *et al.,* 2022; Norton *et al.* 2024; Schmidt *et al.,* 2024; Selfridge *et al.*, 2020).
- **Improvements in social well-being and stability:** Participants noted economic improvements (Haines, Tefoglou, & O'Byrne, 2022; Ivsins *et al.,* 2020b; Marris and King, 2024; Perri, *et al*., 2023a; Selfridge e*t al.*, 2020), reduced inequities stemming from the intersection of drug use and social inequality (Ivsins *et al.,* 2021), better control over time leading to engagement in employment, hobbies, and interests (Atkinson et *al.*, 2023; Haines & O'Byrne, 2024; Haines, Tefoglou, & O'Byrne, 2022; Marris and King, 2024; McMurchy & Palmer, 2022), decreased involvement in and exposure to violence, criminal activities and legal issues (Haines & O'Byrne, 2023; Haines, Tefoglou, & O'Byrne, 2022; Haines *et al.*, 2023b; Haines *et al*., 2024; Ivsins *et al.*, 2020b; Kalicum *et al., 2025;* Kolla *et al.*, 2022; Marris and King, 2024; McMurchy & Palmer, 2022; Schmidt *et al.*, 2023; Sparkes *et al., 2024*), improved general social stability (AVI, 2025; ESCODI, 2022; Schmidt *et al.*, 2023), improved housing access (Atkinson *et al.*, 2023; Haines, Tefoglou, & O'Byrne, 2022; Haines & O'Byrne, 2025; Sparkes *et al., 2024*) and improved relationships with family members and friends (Kolla *et al.*, 2022; McMurchy & Palmer, 2022; Selfridge *et al.*, 2020).
- **Decline in health care costs:** Prescribed alternatives program participants had lower costs for healthcare not related to primary care or outpatient medications in the year after program initiation, with no corresponding change observed in a matched group of individuals who did not access the program (Gomes *et al.*, 2022).

Key findings from population-based studies:

Research involving health administrative data in multiple provinces provides a measure of reassurance regarding the safety of prescribed alternatives programs and the important role they have on the spectrum of substance use health care.

Data from coroners in both BC and Ontario have found no link between prescribed hydromorphone and drug-related overdose deaths: “There is no indication that prescribed safe supply is contributing to illicit drug deaths” (British Columbia Coroners Service, 2023). In Ontario, despite the increasing use of immediate-release hydromorphone during the early

pandemic period, both the percentage and overall number of hydromorphone-related deaths actually decreased (Gomes *et al.*, 2022), including in youth (Iacono *et al.*, 2023).

In Ontario, Gomes *et al.* (2022) analyzed health administrative data and found a significant decline in health services utilization among clients on prescribed alternatives alongside no change in infection rates, opioid-related deaths, or all-cause mortality. An updated version of this study applied a population-based cohort study to compare health outcomes among recipients of prescribed alternatives and methadone in the initial year of treatment (Gomes *et al.,* 2025). Authors found that people starting prescribed alternatives had significantly more health complexities than those starting methadone, including higher rates of HIV, hepatitis C, and prior serious infections and opioid toxicities. Following prescribed alternatives initiation, recipients showed a decline in monthly rates of hospital-treated opioid toxicities, all-cause emergency department visits, all-cause inpatient hospitalizations, incident infections and non-primary-care-related health care costs (Gomes *et al.,* 2025). The outcomes were similar to methadone recipients, with prescribed alternatives recipients showing larger declines in rates of opioid toxicities and all-cause emergency department visits and a smaller decline in the rate of incident infections. Recipients of prescribed alternatives were less likely to discontinue treatment compared to those who were prescribed methadone. Authors of this study highlight the complementary roles of prescribed alternatives and methadone in response to the toxic drug supply, particularly given the higher complexity of care needs and the recent and concurrent OAT among people receiving prescribed alternatives (Gomes *et al.,* 2025).

In BC, Slaunwhite, *et al.* (2024) found that people receiving prescribed alternatives had a 61% lower rate of death from any cause the week after at least one day of opioid prescription, and a 55% lower rate of death from overdose compared to matched peers who did not receive a prescription. People who received four or more days of opioid prescription had a 91% lower rate of death from any cause, and 89% lower rate of death from overdose. Opioid prescription was not associated with acute care use, but people prescribed stimulants used less acute care the following week. The effect of stimulant prescriptions on the risk of death was unclear.

Critiques of prescribed alternatives

A small number of publications have come out offering counter narratives and different perspectives on SOS as an intervention. Nguyen *et al.* (2024) suggested an association between safer opioid supply policy in BC and increased opioid-poisoning-related hospitalizations (Nguyen *et al.*, 2024). This study was critiqued by several research teams for inappropriate methods, not accounting for the unregulated toxic drug supply and inter-provincial differences, and lack of contextualizing the COVID-19 pandemic and related harm reduction services closures at the time of study (Chen *et al.,* 2024; Nosyk *et al., 2024; Reddon et al., 2024).* Another study by Ngyuen *et al.* (2025) found increased opioid-hospitalizations in BC compared to provinces without policies for SOS or decriminalization.

Success factors for prescribed alternatives programs

> *"Safer supply is just one part of more equitable access to health and wellbeing. Providing safer supply is a harm reduction entry-point to addressing other basic needs and priorities. Secure housing, livable income, access to health care, and a caring community to feel a part of, are all necessities." (McMurchy & Palmer, 2022)*

- **Comprehensive ancillary services:** populations served by prescribed alternatives benefit from health and social supports delivered alongside their prescriptions (Gomes, Kolla, McCormack *et al.*, 2022; Haines, Tefoglou, & O'Byrne, 2022; Kolla & Fajber, 2023; Mansoor *et al.*, 2023; McCall *et al., 2024;* Musa *et al., 2025;* Nafeh et al., 2025; Perri *et al*., 2023b; Selfridge *et al.*, 2020).
- **Program flexibility** (Bardwell *et al.*, 2023; Ivsins *et al.*, 2020b; Haines, Tefoglou, & O'Byrne, 2022; Norton *et al.,* 2024; McMurchy & Palmer, 2022; Nafeh et al., 2025, AVI 2025) and adaptability (Glegg *et al.*, 2022; McCall *et al.,* 2024; McMurchy & Palmer, 2022).
- **Low-barrier, client-centred design** (Ivsins *et al.*, 2020b; Hardill and King, 2024; McMurchy & Palmer, 2022; Nafeh et al., 2025; Pauly *et al.*, 2022; Perri *et al*., 2023b; Ranger *et al.*, 2021, AVI 2025). Program approach varies; in one case, a machine was used to recognize approved participants and dispense medications (Bardwell *et al., 2024).*
- **Ability to provide pharmaceuticals that meet people's needs** (dose, formulation, type) (Giang *et al.*, 2023; Kalicum 2023; McCall et al., 2024; Pauly *et al.*, 2022; Ranger *et al.*, 2021; Selfridge *et al.*, 2022, AVI 2025)
- **Community-centred approach**, foregrounding the leadership and engagement of people who use drugs (British Columbia Office of the Provincial Health Officer, 2023; British Columbia Office of the Provincial Health Officer, 2024; Haines & O'Byrne, 2023; Hardill and King, 2024; Kolla *et al*., 2024; Nafeh et al., 2025; Ranger *et al.*, 2021; Scow *et al.*, 2023) and considering the perspectives of professional stakeholders (Foreman-Mackey *et al.*, 2022; Kolla *et al.*, 2024, AVI, 2025).
- **Provider support,** such as guidance documents and specialist consults, build knowledge and confidence among health care professionals when prescribing safer supply (Hardill and King, 2024; Kolla *et al.*, 2024). Program specific protocols to match the needs of the local population (McCall *et al.,* 2024; Nafeh *et al.,* 2025).
- **Program staff willingness to support clients to restart the program** after being forced to stop due to incarceration, hospitalization and other factors external to the program (Haines et al., 2025).
- **Wraparound care supports** and prescribed safer supply as one component of comprehensive substance use and health care (Atkinson *et al.*, 2023; Fajber *et al*., 2025; McCall *et al*., 2024; Schmidt *et al*., 2023; Perri *et al*., 2024; AVI, 2025).

- **Partnerships with community pharmacies** (AVI, 2025) optimizes integrated client care.

> "*The overarching approach to providing safer supply services should be grounded in the community and centred on input from people with lived experience in program co-design, planning and implementation."* (McMurchy & Palmer, 2022)

Program challenges

Prescribed alternatives programs and models have faced some common challenges:

- **Limited medication options:** programs continue to advocate for expanded prescribed alternatives in the form (smokeable, injectable), type (opioid, stimulant), and dose that people prefer or require (British Columbia Office of the Provincial Health Officer, 2023; Foreman-Mackey *et al.*, 2022; Giang *et al.*, 2023; Haines & O'Byrne, 2023; Hardill and King, 2024; Kalicum 2023; Karamouzian *et al.*, 2023; Kolla *et al.,* 2022; Kolla & Fajber, 2023; Ledlie *et al.*, 2024; Mansoor *et al.*, 2023; McMurchy & Palmer, 2022; Pauly *et al.,* 2024; Perri *et al.*, 2023a; Urbanoski *et al.,* 2024, AVI 2025).
- **Challenges obtaining support** from professional colleges and other prescribers (Kurz *et al.*, 2024; Mackey *et al,* 2022; McCall *et al*., 2024; Pauly *et al*., 2024; Macevicus *et al.*, 2023; Nahef *et al*., 2025).
- **Current regulations and policies are limiting** and conventional addiction medicine has not generally been supportive (British Columbia Office of the Provincial Health Officer, 2023; Foreman-Mackey *et al*., 2022; Kalicum 2023; Kolla *et al.,* 2022; Mansoor *et al.*, 2023; McMurchy & Palmer, 2022).
- **Long-term sustainability of program funding** (British Columbia Office of the Provincial Health Officer, 2023; Musa *et al*., 2025*;* Nafeh *et al.*, 2025; Perri *et al*., 2023a).
- **Limits of medicalized safer supply** as a harm reduction intervention (Macevicus *et al.,* 2023).
- **Insufficient program capacity** (Atkinson *et al.* 2023; AVI, 2025; Kolla, et al. 2021).

Expansion of safer supply will require developing and scaling up prescribed and non-prescribed models (Office of the Provincial Health Officer, 2024; Kalicum *et al.*, 2024; Neilsen, Stowe, & Ritter, 2024; Palayew *et al.,* 2024), supporting for individual prescribers, and moving towards decriminalization and regulation (Macevicius *et al.,* 2023).

> *"There are quite a few people in the community that are against unhoused people, including some neighbours who blame the program for attracting unhoused people to the area."* (Nurse- AVI, 2025)

In addition to program limitations, structural factors create challenges for the success of programs and for clients to reach their goals. For example:

- **Social and material conditions of individuals** (AVI, 2025; Hardill and King, 2024) such as poverty, marginalization, exclusion, and social and health inequities are a result of structural drivers, including colonization, criminalization, and stigma. Programs are limited in how they are able to address these conditions due to lack of access to housing, mental health and addiction treatment services, ongoing poverty and severe food insecurity, etc.
- **Stigma, misinformation, and politicization** of harm reduction services, unhoused people, and harm reduction broadly present barriers to programs, demanding program staff to navigate dual roles of healthcare provider and advocate in unsupportive and even hostile settings (AVI, 2025; Hardill and King, 2024).

  "In order for harm reduction to be an effective program, an effective offering, an effective part of the bigger picture…It is not good enough for me that for the next 30 years my clients walk to our door and lovingly receive a safe fentanyl product. I mean, if that is truly what they want, like great… but surely we can all do better, as you know as a community, as a society. At least get some stable housing and predictable food sourcing. I don't have Pollyanna images of everyone getting sober and going to school and getting jobs, but I want to be able to have reasonable ways, when it's appropriate, to talk about… other options. I want people to have access to that…" (Nurse - AVI, 2025).

Diversion

Diversion (the sharing, exchanging, and selling of prescribed medications) is reflective of unmet individual and community needs (British Columbia Office of the Provincial Health Officer, 2023; Hardill and King, 2024). It is not unique to prescribed alternatives medications (British Columbia Office of the Provincial Health Officer, 2023; Haines & O'Byrne, 2023). It can be understood as a harm reduction practice rooted in mutual aid that saves lives (Socias *et al.* 2021) and improves quality of life.

Diversion of prescribed alternatives medications are most commonly motivated by compassion to share with friends, family and community members in pain; other drivers are selling part of prescription to meet unmet needs, and giving away part of prescription due to violence or exploitation (Martignetti *et al*., 2025; Olding *et al.* 2025). Program staff mitigate diversion through maintaining relationships with program clients to identify and address underlying causes, and using urine drug screens as part of routine care and monitoring (Olding *et al.*, 2025). Program responses are relative to the extent and reasons: honest conversations, enrolling partners to reduce sharing within partnership, developing safety plans, observing doses, arranging pharmacy deliveries and discharging individuals from the program when appropriate (Olding *et al.*, 2025; Hardill and King, 2024).

For more information, please see Reframing Diversion for Health Care Providers: Frequently Asked Questions (NSSCoP, 2022).

What clients have said about prescribed alternatives

"Once I was a client of this program, I knew I was safe." (Haines, Tefoglou & O'Byrne, 2022)

"Like I've never been this stable ever since I got on this roller coaster. This is the first time you know I've been stable enough to work, been stable enough to have a car, stable enough to have a house, be around my kids. You know this is what I mean when I say it's helped me so much. Yeah, it's beautiful." (Marris and King, 2025).

"I haven't had an overdose since I've been on the program. I had a couple shortly before where I had to be defibrillated." (Atkinson *et al.*, 2023)

"I just felt like I was having a program tailored just for me and my needs." (Musa *et al.* 2025).

"Since I've been on the program, I've gotten off of fentanyl. And I've reduced my, my methadone and my Kadian. And, you know, it's given me chances to do more things because I wasn't headed for, I wasn't going in a good direction until I came here." (Marris and King, 2025).

It really, really helped changed my life, because the other way, I was probably ready to commit suicide, to be honest…Counseling is always good. Help with housing is definitely a really big need. Like I said, I had lost everything. (Musa *et al.* 2025).

"It's been a miracle...it's made me love life. It's given me a reason to get out of bed. It's changed my whole perspective on life." (Haines, Tefoglou & O'Byrne, 2022).

"It saved my life, and it gave me a whole new outlook on it. It gave me a chance to actually live instead of just being bound by drugs. You got me to the point where I don't even care about drugs anymore. And I'm glad to see them go, and I'm starting to work my way, starting to decrease my methadone and my Kadian now too, trying to get off that." (Marris and King, 2025).

"I'm not in the hospital so much getting my abscesses drained, because I'm actually swallowing my medication. I find it more effective." (Atkinson *et al*., 2023).

"It makes me actually happy to be part of it, because it gave me the opportunity to feel like I have a family." (Haines, Tefoglou & O'Byrne, 2022)

"I don't use street drugs anymore. I never thought it was possible." (McMurchy & Palmer, 2022).

“Got a nice apartment. I'm sober. Got a lot of things back that I've lost due to my addiction. And now I've got a dog. Makes my life a lot better. Yeah. He's unexpected. I'm glad I ended up with him.” (Marris and King, 2025).

“I got a place kind of on my own... using way less drugs, basically giving me the inspiration to get off of drugs and focus on what else is out there in life type of thing” (Haines *et al.,* 2024).

“What’s really been the best part is to see the whole program together, you know. It works. It gives us what we need to handle withdrawal, and support, and it gives us you know, a place in the community, right? Which a lot of a lot of people like me never felt we've had that before.” (Marris and King, 2024).

“[My unregulated stimulant use] decreased very much. I don't have to do sex work. I don't have to put my life on the line, where I had to do stuff like go out and boost or I had to do a dangerous job... Or if somebody would pay me to do something, to go rob a house or anything, I had no choice at that time, but now I don't have to do that stuff no more. So it was a relief” (Haines *et al.,* 2024).

“I thought it was going to be like a methadone program, and it's not. It's good. It's welcoming.” (Marris and King, 2025).

“The best part is the freedom. It just gives me a lot of freedom, more freedom than I had before, more options than I had before. That's a beautiful thing. And the support that comes around with it." (Atkinson *et al.,* 2023)

"There are people that are on this program that started off in tents and now they've actually got themselves to a position where they're renting an apartment. That doesn't happen without safer supply." (Haines, Tefoglou & O’Byrne, 2022)

“I like that it’s community based and, you know, trying to get people together. It's about reconnection. I guess with addiction a lot of people disconnect from the world.” (Marris and King, 2024).

“It’s done nothing but been good for me. I’ve got my family, I’ve been housed for [the] first time in 10 years, I’m volunteering at [organization]. I’m doing things that I just, didn’t care about, had no motivation to before.” (Kolla *et al.*, 2022)

"I got a job, got stable housing, stopped using, connected with kids again, I'm in school." (Atkinson *et al.*, 2023)

“It’s not yet perfect, but it saved my life." (McMurchy & Palmer, 2022)

“I've seen how my life drastically changed. And I have a job, I have an apartment, I have bills I pay for, I have a car. I have real-life responsibilities that I never had before. And all this is because the program I'm in.” (Schmidt *et al*., 2023)

For further information

National Safer Supply Community of Practice resources

- Reframing Diversion for Health Care Providers: Frequently Asked Questions (2022)
- Safer Supply for Health Care Providers: Frequently Asked Questions (2022)
- Safer Supply: A Review of the Literature (2022)
- Safer Supply, Opioid Agonist Treatment & Harm Reduction: National Advocacy Toolkit (2022)

Reports

- Prescribed Alternatives and Outreach Program: Evaluation Report for Hamilton Urban Core Community Health Center (Musa *et al*., 2025)
- The Peterborough 360 NPLC Safer Supply Program: 3 Years of Love and Radical Nonsense (Marris, J and King, C, 2025).
- "Expanding Prescribed Alternatives on Vancouver Island: Practice Brief," (AVI Health and Community Services, 2025).
- Safer Supply Program Evaluation: A Response to Drug Poisonings in Thunder Bay, Ontario (Sparkes *et al*., 2025)
- Embedding a Safer Supply Program in a Small Urban Community - Peterborough 360 Degree Safer Supply Program Evaluation May 2022 through December 2023. (Hardill, K. and King, C. 2024).
- Peterborough 360 NPLC Safer Supply Program: The Participant Experience. (Marris, J. and King, C., 2024).
- Safer Supply Ottawa Evaluation: Summer 2024 (Haines *et al.*, 2024)
- A Prescription for Safety: A Study of Safer Opioid Supply Programs in Ontario (Schmidt *et al*., 2023).
- Outcomes from the Safer Supply Program in Kitchener-Waterloo (Perri *et al*., 2023)
- The Kitchener-Waterloo Safer Supply Program: A Collaborative Model of Care (Perri, *et al*., 2023)
- London InterCommunity Health Centre's Safer Opioid Supply Program Evaluation: A comparison of SOS client outcomes from 2022 and 2023 (Kolla & Fajber, 2023)
- Safer Supply Ottawa Evaluation: Spring 2023 (Haines *et al*., 2023)
- Safer Opioid Supply: A Rapid Review of the Evidence (ODPRN, 2023)
- Parkdale Queen West Community Health Centre Safer Opioid Supply 2023 Evaluation Report (Atkinson *et al*., 2023)
- Safer Supply Ottawa Evaluation - Fall 2022 Report (Haines, Tefoglou, & O'Byrne, 2022)
- Assessment of the Implementation of Safer Supply Pilot Projects - Full Report (McMurchy & Palmer, 2022)
- London InterCommunity Health Centre's Safer Opioid Supply Program Evaluation - Full Report (Kolla *et al*., 2022)

- Cool Aid Community Health Centre Report on Risk Mitigation Guidance Prescriptions: Providing "Safer Supply" in CAMICO Sheltering Sites, Outreach and Primary Care Practice (Selfridge *et al.*, 2020)

Protocols and Guiding Documents

- Safer Opioid Supply Programs (SOS): A Harm Reduction Informed Guiding Document for Primary Care Teams-April 2020 update (Hales *et al.*, 2020).
- Safer Opioid Supply Program Protocols. Parkdale Queen West Community Health Centre (Waraksa *et al.*, 2022)
- Victoria SAFER Initiative: Safer Supply Protocols (AVI Health and Community Services, 2022)

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