MySafe Final Evaluation Report: Impacts of Program Closure

Prepared for: MySafe Society

Prepared by: Changemark Research + Evaluation

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Acknowledgement of Territory

With gratitude, we reaffirm that Changemark is located on the stolen land of the xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh Úxwumixw (Squamish), and səl̓ílwətaɬ (Tsleil-Waututh) Nations. With humility and gratitude, our work also takes place on sovereign Indigenous lands and traditional territories across Turtle Island.

Changemark recognizes that an acknowledgement of territory is not enough but is an important social justice and decolonial practice that promotes Indigenous visibility and serves as a reminder that we are on settled Indigenous Land. We give thanks to the Peoples of these territories for their ongoing stewardship of the land since Time Immemorial and keeping it healthy and strong for future generations.

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Acknowledgments

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This evaluation would not have been possible without your involvement. We would also like to extend gratitude to MySafe Society for funding this impact report, providing us with the opportunity to evaluate MySafe, and for their enduring support and commitment to those who live, work and are involved in the greater substance use community.

Executive Summary

Background

The MySafe program was a biometric medication dispensing model designed to provide secure, low-barrier access to prescribed medications—primarily tablet hydromorphone - paired with wraparound supports including harm reduction education, connections to primary care and social supports, and rapid access to opioid agonist treatment (OAT). Using hand-scan-operated machine located in supportive housing and other community sites, clients could access medications on their own schedule, free from the constraints of more traditional treatment settings. The model aimed to enhance autonomy, improve health and stability, and reduce reliance on an increasingly toxic unregulated drug supply.

In 2024, funding for MySafe was abruptly discontinued, reflecting broader political and regulatory shifts away from prescribed alternatives[1]. This evaluation examines how the program functioned, its impacts on service users, and the consequences of its closure, offering lessons to inform future implementation of biometric dispensing models.

Evaluation Purpose

Between March and June 2025, Changemark Research + Evaluation conducted 40 semi-structured interviews with former MySafe clients and service providers and collected 41 demographic questionnaires to capture client profiles and patterns of substance use.

The evaluation examined how participation in MySafe affected clients across domains of service users' health and wellness including physical and mental health, housing stability, financial security, relationships, and daily functioning. Additionally, how each of these areas were affected after the program's closure. During this evaluation we explored gains and positive impacts during client participation and also the disruptions, losses, and adaptations that followed discontinuation, capturing the human impacts of losing this model of care.

Core Elements of the MySafe Model's Impact

Interviews and questionnaire data identified five interconnected themes, each with distinct effects during the program's operations and after the program closure:

1. Autonomy and Self-Determination

During MySafe, clients valued being able to access medication on their own schedule, manage how they spaced out their daily dose, and choose when to interact with providers, fostering dignity, control, and sustained engagement in care. Post-MySafe, many lost this flexibility and returned to rigid, provider-controlled schedules, which they described as disempowering and disruptive to their stability.

[1] We use the term prescribed alternatives for clarity, as "safer supply" can be defined differently across contexts. Please see the glossary for a full discussion.

2. Accessibility and Continuity of Care

During MySafe, low-barrier, predictable access to their medication through the machine removed many obstacles found in traditional programs, helping clients avoid interruptions that could be destabilizing. Post-MySafe, closures often forced clients to travel farther, creating the need for the client to navigate more restrictive care delivery models, or lose access entirely, leading to increases in withdrawal symptoms, other health risks, or disconnection from care.

3. Stability and Functioning

During MySafe, clients reported improvements in physical health, emotional well-being, housing stability, finances, and daily functioning. Clients reported these improvements being associated with reliable medication access and reduced withdrawal symptoms and cravings. Post-MySafe, many experienced rapid destabilization, with declines in health, housing security, relationships, and emotional resilience.

4. Transitions Experience

The shift out of MySafe was frequently abrupt, confusing, and harmful. While some found alternative programs for care, many faced reduction in dosing, transitions in the type of medications available or prescribed, or more rigid service delivery models that affected prior gains. Very few clients and providers described a seamless transition.

5. Lessons Learned and Future Considerations

During MySafe, strong leadership, supportive prescribers, and dedicated on-site staff were key to smooth operations and building client trust. Clients and providers offered suggestions around opportunities to expand the model to other essential medication programs, enhance biometric verification methods (e.g., moving beyond hand scans to more reliable approaches like facial recognition) to ensure consistent dispensing biometric verification techniques, and place machines in more accessible locations. Post-MySafe, reduced flexibility, dosing restrictions, and limited continuity planning affected stability, highlighting the need for sustainability measures and policy reform in future programs.

Challenges to Sustaining Biometric Dispensing Models

Despite evidence of the benefits, MySafe operated in a climate of restrictive policies, political shifts, and precarious funding. The absence of continuity-of-care safeguards for prescribed alternatives left many clients without adequate alternatives, creating a shared vulnerability among other prescribed alternatives pilots who were also reliant on short-term funding.

Calls to Action

1. Invest in and scale automated dispensing models to improve low no-barrier access to medications for people with complex care needs.
2. Integrate wraparound supports—peer support, counselling, and case management—into these automated dispensing programs.
3. Engage communities in decisions about site placement and medication selection to balance accessibility, safety, and local priorities.

4. Build continuity-of-care safeguards into all pilot programs for high-risk populations, including wind-down funding, transition pathways, and independent oversight.
5. Strengthen political and system-level accountability to uphold the ethical obligation of maintaining access to pilot interventions or medications during program changes or closures.

Conclusion

This evaluation provides evidence that biometric dispensing models, when paired with appropriate supports, can offer a scalable, person-centered approach to delivering medications for people facing multiple barriers to care. It also highlights the critical importance of embedding safeguards, political resilience, and sustainability measures into program design. The evaluation team acknowledges and thanks all service users, providers, and partners who contributed their time and insights to this work.

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1.0 Glossary of Terms

Automated Medication Dispensing: Computerized systems used in healthcare and pharmacy settings to store, track, and release medications in a secure and controlled manner. Automated dispensing machines are commonly used in hospitals, long-term care, and community settings to improve medication safety, reduce errors, and streamline inventory management. In community-based harm reduction models, similar technology can be adapted to provide clients with timely, low-barrier access to prescribed medications.

Biometric Dispensing: The use of biometric identifiers (such as fingerprint, palm vein, or iris scans) to verify identity and authorize medication release through an automated dispensing system. Biometric dispensing has been applied in healthcare to enhance security and ensure that medication access is secure and authorized.

Client: An individual who accesses or is eligible to access a program or service. In the context of MySafe, a client is a person who receives their prescribed medication through the biometric dispensing machine and may also connect with additional health or social supports. The term *client* is used interchangeably with *service user* throughout this report.

Coding: The process of systematically categorizing and organizing qualitative data (e.g., interview transcripts, open-ended questionnaire responses) into themes or patterns. Coding allows evaluators and researchers to identify key insights, track trends, and interpret participant experiences in a structured way.

Demographic questionnaire: A short questionnaire used to collect background information about evaluation participants (e.g., age, gender, ethnicity, income, housing status). This data provides context for interpreting findings and allows for analysis of patterns across different groups.

Harm reduction: Policies and programs that aim to minimize immediate health, social, and economic harm (e.g., the transmission of infectious disease, overdose mortality, criminal activity) associated with the use of psychoactive substances, without necessarily requiring a decrease in substance use or a goal of abstinence. Examples include needle and syringe exchange programs, take-home naloxone programs, supervised injection or consumption services, and outreach and education programs for high- risk populations.

Health Equity: The absence of avoidable or remediable differences among groups of people, ensuring that all people have full access to opportunities that enable them to lead health lives, such as quality affordable healthcare, education, safe housing, environmental quality, social support networks, public policies, stable income and job security, and food security.

Indigenous Cultural Safety: To acknowledge the unique history and service needs of our Indigenous tenants and staff in respect to accessing culturally relevant support, and to provide insight into how non-Indigenous practices can be Indigenized to make space for cultural learning, knowledge and teachings

that moves beyond tokenism. Note that this is not a static definition, rather an ongoing practice of learning and deepening relationships and understandings.[2]

Illicit substance use: Illicit drug use includes both illegal and non-medical substance use. For example, using street heroin is illegal. At the same time, Oxycontin may be medical if used as prescribed or illicit if used by someone it wasn't prescribed for or used in higher quantities than was prescribed.

Informed consent: The process of obtaining permission from an evaluation participant to determine eligibility and complete the interview or questionnaire.

2S/LGBT2Q+: Lesbian, gay, bisexual, trans, Two-Spirit, queer, and other gender, and sexually diverse individuals.[3]

Two-Spirit (2S): A term used by some North American Indigenous societies to describe people with diverse gender identities, gender expressions, gender roles, and sexual orientations. Dual-gendered, or "two-spirited" people have been and are viewed differently in different Indigenous communities.[3]

Lesbian (L): A woman whose enduring physical, romantic, and/or emotional attraction is to other women. Some lesbians may prefer to identify as gay (adj.) or as gay women.[3]

Gay (G): The adjective used to describe people whose enduring physical, romantic, and/or emotional attractions are to people of the same sex.[3]

Bisexual (B): A person who has the capacity to form enduring physical, romantic, and/or emotional attractions to those of the same gender and those of another gender. People may experience this attraction in differing ways and degrees over their lifetime.[3]

Trans (T): Trans is an umbrella term that describes a wide range of people whose gender and/or gender expression differ from their assigned sex and/or the societal and cultural expectations of their assigned sex.[3]

Queer (Q): An adjective used by some people, particularly younger people, whose sexuality is not heterosexual. Once considered a pejorative term, queer has been reclaimed by some LGBT2Q+ people to describe themselves; however, it is not a universally accepted term even with in the LGBT2Q+ community.[3]

MySafe: A secure, biometric medication-dispensing program designed to provide low-barrier access to prescribed opioids. MySafe units were intended to reduce overdose risk, improve treatment continuity, and support harm reduction by allowing clients to safely access medications on-demand without daily supervision.

Opioid: Opioids are substances commonly prescribed for pain management that bind and activate opioid receptors in the brain, suppressing the ability to feel pain. Opioids can be prescribed or obtained illegally, and include synthetic (e.g., fentanyl, methadone, buprenorphine), semi-synthetic (e.g., heroin,

[2] Definitions for these terms were informed by the In Plain Sight report and developed collaboratively with Elders, Knowledge Keepers, Indigenous Health Leads, and Changemark leadership.

[3] Qmunity. Queer Terminology from A to Q. (n.d.). Accessed August 6, 2024. https://qmunity.ca/wp-content/uploads/2023/01/Queer-Glossary_2022_Digital.pdf

hydromorphone, oxycodone) or naturally derived (e.g., opium, morphine, codeine) types. Depending on the opioid type, formulation and individual preference, they are consumed via ingestion, inhalation, subcutaneous, intramuscular or intravenous injection.

Opioid Agonist Treatment (OAT): Opioid agonist medications prescribed for the treatment of opioid use disorder. OAT is typically provided in conjunction with provider-led counselling; long-term substance-use monitoring (e.g., regular assessment, follow-up, and urine drug tests); comprehensive preventive and primary care; and referrals to psychosocial treatment interventions, psychosocial supports, and specialist care as required. In this document, OAT refers to treatment with an opioid agonist medication with an evidence base for use in the treatment of opioid use disorder. "Opioid agonist treatment (OAT)" is the preferred terminology, representing an intentional shift from the use of "opioid substitution treatment (OST)", "opioid maintenance treatment (OMT)", and "opioid replacement therapy (ORT)".

Naloxone: A fast-acting medication used to temporarily reverse the effects of opioid poisonings.

Injectable Opioid Agonist Treatment (iOAT): An evidence-based treatment for people with severe opioid use disorder who have not benefited from other OAT options. Injectable OAT (iOAT) is a more intensive treatment program where people go to a clinic or pharmacy up to three times per day to self- administer hydromorphone or diacetylmorphine under supervision.

Open-ended questions (qualitative interviewing): Questions that allow participants to respond in their own words, without being limited to predefined options. They are designed to elicit detailed, descriptive, and nuanced responses that reflect participants' experiences, perspectives, and meanings.

Participant: An individual who takes part in an evaluation or research project. In the context of the MySafe impact report, participants include former service users, or service providers who contributed their perspectives through interviews or questionnaires.

Peer Support Specialist: A staff member with lived and living experience of substance use that has been trained to support those experiencing substance use, mental health conditions, or trauma, and brings their own lived experience accessing the system to support clientsin accessing care.

People With Lived and Living Experience (PWLLE): People with lived and living experience of substance use are individuals who have current or past personal experience with using substances, including social, structural and health impacts that may come with it. This term recognizes their unique knowledge, expertise, and perspectives gained through direct experience, whether they are currently using substances or have used them in the past.[4]

Prescribed Alternatives: Medications (e.g., hydromorphone, fentanyl, Dexedrine) prescribed by a licensed healthcare provider as a substitute for the toxic, unregulated drug supply. Prescribed alternatives are intended to reduce the risk of overdose, poisoning, and other harms by offering a pharmaceutical-grade option that is safer and consistent in quality and dosage. This approach is one way of implementing safer

[4] Canadian Centre on Substance Use and Addiction. 2021. Lived and living experience. https://www.ccsa.ca/lived-and-living-experience#:~:text=What%20Is%20Lived%20and%20Living,using%20one%20or%20more%20substances.

supply initiatives. In the context of MySafe, hydromorphone tablets were dispensed as prescribed alternatives.

Probing questions (qualitative interviewing): Follow-up questions used by interviewers to encourage participants to expand, clarify, or provide more depth in their responses. Probes help uncover additional details or insights that may not surface in initial answers.

Recruitment: The process of approaching interested individuals, introducing the evaluation purpose, and determining their level of interest. Recruitment is typically followed by obtaining informed consent and formal enrolment in the program or study.

Safer Supply: A harm reduction approach that provides people who use drugs with access to a legal, regulated supply of substances to reduce reliance on the unregulated drug market. Safer supply programs typically involve prescribing *prescribed alternatives* (e.g., hydromorphone tablets instead of illicit opioids like heroin) with the aim of preventing overdose, supporting health and stability, and improving continuity of care.

Semi-structured qualitative interviews: A flexible interview method that uses a prepared guide with key topics and questions while allowing the interviewer to adapt, rephrase, or follow new directions that emerge during the conversation. This approach balances consistency across interviews with openness to participants' unique perspectives.

Stigma: The beliefs and attitudes about people who use drugs, including those with substance use disorders, that lead to negative stereotyping and prejudice against them and their families. These beliefs are often based on ignorance, misinformation, moral judgment, and misunderstanding. Discrimination, which often emerges from stigmatizing beliefs and attitudes, refers to the various ways in which people, organizations, and institutions unfairly treat people living with a substance use disorder. Stigma and discrimination can often act as barriers to accessing health care, housing, and addiction treatment. Additionally, related systemic discrimination such as racism, poverty, sexism, and colonization can compound the stigma and discrimination experienced by people who use drugs and their families.

Substance Use: The consumption of psychoactive or mood-altering substances. Many compounds have psychoactive properties. Regulated substances include things like alcohol, tobacco, cannabis, and prescribed medications, while unregulated, illicit substances can include cocaine, heroin, fentanyl, crystal methamphetamine and other compounds. Many unregulated substances are criminalized, and this greatly impacts the dynamics of where, when, and how people use them. People have used psychoactive substances throughout history and for a variety of reasons. These include spiritual or religious, cultural, social, medical, and scientific reasons, as well as for pleasure. The individual effects of substance use can vary greatly. For the purposes of this document, we use the term "substance use" and "drug use" interchangeably and largely mean the use of unregulated substances or regulated substances (such as medications) in ways other than as prescribed.

Substance Use and Addiction Program (SUAP): A stream of funding from Health Canada for a wide range of innovative and evidence-informed projects including substance use prevention, harm reduction and treatment initiatives across Canada.

Substance Use Disorder: A pattern of substance use leading to clinically significant impairment or distress. The term includes the use of synthetic and naturally derived opioids, which may be prescribed or

obtained illegally. See DSM-5-TR Diagnostic Criteria for Substance Use Disorder for specific criteria for clinical diagnosis and assessment of severity. In recognition of the counterproductive impact of pejorative and stigmatizing labels, the DSM-5-TR terminology represents a deliberate shift away from DSM-IV terminology of ‘substance abuse' or ‘substance dependence' to describe this condition. Accordingly, individuals with substance use disorder are no longer referred to as 'drug abusers' or 'drug addicts’.

Toxic drug poisoning: A life-threatening medical emergency that occurs when the body is overwhelmed by one or more substances. The term emphasizes that many such events are caused by the contamination and unpredictable potency of the unregulated drug supply, rather than intentional overconsumption as implied by the term *overdose*.

Trauma: An experience that overwhelms an individual's capacity to cope. Trauma can result from a series of events or one significant event. Trauma may occur in early life (e.g., child abuse, disrupted attachment, witnessing others experience violence, or neglect) or later in life (e.g., accidents, war, unexpected loss, violence, or other life events out of one's control). Trauma can be devastating and can interfere with a person's sense of safety, sense of self, and sense of self-efficacy. Trauma can also impact a person's ability to regulate emotions and navigate relationships. People who have experienced trauma may use substances or other behaviours to cope with feelings of shame, terror, and powerlessness.[5]

Trauma-and-violence informed care: Expands past trauma-informed care to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person’s life.[5]

Toxic Drug Supply: A term used to describe the current unregulated street drug market in Canada and other regions, which is increasingly contaminated with potent substances such as fentanyl, benzodiazepines, and other adulterants. The unpredictability of potency and contents in the toxic drug supply significantly increases the risk of poisoning, overdose, and death.

Unregulated Drug Supply: Drugs obtained outside of a legal or medical framework, including street-level or black-market substances. The unregulated drug supply lacks quality control, meaning that contents, potency, and contaminants are unknown, which contributes to the toxic drug supply and drives overdose risk.

Urine Drug Screen (UDS): A laboratory or point-of-care test that analyzes a urine sample to detect the presence of specific substances or their metabolites. In substance use treatment and research settings, UDS is often used to monitor medication adherence, substance use patterns, or to inform clinical decision-making.

[5] EQUIP Health Care. (2022). Trauma-and violence-informed care. https://equiphealthcare.ca/resources/equity-essentials/trauma-and-violence/

2.0 Background and Context

The MySafe project was established in 2019 in Vancouver, British Columbia (BC), as a response to the escalating overdose drug poisoning deaths and the toxic unregulated drug supply. It introduced an innovative model of care using secure biometric technology to dispense prescribed pharmaceutical-grade opioids (hydromorphone) to individuals at high risk of overdose. Through a stand-alone kiosk powered by palm vein recognition, clients could access tablet hydromorphone daily without requiring face-to-face contact with a provider.

The overarching goals of the MySafe program were to:

1. Provide a low-barrier, secure, flexible, cost-effective, and user-friendly way to access medications.
2. Reduce reliance on the unregulated toxic drug supply.
3. Create an entry point into health and social services.
4. Increase autonomy and engagement in care for people who use drugs.
5. Build the capacity of service providers and PWLLE to engage in harm reduction efforts.
6. Explore a scalable model to expand access to prescribed alternatives.
7. Involve peers in model design and implementation.
8. Reduce pressure on the healthcare system by introducing a community-driven solution for medication dispensing.

Following a successful pilot in Vancouver in 2020 with 14 individuals, MySafe received funding through Health Canada's Substance Use and Addictions Program (SUAP) to scale to five sites across Canada:

1. Overdose Prevention Society, Vancouver, British Columbia
2. Atira Women's Resource Society, Vancouver, British Columbia
3. Chapman's Pharmacy Addiction Clinic / London InterCommunity Health Centre, London, Ontario
4. Society of Living Illicit Drug Users (SOLID) / Dark Star Therapeutics, Victoria, British Columbia
5. Highfield Park Pharmachoice / Canadian Association of People who Use Drugs (CAPUD), Dartmouth, Nova Scotia

The program experienced varied implementation success across sites, shaped by differing political and regulatory landscapes across the country. In particular, the prescribing of tablet hydromorphone as a safer, regulated alternative to the poisoned drug supply was not uniformly supported. Some provinces did not permit or promote this approach, while others faced barriers such as a lack of willing prescribers or challenges in securing a partnering pharmacy. Institutional liability concerns further contributed to provider hesitancy, leading to more restrictive prescribing practices or limiting where the program could operate.

In 2024, MySafe's funding agreement ended with Health Canada, resulting in the abrupt discontinuation of services. By that point, even regions that had initially supported prescribed alternatives were shifting toward more cautious or restrictive positions, making it difficult, if not impossible, for pilot sites to secure alternative funding. Without viable sources of ongoing financial support, sites were forced to close, leaving clients with few transitional supports.

3.0 Evaluation Background

3.1 About Changemark Research + Evaluation

MySafe Society contracted Changemark Research + Evaluation to assess the implementation and impact of the MySafe program, as well as the consequences of its sudden closure.

The evaluation team brings lived and professional experience across mental health, substance use, community engagement, OAT services, and harm reduction. With expertise in qualitative and quantitative research, policy evaluation, and system change, the team draws on interdisciplinary knowledge grounded in equity, community-based research, and ethical research practices.

3.2 Evaluation Scope

This evaluation examined both the implementation of the MySafe model and the consequences of its discontinuation, with particular attention to:

1. How the MySafe program operated across multiple sites;
2. The role of biometric dispensing in harm reduction;
3. Service users' experiences accessing care through MySafe and the model's stabilization effects;
4. The impact of program closure on client health, housing, and substance use;
5. Lessons learned to guide the development of future secure medication dispensing initiatives.

Importantly, this is not a formal outcome evaluation, as access to baseline and historical data collected during previous evaluations was not made available by the original data stewards. As such, this report draws on new data obtained through qualitative interviews and demographic questionnaires to synthesize program experiences and explore the effects of its discontinuation from the perspective of former clients and service providers.

By documenting the real-world challenges and successes of delivering and ending a novel harm reduction intervention, this evaluation offers timely insights to inform future programming and policy—particularly in settings where conventional models of care continue to fall short in reaching and supporting people who use drugs.

3.3 Evaluation Objectives

The evaluation was designed to:

1. Assess the functioning of the MySafe service model, including the accessibility, usability, and acceptability of biometric medication dispensing when paired with wraparound supports;
2. Examine the impact of MySafe on client's stabilization, with attention to health, substance use, housing, and engagement with services;
3. Analyze the effects of program discontinuation on client's stability and overall well-being;

4. Identify key factors that influenced the implementation, operation, and eventual closure of the MySafe program;
5. Document lessons learned and provide considerations to guide future implementation of biometric dispensing models for similar populations;
6. Inform strategies to support continuity and transitions in care when harm reduction programs are defunded or discontinued.

4.0 Program Overview

The MySafe program used biometric dispensing machines to provide daily doses of medications (i.e., tablet hydromorphone) to individuals with a history of overdose, regular opioid use, and fentanyl detected in their urinary drug screens. Following an initial clinical assessment, clients were prescribed oral hydromorphone by a physician based on individualized dosing needs, up to a maximum of 128 mg per day. Medications were prepared and prepackaged by a partner pharmacy and loaded into the dispensing machine in compliance with all Health Canada and provincial regulations for controlled substances.

The dispensing machine used Fujitsu PalmSecure biometric technology to scan and verify service users' identities via their unique palm vein patterns. This contactless, hygienic system used infrared scanning from 3–4 inches away to authenticate access. Upon verification, the machine dispensed a participant's daily dose. Unlike many traditional programs, MySafe permitted off-site consumption, eliminating the need for witnessed dosing and providing greater autonomy and flexibility.

4.1 Wraparound Care and Service User Engagement

The MySafe model of care extended beyond medication dispensing to offer integrated supports through machine-based messaging and on-site staff engagement. Services included:

- **Harm reduction education** focused on safer drug use practices and minimizing reliance on unregulated opioids;
- **Guidance on safe preparation and use of filters** for those who crushed and injected tablets, to reduce the risk of contaminants and fillers;
- **Health outreach and clinical follow-up** including rapid access to opioid agonist therapy (OAT) for interested service users;
- **Connections to primary care and social supports** including housing, income, and mental health services.

4.2 Enrollment and Care Process

Enrollment in the MySafe program began with an initial assessment by a prescribing physician (virtual or in-person), who reviewed eligibility criteria (see Appendix A). Generally, individuals were eligible if they:

- Self-reported regular illicit toxic opioid use, at least 5 days per week.
- Were at-risk of overdose
- Had previous unsuccessful attempts with OAT

Eligible individuals were issued a personalized prescription for hydromorphone, with dosing tailored to their needs. Program eligibility was restricted to individuals age 18 and older. This was in part to limit enrollment of youth using substances experimentally or those better served by youth-specific programming.

Clients then registered their biometric profile with the MySafe machine, linking their identity to the PalmSecure© system. At this stage, they also received guidance on harm reduction to support safer use and minimize injection-related risks.

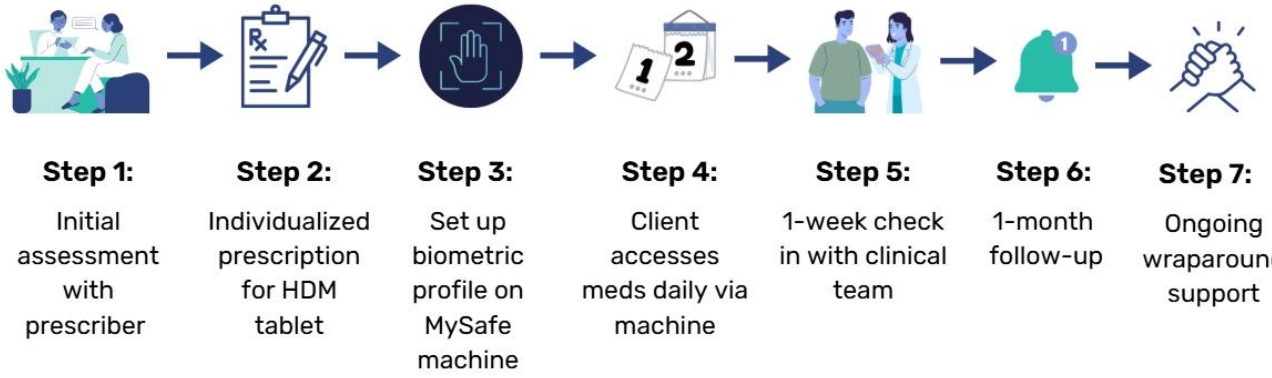
4.3 Follow-Up Care

Once enrolled, clients accessed their medication daily via the MySafe machine. During the first week, structured monitoring was implemented, including a follow-up visit with the prescriber/clinical care team and a urine drug screen (UDS) to assess medication adherence. Doses were adjusted as needed based on clinical judgment and client feedback.

At the one-month follow-up, prescribers reassessed treatment plans, conducted additional UDS testing, and made further dose adjustments as appropriate. The machine interface also delivered appointment reminders to support continuity of care.

Ongoing care was supported by additional clinical visits as needed, initiated by prescribers, staff, or client request. Outreach workers conducted regular check-ins to provide ongoing harm reduction, social service navigation, and wraparound care.

Figure 1. MySafe Model of Care



4.4 Risk Mitigation and Medication Adherence

Urine drug screens occurred at baseline, one week, and one month after enrollment, with additional testing at the discretion of the care team. If hydromorphone was not detected in a client's sample, indicating non-use of prescribed medication, the client was no longer eligible to continue in the program. However,

complete abstinence from unregulated opioids was not required. For example, if fentanyl was detected, care teams responded by offering additional supports and considering dose adjustments to better meet service users' stabilization needs.

4.5 Sites and Implementation

The MySafe program was initially funded by Health Canada's Substance Use and Addictions Program (SUAP) for implementation across five sites in Canada, with the intent to integrate secure dispensing into existing health and harm reduction service locations.

Implementation outcomes across sites varied:

- Three sites in Vancouver (Overdose Prevention Society and two with Atira) became fully operational;
- Two sites (Chapman's Pharmacy Addiction Clinic / London InterCommunity Health Centre in London and Highfield Park Pharmachoice / Canadian Association of People who Use Drugs (CAPUD) in Dartmouth) encountered regulatory and logistical barriers and did not launch;
- One site (originally SOLID Outreach Society) was redirected to Cool Aid Society in Victoria;
- A separate site in Winnipeg (Main Street Project) launched with local adaptations to the model.

Each operational site maintained a core team, including a prescriber, a pharmacy partner, and program support staff. Staffing varied by site, reflecting the local context and service model.

4.6 Core Roles

- **Prescribers** assessed eligibility, prescribed hydromorphone, monitored patient progress, and made dosing decisions;
- **Pharmacies** prepared and delivered medication cartridges, ensured safe storage, and coordinated with care teams;
- **Program Support Staff** oversaw machine operations, enrollment, client engagement, and referrals to additional health and social services.

Site-level adaptations were common and shaped the delivery model. For example, one site was embedded within a volunteer-run overdose prevention site, while others were housed within supportive housing programs. These variations affected the types of wrap-around supports available, delivery method, and client program engagement.

Figure 2. Operational and Non-Operational MySafe sites

5.0 Evaluation Methods

5.1 Participant Eligibility and Recruitment

This evaluation used mixed methods to assess the impact of MySafe implementation and closure. Eligible participants included former MySafe clients and service providers involved in the program's development or operations.

5.1.1 Service User Recruitment

Former clients were eligible if they:

- Participated in MySafe between 2021-2024
- 18 years of age or older
- Speak and comprehend English

Participants were recruited through convenience sampling, led by outreach teams at former MySafe sites. Site leads identified eligible individuals, supported outreach, and shared a recruitment letter (see Appendix B) outlining the evaluation's purpose, eligibility criteria, and honorarium.

Interested individuals were connected to the evaluation team for eligibility screening. When possible, interviews were conducted the same day to reduce participation barriers. A pre-screening and tracking form (developed in Microsoft Forms©) was used to monitor outreach, confirm eligibility, and document participation.

Most interviews were conducted on-site at former program locations. A welcome station was set up to complete a demographic questionnaire and greet walk-in participants. This low-barrier approach facilitated strong participation and minimized attrition.

5.1.2 Service Provider Recruitment

Service providers were eligible if they:

- Delivered direct services at a MySafe site (e.g., prescribers, pharmacists, harm reduction staff, case managers);
- Contributed to program planning, implementation, or oversight for the MySafe site.

Eligible providers were identified through site directories and contacted by the evaluation team via email. Invitation messages included the purpose of the evaluation, eligibility details, and interview logistics.

All participants, both clients and service providers, completed a written informed consent process prior to any data collection. The consent process included an explanation of the evaluation's purpose, data confidentiality, and the voluntary nature of participation, with opportunities to ask questions and withdraw at any time.

5.2 Data Collection Methods

Data collection took place with former MySafe clients and providers across four sites: Overdose Prevention Society (Vancouver), Cool Aid Society (Victoria), Atira – Carl's Room (Vancouver), and Atira – The Lugaat (Vancouver). Former clients could choose to complete the questionnaire only or to participate in both the questionnaire and a semi-structured interview. Some participants identified as both service providers for the MySafe program (e.g., Peer Coordinators, Outreach Workers) and former service users. In these cases, interview questions from both the client and provider guides were asked, but only the client demographic questionnaire was completed.

All client and provider interviews (n=40) were audio-recorded using the Audacity software and transcribed verbatim with Microsoft's transcription tool. Transcripts were reviewed and cleaned by the interviewer to ensure accuracy and completeness. All personal information, questionnaire responses, and interview data were stored on a secure, encrypted server hosted in Canada.

5.2.1 Service User Interviews

Former MySafe clients were invited to participate in a short demographic questionnaire, one-to-one, semi-structured qualitative interview, or both. Participation was voluntary, and individuals received a $10 honorarium for completing the questionnaire and an additional $40 for participating in the interview.

Interviews were guided by an interview guide (see Appendix E) that included open-ended and probing questions about service users' experiences during the operational period of MySafe and following its discontinuation. Topics included how clients were initially engaged in the program, their experiences accessing care and support, perceived impacts on health, substance use, and housing, and their transition after program closure (i.e., where they are now).

Service user participant interviews were conducted in person in private rooms at former MySafe sites and typically lasted 30–40 minutes. In addition to the interview, clients were asked to complete a short demographic questionnaire capturing information on housing status, substance use, treatment engagement, toxic drug poisoning history, and other sociodemographic factors (see Appendix C).

5.2.2 Service Provider Interviews

Semi-structured one-to-one qualitative interviews were conducted with former MySafe service providers, using an interview guide (see Appendix F) with open-ended and probing questions. Interviews explored a range of topics including client-provider relationships, program planning and operations, perspectives on client engagement and retention, the effects of program discontinuation, and observations of client stabilization.

Interviews typically lasted 45 minutes and were conducted in-person or virtually (via Zoom©). Provider participants were also asked to provide basic demographic information (Appendix D), including their role within MySafe, experience working with people who use drugs, and other sociodemographic factors.

6.0 Data Analysis

6.1 Coding and Analysis of Qualitative Data

We used an interpretive description approach to analyze qualitative data, with the goal of identifying thematic patterns that reflect former service users', and providers' experiences with MySafe and to generate insights to inform future service delivery and policy. Interpretive description is a practice-oriented qualitative method well suited to evaluations of care models, as it supports the identification of shared experiences while also capturing contextual complexity (Thorne, 2016). This was complemented by thematic analysis to enable systematic coding and organization of findings in ways that are both meaningful and actionable.

Interview transcripts were coded in Microsoft© Word by EM (Project Lead), in collaboration with RB (Evaluation Assistant) and KC (Project Support). To establish consistency, four transcripts were coded independently before a consensus-building session to discuss emerging codes and themes and develop a

preliminary codebook (EM and RB). The coding process was iterative, incorporating both open coding and category development to refine themes over time. Codes with shared characteristics were grouped into core categories and analyzed relationally to understand how different aspects of the program experience, and its discontinuation, interacted.

As analysis progressed, accessibility and autonomy emerged as two foundational concepts shaping participants' experiences. In this evaluation:

- **Accessibility** refers to the ease, consistency, and dependability of obtaining medication, whether through MySafe's biometric dispensing system or alternative models after the program ended.
- **Autonomy** captures the degree of control clients had across multiple dimensions, including when and how they accessed or used medication, and how (or whether) they engaged with service providers.

These concepts provided an analytical lens for exploring how clients experienced, lost, or reconfigured access and autonomy following MySafe's closure, and how these dynamics related to broader aspects of health, well-being, and stability.

In the final stage of analysis, the team (EM and KC) developed a thematic map to conceptually organize relationships between codes and categories. This mapping exercise helped surface recurring patterns across narratives and supported exploration of mechanisms including how and why certain impacts occurred, and what shaped clients' experiences of stabilization during and after the program. Core insights from this process are presented in the Results section, with an emphasis on implications for future models involving biometric dispensing or programs vulnerable to funding disruptions.

Consistent with interpretive description, we acknowledge that themes do not passively "emerge" from data, but are constructed through a reflective, iterative process of interpretation. Throughout the analysis, we considered both individual narratives and systemic patterns, attending to the structural, contextual, and relational factors that shaped participants' experiences.

6.1.1 Descriptive Analysis of Demographic Data

In addition to qualitative interviews, evaluation participants completed a brief demographic questionnaire that included information on age, gender, housing status, and substance use at the time of the interview. Responses were analyzed using descriptive statistics to provide contextual background on who accessed the program and to identify potential shifts in housing, substance use patterns, and related circumstances following program closure when compared to previous evaluations conducted by other agencies.

This data was not used to draw causal conclusions, but rather to enrich interpretation of the qualitative findings by providing context around service users' broader life conditions after the program's discontinuation.

6.1.2 Linking the Quantitative and Qualitative Findings

Although the evaluation was primarily qualitative, the demographic questionnaire data provided helpful context on participant characteristics and broad patterns related to health, stability, and service access at the time of the interviews. Together, these data sources informed our understanding of core themes, particularly accessibility and autonomy, and the factors shaping clients' experiences with the MySafe model and its discontinuation.

The questionnaire data were descriptive and not intended to validate interview findings, so triangulation was limited. Nonetheless, they offered useful background for interpreting service user and provider perspectives. While a formal literature review was beyond the scope of this evaluation, previously published MySafe studies may offer further context.

6.2 Limitations

A key limitation was the lack of access to baseline and in-program data collected during previous MySafe evaluations. Ideally, this evaluation would have extended that work by incorporating comparable measures, enabling direct analysis across pre-, during-, and post-program periods. Without access to those datasets, our ability to assess change over time was limited.

As a result, the evaluation relied on service user recall to explore shifts in housing, substance use, income generation, and social support. While these self-reported reflections offer valuable insight, they are subject to recall bias and may not fully capture the progression or complexity of clients' experiences. Additionally, outcomes may have been influenced by external factors such as evolving drug policy, provincial regulations (e.g., with regards to prescribed alternatives), housing availability, or healthcare access which could not be fully isolated in this analysis.

Recruitment-related limitations also shaped the scope of the findings. The evaluation reflects the perspectives of former clients who remained connected enough to the former MySafe sites to be reached. It does not include individuals who were eligible for the program but declined to enrolment, nor those who experienced significant instability (e.g., became unhoused, relocated, or lost contact with services), which may introduce sampling bias and underrepresent the experiences of individuals with complex needs or challenges. Clients from the Manitoba site were also not recruited. Because that site operated under a distinct model and would have required interviewer travel in order to meaningfully connect with participants, including them was beyond the scope and budget of this evaluation. Nonetheless, their perspectives could have provided valuable insights into how automated biometric dispensing functions across different program models and medication types, extending understanding beyond prescribed alternatives.

Similarly, perspectives from former service providers are based on a relatively small and role-limited sample, despite MySafe employing a wider range of staff during program delivery. In total, MySafe had five central staff as well as a Program Manager and nurse contracted to each site (eight in total across sites). For this evaluation, however, nearly all of those we were able to interview had worked in peer support or program coordination roles. While peer support was not part of MySafe's formal staffing structure, many

sites independently created these roles to support the program, and these workers often remained connected to the sites even after closure. In contrast, prescribers, pharmacists, and other clinical staff, who were hired specifically for the MySafe program, had generally moved on once the program ended, making them harder to reach for the evaluation. As a result, the findings likely underrepresent the perspectives of these provider groups, whose insights could have added depth regarding MySafe's implementation, the transition and closure process, observed impacts on client health and wellness, and the influence of political and regulatory contexts across the program's lifespan.

Finally, while the evaluation employed a rigorous and reflective approach to analysis, qualitative findings are inherently interpretive. The identification and framing of themes reflect the evaluators' perspectives and positionalities and are shaped by the lens through which the data were analyzed.

7.0 Key Findings

7.1 Descriptive Data

A total of 38 former MySafe clients completed the demographic questionnaire, and 37 participated in a qualitative interview. Clients were recruited from four operational MySafe sites: Overdose Prevention Society (n=9), Atira – Carl's Room (n=7) and Atira – Lugaat (n=10) in Vancouver, and Cool Aid Society (n=12) in Victoria (See Table G1 in Appendix G).

In addition, three service providers completed the demographic questionnaire, and six participated in a qualitative interview. Since the number of provider questionnaire responses was so small, we do not present descriptive statistics here, as the data are not sufficient to be meaningful. Results from the service provider demographic questionnaire are summarized in Tables G1 and G2. Some evaluation participants (n=3) identified as both service providers for the MySafe program (e.g., Peer Coordinators, Outreach Workers) and client. In these cases, only the client demographic questionnaire was completed; however, they were counted as both a client and a service provider for interview data, since questions addressed both roles.

Table 1. Number of participants by role

Role	Participant Count
Former MySafe Client	38
Program Manager	1
Program Coordinator	2
Support Staff (e.g., peer support, outreach)	3

7.1.1 Client Demographic Profile

Tables G1 and G3 summarize client demographics across key categories, including age, gender, race/ethnicity, housing, substance use, care engagement, and financial stability at the time of the interview.

The median age of service users is 46, with most participants identifying as men (n=27, 71%). Sixty-three percent identified as White, and 45% identified as Indigenous, including 18% (n=7) who identified as First Nation and 13% (n=5) who identified as Métis.

7.1.1.1 Housing

At the time of the interview, most clients (n=20, 53%) were living in a single room occupancy or hotel with supports in the past 30 days. Additionally, 32% (n=12) reported living in supportive housing, 13% (n=5) had no fixed address, and 3% (n=1) lived in a shelter, and another 3% (n=1) lived in an apartment.

Most clients (n=26, 68%) were living alone, 18% (n=7) were living with a partner, one individual was living with a roommate, and for 11% (n=4) this did not apply, as they were without a fixed address or living in a shelter.

7.1.1.2 Substance Use Patterns in the Past 30 Days

Clients reported a wide range of substance use in the past 30 days, and the question allowed individuals to select more than one substance and method of use.

Fentanyl was the most reported substance used (n=35, 92%), followed by crystal methamphetamine (n=34, 89%), heroin (n=21, 55%), crack cocaine (n=19, 50%), and benzodiazepines not prescribed to the individual (n=19, 50%). Nearly half reported using cannabis (n=17, 45%), while smaller proportions reported alcohol (n=10, 26%), powder cocaine (n=9, 24%), or other opioids such as hydromorphone or oxycodone not prescribed to them (n=5, 13%). A few participants reported using other substances (n=4, 11%).

Patterns of consumption varied by substance. Among those who used fentanyl, most smoked it (n=31, 89%), with smaller proportions injecting (n=13, 43%) or snorting (n=1. 3%). Crystal meth was overwhelmingly smoked (n=34, 91%), though over one-third reported injecting (n=13, 38%). Heroin was also primarily smoked (n=20, 95%), with about half reporting injection (n=11, 52%). Crack cocaine was smoked by almost all who reported using it (n=17, 89%), and about one-third injected it (n=6, 32%). Powder cocaine was less common and reported as smoked (n=6, 67%), injected (n=4, 44%), or snorted (n=3, 33%). Other opioids were almost always smoked (n=5, 100%), with fewer reporting injection (n=4, 80%) or ingestion (n=1, 20%). Benzodiazepines were primarily smoked (n=18, 95%), though some reported injection (n=6, 32%) or ingestion (n=2, 11%). Cannabis use was mostly smoking (n=16, 94%), with some ingestion (n=2, 12%), while alcohol was exclusively ingested. Participants who selected “other” substances reported smoking (n=2, 50%), ingestion (n=2, 50%), and injection (n=1, 25%).

When asked to identify their preferred substance, fentanyl was the most frequently reported (n=31, 82%), followed by heroin (n=24, 63%). Smaller proportions identified benzodiazepines (n=4, 11%), cannabis (n=2, 5%), other opioids (n=1, 3%), or alcohol (n=1, 3%) as their preferred substance. One individual (n=1, 5%) preferred not to answer.

7.1.1.3 Access to Prescribed Alternatives and OAT

Clients were asked about their current access to prescribed alternatives and/or OAT, and the question allowed them to select more than one option.

Half of participants (n=19, 50%) reported that this was not applicable, as they were not accessing prescribed alternatives or OAT at the time of the interview. Among those who did report access, methadone was the most common (n=9, 24%), followed by slow-release oral morphine (Kadian® or M-Eslon®; n=6, 16%) and oral tablet hydromorphone (Dilaudid; n=6, 16%). Smaller proportions reported buprenorphine/naloxone (Suboxone®; n=1, 3%), fentanyl patches (n=1, 3%), or stimulant-based prescribed alternatives such as methylphenidate (Ritalin®) or dextroamphetamine (Adderall; n=1, 3%).

7.1.1.4 History of Drug Poisoning and Related Complications in the Past 6 Months

Clients were asked whether they had experienced an overdose in the past six months.

Nearly one-quarter of participants (n=9, 24%) reported experiencing at least one poisoning, while the majority (n=29, 76%) did not. Among those who reported a poisoning, just over half (55%) had experienced one event, while smaller proportions reported two events (22%) or three or more (22%).

In addition, 42% (n=16) reported experiencing at least one drug-related complication. The most frequently reported issues were psychosis (n=5, 31%), cellulitis or infection (n=3, 19%), and seizures (n=3, 19%). Smaller numbers reported constipation (n=2, 12%), anxiety (n=1, 6%), and sleep deprivation (n=1, 6%). The remaining 58% (n=22) reported no complications.

7.1.1.5 Sources of Income

Clients reported diverse sources of income over the past six months, with many drawing from multiple streams. Disability assistance was the most common (n=27, 71%), followed by welfare (n=10, 26%), part-time employment (n=8, 21%), and binning/recycling (n=10, 26%). A notable proportion also reported generating income through the drug economy, including selling drugs (n=12, 32%) or sex work (n=4, 11%). Other informal income sources included panhandling (n=5, 13%), reselling (n=6, 16%), and research honoraria (n=7, 18%). Very few reported full-time employment (n=1, 3%) or pensions (n=2, 5%), underscoring the reliance on precarious or non-traditional income streams.

Half of participants (n=19, 50%) reported engaging in illegal or survival-based income-generating activities (e.g., stealing items to resell, selling drugs, panhandling, sex work) within the past 30 days. Among these individuals, the average number of days was 16.9, ranging from 1.5 to 30 days (i.e., every day). Nearly half (n=18, 47%) reported no involvement in illegal activities, and one participant (3%) preferred not to answer.

7.1.1.6 Access to Basic Needs

Participants described significant barriers in meeting their basic needs. While nearly all reported stable access to income assistance (n=36, 95%) and most had consistent housing (n=32, 84%), daily food security

was far less reliable: 29% (n=11) said they never had food for three meals per day, and another 29% (n=11) reported only occasional access.

Housing conditions were uneven. Less than half always had adequate heating (n=18, 47%) or cooling (n=14, 37%), and just over one-third always had functional plumbing and water (n=14, 37%).

Access to healthcare was mixed. While 58% (n=22) reported always being able to access medical care, only 26% (n=10) said they always had access to dental care.

Communication and mobility also varied. Half of participants (n=19, 50%) always had access to a phone, and 63% (n=24) reported dependable transportation. By contrast, fewer (n=17, 45%) had consistent access to other communication methods such as email or social media.

Financial insecurity was widespread. Less than half of the participants (n=16, 42%) always had enough money to pay monthly bills, and only 24% (n=9) always had money for necessities like food or toiletries. The ability to save was almost nonexistent, with 84% (n=32) reporting they never had money to save. More than half of participants (n=20, 53%) never had money to support others, and 58% (n=22) never had money for entertainment.

Rest was also a challenge with fewer than one in five participants (n=7, 18%) reporting that they always had enough time to sleep or rest, while almost one-quarter of participants (n=9, 24%) reported they never did enough time to sleep or rest.

7.2 Qualitative Themes

Overall, clients and service providers (n=40) were closely aligned in their reflections on the value and impacts of the MySafe program, as well as the challenges that emerged during and after its discontinuation. Both groups emphasized that MySafe not only provided consistent access to medication but also reconfigured the conditions under which care was delivered—centering autonomy, flexibility, and trust in ways that participants found rare in more medicalized or punitive systems.

Five interconnected themes illustrate how clients and providers experienced the program and its wind-down:

- Autonomy and Self-Determination
- Accessibility and Continuity of Care
- Health, Safety, and Stability
- Transition Experience
- Lessons Learned and Future Considerations

See Appendix H or thematic maps.

7.2.1 Autonomy and Self-Determination

Participants widely described MySafe as a model that enhanced their sense of agency and independence in care—qualities they felt were often constrained in more traditional substance use programs. In this context, autonomy refers to the ability to access medication on their own schedules, adjust use according to their needs, and decide when or whether to interact with care providers. These elements were closely tied to service users' sense of dignity, control, and willingness to stay engaged in care.

The following themes emerged when participants were questions about their experience while enrolled in the MySafe program:

7.2.1.1 Flexible Medication Access

Clients consistently linked the program's flexible structure to an increased sense of independence. Many (n=16) appreciated being able to access their medication outside of rigid institutional schedules or pharmacy hours, including holidays. For some living in supportive housing, this access was available 24/7, while those at the Overdose Prevention Society described long operating hours that accommodated their personal routines, work schedules, or need for discretion. Several participants (n=24) described the ability to retrieve doses discreetly, at a time of their choosing, as a meaningful departure from pharmacy-based or observed dosing protocols that required "lining up," being watched, or navigating stigma. This shift was consistently described as a key facilitator of adherence and stability.

"It's so convenient. Like, you like wake up in the middle of the night and if you needed it, then it was there. You didn't have to walk like to the pharmacy and worry about it being closed or anything or holidays." - P05

"Some people are morning people that get up and want it early, and some people are sleepers that sleep all day and don't get a chance to go during that time [referring to pharmacy hours] or get up to grab it. So it's kind of nice to be able to go whenever works for you and your day, and that might be different for everybody." - P10

"I got a casual job on it too. So, I was getting up in the morning and I'd eat my meds and then I would leave. So, it worked out great for me. Because sometimes I would have to leave at weird hours. I started work at 2 so I'd wake up at 1, get ready and then go. And it worked out great. I wouldn't have time to stop by the drugstore." - P04

7.2.1.2 Self-Determined Medication Use

Participants (n=22) valued the ability to self-determine when and how to consume their medication without fear of punitive consequences for missed doses. This flexibility allowed them to tailor usage to their needs, such as spreading doses throughout the day, front-loading in the morning/bedtime, or adjusting based on

recent use of the unregulated supply. For some service users, this meant setting doses aside during periods of reduced use to manage later withdrawal or the "come down." Others described sharing or selling doses, often framed as acts of mutual aid or responses to financial hardship, rather than preferred or habitual practices.

"Because I regulated it myself, I wasn't pressured to take them. I didn't have the doctor saying, you know you didn't get your refills, you know why didn't you take them."- P15

"I could not take them all or I could take one at a time or I could, you know take them as I needed them you know what I mean... If I had dope on me, then there wasn't such a rush. So I could save for the middle of the night when everybody's sleeping and I can't find anything. And then that will carry me through till I can go and get something." - P23

"Now it's gotta last me all day instead of, you know, I'm not really ready to take it right now. I don't feel sick yet, you know. It makes a big difference, right? And if you wait long enough until that sickness starts to come, then it's easier to get through it, right? If you take that methadone and you're not getting sick there's no real point. All it's doing is getting high and you know like. And then you start feeling sick later in the day, you end up going out and having to do something else right." - P25

7.2.1.3 Freedom from Relational Obligation

Participants (n=10) described the MySafe model as freeing them from the interpersonal expectations often associated with conventional care. In other programs, individuals felt they needed to be on their "best behaviour", perform stability, or appear polite, composed, or compliant to receive care. Some described simply not wanting to see anyone on certain days. MySafe enabled them to bypass these interactions while still accessing their medication, and to engage with healthcare professionals on their own terms when they chose to. This was seen as a key part of maintaining dignity, particularly for clients with histories of stigma or negative experiences in care.

"Yeah, it was quick. So you didn't have to talk to a doctor. You didn't have to stand in line in front of...or have to wait for them to come in with the package and hand it to you." - P14

"I just didn't have to deal with somebody different every day, you know. It was like the machine was there and I just knew what I wanted, right? When I'd go to the pharmacy, I've gotten in some arguments with people at the pharmacy before. Because they didn't know what the hell they were talking about. They don't know what I'm talking about and I do it every day, the same thing. And we get hassled. So, yeah, I like the machine much better." - P04

"For me, I enjoyed it because, like I said, I didn't have to try to make small talk. I mean, if I wanted to go talk to the pharmacist, I'll go talk to them, right? Not because I have to go. Yeah, it changes that dynamic. Not like needing that thing from them necessarily, right?" - P08

The following themes emerged when participants were questions about their experiences following enrollment of the MySafe program:

7.2.1.4 Loss of Autonomy

Following the program's closure, participants reported that many of these elements of autonomy were lost. Clients who transitioned to alternative care models often reported having to adapt to rigid schedules such as daily pharmacy pickups or medication deliveries (n=11). These systems limited their ability to make choices about how and when to take their medication. Missed delivery times left clients without access, and many were required to consume their full dose at once under observation. Such conditions eliminated the flexibility to self-dose, access care on their own schedule, or avoid triggering interactions, contrasting sharply with the autonomy they had experienced under the MySafe model.

"And then also the way that I have to take it now is so different than what my body was used to with the machine. Like if I fell ill, I could take one at any time and then, but now it's like in the morning the, you know, the delivery person will come and then they want you to take all four at once." - P05

"The pharmacist is going to be in your way because, like you have no clue when they're going to show up or if they…sometime it will be a pharmacist that you've never seen before and they've never seen you before. So they miss your door because he doesn't know which door yours is [referring to deliveries]." - P12

"I saw a lot of people's health go down. Yeah, that'd be the biggest thing. They were still getting their Dilaudid delivered to them daily, but if they weren't home, they weren't getting it. If they weren't home for three days, then they would be asked to phone the pharmacy and phone the doctor." - SP01

7.2.1.5 Breakdown in Shared Decision-Making

Clients also described a diminished role in decisions about their care following the closure of MySafe. Several reported being transitioned to alternative medications (n=23) they had previously found ineffective or difficult to tolerate or being prescribed lower doses with little opportunity for discussion or input. While some of these shifts were understood to stem from broader systemic factors, including the rollback of prescribed alternatives programs and increased prescribing restrictions, the result was erosion of agency.

Even when providers attempted to support continuity, clients described feeling sidelined from decisions about their own treatment.

"I don't know. It was kind of a screw-up at first because I was getting so many pills here [referencing MySafe] and then I wasn't getting them there [referencing pharmacy]. Like they cut me down without even telling me. And I don't even know why." - P04

"Oh yeah, they cut all of my meds off pretty much at one point. Then all of a sudden I was cut down to six pills and I was getting 20. So, it's like, yeah, now I'm withdrawing so then I was going elsewhere and I was getting another substance of fentanyl again." - P04

"I just got told that, you know go over here and pick up your meds now. And it's like, well, I've already got a pharmacy you know, and I really don't like this guy [referencing new pharmacy]. I've had words with him and I really am not comfortable with this guy... 'Well, I guess you don't want your medicine.' I'm like, you can't do that. No, nothing, no if and or buts about it" - P23

"Because when he started taking my dillies away, I'd have to borrow some from someone to get some back and then I don't have them...I'd go to him but he doesn't realize I was using those to quit. 12 days I went. And the frustration. And then everyday he'd cut them down more until I was down to four. And then I was at 4 and he kept it like that for two weeks and then finally he just cut them off." - P19

These structural changes often required clients to re-engage in more medicalized models of care, such as observed dosing or restrictive prescribing practices, that contrasted sharply with the autonomy they had experienced under MySafe. The loss of control over their medication, what they received, how much, and under what conditions, contributed to a broader sense of exclusion from care planning. For some participants (n = 8), this led to disengagement from services altogether.

Across interviews, the loss of autonomy was not viewed as a mere logistical setback, but as a profound disruption to service users' sense of dignity, agency, and wellbeing. MySafe had represented a rare opportunity to exercise choice and control within the healthcare system, one that was abruptly removed. For many, the return to rigid, conditional models of care signaled not only a loss of trust in services, but also a loss of hope in the system's willingness to treat them as partners in their own care.

7.2.2 Accessibility and Continuity of Care

Clients consistently described MySafe as a model that removed many of the barriers they had previously encountered in traditional programs, making medication access easier, more predictable, and more compatible with daily life. In this context, accessibility referred not only to the ability to reach medication

when needed, but also to the program's reliability, responsiveness, and integration into trusted environments. These features directly supported clients' ability to maintain continuity of care without the interruptions that could destabilize their health, housing, or relationships.

The following themes emerged when participants were questions about their experience while enrolled in the MySafe program:

7.2.2.1 Streamlined and Low-Barrier Enrollment

Clients and providers described the intake process as unusually quick and straightforward compared to other programs (n=20). Enrollment could often be completed the same day, with onboarding available in person or remotely. Minimal eligibility requirements and the involvement of trusted staff—particularly peers—helped dispel misconceptions about the program and encouraged participation. The visible presence of the machine in community settings also generated curiosity, prompting organic conversations with staff that led to new enrollments.

"It was basically kind of the same day. No, it pretty much happened within a few days, I think. And then my stuff was in there and I was going" - P04

"I just met and talked to one woman who was feeding the machine one day and I wanted to know more, so she sent me to the like, kind of the resident liaison person who was here to talk to me about it. And then she put me on the list."- P14

One participant, who worked as a Peer Support/Navigator in the program, described their role in supporting recruitment:

"And like try to get more people to be part of the program too, which I did that, I got like everybody in the building." - P12

7.2.2.2 Co-Location in Trusted and Convenient Spaces

MySafe's location was frequently cited (n=33) as a major contributor to accessibility. For those based in supportive housing, the machine was often just steps from their rooms, removing transportation barriers and allowing access even when they were unwell or busy. At the Overdose Prevention Society (OPS), clients were already familiar with the space and staff, creating a sense of psychological safety that reduced anxiety about accessing care. Moreover, for those already visiting OPS for services or working there as peer staff, MySafe fit naturally into their day, making medication access a seamless part of existing routines.

"It was really helpful because like some days you're just, like if you had to go to the, if you had to leave and go to the pharmacy, there'd be days we'd miss it, and if you miss too many days, then you're, yeah, you're screwed, right? Some days you just don't feel like going a couple miles, walking that far to get it, you know what I mean? And if you're not feeling good to begin with."- P08

"Well, it was great because it was 20 feet from my room....so it was very easy to get to." - P07

"I didn't even have to get dressed. I could just come upstairs and get my house coat or my underwear and get my pills." - P04

It was just easy. It was there, you know? Yeah, kind of works for your life. - P02

In supportive housing models, the machine became an unexpected trust-building tool (n=5). Because residents returned regularly to the machine, staff had natural, low-pressure opportunities to check in about health, housing, and other needs. These interactions often opened the door to deeper conversations, referrals, and support, even for individuals who were not otherwise engaged with services. In this way, MySafe strengthened relationships and acted as a bridge to broader care.

"I mean it definitely enabled us to connect in a different way. When we got somebody in from the streets, we were able to not only connect about that, but also connect with all their healthcare needs. Which was awesome." - SP01

"People that weren't from the building signed up for it to you, which I think was smart, because then there was a bunch of people from the community and like, like, come to the building like, like all the time. So. So they all started, started getting the sign up for the machine which was good for two reasons. One, it was like kind of like a foot in the door." - P12

7.2.2.3 Responsive Troubleshooting and Predictable Service

Participants (n=31) reported occasional technical issues, most often related to hand-scanning. While these were generally resolved quickly, sometimes through simple workarounds like washing hands or with staff retrieving doses directly from the machine, disruptions did occur. Some clients missed doses (n=20) entirely when troubleshooting could not be resolved immediately, which interrupted their routines and, in some cases, contributed to withdrawal or use of the unregulated supply. Despite these challenges, most clients still viewed the system as more reliable than other care options, particularly given that problems were often fixed within 24 hours.

“Unless, you know, there was a glitch with my hand and I had to wait until staff came in. It was the odd time on the weekends it would glitch out and then I'd have no meds for two days. But that was very seldom. Very rare. Very rare... Yeah. And they'd, kind of, sort it out? Monday morning or whatever, whenever it was. The next day, I'd just come in and I'd re-scan my hand.” - P04

“The machine was smooth. If it broke down or it didn't work, or it wouldn't dispense for whatever reason, it was always pretty quick to get fixed, and it wasn't like I didn't feel like I was on the back burner. I felt like I was a priority to someone, right? So that was that was nice.” - P14

“But most times, it worked. There was the odd time where it was just pulling your hair out by the roots. It's not going to work and that's that.” - P07

“I only noticed there was a few, uh, a few hiccups with it. At first, the staff here would fix it up. But then I don't know if something happened or something, but then it became that they're [housing staff] were no longer allowed to access the machine and a MySafe person had to come in and do it.” - P23

7.2.2.4 Integration with Wraparound Supports

MySafe’s accessibility extended beyond the machine itself to include the services and staff surrounding it. Staff were able to coordinate with the care team (n=9), arrange drug screens, and facilitate referrals (n=15), reducing the administrative burden on service users. In supportive housing, these interactions often became gateways to deeper engagement with health and social services, even for those who had not been actively seeking care.

“Through MySafe I ended up getting hooked up with the pill a day treatment for my Hep C and it was effective. It it's been treated now. I don't have it anymore. So that was that was big for me. I was really happy about that” - P14

“But he also had physical ailments as well. So, I'd be like, oh, I have so-or-so here. [Cool-Aid doctor] would be like, can you take a picture? Snap. Send it to him. Right. Here's a prescription. So, it's like a really easy point of contact to a doctor.” - SP01

“They were able to also access kind of the wraparound supports. So, it gave them all those wraparound supports. Gave us the ability to do housing forms with them. Once you gain that trust, the doors open, right.” - SP01

7.2.2.5 Limitations: Travel and Multi-Day Carries

Participants reported not having the option of obtaining multiple days' worth of doses created challenges for those who needed to travel. These experiences highlight the potential value of an integrating a straightforward process within a MySafe model of care for requesting and approving travel carries ideally initiated through the machine interface and paired with a brief check-in with staff.

> *"At least with my pharmacy now. I can tell them that I'm going to Puerto Bernardes to my parents for a week and they will transfer my prescription to there and have it delivered to my parents for that week while I'm gone or whatever, right. I don't think I could have really done that with the machine." - P14*

One participant described the logistical and emotional challenges of traveling during MySafe. Since multi-day take-home doses were not available for the dispensed medication (i.e., tablet hydromorphone), they were required to temporarily switch to another medication and coordinate multiple prescriptions to cover their absence:

> *"If I got to go out of town for my mom's funeral and stuff, like I had to get all these prescriptions and take some methadone with me. What is this? You know, I don't know. It's not a bomb." - P09*

The following themes emerged when participants were questions about their experiences following enrollment of the MySafe program:

7.2.2.6 Return to Inflexible or More Rigid Models

Following MySafe's closure, many clients transitioned to programs that operated under far less flexible conditions. This often meant daily pharmacy pickups within limited hours, travel requirements, or scheduled deliveries with no option to reschedule. As previously mentioned, while some clients appreciated delivery as a convenience, missed delivery windows were common, and many were required to consume their full dose at once under observation. These conditions disrupted personal routines, increased the risk of missed doses, and, for some, reduced willingness to remain engaged in care.

> *"I do have issues myself with delivery, and I'm not really particularly happy with it. You know, and like not just me, but then there's like six other people that also miss out because a guy came by and there was nobody here at the front door to let him in. So, he just said, f**k it. And it's like dude, there's like six other f*****g people man. You just don't say, fuck it, right?" - P09*

"There was only the one staff, the delivery, the one that... but I was upset and angry and I was like, you want me to take all 14 at once? Like, would you take all that? And he's like, well, other people do. I'm like, isn't that illegal? And I just refused to take it from him. So I don't know, I know it's his job and he's just doing what's expected of him. But I felt that that was infringing your chartered rights to have that. Knowing that [referencing taking all pills at once] should have been an option. - P06

7.2.2.7 Service Fragmentation and Loss of Wraparound Supports

Clients described the transition process as rushed (n=7) and fragmented (n=12). While some staff worked to connect clients to alternative programs, waitlists and administrative delays were common. In many cases, the priority became securing any available option quickly, rather than finding the most appropriate fit. This often meant returning to siloed medication-only models without the same relational touchpoints or wraparound supports they had come to rely on. For supportive housing residents, the closure meant losing a service that had organically fostered connection and trust with on-site staff.

"Took months for me to get on another program, and it was on the [name of prescribed alternatives program]. And that's because of [staff member]." - P12

"It took a bit before I could fully get connected and get accepted into [name of clinic] clinic. So I went a whole 3 weeks." - P16

*"But you know, it was such a hassle, like my significant other there ended up going off just because his doctor was a d**k, for starters, and it was such a hassle that he just said f**k it". - P07*

*"No, when they did take the machine out, yeah I was off of them for some time. But I did end up getting pretty sick and pretty f****d up and then I went to the doctor finally." - P03*

7.2.2.8 Increased Stigma and Procedural Barriers

With the return to conventional service models, clients described renewed exposure to judgment from staff, rigid paperwork requirements, and procedural hurdles in more conventional models (n=17). The sense of being trusted and treated with dignity—central to their experience with MySafe—was often diminished, making continued engagement more difficult and, for some, less appealing.

"I don't like the pharmacy either because some people at the pharmacy will look down on you differently when you're drug addict, right... Yeah, the machine didn't look down on us. It just spit it out... It's reliable and there's none of that judgment." - P04

Up until I went over there [new pharmacy post MySafe], I didn't like going to the pharmacies. Yeah, because they were kind of, a lot of them were kind of ignorant, actually. They look down on you because, you know, because you got a drug problem." – P08

"I go to shoppers, there's two separate windows: there is the regular person's window and then there's the junkie window. So right away you're segregated. ... It's just, you know, and you feel. I feel awkward. I'm not comfortable with it, you know." -P23

"You know with delivering, you're dealing with....the machine that read your biometrics. It didn't have an attitude. It didn't have feelings. It didn't take things personally. It dispensed your medicine or didn't." - P23

Across accounts, MySafe's accessibility was described as a cornerstone of clients' ability to remain stable in care. By removing transportation barriers, streamlining enrollment, embedding services in trusted spaces, and integrating with wraparound supports, the model provided a consistency that many had not experienced in other programs. Even when technical issues arose, the responsiveness of staff reinforced trust in the service and minimized disruption. Following its closure, clients often faced a return to fragmented, less flexible systems that reintroduced the very barriers MySafe had helped dismantle—interrupting care, eroding relationships, and in some cases, contributing to disengagement. For many, this shift underscored how essential accessibility is not only for maintaining continuity of care, but also for fostering the trust and stability needed to support long-term health and wellbeing.

7.2.3 3. Stability and Functioning

Clients consistently linked MySafe participation to improvements across multiple domains of life, including physical health, emotional well-being, housing, financial security, relationships, and day-to-day functioning. These gains were described as interconnected, rooted in reduced withdrawal and cravings, improved emotional stability, and the reliability of knowing medication would be available when needed. Conversely, the program's closure triggered widespread destabilization, undoing many of these gains and undermining clients' ability to maintain stability in both practical and emotional terms.

The following themes emerged when participants were questions about their experience while enrolled in the MySafe program:

7.2.3.1 Reduced Withdrawal, Cravings, and Risky Use

A central driver of stability was the program's ability to significantly reduce withdrawal and cravings (n=12), which in turn decreased reliance on the toxic drug supply. Many reported shifting away from opioids entirely or reducing the urgency and frequency of unregulated purchases (n=23). The need to "buy from anyone, anywhere" diminished, enabling safer use practices and lowering overdose risk. Notably, no clients reported experiencing a toxic drug poisoning during MySafe.

"It helped the cravings, like, it's just unreal... I didn't use as much, and it was comforting to know I had a substitute." – P05

"When I had my medicine there [referencing in MySafe machine], I wasn't using to, like, I wasn't injecting to get high...which injecting is really a scary one...I didn't do it at all when I was on MySafe." - P04

"I used to inject it too, but then I went under, I guess, or I went down, whatever you want to call it, like four or five times. And it seems when the MySafe came along, I stopped smashing dope and it seems I stopped going under. Go figure, right?" - P08

"As a response worker in the building here and at [name of supportive housing site], I did noticed a lower percentage of responses to overdoses and what not." - P09

"Well, it helps decrease my use of street drugs, I wasn't using street drugs as much. That's a big one." - P21

7.2.3.2 Improved Emotional Health and Social Climate

The relief from constant withdrawal translated into greater emotional stability. Clients described feeling calmer and less anxious (n=20), and more hopeful about the future (n=18), with several expressing confidence in their ability to eventually reduce or stop use. Staff noted fewer altercations and less volatility in communal living spaces, with one supportive housing site reporting a decline in evictions. People were described as more social, cooperative, and willing to engage with staff and neighbors, changes that directly supported housing retention and community cohesion.

"Well, it did help, because you're not always thinking about getting dope somehow. It's a constant, where am I going to get my next one? You know what I mean? Never ending." - P08

"I had no issues... I wasn't angry, I was happy. When they took it away, I was not happy." – P04

"I was happier. I was more content with my lifestyle, and my choices, that they were way better. I didn't make bad choices when I was on MySafe" - P26

"More relaxed and calmer... I didn't have to worry about going out and making money to get my dope." – P25

"Well, I was using a lot less, so I was like more clear headed." - P16

7.2.3.3 Greater Quality of Life and Reconnection

Freed from the daily scramble to secure drugs, clients reported having more time and mental energy for hobbies, day trips, and meaningful social interactions (n=22). Many rebuilt relationships with friends and family (n=15), crediting their improved mood and stability. The MySafe machine itself also became a point of connection—especially in supportive housing, where clients often accessed doses at similar times. When the machine experienced occasional "double dispensing" errors, clients described a shared ethic of care: doses were promptly brought to staff by the person who received the extra, reinforcing trust and mutual responsibility among residents.

"Gave me time to do all kinds of things. I got to play with my dog... My dog got to see me more. It's huge. I got to do things I like to do, like go hiking, biking." - P04

"I went out a lot more, actually. Like I said, my boyfriend and I, we like to ride bikes. He builds bikes, actually. So, yeah, getting exercise more. Just getting out, getting fresh air. If you're indoors all the time, like, it's like being in a fishbowl or something." - P05

"I was socializing with people. I was going out. I was getting family contact back. I was talking to my children. Things were a lot better at home". - P18

"Yeah, there was a little more camaraderie between us, all joking around while we're waiting to get our dose." - P14

7.2.3.4 Financial Stability

Reduced reliance on the unregulated market meant more money could go toward food, rent, and personal needs (n=17). Some clients were able to financially support loved ones. The drop in desperation also reduced engagement in high-risk income generation (n=13) such as theft or sex work, which clients linked

not only to improved safety but also to regaining a sense of dignity and self-worth. Staff described this financial stability as a key buffer against housing loss and other crises.

"Best thing that happened to me and him, it took me crime free. It took me prostitution free and just made me feel better about myself." - P26

"I wasn't selling everything I owned... I had that safety net." – P23

"My food intake went up because I wasn't spending as much buying dope." – P07

"It just gave me another avenue to get my needs met without having to do like crime or steal or whatever." - P14

7.2.3.5 Physical Health Improvements

With cravings reduced and financial strain eased, clients reported eating more regularly and purchasing healthier food. Many regained weight, rebuilt muscle, and became more physically active (n=15). Better nutrition and reduced exposure to unregulated drugs also meant fewer infections, faster healing from wounds, and greater resilience to illness. Clients and providers linked these physical improvements to increased confidence, social engagement, and the ability to maintain housing and employment.

"I was keeping up with my weight. I was eating. I was sleeping. I was continuing with my mental health meds. Yeah, I was doing good." - P18

"I know a lot of guys that were digging through garbages and stuff like that didn't have to do that no more. You know, so it kept it a little more sanitary." – P23

I've always had mobility issues and it fluctuates, so it definitely kept my best interest and safety and overall health priority, I guess you could say. - P06

7.2.3.6 Compatibility with Employment

MySafe's flexible, on-demand access allowed clients to align medication use with work schedules, avoiding missed shifts or income loss due to pharmacy hours (n=9). Those employed at OPS could integrate medication access seamlessly into their workday, removing another potential barrier to both income stability and medication adherence.

"I got a casual job on it too. So, I was getting up in the morning and I'd eat my meds and then I would leave. So, it worked out great for me because sometimes I would have to leave at weird hours.,, I wouldn't have time to stop by the drugstore." - P04

"I noticed a lot of other people that were casually working, it worked good for them." - P09

"It gave me time to make stuff and fix bikes for a few dollars." – P08

The following themes emerged when participants were questions about their experiences following enrollment of the MySafe program:

7.2.3.7 Return to Withdrawal, Cravings, and the Toxic Supply

Following MySafe's closure, and amid broader policy and prescribing changes, most clients lost access to a comparable prescribed alternative. Doses were drastically reduced, medications were changed, and dispensing returned to rigid schedules. This led to increased cravings and withdrawal (n=6), pushing many back to the illicit market (n=16). Riskier use practices returned (n=3), including using alone, and some (n=5) reported experiencing overdoses again since the program ended. At least nine community members are known to have died following the closure of MySafe.

"My cravings are back again… It just never ends. I'm always thinking about, 'I gotta go get some dope. It's crazy, that's the only thing you think about." – P08

"I was cut down to six pills from twenty… now I'm withdrawing, so I was getting fentanyl again." – P04

"With the dose being cut so much, more time now has to be spent filling that gap." – P03

"Like I said, the program was great. It brought my using down quite a bit. And then once it finished, I was using a lot more." - P22

7.2.3.8 Declining Health and Well-Being

Clients (n=16) described using more drugs overall, leading to weight loss, poor nutrition, recurring infections, and increased emotional distress (n=19). The sense of stability, hope, and control fostered during MySafe was replaced by frustration, grief, and a belief that they were being punished.

"When I stopped with the safe program, my habit went up so bad I went from 185 lbs down to 96 lbs." – P18

"But I did end up getting pretty sick…then I went to the doctor finally. I'm pretty stubborn so I gotta be almost like half dead before I go to see the doctor." - P03

"The only reason I go out nowadays is to get dope… most of the time it's not legal." – P08

"I ain't got the the dilly program happening…and it is desperation. Like you get to a point where you're ready to smash your window or something. You know what I mean? It almost makes you sick in the head and you're not thinking clearly. You're not thinking straight." – P23

7.2.3.9 Loss of Quality of Life and Structured Routine

Without predictable medication access, the daily routines that supported stability unraveled. Activities, hobbies, and social connections diminished (n=8). Some Clients became unhoused, re-isolated themselves, or withdrew from care entirely (n=8), undoing many of the relational progress they had made during MySafe.

"I got to do things I like to do, like go hiking, biking…now I don't do that. So, I isolate at home, and I hate isolating. Because that's when people start dying."- P04

"Today it's more like. People are all just in their rooms and there isn't much like community kind of thing going on anymore. It seemed like there was more of that when that was mysafe program was." - P14

"I stopped leaving my room. Period. I stopped answering my door. I stopped having contact with anybody, like, even when my dad wasn't sick and he was coming to see me." - P18

7.2.3.10 Financial Strain and High-Risk Income Generation

Withdrawal and cravings forced many back into high-risk income activities, including theft and sex work. This reintroduced financial instability (n=12) alongside the stress, danger, and shame that clients had worked to leave behind.

"So you don't feel very safe... they're still going to roll you to see what you got just for that $5 or that little piece of dope that you might have cause they gotta get better. It's nothing personal, they just don't want to be sick." – P23

"It's not cheap to do drugs... trying to balance that with food and hygiene stuff." – P05

"We're getting less food... what he's spending on dope could have been going into the fridge." – P07

"I would prostitute a lot more... you do what you can to find drugs." – P26

7.2.3.11 Housing Loss and Disconnection from Care

Some clients and providers linked eviction or housing loss directly to the destabilization that followed MySafe's closure, citing increased conflict, relapse, and emotional volatility. Others stopped accessing OAT or any form of prescribed alternatives, deepening the cycle of instability.

"I quit. I didn't go back to the pharmacy... I just got cut off pills." – P04

*"Well, I had already transitioned myself. So, I was just observing, and you know they kind of, they put a sign on the machine that said it would be ending such and such a date. So please get in touch with your doctor and set something else up, yeah. But you know, it was such a hassle, like my significant other [MySafe participant] there ended up going off just because his doctor was a d**k, for starters, and it was such a hassle that he just said fuck it. I mean he wishes he wouldn't have because his drug consumption has gone way the hell up." – P07*

Across interviews, the loss of stability after MySafe's closure was not described as a simple lapse in service, but as a sweeping disruption to nearly every aspect of clients' lives. MySafe had created conditions where health, housing, relationships, finances, and daily routines could begin to stabilize in ways that clients had rarely experienced within the existing system. The program's abrupt removal dismantled these gains, forcing many back into cycles of withdrawal, risk, and crisis. For service users, this was not only the loss of a medication source, it was the loss of a foundation that had allowed them to function, plan, and imagine a different future.

7.2.4 Transitions Experience

Service users' experiences of transitioning out of MySafe were highly variable, but the process was frequently described as abrupt, confusing, and destabilizing. For many, it marked a break in continuity of

care that could not be fully repaired. These transitions occurred against a backdrop of rising political and media backlash against prescribed alternatives across Canada in 2022/23. National discourse intensified around perceived risks of diversion with media reports highlighting medications allegedly ending up in schools leading prescribers to adopt more conservative practices amid limited regulatory protection. At the same time, inquiries and policy scrutiny were increasing, and critics of safer supply and prescribed alternatives were questioning the evidence base, making it nearly impossible to secure funding outside of short-term Health Canada initiatives. Even initially supportive provincial institutions and ministries became hesitant, uncertain about program legitimacy and durability. Under these conditions, transitioning to alternative care often involved reduced doses, medication changes, or a return to rigid service models that undermined previous stability.

7.2.4.1 Staff Support and Advocacy

Where transitions were less disruptive, clients often credited staff with stepping in to help them navigate the system. Staff worked to identify alternative programs, transfer prescriptions, and coordinate with pharmacies or other prescribers.

"[MySafe manager] helped me in. She brought me in to talk to [doctor]. And so, I've been steadily on that program ever since basically." - P03

"I believe an inquiry was made about getting on fentanyl because I seemed to have been a suitable candidate for it." - P06

However, both staff and clients consistently described the transition process as rushed and resource-constrained (n=14). With little notice of the closure, and funding cut off abruptly, staff were often trying to coordinate complex transfers "off the side of their desk" while balancing other responsibilities. This left little time for in-depth conversations about preferences or for finding programs that truly matched service users' needs. Staff expressed frustration that, despite their best efforts, they could only offer partial solutions.

"We did our best... we were trying fentanyl patches because we needed to find something." – SP01

"It was very abrupt... there was no real solution to the abruptness of the finishing of it, no follow-up on how we could continue. It was just like okay, the program's going to be over shortly and yo know good luck." – P22

"And because I didn't want to use that pharmacy next door, I got cut off all my meds...I didn't think that could happen because I wasn't doing nothing wrong. You know my

urinalysis come back good, I wasn't diverting, nothing, I wasn't selling nothing… I wasn't weaned off them, you're just cut off." – P23

7.2.4.2 Communication and Trust

Communication about the program's closure was inconsistent across sites. Some clients described having open conversations with staff, while others learned through a posted notice or by discovering the machine was gone. Confusion over the reasons for closure (n=11), fueled by incomplete or conflicting explanations (n=9), undermined trust for some service users. Even when they understood the rationale, clients expressed frustration and grief, viewing the loss of MySafe as the removal of a rare and effective support. This erosion of trust with the system also had practical consequences, with some clients disengaging from services altogether.

"One day I didn't know, the machine was gone… I was getting my pills from the pharmacy again." – P04

"They never really gave a reason why… they just said, no more funding or something." – P08

"I got no reasonings. I got no explanations. I got no. You know, and some people are still on them [referencing HDM tablets], and I don't understand why. I don't understand how, it's like I did nothing wrong." - P23

"I think someone just said there was like too many technical issues with it or something. Or like people were having too many problems scanning" – P05

7.2.4.3 Loss of Built-In Engagement and System Navigation

In supportive housing, MySafe had been more than a medication dispenser, it created routine touchpoints that brought tenants into contact with staff on a daily or near-daily basis. These interactions allowed staff to monitor wellbeing, build rapport, and help tenants navigate other health and social services. When the program ended, these built-in engagement opportunities disappeared. For some tenants, this meant fewer connections to care, less proactive support, and missed opportunities for early intervention.

"You don't see the people as much…I was in contact with everybody very very regularly and now that's not available so." - P22

7.2.4.4 Mismatch Between Client Needs and New Models

For many (n=13), the new programs they were referred to did not align with their needs or circumstances. Some faced abrupt dose reductions, medication substitutions, or stricter dispensing schedules that clashed with work or daily life (n=23). Others were placed on waitlists, creating lapses in medication access. These service gaps often led to withdrawal, cravings, and a return to the toxic drug supply, undermining both physical health and emotional stability.

"With the Dilaudid thing there's almost no say in how it's being done now or if it's even helpful…that's just how they have to do it because they can't have the delivery person coming five times a day for five different people or something." – P05

"Until my script was up… then I had to go to my doctor to get them to start me up. And then that took a while and then she started me on four and I was like, WTF." – P24

"If it's too early in the day, I feel like it doesn't help me later… In the morning I'll wake up feeling fine and I don't even feel like I need it yet but then I'll take it anyways and then I'll crash out again for a few hours but then later when I wake up I'll feel like I need something." – P05

Across interviews, the transition out of MySafe was not experienced as a simple program change, it was a disruption to a care model that had been accessible, consistent, and well-integrated into clients' lives. The loss of flexible access, reliable dosing, and regular staff engagement left many feeling less supported and more vulnerable. Even where staff worked tirelessly to smooth the transition, systemic constraints meant that continuity of care was often compromised, reinforcing the fragility of the stability MySafe had helped to create.

7.2.5 Lessons Learned and Future Considerations

Former clients and staff identified concrete lessons from MySafe's implementation and closure, along with recommendations for future programs. Many spoke with urgency about the need to expand and adapt this model, not only for prescribed alternatives, but for a wider range of essential medications. Their reflections highlight operational factors that supported success, systemic barriers that undermined continuity, and broader political forces that shaped the program's trajectory.

7.2.5.1 Strong Leadership and Dedicated Staff

Having a supportive prescriber, described as a consistent, stable partners, and true believer in the prescribed alternatives approach, was critical in getting MySafe up and running, enabling smoother navigation of regulatory processes and greater flexibility in prescribing. Dedicated staff, integrated into service users' broader care teams, were equally essential. They coordinated wraparound supports,

monitored medication access, and problem-solved when issues arose, ensuring the machine functioned as part of a larger continuum of care rather than a stand-alone service.

"But once she found a doctor who would be, who was good with it, it went pretty smoothly." – SP01

"Yeah they [MySafe staff] were here quite frequently you know 2-3 times a week and then we could refer to [onsite Peer support staff] to let him know if anything was going on you know." - P20

"It's not [the machine] like taking away from the human side of things. There is somebody still available like myself. Fortunately I was available to be the liaison, but I think it was important, like I said, to have that person around you know, not an outsider, but somebody that was within the within the building that the program was being run." - P22

"The fact that we're right there, whether it be myself or [MySafe coordinator] later on or [MySafe supervisor], who was the supervisor at the time. We were always there. There was always somebody to talk to. So, it was a really easy for them." - SP01

"Oh, yeah she pointed out other services for me. I didn't want any other services at the time because I was doing good. She kind of let you know she could help with that if you did."-P04

7.2.5.2 Role Flexibility and Regulatory Support

Staff who could step in to address dispensing errors (n=30), such as directly releasing doses stuck in the machine, were able to prevent treatment interruptions. Clients and providers emphasized that part of the program's flexibility came from having *different staff on site* (not just MySafe staff) able to troubleshoot issues when they arose. When this flexibility was removed and only MySafe staff were permitted to open the machine, access became more rigid and interruptions more common. Clients and providers felt future programs should explicitly build in this type of flexibility, with training provided and clear regulatory allowances or written exceptions in place to support continuity of care while maintaining compliance.

"And during the week, [MySafe staff] was here. She'd open it up and give me my meds. Yeah, so, it worked out great." - P04

"So then she would have to open the machine... but then they started cracking down on, like, people opening up the machine." -P12

"At first, the staff here would fix it up. But then I don't know if something happened or something, but then it became that they're no longer allowed to access the machine and MySafe person had to come in and do it." - P23

7.2.5.3 Expanding the Model to Other Medications

Clients and providers (n=9) saw potential for the MySafe model to be applied beyond prescribed alternatives, suggesting antibiotics, HIV or Hep C treatments, mental health medications, OAT, birth control, and other prescriptions taken regularly. For clients managing multiple medications, a unified profile linked to the machine could improve adherence and allow users to review their current prescriptions. Beyond its role in prescribed alternatives, participants saw the model as an innovative tool for managing complex care needs, offering a more reliable way to coordinate treatment for people facing multiple health challenges.

"Or like birth control or something like that even, I could see that working well... that would be cool, then you would know if you missed it or not. It would be nice because it would time it for you too right so you'd take it at the same time." - P05

"You know with people that are transient or this or that. Where are they going to be? They don't even know where they're going to be 24 hours from now, right?...but they knew where the machine was, so they would come in within their 24-hour window and get their fix. At their convenience, so it was great for them, too." - P09

*"I think MySafe should encompass all medications because we have the technology obviously to have that capability... Plus, then you should be able to look up all your medical [inaudible] with that kind of thing... there should be a website or there's some sort of program that like has all that s**t there and make everything way easier."- P12*

"One of the biggest things I thought would be great is to fill it up with, have a machine on site that's filled up with prescriptions. Call a doctor and say such and such has this infection, skin on their hand, bam, there's your amoxicillin, right?... So, yeah, like have a vending machine of drugs that are, you know, not narcotics or maybe minor narcotics, I don't know, but, you know, something that someone can access." - SP01

7.2.5.4 Technology and Accessibility Enhancements

While the hand-scan technology worked for many, it created access barriers for others, particularly those living rough or making their living working with their hands (e.g., binning, construction). Clients recommended exploring alternative biometric authentication methods, such as facial recognition, to

reduce failed scans and speed up access. They also stressed the need for clear communication about who is responsible for the machine on-site, so clients know exactly where to go for troubleshooting and support.

"Where I think it should be more like how like phones work where like they want different angles [re face recognition]." - P12

"Staff that were there for the safe, you know, the ones that were in charge of it, that they were announced, and, you know. If we were more educated about it because I was under the assumption that it was strictly a [name of local community organization] and I had no idea that there was no ambassador or, I can't think of the words right now, you know, direct technicians." - P06

7.2.5.5 Location and Access Considerations

Clients and providers supported placing machines in a wider range of locations, including shelters and other community sites, to serve people who are unhoused, use drugs, or have complex care needs. While supportive housing and SRO placements worked well for residents, some felt that machines in these settings should be reserved for tenants, with separate units placed in public or service-oriented spaces to ensure safety and privacy.

"If they had more machines and more dispensaries like that around town that were available for all of the buildings of users. That are wet buildings or are dry buildings." P12

"But other people from outside would come in, right? And that would give them an excuse to sneak in. So there's definitely some pros and cons." - P20

7.2.5.6 Dosing Flexibility and Medication Fit

Clients and service providers called for more flexible dosing to account for individual tolerance levels (n=23), as well as a stronger focus on ensuring that the medication provided was a good clinical match (n=14). Limited options could undermine stability, and several felt the ability to adjust doses would have improved outcomes.

"I couldn't get a bigger prescription from my doctor because some stupid reasoning they make up in their head. Like if I'm saying that the prescription isn't enough, then it's not enough. - P12

"And I would have preferred that it was something else in there personally than hydromorphone, because it didn't do very much for me." - P14

But part of the issue as well is Dilaudid wasn't enough. And there were some people that were serious about taking it as a safe supply to get off, but they always wanted it increased.... we were able to increase maybe four people from 14 to 18. Again, due to the climate, had we started people off with more at the beginning it might have been different." - SP01

7.2.5.7 Continuity Planning and Weekend Coverage

Breakdowns or service disruptions, particularly over weekends, highlighted the need for stronger contingency planning. Participants recommended tighter integration between machine operations and care teams so that clients could maintain uninterrupted access to medication, even during technical failures or staff absences.

"If the machine broke down on the weekend it was very hard to get answers about when the machine was going to be up and fixed, or who's going to bring the medication or what's going on. So that kind of thing, if there was continuity amongst everybody, maybe there would be better communication." - P22

7.2.5.8 Political Landscape and Implementation Context

Several participants (n=11) described the political climate as a decisive factor in both the program's expansion and its eventual closure. Early in the program, strong leadership and supportive prescribers enabled smooth operations and dosing that aligned with client needs. But as political discourse shifted, particularly following media coverage framing prescribed alternatives in a negative light, clients and providers noticed prescribers becoming less willing to initiate new service users, increase doses, or make flexible prescribing decisions. Urinalysis requirements became more frequent, and standard daily dose caps were described as "easy to lower but nearly impossible to raise."

"I think a lot of that was political and as the political climate changed, it became harder and harder to get people on MySafe, as well as getting the proper amount of the drug to them. There seemed to be like a set amount of 14, which was very difficult to go up from and very easy to go down." - SP01

"But yeah, the populist view changed. And when that happened, the doctors got a little scared and less doctors were... the other doctors would be less inclined to sign people

up, less inclined to increase, less inclined to do anything really. And urinalysis started happening a lot more." - SP01

7.2.5.9 Policy and Funding Reform

Perhaps the most consistent message (n=11) was that MySafe worked and should be reinstated. Participants stressed that current addiction medicine guidelines and funding structures do not reflect the realities of the toxic drug supply. Several expressed frustrations at what they saw as an avoidable loss of life, calling for the government to "open their eyes" and implement measures that match the scale and urgency of the crisis.

"I'd just like to say that it works, and it does save lives. It did save lives; a lot of people's lives here. Because I know a lot of people that got onto it, people that got on it really early when it came... and some of them were in rough shape and then they're functioning fine, like they see a light somewhere, you know?" - P04

"I mean, I can't stress enough that the government needs to open their eyes, and we need to get some better means to deal with this opioid crisis because when it's like they're giving Tylenol for two broken legs and broken arm. - P14

"I wish you guys could bring that program back. I think you would benefit a lot of people." - P18

"Everybody misses it. I know you've already heard that many times." - P18

"It's too bad that the programs ended, it should have been more available and hey, should have continued on. The program could have continued on there didn't seem to be any big issues with the program. I think it was well put together." - P22

The lessons from MySafe extend beyond technical fixes, they speak to the design of a care model that was accessible, trusted, and adaptable to people's lives. Clients and providers envisioned a future where this model is expanded, integrated with broader health services, and backed by policies that prioritize continuity, flexibility, and real-world conditions. Without such systemic changes, the gains achieved through programs like MySafe will remain fragile, and the opportunity to prevent harm will be repeatedly missed.

8.0 Discussion

This evaluation explored the functioning, impacts, and eventual closure of the MySafe biometric dispensing program, drawing on the perspectives of clients and service providers. Findings offer valuable insights into the potential of automated dispensing models to enhance accessibility and autonomy for people who use drugs or with complex care needs, as well as the ethical and practical considerations that arise when such programs are defunded.

8.1 Automated dispensing models: accessibility, usability, and acceptability

Evaluation participants consistently described MySafe as a highly accessible and acceptable way to receive prescribed medications, particularly for people excluded or underserved by traditional care settings. The ability to access medication on-demand, without fixed dosing windows or daily attendance requirements, supported flexible, individualized care. For many, this flexibility meant being able to better manage competing priorities such as work, health appointments, or unstable housing.

Location and placement influenced perceptions of safety and reach. While some supportive housing sites residents expressed safety concerns about non-residents accessing the MySafe machine, others saw the value in expanding to more community-based sites such as overdose prevention services or drop-in centers. These perspectives point to the importance of site-specific safety considerations, balanced with the need to reach priority populations, ideally informed by local community consultation (e.g., with community organizations, local clinics, people who use drugs, and people on OAT).

The evaluation also highlighted operational considerations for scaling and sustaining biometric dispensing. Some clients experienced barriers with hand-scan authentication, suggesting a need for alternative biometric options (e.g., facial recognition) and clear on-site communication about where to get help when technical problems arise. Occasional technical failures temporarily disrupted medication access, reinforcing the need for robust backup systems, such as alternate dispensing methods or manual overrides, to maintain uninterrupted service. Together, these findings suggest that automated dispensing can be a powerful and scalable tool for managing medications for people with complex care needs, provided implementation is supported by robust infrastructure and contingency planning.

8.2 Autonomy and person-centered care

MySafe was more than a dispensing technology, it represented a shift in how care could be delivered. By giving clients autonomy over when and how to access their medication, the model promoted dignity, self-determination, and the ability to shape care around their own life. This flexibility helped clients align dosing with personal routines and goals, reduced the need to organize daily activities around rigid program schedules, and created opportunities for care to adapt to the person, rather than the other way around.

For people navigating unstable housing, chronic health issues, or other competing priorities, this autonomy supported stability and improved engagement with care. Providers noted that this flexibility could help retain individuals in care who might otherwise disengage from traditional services. By reducing the need for

in-person monitoring, the model also minimized intrusions into personal life habits, fostering trust and a greater sense of personal ownership over care. These findings reinforce autonomy as a cornerstone of person-centered care and demonstrate how biometric dispensing can operationalize this principle in practice.

8.3 Continuity of care after program defunding

The abrupt end of MySafe disrupted far more than medication access. It dismantled daily routines, severed links to care, and pushed many clients back toward unpredictable and toxic drug supplies, illegal survival-based activities, heightening overdose risk almost immediately.

This raises an ethical question: what obligations do funders and decision-makers hold to ensure continuity when a program is shown to be working? In clinical research, safeguards are built in to prevent clients from being cut off from lifesaving treatment without a transition plan. For example, in the NAOMI (North American Opiate Medication Initiative) trial in Vancouver, clients stabilized on injectable diacetylmorphine faced serious harms when the study ended and they could no longer access the medication. In response, the NAOMI Patients Association (NPA) (later renamed the SALOME/NAOMI Association of Patients (SNAP)), organized and launched a legal challenge. Their advocacy led to Health Canada granting special access so some clients could keep receiving the medication, and it set an important precedent for patient rights in treatment continuity (Boyd, S., Murray, D., SNAP et al., 2017; Boyd, S., NAOMI Patients Association, 2013).

MySafe—and many other Health Canada-funded prescribed alternatives pilots—were not protected by similar safeguards. While most were expected to submit sustainability plans, the political and regulatory climate shift made many of these plans effectively unworkable. As political opposition to prescribed alternatives intensified, prescribers faced increased risk and regulatory pressure, and funding was withdrawn, leaving few viable pathways to sustain services.

The lesson here is about accountability. When institutions fund pilot programs for populations at high risk of death, there should be clear obligations and resources to protect clients from abrupt loss of care. This could include built-in funding for wind-down periods, alternate service pathways, or special access programs, so that services don't disappear overnight. Equally important is accountability for building the evidence base needed to sustain these programs. Critics often dismiss prescribed alternatives pilots for having too few participants to be considered scientifically significant, yet community organizations and people who use drugs have carried most of the burden of proving they work. Without dedicated resources for larger, community-based research projects, the cycle persists: evidence is required to unlock funding, but funding is withheld because the evidence is deemed insufficient. Breaking this cycle means ensuring that research, evaluation, and dissemination are resourced alongside service delivery. Without this, the harm from both underfunding and defunding is not just predictable, it is preventable.

9.0 Recommendations

1. **Invest in, scale, and strengthen infrastructure for automated dispensing models.** Automated dispensing technology has shown promise in expanding low-barrier access to essential medications, for people with complex care needs. Past client and provider experiences, however, highlighted the need for more robust program design and operational supports to ensure reliability and accessibility. Future programs should prioritize re-introducing and expanding biometric dispensing units with safeguards in place, supported by:

    - Alternative biometric authentication options (e.g., facial recognition) to reduce access failures.
    - Backup manual dispensing options by on-site staff to prevent service interruptions.
    - Clear on-site protocols for troubleshooting technical issues.
    - Integrated full-time wraparound support teams such as peer support, counselling, and case management to address broader health and social needs.
    - Workforce training and technical assistance to ensure local staff and clients can operate, troubleshoot, and maintain dispensing units effectively.
    - Built-in evaluation mechanisms to track dispensing errors, patient experience, and system reliability to inform continuous improvement.

2. **Engage communities in decisions on placement and scope of dispensing.** The success of automated dispensing models in complex care settings depends on whether they are designed and located in ways that meet the needs of the people they intend to serve. Engaging directly with people who use drugs, service providers, and local stakeholders can help ensure that dispensing units are both accessible and safe. Community involvement should guide decisions on:
    - Where dispensing units are located to maximize accessibility while maintaining site safety.
    - What types of medications (e.g., HCV treatment, PrEP, prescribed alternatives, contraception, antidepressants, antipsychotics etc.) are most valuable to dispense in each context, informed by local needs, regulatory context, and prescribing practices.

3. **Build continuity-of-care safeguards and strengthen accountability in all pilot programs serving high-risk populations**. The sudden closure of programs like MySafe demonstrated how quickly clients' stability can be impacted when continuity planning is absent. For individuals relying on potentially lifesaving medications, abrupt service disruptions can have serious consequences. Continuity of care should be treated as a non-negotiable patient right, regardless of political context. To prevent avoidable harms, funders and decision-makers must ensure that safeguards are built into every stage of program design and evaluation. This includes:

    - Requiring funders to allocate dedicated funding to cover a defined transition period, including resources to keep programs staffed and medications available until clients are safely connected elsewhere.
    - Establishing clear transition pathways for pilot projects that are being discontinued, including connections to alternate prescribers or special access programs.

- Mandating sustainability plans that address political and regulatory risks, not just operational feasibility, with commitments to safeguard clinical programs from political shifts.
- Implementing independent oversight to assess the adequacy of continuity plans, with public reporting and accountability measures if avoidable harm occurs.
- Committing to transparent decision-making, advance notice of changes, and intersectional collaboration with affected communities and concerned allies/parties to minimize harm.

10.0 Conclusion

The insights shared through this evaluation reflect the expertise and lived experience of those most impacted by the MySafe program: service users, service providers, and community partners. Their perspectives point to clear opportunities to strengthen automated dispensing models, ensure continuity of care, and design programs that center dignity, choice, and safety. We extend our sincere thanks to everyone who contributed their time, stories, and expertise to this work. Their voices not only illuminate what was lost when the MySafe Program ended, but also help chart a path toward more resilient, equitable, and effective models in the future.

11.0 References

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Appendix A: MySafe Eligibility Checklist and Enrolment

Eligibility Check-List and Enrolment

Participant Name:	**Date:**
Address:	
Email:	**Phone #:**
PHN:	**Date of Birth:**
PC Provider Name:	**Phone #:**

☐ **Male** ☐ **Female** ☐ **Trans** ☐ **Two-spirit** ☐ **Non-binary** ☐ **Prefer not to disclose** _____	☐ **Indigenous (First Nations/Metis/Inuit/ Aboriginal)** ☐ **African/Caribbean/Black** ☐ **Latinx** ☐ **Asian** ☐ **North African/Middle Eastern** ☐ **White** ☐ **Other**

Primary Language:	
Site:	

	Over 18 years old, able to consent to the program
	Self-reported regular illicit toxic opioid use, at least 5 days per week
	Previous unsuccessful attempts with OAT
	No history of severe lung/liver disease based on clinical judgement
	Not currently suicidal, active psychosis, untreated psychiatric illness
	No history of gastrointestinal obstruction or paralytic ileus (able to swallow and digest oral medications)
	Not using alcohol unpredictably and excessively on a consistent basis
	Not intentionally using illicit sedative, anxiolytic (benzodiazepines), or hypnotic drugs
	Not allergic to hydromorphone

Reason for ineligibility (if applicable):

Participant: Name _____ Signature _____ Date: _____

Assessor: Name _____ Signature _____ Date: _____

Appendix B: Evaluation Recruitment Letter

Hey [potential participant name],

My name is _____, and I am working with the MySafe Society team. In [Year of participation], you were part of a program called MySafe Society and received your prescribed safe supply through a distribution machine program at [location].

We're now checking in with folks who were part of that program. We want to hear from you again about how things have been going since the program ended.

We're not redoing the interviews you did before—those were really helpful, and we can provide you with a copy of the results if you want! This time, we want to learn how the program affected your life, both while it was up and running and now that it's been discontinued. It's important for us to hear what worked, what didn't, and how things have changed for you since then.

You are not obligated to participate but if you are interested, we'd love to do an interview with you soon. The interview would last approximately 1 hour and would be done at [Interview location]. Of course, you would be compensated for your time: $10 cash for a demographic questionnaire and $40 cash for the interview. We can also provide you with a public transport voucher, if needed.

Are you interested?

Appendix C: Service User Demographic Questionnaire

1. Participant ID: _____

2. Which MySafe location did you access?
   - ☐ Overdose Prevention Society
   - ☐ The Luggat (Atira)
   - ☐ Carl Rooms (Atira)
   - ☐ Tally Ho (Cool Aid Society)

3. How old are you? _____

4. What is your gender identity? (select all that apply)
   - ☐ Woman
   - ☐ Man
   - ☐ Two-Spirit
   - ☐ Non-binary
   - ☐ Other: _____
   - ☐ Do not know
   - ☐ Prefer not to answer

5. How would you describe your race or ethnicity? (select all that apply)
   - ☐ Indigenous
     - ☐ First Nations (optional text entry, specify nation): _____
     - ☐ Inuk/Inuit (optional text entry, specify community): _____
     - ☐ Métis (optional text entry, specify community): _____
   - ☐ Black
   - ☐ White
   - ☐ East Asian
   - ☐ South Asian
   - ☐ Southeast Asian
   - ☐ Latin American
   - ☐ Middle Eastern
   - ☐ Other: _____
   - ☐ Do not know
   - ☐ Prefer not to answer

6. In the past 30 days, which option best describes your housing situation? (select all that apply)
   - ☐ Supportive housing (optional, specify building): _____
   - ☐ Single room occupancy/hotel (optional, specify building): _____
   - ☐ Apartment
   - ☐ House
   - ☐ Shelter
   - ☐ No fixed address
   - ☐ Other: _____
   - ☐ Prefer not to answer

7. In the past 30 days, who have you lived with? (select all that apply)
   - ☐ Not applicable (i.e., shelter, no fixed address)
   - ☐ Not living with anyone
   - ☐ Partner
   - ☐ Friends
   - ☐ Parents
   - ☐ Children
   - ☐ Relatives
   - ☐ Roommates
   - ☐ Other: _____
   - ☐ Prefer not to answer

8. In the past 30 days, which substances have you used? (select all that apply). For each, please indicate the method(s) of consumption.

Substance	**Method** (inject, smoke, snort, ingest (i.e., swallow), inhale (i.e., chase, huff), no preference)
Powder cocaine	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference
Crack cocaine	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference

Substance	**Method** (inject, smoke, snort, ingest (i.e., swallow), inhale (i.e., chase, huff), no preference)
Crystal meth	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference
Heroin	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference
Fentanyl	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference
Other opioids (i.e., Dilaudid not prescribed to you)	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference
Benzodiazepines	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference
Alcohol	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference

Substance	**Method** (inject, smoke, snort, ingest (i.e., swallow), inhale (i.e., chase, huff), no preference)
Cannabis	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference
Other:	☐ Inject ☐ Smoke ☐ Snort ☐ Inject ☐ Inhale ☐ No preference
Prefer not to answer	☐
I have not used any alcohol or drugs in the past 30 days	☐

9. In the past 30 days, which is your preferred substance? (select all that apply)
   - ☐ Powder cocaine
   - ☐ Crack cocaine
   - ☐ Crystal meth
   - ☐ Heroin and/or fentanyl
   - ☐ Other opioids (i.e., diverted pharmaceuticals)
   - ☐ Benzodiazepines
   - ☐ Alcohol
   - ☐ Cannabis
   - ☐ Other: _____
   - ☐ Prefer not to answer
   - ☐ I have not used any alcohol or drugs in the past 30 days (not applicable)

10. What opioid agonist therapy (OAT) and/or prescribed alternatives (PA) do you currently access (if applicable)?
    - ☐ Methadone
    - ☐ Buprenorphine / Naloxone (Suboxone®)
    - ☐ Sublocade
    - ☐ SROM (Kadian®, M-Eslon®)
    - ☐ Injectable liquid hydromorphone

- ☐ Injectable liquid diacetylmorphine
- ☐ Oral tablet hydromorphone (Dilaudid® / Dillies)
- ☐ Fentanyl patch
- ☐ Tablet fentanyl (Fentora®)
- ☐ Fentanyl powder
- ☐ Stimulant prescribed alternative i.e., Methylphenidate (Ritalin®), Dextroamphetamine (Adderall®)
- ☐ Benzodiazepine prescribed alternative i.e., Clonazepam (Klonopin®), Diazepam (Valium®)
- ☐ Other: _____
- ☐ Not applicable / Not on OAT
- ☐ Prefer not to answer

11. Have you experienced an overdose in the past 6 months?
    - ☐ Yes (please indicate number): _____
    - ☐ None
    - ☐ Do not know
    - ☐ Prefer not to answer
    - ☐ Not applicable (I have not used drugs in the past 6 months)

12. Have you experienced other drug-related complications in the past 6 months (i.e., seizures, psychosis)?
    - ☐ Yes (please indicate): _____
    - ☐ No
    - ☐ Prefer not to answer
    - ☐ Not applicable (I have not used drugs in the past 6 months)

13. What were your sources of income in the past 30 days? (select all that apply)
    - ☐ Full-time job
    - ☐ Part-time job
    - ☐ Casual / temporary job
    - ☐ Income assistance – welfare
    - ☐ Income assistance - disability
    - ☐ Pension
    - ☐ Binning / recycling
    - ☐ Panhandling
    - ☐ Reselling
    - ☐ Support from relatives, friends, partners, etc.
    - ☐ Research honoraria
    - ☐ Selling drugs
    - ☐ Sex work
    - ☐ Other: _____
    - ☐ Do not know
    - ☐ Prefer not to answer

14. In the past 30 days, how many days did you have to engage in illegal activities (i.e., stealing items to resell, selling drugs) for income to support yourself?
    - ☐ Number of days: _____
    - ☐ None
    - ☐ Do not know
    - ☐ Prefer not to answer

15. In the past 6 months, how often have you had the following:

	Never (0% of the time)	**Occasionally** (About 25% of the time)	**Sometimes** (About 50% of the time)	**Usually** (About 75% of the time)	**Always** (100% of the time)	**Do not know**	**N/A**	**Prefer not to answer**
Food for three meals per day	☐	☐	☐	☐	☐	☐	☐	☐
Social assistance	☐	☐	☐	☐	☐	☐	☐	☐
Housing	☐	☐	☐	☐	☐	☐	☐	☐
Adequate heating for your housing	☐	☐	☐	☐	☐	☐	☐	☐
Adequate cooling for your housing	☐	☐	☐	☐	☐	☐	☐	☐
Functional plumbing and water for your housing	☐	☐	☐	☐	☐	☐	☐	☐
Access to medical care	☐	☐	☐	☐	☐	☐	☐	☐
Access to dental care	☐	☐	☐	☐	☐	☐	☐	☐
Access to dependable transportation	☐	☐	☐	☐	☐	☐	☐	☐

	Never (0% of the time)	**Occasionally** (About 25% of the time)	**Sometimes** (About 50% of the time)	**Usually** (About 75% of the time)	**Always** (100% of the time)	**Do not know**	**N/A**	**Prefer not to answer**
Time to get enough sleep / rest	☐	☐	☐	☐	☐	☐	☐	☐
Access to a phone	☐	☐	☐	☐	☐	☐	☐	☐
Access to other modes of communication (i.e., email, social media messaging)	☐	☐	☐	☐	☐	☐	☐	☐
Money to pay monthly bills	☐	☐	☐	☐	☐	☐	☐	☐
Money to buy necessities (i,e., food, toiletries)	☐	☐	☐	☐	☐	☐	☐	☐
Money to support others (i.e., children, relatives, friends, partners)	☐	☐	☐	☐	☐	☐	☐	☐
Money to pay for entertainment	☐	☐	☐	☐	☐	☐	☐	☐
Money to save	☐	☐	☐	☐	☐	☐	☐	☐

Appendix D: Service Provider Demographic Questionnaire

1. Participant ID: _____

2. Which MySafe location did you work with?
   - ☐ Overdose Prevention Society
   - ☐ The Luggat (Atira)
   - ☐ Carl Rooms (Atira)
   - ☐ Tally Ho (Cool Aid Society)

3. What is your gender identity? (select all that apply)
   - ☐ Woman
   - ☐ Man
   - ☐ Two-Spirit
   - ☐ Non-binary
   - ☐ Other: _____
   - ☐ Do not know
   - ☐ Prefer not to answer

4. How would you describe your race or ethnicity? (select all that apply)
   - ☐ Indigenous
     - ☐ First Nations (optional text entry, specify nation):

       _____
     - ☐ Inuk/Inuit (optional text entry, specify community):

       _____
     - ☐ Métis (optional text entry, specify community):

       _____
   - ☐ Black
   - ☐ White / Caucasian
   - ☐ East Asian
   - ☐ South Asian
   - ☐ Southeast Asian
   - ☐ Latin American
   - ☐ Middle Eastern
   - ☐ Other: _____
   - ☐ Do not know
   - ☐ Prefer not to answer

5. Do you identify as a person with lived/living experience of substance use?
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to answer

6. What was your role designation with MySafe? (i.e., prescriber, nurse, peer)

   _____

7. What area did you work in with MySafe? (i.e., program design and development, stakeholder engagement, program implementation)

   _____

   _____

8. How long did you work with MySafe? _____

9. Have you worked with people who use drugs before MySafe? (if yes, please indicate where / what context)
   - ☐ Yes _____
   - ☐ No
   - ☐ Prefer not to answer

10. How long have you worked with organizations providing harm reduction services in total?

    _____

Appendix E: Interview Guide for Clients

Question	Probes
Background, Engagement, and Retention	
1. Could you tell me about how you initially got involved with MySafe?	How did you hear about the program? Why were you interested?
2. What was it like getting started with MySafe?	How easy or hard was it for you to join, and what was the process like? What, if anything, was it about the program that made it easy to get started? What, if anything, was it about the program that made it hard to get started?
3. How long were you a part of MySafe?	How does this compare to other programs you've been a part of?
4. How easy or hard was it to stay in the program?	What, if anything, was it about MySafe that made it easy to stay in the program? What, if anything, was it about MySafe that made it hard to stay in the program?
Accessibility, Usability, Acceptability ***Preamble:*** *For this section, we will ask some questions about the MySafe program and how different parts of it worked for you and your life, and how it compares to other medication treatment programs you've been a part of.*	
1. Overall, how well did the MySafe program work for you and your life? How did it compare to other models you have used (i.e., pharmacy pick up)?	About how long did it take to get to your MySafe location from where you usually stay? Did the location work well for you and your day-to-day life? Why or why not? Were the machine's operating hours convenient for you? Why or why not? How long would it take to get your medications once you got to the machine's site? Was it common to have to wait in line?

Question	Probes
2. How was getting your medications dispensed from a machine compared to other models (i.e., pharmacy pick up)?	What did you like and dislike about it? Were technical issues a problem? What would you think about getting other medications dispensed from machines? If yes, what medications?
3. How was it to connect with additional services offered through MySafe (i.e., list site-specific examples of wraparound supports available)?	What services did you connect with? Was it easier or harder than other programs you've been in? How was it to contact staff in the program, like the prescribers, peer workers, etc.? Could you get in touch when you needed help with something?
4. How comfortable did you feel accessing MySafe compared to other models? Why?	Feelings of safety, personal security? Experiences of stigma, discrimination, or mistreatment?
5. How involved did you feel in making decisions about your care with MySafe? During MySafe, were you able to set your own goals for your care? Were your questions or concerns taken seriously when discussing your goals/care options with MySafe providers/staff?	Did you feel like your preferences and choices were respected when it came to your care? Were you given options to choose from? What were those options? How comfortable did you feel in speaking up if part of your care wasn't working for you? Were there any times you felt you didn't have a choice in your care with MySafe? If yes, what made you feel that way?
6. Would you recommend MySafe to others in your life? Why or why not?	
7. How were your relationships with staff while you were in MySafe? Was there a difference compared to other programs you've been a part of?	Breakdown by provider type? How much trust you felt with your providers? How supported you felt with your providers? What, if anything, made these relationships different for you?

Question	Probes
Discontinuation and Transition ***Preamble:*** *For this section, we will ask some questions about how you heard about the program ending and what has happened since.*	
1. Can you tell me how you heard about the program ending?	What were you told about why the program ended? How did you feel about this? How did you react?
2. How did MySafe ending impact your relationships with program staff?	Are you still in contact with those staff? In what ways did it change your relationship with them? Did it change your trust in them?
3. Were you able to start with a different (prescribed alternatives / prescribed alternatives) program once you found out MySafe was ending? What was this process like for you?	Were you able to keep accessing your medications through a new program? Have you had issues accessing medications since MySafe ended? Did you get help from staff to connect with a different (prescribed alternatives or prescribed alternatives) program?
4. How has the new program been working for you?	How does it compare to MySafe? Is anything better? Is anything worse? How are your relationships with staff in the new program?
Stabilization (during MySafe) ***Preamble:*** *For this section, we will ask some questions about how the MySafe program impacted different areas of your life and health, and how this was affected when the program ended.*	
1. Can you describe your emotional and mental well-being during MySafe? What has your experience been like since the program concluded?	Do you think the program affected your mental health while you were a part of it? Did you notice a difference in your mental health while you were in MySafe? How / in what ways? Did the program ending affect your mental health? How / in what ways?
2. How was your physical health during MySafe? How has it been since the program ended?	Do you think the program affected your physical health while you were a part of it? Did you notice a difference in your physical health while you were in MySafe? How / in what ways?

Question	Probes
	Did the program ending affect your physical health? How / in what ways?
3. Did you notice a change in the ways you made money during MySafe? How about since the program ended?	Has your monthly income changed? How? Did the program ending affect how you earn money? If yes, how?
4. Did your housing situation change while you were in MySafe? How has this been since the program ended?	Where were you mostly living during MySafe? Where are you living now? Who were you living with before vs. now?
5. Did you notice a change in your drug use while you were in MySafe? How about since the program ended?	For example: Types of drugs used? How much used? How you used / method? Frequency of overdose?
6. Did you notice a change in how you used drugs while you were in MySafe? How about since the program ended?	For example: How often you used alone? How often you used at an OPS? How often you got your drugs checked? How often you bought from people you trust?
7. Sometimes when people are a part of programs like MySafe, they find they're able to stay safer from overdose / may experience less overdoses. Is this something you experienced while in the MySafe program? How about since the program ended?	
8. Did you notice a change in your relationships when you were in MySafe? How about since the program ended?	Relationships with friends, family, partners, community members, neighbours, etc.? How or why did this change (if at all)?
9. How did using MySafe affect the amount of time you had to do things in your life that are important to you? How has this changed (if at all) since the program ended?	Time / resources to take care of yourself, explore goals and interests, participate in community events (including hobbies, work, volunteer opportunities, etc.)?
10. Did you notice any other changes in your life or health since the program ended that we haven't talked about yet?	

Question	Probes
Lessons Learned and Future Applications (after MySafe) ***Preamble:*** *Just to wrap up, we have a few questions about the program overall and what can be learned for the future.* ***Note:*** *Only ask if this hasn't already come up in the interview.*	
1. Is there anything you think could have been improved or done differently with the MySafe program to make it better? What worked well or what do you think other programs should try to replicate?	
2. What would you want people to know about the MySafe program?	
3. How could this model be used in the future?	

Appendix F: Interview Guide for Service Providers

Question	Probes
Introduction and Background	
1. Could you tell me a little about yourself and your experience working with MySafe?	What MySafe location(s) did you work with? What was your role with MySafe? How long did you work with MySafe? How did your experiences with MySafe compare to other (prescribed alternatives / prescribed alternatives / substance use) programs you've worked with?
2. We understand that each MySafe location operated a little differently. Could you describe what the MySafe program looked like at your location?	What other staff / types of providers worked with the program? What supports and services were participants able to access through being part of the program?
3. Were you involved in getting MySafe started at your location? If yes, could you tell me about this process?	Who else was involved in getting MySafe started? Why was your location interested in MySafe and why did you think your community would benefit from the program? Were there any barriers or challenges that came up? What was needed to address these barriers? Organization-specific barriers? (i.e., staffing, capacity, space, mission-alignment) Community-level barriers? (i.e., public opinion / response) System-level barriers? (i.e., lack of prescribed alternatives prescribing guidelines, other regulations or policies) What facilitators helped get MySafe started at your location? Organization-specific facilitators? (i.e., staffing, capacity, space, mission-alignment) Community-level facilitators? (i.e., support from partnering organizations / groups) System-level facilitators?
Staff-Participant Relationships ***Preamble:*** *For this section, we have a few questions about your relationships with participants and the ways the MySafe model impacted this.*	
1. How were your relationships with participants during MySafe? How did the	What ways, if any, did this model support relationships?

Question	Probes
MySafe model impact relationships with participants?	What ways, if any, did this model not support relationships?
2. How were these relationships impacted when the program ended?	Did you receive support to handle the program ending? If yes, what support? Were you able to work with participants to connect with other (prescribed alternatives / prescribed alternatives) programs? What was this process like? What factors supported this process and what factors made it difficult?
Program Engagement, Retention, and Discontinuation ***Preamble*:** *For this section, we will ask some questions about how the MySafe model impacted participants engagement and retention in the program, and how this was impacted when the program ended.*	
1. How did the MySafe model impact participant engagement?	How was it getting participants started in the program? How did it compare to other models you have worked in, if applicable? How / in what ways did the MySafe model support or inhibit participant engagement? What aspects of the model helped and/or hindered participant engagement?
2. How did the MySafe model impact participant retention?	How did it compare to other models you have worked in, if applicable? Was it easier or harder for participants to stay in the program? How / in what ways did the MySafe model support or inhibit retention? What aspects of the model helped and/or hindered retention?
3. What happened / how was it for you when you learned MySafe was ending?	What supports, if any, did you receive? What supports would you have liked to receive or would have made this process easier? What did the transition period look like? What was your experience communicating the program ending to participants and/or supporting participants to connect with other programs
Stabilization	

Question	Probes
Preamble: *For this section, we will ask some questions about how the MySafe program impacted participants' lives and health, and how this was affected when the program ended.*	
1. Did you notice changes in participants' mental health and well-being during the program?	In what ways did MySafe contribute to this change?
2. Did you notice changes in participants' physical health during the program?	In what ways did MySafe contribute to this change?
3. Did you hear about changes in the ways participants were making money or supporting themselves during the program?	What changes? In what ways did MySafe contribute to this change?
4. Did you hear about participants' housing situations changing while participating in the program?	What changes? In what ways did MySafe contribute to this change?
5. Were there changes in participants' substance use while participating in the program?	Types of drugs used? How much used? How you used / method? Safer practices (i.e., not using alone/ spotting, using an OPS, drug checking, buying from the same people, etc.)? Frequency of overdose? In what ways did MySafe contribute to this change?
6. Did you notice or hear about changes in participants' time or capacity for things that are important to them and their lives?	Relationships with friends, family, neighbours, community members, etc. Time / resources to take care of yourself, explore goals and interests, participate in community events (including hobbies, work, volunteer opportunities, etc.)
7. Were there any other changes or impacts of the program in participants' lives that you noticed while working for MySafe?	Anything surprising or unexpected?
8. Have you kept in touch with any participants since the program ended? Have you heard of or seen any impacts of the program ending on these areas of health and well-being?	Mental health Physical health Employment and income Housing Substance use Time and resources for other areas of life that are important

Question	Probes
Lessons Learned and Future Applications ***Preamble:*** *For this section, we will ask a few questions about lessons learned through implementing MySafe and potential future applications for this program model.*	
1. Thinking about program operations, is there anything you think could have been improved or done differently with the MySafe program to make it better? What about program operations worked well?	What site-specific needs emerged to make this program work at your location? (i.e., staffing requirements, workflow and day-to-day operations or procedures, how to set up the physical space, etc.)
2. Thinking about the broader context, what was learned about the facilitators and barriers to implementing a program like MySafe in this community?	Regulations or policies that had to be considered? Logistical challenges that emerged? Political or community responses?
3. What "best practices" emerged while MySafe was operating that you think should be replicated by other programs or harm reduction / substance use initiatives?	
4. How do you see this model being used in the future?	

Appendix G: Evaluation Participant Respondent Demographic Characteristics

Table G1. Demographic characteristics of evaluation participants clients and service providers

	Clients(n=38)	Service Providers (n=3)
Age		
Mean	46	-
Range	25, 64	-
Gender	n	n
Man	27	1
Woman	11	2
Ethnicity	n	
Indigenous	17	0
First Nations	7	0
Metis	5	0
Black	3	0
White/Caucasian	24	3
South Asian	2	0
Middle Eastern	1	0
MySafe Location		
Cool Aid Society	12	3
Overdose Prevention Society	9	0
Carl's Room	7	0
The Luggat	10	0

Table G2. Demographic characteristics of former MySafe service providers

	Frequency
Identification as person with lived/living experience (n=6)*	n
Yes	6
No	0
MySafe Role (n=6)**	n
Program Manager/Coordinator	3
Peer Support/Navigator	3
Area of Involvement in MySafe Program (n=3)	n
Program implementation	2
Day to Day operations	3
Number of years working for MySafe (n=3)	n
Mean	1.67
Range	1,2
Experience working with PWUD prior to MySafe (n=3)	n
Yes	3
No	0
Number of years working with organizations providing harm reduction services (n=3)	n
Mean	6
Range	3,10

*While six service providers participated in interviews, three also identified as service users. These participants only completed the client demographic questionnaire, not the service provider demographic questionnaire.

**While six service providers participated in interviews, three also identified as service users. These participants only completed the client demographic questionnaire, not the service provider demographic questionnaire. As a result, the sample size for service provider demographics varies by question, since some items were unique to the provider questionnaire and were not answered by all six. As a result, the sample size for service provider demographics varies by question, since some items were unique to the provider questionnaire and were not answered by all six.

Table G3. Demographic characteristics of former MySafe clients

	Frequency (n=38)	Percentage (%)
Housing Situation in the past 30 days (n=38)	n	%
Supportive Housing	12	32
Single room occupancy /hotel with supports	20	53
Apartment	1	3
Shelter	1	3
No fixed address	5	13
Living Situation in the past 30 days	n	%
Not living with anyone	26	68
Partner	7	18
Roommates	1	3
Not applicable (i.e., shelter, no fixed address)	4	11
Self-reported substances use in the past 30 days and method of consumption	n	%
Powder cocaine	9	24
Inject	4	44
Smoke	6	67
Snort	3	33
Crack cocaine	19	50
Inject	6	32
Smoke	17	89
Prefer not to answer	1	5
Crystal meth	34	89
Inject	13	38
Smoke	31	91
Heroin	21	55
Inject	11	52
Smoke	20	95
Fentanyl	35	92
Inject	15	43
Smoke	31	89
Snort	1	3
Prefer not to answer	1	3
Other opioids (i.e., Dilaudid® or Oxycodone® not prescribed to you)	5	13
Inject	4	4
Smoke	5	100

	Frequency (n=38)	Percentage (%)
Ingest (i.e., swallow)	1	20
Benzodiazepines (i.e., Valium® or Ativan® not prescribed to you)	19	50
Inject	6	32
Smoke	18	95
Ingest (i.e., swallow)	2	11
Alcohol	10	26
Ingest (i.e., swallow)	9	100
Cannabis	17	45
Smoke	16	94
Ingest (i.e., swallow)	2	12
Other	4	11
Inject	1	25
Smoke	2	50
Ingest (i.e., swallow)	2	50
Preferred Substance	n	%
Heroin	24	63
Fentanyl	31	82
Other opioids (i.e., Dilaudid®or Oxycodone®not prescribed to you)	1	3
Benzodiazepines (i.e., Valium® or Ativan® not prescribed to you)	4	11
Alcohol	1	3
Cannabis	2	5
Prefer not to answer	1	5
Self-reported access to prescribed alternative or opioid agonist treatment (OAT)	n	%
Methadone	9	24
Buprenorphine & Naloxone (Suboxone®)	1	3
Slow-release oral morphine (Kadian®, M-Eslon®)	6	16
Oral tablet hydromorphone (Dilaudid® / Dillies)	6	16
Fentanyl patch	1	3
Stimulant prescribed alternative (i.e., Methylphenidate (Ritalin®), Dextroamphetamine (Adderall®)	1	3
Not applicable (not on OAT and/or PA)	19	50
Self-reported history of toxic drug poisoning in the past 6 months.	n	%
Yes	9	24
Number of toxic drug poisonings experienced:		
1	5	55

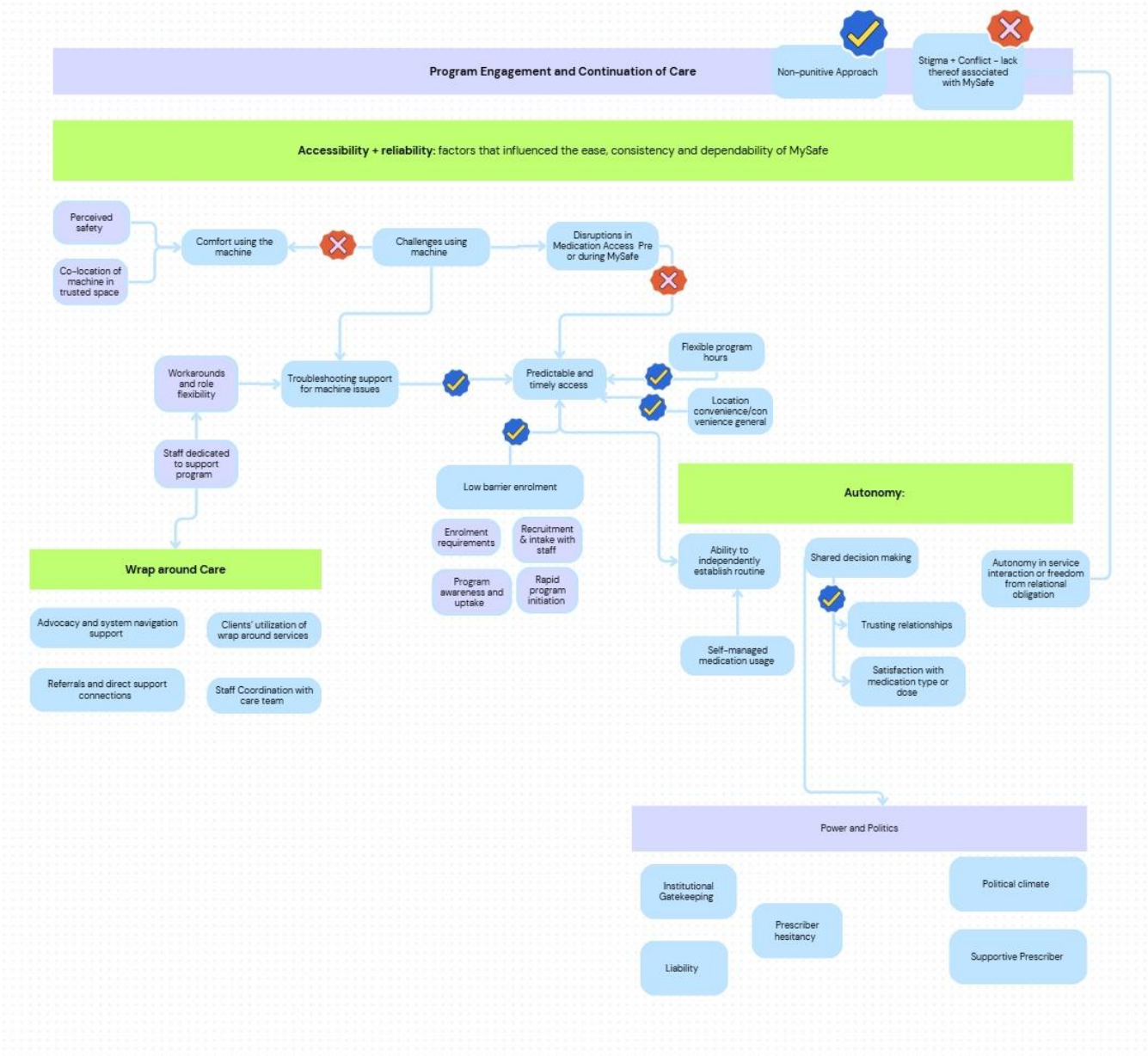
	Frequency (n=38)	Percentage (%)
2	2	22
3 or more	2	22
None	29	76
Self-reported history of drug-related complications in the past 6 months	n	%
Yes	16	42
Types of drug-related complications		
Psychosis	5	31
Constipation	2	12
Seizures	3	19
Cellulitis/infection	3	19
Anxiety	1	6
Sleep deprivation	1	6
No	22	58
Sources of income in the past 6 months	n	%
Full-time job	1	3
Part-time job	8	21
Casual/temporary job	2	5
Income assistance - welfare	10	26
Income assistance - disability	27	71
Pension	2	5
Binning/recycling	10	26
Panhandling	5	13
Reselling	6	16
Support from relatives, friends, partners, etc.	2	5
Research honoraria	7	18
Selling drugs	12	32
Sex work	4	11
Other (please indicate)	2	5
Number of days engaged in illegal activities in the past 30 days	n	%
Yes	19	50
Mean	16.9	-
Range	1.5, 30	-
No	18	47
Prefer not to answer	1	3
Access to Basic Needs	n	%

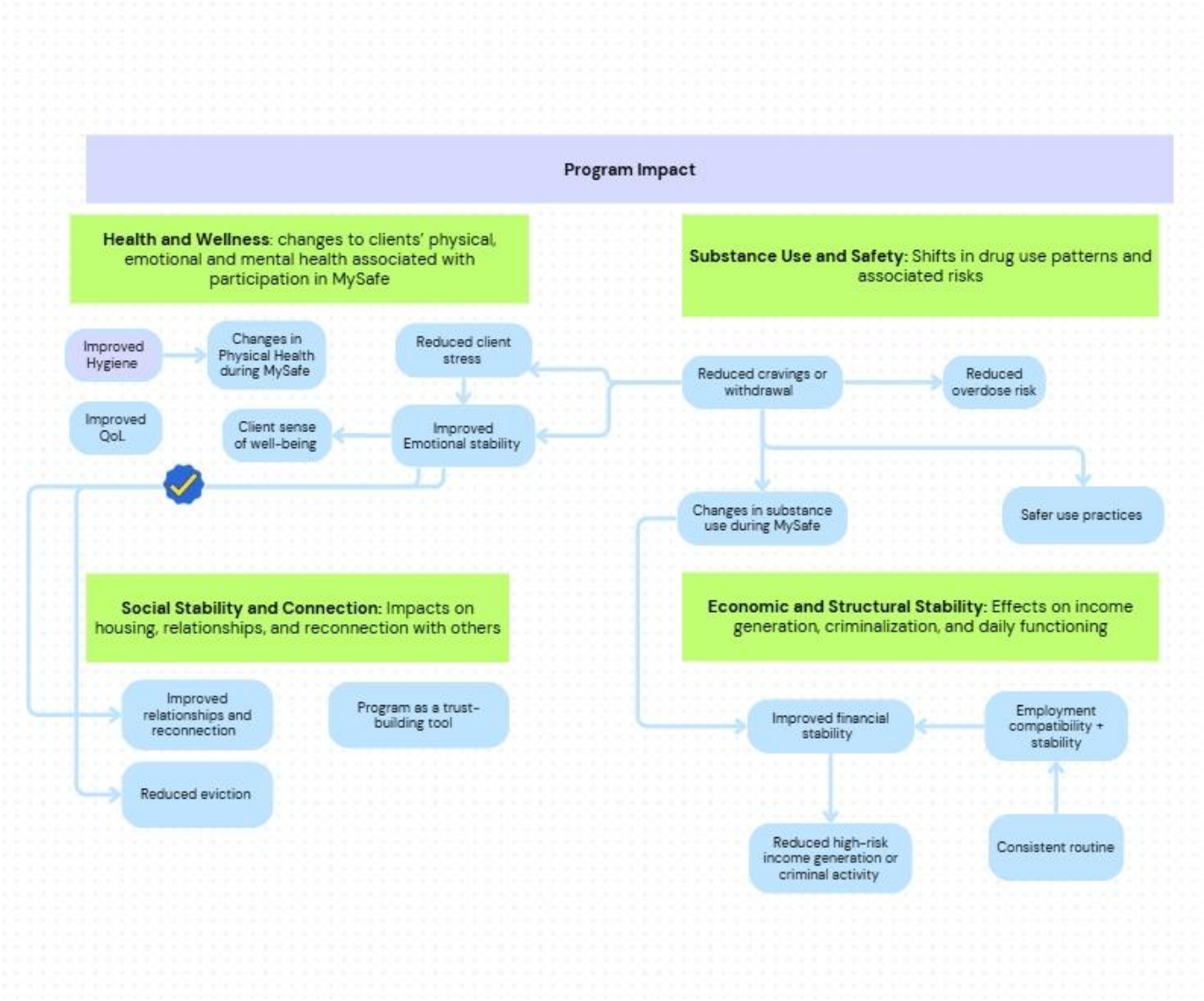
	Frequency (n=38)	Percentage (%)
Food for three meals per day		
Never (0% of the time)	11	29
Occasionally (about 25% of the time)	11	29
Sometimes (about 50% of the time)	7	18
Usually (about 75% of the time)	2	5
Always (about 100% of the time)	7	18
Income assistance		
Never (0% of the time)	0	0
Occasionally (about 25% of the time)	1	3
Sometimes (about 50% of the time)	1	3
Usually (about 75% of the time)	0	0
Always (about 100% of the time)	36	95
Housing		
Never (0% of the time)	5	13
Occasionally (about 25% of the time)	1	3
Sometimes (about 50% of the time)	0	0
Usually (about 75% of the time)	0	0
Always (about 100% of the time)	32	84
Adequate heating for your housing		
Never (0% of the time)	7	18
Occasionally (about 25% of the time)	1	3
Sometimes (about 50% of the time)	3	8
Usually (about 75% of the time)	3	8
Always (about 100% of the time)	18	47
Adequate cooling for your housing		
Never (0% of the time)	10	26
Occasionally (about 25% of the time)	0	0
Sometimes (about 50% of the time)	6	16
Usually (about 75% of the time)	2	5
Always (about 100% of the time)	14	37
Functional plumbing and water for your housing		
Never (0% of the time)	4	11
Occasionally (about 25% of the time)	2	5
Sometimes (about 50% of the time)	3	8
Usually (about 75% of the time)	7	18
Always (about 100% of the time)	14	37
Access to medical care		
Never (0% of the time)	2	5
Occasionally (about 25% of the time)	6	16

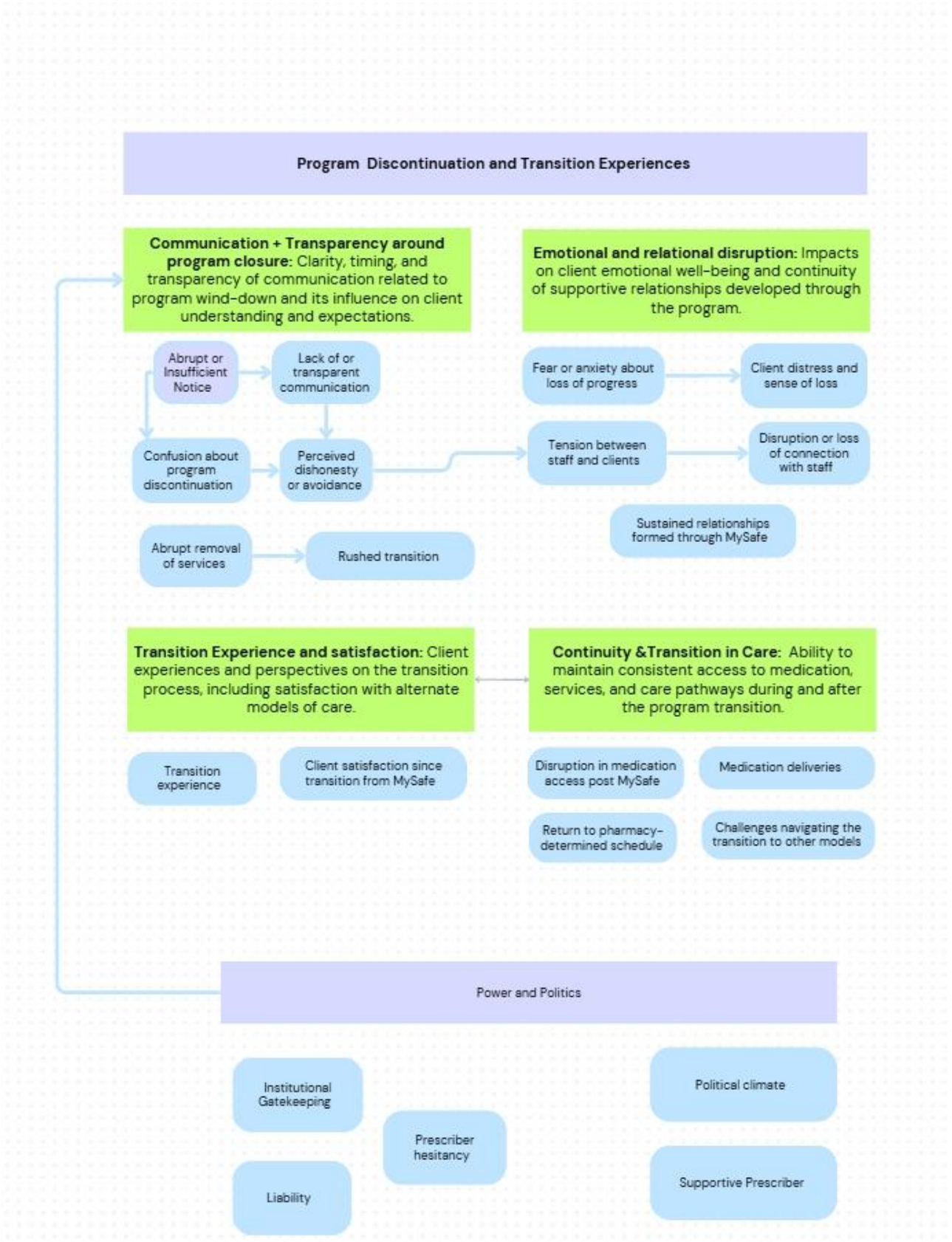
	Frequency (n=38)	Percentage (%)
Sometimes (about 50% of the time)	4	11
Usually (about 75% of the time)	4	11
Always (about 100% of the time)	22	58
Access to dental care		
Never (0% of the time)	18	47
Occasionally (about 25% of the time)	6	16
Sometimes (about 50% of the time)	1	3
Usually (about 75% of the time)	2	5
Always (about 100% of the time)	10	26
Access to dependable transportation		
Never (0% of the time)	5	13
Occasionally (about 25% of the time)	0	0
Sometimes (about 50% of the time)	4	11
Usually (about 75% of the time)	5	13
Always (about 100% of the time)	24	63
Time to get enough sleep/rest		
Never (0% of the time)	9	24
Occasionally (about 25% of the time)	5	13
Sometimes (about 50% of the time)	10	26
Usually (about 75% of the time)	7	18
Always (about 100% of the time)	7	18
Access to a phone		
Never (0% of the time)	1	3
Occasionally (about 25% of the time)	7	18
Sometimes (about 50% of the time)	5	13
Usually (about 75% of the time)	6	16
Always (about 100% of the time)	19	50
Access to other modes of communication (i.e., email, social media)		
Never (0% of the time)	9	24
Occasionally (about 25% of the time)	4	11
Sometimes (about 50% of the time)	4	11
Usually (about 75% of the time)	2	5
Always (about 100% of the time)	17	45
Money to pay monthly bills		
Never (0% of the time)	5	13
Occasionally (about 25% of the time)	6	16
Sometimes (about 50% of the time)	7	18
Usually (about 75% of the time)	3	8

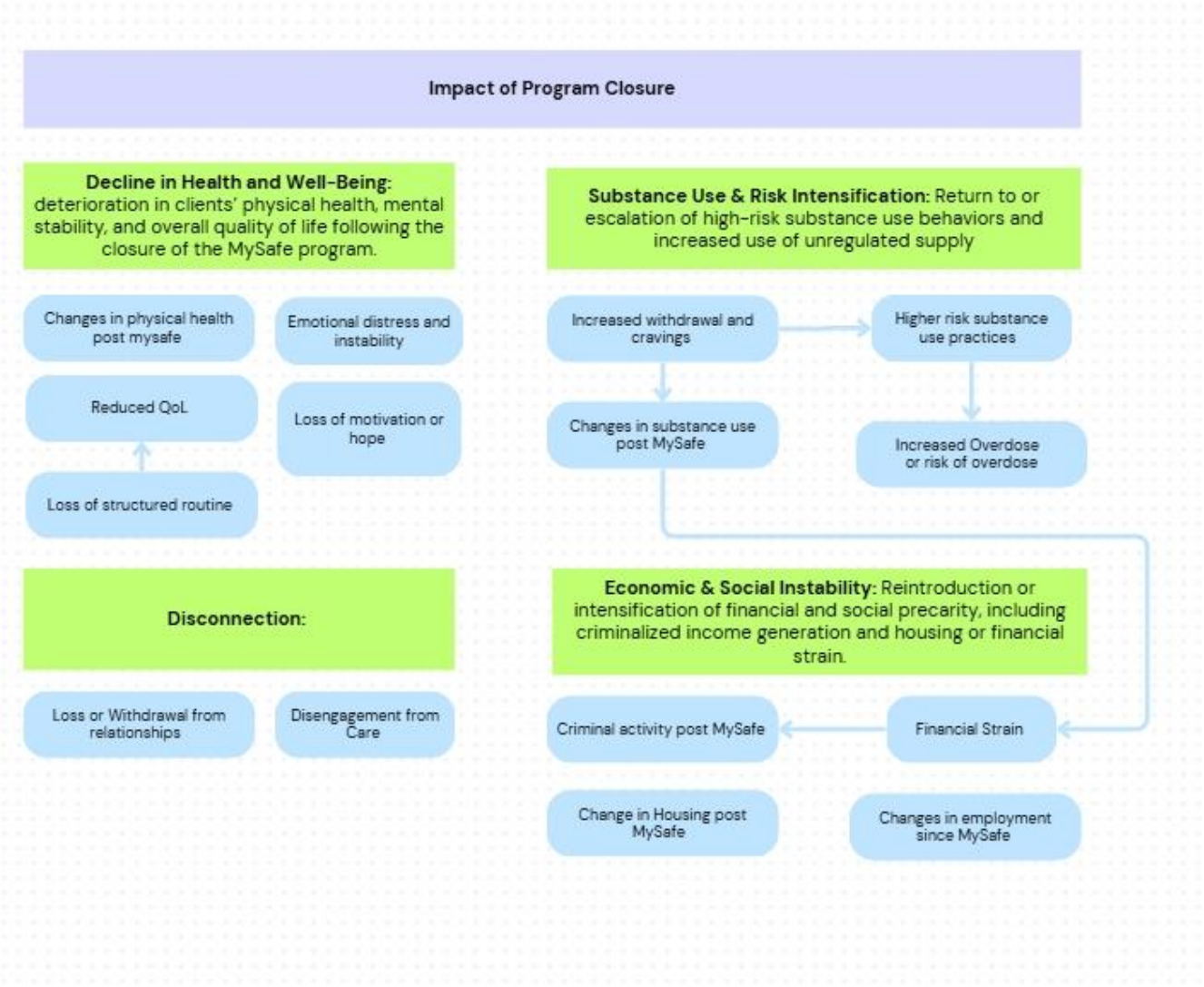
	Frequency (n=38)	Percentage (%)
Always (about 100% of the time)	16	42
Money to support others (i.e., children, relatives, friends, partners)		
Never (0% of the time)	20	53
Occasionally (about 25% of the time)	10	26
Sometimes (about 50% of the time)	2	5
Usually (about 75% of the time)	0	0
Always (about 100% of the time)	5	13
Money to pay for entertainment		
Never (0% of the time)	22	58
Occasionally (about 25% of the time)	4	11
Sometimes (about 50% of the time)	8	21
Usually (about 75% of the time)	1	3
Always (about 100% of the time)	3	8
Money to save		
Never (0% of the time)	32	84
Occasionally (about 25% of the time)	3	8
Sometimes (about 50% of the time)	2	5
Usually (about 75% of the time)	1	3
Always (about 100% of the time)	0	0
Money to buy necessities (i.e., food, toiletries)		
Never (0% of the time)	6	16
Occasionally (about 25% of the time)	6	16
Sometimes (about 50% of the time)	9	24
Usually (about 75% of the time)	6	16
Always (about 100% of the time)	9	24

Appendix H: Thematic Map




Program Impact
Health and Wellness: changes to clients' physical, emotional and mental health associated with participation in MySafe
Substance Use and Safety: Shifts in drug use patterns and associated risks
Improved Hygiene
Changes in Physical Health during MySafe
Reduced client stress
Reduced cravings or withdrawal
Reduced overdose risk
Improved QoL
Client sense of well-being
Improved Emotional stability
Changes in substance use during MySafe
Safer use practices
Social Stability and Connection: Impacts on housing, relationships, and reconnection with others
Economic and Structural Stability: Effects on income generation, criminalization, and daily functioning
Improved relationships and reconnection
Program as a trust-building tool
Improved financial stability
Employment compatibility + stability
Reduced eviction
Reduced high-risk income generation or criminal activity
Consistent routine


Program Discontinuation and Transition Experiences
Communication + Transparency around program closure: Clarity, timing, and transparency of communication related to program wind-down and its influence on client understanding and expectations.
Abrupt or Insufficient Notice
Lack of or transparent communication
Confusion about program discontinuation
Perceived dishonesty or avoidance
Abrupt removal of services
Rushed transition
Emotional and relational disruption: Impacts on client emotional well-being and continuity of supportive relationships developed through the program.
Fear or anxiety about loss of progress
Client distress and sense of loss
Tension between staff and clients
Disruption or loss of connection with staff
Sustained relationships formed through MySafe
Transition Experience and satisfaction: Client experiences and perspectives on the transition process, including satisfaction with alternate models of care.
Transition experience
Client satisfaction since transition from MySafe
Continuity &Transition in Care: Ability to maintain consistent access to medication, services, and care pathways during and after the program transition.
Disruption in medication access post MySafe
Medication deliveries
Return to pharmacy-determined schedule
Challenges navigating the transition to other models
Power and Politics
Institutional Gatekeeping
Prescriber hesitancy
Liability
Political climate
Supportive Prescriber


Impact of Program Closure
Decline in Health and Well-Being: deterioration in clients' physical health, mental stability, and overall quality of life following the closure of the MySafe program.
Changes in physical health post mysafe
Emotional distress and instability
Reduced QoL
Loss of motivation or hope
Loss of structured routine
Substance Use & Risk Intensification: Return to or escalation of high-risk substance use behaviors and increased use of unregulated supply
Increased withdrawal and cravings
Higher risk substance use practices
Changes in substance use post MySafe
Increased Overdose or risk of overdose
Disconnection:
Loss or Withdrawal from relationships
Disengagement from Care
Economic & Social Instability: Reintroduction or intensification of financial and social precarity, including criminalized income generation and housing or financial strain.
Criminal activity post MySafe
Financial Strain
Change in Housing post MySafe
Changes in employment since MySafe

Appendix I: Previous MySafe Evaluations and Publications

Bardwell, G., Ivsins, A., Mansoor, M., Nolan, S., & Kerr, T. (2023a, April). *Findings from year 1 of the MySafe study*. British Columbia Centre on Substance Use. https://www.bccsu.ca/wp-content/uploads/2023/05/MySafe_One-Pager_FINAL.pdf

Bardwell, G., Ivsins, A., Mansoor, M., Nolan, S., & Kerr, T. (2023b). Safer opioid supply via a biometric dispensing machine: A qualitative study of barriers, facilitators and associated outcomes (MySafe). *CMAJ, 195*(19), E668–E676. https://doi.org/10.1503/cmaj.221550

Bardwell, G., Ivsins, A., Wallace, J. R., Mansoor, M., & Kerr, T. (2024). "The machine doesn't judge": Counternarratives on surveillance among people accessing a safer opioid supply via biometric machines (MySafe). *Social Science & Medicine, 345*, 116683. https://doi.org/10.1016/j.socscimed.2024.116683

Ivsins, A., Mansoor, M., Bowles, J. M., & Bardwell, G. (2024). Reasons for enrolling in safer supply programs: A longitudinal qualitative study on participant goals and related outcomes in the MySafe program. *Journal of Studies on Alcohol and Drugs, 85*(6), 845–855. https://doi.org/10.15288/jsad.23-00388

Mansoor, M., Foreman-Mackey, A., Ivsins, A., & Bardwell, G. (2023). Community partner perspectives on the implementation of a novel safer supply program in Canada: A qualitative study of the MySafe Project. *Harm Reduction Journal, 20*, 61. https://doi.org/10.1186/s12954-023-00789-8

Tyndall, M. (2020). Safer opioid distribution in response to the COVID-19 pandemic. *International Journal of Drug Policy, 83*, 102880. https://doi.org/10.1016/j.drugpo.2020.102880