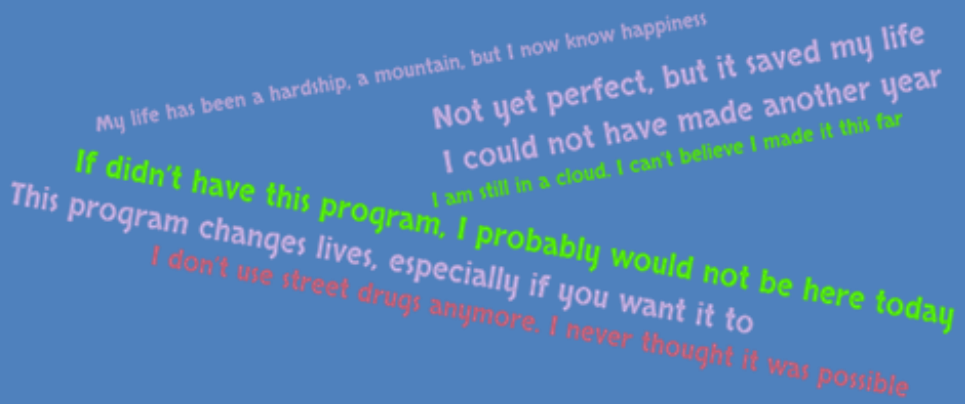
Assessment of the Implementation of Safer Supply Pilot Projects



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River Stone Recovery Centre
London InterCommunity Health Centre
Downtown East Collaborative Safer Opioid Supply Program
-South Riverdale CHC
-Regent Park CHC
-Street Health
Parkdale Queen West CHC Safer Opioid Supply Program
Pathways to Recovery
-Recovery Care
-Ottawa Inner City Health
-Somerset West CHC
-Sandy Hill CHC
-Respect Rx
Victoria SAFER Initiative, AVI Health and Community Services Society
Kilala Lelum, Urban Indigenous Health and Healing Cooperative
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Executive Summary

As the overdose crisis worsened during the COVID-19 pandemic, health care experts and people who use drugs called for greater access to a safer supply of prescription medications as an alternative to the toxic illegal drug supply.

In 2020, the Substance Use and Addictions Program at Health Canada funded ten time-limited safer supply pilot projects in three provinces (British Columbia, Ontario, and New Brunswick). Health Canada then contracted a four-month qualitative assessment, from December 2020 to March 2021, of these projects to capture early learnings, including effective strategies for program delivery.

This is an independent assessment report prepared by Dale McMurchy Consulting based on information gathered through surveys and interviews with safer supply program leads, staff and participants. While this assessment was funded by Health Canada, the information provided herein does not necessarily represent the views of Health Canada.

The assessment found that having access to a safer supply of drugs has had tremendous immeasurable (and measureable) positive impacts on many clients' lives. Many are more positive and happier, and have better health outcomes, greater stability and improving relationships with family and friends. Some have secured housing and/or employment. They are highly appreciative of having these services available to them. One client shared "*It's surprising; I didn't think the government would provide this. We are addicts and not really a priority*."

The safer supply programs differ in the range of prescription medication and dosage options offered. Most participants receive tablet hydromorphone. Fewer receive injectable hydromorphone, fentanyl patches or oxycodone. Many also take a longer-acting opioid (sometimes called a "backbone"), such as methadone or slow-release oral morphine. Some programs also prescribe stimulant replacements (such as methylphenidate and dextroamphetamine). Prescribers are working with clients – based on established parameters – to find the approach that works best for them, and clients have effectively developed their own goals and processes for managing their medications. For example, they combine injections and tablets, take their medications as needed throughout the day, and reserve enough to get them through until the next day.

It was reported that client needs are evolving and increasingly unsupported by recommended approaches in the existing prescribing guidance and the medications that are currently available. Safer supply programs are finding it difficult to manage client tolerance levels as a result of their fentanyl use. Most clients still struggle to manage withdrawal symptoms, but few have overdosed. While many participants have stopped using street drugs, others still use them, but at a progressively decreasing rate. From the perspective of program staff, it is anticipated that this downward trend will continue with increased participant time in the program and as prescriptions are adjusted to match their needs

Safer supply projects are generally staffed with diverse teams that communicate well and work collaboratively. Staff address many of their clients' health and social care needs and clients are very appreciative of staff, including the respect and attention they pay. Staff-to-client ratios are high. However, most programs have insufficient funding for the number and type of staff needed to meet overall demand for services and the needs of their current clientele. The safer supply programs benefit from numerous collaborations and partnerships. For example, primary care, pharmacists and supervised consumptions sites are important members of the team. In some instances, they see clients most often. Such reciprocal relationships in support of clients' health and wellbeing benefit them greatly.

It was reported that the overdose crisis is not improving and the current safer supply services available across the country are not meeting demand. Many programs have reached capacity or are too busy to take new participants. Broad access to these services, whether through primary care, harm reduction services or other modalities, is needed to meet the demand and help to address the crisis by providing the necessary services (medications and comprehensive health and social services) to people with substance use disorders.

Some of the key lessons learned related to design and implementation are that safer supply programs should:

1. be grounded in the community and centred on the input and involvement of people with lived and living experience in program co-design, planning and implementation
2. focus on the client and continue to innovate based on clients' experiences and evolving needs
3. have requisite organizational and management structures in place, including processes and protocols outlined

4. understand and address federal and provincial legislation and regulations, professional regulations and scopes of practice, and employers'/organizations' policies and standards
5. offer different delivery models to meet client needs and based on the principles of harm reduction

In conclusion, at this early stage of their implementation, the safer supply pilot projects have positively impacted client's lives. Those working on the ground have seen the results and emphasize the need to expand access to address the overdose crisis and provide medications and comprehensive health and social services to people with opioid use disorder.

Introduction

Purpose of this Report

This report provides the results of a preliminary qualitative assessment, from December 2020 to March 2021, of ten safer supply pilot projects funded by Health Canada's Substance Use and Addictions Program (SUAP). While this assessment was funded by Health Canada, the information provided herein does not necessarily represent the views of Health Canada.

The objective of this assessment is to provide early observations on effective implementation strategies and lessons learned in the establishment of lower-barrier safer supply programs. The report's purpose is to support current and future safer supply programs by:

1) Identifying barriers and effective strategies for establishing and implementing safer supply programs
2) Contributing to the evidence base on best or promising practices for the future design and implementation of lower-barrier safer supply programs

Approach to Safer Supply

As stated on the Health Canada safer supply webpage, safer supply services provide prescribed medications to people who use drugs, overseen by a health care practitioner, with the goal of preventing overdoses and saving lives. The principle behind SUAP-funded safer supply programs is to provide people who use drugs with prescription drugs of known quality, concentration and origin, as a substitute for street drugs, without being part of a medical treatment or the expectation or condition that they will enter treatment for opioid use disorder. The focus of safer supply programs is to create a healthier environment for people who use drugs, and not on individual behaviour change. The goal that is paramount is to reduce death and overdoses.[1]

The SUAP-funded safer supply programs:

1) are lower barrier (e.g., wide eligibility, reduced barriers to access through various service sites and appointment types, different dispensing options)
2) are accessible (i.e., available in a variety of settings)
3) have an appropriate degree of prescriber/health care provider involvement
4) connect people with other health and social services, where possible and appropriate

Safer Supply Pilot Projects

SUAP provides grants and contributions funding to other levels of government and community-led and not-for-profit organizations to respond to drug and substance use issues in Canada. In July 2019, SUAP issued a call for proposals for – among three priority areas – innovative approaches to providing people with opioid use disorder with a prescribed pharmaceutical-grade alternative to the toxic illegal street supply. In 2020, five projects were selected to receive funding over five years. As the overdose crisis worsened during COVID-19, SUAP funded an additional six projects for ten months, with a two-year extension granted in April 2021. The projects are listed in Table 2 and described in Appendix A.

These safer supply programs differ in their organization and approach to service delivery. For example, two programs are a group of collaborating sites and two are partnered with and administered by a health authority, but have not yet commenced services. One program is dedicated to the local Indigenous population. The programs are based in British Columbia, Ontario and New Brunswick and are thus impacted by the health system context within their jurisdictions. The various structures and approaches are described in this report, along with key design and implementation considerations for improving and expanding the provision of safer supply services.

[1] Safer Supply Implementation Task Force. *Considerations and support tools for establishing safer supply pilot projects in Canada.* July 2019.

Several of the safer supply programs are based within a primary care centre, including community health centres. Others are standalone services or offered as part of other harm reduction and/or addiction services. Among the safer supply service sites, most are based at a single service delivery site. Three are at more than one site. One does not have a physical site; this program – along with two others – offers mobile services (Table 1).

Table 1. Types of service sites

Type of service site	Number of programs
One physical site	6
More than one physical site	3
Mobile services	3

Based on the responses to the program questionnaires, there were approximately 1,100 clients receiving safer supply services via SUAP-funded programs in early 2021 (Table 2). These numbers are fluid and the programs are striving to take on new clients within their current capacity. Two programs have yet to open their doors to clients.

Table 2. Estimated number of clients by program (Jan/Feb 2021)

Program	Number of clients
River Stone Recovery Centre *	166
London InterCommunity Health Centre (LIHC) *	237
Downtown East Collaborative Safer Opioid Supply Program (DEC SOS)**	
-South Riverdale CHC	31
-Regent Park CHC	21
-Street Health	31
Parkdale Queen West CHC Safer Opioid Supply Program (PQW SOS)**	70
Pathways to Recovery **	
-Recovery Care	156
-Ottawa Inner City Health	41
-Somerset West CHC	108
-Sandy Hill CHC (Wraparound support to clients only)	80
-Respect Rx (Pharmacy support for clients)	170
Victoria SAFER Initiative, AVI Health and Community Services Society (SAFER AVI)**	89
Kilala Lelum, Urban Indigenous Health and Healing Cooperative **	100
Hope to Health, Providence Health Care Research Institute, BC Centre for Excellence in HIV/AIDS **	55
SAFER Initiative, Vancouver Coastal Health Authority (not yet operational) (VCH)*	0
TiOAT (Tablet Injectable Opioid Agonist Treatment), Vancouver Island Health Authority (not yet operational) (VIHA)*	0

* Five-year funding ** Three-year funding
*** The fifth program funded for five years is on hold until FY 2021/2022 and is not included in this assessment

SUAP-funded safer supply programs mainly offer (or will be offering) tablet hydromorphone as an opioid replacement for clients. For several programs, it is newly offered or has expanded as a result of SUAP funding. In addition to hydromorphone, many clients also receive a “backbone” therapy of methadone, slow-release oral morphine (SROM, brand name Kadian) or buprenorphine/naloxone (brand name Suboxone). A few programs offer injectable hydromorphone, oxycodone or fentanyl patches on a limited or pilot basis as an alternative to tablet hydromorphone. Some also offer prescriptions for stimulant use disorder.

Methods

Key Assessment Questions

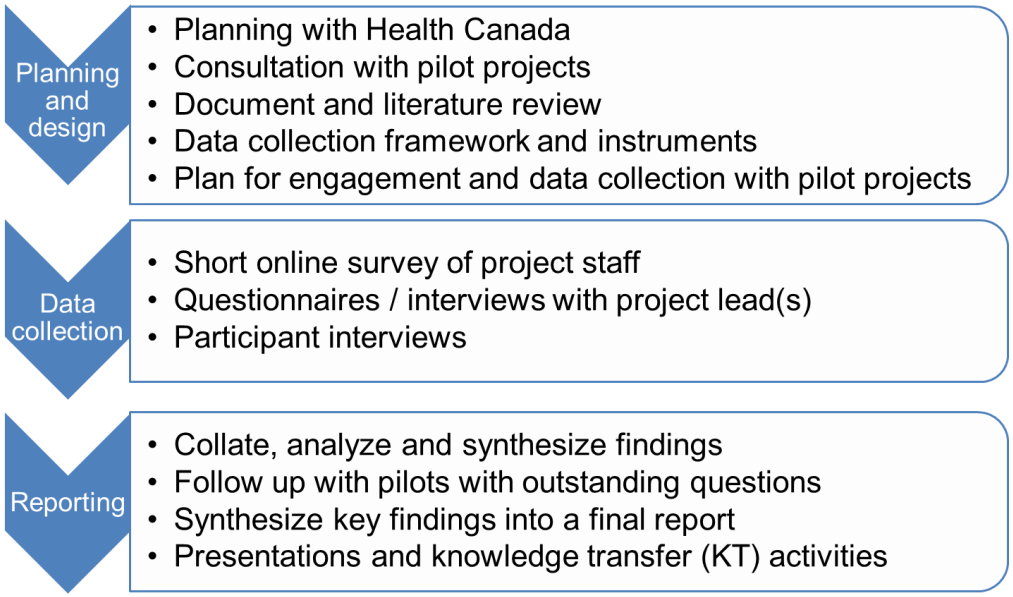
This preliminary assessment of the safer supply pilot programs aims to provide early observations and answer the following questions:

1. What are the basic features of the SUAP-funded safer supply programs, and the policies and procedures in place? What are the key considerations and critical factors for success in the design and ability to start offering services?
2. What are the most effective implementation strategies? What works; what does not?
3. What implementation challenges and barriers have been experienced? How were they addressed?
4. What are the staff experiences with project design, implementation and delivery?
5. What population groups are being served?
6. What is the participant experience with the safer supply? Does it address their needs? What is required to improve their experience?
7. In what ways have the programs been beneficial to clients?
8. How has the community responded to the safer supply programs?
9. How are the safer supply programs partnering or integrating with the existing health, social and public safety systems?
10. What are the key lessons learned? What improvements can be made moving forward?
11. What can Health Canada do to improve the implementation of safer supply programs?

Overall Approach

The assessment team conducted an in-depth review of the safer supply programs' design, implementation, processes and procedures, and initial outcomes. As show in the graphic below, the team applied a mixed-method approach, with triangulation of the data.

The methods entailed program document and high-level literature reviews. The staff survey received 100 responses from staff at eight safer supply programs; two-thirds responded to three opened-ended questions. Each program completed a program questionnaire and 15 interviews/focus groups were conducted with program leaders and key staff. Fifteen semi-structured client interviews (via telephone or videoconference) were conducted at seven programs in early 2021 (For further details on the methods, see Appendix B).



Safer Supply Pilot Project Service Characteristics

Impact on Clients' Lives

Analysis and Summary of Key Findings

Having access to a safer supply of drugs has resulted in significant improvements to many clients' lives.

Many are more positive and happier, and have better health, greater stability and improving relationships with family and friends. Some have secured housing and/or employment.

Overall Impact

"Measures for success need to include self-reported benefits. Participants tell us that they are using less street fentanyl and feel better for having access to a safer supply. They tell us that they have more stability in their lives. People ARE benefiting from the provision of pharmaceutical alternatives. Our participants are all still alive[2]"

Almost all clients interviewed reported significant improvements to their lives as a result of their receiving pharmaceutical grade drugs as safer alternatives to the contaminated illegal drug supply, along with other health and social support services. The following quotes from clients demonstrate how they expressed these changes.

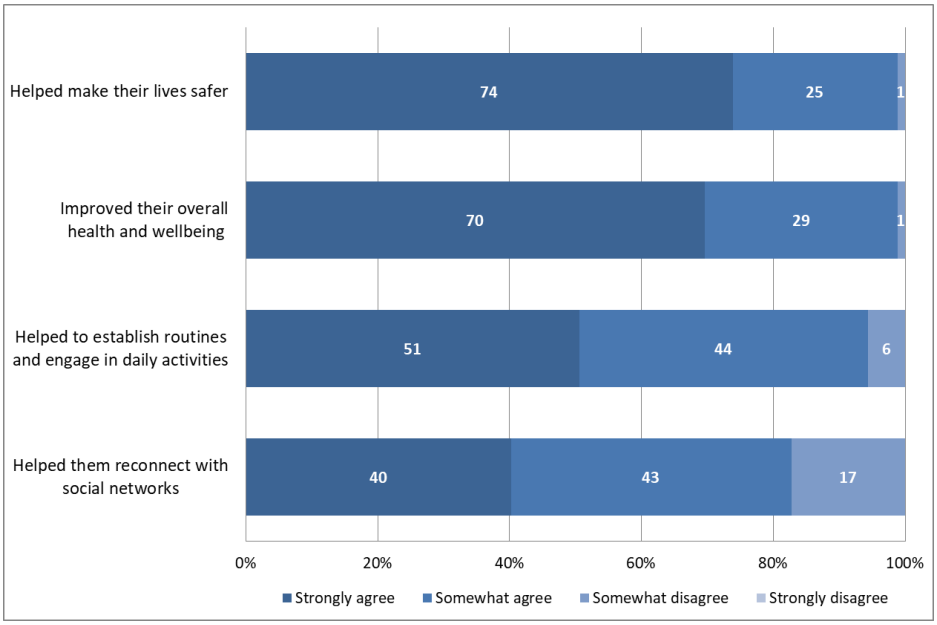
[2] Victoria SAFER Initiative, *Top Ten*. 2021

Clients who have stabilized as a result of their access to a safer supply reported the following improvements to their lives. Staff have also observed the impacts on clients' lives.

Clients		Staff
➢ Are healthier overall ➢ Are more active ➢ Are sleeping better ➢ Are eating better ➢ Have more energy ➢ Are housed ➢ Are employed ➢ Have more money ➢ Have more time in the day ➢ Can pursue hobbies and interests ➢ Have fewer self-destructive behaviours	➢ No longer have to hustle ➢ Have to interact less often with the street (e.g., dealers, violence, crime, police) ➢ Are less likely to commit a crime ➢ Are no longer engaged in survival sex work ➢ Have addressed health issues related to drug use, mental health and other health conditions ➢ Have reduced stress ➢ Have improved/improving relationships	➢ Regaining hope that they matter in society ➢ Feeling 'human' for the first time in a long time ➢ Feeling hopeful for their future ➢ Increased stability in their life ➢ Improved quality of life ➢ Better able to focus on what is important to them ➢ Becoming housed ➢ Joining the workforce ➢ Reduced survival sex work and criminal activity ➢ Reinvesting in relationships with service providers, family, friends and supports

Based on the program staff survey, almost all staff *strongly or somewhat agreed* that their safer supply program had helped make clients' live safer and improved their overall health and wellbeing. Seven in ten *strongly agreed*. Half of staff *strongly agreed* that accessing safer supply had helped client establish routines and engage in daily activities, and 40% *strongly agreed* it had helped them reconnect with social networks. While most agreed, 17% *somewhat disagreed* that the program had helped clients reconnect with social networks, i.e., family and friends (Figure 1).

Figure 1. Staff reported safer supply impact on clients' lives



Health

"I now pay more attention to my health and take better care of myself."

Many clients are no longer using street drugs – "*I don't use street drugs anymore. I never thought it was possible."* Others have reduced their use significantly. Many clients acknowledged that their access to safer supply has saved their lives. Several reported previous (often multiple) overdoses – "*I'm sick of dying*" – and that their access to a safer supply of drugs has averted more.

> *"I could not have made another year"*
> *"If didn't have this program, I probably would not be here today"*
> *"It's not yet perfect, but it saved my life"*

Importantly, many clients are experiencing reduced withdrawal symptoms ("dope sickness"). However, for some fentanyl users, the alternative medications prescribed and/or the dosages provided are insufficient to match and replace the withdrawal effects of their regular street supply and they still need to supplement their safer supply with street fentanyl. Some of these individuals remain desperate; "*I am living with a ball and chain…. Every day we are on the street we risk our lives…. It seems so surreal this lifestyle, like Russian roulette. We want something so we don't have to live this lifestyle*."

Most clients reported that their overall health had improved. Several have experienced improvement in health conditions associated with drug use, as well as the management of concomitant conditions. Some reported not going to the hospital as often and now having time to attend dentist appointments and elective surgery. Some are more active ("*other than looking for drugs*") eating better and getting more sleep. Some clients reported improvements in their mental health, while others identified this as an outstanding need.

Staff have also observed a significant change in clients' substance use, including decreased overdoses and deceased use of street drugs. In addition to a reduction in overdoses, staff reported that clients experience fewer adverse reactions associated with their drug use.

> *"As patients begin to use less illicit, tainted drugs and have access to a safer supply, their success is almost instantly apparent. We see patient's complexion and skin clear up from sores and abscesses. A milestone I talk about with some patients is how long it's been since they used a needle. Cutting down needle use reduces infections, and helps the veins recuperate to better the circulation in their extremities. Also, patients begin to gain some weight back. These improvements and small wins, while they seem superficial, help patients gain confidence in themselves to be able to push forward and continue to improve."*
>
> *"I am noticing a number of participants who are looking and feeling better, who are becoming more involved in their own community, and reporting fewer incidents of substance use outside of the program. It is working!!!"*
>
> *"Patients with depression/anxiety finally experience relief from their thoughts and get sleep at night."*

Staff reported that participation in the program has allowed them to identify many acute and chronic health issues that clients did not know they had or could be addressed. They have seen improved health outcomes. Many clients are "*engaging with health care providers and restarting on other medications, as well as treating many unmet health care needs (Hep C, HIV, mental health meds, other primary health care needs)*."

While many clients' health has improved, some are still finding their way in the program and will take time to stabilize. According to one team member, "*It really isn't realistic to see significant behaviour or health outcome changes in the course of a few months. And even engagement has been difficult due to the high degree of instability our clients experience in this time of COVID-19*."

The Hustle

"As the hustle reduces, other things do too"

Clients reported spending less time and money securing illegal substances. Many are no longer using street drugs; others continue to use at a reduced frequency and dosage. Many described the relief from not having to constantly hustle to get money and buy drugs. The daily hustle was described as "*exhausting*," "*stressful*" and "*dangerous*." Many reported a reduction in the need to panhandle and the ability to use those monies towards other essentials. As a result, several clients reported having more time available to do other things. Nonetheless, most still need to go to the pharmacy once a day and, if they are on an observed regimen, they need to be at the clinic or supervised consumption site (SCS) several times a day.

Housing and Employment

"I have housing and a job. I never thought that would happen again."

Since participating in the safer supply program, some clients are now housed or are being supported to find housing. Some are now able to divert monies formerly used for drugs towards their housing. However, many continue to be unhoused or unstably housed and experience inconsistent and often changing housing situations, especially as a result of COVID-19. Several of those experiencing homelessness reported challenges – especially related to their safety and the ready availability of street drugs – in shelters, COVID-19 hotels and publicly-funded apartment buildings (some of which they call trap houses). Some have opted to remain outside these facilities.

While not feasible for many clients, some have gained employment subsequent to getting a safer supply, including as peer workers with the safer supply programs and other non-profit services. Others are being supported by the programs in developing their résumé and looking for work. One client lost their job due to COVID-19 lockdowns

and is struggling financially as a result. One staff member reported, "*we are along for the journey with patients as they apply for jobs, and search for housing, and when they hear "yes" or "approved", the relief and the joy on their faces is unmatched*."

Family and Friends

"I've heard of several fathers who earned more time with their children, whether that be hours or days. I've seen adolescents/young adults move back into their parent's homes after bouncing around the shelters and the streets for years."

As a result of receiving a safer supply, some clients with partners and/or children reported less stress, greater presence and a more stabilize family life. Some reported improved or improving relationships with other family members and friends. For some, the constant worry has been relieved for their families. "*My family are very happy. At first they were upset, now they realize it is saving my life*." One client said that friends had seen a difference in them; another was able to take care of their mother when she was ill.

Some clients moving to a safer supply have had to address new challenges with family, friends and acquaintances who use drugs. Some are receiving safer supply along with their partners. However, other clients' partners are waiting to access the program, which creates worry and stress, as well as challenges with one using illegal drugs while the other uses a safer supply. "*It is impossible for me to sit there and have my husband do a drug that I want."* Transitioning to a safer supply can also mean a different dynamic in clients' relationship with others who use drugs. They may experience pressure to use street drugs or to sell or share their safer supply. As a result, they may need to distance themselves from this community. Several clients reported that they had recommended the safer supply program to acquaintances, friends and family. Some are now on a waiting list. However, most clients continue to lose – and be traumatized by the loss of – friends and family members to overdoses. "*There's a hole in your heart as you are trying to stay away from people – there's friends lost, people dying, guilt*."

COVID-19 Challenges

In addition to creating greater inconsistency and toxicity in street drugs, the COVID-19 pandemic has added additional challenges and anxiety for clients. Some are using alone more frequently. For those who have stabilized on safer supply, there are long days on their own with nothing to do. The isolation is breaking down mutual aid and support systems, and some are finding it difficult to be alone. There are fewer community services open (e.g., transportation, AA meetings, drop-in, meals, showers), less access to public spaces, few public bathrooms and it is difficult to get access to a phone.

> *"COVID-19 has meant that there has been no programming. Without something for clients to do during their day, they may be less able to maintain on safer supply. Relying on street supply requires a lot of hustle that occupies the day and involves a social group. Moving to safe supply leaves people with little to do during the day and may also isolate people. This can lead to boredom, reliving of trauma, loneliness, and isolation. All of these may impact the successful engagement in safer supply and client outcomes."*
>
> *"Our program participants have been impacted the most by COVID-19, as many are experiencing homelessness or precarious housing and all public places are closed for them"*

Safer Supply Medications

Analysis and Summary of Key Findings

The safer supply programs differ in the range of prescription medication and dosage options offered. It was reported that client needs are evolving and increasingly not supported by the recommended approaches in the existing prescribing guidance. Prescribers are working with clients – based on established parameters – to find the approach that works best for them. For many clients using hydromorphone, the addition of a Kadian and/or methadone backbone and/or a medication, such as Ritalin, to address their stimulant use have proved successful. Some are finding success with other opioid medications, including fentanyl patches and oxycodone.

Clients have effectively developed their own goals and processes for managing their medications, including combining injection and oral administration, taking their medications as needed throughout the day, and reserving medications to get them through until the next day. Most struggle to manage withdrawal symptoms. Few have experienced an overdose.

Many clients have stopped using illegal drugs; others are still using them, although at a progressively decreasing rate. As this is early in the program, one would anticipate that this downward trend would continue if prescriptions can be adjusted to match clients' needs.

Medications Provided

There is some debate about what constitutes a safer supply medication. Some suggest that safer supply constitutes the continuum of medications available to replace illegal street drugs, mitigate withdrawal and prevent overdose. Others believe that the traditional opioid agnostic therapies (OAT) methadone, slow-release oral morphine or slow-release oral morphine (SROM, brand name Kadian) or buprenorphine/naloxone (brand name Suboxone) on their own do not constitute a safer opioid supply. Others view injectable opioid agonist treatment (iOAT) as fitting more within a treatment, rather than a flexible, low-barrier, model given it is observed, (but say that it could constitute safer supply if it were dispensed daily or as carries).

The SUAP-funded safer supply programs mainly offer (or will be offering) clients hydromorphone tablets as their opioid replacement. For several programs, it is newly offered or has expanded as a result of SUAP funding. Most programs provide both daily pick up and observed administration of hydromorphone tablets. Two do not have observed arms and one will only offer observed dosages. Four of the programs offer carries for the tablets. Some programs started safer supply under the assumption that they would only be prescribing hydromorphone. However, the majority of clients are also on a "backbone" of methadone, Kadian (SROM) and, to a lesser extent, Suboxone. In combination with hydromorphone, Kadian is usually observed during daily pick up. Four programs allow for daily pick up of both hydromorphone and Kadian, while three allow for carries[3] (Table 3).

The program in New Brunswick offers hydromorphone only in an injectable liquid form. Three in B.C. offer liquid hydromorphone (in addition to tablets) to a smaller proportion of their clients. Some programs are offering fentanyl patches on a limited or pilot basis. A few programs prescribe oxycodone as an alternative to hydromorphone, as it is preferred by some clients. For stimulant use disorder, the following are prescribed: Ritalin (methylphenidate hydrochloride), Adderall (dextroamphetamine and amphetamine) and Dexedrine (dextroamphetamine) and Risperidone/Aripiprazole.

Table 3. Safer supply prescription medications (as of January 2021)

Prescription medication	Number of programs providing	New or expanded due to SUAP funding
Methadone	10	5
Buprenorphine/naloxone (Suboxone)	9	4
Kadian/M-Eslon (SROM)	9	4
Tablet hydromorphone observed/witnessed	7	5
Tablet hydromorphone carries	5	4
Tablet hydromorphone daily pick up	8	5
Tablet hydromorphone + SROM observed/witnessed	5	3
Tablet hydromorphone + SROM carries	3	2
Tablet hydromorphone + SROM daily pick up	6	3
Injectable hydromorphone	4	3
Fentanyl patch	6	3
Other medications	5	4

[3] Observing OAT is not a federal requirement; but there may be provincial/territorial guidelines, policies or scope of practice restrictions on who can witness OAT.

Other combinations	3	0

Table 4 shows the safer supply medications that the SUAP-funded projects reported providing. The medication list is changing as programs evolve, and they may or may not be new or expanded due to SUAP funding.

Table 4. Safer supply prescription medications by program (as of January 2021)

Prescription medication	River Stone	Pathways*	PQWSOS	DECSOS	LIHC	Kilala Lelum	SAFER AM	Hope to Health BCCE	VCH**	VIHA**
Methadone	X	X	X	X	X	X	X	X	X	X
Buprenorphine/naloxone (Suboxone)	X	X	X		X	X	X	X	X	X
Kadian/M-Eslon (SROM)	X	X	X	X	X	X	X	X	X	
Tablet hydromorphone observed		X	X			X	X	X	X	X
Tablet hydromorphone carries			X		X	X		X	X	
Tablet hydromorphone daily pick up		X	X	X	X	X	X	X	X	
Tablet hydromorphone + SROM observed		X	X			X	X		X	
Tablet hydromorphone + SROM carries					X	X			X	
Tablet hydromorphone + SROM daily pick up		X	X	X	X		X		X	
Injectable hydromorphone	X					X		X	X	
Fentanyl patch	X		X	X	X	X			X	
Other medications	X					X	X	X	X	
Other combinations					X		X		X	

* There are 3 different sites prescribing with some variation. Some may provide additional medications. All sites expanded hydromorphone with SUAP funding.
** Planned, SUAP component not yet operational

Prescribing Practices

"Instead of having people who don't fit our model, we change our model to best match up with the people who need our services most. Some of the people ...haven't missed doses in weeks and are reporting feeling the best they have in a long time. We also have people now who are showing zero fentanyl in their urine drug screens and only their safe supply."

Many clients have stabilized on the safer supply program. This includes many of those for whom methadone or buprenorphine/naloxone did not work in the past and those who are still using some – but a reduced amount of – fentanyl. Many have stabilized with the addition of a backbone.

Table 5 provides examples of the types and dosage of medications that safer supply participants reported taking. Clients were well-versed and precise about the dosages and frequency of the medications they were taking. Most take hydromorphone tablets orally or by injection; some do both. Many are using hydromorphone in combination with a backbone. Some take Ritalin to address stimulant use. About half of the clients interviewed are still using street drugs (among those still using street drugs, two-thirds were using fentanyl and one-third stimulants), but mostly at a progressively decreasing rate. Almost all clients reported that they had stabilized on their safer supply, which had allowed them to either stop taking fentanyl or reduce the amount and/or frequency taken.

Table 5. Examples of safer supply client prescriptions

No.	Hydromorphone	Backbone (Kadian and/or methadone)	Ritalin
1	<10 tabs – inject		
1	<10 tabs – inject & oral		
1	10–19 tabs – oral		
1	10–19 tabs – oral	Yes	
1	10–19 tabs – inject		
3	10–19 tabs – inject	Yes	1
2	20–30 tabs – oral	Yes	1
2	20–30 tabs – inject & oral	Yes	1
1	Injectable		
1	Other opioid (oxycodone)		
1	-	Yes	

Prescribers are guided by existing guidance for substance use disorder.[4] However, it was reported that client needs are evolving and increasingly not supported by the recommended approaches in the prescribing guidance. Many prescribers are creating their own prescribing guidelines and working within a community of practice in order to address clients' medication needs. Based on the initial assessment, clients are prescribed a dosage based on existing guidance (national and within the safer supply program) and prescriber experience and knowledge. Starts are reported to be four to 12 8mg hydromorphone tablets per day. If the initial dosages are inadequate, they are titrated up incrementally. As reported by most program clients and staff, the majority of clients are on between 16 and 24 tablets a day. Dosages in some programs reach 30 to 40 tablets a day (where most clients are said to "max out" and no further benefit is conferred). Some programs work under stricter, lower caps (e.g., 10 tablets a day).

Prescribers follow relatively standardized titration regimens. However, there are differences in the dosage and frequency with which they titrate up. As well, one program is implementing as needed (PRN) hydromorphone dosing for those not on a titrated regular dose, but prefer to come in when they need to. Another program does not titrate, but offers up to 10 observed tablets a day, with a maximum of two tablets available per visit. For injectable hydromorphone, dosages are reported to be increased in 2mg increments. Generally, these clients are on 10mg three times a day; although, some are on twice that dosage.

Most clients pick up their medications daily at pharmacies. While they pick up hydromorphone, many are observed taking their Kadian and/or methadone (always during titration). Few clients receive more than a day's medications (even over weekends and holidays). Some programs make exceptions or offer compassionate carries in certain circumstances. While most programs do not, a couple offer carries for longer standing stabilized clients. The length of carries is increased incrementally (e.g., by day up to seven days). Generally, individuals using iOAT and more vulnerable clients using hydromorphone tablets orally or by injection (TiOAT) are observed onsite. Some programs use an observed model for initial titration before transitioning clients to a daily pick up model. All who inject hydromorphone tablets are encouraged to use the supervised consumption services (SCS) onsite or nearby. One program reported a few clients receive an observed injectable hydromorphone in the morning and carry an afternoon injection.

After receiving the first safer supply prescription, clients generally see the prescriber (a physician or nurse practitioner) and/or nurse once a week to check in regarding their overall health, review their experience with their prescription, have a urine screening test and renew their prescription. One prescriber offers weekly group appointments. In some cases, longer standing clients are seen once every two weeks or, more rarely, monthly. As the programs evolve and clients are there longer and stabilize, the interval can lengthen.

An important aspect of the safer supply service has been the ability to successfully engage and retain clients. Critical to retention is finding the appropriate approach, especially for those who have failed or been shut out of other programs and services. Prescribers work with clients towards achieving the right dosage and combination. Staff identified the need to recognize the extent of client need and to be willing and able to prescribe what is being asked for/needed. According to one physician: "*I don't nickel and dime over a milligram here and there*" For clients, whose medications and dosages are not working, it is important to continue to work with them to find solutions. "*The period when they become disengaged can increase risk for overdose."* "*What matters is that we keep showing up and they keep finding us here*."

> *"Safer supply programs offer an opportunity to listen to people; it is a shift in the typical paternalistic approach in medicine."*
>
> *"NOT to be supportive of prescribing what the client needs; this may be also a barrier for retention in care for those who need it most."*
>
> *"If you give strong doses (because the needs are extremely high), you receive more benefit and patients will remain engaged (whereas, if you prescribe too little, you risk losing the client because it doesn't work for them)."*

Clients especially appreciate the steady, predictable supply of drugs with known and consistent dosages. "*You know exactly what is in it and how it will react*." Within the parameters of the program, they are working out the approaches that work best for them. "*People can own their process, within safe parameters."* For example, some who receive hydromorphone tablets started off injecting and have slowly transitioned to taking them orally. Some now use tablets exclusively, others do both. However, for many, the tablets do not create the same experience and

[4] College of Physicians and Surgeons of Ontario (CPSO) *Advice to the Profession: Prescribing Drugs (*on safer supply opioid prescribing (Dec 2020); *Risk Mitigation in the Context of Dual Public Health Emergencies* (March 2020); *Safer Opioid Supply Programs (SOS): A Harm Reduction Informed Guiding Document for Primary Care Teams* (2020); *National Injectable Opioid Agonist Treatment Guideline* (Sept 2019); *Toolkit for Substance Use and Addictions Program Applicants* (2019).

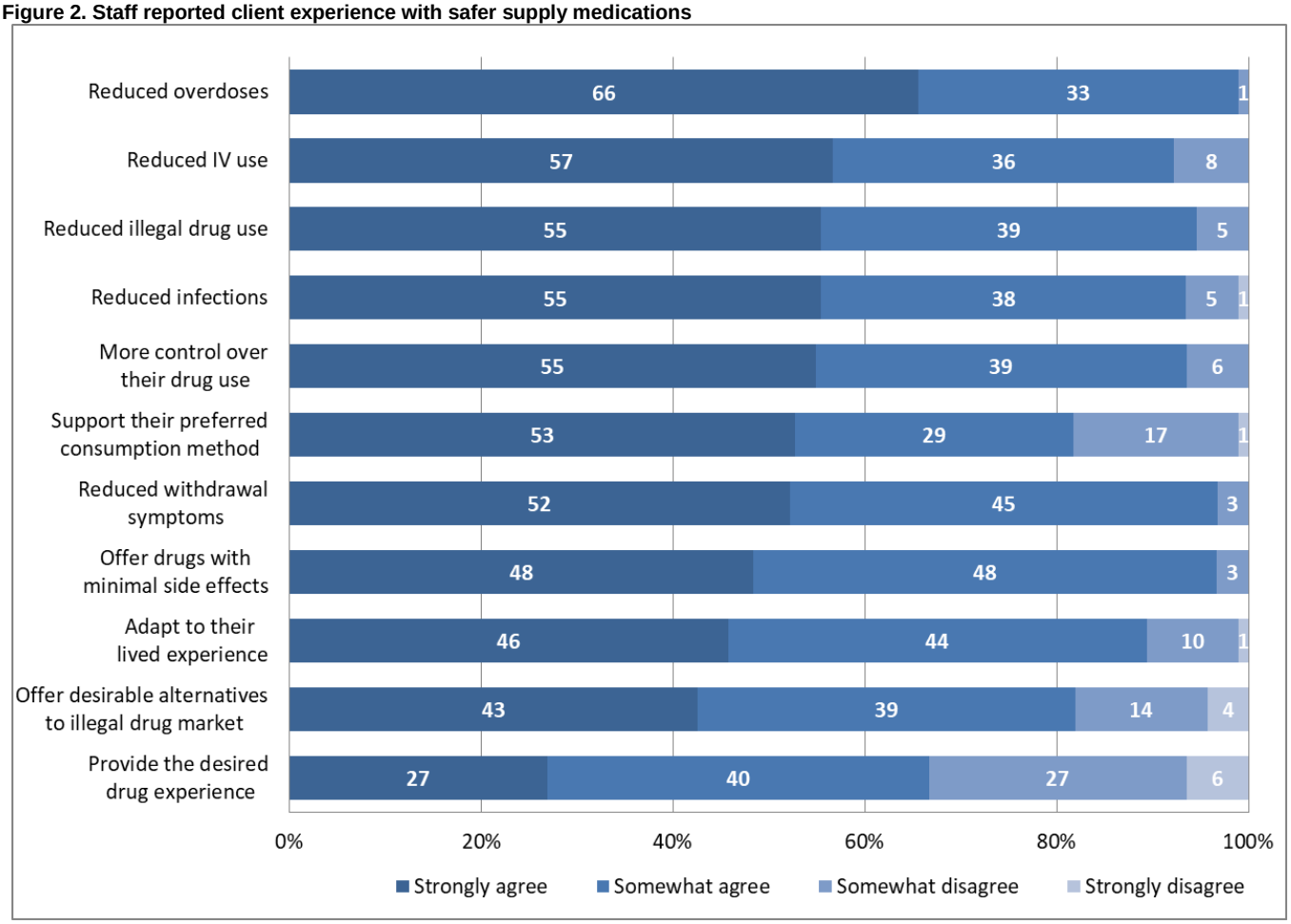
effect as injecting. Nonetheless, the ability to balance injection with taking tablets orally is important to some. Those who do both tend to inject in the morning and take the tablets as needed throughout the day. Some set dosage goals for the day or use as needed to manage withdrawal symptoms. "*I take them at random times. I eat a bunch when I get really sick*." Clients also manage their doses through the day to ensure they still have some for the next morning before the pharmacy opens.

"People who use drugs can manage their own drug use, set their own goals, figure it out for themselves and it is respectful to put it in their hands. They are alive, so have the skills to use."

Staff Opinion on Client Experience with Safer Supply

Staff survey responses reflect the qualitative input provided by clients and staff. Almost all program staff *strongly or somewhat agreed* that the safer supply program has reduced overdoses. At least nine in ten *strongly or somewhat agreed* that the program was associated with reduced injection, illegal drug use, withdrawal symptoms, infections, and side effects. While most staff agreed, others *somewhat or strongly disagreed* that their safer supply program adapted to clients' lived experience (11%), supported their preferred consumption method (18%), offered desirable alternatives to the illegal market (18%), and provided the desired drug experience (33%) (Figure 2). Reasons for these findings are outlined in the Safer Supply Medications Challenges section below.

Figure 2. Staff reported client experience with safer supply medications



Safer Supply Medication Challenges

Analysis and Summary of Key Findings

The safer supply programs are struggling to manage clients' tolerance levels as a result of their fentanyl use. They have identified several additional medications that are required to counter fentanyl, as well as other substance withdrawal. Access to the desired medications has been hindered by the regulatory environment, lack of coverage by provincial formularies, and supply interruptions (with generics proving to be less effective).

Some clients are finding observed dosing and daily pick up time consuming and inhibiting to their daily lives. Programs would benefit from documented guidance on how best to safely execute both tablet and injectable carries and increase client freedom and control.

Urine drug screens are used differently among the programs, with some using them mainly to determine whether to remove or reduce safer supply and others mainly for surveillance of the content of illegal street drugs. While some clients do not mind providing a urine sample – especially for alerting them to what is in the street supply – others find it punitive.

While most programs have a standardized approach to missed doses and restarts, they vary greatly. Some clients' medications are stopped for a period of time; others' dosages are reduced (sometimes one drug and not others). This process is challenging for clients with unstable lives or while seeking to establish a regimen that works for them. Some have overdosed while their dosage has been stopped or reduced. Some programs do not have immediate ramifications for missed doses. They work with clients and may change or increase their medications.

Diversion is taking place. Some programs remove clients from the program for diversion. However, there is a number of reasons for diversion, including inadequate dosages or safer supply options, limited access to safer supply programs (and thus demand on the street), needing to meet other basic needs or providing support to a friend. It was shared that, with diversion, someone is still accessing an uncontaminated medication and lives are being saved. However, there is concern that these drugs will be accessed by those who do not currently have an opioid use disorder.

An explicit step-by-step approach to missed doses and suspected diversion and clear messaging about the approach that will be taken – including pathways for transitioning clients who are removed from the program – is recommended. The approach should consider all factors that may lead to missing doses and diversion.

Tolerance

"For those who have been using fentanyl, their tolerance is such that even maximal doses of Dilaudid have little effect except withdrawal management. This leads people to continue to use street fentanyl, as the Dilaudids do not approximate the effect they get from fentanyl."

The toxicity of the illegal drug supply has made the safer supply medications that are available – their formulations and potency – inadequate for meeting many people's tolerance levels. COVID-19 has exacerbated the situation. Program staff expressed great concern about the increasing toxicity of fentanyl, the variety of substances found in street drugs and the looming risks associated with carfentanil use. **"***Fentanyl with a wide variety of other substances mixed in and high fentanyl and benzodiazepine street supply creates two medical interventions as both cause withdrawal*."

While hydromorphone with or without a Kadian or methadone backbone is helping many clients, these medications generally do not create a euphoric effect for clients, but help many manage their withdrawal symptoms. However, for several clients, their current safer supply medications and/or dosages are insufficient to counter fentanyl withdrawal. These clients have not stabilized on these medications and find them inadequate. Some programs do not provide hydromorphone at sufficient dosages to meet clients' needs – their caps are too low. In other instances, even the maximal doses of hydromorphone do not work. "*Options and maximal dosage do not always provide relief/effective treatment to clients' symptoms/use."* Programs experience challenges *"prescribing doses that are aligned with the daily need of the client*." For some clients:

> *"I barely feel it [hydromorphone]; it's like taking an aspirin after morphine."*
>
> *"It's not effective. I don't feel it. It barely helps with dope sickness and cravings"*
>
> *"Fentanyl is a monster compared to Dilaudid and heroin – they're a mouse"*

Several programs are now offering fentanyl patches for those who have been unable to stabilize on hydromorphone. The patch is started at a standard dose and can be titrated up weekly. It may be offered instead of or with a titrated down hydromorphone dosage when it replaces an existing backbone of Kadian or methadone. Most programs only provide this option for those with concurrent chronic pain and have a two physician approval process.[5] As well, prescribers may also need to adhere to their regulatory college's advice related to prescribing fentanyl patches.[6]

Clients and program staff alike identified gaps in the medication options available – including additional PRN (as needed) and titration options – and the additional ones required. Several clients wanted the addition of a Kadian backbone if they were not on one or a fentanyl patch. Program staff identified the need for better options for people with high fentanyl tolerance, as well as those who use stimulants and smoke/inhale. *"It would be excellent to be able to provide medications such as diacetylmorphine and/or fentanyl that could better match the tolerance of participants."* The additional pharmaceutical-grade medication requirements identified included:

- High dose injectable hydromorphone
- Medical heroin (diacetylmorphine)
- Injectable morphine
- Fentanyl (powdered, injectable, buccal tablets (Fentora), patches (250, 500 and 1000 mg))
- Oxycodone (Percocet, OxyContin)
- Amphetamine (Ritalin, Adderall)
- Sufentanil (Sufenta)
- Methamphetamine (Desoxyn)
- Cocaine

Drug Regulations and Policies

Clients and safer supply providers are experiencing barriers to accessing some of the desired safer supply medications listed above due to the federal and provincial regulatory environment. Some of the medications provided – and several the programs would like to provide – are not readily available in Canada, approved for the treatment of opioid use disorder or covered by provincial/territorial formularies. Primarily, the medications identified in this regard are injectable formulations of hydromorphone and diacetylmorphine and various forms of fentanyl, as well as other opioid and stimulant substitutes.

The medications provided through the safer supply programs are regulated under the federal *Controlled Drugs and Substances Act (CDSA)* and its regulations. Within this regulatory framework, physicians and nurse practitioners can "*prescribe, administer, provide and sell*" controlled substances and the prescriber is required to be in a care relationship with clients, as is the case with the safer supply models. Safer supply clients generally access their medications from a community or on-site pharmacy. Based on the regulations under the *CDSA*, pharmacists can "*dispense, provide and sell*" these drugs pursuant to a prescription.

The federal government has reduced barriers to accessing some safer supply medications. For example, Health Canada approved an injectable formulation of hydromorphone for the treatment of severe opioid use disorder in adults in May 2019. However, hydromorphone tablets, most frequently available through SUAP-funded programs, have not been approved for this indication. Currently, oral hydromorphone is only approved for use for relief of moderate to severe pain. A pharmaceutical company has not submitted an application for its treatment of opioid use disorder. If such an application were received, it would be assessed by Health Canada on the basis of the evidence of safety and efficacy provided in the submission. Injectable diacetylmorphine is an established standard of care in countries such as Belgium, Denmark, Germany, the Netherlands, Switzerland and the United Kingdom.[7] In 2019, the federal government added it to the *List of Drugs for an Urgent Public Health Need,* enabling provinces or territories to import it for the treatment of opioid use disorder. However, it is not yet widely available in Canada.

Provincial and territorial governments have most of the responsibility for delivering health and other social services. As such, they determine which drugs are included on their formularies and under which circumstances. Prescription drug coverage varies by province and territory. In Ontario, hydromorphone tablets are covered in the

[5] Parkdale Queen West CHC, *Fentanyl Patch Policy and Procedure*
[6] For example, College of Physicians and Surgeons of Ontario (CPSO) *Prescribing Drugs* (December 2019)
[7] Maghsoudi N, Bowles J, Werb D. *Expanding access to diacetylmorphine and hydromorphone for people who use opioids in Canada*. Can J Public Health. 2020 Aug;111(4):606-609

formulary, but high-dose injectable formulations of hydromorphone and diacetylmorphine are not. In British Columbia, the medications identified in the risk mitigation guidance – developed for clinicians who are supporting people with substance use disorder during the pandemic – are generally covered by Pharmacare. However, this does not apply to all safer supply programs. At least one program has to pay for the hydromorphone tablets it provides with its SUAP funding. Dispensing fees are also expensive ($10 each). To reduce costs, the program worked with a community pharmacy to secure lower pricing. The program also investigated offering less frequent dosing to reduce the cost, but was unable to given the regulatory requirements for managing narcotics. New Brunswick has approved the use of injectable formulations of hydromorphone under strict conditions. Additionally, many of the other desired safer supply medications are prescribed off-label (i.e., use for an unapproved indication).

Provincial and territorial ministries of health are also responsible for regulating the health care providers in their jurisdictions. But, it is the regulatory colleges that are responsible for ensuring health care professionals comply with regulatory requirement and provide services in a safe, professional and ethical manner, including through issuing practice guidelines. While there is currently "guidance" and "advice," there are no official guidelines from professional colleges for prescribing opioids or stimulants as a pharmaceutical alternative to the illegal drug supply. This has created challenges for safer supply prescribers. Programs reported that "*prescribing off-label and outside of existing guidelines has left some prescribers concerned that they will be held to criminal, professional and medicolegal liability*." In the absence of guidelines for prescribing controlled substances for safer supply, prescribers document how they follow standards of care, apply the evidence, adhere to research protocols and follow practices of their peers.[8] Additional challenges related to professional regulatory colleges and prescribing and dispensing are discussed in the section entitled "The Professional Regulatory Environment" below.

Supply Interruptions

"Due to a drug shortage we are having to prescribe the generic hydromorphone over the brand name Dilaudid which is easier to prepare and inject."

Programs and their clients have experienced challenges with drug supply interruptions, including shortages of Dilaudid, Kadian and Suboxone. Due to these shortages, some clients have received generic replacements which they have found are not as effective or desirable an alternative. With generics, clients reported a different drug experience and withdrawal. As well, Dilaudid is easier to prepare and inject than generic hydromorphone.

Some of the shortages have been associated with COVID-19. In response, programs have gathered data from across the country to show the current and anticipated demand. Provinces monitor shortages and work with Health Canada and the supply chain to address shortages.[9] In March 2020, the federal government enacted measures to make it easier to import some safer supply drugs and continues to work with stakeholders to address these drug shortages issues.

Client Time Requirements

"It continues to be a struggle for participants to not feel like their time using drugs/looking for funds for drugs hasn't just been switched to time with medical appointments."

As reported above, most safer supply clients pick up their medications daily from a selected pharmacy. Some want longer carries because they were getting their lives back on track and are still tied to a daily schedule that revolves around drugs. Those with observed dosing may visit the program site several times a day. For clients who are employed or panhandle, the daily schedule can affect their income. *"The experience would be improved by not having to come as often." "Coming twice a day – it's bothersome – I have a life."* Notably, other clients have found the daily schedule helpful, especially if they experience depression. Going to the pharmacy each day "*creates a routine. I get up, get dressed and wash and get out – it's a pleasant walk*."

Clients who do not live or work in close proximity to the pharmacy and safer supply site have experienced challenges with public transport and getting downtown in time for their pick up or first and/or last daily dose. A couple of clients reported challenges with travel to see families and friends. They were unable to transfer their prescription to another city or extend it while away. One found themselves having to seek out street drugs.

[8] Safer Supply Implementation Task Team. *Considerations and support tools for establishing safer supply pilot projects in Canada*. July 2019.
[9] Online at https://www.canada.ca/en/health-canada/services/substance-use/toolkit-substance-use-COVID-19/frequently-asked-questions.html

The number of carries is not limited by federal regulations, but there may be provincial or territorial guidelines or policies that practitioners and pharmacists must follow. Program staff suggested more support and documented guidance was required on how to best execute both tablet and injectable carries in order to maximize client control and freedom (their not being "*shackled to the health care system*") while maintaining safety. "*There is also a lack of clear guidance on carries for individuals (after a period of time as they stabilize, we need to look at how we improve options for carries for them). This allows us to actually improve their quality of life and support them in moving forward in their life (maintain a job, etc.)*."

"Urine drug screens, daily pick-ups/lack of carries, and short prescription durations are barriers to access and tools of surveillance which reinforce the lack of trust PWUD have in health care systems that have marginalized them"

Injectable Hydromorphone

There are challenges unique to injectable hydromorphone (iOAT). Given that clients come for their doses at regular intervals during the day, some struggle with the time requirements and hours of operation discussed above. For example, "*we see, daily…patients having to wait for medications dispensed at 10am when they have been in withdrawal since 6am. This just is not appropriate or feasible as a way forward, especially since carries are so difficult/highly regulated*." As well, receiving to injectable hydromorphone as a pre-packaged single vial is difficult for clients who require two to three injections at a time. They would prefer one injection. One program is investigating purchasing larger hydromorphone vials and having nurses (observing each other) draw requisite dosing. As this is within a licensed practice nurse's scope of practice, it is also a cost-saving compared to the cost of a pharmacist. As well, many clients are both injecting and taking their hydromorphone tablets orally. For convenience and to support evolving away from injecting, there should be options for a combined prescription of injectable and tablet medications.

Only four of the safer supply programs currently provide injectable hydromorphone. These programs work closely with a local or on-site pharmacy to dispense these medications. However, offering injectable hydromorphone entails costs over and above oral formulations related to storage, refrigeration, compounding, dispensing, client support and additional human resources, e.g., pharmacists, nurses and SCS staff. The *National Association of Pharmacy Regulatory Authorities* (NAPRA) provides guidelines for compounding and dispensing these preparations, requiring specialized equipment and procedures to be followed. Colleges of pharmacists also have regulations for compounding based on NAPRA's standards. Injectable hydromorphone (and diacetylmorphine) can be dispensed by a NAPRA-compliant pharmacy through advanced compounding and preparation of doses provided directly to the client or delivery in single-use vials to safer supply sites. However, because the required infrastructure requirements and procedures (e.g., negative pressure sterile hoods) are costly, many community pharmacies choose to forgo advanced compounding.

Missed Doses and Restarts

"We are not serving the number of people we had planned to because our patients are highly complex and are frequently missing doses and follow-up, thus aren't "stabilizing" to less frequent visits."

In addition to the many challenges experienced by people who use drugs, COVID-19 and housing and shelter issues have created "*instability that translates into difficulty maintaining engagement and so having to restart with people repeatedly*." For some clients, such challenges account for missed doses. For others, it is finding a regimen that works. One client reported that "*it took a while to get to the spot that works – lots of misses and restarts*." When clients miss doses, some have to stop their medications and then restart and titrate back up later. When clients have to restart, titrating back up too slowly creates hardship. Some have called it "*punitive*" and "*anti-harm reduction*." Many experience withdrawal, some resort back to or increase their use of street drugs, and some have overdosed during that time.

The safer supply programs' approach to missed doses varies. Most have a standardized approach. Some say they seek to have a "*consistent and predictable trauma informed framework*" and to have a "*warm welcome*," yet have clearly stated parameters and rules – "*rules with explanations.*" Some have been informed by client input.

Programs also have policies about lost doses. For example, in one program, a lost or stolen dose will only be replaced twice. (One program offers locked boxes to help mitigate this).

When clients miss their doses for two to four consecutive days, they are assumed to have a decreased tolerance. Pharmacists are requested to contact program staff if clients miss their daily pick up for a given number of days. The prescriber will then assess the appropriateness of resuming, restarting or changing medications. In many programs, clients have to restart. Some are temporarily cut off and can restart after a given period of time. Others' dosages are reduced – either for all medications or for one but not others (e.g., reducing Kadian or methadone, but not hydromorphone). Some programs do not immediately reduce the dosage after missed doses and take an explicitly non-punitive approach to working with clients where "*missed doses or assessments…are addressed through dialogue and support and will not result in discharge from the program*." In one program, missing days does not result in a reduction in the client's maximum daily dose. The prescriber is notified after 14 days.

Requisite urine drug screens (UDS) are applied differently among the safer supply programs. Some use them mainly to monitor continued safer supply eligibility based on whether other drugs are detected and/or the safer supply is not. In some instances, if the safer supply is not detected, it will be removed or reduced. Other programs emphasize their use for determining what is currently in street drugs to keep the community informed about their content and toxicities, and to support discussions with clients about their other drug use and diversion.

Opinions differ on the application of urine drug screens. Some program staff reported that urine screening is time consuming, and for those who predominantly provide outreach services, it is difficult to find a place to get a sample and it affects their relationship with clients. One staff member suggested offering observed doses as an option for removal of the urine sample requirement. However, it is important to note that as part of their college regulations, prescribers are required to monitor the drugs they prescribe.

> *"It's as if physicians are being forced to actually criminalize their patients [who use drugs] – requiring [urine drug screens] UDS, stopping scripts if these aren't provided, or stopping scripts if the patient's UDS is negative for the safe supply drug they're prescribed (which perhaps is because of episodic use, diversion as a protective strategy, etc.)."*
>
> *"Many report decreased reliance on the illegal market. Some have stopped using fentanyl altogether. Others tell us that they experience less withdrawal/dope sickness. That should count more than the results of a urine drug screen."*

Methadone/OAT Programs

Program and clients from across the country reported having had issues with some methadone/OAT prescribing physicians who have expressed concerns about safer supply program to them. Clients have been contacted directly by their OAT prescribing physicians and told that safer supply "*is not appropriate*," "*would not benefit me*" and "*you will come back with your tail between your legs*." Some stated it is unproductive for clients to feel threatened in this manner. OAT prescribing physicians with concerns may require more education about safer supply. However, some practitioners working in the field suggest that because they are remunerated well for providing OAT services, they may have an incentive to deter clients from the alternative safer supply service.

Diversion

"Recognize [diversion] will be a part of the program regardless to how you implement. Consider options for management, communication to clients, community members and internal teams."

Some diversion of safer supply medications is occurring. According to clients, there is more Dilaudid on the street and the price has dropped. Diversion is of concern due to potential harms of increased hydromorphone on the street and impact on prescribers' license to practice. There may be several reasons why diversion is occurring. The main reason reported was that the medications offered were not working for clients due to insufficient dosages of hydromorphone, a lack of combination or backbone treatment, slow titration and the inadequacy of generics. "*If they need to sell what they are getting it is because there are lots of things that still need to be addressed, probably that the safer supply is not yet right for them (i.e., not enough, not the right drug, etc.)*." As well, there is inadequate access to safer supply programs (thus increased demand on the street) and some clients are supporting friends or being pressured to sell. "*Clients are being targeted/ aggressively pressured to divert their SS [safer supply] prescription. This was reported more when there were fewer clients enrolled in the program*."

"People who use drugs take care of each other. When drugs are shared, sold, or exchanged, it is often about providing care and meeting basic needs. Many participants...self-referred after accessing "diverted" safe supply. It was a gateway for them to seek out their own safer supply. Rather than punishing people for their hard-earned resilience and survival skills, safer supply efforts should seek to understand how drugs are actually used in communities and to respectfully engage people from that understanding instead of a 'War on Drugs' mentality.[10]"

Some contend that even though there may be some diversion, someone is still accessing an uncontaminated medication and lives are being saved. Some clients started using a safer supply of hydromorphone on the street before formally entering the program. Some prescribers express concern about people without an existing opioid use disorder having greater access to Dilaudid; but others point out that at least it is not fentanyl. Moreover, if clients are diverting some pills to purchase fentanyl, they are potentially involved in less criminal activity to secure money to purchase drugs.

Some programs reported concerns and challenges related to diversion; others did not. Some are more punitive towards clients than others in this regard. If clients are found to be diverting (e.g., via no hydromorphone in their urine), some programs remove their safer supply. Others first attempt to work with the client to address the issue. Some may reduce the dosage, require more frequent visits or switch to observed dosing. Others may increase the dosage of hydromorphone for people trading/selling in order to buy fentanyl or add another medication (e.g., a stimulant) if they are trading for meth or crack.

Some programs recommended having an explicit step-by-step approach to suspected diversion and clear messaging about the approach that will be taken, including printed materials and posters in waiting rooms.

It is important to consider the ramifications for clients removed from the program, especially if they are not supported in a transition elsewhere. "*Clients who are discontinued from the program (typically for diversion/or behaviour) report receiving little support during the transition, with increased risk of negative outcomes on their physical and mental health. This may include an increase in overdose, reverting to harmful behaviours that assist in securing a new drug supply (violence/theft, etc.)*."

Safer Supply Team Members

Analysis and Summary of Key Findings

Team members communicate well and work collaboratively, with a few exceptions. They work together to find solutions for their clients and have introduced a number of innovative practices.

The core team that generally works together includes: a physician or nurse practitioner; a registered nurse (RN) and/or registered/licensed practical nurse (RPN/LPN); and a case, social, community health, harm reduction or peer support worker. Clients are very appreciative of the safer supply staff, including the respect and attention they pay.

Peers play many roles and are important to program success. Their participation is also beneficial to themselves. Their roles should be tailored to and align with their life experience and stage of recovery, with consideration to their self-care, resilience, training and capacity building needs. Standards and guidelines would support the effective recruitment and retention of peer support workers, including defined goals, expectations and outcomes, best practices and mentoring.

Most programs have insufficient funding for the number and type of staff needed to meet the overall demand for services and adequately meet the needs of current clientele. Staff-to-client ratios are low. Many work long hours, are unable to take time off, are experiencing stress and trauma, and are burning out. Programs would benefit from more of each type of provider. Several have met challenges recruiting staff.

Programs should ensure that staff have access to adequate team building, capacity building and mental health supports. Clinical training, whether initial or continuing education, needs to better address and develop skills in harm reduction, anti-oppression and anti-stigma approaches to care.

"After a lifetime of struggling to be heard and validated, I am seen as an individual case, not just another junkie. I finally have a group of people who see and hear me."

[10] Victoria SAFER Initiative, *Top Ten.* 2021

Almost all clients are extremely complimentary of the safer supply staff. They were said to be "*amazing*," "*open*," "*knowledgeable*," "*informative*," "*very kind*," "*attentive*," "*respectful*," "*sensitive*" and "*cool*." They make the clients feel "*comfortable*" and "*at ease*," while working to gain their trust. Clients appreciate that staff try to be available when needed and take the time required to discuss their concerns without their fearing stigma or judgement.

> *"They go above beyond call of duty."*
>
> *"I never expected this type of health care. I appreciate it, as I never had this kind of help."*
>
> *"They do everything in their power to accommodate."*
>
> *"They know who we are and what is going on in our lives."*
>
> *"They ask how you are doing – they pay attention and care."*

A couple of clients felt their provider was not listening to them. These individuals reported that the safer supply they had been prescribed was not working at all to address their fentanyl addiction. They were requesting a higher dosage of hydromorphone with a Kadian backbone or a fentanyl patch.

Team Members

The types of team members listed below provide and support safer supply services. Many, but not all, have been hired with SUAP funding. Staff are a mix of full time and part time employees. Among staff survey respondents, 61% were full time and 39% were part time. Most of the nurses, outreach workers and case managers are funded through SUAP. Where the safer supply program is integrated with primary care services, additional providers (e.g., nurses, social workers) may also be providing services as part of the program. In instances where nurse practitioners are prescribers, they generally work full time with the safer supply program. All programs have at least one registered nurse (RN); many have registered/licensed practical nurses (RPN/LPN). Several have an RN as the clinic manager or clinical lead. Many of the services with Indigenous clients have Elders on staff to address trauma and provide spiritual healing. The physicians may or may not be remunerated using SUAP funds and generally work part time with the safer supply program. For example, one program has five physicians who share a weekly rotation, including on-call support on weekends and holidays.

Physicians and nurse practitioners (prescribers)	
RNs, RPNs, LPNs	Program managers
Outreach and community health workers, many of whom are peers	Medical director
Social worker and counsellors	Operations
Case management	Research
Care/health navigators	Medical office assistant
Cultural worker/Elders	
Pharmacy	

The core team that generally works together to provide services to each client includes: a physician or nurse practitioner, an RN, RPN or LPN, and a caseworker, social worker, community health worker, harm reduction worker or peer support worker. All are critical to client support and care.

Peer Support Workers

"Our outreach workers are hired specifically for their lived/living experience of criminalized drug use and are an invaluable part of our team. They are the "face" of the program, often being the first point of connection with participants. They bring authenticity, knowledge and skills around harm reduction, accessible health care practice, and respectful communication with a population that faces immense stigma, discrimination and structural violence."

Including people with lived experience is critical to program success. Peers may play various roles in safer supply programs, including:

➢ Community relationship building, including gaining feedback on service needs, spreading the word and providing education ➢ Guiding service development ➢ Participating in team meetings ➢ Outreach for client engagement and recruitment ➢ Role model ➢ Supporting the front desk and in the waiting room ➢ Liaising with other program staff and clients ➢ Collegial one-on-one support and guidance ➢ Leading wellness and empowerment groups	➢ Case management ➢ Referrals ➢ Accompaniment and advocacy during appointments ➢ Paired service and medication delivery ➢ Outreach and visits to home or encampments ➢ Providing harm reduction supplies ➢ Securing basic necessities food, water, clothing ➢ Support finding housing ➢ Support getting identification, health cards, etc. ➢ Charting and documentation

Peers play an important role in outreach, relationship building and case management. Clients express appreciation for the support they receive from peers. Many have had bad experiences with the medical system in the past. "*Participants feel more comfortable and more relaxed with people who have lived through the same experiences and can respond to them in a more personal way*." "*Talking to people who have been through it is it invaluable. It creates a bridge of trust*." Peer support work is also "*a valuable way for people who use drugs to be part of their community*." Some peers have pre-existing relationships with clients, which goes further to build trust. "*I've been in jail with many of them, homeless with them, used with them, spent winters outside with them…. Some, I have known for a long time and they've been there for me – this is an opportunity to return the favour*."

Program staff emphasized the importance of peer workers and including people with lived experience in service delivery, and several suggested more were needed. Importantly, peers can be a voice for clients and help other service providers better understand their experiences, perspectives and needs. They have "*created more dialogue and honesty between participants and providers about drug use*." "*The knowledge we get…can often be used to change practice and benefit other clients on the program*." However, one peer worker reported that they sometimes felt left out and that their views were considered secondary to those of nurses and doctors. "*It usually it ends up that the peer is right and because they've experienced it in their prior life to working here and that's why that knowledge is important*."

Peer workers described the multiple roles they play, the fulfilment of the work and they ways in which it has influenced their lives. Nevertheless, there are important considerations when introducing peer support services and integrating people with lived experience into the team. Some programs experienced challenges maintaining their peer-based programs due to limitations imposed by COVID-19. Others found it difficult to find people with lived experience who had work experience. Some needed to recognize that processes like "*timesheets or workplace rules can be a challenge*." Additionally, it can be difficult to provide peer workers with the support they need to succeed in their role because they may not have the same resources as other staff members, e.g., stable housing, family support, adequate transportation, etc. Care needs to be taken so that they are not re-traumatized or exploited. According to one team member, "*I have managed harm reduction for many years. The inclusion of people who use drugs is very important and fundamental. But it can be done poorly and could be exploitive if they are not given enough support*."

Safer supply programs would benefit from standards and guidelines to support the recruitment and retention of peer support workers, including defined goals, expectations and outcomes. Their roles should be tailored to and align with their life experience and stage of recovery, with consideration of their self-care, resilience, training and capacity building needs. Some programs are currently "*evaluating and redesigning the peer support program to better assess suitability of peers in different settings, what training and ongoing support would help optimize peer support delivery."* Newer programs can learn about integrating peer roles from longer-standing programs, including peer mentoring and best practices.

Teamwork

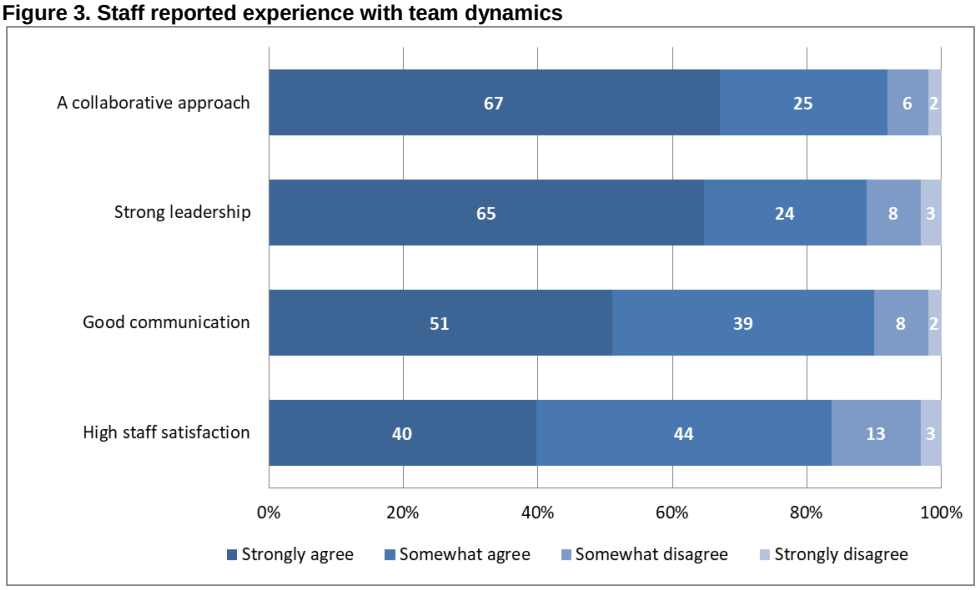
Many safer supply teams have established effective ways to work. They have flexibility in their roles, with team members working to their full scope of practice and through directives and order sets (e.g., LPNs drawing injectable doses, outreach workers providing wound care, collecting urine samples and developing care plans, and nurses conducting assessments and providing primary care). According to staff:

"Our team works incredibly well together to provide wraparound services. We've implemented a strong foundation for our team-based approach, including client discussions, regular review of high risk patients and priority intake."

"Key successes related to staffing have included the benefits of a multidisciplinary team where team members have diverse perspectives and common goals. The team is well-rooted in community harm reduction practice, has a keen social justice analysis, and have established open modes of communication and support."

"The team complement is presently navigating and breaking down systemic, oppressive barriers to provide service to folks...through education and approaches in collaborating."

Figure 3. Staff reported experience with team dynamics



In the staff survey, in relation to their team, approximately nine out of ten safer supply project staff *strongly or somewhat agreed* that as a team they had a collaborative approach, strong leadership and good communication. Somewhat fewer agreed that there was high staff satisfaction. Those who disagreed tended to be from the same sites (Figure 3).

Teams work together to find solutions for their clients and have introduced a number of innovative practices. Examples include conducting strategic outreach, developing formal and informal networks, securing referrals, helping clients navigate social services (e.g., housing, income supports and health cards and identification), offering telephone and video services, and providing services in the field, (e.g., at harm reduction sites or encampments).

Staffing Requirements

All sites reported insufficient staff to meet the demand for services. They cannot provide the extent of care needed by current clients or take on new clients. Their client-to-staff ratios are too high (up to +/- 90:1) to adequately support individuals with high needs (such as those experiencing homelessness, mental health conditions, medical complications, outstanding legal issues, street involvement, high risk of overdose). Some are still adjusting their staffing roles and trying to establish a workable client-to-staff ratio. To work within its budget, one program had to lay off a social worker in order to fund an additional nursing role to meet its clinical requirements.

"We have one case manager/community health worker per site. Given the social complexity of the clients, this creates an enormously heavy case load for each worker. We desperately need funding to hire additional wraparound support team members, e.g., case managers, health navigators, harm reduction or overdose prevention workers. This will also balance out the team in terms of the clinical/social balance. Really, we need more of EVERY role."

Several programs need more prescribers. Many only have one prescriber on site at a time. Having scheduled appointments has created challenges and greater flexibility is needed. Staff suggested that having one prescriber to do booked appointments and another doing walk-ins would be ideal. Another suggestion was to collaborate with other programs and have larger teams within the same site or develop new models for collaboration. As well, more physicians are needed to prescribe safer supply so that clients who have stabilized can be supported and safer supply prescribers can continue to take on additional new clients.

Some programs had not anticipated the extent of clinical and non-clinical work required, e.g., working with pharmacists and the requirements for prescribing a backbone. Prescribers have several tasks in addition to appointments; they need to "*respond to several emergencies during clinic day in addition to a full schedule*" They

are required to "*manage the overwhelming number of pharmacy inquiries*" and "*answer calls from pharmacists when a patient has missed doses, entered detox, is sick at home in isolation, needs to leave town, is banned from a store for stealing something, and the list goes on*." They frequently work outside office hours to meet the needs.

> *"Time management has also been a constant challenge for our team...because the need is so great and so urgent amongst our participants."*
>
> "And the stakes are high: *Somebody walking through the door looking for care sometimes takes a lot of courage, and we want to capitalize on this patient's initiative. I've seen a patient walk through the door outside clinic hours, after being MA for about a month, and I reluctantly had to beg him to come back the next day. I haven't seen him since."*

Several programs reported that they needed more staff in several roles, including more capacity to increase the extent of wraparound services. They underscored the importance of the community outreach, social work, harm reduction and case management, as well as the complexity and time required to provide the health and social services required. These roles are especially important in the programs where the prescriber does not know the client as well.

Some programs are experiencing challenges recruiting staff. Safer supply programs need staff who are the right fit and have harm reduction and cultural competencies, including for racialized, Indigenous and immigrant populations. Some standalone programs have experienced challenges hiring part-time physicians on a fee-for-service or sessional basis because of the payment structure and on-call requirements. As well, there are shortages and it has been challenging to attract staff without permanent program funding. For example, nurses are in high demand and there are shortages, especially of those with harm reduction experience. Some programs, especially those not based within primary care, appreciate having nurses with critical care experience (e.g., emergency department and intensive care unit) who understand the administration of opioids and the diagnosis and treatment of acute medical conditions (e.g., abscesses, sepsis, endocarditis, overdose).

Programs also should be able to employ casual staff to cover staff sick and vacation time. Need is also high after hours and prescribers and other staff at some programs are on-call evenings and weekends. Cross training staff to fill roles (e.g., nurse practitioners, nurses and community outreach workers) was suggested to address the need for vacation, sick leave and emergency leave. There is little or no back up support for prescribers. Several have been unable to take time off. Critically, they do not have back up support from other physicians in addiction medicine and family medicine, sometimes even in the same organization. *"This problem would be rectified by compensating staff for on-call hours, this way we could create a schedule. Also having a budget for locum coverage when someone needs to go on vacation or is sick. Unfortunately, there are no locums I know of that would feel competent to prescribe safe supply, so this solution might not be available immediately. Therefore, I think it would be best to hire another full time prescriber and train them, but there is no money for that."*

Staff Stress, Wellbeing and Support Needed

Some program leads spoke about the burden on program staff, including the heavy workload, long hours, limited backup, level of responsibility, ethical dilemmas, safety issues and emotional toll. Some staff are experiencing stress, anxiety, trauma and burnout.

> *"The entire staff...are beyond exhausted and carrying enormous grief and anxiety due to significant losses in the community and worry about the sustainability of the program"*
>
> *"Challenges have been the nature of the work – it is very difficult to act as a witness to ongoing systemic violence and oppression and this undeniably takes a toll of on frontline workers."*
>
> *"Our teams are EXHAUSTED. COVID-19 impacts their ability to do their work (e.g., service restrictions) and also impacts their personal lives (e.g., children at home). There is stress of lockdown on personal level, as well as professional level."*

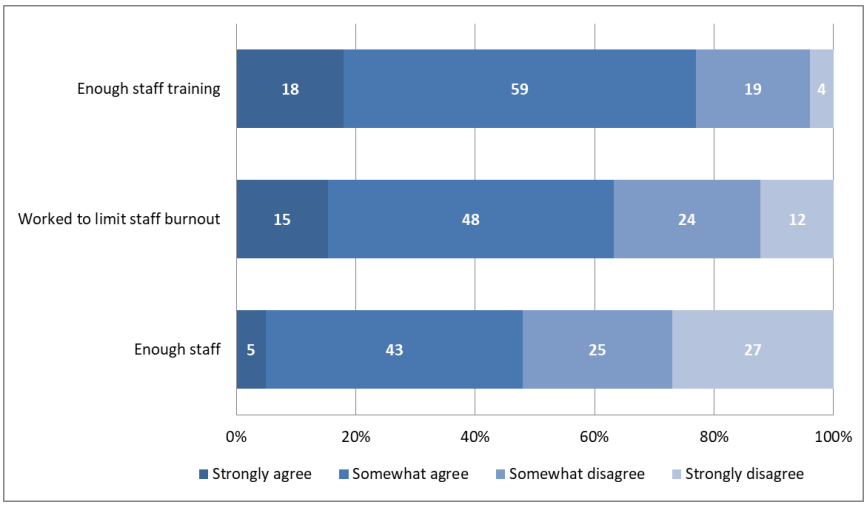
Being in a high stress environment can, at times, lead to interpersonal conflict. Some sites have consciously implemented team building and conflict resolution processes. Some hold regular team meetings and smaller huddles. Programs have also worked to build a workplace environment that supports staff, including wellbeing, counselling and grief supports. One site reported a support group for peer outreach workers to ensure they are supported and their emergent needs (e.g., housing, medical, mental health) are addressed. Some staff believe additional support is required. "*There is a need for increased psychosocial support for staff and in particular, supports that are informed by anti-oppressive practice and an advanced understanding of harm reduction*

practice—this is very difficult to find via typical Employee Assistance Programs and other affordable counselling options, for example."

Staff have suggested additional skills building and training are needed to address the above concerns, as well as to improve their technical and critical thinking (e.g., ethically challenging scenarios) skills for providing harm reduction, safer supply and overdose response services, as well as other health care services. *"There is so much stigma in the system that needs to be addressed. In one physician's experience, substance use disorders were not addressed in medical school except the pervasive belief that you have to be 'prepared' to deal with addicts (i.e., 'addicts lie').Those are the kinds of attitudes that are out there in the system and being perpetuated. More training, support and ongoing information need to be provided."*

The staff quantitative survey results echoed the answers provided in the open-ended questions and program interviews. Teams are struggling with insufficient staff, training and burnout. Only 5% *strongly agreed* that there were enough staff, 15% *strongly agreed* the team worked to limit staff burnout, and 18% *strongly agreed* there was sufficient training (Figure 4).

Figure 4. Staff reported team experience



Wraparound Service Models

Analysis and Summary of Key Findings

A single design does not meet the needs of all clients. Having safer supply embedded within primary and social care is desirable and can readily support clients' overall health and wellbeing. However, standalone programs may be preferred by clients who find them lower-barrier than the formal health system or want to receive their health care separately.

Whether integrated within primary care or standalone, safer supply programs provide much of their clients' primary and social care services. Clients generally prefer a one-stop-shop with providers they trust. This has put pressure on the staffing capacity of safer supply programs.

Whatever the model, it is critical that programs operate with harm reduction lens and take a holistic, trauma-informed approach. In additional to safer supply, programs should offer a range of health and social services within the program or as part of effective partnerships with external services and agencies that ensure seamless transitions in care. As well, new and innovative approaches should be contemplated.

Safer supply services for Indigenous peoples should reflect their unique culture and lived experience, offering a "wholistic" approach to services across the care continuum. Services must be culturally safe and trauma-informed.

"Providing pharmaceutical alternatives to the toxic, illegal supply is not just about distributing medications and must include ongoing support for improving the conditions in which people live. People who use drugs are significantly impacted by systemic issues such as homelessness, poverty, impacts of racism and colonization, trauma and mental distress which cannot be solved by the provision of safer substances alone."

Safer supply clients have access to a wide range of services in addition to the safer supply prescriptions. Some reported receiving acute and chronic care services either onsite as part of the organization's services or through a referral to a partner primary care organization. In addition to primary care, safer supply programs reported using program funding to provide:

➢ Case management ➢ Housing supports ➢ Advocacy ➢ Harm reduction supports ➢ Peer support ➢ Outreach ➢ Crisis support ➢ Social support ➢ Applications for income support	➢ Applications for prescription drug coverage ➢ Assistance getting health cards, ID, etc. ➢ Referrals ➢ Treatment options ➢ Medication delivery ➢ Cultural programming ➢ Indigenous Elder support in cultural wellness program ➢ Legal support ➢ Teaching other providers

Program staff emphasized the importance of being able to address their clients' concurrent needs and offer wraparound services. They said the ensuring clients benefit from the wraparound aspects of safer supply programs was critical to program effectiveness.

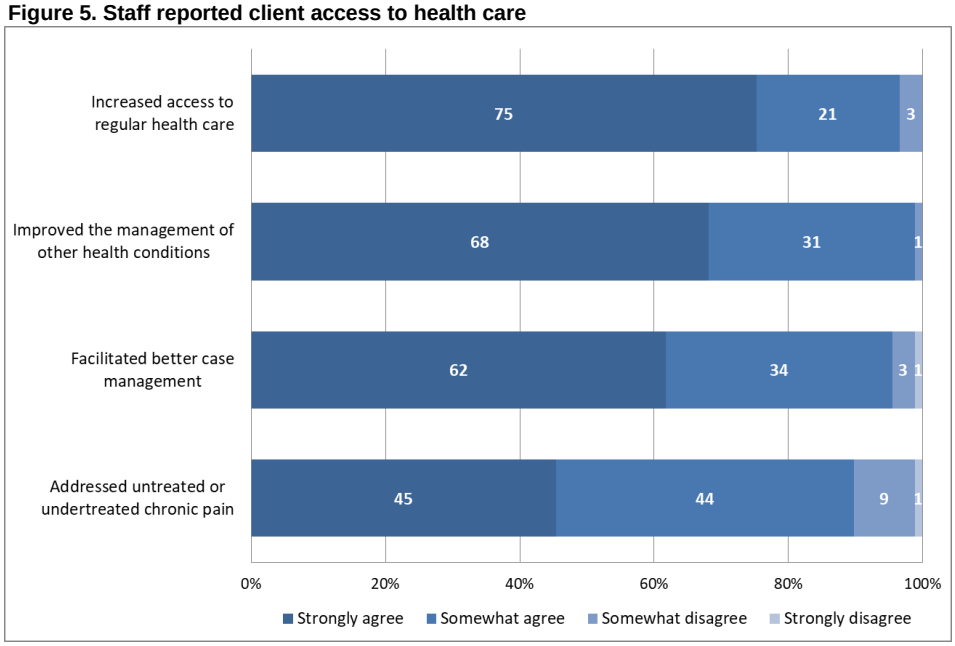
> *"It is critical that funding be provided to support relational, community-based approaches that don't assume that a short-term provision of pharmaceuticals will be a sustainable solution to the reduction of overdose and overdose deaths."*
>
> *"Due to the nature of complex health issues experienced by clients, we believe wraparound primary health care services are required in order to have sustainable long term health impacts."*
>
> *"I think it speaks to the broader system issues of the importance of interventions outside of "safer supply" – i.e., housing, access to nutrition, meaningful social engagement, comprehensive primary care, mental health services that are accessible and trauma-informed, etc."*

An important part of the care process is gaining client trust and comfort in receiving the services. "*Getting people connected/engaged with case management and primary care right away when they are initiated onto safer supply [is] often key to bring people into care effectively."* Many clients have previously been disengaged with the health care system and have limited contact with services on a regular basis. Many have had bad experiences with the system, experiencing stigma and discrimination from treatment centres, OAT providers, and acute and primary care. Some clients indicated they are uncomfortable divulging their opioid use and related concerns to providers outside the safer supply circle of care. Providing culturally safe services, reflecting their unique backgrounds and lived experiences, creates a situation where clients "*feel more empowered to access care safely*."

> *"This is an opportunity to welcome people who have been neglected forever into the health care system"*
>
> *"Offering...supports has significantly improved so many people's views in the medical sector and we are rebuilding trust with the people who did not trust the health care system"*
>
> *"It's not just accessing services, but developing a trusting supportive relationship with providers – this is so fundamental and so key."*

Based on the program staff survey, almost all staff *strongly or somewhat agreed* that their safer supply program improved client access to health care, management of other health conditions and case management. Three-quarters *strongly agreed* that access to regular health care increased. Somewhat fewer staff *strongly or somewhat agreed* that accessing the program had helped to address untreated or undertreated chronic pain (Figure 5).

Figure 5. Staff reported client access to health care



The service delivery models of the SUAP-funded safer supply programs vary greatly. The different models offer a comparison of the strengths and challenges associated with each and show the need for a variety of service options to meet client needs. All programs are co-located and/or integrated with at least one other service. Many are integrated, co-located or affiliated with primary and/or community care services. Several are based at community health centres. Three offer services as part of harm reduction programs that include supervised consumption sites (Table 6).

Table 6. Co-location and integration of safer supply programs (16 sites)

Services	Yes, co-located	Yes, integrated
Community/social services	2	10
Primary care services	2	8
Standalone harm reduction services, including SCS	6	3
Speciality care (e.g., HIV/AIDS, chronic disease, mental health, cultural and Indigenous services)	3	-

* Pathways and the Downtown East Collaborative have four and three service sites respectively that are either integrated with primary and social care or harm reduction services

Main Primary Care Provider

"I believe we need to move to case management. With our clients not accessing primary care elsewhere and many having other health issues beyond their addiction, we need to consider the scope of what we provide and acknowledge that we are the primary care provider for the majority of our clients. This needs to be considered in the staffing model moving forward."

"*The safer supply site has become a portal into improving [clients'] overall situation*." For most clients, their safer supply prescriber is also their main primary care provider. Others have less interaction with the prescriber and receive primary care from other safer supply staff, affiliated primary care services or not at all. Clients without a regular primary care provider reported using the emergency or walk-ins for their health concerns. A few felt their other health concerns were not adequately addressed and they needed access to a more comprehensive team.

Whether or not the programs are integrated with a primary care service, the safer supply staff tend to provide much of their clients' primary and social care services. Clients prefer care from those with whom they have developed a trusting relationship. Receiving additional care at another location – even close by – can present challenges for engaging clients and keeping them in care, especially when they are frequently interacting with the safer supply site. "*Most people who use these services have multiple competing priorities on their time and barriers to accessing multiple locations – a one-stop shop model tends to offer better access and better outcomes."* However, this model puts pressure on the safer supply program if only their staff are providing most of the care.

Integration with Primary Care

Some believe that safer supply "*should be provided as part of a continuum of care – it should not be hived off in a corner*." The safer supply programs that are fully integrated with comprehensive primary care services can provide regular health care to clients, through access to an interprofessional team and a wide range of programs and services. Programs embedded in primary care highlighted the benefits of being able to address multiple client needs. Those primary care services that appear to be best suited to providing safer supply services, especially to the most vulnerable populations, are those that also provide outreach, case management, social care and harm reduction support. As well, clients greatly appreciate and benefit from having a SCS within their primary care service site. Many argue that safer supply should be a standard of care throughout the entire primary care system.

> *"Resources available at the site where the client attends significantly increase the potential that they will further engage past safer supply."*
>
> *"Direct access to primary care has made an impact on the holistic approach to a patient."*
>
> *"I think the advantage of having imbedded services has the advantages of increasing the ability to have patient-centred care. These programs are quite intensive and require participants to come attend the clinics so frequently it is an opportunity to provide other types of care that otherwise would go unmet (i.e., primary care)."*
>
> *"People don't just need another opioid. Primary care is the gateway to other things."*

Even when housed within primary and social care service organization, the safer supply program may be separated from other services in various ways. For example, not all team members are readily available to provide comprehensive services to safer supply clients, and clinical services – prescribing and clinical care – may be in one location in the building and community services – harm reduction, social care and case management – in another. One program embedded in primary care still reported that "w*raparound supports are insufficient: We have one case manager for the whole program…. She has over 40 clients with extremely high and extremely complex needs. This is unsustainable."*

Another potential challenge with an integrated service is that if clients opt to stop or are removed from the safer supply program, they may also lose their primary care provider. This is reportedly rare, but does occur. "*In regards to potential disadvantages of this model is that in the event that a program participant has challenges with their substance use disorder treatment provider then they also lose their primary care if it is with the same physician at the same location."*

Where safer supply is integrated with primary care, program staff are still determining where it should be housed from a management perspective, how seamless services can be ensured, what other services are needed and what clients prefer. These types of questions highlight some of the issues comprehensive primary and social care organizations should consider as they integrate safer supply, including finding balance between medical and harm reduction approaches. (This topic is further discussed below).

Standalone Models

While most program staff believe that safer supply services should be offered in primary care settings – serving vulnerable populations and throughout the health system – many acknowledged that this approach should be part of a spectrum of safer supply options, which include standalone and mobile delivery models to ensure low-barrier entry to services where people are most comfortable.

It is important to note that there are different types of standalone safer supply services models. Some have evolved from standalone OAT services, some of which have a more medical orientation and tend to operate "*more like clockwork*." Other standalone models are rooted in a low-barrier, community-driven harm reduction approach. These programs often operate within a network and provide referrals to a "*continuum of services which extend from housing to peer employment to primary care to harm reduction and specialized substance use services."*

> *"For some clients, the goal is accessing the safer medications – this service needs to be accessible and less a part of the system"*
>
> *"Not everyone is ready to engage in with the health care system; SCS and harm reduction could be door to step into health care system"*
>
> *"Connections to primary care are important as the target population is poorly served by the health care system and has high rates of treatable health conditions, but operating in a standalone fashion provides separation from more clinical programs that may act as a barrier to people accessing safer supply."*

As well, *"standalone services may be advantageous for patients who want to maintain division in their care."* Some clients prefer to receive their health care in another environment, such as those who have an existing relationship with a primary care or OAT provider. This may include clients "*who do not identify with street-involved people and services."* For those receiving care elsewhere, providers should ensure that there are warm hand offs, limited duplication of care, good communication, and information and management continuity.

Several standalone safer supply programs have community health centres or similar services in close proximity to which they refer clients. However, a few programs do not have this type of relationship with primary care services. Those not fully integrated with primary care struggle to provide comprehensive care for their clients and reported that primary care is a "*giantly missing piece*." "*We can't provide robust primary care services – we have a challenge getting primary care to refer to." "We would benefit from having access to primary care within our clinic*." As well, some standalone programs have found that their clients' regular doctor did not want to continue serving the client once they had a safer supply prescriber. In these instances, the programs become responsible for all client primary care, limiting the number of clients they can take on. In this context, there was a suggestion for more funding for fee-for-service physicians to provide case management for their safer supply clients.

Another challenge reported by standalone programs included inadequate information continuity. Some primary care partners to whom safer supply clients are referred agreed. Staff reported the need for greater communication among service providers and shared electronic records. They also identified the need for greater role clarification. *"Even now would be helpful to have regular check in with providers/ prescribes to clarify who is providing primary care versus addiction care…. Many agencies are involved in care of client, not one single agency." "I think it is challenging to have two or three agencies, maybe even more, chasing down one client for multiple goals."*

Indigenous Services

Indigenous peoples require a model of care that reflects their unique culture and lived experience. Ideally, Indigenous services are rooted within Indigenous communities and organizations and are self-governed. A "wholistic" continuum of care model addresses all aspects of health and wellbeing – physical, mental, emotional and spiritual – from a health equity lens. Services demonstrate a commitment to inclusion, equity and anti-racism, and are culturally safe and trauma-informed. The relevance of cultural services supports a positive Indigenous cultural identity. As such, Elder leadership is an important aspect of programming. Encounters with Elders, as part of routine primary care, have been associated with reduced depressive symptoms, suicide risk and emergency department use.[11] However, it is important to recognize the uniqueness of varied cultures and that because Indigenous peoples vary in their journey towards reclaiming their culture, some may not yet want to engage in cultural practices or traditional healing.[12]

Several safer supply programs provide cultural programming to support their Indigenous clients. One entirely Indigenous program offers relational care and cultural wellness programs that provide space for gathering, cultural activities, food and nutrition, case management, social support and Elder-led support services. For some Indigenous clients, joining safer supply has alerted them to the cultural programming available at some of the service sites. These individuals reported thus taking part in some of these activities.

> *"Embedding programs in organizations that are already providing harm reduction programming and operating from that philosophy…is most likely to reach those who have been most significantly impacted by negative experiences with health care and those who are most marginalized, and so at greatest risk of overdose From there, a key part of the work is to provide a new experience of primary care/substance use care for PWUD [people who use drugs] in which the providers invest heavily in building trusting relationships and rapport with clients."*
>
> *"We also need to look at modalities and health care in a different lens. Many services are not tailored to the high rate of trauma our clients have survived and continue to see in their daily lives. What other, more radical ideas can we implement?"*

[11] Tu D, Hadjipavlou G, Dehoney J, Price R, Dusdal C, Browne A, Varcoe C.*Partnering with Indigenous Elders in Primary Care Improves Mental Health Outcomes of Inner-City Indigenous Patients Prospective Cohort study*. Kilala Lelum.
[12] Indigenous Primary Health Care Council. *Ne' iikaanigaana Toolkit, Guidance for Creating Safer Environments for Indigenous Peoples*.

Types of Wraparound Services

Analysis and Summary of Key Findings

Safer supply programs offer a range of health and social services that are critical components of the ongoing wraparound support needed by clients to support their care. Many programs are innovating in this regard, including offering satellite and mobile outreach.

Housing and mental health support services are among the most pressing client needs and are a critical part of their stabilization pathways. While several programs provide these support services, greater availability and tailored responses are required, especially in collaboration with external providers and through government initiatives.

Innovative and individualized stabilization and recovery pathways are required for clients who have stabilized on safer supply or desire additional recovery pathways. Services could entail case management, housing, training and job support, and trauma-informed mental health services, and include additional and new types of service partners. Barriers to accessing treatment centres for those still using some types of drugs should be addressed.

Support and care pathways are also needed for individuals for whom the safer supply is not working.

Social Care and Outreach

"We need to create programming that is social services heavy at the front, as this is a social issue with a medical intervention at present time."

Clients reported numerous ways in which they were receiving social support, including assistance getting health cards and income support, transportation to health care, food packages, clothing, glasses, and résumé and job search support. Safer supply programs teams reported providing:

- Harm reduction
- Outreach
- Drop-in and group offerings
- Case management
- Cultural services
- Income assistance
- Food security
- Employment support
- Housing support
- Legal services
- Social services paperwork

Social support and case management are important components of the safer supply program and critical to its success. Community outreach workers, social workers and case workers/managers play a crucial role in "*helping build trust with vulnerable populations to encourage them to access help."* (One program includes prescribers in its outreach). Many use their networks and relationships to actively seek new clients. "*Being able to meet people in the community and provide low-barrier access to the program has really helped to reach people who would not normally come in and have access to a safe supply and clinical/case management support*."

Three safer supply programs offer or are in the processing of launching mobile outreach services. The mobile teams meet the clients in drop-in centres, shelters, encampments and other places where they congregate. They include peers workers and aim to build relationships and provide clients with safer supply services and primary care. One program delivers medications to those with the greatest vulnerability.

Many clients need social support and case management on an ongoing basis. Case management and community health/outreach workers play an important role in this regard, including "*creating client- centred trauma informed care plans with each [client] to best support their needs*." Some clients require assistance to address various needs as they arise, ensure they access their medications, support their adjustment to and stabilization on safer supply, address concomitant conditions, access basic supports, and secure referrals. Not all programs have adequate staff to address these needs. Some only have (or initially had) nurses in this role. In these instances, nurses spend a great deal of their time assisting with income support applications, helping clients get identification and health cards, addressing legal issues and organizing referrals. More appropriate staff were said to be needed to provide these types of services.

Housing

"More provincial money needs to be funnelled into housing and people given options as to where they would like to be vs the current paternalistic warehousing model. With the low rates of disability [payments] and a lack of money available for rent, people have no options."

Housing was identified as a key priority by most programs. Many clients are unhoused, unstably housed or in temporary COVID-19 hotels or shelters. Many have had difficulty accessing temporary shelter and housing given long waiting lists, limited housing options and low supportive/affordable housing stock. As well, "*access and links to supportive housing programs (housing workers) and other services have been suspended due to COVID-19*." Ultimately, safer supply clients require adequate and stable permanent housing.

Housing is a critical component of stabilizing clients' drug use (as shown by Housing First initiatives). The lack of housing causes instability. It increases the chaos in clients' lives, including being moved from site to site, and consequently their ability to engage with support and care. Without housing, client contact is potentially lost and it can be difficult to find them. Being unhoused also affects clients' ability to store their medications safely, develop a routine, sleep, eat well and maintain their overall health. Unhoused clients reported often getting robbed and having few options for avoiding the street scene while they are trying to stabilize on their new drug regimen.

Several clients have received support finding housing through the safer supply program. Having "*direct access to a housing worker has made a huge impact on having patients get out of homelessness, and into proper housing*." Case management and community health/outreach workers play a critical role in this regard. Nonetheless, many program staff indicated more housing supports are required, including new and innovative programming, effective referrals to and partnerships with external organizations, income and rental support programs, affordable housing and more government initiatives – including collaboration across levels of government.

Mental Health

"I believe services would be greatly improved with greater collaboration and more timely delivery and availability of mental health services."

Several clients described how the staff at the safer supply programs had provided moral and emotional support and were available to talk to them when needed. "*If I am having a hard day I can talk to them. Even if [a staff member] is not available, if you are having a tough time, they will find someone to help you.*" These informal services are provided by all staff, but providing such support is time consuming and, given the extent of the need, challenging within the existing capacity constraints.

Many clients identified the need and desire for more formal and longstanding support with their mental health concerns, including their experiences with depression, anxiety, trauma, violence, loss and eating disorders. Several suggested that mental health services should be an integral part of the program. One client even suggested it be a program requirement. Some suggested the access to group services would be beneficial. Those who had attended safer supply drop-in groups found them helpful. Clients also suggested the having urgent counselling sessions available "*when there is a lot of chaos*" would be valuable.

Some clients had been offered formal counselling options; others had not. Some of those offered counselling were still gaining the confidence to request or seek it. "*For an addict to ask for counselling is hard."* They expressed that, although they had "*a lot to talk about*," they were "*not comfortable to divulge.* They recounted apprehension related to nervousness, trust, opening up, being closed up for a long time, potential ramifications of sharing and being honest. Other challenges reported in accessing such care included: "*It's hard to hold an appointment*" and "*they gave me a phone number for mental health, but I don't have a phone and can't get access to one to use to call*."

Clients emphasized the need for services adapted to their lived experiences and that addressed the underlying reasons for their drug use. Importantly, some who had counselling in the past, had not had good experiences, calling it "*textbook and hallmark.*" Some would prefer peer support with their mental health concerns, "*they need to know what that is like before I can talk to them*." Staff emphasized that mental health services need to be low-

barrier, rooted in a harm reduction approach, trauma-informed and tailored to clients' needs. As well, services "*appropriate to various cultures are needed for healing the root causes of addictions*."

Many program staff are in agreement with the feedback provided by clients that counselling and mental health supports are difficult to access and more of these services should be integrated with safer supply programs. They identified the need for additional staff with mental health expertise, including social work, psychology and psychiatry and more staff training in this area. They also indicated that greater access to and more support from external mental health services was required.

> *"We also very much need a counselling service, for example a social worker… It's nearly impossible to find free counselling services and the folks we work with have a massive burden of trauma and mental health issues. They are ready to engage with counselling and asking for this service, but we have nothing to offer them"*
>
> *"The challenge of limited ability to directly provide links into our mental health system (larger systemic issue) has been frustrating. We are currently helping train one of our staff to provide dialectic behavioural therapy…as this is a much needed therapy that is otherwise on a two year wait list to access."*
>
> *"Huge difficulty getting people connected to psychiatry, and lack of understanding in psychiatry about SS, trauma, etc."*

Stabilization and Recovery Pathways

"Once patients start to become stable on a SS [safer supply] regimen, they start to work on other aspects of their life…. This is crucial in their recovery and pivotal to getting their life back."

Currently lacking are innovative services and care pathways for safer supply clients once they have stabilized or desire additional recovery pathways (whether or not they include being drug free). Once stabilized, they have different needs and require enhanced and different types of support. The requirements for those who are stabilized should be identified and dedicated services developed and tailored to these emerging needs. Services would entail case management, including support for accessing housing, training and job opportunities. It would also include trauma-informed mental health services. For example, clients may need help "*to reduce the loneliness, isolation, boredom and trauma that people experience*" once they are stabilized or housed. Importantly, clients' trauma may become more acute and overwhelm them as they stabilize. With the "*lack of counselling and mental health supports for our clients…, people have nothing to do, but sit with their trauma."* As well, additional and new types of service partners are needed to support clients in adapting to their new circumstances, including the broader primary and community care sectors.

Safer supply programs are also experiencing barriers to accessing recovery pathways for their clients who desire them. Policy rigidities are hindering access. For example, most clients desire coordinated support through the transition. "*We attempt to do warm handovers when necessary, however because of the way that addiction medicine clinics work, this is difficult as we are told that they just need to show up and they will get started right away, but our clients often want a name of someone and an appointment to take away some of the fear of attending these clinics*." Couples are not allowed to attend treatment centres together, but do not want to leave each other alone on the streets. Moreover, most treatment centres will not take clients who are currently using drugs, even if they have stopped fentanyl. Clients may be keen to enter a recovery program, but "*unfortunately, the recovery community has not kept up with changing approaches to treatment (not many centres will accept patients on benzos, opioid tablet safer supply programs); this often leaves people…with little options with what to do next*."

"We need the addiction medicine world to jump on board and change their practices."

There also needs to be support and care pathways for individuals for whom the safer supply is not working. Several of the programs are not equipped to continue to support these individuals, but suggested this type of support should be part of the care continuum.

> *"Ending case management and support services to those who are no longer interested in their safe supply prescription can be difficult. Some people find that the safe supply options do not adequately meet their needs and decide they don't want to continue with the prescription, but either don't want to say this outright because of concerns about losing connection with their support team, and the support team doesn't want to cut them off of supports simply because they haven't been able to find a safe supply prescription that truly works for them. Solutions could*

include more and better outreach and case management teams to work with and refer to, larger staff to help transition the workload and case management of those who haven't found a fit within the safe supply program"

Partnerships

Analysis and Summary of Key Findings

Safer supply programs benefit from numerous collaborations and partnerships. Their closest linkages are with other harm reduction services (e.g., SCS), pharmacists and primary care (discussed above). Programs have worked to educate community partners about the program and the stigmatization experienced by their clients, and to build working relationships. Nonetheless, clients would benefit from increased buy-in and better collaboration and care coordination among service providers. Establishing training, referral networks and pathways, and guidelines for providing services to safer supply clients would support seamless transitions and continuity of care.

Pharmacists are important members of the safer supply team and, in many instances, see clients most often. A reciprocal working relationship in support of client health and wellbeing benefits them greatly. While some pharmacists have been resistant to dispense and a few clients have had bad experiences, many clients appreciate the respectful relationship developed with their pharmacist. Some clients struggle with pharmacy hours of operation and a few have successfully transferred their prescriptions to unaffiliated pharmacies (if permitted). Clients appreciate the option to access their medications via the biometric dispensing machine, *MySafe*.

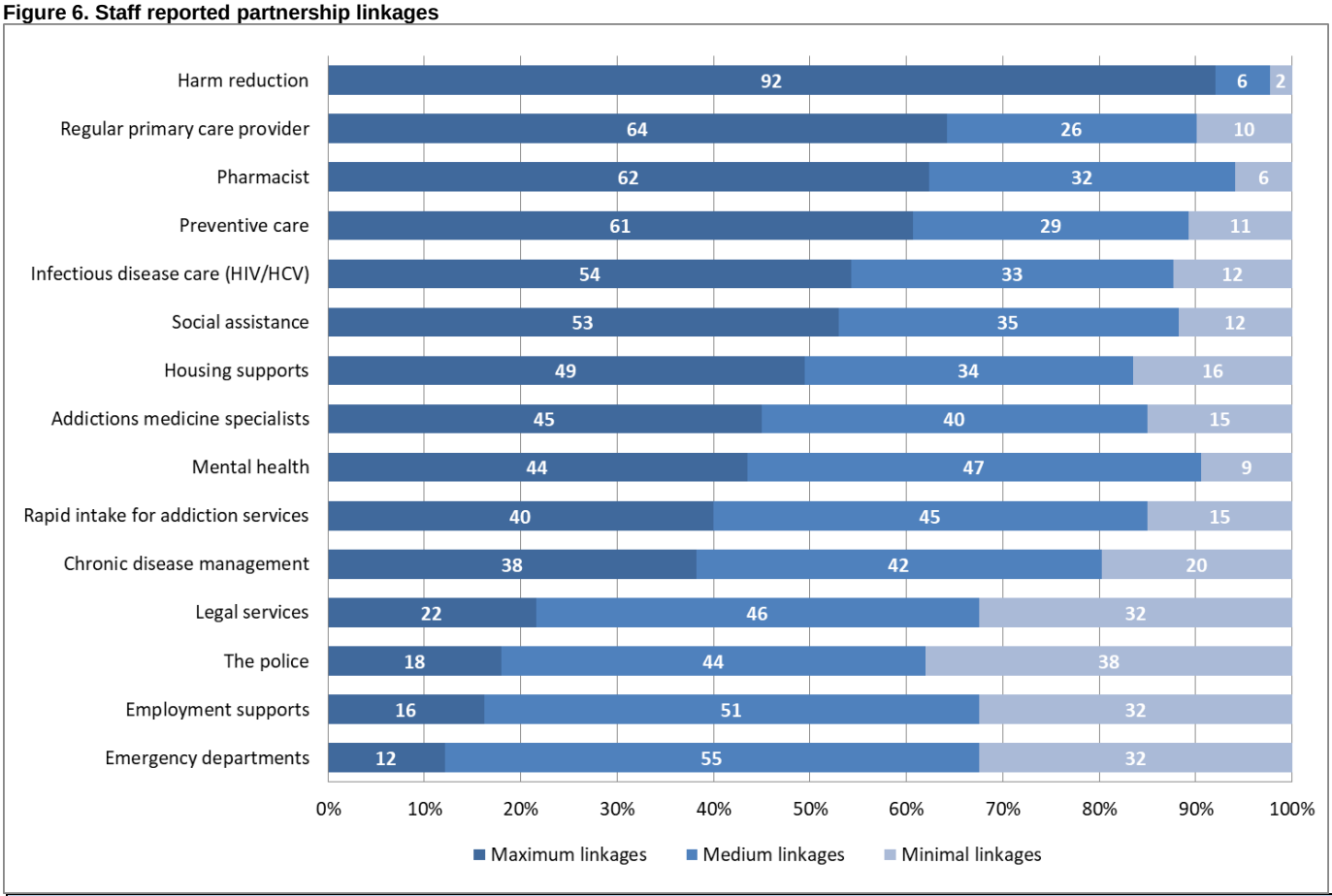
Supervised consumption sites (SCS) are also an integral part of the team and see many of the clients each day. They play a role in recruiting clients, keeping them connected, monitoring their health, facilitating onsite safer supply appointments, and providing feedback to safer supply staff. Clients also struggle with SCS hours, especially if they work or panhandle or require a minimum amount of time between multiple injections. Many prefer using SCS at the safer supply site; several would like to have SCS space dedicated to safer supply clients.

External Partners

"Educated community partners are supportive and collaborative. Partners that are less educated and less informed are less supportive"

The safer supply programs have several collaborations and partnerships. They may not have formal partnerships or signed agreements, but have strong relationships with many community partners. Most staff reported that they had *maximum linkages* in the way in which they work with harm reduction services to support clients. Approximately 60% reported *maximum linkages* with primary care, pharmacists and preventive care. At least two-thirds reported *maximum or medium linkages* with the other health, social and justice services listed in Figure 6. Additional partnerships reported by program staff included outreach services, drop-in centres, warming spaces and shelters, food security, Elders, hospitals, EMS, OAT providers, trauma support, addiction treatment centres, prisons, researchers, and other safer supply programs.

Figure 6. Staff reported partnership linkages



Maximum linkages: Work closely together, including often discussing participant needs, following up on referrals, navigating participant access to services, collaborating with other programs or jurisdictions to provide integrated participant care.
Medium linkages: Sometimes work together, including sometimes discussing participant needs, sharing information, participating in meetings with other programs or jurisdictions.
Minimal linkages: Refer participants to other programs or jurisdictions with little or no discussion or information sharing

Safer supply program staff have worked to build relationships with various groups and services in the community. They have addressed misperceptions about the program and the stigmatization of their clients by providing information and education to existing and potential allies and partners about the program. Many program staff believe that clients would benefit from increased buy-in and better collaboration and care coordination among service providers. For example, they have faced pharmacies refusing to dispense and hospitals not honouring clients' safer supply dosages. As well, a lack of understanding and support for safer supply has hampered partnerships with addiction treatment agencies.

> *"Unfortunately as a controversial program, we do not have support and understanding from all service providers. We have made pamphlets and a letter that accompany our clients to hospital, pharmacies, etc. to give background and context on our program and why it's important in order to reduce stigma and barriers."*
>
> *"There is little or mixed support for these programs in prisons and in hospitals and clients are quickly destabilized when they are incarcerated or if admitted to hospital if providers there are unwilling to work with the client's SS care team to continue to provide the medications they need, putting them at risk of leaving hospitals against medical advice even if there have a serious infection that needs to be treated, or at increased risk of overdose in the community if they suddenly start using street drug supply again."*

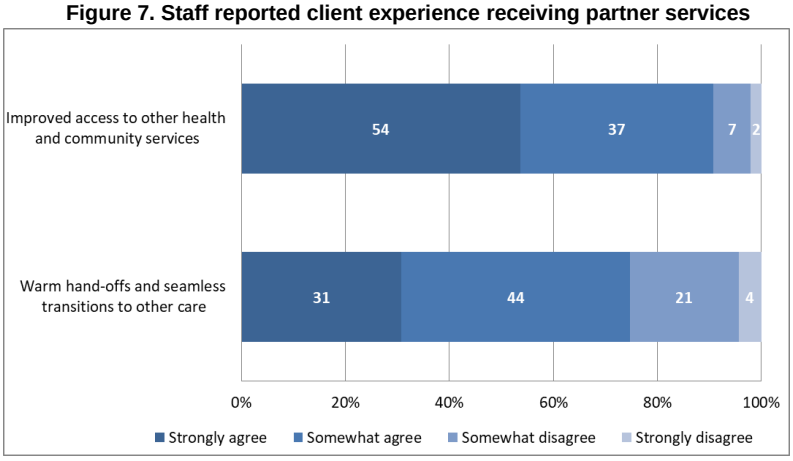
A few programs have communicated with clients' other providers prior to their starting safer supply, including letters to family physicians and community pharmacies. The relationship with other prescribers is also important. Some staff reported that there can be "*inconsistency between providers within the region so clients get confused about dosages and options. More linkages and timely communication about changes to practice"* are needed.

In spite of the barriers, the safer supply programs have leveraged existing partnerships and developed new ones to address services gaps and provide clients with the support they need. Several work closely with other health

services in close proximity, including community health centres, SCS, outreach services, housing services and social services. They have provided training to community partners, networked with community outreach services, developed referral pathways specifically for their client groups, opened communication channels with the police, and supported other agencies in the creation of guidelines for providing services to safer supply clients.

In the staff survey, most staff *somewhat or strongly agreed* that partnerships had improved client access to other health and community services. Over half of program staff *strongly agreed* that their program improved client access to other services; nearly one-third *strongly agreed* that they were able to provide warm hand-offs and seamless transitions to other care (Figure 7).

Figure 7. Staff reported client experience receiving partner services



Pharmacy

"I firmly believe [pharmacy] can really make more of a difference in primary care. Many ailments can be controlled with the help of pharmacies evaluating progress daily and ensuring proper medication ingestion or use."

Pharmacy is a critical component of safer supply. In many instances, pharmacy staff see clients most often. The programs generally work closely with one pharmacy and interact with several others. Explaining the program, managing inquiries and discussing dosages takes a significant amount of prescribers' time and good communication and a strong working relationships with pharmacists is important to ensuring a streamlined service. Program staff emphasized the importance of engaging with pharmacy staff/pharmacists early in the implementation process to improve their understanding of safer supply and debunk any myths, especially among those who are hesitant. Program staff have observed that the "*pharmacy's comfort level grows over time*"

Many programs have integrated or partnered with a local pharmacy. In these instances, pharmacists work as part of the team supporting clients. For example, "*the rapid-access partnership between physicians, pharmacist and nursing staff allows rapid titration of dosages for participants to meet desired dosages quickly*." Some pharmacists support clients with all their prescriptions, reminders about renewals and advice about their health and wellbeing.

The way in which clients experience the pharmacy is critical to their retention. "*If clients feel judged, they won't stay on the program*." Several clients showed appreciation of their pharmacists' helpfulness and respect shown. *"They go out of their way to make people feel like they are somebody – not a nobody who doesn't belong."* They "*pay attention and care*." While some programs require clients to use the affiliated pharmacy, others do not. In those instances, some clients have successfully transferred their prescription to pharmacies closer to home. However, several have had bad experiences with certain pharmacies and have had to shop around. As well, pharmacy hours can pose problems for clients when they are not open early enough in the morning or late enough in the day to provide needed medications. As well, some have reduced weekend hours. Clients accessing their medications via the biometric dispensing machine, *MySafe,* reported having a good experience with this method.

Supervised Consumption Sites

Supervised consumption sites (SCS) are an integral part of the safer supply program. They also see many of the clients every day, often several times. SCS play a role in recruiting clients, keeping them connected to the program, monitoring their health and wellbeing, and providing feedback to safer supply staff. For example, SCS staff may call safer supply staff when clients who have missed several appointments show up at the SCS. "*They function more like a drop-in and then connect us with clients we have been trying to connect with for some time.*" Some SCS also advocate for and help connect clients with other services. For access to the safer supply team, some SCS facilitate phone, virtual (OTN or Telus) and in-person visits with safer supply staff for clients who experiences barriers to accessing the safer supply site each week. This "*has been very well received by clients, they report feeling*

supported and cared for." "*Having the SS team see clients at sites that have SCS is helpful both for recruitment of clients, but also for encouraging clients to use on site*."

Some clients have access to a SCS at their safer supply service site; others do not. A few of the programs offer SCS spaces solely for their safer supply clients. Many clients indicated that they preferred using a SCS at the program site, rather than larger sites used by more people, including those who are not on a safer supply. Clients suggested they have a better experience at SCSs where there is a "*community*" of people who use drugs. However, clients have also experienced challenges with SCSs based at the safer supply site that serve a wide range of clients. For example, for one client, "*coming here brings me in contact with dealers which I am trying to avoid right now*." "*Old fishing buddies, people who want to buy Dilaudid, it's too risky and in your face*." Some inject at home in order to avoid the SCS. Many staff where there are not onsite SCS suggested adding one. Several suggested having onsite SCS space specifically dedicated for safer supply patients.

SCS operating hours can pose challenges for clients, especially for those who require a minimum amount of time between injections, work or panhandle (especially at the end of day) or have different daily routines. Several SCS have capacity challenges, with reported space and privacy issues. With limited space, long wait times sometimes cause people to leave and inject elsewhere. Another challenge is that a couple of programs provide SCS onsite for clients' to use their safer supply, but not other drugs, forcing them to go elsewhere and potentially use unsafely.

Key Design and Implementation Features

There are several design and implementation features of safer supply services to consider when providing safer supply services. The services should be grounded in the community, co-designed with people with lived experience and focused on the client. To help team members work effectively and focus on their clients, the requisite organizational and management structures should be in place. As well, various service processes and procedures should be developed in planning and implementing safer supply in order to optimize client access and experience.

Different models of safer supply are needed, as a single design will not meet the needs of all clients. While safer supply programs may be implemented differently, at their core, they should be based on the principles of harm reduction. People with opioid use disorder should have the option of safer supply as part of the continuum of harm reduction services provided within a health system that addresses all medical conditions, including addictions. It is also important to acknowledge that some people are hesitant to engage with a medicalized service and require alternative options.

A Community-Centred Approach

Analysis and Summary of Key Findings

The overarching approach to providing safer supply services should be:

- Grounded in the community
- Centred on input and involvement of people with lived experience in program co-design, planning and implementation

To support advocacy and secure community support, safer supply programs should:

- Identify and engage community allies and program partners, including through consultations and representation on committees
- Develop an education and communication strategy (including an online presence), potentially using communication experts

Involving People with Lived Experience

"Meaningfully engage with people who have lived/living experience...and take their lead as much as possible."

Many safer supply programs have integrated people with lived experience into all aspects of their programming; others have included them in select roles. Program staff give high priority to the involvement of these individuals in program co-design and implementation. The "*lived experience lens is central to the development of the program*." People with lived experience are members of advisory committees, trained to support research and community outreach workers. *"This [input from people with lived experience] has ensured that our engagement with participants has been respectful, accessible, relevant, flexible and as responsive to their needs as possible."*

Most programs have people with lived experience on advisory committees or councils, either as members among many stakeholders or as a designated committee. Some programs have introduced additional advisory councils for specific groups, such as an Indigenous advisory council with Indigenous staff members and clients who provide input on how best to reach, enrol and serve the needs of Indigenous people in the program. As well, one safer supply program has supported the formation of a regional drug users group and encouraged them to link with other national advocacy and support groups. "*This level of self-empowerment and confidence in encouraging the voice of participants has provided strong motivation for people to want to be heard and to feel deserving of care*."

People with lived experience have provided input on service design and ongoing development, service delivery, research and evaluation. As an example, one program held focus groups with people with lived experience and used concept mapping to help them develop and evaluate their program. However, for many programs, with COVID-19 physical distancing requirements, it has been more difficult to engage this community in traditional focus groups, meetings and active feedback. As discussed in the "Safer Supply Staff" section above, the integration of peers into safer supply team has helped "*shape the program, spread the word of our work, [and] also build relationships with our participants*."

Community Engagement

"Take the temperature and look like that community."

Importantly, the safer supply programs should be grounded in community. "*This is a grassroots driven program. That is the key to its success*." Programs, especially those launching an entirely new program, identified "*engaging the immediate community and community partners for education and awareness prior to program launch and ongoing for feedback*" as key to their program planning. They emphasized that these efforts entail both providing education about safer supply and listening to others' perceptions in order to better understand how to respond to their concerns. Several programs engaged in regular consultations with key partners prior to launch. For example, one program reported meeting frequently with police and paramedics, including regular meetings, site tours and providing regular opportunities for input and sharing information. Consultations and advisory committee membership have included representatives from the local hospital emergency department and inpatient services, paramedics, mental health and addictions, social services, shelters, the police, government departments and resident associations, among others. The community being served should also be engaged. For example, people with lived experience are on advisory committees; not only clients, but individuals from the local community. Where appropriate, Indigenous communities and organizations should be engaged in co-design and sustained reciprocal relationships. Community outreach, education and consultation were undertaken in order to:

> *"Improve the overall attitude of the health care system on harm reduction and PWUD to facilitate better access to care."*
>
> *"Help to ground our work in community-based, harm reduction practice that is person-centred, relational and conscious of greater social justice aims."*
>
> *"Take a courageous stand with the community and more broadly. It is not ok to stand by."*

Having a communication strategy for the program is beneficial. Safer supply programs have undertaken public education – some using communication experts – to provide information about safer supply to the community and to address public perceptions and stigma against people who use drugs. Some have developed an online and social media presence.

A Focus on the Client

Analysis and Summary of Key Findings

Program design and implementation processes should keep the focus on the client. Programs that continue to innovate based on clients' experiences, evolving needs and feedback are most responsive. Key learnings from safer supply implementation related to optimizing client experience are to:

- Understand clients' realities on the ground and reflect the community served
- Create a welcoming, culturally-safe, judgement-free environment
- Provide services that reflect individuals' lived experiences and are tailored to promote their health and wellbeing, including stigmatized and racialized populations such as Indigenous peoples, immigrants and 2SLGBTQ+
- Provide services that reflect and address trauma experienced
- Emphasize client empowerment in their health and wellbeing
- Build trust and believe clients
- Acknowledge clients' skills and knowledge
- Set individual goals and individualize services
- Provide several safer supply options for clients, including type of drugs (opioid and stimulants), method and dosage (including PRN)
- Ensure shared decision-making
- Work to ensure client retention
- Work for quick wins/success to gain trust
- Provide comprehensive wraparound/scaffolding services, potentially co-located
- Develop new service delivery models, e.g., drop-ins and group appointments, a variety of touch points, such as medication delivery, vending machines, outreach, satellite clinics, in-home, virtual services, via mobile phones, etc.
- Adapt to changing client circumstances
- Provide high quality services
- Seek ongoing feedback

"Position drug users as the experts in their own health and wellbeing."

Program staff attributed a high priority to participant empowerment in their health and wellbeing. Staff work with clients to set their safer supply goals and tailor their care. These goals are individualized and vary greatly – from staying alive, reducing injection or stopping street drugs to changes in lifestyle and health. It is important for program staff to work within the framework of clients' individual goals, and provide sufficient options and choice to fit their needs. According to one provider, individualized care requires both clear policies and flexibility to develop medication regimens that work for clients. Importantly, decision-making needs to be in partnership with clients.

> *"Allowing people to inform and have autonomy of their bodies has given people a sense of belonging and self-worth."*
>
> *"The staff here listen to participants, adapt accordingly, and have seen amazing results."*
>
> *"Participants are the experts in their experience with drug use. We meet people where they are at and support them with their individual goals."*
>
> *"We have the capacity to build respectful relationships, to listen to what people want and need, to provide support to the best of our abilities and with the resources we have access to."*

Focusing on the factors associated with client retention is essential. Program staff should ensure that they develop trust through a culturally safe, trauma-informed and judgment-free environment and a "*space people want to come back to*." "*We see how the attitudes and treatment of people who use drugs, particularly those who are homeless, have direct impacts on their health and ability to survive. Safer supply affirms that people who use drugs are valuable human beings*." The cultural competencies of staff should to be rooted in and reflect the community and an understanding of the realities on the ground and individuals' lived experiences, including stigmatized and racialized populations such as Indigenous peoples, immigrants and 2SLGBTQ+.

The way in which clients are engaged and consulted significantly impacts their experience. Many reported that they have not been consulted about their needs throughout out their life. Building trust from and in clients entails acknowledging their skills and knowledge, achieving some quick wins – however small – to gain trust and "*being humble*." Retention is especially difficult for those for whom the safer supply is less effective and their ongoing engagement and feedback is paramount to their retention.

Peers and Indigenous Elders can have a great impact on the way in which clients experience care. In their role, they influence the way in which clients experience the clinic setting and interact with other staff. Peers act as advocates and "*translators,*" often acting as a voice for clients with the clinical team. Elders support the development of a positive identity and a connection to Indigenous teachings, medicines and culture.

Program Management

Analysis and Summary of Key Findings

While the team members at the safer supply programs are predominantly focused on clients, to enable effective program operation and facilitate their work, the underlying organizational and management structures should be in place. As part of planning and implementation, programs should consider and develop approaches for:

- Defining and documenting the governance structure
- Establishing the leadership and management structure, including defining roles and responsibilities and reporting and decision-making processes
- Assessing capacity and resource requirements
- Establishing financial management systems
- Planning for growth and expansion
- Developing and documenting human resources requirements and protocols, related to scope of practice, job descriptions, hiring for fit, harm reduction experience and training, capacity building, mental health supports, insurance, benefits
- Ensuring adequate infrastructure, information technology (IT), equipment, storage and security
- Developing communication strategies, documenting with whom, how and when information should be shared
- Developing implementation plans
- Embedding quality improvement processes, including PDSA cycles, within their operations

Governance and Management

Having effective program management allows team members at the safer supply programs to focus on their clients and effectively provider services. Firstly, safer supply programs should define and document their governance model, including whether or not they need to establish a board. Some will need to establish whether and how they will operate under the pre-existing governance structures within their organization. They also should establish a management structure, with strong program leadership. And, as with any program, financial, operations and human resource protocols should be developed and documented.

An understanding of processes and procedures is required when a new program is introduced into an existing organization. Some organizational managers found introducing the safer supply program into their organization to be "*challenging*," "*a big shift*" and "*operationalized differently*," especially at first. Larger organizations implementing safer supply should assess their capacity, determine the level of engagement required of senior leadership, and outline the reporting and decision-making processes for safer supply, especially when organizational managers are responsible for multiple portfolios. In these instances, safer supply program staff should meet and consult with senior leadership to develop an implementation plan, including the leadership and management models to be applied. Roles and reporting responsibilities should be clearly delineated. Communication protocols are also important, indicating with whom and how information should be shared and under what circumstances.

Safer supply programs should establish human resource protocols that include job descriptions, scope of practice, the requisite experience, insurance and benefits. Team members should be hired for fit, trained appropriately and supported to become part of an agile, highly competent team. The program should also have mechanisms to support the team's mental health needs. "*Anticipate the immense toll that harm reduction work can take on staff due to ongoing structural violence and oppression that not only impacts the lives of people you're working with but also your staff; set up support systems right from the beginning of the project and factor that into the budget as much as possible*."

Programs funded for nine months found it challenging to plan "*for a long-term challenge with short-term funding*" and to scale up within their budgets. "*It feels scary to implement a service for patients that we might not be able to continue*." "*This causes a lot of stress to staff and to clients.*" Many reported inadequate resources for administrative, clinical and harm reduction staff, as well as physical space. Some organizations faced challenges with funding silos and organizational barriers to sharing or reallocating resources.

Ideally, as part of the planning processes, programs would develop plans for sustaining their clientele, along with plans for growth and expansion. The programs have faced high demand and should determine how to increase their capacity to accommodate more clients. Such planning would include determining the human resource and space requirements as the program expands, considering team member roles and alternative ways in which to deliver services, identifying medications that may be added to the safer supply, planning for additional services that may be required, and developing transition options for clients.

In terms of external partnerships, working arrangement and processes for working with them should be clearly defined whether or not there are formal arrangements. Programs should work to ensure transparency among partners and team members.

Finally, safer supply programs should embed quality improvement processes into their operations, including a plan-do-study-act (PDSA) approach to support change and improvement initiatives. One program lead suggested that employing a quality improvement approach can also help to avoid mission drift. Discussions can occur within an established framework and help to define why and what change is required. As well, research and evaluation are important to show effectiveness and guide service delivery best practices. One project emphasized working with "*community-based researchers who understand the context in which you're working, are respected allies of people who use drugs, and who can support the evaluative work of your project and help make evidence accessible."*

Technology

Safer supply programs would benefit from greater use of technology for sharing information and knowledge, creating better collaboration and coordination of services to meet client needs. Programs that did not formerly

provide clinical services have had to secure the requisite technology and equipment, including electronic medical records (EMRs), scanners, laboratory equipment, etc. to support their work and have experienced a "*steep learning curve*." In some cases, they have opted to use other organizations' EMR systems. As well, programs without integrated EMRs have struggled. "*All of our team members spend many hours per week wrestling with workarounds for our EMR which doesn't support e-faxing, uploading of lab reports, scheduling or flagging reminders. This could be rectified by working as part of the CHC teams or using their EMR's*." As well, some team members have limited access to computers which affects communication with other members of the team. One program created a secure shared drive for community partners to share client and program information. Additionally, some of the safer supply programs have been able to use virtual technology – such as videoconferencing – to connect clients with prescribers and other team members. One program has secured 1,400 mobile phones that will provide clients with reminders and follow-up information, as well as making it easier to monitor and contact them.

Team Building

Analysis and Summary of Key Findings

To ensure they have robust and effective teams, safer supply programs should:

- Address differing professional cultures, professional hierarchies and power differentials among clinicians and between clinical and community health staff
- Engage teams members in program design and improvement
- Undertake regular team meetings and follow up on the issues and action items identified
- Provide formal and informal team building, capacity building, and mental health and wellness supports

"Establish open and respectful relationships amongst your team as there are power differentials at play that need to be identified, acknowledged and worked on, together."

Safer supply team members can include physicians and/or nurse practitioners, RNs, RPNs and/or LPNs, caseworkers or social workers, and community health workers, harm reduction workers and/or peer support workers. Staff agree that safer supply teams generally communicate well and work collaboratively. Teams have worked together to find innovative solutions to meet their clients' needs and clients are very appreciative of staff. However, as with every health and social care team, team building and support is important. Managers highlighted the importance of "*investing in the frontline*." One team member reported that "*interdisciplinary teams are made up of members with different approaches and cultures. This has presented some challenges.*"

Differing professional cultures, professional hierarchies and power dynamics can challenge interdisciplinary teams. These dynamics can present themselves among clinical professions (e.g., physicians and nurse practitioners). In the case of safer supply, tensions may also occur between the clinical and community health team members. These dynamics can be influenced by the extent of collaborative team planning, case consultations and decision making, and the extent to which respective team members feel they have voice and are heard, including peers. Notably, a greater proportion of the safer supply program resources go to the clinical component of the program, which also tends to receive more administrative support and have lower client-to-staff ratios. As well, some programs have separate leadership for the clinical and community health component of their programs. These factors also have the potential to influence team dynamics and the extent of interaction.

Safer supply programs should explicitly address professional hierarchies and power dynamics and team members' concerns. Frequent interaction can support these discussions. Some teams meet often as a whole and among core members to discuss clients and program features. Some highlighted the importance of having following up on issues and action items arising from the meetings. Some teams have indicated that they would benefit from "*some expertise in putting together interdisciplinary teams, how to support them to work together well.*" Opportunities to further learn to work together, including formal and informal team building exercises, should be considered.

Collaborating Safer Supply Programs

Analysis and Summary of Key Findings

For collaborating safer supply programs to work together effectively, they should develop approaches for:

- Establishing the leadership and management structures
- Defining roles and responsibilities
- Sharing resources
- Communicating
- Streamlining policies and procedures
- Sharing client information
- Ensuring seamless client transitions
- Leveraging the community of practice

Some SUAP-funded programs are comprised of a group of individual service providers. They collaborated to develop program plans and secure funding. Subsequently, the individual organizations have either worked in partnership or independently. For example, in one safer supply program, a primary care team member provides wraparound services for standalone safer supply partners. However, there can be challenges working within a group of organizations that can impact collaboration and client care, including:

- Communication
- Working on different timelines
- Different organizational cultures
- Unequal resources and capacity
- The inability to share or reallocate staff and other resources
- Collective agreements
- Lack of role clarity among providers
- Different EMRs
- Referrals and transition pathways
- COVID-19 reducing the ability to meet, plan, resolve challenges, etc.

Without common policies, procedures and communication pathways across organizations, as well as shared medical records, challenges related to ensuring clients receive coordinated, continuity of care have arisen. For optimal access, clients need to be aware of the intake points for each agency and their respective expectations. However, "*if agencies are not aligned in how they work with a client, it makes it much more difficult."* For some, "*it would be preferable for resources to be better shared across sites. By integrating the programs/sites, there would be potential to ensure that those who need the service most could access it regardless of where the client is based*." As the partners' ability to communicate effectively is critical, the collaborating programs have developed program guides to clarify universal processes. One created "*a shared drive and appropriate compliance documentation, allowing multiple community partners to share patient lists and wait lists, as well as program tools and processes*."

Projects led by regional health authorities have been delayed. At the time of this assessment, both had not yet launched. In each case, they had partnered with or contracted another agency to deliver the services. But, the various requirements for these types of agencies to implement programs (as well as COVID-19) mean that they are likely to be less nimble and have a slower implementation.

As well, several safer supply programs have developed strong working relationships with other programs and services within their organization. However, for some, the services for safer supply clients have not been fully incorporated throughout their organization.

Additionally, the safer supply programs have created a community of practice to share learnings and best practices, and for the more experienced to provide mentorship to new programs and providers. The community of practice has provided mutual support in developing policies and processes, and helps to ensure that programs are using best practices and not reinventing the wheel in isolation. It also delivers presentations about safer supply to the community and other stakeholders and supports advocacy. This has facilitated informal partnerships with other organizations. One program reported that with these connections, they are "*constantly reviewing our practice and*

seeking advice and innovation. This has changed the way we deliver care, as well as patient specific experiences and outcomes."

Service Design Processes and Procedures

Analysis and Summary of Key Findings

As part of design, planning and implementation, safer supply programs should:

- Conduct a needs assessment
- Review research and expertise
- Develop and document structures, processes, protocols and guidelines
- Define and document processes and protocols associated with prescribing, titration, daily pick up, observed or carries doses, frequency of visits and missed doses or appointments
- Develop and document safety, security and medication handling procedures
- Conduct process mapping, workflow and client pathways
- Develop work plans
- Build in flexibility and revise protocols, procedures and guidelines as needed

Several of the safer supply programs found it challenging to start up the program quickly – "*planning and implementing simultaneously*." As a result, there was a great deal of trial and error, with "*multiple changes at the onset*." Ideally, more time would have been spent developing structures, processes and protocols prior to implementation, but the pressing need to provide services as soon as possible was recognized. COVID-19 presented a number of challenges, including delayed planning and implementation and greater difficulty innovating. Two SUAP-funded programs have yet to launch. One program had to delay a wraparound wellness and empowerment program because of the urgent acute needs presented by COVID-19.

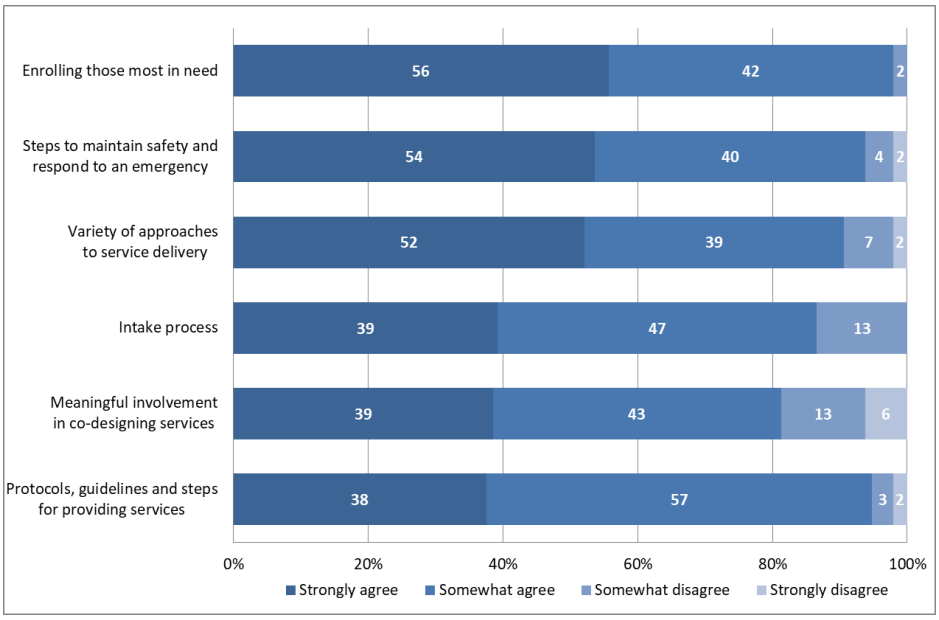
Some programs described their planning and implementation processes, emphasizing the need to apply best practices. Some reported conducting needs assessments and relying on the experience of those with lived experience to understand the community and to guide the design.

Program staff advised that a clear plan and program structure – accompanied by documented processes and procedures – were essential. In addition to guidance documents, some programs have developed infographics, short program summaries, articles and PowerPoint presentations describing their processes. During the planning process, the programs emphasized the need to maintain focus on clients' needs and to "*design services based on the individuals who will use them."* Prior to implementation, some programs developed process mapping, service workflows and pathways. They ran tabletops exercises and scenarios of workflows with their staff to develop service pathways and support their training. Some programs worked together across teams to learn as a group and develop common processes. One reported that it aimed to develop a "*program that is scalable and transferable …and provide a template for partner agencies to develop their own safer supply initiatives*." These exercises also helped programs reassess the capacity, scope of practice, technology and other program components required for implementation.

At the same time as programs need to plan and clearly define their processes and procedures, they also need to allow for being nimble and flexible on the ground and to adapt as services evolve. One program reported that it may have been "*heavy in processes*" at the onset, but the framework they developed supported implementation and service delivery, and helped them gain confidence in their work and to make requisite adjustments. Because the field is moving quickly and models and approaches have evolved since launch, some of the original proposals, plans and approaches have become outdated. For example, some programs underestimated the amount of work required for some aspects of program implementation and needed to rework some of their approaches. For example, some programs found greater effort was required to build the clinical and prescribing components of the program and, because they had to reallocate resources, it took longer than anticipated to implement the planned wraparound services. Applying continuous quality improvement and PDSA approaches could facilitate making adjustments and enhancements.

Processes and protocols associated with prescribing, titration, daily pick up, carries and observed doses, frequency of visits and missed doses or appointments are described in the "Medications" section above. Several programs have or are developing their own protocols and guidelines related to prescribing. Other the key policies and procedures are outlined below, including program recruitment, eligibility criteria and intake.

Figure 8. Staff reported opinion on safer supply processes and procedures



Based on the staff survey, most *strongly or somewhat agreed* that their safer supply programs processes and procedures were meeting clients' needs, including service delivery guidelines and approaches, enrollment, intake criteria, safety measures and co-design. Client co-design, intake processes and developing protocols, guidelines and steps for providing services are potentially areas for improvement (Figure 8).

Intake Processes

Analysis and Summary of Key Findings

Related to intake processes, safer supply programs should:

- Develop effective means to increase awareness of and client comfort with approaching the program, especially among the most vulnerable and those not connected to harm reduction services
- Work with partners to identify safer supply candidates
- Communicate the eligibility criteria
- Document the intake assessment process
- Reassess the eligibility criteria as programs evolve and capacity increases, working towards universal access for people with opioid use disorder
- Try to ensure clients' partners/spouses who require it are admitted to the program at the same time
- Develop programs, processes and pathways for those who do not qualify

Recruitment

The programs have made great efforts to disseminate information throughout the community about safer supply and conducted strategic outreach to identify and recruit those most at risk. Individuals most in need are often the hardest to reach, as they move frequently, do not have access to telephones, etc. Many programs have worked with formal and informal partners and networks to identify potential clients, develop trust and ensure them that they can access judgement-free safer supply services.

Some clients reported that there was still limited awareness about the program, especially among those not connected to harm reduction services. They suggested more advertising was necessary. A few clients had seen advertisements in the local papers and newsletters, which had started them contemplating the program, but none interviewed took the next further step without support. Notably, several reported long waits to get into the program.

> *"One of the greatest challenges has been managing barriers with the intake process. Although we have done our best to reduce barriers, this has been a constant concern and on the forefront of our minds throughout planning and implementation. The way to access the program to determine if [they are] eligible for safer supply has been by phone or through connecting with our organization or our partner organizations, but not everyone has access to a phone and/or is connected to an organization or outreach worker who could assist them with this. We need to*

have harm reduction/peer workers attached to our safer supply program doing outreach in the community and at encampments to try to find the most marginalized and hard to reach clients so that they can have equitable access to the program"

Many safer supply programs work closely with community partners to facilitate recruitment and ensure direct referrals to the service. Many clients found out about the program through a CSC or other harm reduction and community services. Often in these instances, partner staff will either introduce clients to a safer supply outreach worker at their site or accompany them to the safer supply program. Safer supply programs with connections to hospitals and their emergency departments have also received referrals from there. As programs continue to determine how to best meet demand and define their target client groups, there has been some confusion among partner organizations trying to make appropriate referrals to the program.

Some clients said they heard about the program through family and friends. Others met safer supply outreach workers at their encampment, shelter, drop-in centre or other common congregating locations. Several reported how, once potential clients were identified, the outreach workers sought them out, continued to follow up and advocated for them. One client recounted how an outreach worker continued to pursue them and leave messages, resulting in her eventually joining the program.

Eligibility Criteria

"We have had to develop a set of criteria for our program to help us to narrow down who we can take on in our program. These criteria help us to reach the most at risk clients; however, it also means that we have to say 'no' to far too many people and these people need the program as well – this leads to daily ethical dilemmas within our team. Anyone who is currently using the toxic illicit street supply…should have access to a safer supply, without needing to fit certain criteria."

The eligibility criteria for entry to safer supply vary by program. Programs have had to restrict the entry criteria because of limited capacity. The following are examples of eligibility requirements:

- Current use of illicit drugs, experiencing cravings or withdrawal and at risk for an overdose
- Current use of illicit drugs, at risk of overdose, urine screen
- Current use of illicit drugs, unsuccessful with or do not want conventional OAT or iOAT
- Opioid use disorder in Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) and clinical indication of benefit
- Opioid use disorder (DSM 5), regular illicit toxic drug use (ESSP Clinical Protocol), unsuccessful or do not want oral OAT only, urine positive for opioids
- Severe opioid use disorder DSM-5 (6+), injection use of opioids
- Severe opioid use disorder DSM-5 (6+), unsuccessful with oral OAT or at high risk of an overdose, current injection drug use or high risk of returning to IV drug use (for iOAT)
- Severe opioid use disorder DSM-5 (6+), AUDIT Tool, opioid use, injection drug use, unsuccessful treatment on oral OAT, not taking benzos and Z drugs, other significant health risks (overdose, HIV, Hep C)
- Fentanyl use, with three of the following: 1) HIV with unsuppressed viral load, Hep C, current or history of endocarditis, spinal abscesses, sepsis, osteomyelitis or previous prolonged hospitalization due to IV drug use; 2) experienced an overdose; 3) homelessness, precariously housed or in a high risk housing situation; and 4) Indigenous, Black, person of colour, woman, 2SLGBTQ+

Clients are usually accepted based on a team assessment and prescriber decision. Criteria are strictly adhered to, although some programs offer some flexibility. Eligibility is also assessed based on a medical and substance use history and client capacity to consent and attend clinic appointments, regular safe injection and pharmacy pick up.

Some staff and clients in programs where OAT or fentanyl is a prerequisite do not support that approach.

"Every other clinic in town is requiring that OAT be prescribed in order to access other safer supply medications and this does not necessarily fit with people's needs/wants/goals."

"The provision of pharmaceutical alternatives through an addiction medicine model is limiting the impacts and reach of overdose prevention and harm reduction. Making opioid agonist therapy a condition of safer supply is coercion, even if it isn't intended to be.[13]"

[13] Victoria SAFER Initiative, *Top Ten.* 2021

> *"You have to be addicted to fentanyl to qualify. By time that happens, Dilaudid are not useful."*

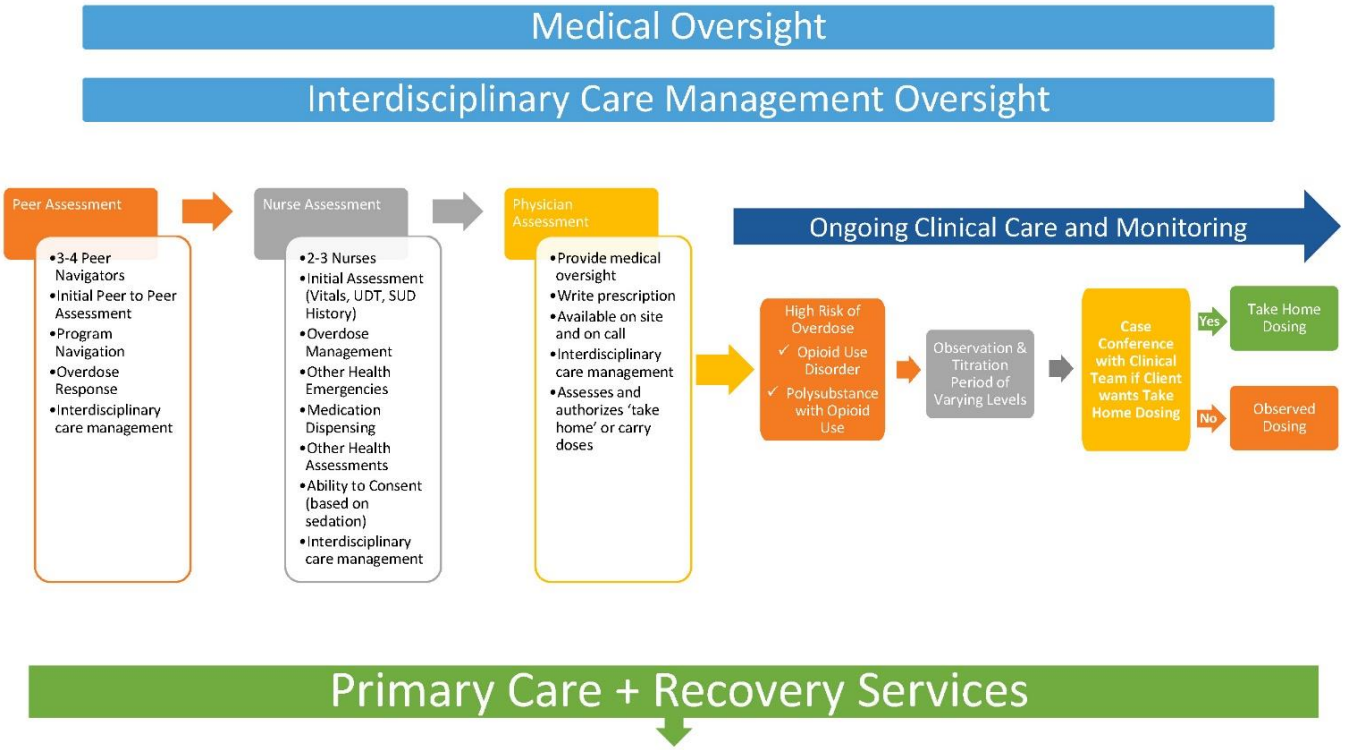
Several clients have recommended the program to family, friends and acquaintances who could not get in due to the stringent eligibility criteria. "*It depends on the prescribers and they have different rules. Some who are homeless, but have not had enough ODs were turned down. They use daily at SCS and want off, but can't get on the program.*" The first thing some clients spoke of during the interviews was family and friends waiting to access the program. "*It's hard to see some on the program and others not. They need help now!*"

Some programs have developed processes for people who use drugs who do not qualify.

> *"We have been giving advocacy kits and one-on-one teaching on how to advocate for themselves to anyone who does not qualify for the program. We have also provided access to one of the ordering providers on the team to any ordering provider in the community who is willing to learn how to prescribe safer supply for their clients [or prescribes OAT]. We attempt to do warm handovers when necessary…"*
>
> *"We have advocated for patients previously-banned from services to be able to re-access services or connect with services that are more appropriate to their needs."*

Intake Assessment

Once clients are accepted into a safer supply program, there is an intake assessment. There are similarities in this process among programs, but also differences. Team members, often a nurse or nurse and a social worker or peer worker, conduct the initial assessment. Clients receive a thorough assessment, including a detailed medical, social and drug use history, physical examination and bloodwork. Some programs are able to access additional client medical history via health care records and administrative data. At intake, program staff may also provide urgent primary care (e.g., wound care, naloxone kits, COVID-19 assessments, referrals, etc.). The team will discuss and document the client's goals in terms of safer supply. Thereafter, clients meet with a prescriber, develop a care plan and receive a safer supply prescription. In one program, nurses conduct the assessment in the community and then work with the physician to determine the best prescription options and develop a plan for the client's other health care needs. The following graphic provides an example of an intake process and care thereafter.[14]



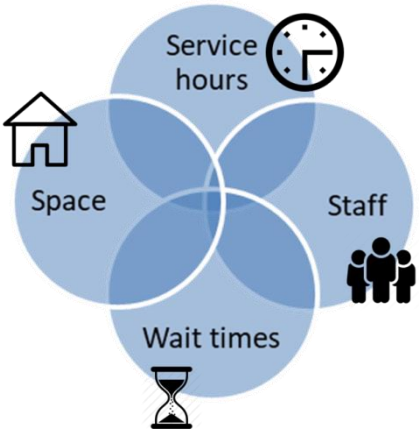
[14] Victoria SAFER Initiative, *Top Ten*. 2021

Accessing Services

Analysis and Summary of Key Findings

To improve client access and experience, safer supply programs should:

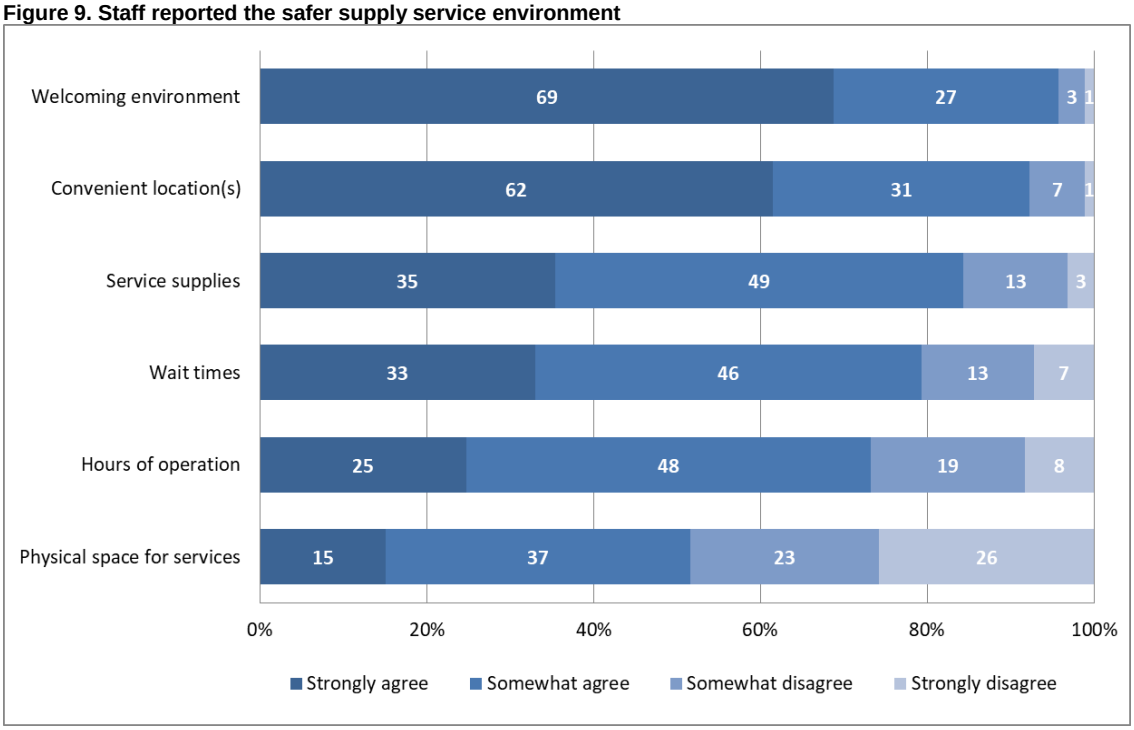
- Ensure that hours of operation are sufficient to reflect clients' dosing schedules and regular routines
- Develop innovative methods for, and alternatives to, scheduled appointments, e.g., reminder systems; drop-in and group appointments; and various entry points – such as medication delivery, vending machines, outreach, satellite clinics, in-home, via cellphones, virtual services, etc.
- Ensure medical secretaries are well-trained and knowledgeable about harm reduction, safer supply and client needs
- Provide a convenient and accessible location
- Assess and plan for adequate physical space
- Create a welcoming space
- Consider seeking expertise in allocating and designing service delivery space



The interaction between inadequate physical space, staffing, service hours and wait times has affected client access to safer supply services, as have challenges with attending booked appointments.

The staff quantitative survey results echoed the answers provided in the open-ended questions and program interviews. Most project staff *strongly or somewhat agreed* that the safer supply services are effectively meeting clients' needs in terms of a welcoming environment and convenient locations (96% and 92% respectively). Fewer *strongly agreed* they were meeting client needs in terms of wait times (33%), hours of operation (25%) and the physical space to provide services (15%) (Figure 9).

Figure 9. Staff reported the safer supply service environment



COVID-19 has impacted clients' access to services. "*COVID has presented additional challenges in capacity, staffing and access to our services (e.g., public transportation has been reduced significantly).*" Clients may also experience longer wait times due to spacing requirements. Client engagement has been more difficult due to hardships associated with the pandemic. For example, some clients have moved frequently among the various accommodations provided as a response to COVID-19, making it difficult to keep track of them.

Hours of Operation

Hours of operation vary greatly across the safer supply programs. Generally, prescribing and supporting health and social care services are available weekdays from 8am to 4pm, 9am to 5pm or 10am to 6pm. Some programs with observed doses – but not all – are open seven days a week. Examples of observed service hours include 7am to 11pm, 8:30am to 6:30pm and 9am to 6:30pm.

Several of the programs reported that the current hours were sufficient for clients, but that many would benefit from extended hours of operation. Having adequate hours is important to ensure clients on observed and daily doses can receive their medications when needed and do not have to seek street drugs. "*It would be ideal to extend [the hours] earlier to facilitate clients who work in the am and later to give an evening dose*." This applies especially to clients on three or more doses a day who struggle to get all needed doses within the current hours of operation, while also leaving the requisite time between them. Getting to the site in time of the evening dose can present a challenge for those in paid employment and who panhandle during the peak times at rush hour. Longer operating hours would also help clients – especially those not on a backbone – to adequately manage their withdrawal overnight and the following morning.

> *"We see, daily, the issues here; patients having to wait for medications dispensed at 10am when patients have been in withdrawal since 6am. This just is not appropriate or feasible as a way forward, especially since carries are so difficult/highly regulated."*
>
> *"Another challenge...is clinic hour limitations. Patients coming in to pharmacy without a prescription and outside of clinic hours must wait until the clinic re-opens. This could be overnight, but it could also be 2 to 3 days. From the patient's point-of-view, and in all honesty, they rarely know which day of the week it is. From our point-of-view, we desperately want to provide care, because this may be our only, or even last, opportunity to help them."*

To expand operating hours, many programs would need more resources and to hire more staff or to be further integrated with a larger primary care or community-based team. Nonetheless, some programs have extended their hours. One now offers access to its team members, as well as safer supply pick up, between 7am and 11pm. Several have developed innovative ways to address service hours. For example, one offers a "*delivery option of safer supply medications for people living in complete survival mode - where it is difficult to schedule time to attend appointments and go to pharmacy*."

Appointments

As discussed above, clients generally have appointments at set times each week with prescribers and/or clinic staff. These appointments can be time consuming and by their nature often need to address various concerns the client may have. Because the prescriber role can include that of case manager and goes "*beyond traditional medical model and relationships with patients,*" the standard 10 to 15 minute appointment is generally not feasible. Programs with only one prescriber are especially challenged in adhering to the appointment schedule.

In addition, programs with schedule-based clinical appointments often have no shows and clients arriving at different times than the set appointment. *"Clients often do not have reliable phone and given the chaos of their life circumstances, can be hard to engage and attend appointments consistently."* Staff also indicated that it important that clients not have to wait for extended periods and then "*have to 'walk' and miss their safe supply opportunities*."

The programs have had to increase their flexibility related to appointments with prescribers and other clinical and community health staff, and many are still working to find the best approach. One program implemented a reminder system with colour-coded "membership cards" to indicate the timing of appointments. One offers an appointment day, rather than time; another offers group appointments. Some offer in-person or virtual appointments at the SCS. Several have introduced the option of walk-in appointments or stopped scheduled appointments all together. However, while "*a drop-in format may better serve clients. In the context of COVID-19, drop-in is difficult to schedule due to spacing and management of waiting rooms*." Some programs suggested that at least two clinical staff are needed, one to do scheduled appointments, while the other sees walk-in clients and manages pharmacy inquiries. Others recommended having collaborative interprofessional clinics, with multiple programs operating in one physical space, to facilitate an effective drop-in model and ensure sufficient coverage.

> *"The team has determined it would be ideal for them to be offering a drop-in clinic a couple of days a week in a location where all three teams are present in one space. This would enable greater integration and provide a better way of matching clients to teams (also accounting for caseloads) and provide much more flexibility. But this isn't possible given space limitations at all three sites, costs of renting space in the community, and current funding budgets."*

Additionally, the role of the medical office assistant (MOA) is critical. These individuals should be hired to fit the needs of the clients, be adaptable and work well in changeable circumstances. Where they are working as part of a larger organization, it is important that they be trained and knowledgeable about harm reduction, safer supply and client needs.

Location and Space

Many clients reported that the safer supply site was in a convenient downtown location, accessible by walking or public transit (although, at least one is not accessible by public transit on Sundays). They reported that the locations are accessible for people who use drugs as they as based in their neighbourhoods. In addition, having a welcoming environment where they feel comfortable is important to clients.

> *"[It is important to have] cues of acceptance of their drug use to encourage engagement with an unfamiliar and clinical environment."*
>
> *"Many clients opt to use in this space with safer supply nurses as they like the community feeling."*
>
> *"We involved clients in painting murals on the walls so they feel emotionally a part of the space and valued. This seems to be giving deep meaning to all of us, and is building trust and engagement."*
>
> *"The program brings a group of people into a community…It gives us a place where we feel like we have somewhere to belong."*

Clients appreciate those sites that have dedicated additional space from them. A program integrated with a SCS reported that "*clients love to have their own space in the SCS (in back of the SS injecting/use area), working to make it their own has been incredible to watch."* Another site offers a lounge/activity room for people to use between injections. One opened an outreach centre to provide services such as showers, refreshments and a place to rest during the day when shelters are closed. These types of services were especially needed because the "*already minimal services were reduced*" due to COVID-19. Programs are also creating space to accommodate certain populations, including women and Indigenous clients. For example, *"the current space may pose some challenges to offering a safe space for women right away; however, this will be addressed by re-evaluating the site's floor plan and converting some office space into a medication storage area. The goal is to ensure a safe space for women can be offered in the long term."*

However, a few clients expressed concern about the design of the physical site (e.g., having barriers or seeming like a "*labyrinth*"). Some noted the segregation from the rest of the health services. "*With harm reduction in the front room, it feels like "harm reduction island."* Others expressed concern about going to safer supply sites where they intermingle with other people who use drugs, but who are not on the safer supply program. "*I would like to find a different location to see the doctor – to keep out of that scene. It's hard to be around that scene*." One staff member reported that "*clients pick up their doses in a populated area where they are often harassed by other clients. Moving safer supply services into a different area would help, away from the heavy traffic of people.*" Some programs reported that their building and/or space were suboptimal. Some are operating out of old buildings that are not up to standard. Some have capital upgrades in the works.

Most programs have struggled to adequately provide services to their clients due to limitations in their site's physical capacity. Some underestimated the level of demand and space requirements and quickly outgrew their space. Many have faced challenges accommodating clients with the additional spacing requirements related to COVID-19. Some programs have been unable to expand their program space due to limited funds or having reached the capacity of their building. One program's newly acquired "*physical space has never matched the capacity or need for our programming. This is due to high rents, limited land, inadequate funding and stigma related to poverty, homelessness, mental health and substance use*."

Some programs reported that space constraints have hindered workflow and, with limited space, confidentiality and client safety are harder to manage. Some program staff work in hallways and closets, on separate floors and different buildings. Without dedicated offices, many staff share offices or move between offices. In one site without sufficient work space, "*staff have to change offices every day and it is very difficult for clients to get a hold of staff*." "*A lot is lost in having to shift supplies and materials around the building for new room assignments*." Staff also reported inadequate space in waiting rooms, injection rooms and for one-on-one consults. Many identified the importance of having the team co-located and ideally near the harm reduction and SCS spaces. But, the lack of space has "*made it impossible for the teams to offer a joint clinic*."

Some programs have addressed the space constraints by taking programming out of their site and into the community. Some are exploring additional satellite locations to provide easier access. Others have employed mobile health outreach to overcome space obstacles.

Some programs have been able to create new spaces. For many, it required a reallocation of office space and/or renovations. Safer supply programs would benefit from support from those with expertise in allocating and designing service delivery space.

Need and Retention

Analysis and Summary of Key Findings

There is significant demand for safer supply services and the programs are unable to serve many of those who seek their services. This has created hardship for people on the wait list and for staff. Access to safer supply services needs to be expanded.

The proportion of clients who have been lost to follow-up has been relevantly low. A wide range of safer supply locales, approaches and delivery models are required to meet the needs of individuals with opioid use disorder.

Demand

Both staff and clients reported that safer supply programs are currently not meeting the high demand for safer supply in the community. Several clients indicated that they had friends and family who were interested in and/or waiting to access the program. Program staff reported that hundreds of people in their region are in need and many would be eligible. They serve only a fraction of the people in need. For example, one program estimated 6,000 people in their region would benefit from these services; they are only serving 300. According to staff:

> *"We need programs to be massively funded so we can reach and meet the needs of the community in crisis. Our present reach is so limited and is a small percentage of a much larger demographic. We need to be able to meet the needs of the entire community, not just those at the 'greatest risk' as all users of street supply are at the 'greatest risk'."*
>
> *"We are not able to provide safer supply medications to everyone in the community who needs it. We have had to develop a set of criteria for our program to help us to narrow down who we can take on in our program... People are dying and we are having to say no – this leads to daily ethical dilemmas within our team"*

Some programs have wait lists; others are not keeping a formal waiting list because "*it can cause a lot of stress for people to feel that they are in limbo*." Programs with wait lists reported having 25 to over 100 people waiting to gain entry to the program. Some have had people die while on the wait list. Program staff lamented having wait lists and the program being unavailable when clients are ready and motivated – "*the desperation is heartbreaking*."

> *"The difficulty of turning down a client who uses street supply but who is not eligible for the program is enormously difficult for the staff."*
>
> *"The team are constantly balancing between their own capacity and the knowledge that there are a large number of clients who need safer supply and who may die while waiting to access it."*
>
> *"Unfortunately, with only a small number of ordering providers currently involved in prescribing safer supply, we have had to say no to people or have had people sit on a waiting list for far too long while waiting for access to the program. One person on this waiting list died by the time we were able to do an intake with them and this was an unnecessary reminder of the urgency of this program..."*
>
> *"The biggest challenge is retaining patients as they await a spot in the safer supply program. It is hard to convince someone to keep coming in when they're looking for a supply to use on their own terms, and not a bridge to therapy [OAT] that doesn't provide them the relief they seek. These patients would visit the pharmacy sparingly, occasionally slip into heavy usage, and would often have to restart at the bottom of the dosing scale. This has improved lately, as the wait list has been eased."*

Loss to Follow-up

The safer supply programs reported a range from "*very few*" to about 10% of clients who started safer supply prescriptions but have not returned. Some have been lost to follow-up; others have moved away or been

incarcerated. As well, a few programs reported a handful of clients transitioning to other addiction treatment or harm reduction programs. Generally, programs that have fewer clients lost to follow-up are those that dedicate more resources to outreach and maintaining contact. Some clients reported that community outreach workers were relentless in trying to find them and acknowledged the positive impact of those efforts to bringing them into or back into the program. Some clients have been removed from the program due to inappropriate behaviour or diversion. Programs vary greatly in their criteria for removal, with removal being the very last resort for most.

The Professional Regulatory Environment

Analysis and Summary of Key Findings

When safer supply programs launch they need to address the regulatory environment. They should:

- Understand federal and provincial legislation related to health service provision and prescription medications
- Understand the professional regulatory environment and scope of practice
- Understand employers'/organizations' policies and standards
- Reach out to and develop working relationships with professional colleges
- Create policy documents and compliance plans to reflect the relevant regulatory, legislation and safety requirements

Several programs have faced challenges understanding and navigating the federal and provincial legislative and regulatory environment, as well as provincial professional scopes of practice. Many have experienced barriers and resistance to implementing safer supply from regulators and recounted the "*urgent need to change hearts and minds*." Safer supply programs should create policy documents and compliance plans to reflect the relevant regulatory, legislative and safety requirements. Programs acknowledged that they "*need support and policies from regulatory and government bodies to back up our programming.*" For some, developing working relationships with professional colleges has allowed them to work through the challenges and create the policies and protocols required for programming.

Many programs have dedicated a great deal of time to discussing safer supply with regional, provincial and professional bodies to advocate both for professionals to adhere to existing regulations and for regulatory changes. They have also experienced challenges with the time needed for local regulatory bodies to create or update policies to reflect legislative changes at the federal level. Programs that have established working relationships with regulatory bodies emphasized the importance of understanding their regulations, perspective and role, holding discussions at a senior level, and clearly laying out what is required of them – "*get all ducks in a row first*."

Pharmacists

Analysis and Summary of Key Findings

For pharmacists, safer supply programs should:

- Understand pharmacists' role under the *CDSA* and their provincial regulations
- Develop protocols related to the types of safer supply medications that can be dispensed by pharmacists
- Engage local pharmacists early in program development, including establishing working relationships and involving them in planning for program design, logistics and care pathways.

Under the *CDSA* regulations,[15] pharmacists can adjust medication formulations (e.g., change from pill to liquid formulations), adjust the dose and regimen, de-prescribe and partially fill scripts. Section 56 of the CDSA allows the Minister of Health to exempt any persons or controlled substance from the application of all or any provisions of the CDSA or the regulations if the exemption is necessary for a medical or scientific purpose "or is otherwise in the public interest." In response to the public health emergency caused by the COVID-19 pandemic, in March 2020, Health Canada issued a Subsection 56(1) class exemption for patients, practitioners and pharmacists prescribing and providing controlled substances in Canada. This exemption expanded pharmacists' role and permitted them to extend and renew prescriptions; transfer prescriptions to other pharmacists; take verbal prescriptions from practitioners; and deliver prescribed controlled substances to patients.

[15] Health Canada. *Prescription management by pharmacists with controlled substances under the Controlled Drugs and Substances Act and its regulations* Online at https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/prescription_management_pharmacists_controlled_substances.html

Safer supply programs have experienced challenges with the provincial colleges of pharmacists with regard to some of the medications they seek to provide and the manner in which they are dispensed. With safer supply medications subject to various federal and provincial/territorial regulations, the programs reported that some pharmacists have expressed concern about supply, transport, storage, transfers, compounding, the time required to supervise injections and the tracking and disposal of unused drugs. In B.C., discussions are ongoing about policy changes required for the adoption of the Section 56(1) exemptions.

Program staff have engaged in discussions with their provincial government and colleges for guidance and to develop protocols related to medications (e.g., tablets, liquid hydromorphone, fentanyl patches) that can be prescribed by physicians and nurse practitioners and dispensed by pharmacists. In instances where pharmacists are able to dispense, but are unable to draw an injectable dose into a syringe, safer supply nurses have been drawing doses as a delegated act. For programs that dispense hydromorphone tablets without a pharmacist on site, there are a series of chain of custody regulatory requirements which have to be adhered to. Processes have been developed and adapted to the program within those parameters.

Related to their relationship with community pharmacists, safer supply program staff emphasized the importance of engaging pharmacists early in program development, establishing working relationships, and involving them in planning for program design, logistics and care pathways. Several observed that the comfort level of pharmacists has grown over time. They also reported that some pharmacists remain unwilling to dispense safer supply as they are not comfortable in doing so based on the current regulations (or their understanding of them) or do not support the program.

Physicians

Analysis and Summary of Key Findings

Related to physicians:

- More prescribers in the community are needed to: 1) help meet the overall demand for safer supply, 2) take clients who do not meet the safer supply programs' eligibility criteria; and 3) accept current clients who have stabilized to allow safer supply programs to enrol new clients.
- Continued advocacy from physicians leaders is needed
- Safer supply physicians need the backing of their professional colleges to support their work and address resistance from other physicians. This would include: i) endorsing the existing guidance and advice to the profession; ii) acknowledging the guidance represents a professional expectation of a standard of care for addressing opioid use disorder in the community; and iii) developing professional safer supply guidelines
- National and provincial/territorial supports are needed for physicians, such as continuing medical education (CME), micro-credentialing, and practice mentoring and facilitation, to help increase their willingness and capacity to prescribe safer supply

"Another challenge has been the lack of support from [other] providers both in addiction medicine and general practice outside of safer supply programs. Due to this fact and the small number of funded organizations with...providers prescribing safer supply, we are not able to provide safer supply medications to everyone in the community who needs it."

The safer supply programs reported a pressing need for additional support for their physician prescribers who are working beyond capacity. More prescribers are needed to help meet the overall demand for safer supply, including taking on clients who do not meet the safer supply programs' eligibility criteria and current clients who have stabilized to provide a transition pathway that allows safer supply programs to then enrol new, more vulnerable clients. As well, "*there are many individuals who already have relationships with OAT providers or primary care providers, and they would benefit from having those providers' willingness to prescribe SS [safer supply].*"

> *"It would be ideal if there were more providers both within our organization and at partner organizations who are willing to prescribe safer supply to take some of the burden from our program so that we can continue to take the most at risk, so that there is a secondary program for those who are less at risk, but who are still using the toxic illicit street supply."*

Prescribing physicians have taken on the "*ethical stress*" related to ensuring a safer supply and have not received sufficient backing from their colleges and colleagues. Programs have faced challenges related to the professional

colleges' regulations and physicians' concern about safety, audits, liability and losing their licenses if they were to participate. When recruiting, they encountered "*prescribers not actually wanting to prescribe in this manner or not being adequately backed by their College to do so;*" they need to be "*assured* [by their College and peers] *they are not putting their license on the line*." Some physicians who are hesitant to prescribe say there is insufficient evidence to support the program. Others do not differentiate between the issues related to overprescribing opioids for pain relief and client needs related to opioid use disorder. Additionally, there are those who do not want to prescribe daily pick up or carries. Some organizations that provide safer supply will no longer hire clinical staff who do not support a harm reduction approach to opioid use disorder.

B.C.'s risk mitigation guidance issued by the British Columbia Centre on Substance Use was released in March 2020 in response to the COVID-19 pandemic;[16] it was also released in Quebec.[17] In December 2020, the College of Physicians and Surgeons of Ontario (CPSO) issued *Advice to the Profession* on safer supply opioid prescribing. While a positive step forward, it did not provide detailed prescribing guidance other than the general *Prescribing Drugs* policy as it relates to prescribing narcotics and controlled substances.[18] There has been other guidance released as well.[19] Many safer supply physicians have urged their professional colleges to endorse the existing safer supply guidance and to develop their own guidelines related to prescribing, as well as scope of practice and shared care models. However, provincial colleges are reported to still be dissuading some physicians from prescribing, and thus, as described above, many remain reticent to participate in safer supply, even within organizations where these services are provided. In advance of college-endorsed guidelines, some have suggested that the current safer supply guidance and advice to the profession represent a professional expectation of a standard of care in the community.

To encourage greater uptake by physicians, safer supply prescribers and other staff are dedicating their limited time to support and mentor new prescribers and advocate for safer supply. A safer supply community of practice is working to develop supports and mentoring for physicians, including ongoing continuing medical education (CME), micro-credentialing, and practice mentoring and facilitation Approaches, emulating the Primary Health Care Opioid Response Initiative in Alberta described below, could be applied to support increasing the willingness and capacity of family physicians to prescribe safer supply.

Alberta's Primary Health Care Opioid Response Initiative (PHCORI)

The Accelerating Change Transformation Team (ACTT) at the Alberta Medical Association, with a grant from the Alberta College of Family Physicians, supported PHCORI. The aim was to increase awareness, reduce stigma, build capacity, shift practice beyond a specialist model of care and build on the patient-provider relationship within primary care. In consultation with people with lived experience, ACTT developed tools and supports for practice level change (a change package); trained practice facilitators; supported the identification of patients with, or at risk of, opioid use disorder; and helped practices to implement and measure their services, including OAT. The change package provided a range of resources for assisting people with opioid use disorder, including support to improve prescribing, case management, documentation and coordination of care within the context of the Patient's Medical Home. Based on the program evaluation, multiple resources, webinars and workshops were provided and approximately 700 primary care providers were formally trained to prescribe OAT. Almost all Primary Care Networks in Alberta had at least one health professional undergo in-person training. Many participants reported that they had changed their approach to identifying people with opioid use disorder, initiating conversations and prescribing OAT. Across the province, there was a 49% increase the number of OAT prescribers and an 18% increase in the number of people receiving OAT.[20]

Nurses

Analysis and Summary of Key Findings

For nurse practitioners (NP), registered nurses (RN), registered psychiatric nurses (RPN) and licensed practical nurses (LPN):

- Several programs have nurses as clinical managers and leads
- Understand that their scope of practice allows for various clinical and non-clinical roles within the safer supply team
- Depending on the province, they may be able to prescribe, draw into a syringe, administer and monitor the use of controlled substances

[16] *Risk Mitigation in the Context of Dual Public Health Emergencies* (March 2020)
[17] Goyer MÈ, Hudon K, Plessis-Bélair M-C, et al. *Substance Replacement Therapy in the Context of the COVID-19 Pandemic in Québec: Clinical Guidance for Prescribers*. Montreal: Institut universitaire sur les dépendances (IUD) du CIUSSS du Centre-Sud-de-l'Île-de-Montréal; n.d.
[18] College of Physicians and Surgeons of Ontario (CPSO) *Advice to the Profession: Prescribing Drugs (*on safer supply opioid prescribing (December 2020); Prescribing Drugs (December 2019)
[19] Safer Opioid Supply Programs (SOS): *A Harm Reduction Informed Guiding Document for Primary Care Teams* (2020); *National Injectable Opioid Agonist Treatment Guideline* (2019); *Toolkit for Substance Use and Addictions Program Applicants* (2019).
[20] Accelerating Change Transformation Team, AMA. *Primary Health Care Opioid Response Initiative, Year 2 Evaluation Summary*. (March 2020).

Nurses – NPs, RNs, RPN and LPNs – play an important role clinical and managerial role in safer supply services. For example, several programs have an RN as the clinic manager or clinical lead. While many programs are taking advantage of the nurses' full scope of practice, some are not. It is thus important for programs to understand and take advantage of advances in the scope of practice and professional roles of nurses when considering their role in a safer supply team. For example, many nurses, including RPNs and LPNs, have experience administering liquid opioids in emergency departments, hospital and long-term care settings, and can draw into a syringe and supervise injectable doses and monitor clients post injection as part of their scope of practice. A federal Section 56(1) class exemption from the *CDSA* issued in 2018 allows nurses who provide health care at a community health facility to provide and administer controlled substances to people receiving treatment.[21] Several programs have taken advantage of the authority in the exemption for practitioners to verbally prescribe safer supply drugs and have nurses administer them and monitor clients. In addition, through Medical Directives, nurses often do the initial and follow-up assessment of clients and notify the prescriber if there are deviations from the directives. Many nurses also fulfil the documentation requirements. There is also a growing role for nurses in prescribing safer supply. Nurse practitioners can prescribe these medications in many provinces. In B.C., select registered and registered psychiatric nurses can prescribe buprenorphine/ naloxone (Suboxone). An expansion to allow the prescribing of Kadian and methadone is underway and the prescribing of addiction medications is under discussion.[22]

Medical and Harm Reduction Approaches

Analysis and Summary of Key Findings

Medical and harm reduction approaches to safer supply are understood and implemented differently.

- At its core, safer supply should be based on the principles of harm reduction
- Safer supply should be an option for treating opioid use disorder as part of the continuum of services provided within a health care system that treats all medical conditions, including addictions
- The primary care system should be rooted in a social and moral determinants of health[23] approach in the provision of comprehensive addictions care
- The traditional approach of addiction medicine has not been conducive to addressing the needs of safer supply clients, and new models and pathways are required to support the continuum of client goals
- Some people with opioid use disorder are hesitant to engage with a clinical/medicalized service, especially located within a health care service, and require alternative options
- Alternative safer supply models, such as cooperatives and compassion clubs, should be considered, addressing any financial barriers to access

Related to laws and regulations:

- Consider expanding the group of professionals that can prescribe and administer controlled substances
- Further investigate and consider legalizing the personal use of controlled substances and amending the regulations pertaining to them, including removing the prohibition on simple possession of opioids

"Just as human needs are diverse, so must be our conceptions of healing and our approaches to supporting one another to access a better quality of life on our own terms."

Harm Reduction

There has been much discussion about the merits of various models of safer supply delivery. Some program staff have suggested that there are "*implicit tensions between addiction medicine and harm reduction approaches*." However, there is a range of understandings and beliefs about what a harm reduction approach entails.

The core values underlying a harm reduction approach are reported to include social justice, equity, caring, inclusion, respect and human rights – including the right to health care. It is "*recognising that all basic needs must be met in order to promote healthy lives and communities*." Harm reduction was also described as outreach and building relationships in the community. For clients, applying a harm reduction approach "*increases skills,*

[21] Online at: https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/subsection-56-exemption-nurses-providing-primary-care-community-health-facility.html
[22] *RNs begin prescribing addiction treatment medications, a Canadian first*, Online at https://news.gov.bc.ca/releases/2021MMHA0003-000219
[23] Berwick DM. *The Moral Determinants of Health*. *JAMA.* 2020;324(3):225–226.

confidence, social connectivity and wellness" and "*reduces the social stratification and structural barriers created by prohibition and helps those impacted by homelessness, poverty, mental health issues, racism and stigma to access primary care*" Those advocating for a harm reduction approach to safer supply emphasized that the priority is to have low-barrier accessibility and to work with clients where they are at in order to find workable solutions.

> *"The harm reduction model takes a collaborative and strengths-based approach to working with clients, following their own goals, building on their successes and their skills, and really addressing the whole person, also addressing pleasure and other benefits of drug use."*
>
> *"These initiatives should not be driven by a medical model approach but rather a social justice orientation of harm reduction practice that respects the full autonomy and inclusion of people who use drugs."*
>
> *"Harm reduction recognizes that people who use drugs are knowledgeable about the culture of drug use and their own goals and needs."*

By the nature of the current program, safer supply is accessed through prescribing physicians and nurse practitioners. This has raised discussions about medical and harm reduction approaches. According to some, "*access to alternative pharmaceuticals is inherently reliant upon prescribers. It is a model that is 100% prescriber driven. It has been difficult to balance the lack of evidence to support pharmaceutical alternatives with the harm reduction model that informs SS [safer supply]*." With professional hierarchies and power differentials, tension can occur between clinical and community health cultures.

> *"Safer supply guidance has really caused tensions and pitted prescribers against patients, nurses, harm reduction workers, the broader community."*
>
> *"It's important to note that our clinicians are used to working with street-involved populations and they work very much from a harm reduction perspective and really try to break away from an overly medicalized model – and compared to most health care spaces they are very successful. But the power structures and clinical culture lingers..."*

Different team members may emphasize a different focus. For example, for many programs, the design and initial emphasis focused on getting clients assessed and titrated on their medications, and then addressed other health and social issues. This approach worked in many instances, but not for everyone. A great deal of upfront support was required for clients who did not have the stability and conditions required to get through the assessments and titrate up to a suitable dosage. For some, staff felt that the harm reduction/ community health approach should have been be emphasized first, "*meeting clients where they are at, developing rapport and building trust with health care providers, helping them get comfortable with a pharmacy, help them access shelter/housing – all this before they were ready to fully participate in the safer supply program*."

Some staff also discussed the nature of the relationship and power dynamics between clients and medical staff and ways in which it could be reconfigured. They pointed to stigma and the assumptions implicit in medical training as barriers. They suggested the power dynamics and client experience of oppression needed to be better understood and made explicit, as developing a mutually trusting relationship with clients is critical. They described an ideal situation whereby "*the relationship between the client and provider is reconfigured: clients are experts in identifying their own needs and goals, clients determine the pace and direction of care, and providers respond to the needs and goals identified by clients*."

A Harm Reduction Model within Comprehensive Medical Services

> ***"Safer supply is just one part of more equitable access to health and wellbeing. Providing safer supply is a harm reduction entry-point to addressing other basic needs and priorities. Secure housing, livable income, access to health care, and a caring community to feel a part of, are all necessities.[24]"***

Many program staff believe that people who use drugs should have equitable access to the continuum of comprehensive primary health care. They take the position that safer supply is a medical option for treating opioid use disorder as part of the continuum of services within a health care system that treats all medical conditions, including addictions. As well, those receiving safer supply benefit from concurrent primary health care. "*Offering quality primary care is an important element to safer supply*." Some also suggest that prescribing by medical professionals can increase safety and reduce harm and diversion.

[24] Victoria SAFER Initiative, *Top Ten.* 2021

"Safer supply should be one tool in a primary care provider's tool bag in the treatment of opioid use disorder – along with other problems."

"Harm reduction should be considered as a medical intervention, since we are treating substance use disorder as a medical condition. The more substance use disorder can be seen as a medical condition and normalized as such the sooner stigma will be mitigated. We have rapid access built into our program so this may be a hallmark of harm reduction, but optimal access to care should be available for health care conditions in general."

Many believe that the entire primary health care system needs to evolve and that safer supply prescribing should be just another part of comprehensive care. These services would be based on a social determinants of health, trauma-informed, decolonized approach, and safer supply and all other treatment options for opioid use disorder should be available as part of that care. They argue that a whole-person approach should address all aspects of clients' lives – their physical, mental, emotional and social care needs – including the underlying reasons for drug use. Thus, they put forth that wraparound primary health care services, rooted in harm reduction policies and practices, can best meet the various needs of people with opioid disorder. They also emphasized the importance of relational continuity and team-based care as part of comprehensive services. "*People are disconnected from the system. Recreate a system with meaningful relationships, trust and access*."

"Our approach is informed by the treatment as prevention model and the latest evidence in primary and preventative care. We utilize the full skill sets of the peers, social workers, nurses, counsellors, and doctors in a team-based care approach to optimize patients' health and wellness outcomes. The safer supply service is delivered in the context of multidisciplinary team-based care. This requires that our team be trained for and familiar with a broad spectrum of medical presentations – more than a specialized service."

Some safer supply programs have tried explicitly to be a hybrid harm reduction/addiction medicine model, and "*have an arsenal of options*" and "*bring all tools to the table*." For one program, "*the approach is firmly rooted in harm reduction, and the benefits of the hybrid approach mean that we can co-prescribe more traditional, long-lasting OAT in addition to safe supply and…bring urgent primary care to people where they are.*" Another program "*is a more medical, addiction medicine model because it requires the participant to come to the clinic, it's based on physician assessment and prescription and doses need to be witnessed. We have embedded this medical model within an overdose prevention site so it will be as closely tied to a broader harm reduction service as possible*." Those at hybrid sites suggested a broader harm reduction approach (including decriminalization or legalization) would bring more flexibility than a medical model, but including a medical model would be more appropriate for some individuals, and "*tailored to meet the needs of the most medically complex, treatment focused individuals*."

"Having the safer supply pilot program integrated within a network of low-barrier primary care and safe consumption site allows us to provide more wraparound, integrated care for the community we serve. We believe team-based wraparound services that integrate harm reduction and substance use medicine create more opportunities for patients to engage in care in a convenient, safe, and familiar manner."

Addiction Medicine

"The medical / addiction medicine model haunts the clinical team and the clients. Following aspects of guidelines established by addiction medicine model has been important for protecting prescribers and establishing legitimacy within the medical community. BUT our prescribers are actively engaged in approaching their practice with an eye towards not replicating medical violence, including the paternalistic, punitive, and moralizing tone entrenched in many addictions medicine and medical providers."

Many of the safer supply providers have called for a new model for addictions medicine. They believe a medicalized/addiction medicine model should have harm reduction at its core. However, they suggested that harm reduction is "*drowned out by the primacy of addiction medicine and abstinence-oriented treatment and recovery interventions*" and "*not given enough respect and legitimacy on the continuum of care*." Some in the safer supply programs described addiction medicine as "*being risk averse and conservative; not understanding/valuing harm reduction."* Some addictions medicine specialists have been resistant to safer supply, spoken out against it, discouraged colleagues from prescribing and chastised clients for participating. This has reduced the number of

prescribers who are willing to take on clients. As well, safer supply prescribers have experienced push back and the wielding of differential power dynamics from some in the addictions medicine field. "*It has been a challenge maintaining collegial relations with the broader addiction medicine community of care providers who tend to see us as nothing more than reckless enablers*."

Additionally, programs have experienced difficulties getting clients who want it into treatment services. They maintained that existing treatment models are based on "*judgement*," "*morality*" and the "*wrong attitude*." Clients need treatment pathway options that support them in attaining their goals. A focus on treatment and recovery "*misses that there are different ways to recovery*." Importantly, various pathways should be open to support them through withdrawal, whether to reduce their drug intake or free them of street drugs or all drugs. Current treatment models generally require abstinence to gain entrance. So, safer supply clients do not qualify. Even if treatment programs would accept clients who are on a safer supply, some may still be using street drugs albeit at a reduced rate and would not qualify.

Many in safer supply programs believe that addiction models need to better recognize marginalization and clients' experiences related to trust. For example, much of addictions medicine language does not fit with the safer supply approach. According to staff member, "*addictions medicine…the maxim is to 'trust but verify'. This doesn't actually sound like trusting*." A change in approach and perspective was suggested in that "*drugs are not the problem – it's how we treat people [with opioid use disorder]*."

De-Medicalized Approaches

While many acknowledged that the "*medicalization of safer supply programs is having amazing impacts on many*," there are challenges working within a medical model. As described above, based on the regulations under the *CDSA*, physicians and nurse practitioners can "*prescribe, administer, provide and sell*" controlled substances and the prescriber is required to be in a care relationship with clients, as with the current safer supply programs. The need for prescribers to work within college regulatory requirements has created barriers to access and influenced the nature of service delivery. "*Our program definitely aims to work from a harm reduction perspective, while also having to check off the boxes required to meet professional regulatory standards*." The need to carefully document prescribers' work has created "*a significant work load*" and "*made the work of staff significantly more difficult*." As well, *"the most 'treatment-resistant' and "highly marginalized people fall through the cracks*." Some staff considered "*requiring those with opioid use disorder to formally engage with the health care system to have access to safe drugs [to be] a major barrier*."

Some program staff suggested that safer supply be provided with prescribers removed from the process; others said alternative options should be offered in parallel with medically-based services. Several believe that safer supply "*models need to be removed from a biomedical approach*" and suggested alternative models to the current safer supply. They suggested that "*if opioids were available in a regulated system, outside of the medical model, many more would have access to safer drug supply*."

> *"A de-medicalized model should be developed as much as possible and supported by regulatory changes so that people have access to the 'right substances, in the right form, at the right time'."*
>
> *"Physician gatekeeping, as long as this is done through a prescriber driven model, patients will never have autonomy over their care and doctors will continually under-prescribe, force OAT as a condition of safe supply, and hold their patient hostage by their ideologies. This needs to go the next step and be delivered via a regulated public health model."*
>
> *"Ideally, alternative pharmaceuticals would be taken out of prescribers' responsibilities and moved in to a harm reduction/public health model with support of federal and provincial decision makers to do this. This is a truly peer-driven, sustainable model."*

Examples of suggested models without prescribers include distribution by dispensaries and compassion clubs.[25] Similar to cannabis compassion clubs and buyers' clubs, compassion clubs for safer supply have garnered discussion of late. These clubs would operate like buyers' cooperatives. Access could be restricted to members and medications would be legally obtained from a pharmaceutical manufacturer and securely stored in the same way as they are obtained and stored for some safer supply programs. Supporters suggest there would be no cost to the public and they could potentially charge on a sliding scale based on income. Advocates argue that they would provide predictable dosages and help to reduce stigma and the hustle for drugs. Currently, Canada is a signatory to the Single Convention on Narcotic Drugs of 1961 and the amended 1972 Protocol, which require

[25] See for example, BCCSU, Heroin Compassion Clubs https://www.bccsu.ca/wp-content/uploads/2019/02/Report-Heroin-Compassion-Clubs.pdf

controlled drugs listed on the schedules to the Convention to be made available via a "medical prescription." Non-prescriber models would violate these conventions.[26]

> *"Ultimately, safe supply needs to be de-medicalized and come from a peer-driven compassion club type program, rather than having harm reduction nurses and physicians be the gatekeepers for drugs."*
>
> *"I don't think it's actually reasonable to ask even addiction medicine physicians to practice medicine in this way - reducing harm is medicine, yes, but doctors don't prescribe alcohol or marijuana to patients with those substance use disorders - we have safe supply at liquor stores and dispensaries where I, as the "patient", can choose my own dose, route, and drug of choice without needing a prescription or having to follow certain rules and jump through hoops like [urine drugs screens]."*

"Safer supply is not 'the' answer to the overdose crisis. The best approach/answer we have now is decriminalization and legalization."

Several prescribers support the decriminalization or legalization and amendments to the regulations pertaining to controlled substances. They do not necessarily want to be gatekeepers to a safer supply, but "*have the power to address the urgent need*" – they believe they have the "*moral and professional obligation to act. To not act puts people at risk of greater harm."* They recognize that *"some of this is a public health intervention that is not always easily realized with a medical model*." But, *"in the meantime, here is another pathway." "Ultimately, decriminalization alongside of a medicalized model is likely to be more impactful*."

Based on the large body of evidence and input from program staff and clients, the laws criminalizing controlled substances have not resulted in their decreased use.[27] Many people who use drugs, service providers, advocates, and many health and social organizations have called for the decriminalization or legalization of these illegal drugs. They highlight the stigma, marginalization and barriers to accessing support that people who use drugs experience due to their criminalization.[28] [29] Strategies to reduce harm and address the social conditions underlying problem substance use are wanted. Efforts that focus on the social determinants of health, harm reduction, safer supplies and access to effective treatment have shown to be more effective.[30]

> *"As long as we continue to wrongfully criminalize people who use drugs, the overdose crisis will only worsen."*
>
> *"Safer supply initiatives need to be accompanied by urgent drug policy reforms to decriminalize, legalize and regulate substances in order to undermine systemic harms and centre people with lived/living experience in their own lives."*
>
> *"We need rapid efforts to decriminalize people who use drugs across Canada and rapid action on legalization and regulation of all substances. This must involve meaningful inclusion of people with lived/living experience of criminalized drug use and people who are champions of a social justice orientation to drug use."*
>
> *"Until we can truly address the roots of why decriminalization, legalization and regulation are not options federally and provincially, we will continue in cycles of inequity and inaccessibility."*

[26] Online at https://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Ebook/The_International_Drug_Control_Conventions_E.pdf
[27] E. Wood et al., *The war on drugs: a devastating public-policy disaster. The Lancet* 373:9668 (2009). Statistics Canada, *Unfounded criminal incidents in Canada, 2017: Police-reported crime for selected offences, Canada, 2017*, July 23, 2018; Canadian Mental Health Association, *Care not Corrections: Relieving the Opioid Crisis in Canada*, April 2018. Online at https://cmha.ca/wp-content/uploads/2018/04/CMHA-Opioid-Policy-Full-Report_Final_EN.pdf; Statistics Canada, *Police-reported crime statistics, 2018*, July 22, 2019; Statistics Canada, *Police-reported crime statistics in Canada, 2019,* October 29, 2020; and S. Boyd, *Drug use, arrests, policing, and imprisonment in Canada and BC, 2015–2016*, March 9, 2018, and S. Boyd, *Addendum: Drug Arrests in Canada, 2017*, September 15, 2018.
[28] Canadian Public Health Association, *Decriminalization of personal use of psychoactive substances, position statement*, October 2017. Online at www.cpha.ca/sites/default/files/uploads/policy/positionstatements/decriminalization-positionstatement-e.pdf; British Columbia Office of the Provincial Health Officer, *Stopping the Harm: Decriminalization of People who use Drugs in BC*, April 2019. Online at www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf; Canadian HIV/AIDS Legal Network, *Letter to Canadian Government: Decriminalize Simple Drug Possession Immediately*, June 25, 2020. Online at www.hivlegalnetwork.ca/site/letter-to-canadian-government-decriminalize-simple-drug-possession-immediately/?lang=en; HIV Legal Network. *A Primer For Municipal And Provincial Governments- Decriminalizing People Who Use Drugs Making the Ask, Minimizing the Harms*, Toronto, Canada, 2020; and Canadian Centre on Substance Use and Addiction, *Decriminalization: Options and Evidence*, 2018. Online at www.ccsa.ca/sites/default/ files/2019-04/CCSA-Decriminalization-Controlled-Substances-Policy-Brief-2018-en.pdf.
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[30] Canadian HIV/AIDS Legal Network, *Canada must adopt a human-rights based approach to drug policy*, November 22, 2018. Online at www.hivlegalnetwork.ca/site/statement-canada-must-adopt-a-human-rights-based-approach-to-drug-policy/?lang=en; International Centre on Human Rights and Drug Policy, UNAIDS, UNDP, and WHO, *International Guidelines on Human Rights and Drug Policy*, March 2019. Online at www.humanrights-drugpolicy.org/; Drug Policy Alliance, *Drug Decriminalization in Portugal: Learning from a Health and Human-Centered Approach*, February 20, 2019. Online at www.drugpolicy.org/sites/default/files/dpa-drug-decriminalization-portugal-health-human-centered-approach_0.pdf; and J. Csete, and R. Elliott, "Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction," *International Journal of Drug Policy*, (2020) Online at https://doi.org/10.1016/j.drugpo.2020.102976.

In Conclusion

Safer Supply Services

Having access to a safer supply has had tremendous immeasurable (and measureable) positive impacts on clients' lives. According to clients and staff, many are more positive and happier, and have better health outcomes, greater stability and improving relationships with family and friends. Some have secured housing and/or employment. Many have achieved their goals with the program, and others are working toward them. "*I have achieved my goals with it. It works for everything I am looking for – every avenue that needs to be met."* Clients are highly appreciative of having these services available to them. "*It's surprising; I didn't think the government would provide this. We are addicts and not really a priority*." "*It's amazing, I never in my life thought I would have something like this."*

Safer supply programs differ in the range of prescription medication and dosage options offered. Prescribers work with clients – based on established parameters – to find the approach that works best for them. For many clients using hydromorphone, the addition of a Kadian and/or methadone backbone and/or a medication, such as Ritalin, to address their stimulant use has proved successful. Some are finding success with other opioid medications, including fentanyl patches and oxycodone. The proportion lost to follow-up has been relevantly low.

Clients have effectively developed their own goals and processes for managing their medications, including combining injection and oral administration, taking their medications as needed throughout the day, and reserving medications to get them through until the next day. However, some clients are finding observed dosing and daily pick-up time consuming and inhibiting to their daily lives. Programs would benefit from documented guidance on how best to safely execute both tablet and injectable carries and increase client freedom and control.

Most clients struggle to manage withdrawal symptoms, but few have experienced an overdose. Many have stopped using street drugs; others are still using them, although at a progressively decreasing rate. As this is early in the program, one would anticipate that this downward trend would continue if prescriptions can be adjusted to match their needs. However, it was reported that client needs are evolving and increasingly are not supported by the recommended approaches in existing prescribing guidance. The safer supply programs are finding it difficult to manage client tolerance levels as a result of their fentanyl use. They have identified several additional medications that are required to counter fentanyl, as well as other substance withdrawal. Access to these desired medications has been hindered by the regulatory environment, coverage by provincial formularies, and supply interruptions (with generics proving to be less effective).

While most programs have a standardized approach to missed doses and restarts, they vary greatly. Some clients' medications are stopped for a period of time; others' dosages are reduced. This process is challenging for clients with unstable lives or working to establish a regimen that works for them. Some have overdosed while their dosage has been stopped or reduced. For some clients, there are no such ramifications. In these instances, the medications may be changed or increased. Diversion is taking place. Some programs remove clients from the program for diversion. However, there is a number of reasons for diversion, including inadequate dosages or safer supply options, insufficient access to safer supply programs to meet demand, needing to meet other basic needs or providing support to a friend. It was shared that, with diversion, someone is still getting a safer supply. Still, some are concerned that these drugs will be accessed by those who do not currently have an opioid use disorder. An explicit step-by-step approach to missed doses and suspected diversion and clear messaging about the approach that will be taken – including pathways for transitioning clients who are removed from the program – is recommended. The approach should consider all factors that may lead to missing doses and diversion.

Safer supply team members communicate well and work collaboratively. They work together to find solutions for their clients and have introduced a number of innovative practices, with peers playing important roles. Clients are very appreciative of the safer supply staff. However, staff-to-client ratios are high and most programs have insufficient funding for the number and type of staff needed to meet the overall demand for services or adequately meet the needs of current clientele. Many work long hours, are unable to take time off and are burning out. Programs would benefit from more of each type of provider. Several have met challenges recruiting staff. As well, programs should ensure that staff have access to adequate team building, capacity building and mental health

supports. Clinical training, whether initial or continuing education, needs to address and develop skills in harm reduction, anti-oppression and anti-stigma approaches to care.

Some stated that different models of safer supply are needed, as a single design would not meet the needs of all clients. Having safer supply embedded within primary and social care is desirable and can readily support clients' overall health and wellbeing. However, standalone programs may be preferred by clients who find them lower-barrier than the formal health system or want to receive their health care separately. Safer supply services for Indigenous peoples must reflect their unique culture and lived experience. Whatever the model, it is critical that all programs operate with harm reduction lens and take a holistic, trauma-informed approach. In additional to safer supply, programs should offer a range of health and social services within the program or as part of effective partnerships, with seamless transitions in care ensured. Thus, a wide range of safer supply locales, approaches and delivery models are required to meet the needs of individuals with opioid use disorder, with new and innovative approaches to delivering safer supply contemplated.

Safer supply programs benefit from numerous collaborations and partnerships. Their closest linkages are with other harm reduction services (e.g., SCS), pharmacists and primary care. Pharmacists and SCS are important members of the safer supply team and, in many instances, see clients most often. A reciprocal working relationship in support of client health and wellbeing benefits them greatly. Programs have worked to educate community partners about the safer supply and the stigmatization experienced by their clients, and to build working relationships. Nonetheless, clients would benefit from increased buy-in and better collaboration and care coordination among service providers. Establishing training, referral networks and pathways, and guidelines for providing services to safer supply clients would support continuity of care. Additionally, innovative, dedicated and individualized stabilization and recovery pathways are required for clients who have stabilized on safer supply or desire other recovery pathways.

Design and Implementation Features

The overarching approach to providing safer supply services should be grounded in the community and centred on input from people with lived experience in program co-design, planning and implementation. Design and implementation processes should keep the focus on the client. Services should be welcoming, culturally-safe, judgement-free and trauma-informed and emphasize trust and client empowerment in their health and wellbeing. Programs that continue to innovate based on clients' lived experience, evolving needs and feedback are most responsive. Ideally, they would provide comprehensive wraparound services, potentially co-located.

To help team members work effectively and focus on their clients, the requisite organizational and management structures should be in place. As part of planning and implementation, programs should develop and document approaches for: governance; leadership and management; financial management; growth and expansion; human resources requirements; team building and support; infrastructure; information technology (IT); equipment; storage and security; communication strategies; quality improvement; and partnership arrangements.

Safer supply programs also should establish service design processes and procedures as part of planning and implementation, through needs assessments, research, expert input, process mapping, client pathways and work plans. Design steps involve developing and documenting structures, processes, protocols and guidelines, including those for safety and security; medication handling procedures; intake criteria and assessment; prescribing; titration; daily pick-up, observed and carries; frequency of visits; and missed doses or appointments. Design also entails building in flexibility and revising protocols, procedures and guidelines as needed.

To improve client access and experience, safer supply programs should ensure that access options and hours of operation are sufficient to reflect clients' dosing schedules and regular routines. This would include developing innovative methods for, and alternatives to, scheduled appointments, such as reminder systems; drop-in and group appointments; and various entry points – including medication delivery, vending machines, outreach, satellite clinics, in-home, via cellphones, virtual services, etc. Improving clients' experience in accessing care also entails the provision of a convenient and accessible location and an adequate and welcoming physical space. It is also important to ensure that medical secretaries are well-trained and knowledgeable about harm reduction, safer supply and client needs.

When safer supply programs launch they should understand and address federal and provincial legislation and regulations, profession regulations and professional scope of practice, and employers'/ organizations' policies and standards. This would include reaching out to and developing working relationships with professional colleges, and

creating policy documents and compliance plans to reflect the relevant regulatory, legislation and safety requirements. The following should be considered for each of the following group of professionals:

- Pharmacists: Safer supply programs need to understand their defined role under the various federal and provincial/territorial regulations, and engage community pharmacy partner early to establish working relationships, develop protocols and involve them in planning for program design and care pathways
- Physicians: Increase the number of prescribing physicians through advocacy from physician leaders, backing from their professional colleges, education and mentoring, developing guidelines and establishing safer supply as a standard of care
- Nurses: Understand their scope of practice and various possible roles within the safer supply team, including the ability to prescribe, draw, administer and monitor the use of controlled substances

At its core, safer supply should be based on the principles of harm reduction. The traditional approach of addiction medicine has not been conducive to addressing the needs of safer supply clients, and new models and pathways are required to support the continuum of client goals. Safer supply should be an option for treating opioid use disorder as part of the continuum of services provided within a health care system that treats all medical conditions, including addictions. The primary care system should be rooted in a social and moral determinants of health[31] approach in the provision comprehensive addictions care. It is also important to acknowledge that some people with opioid use disorder are hesitant to engage with a medicalized service, especially located as part of a health care service, and require alternative options. It was suggested that other innovative models, such as cooperative and compassionate club, should be further investigated. To support such models, programs and clients suggested that steps should be taken to legalize and regulate the use of controlled substances used to treat substance use disorder.

High Demand and the Need to Scale Up

The overdose crisis continues unabated and there is a continued need for urgent action. For example, in the first six months of the COVID-19 pandemic, there was a 79% increase in opioid-related deaths in Ontario or an additional 17,843 years of life were lost due to opioid overdose compared with the 6 months prior. The highest rates of opioid-related deaths are among men, people ages 25 to 44, those working in the construction industry and those experiencing homelessness. Most deaths were directly attributed to fentanyl. "*The rising rates of harm among young adults, as well as the increased contributions of fentanyl and stimulants to these deaths emphasize the urgent need for low-barrier access to evidence-based harm reduction services and treatment for opioid use disorder in all jurisdictions grappling with the overdose–COVID-19 syndemic*."[32] [33]

The current SUAP-funded programs and other safer supply services in the field are not meeting the demand. Many programs have reached capacity and are too busy to take new clients or expand. Those working on the ground have seen the results and emphasize the need to expand access. While research and evaluation of these services is ongoing, "*There is frustration among those working in this field, with the sentiment being: 'why isn't this being normalized?' We have a mountain of evidence showing how this is beneficial, yet the barriers to act on this science are pervasive*." Broader access to safer supply services, whether through primary care, harm reduction services or other modalities, is needed to address the overdose crisis and provide the necessary services – medications and comprehensive health and social services – to people with opioid use disorder. According to one client, "*We have been preaching about safer supply for 15 to 20 years – finally – after one step at a time. The more these programs prove success, the more people will realize it is the right thing to do and it makes sense*."

[31] Berwick DM. The Moral Determinants of Health. *JAMA.* 2020;324(3):225–226. doi:10.1001/jama.2020.11129
[32] Gomes T, Kitchen SA, Murray R. Measuring the Burden of Opioid-Related Mortality in Ontario, Canada, During the COVID-19 Pandemic. *JAMA Netw Open.* 2021;4(5):e2112865. doi:10.1001/jamanetworkopen.2021.12865
[33] Gomes T, Murray R, Kolla G, Leece P, Bansal S, Besharah J, Cahill T, Campbell T, Fritz A, Munro C, Toner L, Watford J, *Changing Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic*. Toronto, ON: Ontario Drug Policy Research Network; 2021.

Appendix A. SUAP Pilot Projects

Program Description

Organization	Project Title	Programs' Reported Description
AVI Health and Community Services Society	*The Victoria Safer Alternative For Emergency Response (SAFER) Initiative* *Name preferred by the project: Victoria SAFER Initiative*	This project provides pharmaceutical grade medications (opioid/OAT/stimulant) to address the overdose risk posed by the toxic illegal drug market. It serves individuals whose needs have not been adequately met by current interventions (such as people experiencing homelessness) and those who have not been engaged through traditional public health and addiction treatment measures. It aims to provide legal substances that are as close as possible to what people are currently using. The program is delivered as a distributed model for assessment, prescribing, and delivery of alternatives to illegal drugs. This includes outreach and medication delivery, and fixed site services, with an emphasis on current gaps in the service continuum. The program is delivered by a team consisting of outreach workers with lived/living experience, nurses, pharmacists and physicians. People with lived/living experience of criminalized drug use play an integral role in the design, planning, and implantation stages, ensuring that the multiple needs of clients could be met. In addition to the harm reduction and addiction medicine services, the project also serves as a point of entry to wraparound health and social services including primary and addiction care. To address participants' needs in the context of the COVID-19 crisis, these services also facilitate access to support and testing.
Providence Health Care Research Institute (BC Centre for Excellence in HIV/AIDS)	*An innovative safe supply program to support people with severe opioid use disorder within a low barrier primary care setting in the Downtown Eastside of Vancouver* *Name preferred by the project: Hope to Health*	This project enhances access to opioid agonist therapy (OAT), as well as alternative therapies such as injectable opioid agonist therapy (iOAT), including hydromorphone. The project also assesses the feasibility of using other opioids such as fentanyl patches to provide a more personalized medical intervention. This program is offered at the Hope to Health Complex with other integrated services including a supervised consumption site. It provides an entry point to primary care for clients, and provides opportunities for ongoing monitoring and evaluation of the program's interventions within an integrated health care setting. The project operates within the Government of BC guidelines to reduce the risk of transmission of COVID-19 in people with opioid use disorder through expanding access to safer prescription alternatives to the illegal opioid supply beyond OAT and iOAT.
London InterCommunity Health Centre	*Safer Opioid Supply Program (SOS)*	This project aims to reduce deaths and harms related to the toxic drug supply by providing prescribed opioids to patients with opioid use disorder while offering a supportive environment where clients can engage in care and embark on the path to stability and wellness. The initiative is built upon a flexible, low-barrier, community-based safer supply model that can be delivered with minimal resources, and that is embedded in the London InterCommunity Health Centre's (LIHC) – Health Outreach Program – Health Outreach Mobile Engagement (HOME), Safer Opioid Supply (SOS) model of care. The SOS prescribers provide assessment, monitoring, and prescriptions for daily-dispensed, take-home oral hydromorphone tablets, and slow-release oral morphine. Clients will be engaged with LIHC's psychosocial supports, a range of health and social services that address the social determinants of heath, to work towards stability.
Parkdale Queen West Community Health Centre	*Safer Opioid Supply Program (SOS)*	This project provide people who have severe opioid use disorder (OUD) with a pharmaceutical opioid of known quality, quantity, and strength as an alternative to drugs found in the contaminated illegal supply. Known as the Safer Opioid Supply Program (SOS), the approach is intended to reduce lethal and non-lethal overdoses and other harms related to use of contaminated illegal drugs, and increase client engagement with health care and social services. The SOS consists of three key activities: primary care, supervised consumption services, and the harm reduction drop-in. Clients meet with a primary care provider weekly for monitoring, assessment, and their prescription. Additional health care needs are addressed through primary care services or other health care teams. All clients receive safer use education and equipment, and are offered two safer supply pathways: a daily-dispensed take-home stream and an observed stream

		Clients are encouraged to attend the harm reduction drop-in, which provides access to supports, information, supplies, food, and referrals to additional health and social services. The SOS is embedded in the PQMCHC, which offers a wide range of health and social services. The project also explored piloting other opioids, such as fentanyl patches, for a more personalized medical intervention. In collaboration with the SOS Community of Practice (i.e., London InterCommunity Health Centre, South Riverdale Community Health Centre, Street Health, and Regent Park Community Health Centre), clinical and operational guidelines and program tools were produced, and expertise and resources shared.
Pathways to Recovery	*Safer Supply Ottawa*	This project provides prescribed pharmaceutical opioids to people who use drugs in Ottawa as an alternative to the contaminated illegal drug supply. In partnership with Ottawa Inner City Health, Sandy Hill Community Health Center, Somerset West Community Health Centre, Respect Rx Pharmasave, and Recover Care, the project offers daily-dispensed medications (observed and unobserved), and a range of wraparound services such as injection sites, primary care, nurse practitioners and peer supports, and counselling, housing and social work. All five sites have some dedicated wraparound services which vary for each site. Taking a public health approach, Safer Supply Ottawa provides more accessibility and flexibility for clients, including low barrier eligibility requirements and dosing restrictions, as well as additional medication options including fentanyl patches, prescribed by authorized health professionals, ensuring a broader population of people who use drugs are reached.
River Stone Recovery Centre	*River Stone Recovery Centre*	This project implemented a full spectrum recovery clinic that incorporates individualized care pathways, flexible medical appointments, group therapy sessions, peer support, social support services, oral opioid agonist therapy, supervised injectable OAT (injectable hydromorphone 2mg/ml and 10mg/ml, 50mg/ml), and stimulant replacement therapy (dextroamphetamine, risperidone, aripiprazole and/or bupropion) in a safe, clean and supportive health care environment.
South Riverdale Community Health Centre	*Downtown East Collaborative Safer Opioid Supply Program*	This project provides people with opioid use disorder flexible options to receive a reliable pharmaceutical-grade opioid as an alternative to the contaminated illegal supply, as well as provide opportunities for clients to access a range of program options and wraparound services. In partnership with Street Health and Regent Park Health Centre, the project offers daily dispensed take-home oral hydromorphone (Dilaudid) and morphine extended-release (Kadian), and wraparound services such as primary and specialists care, addiction and mental health services, peer and social supports. The project also explored piloting other opioids, such as fentanyl patches, for a more personalized medical intervention. In addition, the project partners with community organizations, and act as a referral service providing consultations that support the initiation of safer supply for individuals in isolation, and take over care management where needed, post-isolation. In collaboration with a Safer Opioid Supply - Community of Practice, (i.e., London InterCommunity Health Centre, Parkdale Queen West Community Health Centre, Street Health, and Regent Park Community Health Centre, AMI Health and Community Services, Pathways to Recovery etc.,) clinical and operational guidelines and program tools are produced, and expertise and resources shared.
Urban Indigenous Health and Healing Cooperative	*UIHC Overdose Response Expansion Project - Providing Cultural Safety and Safer Prescription Medicine Alternative* *Name preferred by the project: Kilala Lelum*	This project promotes the health and wellbeing of Indigenous people living with Opiate Use Disorder (OUD) and improves health outcomes with a focus on the reduction in illicit opiate overdose events and death. This is done by expanding existing primary care and oral opioid agonist treatment (oOAT) services, Indigenous Elder led cultural healing programs, and implementing a new injectable OAT (iOAT) program. Activities are conducted in such a way that individuals with OUD are "met where they are at" with flexibility on the pathways of care based on the UIHC's experience delivering health care for Indigenous people living with OUD. Knowledge products include the model of service, impacts on the health care providers and Indigenous Elders involved, as well as published findings from a Prospective Cohort Study examining the impact of Indigenous people living with OUD connecting with Indigenous Elders as part of routine primary care that includes oOAT and iOAT.
Vancouver Coastal Health Authority *	*The "Safer Alternatives For Emergency Response" (SAFER) Initiative*	This project will address the overdose risk posed by the toxic illegal drug market by prescribing commercially available pharmaceutical-grade opioids to those of greatest risk of overdose death, while also connecting them to other treatments, care, services and

		social supports. Medication options will be discussed with participants and selection will be determined between the participant and prescriber. Unlike traditional injectable opioid agonist treatment programs (iOAT), which require a titration phase, and tablet iOAT (TiOAT) programs that require observed consumption, the SAFER project will offer a lower-barrier model in which participants will come "as needed", can start at the maximum dose each visit. Avoiding the titration phase could help manage participant withdrawal symptoms, resulting in increased retention and decreased risk of overdose from illicit opioid use. On a case by case basis, the program will be able to titrate above the standard dosing for people whose opioid tolerance is extremely high. Oral use of tablets and capsules will be encouraged, but the program will provide safer injection education and supplies, including long strand cotton and Sterifilt filters, for those who may inject their medications.
Vancouver Island Health Authority*	*Tablet Injectable Opioid Agonist Treatment (TiOAT) in a Small Urban Community*	This project will engage people who use opioids who are at risk for overdose and have not or cannot be successful in traditional OAT or iOAT. The project will deliver TiOAT in the form of hydromorphone tablets, which may be injected, ingested orally or nasally under the observation of program staff. The pilot will be temporarily co-located with the Duncan Overdose Prevention Site, permanent site located in Cowichan Valley, will operate 7 days per week and be integrated within other low barrier substance use services in order to maximize opportunities to connect those at risk of overdose to care and treatment. In addition to the dispensing and witnessing of prescribed opioids by a licensed prescriber, clients will be offered wrap around services such as peer support, linkage with primary care, mental health support and case management.

* Not yet commenced

Program Details

Organization	Start Date	End Date*	Duration (Months)*	Location	Funding
AVI Health and Community Services Society	2020-06-05	2021-03-31	10	Victoria, BC	$1,000,000
Providence Health Care Research Institute (BC Centre for Excellence in HIV/AIDS)	2020-06-05	2021-03-31	10	Vancouver, BC	$1,000,000
London InterCommunity Health Centre	2020-02-20	2024-03-31	49	London, ON	$6,510,007
Parkdale Queen West Community Health Centre	2020-06-05	2021-03-31	10	Toronto, ON	$582,500
Pathways to Recovery	2020-06-05	2021-03-31	9	Ottawa, ON	$1,400,000
River Stone Recovery Centre	2020-02-20	2024-03-31	49	Fredericton, NB	$2,413,768
South Riverdale Community Health Centre	2020-06-05	2021-03-31	10	Toronto, ON	$1,000,000
Urban Indigenous Health and Healing Cooperative	2020-06-05	2023-03-31	10	Vancouver, BC	$800,000
Vancouver Coastal Health Authority	2020-07-23	2024-03-31	44	Vancouver, BC	$4,980,000
Vancouver Island Health Authority	2020-06-29	2024-03-31	45	Duncan, BC	$1,999,195

* The 10-month projects have been extended by two years

Appendix B. Methods

Data Collection Framework

The design of the preliminary assessment was supported by the following data collection framework, which outlines the key themes, questions, type of information collected, and the source. The framework was designed based on discussions with Health Canada and safer supply program representatives, as well as program documentation, safer supply documentation and research evidence. Data collection entailed gathering detailed information about the safer supply program's features, operations and populations served, and included the various elements outlined below (Table 7).

Table 7. Data Collection Framework

Theme and questions	Type of information Service provision and project staff	Project participants/clients
Design -What are the basic safer supply program features, and the policies and procedures in place? -What population groups are being served? -What are the key considerations and critical factors for success in the design and ability to start offering services? -What are the key lessons learned? What improvements can be made moving forward?	Project goals and targets History of harm reduction services in the organization Legal and regulatory environment (e.g. any legal or regulatory barriers related to federal, provincial or professional regulatory body requirements) Prescribing guidelines Policies, procedures and protocols, including service processes, safety and emergency measures, COVID-19, dismissal Basic program features, including lower barrier design Range of services offered, e.g., OAT, iOAT, stimulant prescription alternatives, drug checking, carries, additional support service referrals or on-site connections Service mode, e.g., one or two sites, mobile, etc. Site infrastructure Technology, medical records, data collection Convenience of location(s) and environment Staffing complement and ratio to clients Populations served Eligibility criteria and intake processes Staff code of conduct Participant expectations and code of conduct Involvement of Elders and other community leaders	Extent of involvement in service co-design Perspective on program design features Perspective on infrastructure and location
Implementation -What are the most effective implementation strategies? What works; what does not? -What implementation challenges and barriers have been experienced? How were they addressed? -What are the staff experiences with implementation and delivery? -What are the key lessons learned? What improvements can be made moving forward?	Nature of relationship and communication between the funder/policymakers and program Leadership Team culture, communication and collaboration Staff capacity building and training Staffing levels and composition Employment of PWUDs Involvement of Elders and other community leaders Program promotion, outreach and recruitment Client populations served Medications available Adequacy of program supplies Medication dispensing prescribing, titration practices, Participant monitoring requirements (e.g., urine screens) Observed dosing procedures Carry policies and procedures Observed drug tolerance Program flexibility (e.g., use of prescribed and illegal drugs allowed on site) How ethical challenges are addressed Approaches to addressing diversion Start-up and ongoing program costs, and sustainability Performance monitoring, evaluation and reporting	Goals and objectives of program participation Medication and dosage received and method(s) of consumption Extent of input and involvement in service delivery approach Other on-site harm reduction services used (e.g., drug checking, medical or social care, treatment and recovery)
Accessibility and Acceptability -What is the participant experience with the safer supply? Does it address their needs? What is required to improve their experience? -How has the community responded to the safer supply programs?	Needs and desires of populations served are understood and defined Number of clients Number lost to follow-up Hours of operation and wait times Level of service demand versus service availability Suitable and sufficient physical space Unique needs of populations served are addressed	Experience gaining access to the program (e.g., any challenges with eligibility requirements) Timely and flexible access, including walk-in access Accessible locations, including non-conventional venues and transportation needs Wait times

Theme and questions	Type of information Service provision and project staff	Project participants/clients
-What are the key lessons learned? What improvements can be made moving forward?	Cultural competency Provider experience, e.g., service design and delivery Provider satisfaction, e.g., overtime, burnout, frustration Relationship with and reaction of local community, local authorities and other stakeholders	Physical space acceptability, welcoming environment, adequate capacity Adaptations to clients' lived experience and unique needs Knowledge and preferences recognized, including drug choice and dosing Ability to incorporate consumption method preferences Quality of drug experience (i.e., sufficient dosage) Experiences with program staff Stigma, discrimination, racism Involvement of friends, caregivers or other supports Financial or physical/mobility barriers
Health and Wellbeing Impact -In what ways have the programs been beneficial to clients?	Observed overall impact on participant health and wellbeing Changes to methods of consumption Impact on participant withdrawal symptoms Impact on illegal drug use Extent of overdose prevention Other health impacts (e.g., infectious complications) Evaluation and reporting	Overall quality of life and health status Experience with withdrawal symptoms Use of illegal drugs Overdose experiences Any changes to method of consumption Ability to access and engage in medical care Ability to establish routines and engage in other daily activities Safety and violence experiences Poverty easement and housing Reconnections with social networks Recidivism
Integration -How are the safer supply programs partnering or integrating with the existing health, social and public safety systems? -What are the key lessons learned? What improvements can be made moving forward?	Participant referral and access to other health and community services Co-location and/or integration with other services Formal and informal partnerships with health, social and public safety system Client advocacy and supported pathways to the health, social and public safety system Information continuity or case management in place Nature of support services needed and gaps Impact on identification and management of other health conditions, including chronic pain	Access to regular primary health care Referrals to other health and social services Improved case management, including warm hand-offs and seamless transitions to other care Improved management of other health conditions Address untreated or undertreated chronic pain Identification of other health conditions/risk factors Participant experiences and satisfaction with other health, social and public safety services Experiences stigma or discrimination

Background Review

Program Document Review

The research team reviewed the overall program objectives and design, including relevant strategy and planning documents, program frameworks, implementation plans, and program progress and interim reports, as well as the various safer supply guidance documents. The team reviewed documentation for relevant content and requisite detail to create an initial overview of the program and inform data collection.

High-level Literature Review

To support the development of the approach to the assessment, ensure they are well-informed on the evidence on safer supply, and apply the most appropriate and pertinent information, the team conducted a focused review of published and grey literature on implementation and processes related to similar initiatives in Canada and internationally, including a number of recent Canadian rapid reviews and publications. The review included the features of and experience with implementing similar initiatives, barriers and facilitators identified, measures and methods used in evaluation, and appropriateness and applicability of the study designs. The bibliographical and database searches of the published and unpublished literature and review process were based on existing formalized approaches. The references and abstracts were catalogued using a commercial bibliographic software program.

Data Collection

The research team administered an online staff survey; a project lead questionnaire with follow-up interviews; and client participant interviews. The data collection tools were developed based on the elements in the data collection

framework. The team consulted Health Canada and representatives from the safer supply programs to refine the survey and interview guides.

Staff Survey

The online staff was administered to program staff at each of the eight operational safer supply pilot project sites in early 2021. The survey included both closed- and open-ended questions. With privacy and confidentiality in mind, the team worked with the programs to determine the best approach to providing staff with the link to the survey. The aim was to receive responses from all types of staff, including peer support workers. A total of 102 staff members responded, with about two-thirds responding to the open-ended questions (Table 8).

Table 8. Number of staff members responding to staff survey by program

Project	N
River Stone Recovery Centre	13
London InterCommunity Health Centre	9
Kilala Lelum, Urban Indigenous Health and Healing Cooperative	8
Victoria SAFER Initiative, AVI Health and Community Services Society	14
Downtown East Collaborative Safer Opioid Supply Program – South Riverdale CHC	5
Downtown East Collaborative Safer Opioid Supply Program – Regent Park CHC	8
Downtown East Collaborative Safer Opioid Supply Program – Street Health	6
Parkdale Queen West CHC Safer Opioid Supply Program	10
Pathways to Recovery – Recovery Care	4
Pathways to Recovery – Ottawa Inner City Health	6
Pathways to Recovery – Sandyhill CHC	3
Pathways to Recovery – Somerset West CHC	9
Pathways to Recovery – Respect Rx	1
Hope to Health, Providence Health Care Research Institute, BC Centre for Excellence in HIV/AIDS	6
Total	102

Project Lead Questionnaire/Interviews

Data collection from safer supply program leads (as well as other team members as desired) entailed gathering information through a phased approach, using a mix of quantitative and qualitative methods, in early 2021. This commenced with the project leads (and their staff) completing and returning an open and closed-ended questionnaire/ interview template regarding their project, which included details related to the data collection framework above. They were also asked to provide any pertinent documentation supporting or augmenting the information provided.

Once the questionnaires were completed by each of the ten programs, the project leads participated in an interview to provide additional information and describe the information provided in greater depth. This included confirming program details and gathering any missing content. In addition, two focus groups were held with programs that had multiple program sites. The interviews followed a semi-structured approach, with the interviewer asking probing questions to gain clarity. The interviews allowed for exploring the responses to open-ended questions and greater elaboration on program features, delivery and the factors associated with success and challenges, as well as any unique program components or circumstances. The approach also entailed reflecting on remarks made by other clients to allow for the discovery and elaboration of themes and information important to clients, while ensuring confidentiality.

Program Clients

The research team conducted interviews with 15 client participants at seven sites providing SUAP-funded safer supply services. There participants were 18 years and older. Seven identified as male, seven as female and one as gender neutral. Interviews were from 30 to 45 minutes in length and took place via videoconference (Zoom) or telephone in early 2021.

The research team consulted and worked closely with the safer supply programs to determine the design an appropriate recruitment and information gathering approach. With the program, the researchers established a block of time for interviews. Clients were recruited in advance or at the time of the interview times. The program staff were provided with an information sheet which included the consent process and suggested wording, including the objectives of the study and that participation was voluntary. The interview repeated the consent elements at the beginning of the interview. Most interviews took place in a private location at the service site; a few took place by phone in the client's home. If the client preferred, a program staff member sat in on the interview. The interviews followed a semi-structured approach based on the interview guide, but allowed for clients to share their stories and experiences in the manner in which they preferred. This component of the study received ethics approval from the Health Canada and Public Health Agency of Canada Research Ethics Board.

Data Analyses

The closed-ended responses to the surveys and questionnaires/interviews were coded, grouped and reported by theme and subtheme based on the data collection framework and additional themes that emerged during the study. The process of theming and analyzing the qualitative data was iterative, allowing for the identification of meaningful patterns in the data and a descriptive expansion of themes (e.g., challenges, leading practices, enablers). Program features and descriptive information was summarized, compared and contrasted. The terms in the order of most, many, some, several and few were used to describe the relative frequency of a particular finding. Most and many refer to at least half of the participants. The survey data were analyzed using statistical software.

Appendix C. Summary of Findings

Summary of Client Findings

Ways in which the programs have been beneficial to clients

- *"I got my life back."*
- *"It saved my life."*
- *"My life has improved drastically."*
- *"Life is so much better."*
- *"My whole lifestyle improved."*
- *"It opened a whole new outlook and positive way of living."*
- *"It allowed me to focus on more positive direction."*
- *"I'm 100% more stable than I have ever been."*

Clients who have stabilized as a result of their access to a safer supply reported the following improvements to their lives. Staff have also observed the impacts on clients' lives.

Clients		Staff
➢ Are healthier overall ➢ Are more active ➢ Are sleeping better ➢ Are eating better ➢ Have more energy ➢ Are housed ➢ Are employed ➢ Have more money ➢ Have more time in the day ➢ Can pursue hobbies and interests ➢ Have fewer self-destructive behaviours	➢ No longer have to hustle ➢ Have to interact less often with the street (e.g., dealers, violence, crime, police) ➢ Are less likely to commit a crime ➢ Are no longer engaged in sex work ➢ Have addressed health issues related to drug use, mental health and other health conditions ➢ Have reduced stress ➢ Have improved/improving relationships	➢ Regaining hope that they matter in society ➢ Feeling 'human' for the first time in a long time ➢ Feeling hopeful for their future ➢ Increased stability in their life ➢ Improved quality of life ➢ Better able to focus on what is important to them ➢ Becoming housed ➢ Joining the workforce ➢ Reduced survival sex work and criminal activity ➢ Reinvesting in relationships with service providers, family, friends and supports

Clients especially appreciate the steady, predictable supply of drugs with known and consistent dosages. Few have experienced an overdose. Staff survey responses reflect the qualitative input provided by clients and staff. Almost all program staff *strongly or somewhat agreed* that the safer supply program has reduced overdoses. At least nine in ten *strongly or somewhat agreed* that the program was associated with reduced use of injections, illegal drug use, withdrawal symptoms, infections, and side effects. While most staff agreed, others *somewhat or strongly disagreed* that their safer supply program adapted to clients' lived experience (11%), supported their preferred consumption method (18%), offered desirable alternatives to the illegal market (18%); and provided the desired drug experience (33%).

In addition to creating a greater inconsistency and toxicity in street drugs, COVID-19 has added additional challenges and anxiety for clients. Some are using alone more frequently. For those who are stabilized on safer supply, there are long days on their own with nothing to do. The isolation is breaking down mutual aid and support systems, and some are finding it difficult to be alone. There are fewer community services open (e.g., transportation, AA meetings, drop-in, meals, showers), less access to public spaces, few public bathrooms and it is difficult to get access to a phone.

Population groups are being served

1) Current use of illicit drugs, experiencing cravings or withdrawal and at risk for an overdose
2) Current use of illicit drugs, at risk of overdose, urine screen
3) Current use of illicit drugs, unsuccessful with or do not want conventional OAT or iOAT
4) Opioid use disorder in Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) and clinical indication of benefit
5) Opioid use disorder (DSM 5), regular illicit toxic drug use (ESSP Clinical Protocol), unsuccessful or do not want oral OAT only, urine positive for opioids
6) Severe opioid use disorder (DSM-5 (6+)), injection use of opioids
7) Severe opioid use disorder (DSM-5 (6+)), unsuccessful with oral OAT or at high risk of an overdose, current injection drug use or high risk of returning to IV drug use (for iOAT)
8) Severe opioid use disorder (DSM-5 (6+)), AUDIT Tool, opioid use, injection drug use, unsuccessful treatment on oral OAT, not taking benzos and Z drugs, other significant health risks (overdose, HIV, Hep C)
9) Fentanyl use, with three of the following: 1) HIV with unsuppressed viral load, Hep C, current or history of endocarditis, spinal abscesses, sepsis, osteomyelitis or previous prolonged hospitalization due to IV drug use; 2) experienced an overdose; 3) homelessness, precariously housed or in a high risk housing situation; and 4) Indigenous, Black, person of colour, woman, 2SLGBTQ+

Participant experience with the safer supply and how best to address their needs

Key learnings from safer supply implementation related to optimizing client experience are to:

- Understand clients' realities on the ground and reflect the community served
- Create a welcoming, culturally-safe, judgement-free environment
- Provide services that reflect individuals' lived experiences and are tailored to promote their health and wellbeing, including stigmatized and racialized populations such as Indigenous peoples, immigrants and 2SLGBTQ+
- Provide services that: reflect and address trauma experienced
- Emphasize client empowerment in their health and wellbeing
- Build trust and believe clients
- Acknowledge clients' skills and knowledge
- Set individual goals and individualize services
- Provide several safer supply options for clients, including type of drugs (opioid and stimulants), method and dosage (including PRN)
- Ensure shared decision-making
- Work to ensure client retention
- Work for quick wins/success to gain trust
- Provide comprehensive wraparound/scaffolding services, potentially co-located
- Develop new service delivery models, e.g., drop-ins and group appointments, a variety of touch points, such as medication delivery, vending machines, outreach, satellite clinics, in-home, virtual services, via mobile phones, etc.
- Adapt to changing client circumstances
- Provide high quality services
- Seek ongoing feedback

Summary of Design Features

The following table summarizes the safer supply program design features, including some basic attributes, effective strategies and success factors, challenges and areas for improvement. Greater detail on each topic can be found in the body of the report.

Topic	Basic features	Effective strategies and success factors	Challenges and barriers	Improvements needed
Management	Safer supply programs differ in their organization and approach to service delivery. The programs are based in British Columbia, Ontario and New Brunswick and are thus impacted by the health system context within their jurisdictions. Two SUAP programs are comprised of a group of individual organizations. They collaborated to develop program plans and secure funding. Two are partnered with and administered by a health authority, but have not yet commenced services. One program is dedicated to the local Indigenous population. Several programs are based within a primary care centre, including community health centres. Others are standalone services or offered as part of other harm reduction and/or addiction services. Among the safer supply service sites, most are based at a single service delivery site. Three are at more than one site. One does not have a physical site; this program – along with two others – offers mobile services	See "improvements needed" for best practices. Several safer supply programs have developed strong working relationships with other programs and services within their organization. Some collaborating programs have developed program guides to clarify processes. One created a shared drive and compliance documentation, allowing multiple community partners to share patient lists and wait lists, as well as program tools and processes. The programs have created a community of practice to share learnings and best practices, and for the more experienced to provide mentorship to new programs and providers. The community of practice has provided mutual support in developing policies and processes, and helps to ensure that programs are using best practices and not reinventing the wheel in isolation. It also delivers presentations about safer supply to the community and other stakeholders and supports advocacy. This has facilitated informal partnerships with other organizations.	Programs found it challenging to plan for the long-term and to scale up within short-term budgets. Many reported inadequate resources for administrative, clinical and harm reduction staff, as well as physical space. Some faced challenges with funding silos and organizational barriers to sharing or reallocating resources. Some managers found introducing the program into an existing organization challenging. They needed a better understanding of processes and procedures and experienced unclear roles, reporting responsibilities and lines of communication. Challenges working in a group organizations included: • Communication • Working on different timelines • Different organizational cultures • Unequal resources and capacity • The inability to share or reallocate staff and other resources • Collective agreements • Lack of role clarity among providers • Different electronic medical records (EMRs) - shared records were needed • The need for common policies, procedures and communication pathways • Referrals and transition pathways • COVID-19 reducing the ability to meet, plan, resolve challenges, etc. • Ensuring clients received coordinated, continuity of care • Ensuring clients are aware of the intake points for each agency and their respective expectations.	As part of planning and implementation, programs need to consider and develop approaches for: • Defining and documenting the governance structure • Establishing the leadership and management structure, including defining roles and responsibilities and reporting and decision-making processes • Assessing capacity and resource requirements • Establishing financial management systems • Planning for growth and expansion • Developing and documenting human resources requirements and protocols, related to scope of practice, job descriptions, hiring for fit, harm reduction experience and training, capacity building, mental health supports, insurance, benefits • Ensuring adequate infrastructure, information technology (IT), equipment, storage and security • Developing communication strategies, documenting with whom, how and when information should be shared • Developing implementation plans • Embedding quality improvement processes, including plan-do-study-act (PDSA) cycles, within their operations • Defining partner working arrangements and processes Large organizations should: • Assess their capacity to deliver safer supply • Determine the level of engagement required of senior leadership • Outline the reporting and decision-making processes, especially when managers are responsible for multiple portfolios • Develop an implementation plan, including the leadership and management models For collaborating safer supply programs to work together effectively, they need to develop approaches for: • Establishing the leadership and management structures • Defining roles and responsibilities • Sharing resources • Communicating • Streamlining policies and procedures • Sharing client information • Ensuring seamless client transitions • Leveraging the community of practice
Design	Programs took different approaches to design. Basic features include prescribing of safer supply and provision of or	Programs emphasized the need to apply best practices. Some conducted needs assessments and gaining input from those with lived experience to understand the community and to guide the design.	Several of the safer supply programs found it challenging to start up the program quickly – "*planning and implementing simultaneously*." As a result, there was a great deal of trial and	As part of design, planning and implementation, safer supply programs need to: • Conduct a needs assessment • Review research and expertise

	referral to primary and social care.	Several programs developed their own protocols and guidelines related to prescribing and other key policies and procedures. Most staff agreed that their programs, processes and procedures were meeting clients' needs, including service delivery guidelines and approaches, enrollment, intake criteria, safety measures and co-design.	error, with "*multiple changes at the onset*." Ideally, more time would have been spent developing structures, processes and protocols prior to implementation, but the pressing need to provide services as soon as possible was recognized. COVID-19 presented a number of challenges, including delayed planning and implementation and greater difficulty innovating. Two SUAP-funded programs have yet to launch. One program had to delay a wraparound wellness and empowerment program because of the urgent acute needs presented by COVID-19.	• Develop and document structures, processes, protocols and guidelines • Define and document processes and protocols associated with prescribing, titration, daily pick up, observed or carries doses, frequency of visits and missed doses or appointments • Develop and document safety, security and medication handling procedures • Conduct process mapping, workflow and client pathways • Develop work plans • Build in flexibility and revise protocols, procedures and guidelines as needed • Client co-design, intake processes and developing protocols, guidelines and steps for providing services are potentially areas for improvement There are a number of supporting guidance and guideline documents that could support the implementation of safer supply. Such materials could include an information document and toolkit outlining the key considerations, prerequisites and action items for implementing safer supply services, including community and client engagement in program co-design; governance and management; legal and regulatory considerations; policies, processes and procedures; HR management, training and team building; hours of operation; physical space; and quality improvement
Community engagement	Most programs have people with lived and living experience on advisory committees or councils, either as members among many stakeholders or as a designated council. Some programs have introduced additional advisory councils for specific groups, such as an Indigenous advisory council with Indigenous staff members and clients who provide input on how best to reach, enrol and serve the needs of Indigenous people in the program.	Programs have worked to educate community partners about the program and the stigmatization experienced by their clients, and to build working relationships with partners. Several programs engaged in regular consultations with key partners prior to launch. Programs, especially entirely new programs, identified "engaging the immediate community and community partners for education and awareness prior to program launch and ongoing for feedback" as key. These efforts entailed providing education about safer supply and listening to others' perceptions to better understand how to respond to their concerns. Some programs involved people with lived and living experience in program co-design, planning and implementation. Others have included them in select roles.	Stigmatization of clients is an ongoing challenge COVID-19 hindered community engagement One program had to locate elsewhere as the community objected to its initial site	• Integrate people with lived experience into all aspects of programming, including co-design and implementation. • Identify and engage community allies and program partners, including through consultations and representation on committees • Develop an education and communication strategy (including an online presence), potentially using communication experts • Continue to advocate, widely communicate and raise public awareness about the benefits of a safer supply for people with opioid use disorder and society, with the aim of reducing stigma and discrimination, and to increase acceptance of this harm reduction approach. • Revisit and augment the communication strategy for the public awareness campaign (including documented lived experiences, resources for opioids (e.g., videos, fact sheets, posters) and best practices in order to reach and influence an even broader audience).

Intake	Eligibility criteria vary greatly by program. Most programs undertook targeted recruitment based on these. Clients are usually accepted based on team intake assessments and prescriber decisions. There are similarities among programs, but also differences. Team members, often a nurse alone or with a social worker or peer, conduct the intake assessment, including a medical, social and drug use history, physical exam and bloodwork. Staff may also provide urgent primary care (e.g., wound care, naloxone kits, COVID-19 assessments, referrals, etc.). The team discuss and document client goals. Then, clients meet the prescriber, develop a care plan and receive a prescription.	The programs disseminated information about safer supply and conducted strategic outreach to identify and recruit those eligible. Many clients learned about the program through a supervised consumption site (SCS) or other harm reduction and community services. Programs work with community partners and networks to identify clients, develop trust, and facilitate referrals. Some clients heard about the program through family and friends or outreach workers at their encampment, shelter, drop-in centre or common congregating locations. Some outreach workers actively sought out potential clients. Some programs adhere strictly to eligibility criteria; some offer flexibility. Eligibility is also based on substance use history and capacity to regularly attend appointments, SCS and pharmacy pick up. Some programs have processes for those who do not qualify, including advocating for clients, teaching them on how to advocate for themselves, and providing support and guidance to community physicians.	Those most in need are often the hardest to reach. There is still limited awareness about the programs, especially among those not connected to harm reduction services. Programs restricted entry criteria because of limited capacity. Several clients recommended the program to family and friends but they could not get in due to the eligibility criteria or no capacity. In some programs, opioid agonist therapy (OAT) or fentanyl use is an eligibility requirement. Most staff and clients do not support either of these criteria.	For the intake processes: • Develop increased awareness of and client comfort with approaching the program, especially for the most vulnerable • Work with partners to identify safer supply candidates • Communicate the eligibility criteria • Document the intake assessment process • Reassess the eligibility criteria as programs evolve and capacity increases, working towards universal access for people with opioid use disorder • Ensure clients' partners/ spouses who require it are admitted to the program • Develop programs, processes and pathways for those who do not qualify
Types of prescription medications	SUAP-funded safer supply programs mainly offer (or will be offering) tablet hydromorphone. Some programs started under the assumption that they would only be prescribing hydromorphone. However, the majority of clients are also on a "backbone" of methadone, Kadian (SROM) and, to a lesser extent, Suboxone. One program offers iOAT exclusively. Another two offer it selectively. A few programs offer fentanyl patches for those unable to stabilize on tablet hydromorphone.	Adding a Kadian and/or methadone backbone has proved successful for many. As has medication such as Ritalin to address stimulant use. Some find success with other opioid alternatives, including fentanyl patches and oxycodone. Some programs are now offering fentanyl patches for those who have been unable to stabilize on hydromorphone. Many *clients* have stopped using illegal drugs; others are still using them, although at a progressively decreasing rate.	*Client* needs are evolving and increasingly are not supported by the recommended approaches in the existing prescribing guidance. Clients and staff identified gaps in the medication options available.	Additional medications are required as options to counter fentanyl, as well as other substance withdrawal, including: • High dose injectable hydromorphone • Medical heroin (diacetylmorphine) • Injectable morphine • Fentanyl (powdered, injectable, buccal tablets (Fentora), patches (250, 500 and 1000 mg) • Oxycodone (Percocet, OxyContin) • Amphetamine (Ritalin, Adderall) • Sufentanil (Sufenta) • Methamphetamine (Desoxyn) • Cocaine Access to these medications has been hindered by the regulatory environment, coverage by provincial formularies, and supply interruptions.
Injectable Opioid Agonist Treatment (iOAT)	New Brunswick offers observed iOAT to its clients. iOAT is currently offered at two BC sites selectively. Clients usually attend the clinic two to three times a day to receive their doses. One BC clinic offers iOAT carries in the afternoon to select clients.	One program is investigating purchasing larger hydromorphone vials and having nurses (observing each other) draw requisite dosing. Within a licensed practical nurse's (LPN) scope of practice, it is a cost-saving compared to a pharmacist.	Providing injectable hydromorphone entails additional costs versus oral hydromorphone for storage, compounding, dispensing and client support. Costs include refrigeration and additional human resources, such as pharmacists, nurses and SCS staff.	Receiving iOAT as a prepackaged single vial is difficult for clients who require two to three injections at a time. One injection options should be available. Many *clients* both inject and take hydromorphone tablets orally. For convenience and to support evolving away from injecting, there should be options for a combined prescription of injectable and tablet medications.

Dosages	Prescribers are guided by existing provincial substance use disorder (SUD) guidance and best practices. They follow relatively standardized titration regimens, but differ in dosages and frequency with which they titrate up. Maximum dosages vary greatly. One program will offer as needed (PRN) hydromorphone for those who prefer to come when they need. Another program does not titrate, but offers up to 10 observed tablets a day, with a maximum of two tablets per visit.	After an initial assessment, clients are prescribed a dosage based on existing guidance and prescriber experience. Many are creating their own guidelines and working within a community of practice. Starts are often four to 12 8mg hydromorphone tablets per day. If inadequate, they are titrated up incrementally. Most clients are on between 16 and 24 tablets a day, with a max of 30 to 40. Some programs are stricter, with lower caps (e.g., 10 a day). For injectable hydromorphone, dosages are increased in 2mg increments. Most clients are on 10mg three times a day; some are on twice that. Prescribers work with clients to achieve the right dosage and combination. They need to recognize the extent of need and be willing and able to prescribe what is being asked for/needed. *Clients* have effectively developed goals and processes for managing medications, e.g., combining injection and oral, taking as needed.	*Client* needs are evolving and increasingly are not supported by the recommended approaches in the existing prescribing guidance. For many, current medications and/or dosages are insufficient to counter fentanyl withdrawal. They have not stabilized and find them inadequate. Some programs do not provide hydromorphone at sufficient dosages to meet clients' needs – their max is too low. In other instances, even the maximal doses of hydromorphone do not work	Some programs need to work with the clients to ensure their dosages are adequate, including increasing the rate of titration and the maximal dosage allowed.
Shortages	Programs are experiencing regular drug supply interruptions due to drug shortages	Programs are working together to quantify the current and anticipated national demand to provide to manufacturers in order for them to increase supply.	Supply interruptions have meant replacing medications with generics, which are reported to be less potent and harder to inject. Programs have provided suppliers with data to show anticipated national demand. But some shortages persist.	Continue to work with federal and provincial partners and manufacturers to quantify demand to ensure that an adequate supply of requisite medications is available.
Observed, daily up and carries	Most programs provide both daily pick up and observed hydromorphone tablets. Two do not have observed arms and one will only offer observed dosages. Four of the programs offer carries for the tablets. In combination with hydromorphone, Kadian is usually observed during daily pick up. Four programs allow for daily pick up of both hydromorphone and Kadian, while three allow for carries.	Generally, those using iOAT and vulnerable clients using hydromorphone tablets are observed. Some programs use an observed model for initial titration before a transition to daily pick up. All who inject are encouraged to use the SCS. A few programs offer carries for longer standing stabilized clients. The length of time is increased incrementally. Some programs make exceptions or offer compassionate carries. In one program, a few clients receive observed iOAT in the morning and carry an afternoon injection.	Some *clients* find observed dosing and daily pick up time consuming and inhibiting to their daily lives. Few receive more than a day's medications (even over weekends and holidays). For *clients* who are employed or panhandle, it can affect their income. Those with observed dosing have to visit the site several times a day. Clients who do not live or work near the pharmacy or safer supply site have challenges with public transport and getting downtown in time for their pick up or first and/or last daily dose. The number of carries is not limited by federal regulations, but there may be provincial/ territorial guidelines that	Programs would benefit from documented guidance on how to safely execute both tablet and injectable carries and increase client freedom and control.

			prescribers and pharmacists must follow.	
Urine Drug Screen (UDS)	Urine drug screens are used differently among the programs, with some using them mainly to determine whether to remove or reduce safer supply and others mainly for surveillance of the content of illegal street drugs.	Some programs use UDS to monitor whether other drugs are detected and/or safer supply is not and remove or reduce dosages. Others focus on what is in street drugs to keep the community informed about content and toxicities and support discussions about other drug use.	Some ***clients*** do not mind providing a urine sample, especially for alerting them to what is in the street supply; others find it punitive. UDS is time consuming. For outreach services, it is difficult to find a place to get a sample and it affects their relationship with clients.	Opinions differ on UDS. Some want like them removed entirely. However, as part of college regulations, prescribers are required to monitor the drugs they prescribe. Consider ways to reduce the burden of UDS, including offering observed doses as an option for removal of the urine sample requirement.
Follow up appointments	Clients generally see the prescriber (a physician or NP) and/or nurse once a week.	Appointments are to check overall health, have a UDS, review their experience with prescriptions, and renew it. One program offers weekly group appointments. Some longer standing clients are seen once every two weeks or, more rarely, monthly. Some programs have developed unique ways to remind clients about their appointments.	Some clients experience challenges attending their appointments as scheduled. Some clients have their medications removed if they miss two or three appointments in a row.	Consider lengthening the interval between visits as the program experience evolves and clients participate longer and stabilize. Find innovative ways to allow for greater flexibility in follow-up appointments, (e.g., drop-in options)
Missed doses	Several clients have had to restart safer supply and titrate back up after missing doses. Most programs have a standardized approach to missed doses and restarts, but these vary greatly. Some clients' medications are stopped for a period of time; others' dosages are reduced.	When clients miss their doses for two to four consecutive days, they are assumed to have a decreased tolerance. Pharmacists contact program staff if clients miss their daily pick up for a given number of days. Based on the program, the prescriber assesses whether to resume, restart, increase, or change medications.	Finding the right regimen and dosage can mean starts and stops, especially for clients with unstable lives. When clients have to restart, titrating back up too slowly creates hardship and experiences of withdrawal. Some resort back to or increase their use of street drugs and have overdosed when their dosage was stopped or reduced.	Some programs have active loss to follow up, often by peers. These approaches could be applied more consistently across programs. The community of practice or other experts should review the policies for missed dosages and outline best practices, considering all factors that lead to missed doses.
Diversion	Diversion is taking place. Some programs remove clients for diversion. Some clients use a safer supply of hydromorphone on the street before entering the program. With diversion, someone still accesses an uncontaminated drug and lives are saved. But, there is concern they will be used by those who do not currently have an opioid use disorder.	If clients are diverting (e.g., via no hydromorphone in UDS), some programs remove their medication. Others work with them to address the issue. Some programs reduce the dosage, require more frequent visits or switch to observed dosing. Some increase the dosage of hydromorphone for people trading to buy fentanyl or add another medication if they are trading for stimulants.	Diversion is of concern due to the potential on prescribers' license to practice. The main reasons for diversion are safer supply is not working due to insufficient dosage, lack of combination or backbone, slow titration and inadequacy of generics. It also occurs because of inadequate safer supply options, insufficient capacity meet overall demand, the need to meet other basic needs, and supporting a friend.	An explicit step-by-step approach to suspected diversion and clear messaging about the approach that will be taken – including pathways for transitioning clients who are removed from the program – is needed. The approach should consider all factors that may lead to diversion.
Drug coverage	Drug coverage varies at the provincial and territorial level. In Ontario, while hydromorphone tablets are covered in the formulary, high-dose injectable hydromorphone and diacetylmorphine are not. In B.C., medications in the risk mitigation guidance (developed to reduce risk to PWUDs during COVID-19) are covered by Pharmacare (i.e., hydromorphone and a backbone). But, not for all programs. At least one has to pay for the hydromorphone tablets through SUAP funding. New	To reduce costs, a program worked with a community pharmacy to secure lower pricing. It investigated less frequent dosing to reduce the cost, but was unable to given the regulatory requirements for managing narcotics.	Provincial and territorial governments determine which drugs are provided through their drug formularies and under which circumstances. Clients and programs experience barriers accessing some desired medications due to limitations on the types of medications approved for use for opioid use disorder, the management of narcotics, cost and the extent of provincial/ territorial coverage. Some are not readily available in Canada. Primarily, the medications identified in this regard are injectable	Continue to advocate for federal and provincial authorities to authorize and cover a broader range of medications for opioid use disorder, including: • High dose injectable hydromorphone • Medical heroin (diacetylmorphine) • Injectable morphine • Fentanyl (powdered, injectable, buccal tablets (Fentora), patches (250, 500 and 1000 mg) • Oxycodone (Percocet, OxyContin) • Amphetamine (Ritalin, Adderall) • Sufentanil (Sufenta) • Methamphetamine (Desoxyn)

	Brunswick approved injectable hydromorphone under strict conditions. Many of the other desired safer supply medications are prescribed off-label.		formulations of hydromorphone and diacetylmorphine, as well as other opioid and stimulant substitutes.	• Cocaine
Access	Hours of operation vary greatly. Generally, prescribing and supporting services are available weekdays from 8am to 4pm, 9am to 5pm or 10am to 6pm. Some programs with observed doses – but not all – are open seven days a week. Examples of observed service hours include 7am to 11pm, 8:30am to 6:30pm and 9am to 6:30pm. Clients generally have appointments at set times each week with prescribers and/or clinic staff.	Some programs have extended their hours. One now offers services and pick up, between 7am and 11pm. Some programs have increased flexibility related to clinical appointments, and many are working to find the best approach. Some implemented reminder systems, an appointment day, rather than time and group appointments. Several have introduced walk-ins or stopped scheduled appointments all together. Some offer in-person or virtual appointments at the SCS. Some deliver medications to people in encampments. One program has secured 1,400 mobile phones that will provide clients with reminders and follow-up information, as well as making it easier to monitor and contact them.	There is significant demand for safer supply services and the programs are unable to serve many of those who seek their services. This has created hardship for people on the wait list and for staff. Inadequate staffing, service hours, wait times and physical space has affected client access. Many ***clients*** face challenges attending booked appointments. There are often no shows and clients arrive at different times than the set appointment. Current hours are sufficient for most clients, but many would benefit from extended hours, especially for observed doses. Longer hours would also help clients – especially if not on a backbone – manage withdrawal overnight. Appointments often need to address numerous concerns. The team's role can include case management and appointments can be long. With only one prescriber, they are especially challenged adhering to the appointment schedule. COVID-19 has impacted client access. Drop-ins are difficult to manage and some experience long wait times due to spacing and waiting room requirements. Some clients moved frequently, making it difficult to keep track of them.	Access to safer supply services needs to be expanded. • Ensure hours of operation are sufficient to reflect clients' dosing schedules and regular routines • Develop innovative methods for, and alternatives to scheduled appointments, e.g., reminder systems; drop-in and group appointments • Provide various entry points, such as medication delivery, vending machines, outreach, satellite clinics, in-home, via cellphones, and virtual/telehealth services. • Have at least two prescribers, one for booked appointments, the other for walk-ins and managing pharmacy inquiries. • Have collaborative interprofessional clinics, with multiple programs and larger teams in one physical space, to facilitate a drop-in model and ensure sufficient coverage • Ensure medical secretaries are well-trained and knowledgeable about harm reduction and client needs
Space	Services are provided in primary care clinics and harm reduction sites. One program operates out of stationary trailer and another is entirely mobile. Some programs are still waiting to attain an adequate service site. Clients generally find the services to be in convenient locations, accessible by walking or public transit (although, some are not accessible by public transit on Sundays). They are reported to have a welcoming environment where clients feel comfortable.	Clients appreciate having dedicated space in the clinic. One program has a lounge for people to use between injections. One opened an outreach centre with services such as showers, refreshments and a place to rest during the day. Some programs addressed space constraints by exploring satellite locations to provide easier access or employing mobile health outreach.	Some buildings are suboptimal. They are old not up to standard. Some clients expressed concern about the design of the physical site (e.g., having barriers, seeming like a "*labyrinth*" or segregation from the rest of the health services. Programs have limited physical capacity. Some underestimated demand and space requirements and outgrew their space. Many faced challenges with COVID-19 spacing requirements. Some were unable to expand space due to funding or having reached the capacity	• Provide a convenient and accessible location • Assess and plan for adequate physical space • Create a welcoming space • Ideally, services and staff would be co-located, including proximity to SCS • Consider dedicated space specifically for safer supply clients • Consider seeking expertise in allocating and designing service delivery space

			of their building. Space constraints have hindered workflow and confidentiality and client safety are harder to manage. Some staff work in hallways and closets, on separate floors and different buildings. Without dedicated offices, many staff share offices or move between offices. There is also insufficient space in waiting rooms, injection rooms and for one-on-one consults. Some *clients* are concerned about intermingling with people not on the safer supply program.	
Prescribers	Physicians and nurse practitioners prescribe safer supply medications. As per the *Controlled Drugs and Substances Act (CDSA)* they can "*prescribe, administer, provide and sell*" controlled substances, and are required to be in a care relationship with clients. Provincial/territorial ministries of health regulate health care professionals and regulatory colleges are responsible for ensuring they provide services in a safe, professional and ethical manner, including through issuing practice guidelines. Colleges also ensure that health professionals comply with applicable provincial and territorial legislation related to their scope of practice.	Prescribers refer to B.C.'s risk mitigation guidance and other guidance documents for safer supply. Some are developing their own guidance and practices. In the absence of guidelines, prescribers document how they follow standards of care, apply the evidence, adhere to research protocols and follow practices of their peers. Prescribers are dedicating time to supporting and mentoring new prescribers and advocating for safer supply.	There is "guidance" and "advice," but no official guidelines from professional colleges for prescribing opioids or stimulants as an alternative to illegal drugs. Safer supply physicians have urged their colleges to endorse existing safer supply guidance and develop guidelines related to prescribing, scope of practice and shared care models. There are reports that the College of Physicians and Surgeons in B.C. challenges physicians prescribing under the guidance. The College of Physicians and Surgeons of Ontario issued *Advice to the Profession* on safer supply prescribing. While a positive step, it does not provide detailed prescribing guidance other than the general *Prescribing Drugs* policy related to prescribing controlled substances. Thus, it was heard that many physicians remain reticent to prescribe safer supply. They are concerned about safety, audits, liability and losing their licenses if they participated. There is pressing need for additional physician prescribers. They do not have back up support from other physicians in addiction and family medicine, sometimes even in the same organization. Many only have one on site at a time. They have many tasks in addition to appointments and frequently work outside office hours. They also need help to meet the overall demand	• More prescribers are needed to: 1) help meet the overall demand for safer supply; 2) take clients who do not meet the programs' eligibility criteria; and 3) accept current clients who have stabilized to allow safer supply programs to enrol new clients. • Continue advocacy by physicians leaders • Safer supply physicians need the backing of their professional colleges to support their work and address resistance from other physicians, including recognizing existing guidance and advice represent a professional a standard of care, and the development of professional safer supply guidelines • National and provincial/ territorial mentoring supports are needed for physicians, including ongoing continuing medical education, micro-credentialing and quality improvement collaborative initiatives to increase the willingness and capacity to prescribe safer supply

			for safer supply, with clients who do not meet program eligibility criteria and with clients who have stabilized to allow safer supply programs to then enrol new clients.	
Pharmacists	Many programs have integrated or partnered with a local pharmacy. In these instances, pharmacists work as part of the team supporting clients. Under the *Controlled Drugs and Substances Act (CDSA)* regulations, (*Prescription management by pharmacists with controlled substances under the Controlled Drugs and Substances Act and its regulations*) pharmacists can adjust medication formulations (e.g., change from pill to liquid formulations), adjust the dose and regimen, de-prescribe and partially fill scripts. The March 2020 Health Canada *Subsection 56(1) class exemption for patients, practitioners and pharmacists prescribing and providing controlled substances in Canada* in the *CDSA* permits pharmacists to extend and renew prescriptions; transfer prescriptions to other pharmacists; take verbal prescriptions; and deliver controlled substances to patients.	Programs have engaged in discussions with government and colleges for guidance and to develop protocols related to the types of medication that can be prescribed and dispensed by pharmacists, physicians and nurses. Pharmacists are important members of the team and may see clients most often. Having good collaboration and communication is critical. Many have a reciprocal working relationship in support of client health and wellbeing. Some support clients with all their prescriptions, renewal reminders and advice about their health. The way in which clients experience the pharmacy is critical to their retention. Many clients appreciate the respectful relationship developed with their pharmacist. A few have successfully transferred their prescriptions to unaffiliated pharmacies (if permitted). Clients appreciate the option to access their medications via the biometric dispensing machine, *MySafe.* Where pharmacists are able to dispense, but are as yet unable to draw an injectable dose, safer supply nurses can draw doses as a delegated act. For programs that dispense hydromorphone tablets without a pharmacist on site, there are a series of chain of custody regulatory requirements which have to be adhered to. Processes have been developed and adapted to the program within those parameters. Some programs engaged community pharmacists early in program development to develop working relationships and involve them in program planning. Comfort levels have grown over time.	Some provincial colleges of pharmacists have not been supportive of the program. Pharmacists have expressed concern about supply, transport, storage, transfers, compounding, the time required to supervise injections and the tracking and disposal of unused drugs. Some provincial colleges delayed adoption of federal exemptions and discussions about the policy changes needed are ongoing. There are challenges particular to injectable medications. The *National Association of Pharmacy Regulatory Authorities* (NAPRA) guidelines for compounding and dispensing require specialized equipment and procedures. Colleges also have regulations for compounding. Injectable hydromorphone or diacetylmorphine may be dispensed through advanced compounding and preparation of doses directly to the client or delivery of single-use vials to safer supply sites. However, many community pharmacies choose to forgo advanced compounding. Some pharmacists remain unwilling to dispense safer supply and programs have faced pharmacies refusing to dispense. A few clients have had bad experiences. Some clients struggle with pharmacy hours of operation. Explaining the program, managing inquiries and discussing dosages takes a significant amount of prescribers' time, making a strong working relationship with pharmacists important.	• Understand pharmacists' role under the *CDSA* and their regulatory colleges • Develop protocols and procedures related to the types of safer supply medications that can be dispensed by pharmacists • Engage pharmacists to ensure they have an understanding of safer supply and to debunk any myths • Engage local pharmacists early in program development, including establishing working relationships and involving them in planning for program design, logistics and care pathways.
Nurses	Nurses play an important role in staff supply programs. The Section 56(1) class exemption from the *CDSA* allows nurses at a community health facility to provide and administer controlled substances	Several programs have a registered nurse (RN) as the clinic manager or clinical lead. Several programs are using nurses as part of their team to the full scope of their practice. Many, including registered and licensed practical nurses (RPN/LPN) are	Some programs are not using nurses to their full scope of practice. There are currently nursing shortages and programs have had recruitment challenges.	• Understand the regulations, scope of practice and professional roles of the various types of nurses when considering their role in a safer supply team • Consider expanding clinical and management roles for nurses within the safer supply team • Depending on the province, nurses may be

	to people receiving treatment. Several programs have taken advantage of the authority in another exemption for practitioners to verbally prescribe safer supply drugs and have nurses administer them and monitor clients. In addition, through Medical Directives, nurses often do the initial and follow-up assessment of clients and notify the prescriber if there are deviations from the directives. Many nurses also fulfil the documentation requirements.	experienced administering liquid opioids in emergency departments, hospital and long-term care settings. They draw and supervise injectable doses and monitor clients post injection as part of their scope of practice. The ability for nurses to prescribe is expanding. For example, in B.C., select registered and registered psychiatric nurses can prescribe buprenorphine/ naloxone (Suboxone). An expansion to allow the prescribing of Kadian and methadone is underway and the prescribing of other medications is under discussion.		able to prescribe, draw, administer and monitor the use of controlled substances.
Staffing	The core team generally includes: a physician or nurse practitioner, an RN, RPN or LPN, and a caseworker, social worker, community health worker, harm reduction worker or peer support worker. Staff are a mix of full time and part time employees. Where the program is integrated with primary care services, additional providers may also provide services.	Team members communicate well and work collaboratively, with a few exceptions. They work together to find solutions for clients and have introduced a number of innovative practices, including strategic outreach, formal and informal networks, referrals, helping clients navigate social services, telephone and video services, and mobile services. Teams have flexibility in their roles, ensuring they work to their full scope of practice and through directives and order sets (e.g., LPNs drawing injectable doses, outreach workers providing wound care, collecting urine samples and developing care plans, and nurses conducting assessments and providing primary care). Some have implemented team building and conflict resolution processes. Some hold regular team meetings and smaller huddles. Programs have worked to build a supporting workplace environment, including wellbeing, counselling and grief supports. Clients are complimentary and appreciative of staff, including the respect and attention they pay. They appreciate staff are available when needed and take the time required to discuss their concerns without stigma or judgement.	• Insufficient staff to meet the demand for services • Low staff-to-client ratios • Staff burnout • Staff shortages • Insufficient and lack of permanent funding • Recruiting challenges • Inadequate resources to support individuals with high needs (homelessness, mental health, medical complications, outstanding legal issues, high risk of overdose) • Some sites have lower staff satisfaction Differing professional cultures, professional hierarchies and power dynamics can challenge interdisciplinary teams. These dynamics present themselves among clinical professions (e.g., physicians and nurse practitioners) and between clinical and community health team members. Dynamics are influenced by the extent of collaborative planning, case consultations and decision-making, and whether members feel their voice is heard, including peers. Dynamics are also affected as most resources go to the clinical component of the program, which also tends to receive more administrative support and have lower client-to-staff ratios. As well, some programs have separate leadership for clinical and community health programming, influencing team dynamics and the extent of interaction.	• Programs would benefit from more of each type of provider. • More community outreach, social work, harm reduction and case management are required. • Staff need to be the right fit and have harm reduction and cultural competencies, including for racialized, Indigenous and immigrant populations. • Cross training staff to fill roles for vacation, sick leave and emergency leave. • Address professional cultures, professional hierarchies and power differentials among clinicians and between clinical and community health staff • Engage teams members in program design and improvement • Undertake regular team meetings and follow up on the issues and action items identified • Provide formal and informal teaming building • Ensure that staff have access to mental health and wellbeing supports • Clinical training, whether initial or continuing education, needs to better address and develop skills in harm reduction, anti-oppression and anti-stigma approaches to care.
Peers	Peers play many roles: • Community relationship building,	Peers are important to program success and their participation benefits them. They are a	Some programs experienced challenges maintaining their peer programs due to	Peers' roles should be tailored to and align with their life experience and stage of recovery, with

	gaining feedback on service needs, spreading the word and providing education • Guidance in service development • Participants in team meetings • Outreach for client engagement and recruitment • Role models • Support at the front desk and in the waiting room • Liaisons between other program staff and clients • Collegial one-on-one support and guidance • Lead wellness and empowerment group • Case management • Referrals • Accompaniment and advocacy during appointments • Paired service and medication delivery • Outreach and visits to home or encampments • Providing harm reduction supplies • Securing basic necessities food, water, clothing • Support finding housing • Support getting identification, health cards, etc. • Charting and documentation	voice for clients and help other service providers better understand their experiences, perspectives and needs. One program has a support group for peer workers to ensure they are well-supported and emergent needs (e.g., housing, medical, mental health) are addressed.	COVID-19. Others found it difficult to find people with lived and living experience who had work experience. Some needed to recognize that work processes like timesheets and workplace rules can be a challenge. Peer workers may have challenges succeeding in their role as they do not have the same resources as other staff, e.g., stable housing, family support, adequate transportation. Care needs to be taken that they are not re-traumatized or exploited. Some peers may feel left out and that their views were considered secondary to those of nurses and doctors.	consideration to their self-care, resilience, training and capacity building needs. Standards and guidelines to support the effective recruitment and retention of peer workers, including defined goals, expectations and outcomes, best practices and mentoring.
Comprehensive wraparound services	Whether integrated within primary care or standalone, programs provide much of their clients' primary and social care services, including: • Acute and chronic care • Counselling • Case management • Housing supports • Advocacy • Harm reduction • Peer support • Outreach • Drop-ins • Crisis support • Social support • Food security • Legal services • Applications for income support • Applications for prescription drug coverage • Assistance getting health cards, ID	The ability to address clients' concurrent needs and offer wraparound services is critical to program effectiveness. Clients generally prefer a one-stop-shop with providers they trust. Gaining client trust and comfort in receiving services is important. Creating culturally safe services, reflecting their unique backgrounds and lived experiences, creates a situation where clients "feel more empowered to access care safely." Programs offer a range of social services critical to client success on safer supply. Many programs are innovating in this regard. Several standalone programs have community health centres or similar services in close proximity to which they refer clients. Social support and case management are	Providing wraparound services has put pressure on the staffing capacity. Many clients need ongoing social support and case management. A few programs do not have a relationship with primary care services and struggle to provide sufficient care for their clients in addition to their core services. Some standalone programs report inadequate information continuity. Even when housed within primary and social care service organizations, program may be separated from other services. Some clients prefer to receive safer supply from a site other than their regular health care provider or outside the medical system. Housing is among the most pressing	• Different models of safer supply are needed, as one design does not meet the needs of all clients. • Having safer supply embedded within primary and social care is desirable and can readily support clients' overall health and wellbeing, working towards it being a standard of care. • Standalone programs may be preferred by clients who find them lower-barrier than the formal health system or want to receive their health care separately. • Safer supply services for Indigenous peoples must reflect their unique culture and lived experience, offering a "wholistic" approach to services across the care continuum. Services must be culturally safe and trauma-informed. • Greater resources for case management are required • Greater access to housing supports is required. • Innovative and individualized stabilization and recovery pathways are needed. Services could entail case management, housing, training and

	• Referrals • Treatment options • Medication delivery • Cultural services • Indigenous Elder support in cultural wellness program • Legal support • Teaching other providers	important components of safer supply services and critical to its success. Community outreach workers, social workers and case workers/managers play a crucial role in building trust and supporting clients to access care. Clients greatly appreciate and benefit from having a SCS within their primary care service site.	client needs and is a critical part of their stabilization pathways. Programs need innovative services and care pathways for clients once they have stabilized or desire additional recovery pathways.	job support, and trauma-informed mental health services, and additional and new types of service partners to support clients in adapting to their new circumstances, including the broader primary and community care sectors. • Barriers to accessing treatment centres for those still using some types of drugs need to be addressed. Addictions services that do not require abstinence are needed. • Support and care pathways are needed for those for whom the safer supply is not working.
Mental health	The extent of mental health support varies by program. Generally, informal support is provided by staff. Some clients have been offered formal counselling options; others have not.	Clients report that staff make themselves available to discuss their pressing needs, including the challenges they are facing. Programs offer access to some mental health supports; some are in-house, but generally through referrals.	Mental health support is one of the most pressing *client* needs and is a critical part of their stabilization pathway. Many want (but often cannot access) formal support with their mental health concerns, including their experiences with depression, anxiety, trauma, violence, loss and eating disorders. Some *clients* have apprehension related to nervousness, trust, opening up, and the potential ramifications of sharing and being honest. Providing mental health support is time consuming and, given the extent of the need, it is challenging to meet demand within the existing capacity constraints. External counselling and mental health supports are difficult to access.	• Access to a continuum of mental health services is required. • These services should be an integral part of programs. Some clients suggest it should be a requirement. Services could include: group sessions; drop-ins; urgent counselling sessions; and peer support. • More staff with mental health expertise are needed, including social work, psychology and psychiatry. • Greater access to and more support from external mental health services is required. • Services need to be adapted to lived experiences and address the underlying reasons for drug use. Some who had counselling in the past, had poor experiences. Services need to be low-barrier, rooted in a harm reduction approach, trauma-informed and tailored to clients' needs.
Partnerships	Programs have several collaborations and partnerships. They may not have formal partnerships or signed agreements, but have strong relationships with many community partners Their closest linkages are with other harm reduction services (e.g., SCS), pharmacists and primary care and they are an integral part of safer supply services. Several programs work closely with other health services in close proximity, including community health centres, outreach services, housing services and social services.	Safer supply programs benefit from numerous collaborations and partnerships. They leveraged existing partnerships and developed new ones to address services gaps and provide clients with the support they need Several programs engaged in regular consultations with key partners prior to launch. It was important to provide information and education to existing and potential allies and partners about the program. Some wrote pamphlets and developed a letter to accompany clients to hospital, pharmacies, etc. that gives background and context to the program and the importance of reducing stigma and barriers. They have provided training to community partners, networked with community outreach services, developed referral	Programs faced pharmacies refusing to dispense and hospitals and prisons not honouring clients' safer supply dosages. A lack of understanding and support for safer supply has hampered partnerships with addiction treatment agencies. Clients struggle with SCS hours, especially if they require a minimum amount of time between multiple injections. Several SCS have capacity challenges, with reported space and privacy issues. With limited space, long wait times sometimes cause people to leave and inject elsewhere. Clients have experienced challenges with SCSs that serve a wide range of clients. Some inject at home in order to	Clients would benefit from increased buy-in and better collaboration and care coordination among service providers. For external partnerships, working arrangements and processes should be clearly defined whether or not there are formal arrangements, including guidelines for universal processes. Programs should work to ensure transparency among partners and team members. For clients receiving care elsewhere, providers need to ensure that there are warm hand offs, limited duplication of care, good communication, and information and management continuity. Establishing training, referral networks and pathways, and guidelines for providing services to safer supply clients would support seamless transitions and continuity of care. Many clients prefer using SCS at the safer

		pathways specifically for their client groups, opened communication channels with the police, and supported other agencies in the creation of guidelines for providing services to safer supply clients. SCS see many of the clients every day, often several times. They play a role in recruiting clients, keeping them connected to the program, monitoring their health and wellbeing, and providing feedback to safer supply staff. Some SCS also advocate for and help connect clients with other services. For access to the safer supply team, some SCS facilitate phone, virtual (OTN or Telus) and in-person visits with safer supply staff for clients who experiences barriers to accessing the safer supply site each week.	avoid the SCS. Another challenge is that a one program provides SCS onsite for clients' to use their safer supply, but not other drugs, forcing them to go elsewhere and potentially use unsafely.	supply site; several would like to have SCS space dedicated to safer supply clients.
Delivery Approach	Programs differ in their model of delivery, with some providing more of a medicalized addiction model of services and others more of a community health model. Medical and harm reduction approaches to safer supply are understood and implemented differently.	Programs base their services on a social determinants of health, trauma-informed, and decolonized approach. All emphasize the priority of low-barrier accessibility and working with clients where they are at to find workable solutions within a harm reduction model. Some programs provide their clients with safer supply as part of comprehensive primary care, within a continuum of that includes safer supply among available treatment options for opioid use disorder. Some programs are a hybrid harm reduction/addiction medicine model, with "*an arsenal of options.*" One program co-prescribes OAT in addition to safe supply and brings urgent primary care to people where they are." Another program is a more of a medical, addiction medicine model based at a clinic, with ties to a broader harm reduction services.	There are challenges working within a medical model. The need for prescribers to work within college and regulatory requirements has created barriers to access and influenced the nature of service delivery. *"Some of this is a public health intervention that is not always easily realized with a medical model*." It was shared that it has been difficult to balance the lack of evidence to support pharmaceutical alternatives with the harm reduction model that informs safer supply. Some addictions medicine specialists are resistant to safer supply, have spoken out against it, discouraged colleagues from prescribing and chastised clients for participating. Staff and clients reported some OAT prescribing physicians expressed concern about the program to prescribers and their clients. It was shared that harm reduction can be "drowned out" by addiction medicine and abstinence-oriented treatment and recovery interventions and not given enough space in the continuum of care. With professional hierarchies and power differentials, tension can occur between clinical and community health cultures. Different team members may emphasize a different focus. As well, safer supply prescribers have experienced push back and the wielding of differential power	• At its core, safer supply should be based on the principles of harm reduction • The traditional approach of addiction medicine has not been conducive to addressing the needs of safer supply clients, and new models and pathways are required to support the continuum of client goals, and provide sufficient options and choice to fit their needs. • Safer supply should be an option for addressing opioid use disorder as part of the continuum of services provided within a health care system that treats all medical conditions, including addictions • Primary care should be rooted in a social and moral determinants of health approach in the provision comprehensive addictions care • People with opioid use disorder hesitant to engage with a medicalized service require alternative options • Power dynamics and client experience of oppression need to be better understood and made explicit, as developing a mutually trusting relationship is critical • Barriers to accessing treatment centres for those still using some types of drugs need to be addressed. Addictions services that do not require abstinence are needed. • It was shared that new and innovative medical and less-medicalized models and pathways should be investigated and tested to increase low-barrier access to safer supply and address the continuum of client needs, experiences and goals • Some suggest a hybrid model with a broader harm reduction approach (including decriminalization or legalization) that would

			dynamics from some in the addictions medicine field. There can be challenges in the nature of the relationship and power dynamics between clients and medical staff. There is some stigma and assumptions implicit in medical training. Programs have experienced difficulties getting clients into treatment services. Policy rigidities and other barriers are hindering access to recovery pathways. For example, couples are not allowed to attend treatment centres together, but do not want to leave each other alone on the streets. Moreover, most treatment centres will not take clients who are currently using drugs, even if they have stopped fentanyl.	bring greater, along with a medical model being more appropriate for the most medically complex, treatment-focused individuals. • Others suggest alternative models with prescribers be removed from the process - within a regulated system, but outside a medical model. Examples include distribution by dispensaries and compassion clubs, operating like cooperatives.