ALTERNATIVES TO UNREGULATED DRUGS: **ANOTHER STEP IN SAVING LIVES**

BRITISH COLUMBIA

Office of the Provincial Health Officer

PROVINCIAL HEALTH OFFICER'S SPECIAL REPORT

Cover artwork by Hawkfeather Peterson.
The image is inspired by the idea of surrounding people who use drugs with support and care.

Electronic copies of this report and supplementary materials are available at:
https://www.health.gov.bc.ca/pho/reports/special.

Ministry of Health

Victoria, BC

July 9, 2024

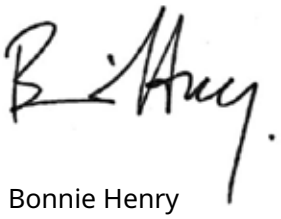
The Honourable Adrian Dix

Minister of Health

Sir:

As the Provincial Health Officer, my role is to provide independent advice and public reporting to support and advance the health of people in British Columbia. This includes making recommendations for policies and programs that will improve health. I am pleased to present this Provincial Health Officer Special Report, which highlights the urgent need to expand access to alternatives to unregulated drugs.

Sincerely,



Bonnie Henry
OBC, MD, MPH, FRCPC
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A Message from BC's Provincial Health Officer

We are in the ninth year of a public health emergency related to poisonings and deaths from unregulated drugs. Throughout this emergency, families of people who use drugs, as well as peer, advocacy, and community groups have shared their grief and sorrow at the loss of their loved ones. They have shown immense strength in telling their stories and publicly expressing their pain—pain that their loved one is no longer with them, and that the emergency continues.

In January this year, former BC Chief Coroner Lisa Lapointe presented the 2023 year-end data for the emergency. In Lisa's remarks, she described how when she spoke with parents who had lost a child to this emergency, they often shared the hope that their child had not died in vain. That other families would not have to go through the same loss. That someone is listening.

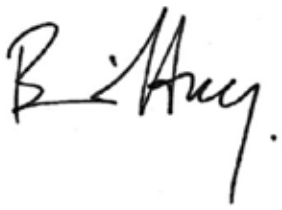
I too have met with loved ones of people who have died during these last eight years and have heard this same message. Yet, I have spoken with only a small number of those families affected—more than 2,500 last year alone; a stark reminder that the tragedy of this emergency is affecting our entire province. We know it reaches into every community.

In media coverage of drug poisoning deaths, it is also common to hear people say that if their loved one had access to a safer alternative, they might still be here. They know how difficult it can be to support a loved one who is using drugs, particularly with the deadly risk of the unregulated drug supply. Yet it is still more difficult to know that their death could have been prevented if the right supports had been available.

For some, a safer alternative to unregulated drugs could have been the right support.

In publishing this report, my intention is to provide a clear and truthful description of the reality of this crisis, of which the main driver is a prohibitionist approach to drugs that has produced a highly toxic unregulated drug supply.

I hope that this report will be received with open-mindedness, and willingness to consider how alternatives to unregulated drugs might fit within our response. It will never be our only tool; prevention and early intervention, harm reduction, medication-assisted treatment, and other evidence-based treatment and recovery services and social supports must be available when people need them and are ready for them. However, I believe we owe it to those affected, to those lost and those who love and miss them, to explore what might be possible. To put in place a safeguard and an alternative option to help separate people from the toxic, unregulated drug supply. To show them that we are listening.



Acknowledgements

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The following individuals provided advice and assistance in the creation of this report. Many others contributed their thoughts and ideas by providing feedback on a draft of this report.

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Land Acknowledgement

We acknowledge with great respect the territories of the lək̓ʷəŋən Peoples on which the Office of the Provincial Health Officer stands, and the Songhees, Esquimalt (Xwsepsum), and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day. We recognize and express our gratitude for the medicines within these territories, and the First Nations territories that stretch across every inch of the province of British Columbia.

Rights Acknowledgement

We acknowledge with respect the inherent rights of the First Nations whose ancestral territories cover every inch of the province now known as British Columbia, including their unextinguished land rights and rights to self-determination, health, and wellness within these territories. Laws and governance systems rooted in the land have upheld the sovereignty of these diverse Nations for thousands of years. The rights and responsibilities of First Nations to their ancestral territories have never been ceded or surrendered, and are upheld in provincial, national, and international law.

We also acknowledge that many Indigenous Peoples (First Nations, Métis, and Inuit) from elsewhere in what is now known as Canada also call these lands and waters home, and we have obligations to uphold their rights to self-determination, health, and wellness. This includes Métis Nation British Columbia and its Chartered Communities across BC, as well as those whose ancestral territories are outside of BC.

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Executive Summary

This report discusses the unregulated drug emergency and focuses on one intervention of the many needed—enabling access to alternatives to unregulated drugs (also known as "safer supply"). Based on emerging evidence, the magnitude of harm from unregulated drug poisonings, and the direct correlation between the toxicity of the unregulated drug supply and mortality, this report's recommendation is to continue to refine and expand prescribed alternatives to unregulated drugs, and critically, to explore implementation of models that do not require prescription as a necessary enhancement to BC's response to the unregulated drug emergency.

More than 14,000 people have died of drug poisoning in BC since the public health emergency was declared in 2016. Despite the implementation of a multi-faceted response, the death toll has increased almost every year since the declaration of the emergency, with 2023 being the deadliest year yet. The scale of the emergency is enormous due to the high toxicity of illegally manufactured street drugs containing fentanyl-like drugs and other dangerous substances in the unregulated drug supply, which is accessed by an estimated 165,000 to upwards of 225,000 people in BC in a 12-month period.

Synthetic opioid fentanyl-like drugs have been detected in more than 80 per cent of drug poisoning deaths since 2017, have largely displaced other opioids from the drug supply, and are also increasingly found in samples of unregulated stimulants. Because of the presence of illegally manufactured fentany-like drugs in the unregulated drug supply, along with other adulterants such as benzodiazepines and xylazine, a small quantity of unregulated drugs can be fatal. When illegally manufactured and distributed, opioids and stimulants such as fentanyl-like drugs, heroin, methamphetamine, and cocaine are mixed with other adulterants such as benzodiazepines and cutting agents such as talc to produce individual doses of drugs that are sold in the unregulated market. The composition, contents, and potency of these unregulated drugs are unpredictable, and inherently distinct from pharmaceutical-grade opioid and stimulant products that are quality-controlled and manufactured in strictly regulated environments.

The emergency has been exacerbated by various factors, including chronic gaps in the health-care system, housing instability and homelessness, poverty, the impacts of colonialism and racism, criminalization, and stigma, as well as other determinants of health and inequity. This has resulted in an inequitable distribution of deaths across BC's population, with disproportionate impacts on Indigenous Peoples.

While people with substance use disorders represent most drug poisoning deaths, **many people who have died over the past eight years did not have a substance use disorder**. This presents unique considerations for addressing the emergency in a way that looks beyond medicalized approaches and solutions that focus on people with substance use disorders. Non-medicalized approaches are

necessary to address the needs of a substantial portion of the population at risk of drug poisoning and other harms.

This is one example of why, to have a real impact on reducing drug poisonings, **it is essential to name and address the underlying cause: drug prohibition and the resulting highly toxic unregulated drug supply**.

Drug prohibition—the system of laws and policies that constitute how Canada has regulated many psychoactive substances—restricts access to and criminalizes the production, possession, and sale of certain drugs and substances. This system authorizes access to pharmaceutical-grade versions of these substances for limited medical or scientific uses. In all other instances, the manufacture, supply, and distribution of prohibited drugs has become the territory of organized crime, which has resulted in the creation of the toxic unregulated drug supply.

Prohibition limits the establishment of protection and quality control measures for unregulated drugs. As a result, regulatory controls for legal products—such as foods and pharmaceuticals—that are designed to protect consumer safety are absent for illegal drugs. The rationale is that outlawing these substances and criminalizing manufacturers, suppliers, and consumers will protect society and individuals from harms related to drugs.

The ongoing high rates of mortality and morbidity related to the use of unregulated drugs is clear evidence and just one indicator that prohibition has not been successful. Ironically, prohibition has failed to control both the supply and composition of illegal drugs, and ultimately has been the primary driver of the current public health emergency—an unregulated and toxic drug market characterized by shifts toward increasingly potent and dangerous drugs.

Enabling access to alternatives to unregulated drugs involves providing people who use drugs with products of known quality, composition, and purity that they can use instead of unregulated drugs. While all drug use has risks, this approach reduces the risks posed by the contamination, adulteration, and unpredictable potency of unregulated drugs.

Providing access to alternatives to unregulated drugs is aligned with a public health approach to psychoactive substances, which typically involves (1) moving away from treating substance use as a criminal justice issue, (2) considering population-level impacts of substances, based on evidence, and (3) using a comprehensive range of strategies. This is consistent with the approach and rationale used with other consumer products that are subject to regulatory protections: consuming products of known content and purity that are free from contamination and adulteration is safer than consuming products whose contents are unknown and highly contaminated. Providing access to alternatives extends this principle to drugs as a means of reducing drug poisonings and deaths.

BC has made important strides in recent years in introducing new programs and policies to enable access to alternatives to unregulated drugs by individual prescription through the health-care system. Several such programs have also been implemented in Ontario. Consequently, there is a small but growing

network of prescribed alternatives programs operating in Canada that provide people at risk of drug poisoning with an alternative to the unregulated supply, as well as opportunities to study this approach.

Early evaluation and research show promising evidence of benefits for people enrolled in prescribed alternatives programs. Research indicates that for people who use drugs, these programs reduce the risk of death and the use of drugs from the unregulated market, promote engagement and retention in health care, and improve physical and mental health and well-being. The provision of opioid prescribed alternatives is also informed by many decades of clinical experience with offering opioid agonist treatment for opioid use disorder. For some clinicians, prescribed alternatives have been a useful and effective tool in connecting people to opioid agonist treatment.

However, while useful, these prescription-based models have faced many barriers and challenges due to the requirements, practices, and limited capacity of the health-care system. This **impedes the ability to sufficiently expand access to alternatives to unregulated drugs** to address the magnitude of the problem. Barriers include **medicalization** related to diagnostic and monitoring requirements, such as urine drug screens and witnessed doses; limited numbers of primary care providers; limited hours of operation of prescribers and pharmacies; care that is not patient-centred (e.g., discomfort with the surroundings, feelings of being patronized and stigmatized); mandatory dosing adjustments linked to missing doses; and inadequate dosing that does not meet the needs of people who use drugs. In addition, many prescribers feel that they do not have appropriate training or adequate support from their regulatory colleges to prescribe alternatives to unregulated drugs. Other barriers include **regulatory and implementation challenges**; i.e., lack of desired substances and modes of use for people who use drugs, geographical and transportation challenges, and **lack of cultural appropriateness and cultural safety**. These challenges have been put into focus by the limited reach of prescribed alternatives so far, as well as the limited number of prescribers who have embraced this practice.

Barriers need to be addressed to continue to scale-up and increase the accessibility of prescription-based programs. However, experience so far shows that providing access only through the health-care system makes it unlikely that this intervention will reach a large enough proportion of the population at risk to reduce rates of poisonings and deaths. **Therefore, it is imperative to explore opportunities for providing access to alternatives beyond the health-care system**.

Requiring that controlled substances are available only by prescription has made it difficult to implement, study, or evaluate non-prescribed approaches to enabling access to alternatives to unregulated drugs. However, **research on alternative regulatory frameworks for controlled substances, as well as community-led models such as buyers' clubs and compassion clubs, offer useful insights on this approach**. People who use drugs have also shared their perspectives on facilitators of and barriers to offering this service, including the need for respect and trust; substances that can effectively replace

unregulated drugs; and accessible, safe, and welcoming spaces. Also, people who use drugs need to be involved in planning and implementation.

In addition, several agencies and organizations have identified required safeguards that would promote individual and public health and safety if access to alternatives beyond the health-care system is pursued. This recognizes that, as with any new approach, there are legitimate questions about the mechanisms and systems that are essential to protect against unintended consequences. A BC Coroners Service death review panel recently proposed a non-prescriber model for access to alternatives that highlights many of these considerations, including governance structures; eligibility criteria; program access procedures; supply and distribution systems; staffing and training standards; storage and security requirements; and monitoring, evaluation, and research needs. **This report echoes that message: expanding access to alternatives beyond the health-care system includes ensuring appropriate system-level protections**.

While there are no magic bullets for ending this crisis, **enabling access to alternatives to unregulated drugs presents the best opportunity to address its fundamental driver—the highly toxic and unpredictable unregulated drug supply**. Access to alternatives to unregulated drugs has been called for by people who use drugs, their families, public health officials, and other advocates for many years. And while BC has made important strides in offering prescribed alternatives, the ongoing high rate of death caused by the toxicity of the unregulated drug supply and the barriers inherent in enabling access to alternatives exclusively within the health-care system, shows that exploration of **innovative, scalable, and thoughtfully designed non-prescribed approaches is urgently needed. These programs would be a part of a wider suite of services and interventions for addressing substance harms and would be the next step in developing a comprehensive response to drug poisonings.**

Ultimately, we cannot prescribe our way out of this crisis. Finding new ways to enable access to alternatives to unregulated drugs will require bold conversations, system-level changes, and thinking outside of the constraints that have so far failed to turn this crisis around.

Recommendations

1. **The Province of British Columbia should explore implementing, with appropriate safeguards, and evaluating scalable programs that enable access to non-prescribed alternatives to unregulated drugs.**

   These programs would be in addition and complementary to the ongoing implementation and improvement of prescribed alternatives policies and programs. This multi-model approach is required to meet the needs, and thereby save the lives, of people who use drugs. Much depends on the details of how non-prescribed alternatives would be made available. BC has world-leading expertise that can be called upon if given enabling leadership, encouragement to explore innovative solutions, and investment by decision makers.

2. **People and organizations that represent those with lived and living experience of substance use must be engaged in the planning, design, and implementation of all programs and policies that enable access to alternatives to the unregulated drug supply.**

3. **The Province of British Columbia should pursue meaningful partnership in this work through effective co-governance with Indigenous organizations and governing bodies as is required to uphold the inherent rights and title of First Nations in BC, and the inherent rights of First Nations, Métis, and Inuit people in BC.**

   Strategies must be developed to ensure that the obligations described in the Unlearning and Undoing section of this report are met in the context of alternatives to unregulated drugs. This would include increasing Indigenous communities' self-direction on matters related to psychoactive substances, addressing issues related to rural and remote communities and urban and away-from-home Indigenous populations, and determining how enabling access to alternatives can complement Indigenous harm reduction and other efforts.

Unlearning and Undoing White Supremacy and Anti-Indigenous Racism in BC's Office of the Provincial Health Officer

The Office of the Provincial Health Officer (OPHO) is committed to upholding anti-racist approaches, Indigenous rights, and truth and reconciliation with Indigenous Peoples.[a] The OPHO is committed to identifying anti-Indigenous racism and white supremacy in its day-to-day work and deliberately taking anti-racist and anti-white supremacy approaches.[b] Progress in this uncomfortable and challenging work is often slower than desired, and mistakes will continue to be made along the way, but this work is continuing in good faith.

Anti-racist Approaches Within the Alternatives to Unregulated Drugs Report

Settler colonial governments and institutions have created the social and structural conditions within which substance use and its related harms disproportionately occur in Indigenous populations. Harm reduction must include reducing the harms of settler colonialism.[1] As such, reducing substance harms through decolonization is a shared responsibility across all government portfolios.[2] The OPHO acknowledges its responsibility to eradicate racism and settler colonialism within its reporting structure and processes. This office is currently reviewing its report writing process to identify where and how racism and white supremacy manifest, with the goal of undoing racist policies and practices. The OPHO also acknowledges its responsibility in addressing the disproportionate impact of the unregulated drug emergency on Indigenous people, outlined in BC's *Declaration on the Rights of Indigenous Peoples Act* Action Plan, Action 4.12,[3] as well as in multiple foundational obligations to resource culturally safe, Indigenous-led mental health and wellness and substance use recovery services (see Table 1).

[a] In this report, the term "Indigenous Peoples" is used when referring to multiple Indigenous Nations or groups; the term "Indigenous people" is used when referring to individuals who are Indigenous. Exceptions are made where source material does not capitalize "Peoples."

[b] For more information, see https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/unlearning-undoing-project.

Table 1. Foundational Obligations to Resource Culturally Safe, Indigenous-led Mental Health and Wellness and Substance Use Recovery Services

***Declaration on the Rights of Indigenous Peoples Act* Action Plan**	**Action 4.12**: Address the disproportionate impacts of the overdose public health emergency on Indigenous Peoples by: • applying to the Government of Canada to decriminalize simple possession of small amounts of illicit drugs for personal use, and continuing campaigns and other measures to help end the stigma and shame associated with addiction; • expanding prescribed safer supply and other harm reduction measures; and • ensuring accessibility of recovery beds and evidence-based, culturally relevant and safe services to meet the needs of Indigenous Peoples, including youth.
Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls While the report's title refers to women and girls, the scope of this work also includes people who are Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and additional identities (2SLGBTQQIA+).	**Call for Justice 3.2**: We call upon all governments to provide adequate, stable, equitable, and ongoing funding for Indigenous-centred and community-based health and wellness services that are accessible and culturally appropriate, and meet the health and wellness needs of Indigenous women, girls, and 2SLGBTQQIA+ people. The lack of health and wellness services within Indigenous communities continues to force Indigenous women, girls, and 2SLGBTQQIA+ people to relocate in order to access care. Governments must ensure that health and wellness services are available and accessible within Indigenous communities and wherever Indigenous women, girls, and 2SLGBTQQIA+ people reside. **Call for Justice 3.3**: We call upon all governments to fully support First Nations, Inuit, and Métis communities to call on Elders, Grandmothers, and other Knowledge Keepers to establish community-based trauma-informed programs for survivors of trauma and violence. **Call for Justice 3.4**: We call upon all governments to ensure that all Indigenous communities receive immediate and necessary resources, including funding and support, for the establishment of sustainable, permanent, no-barrier, preventative, accessible, holistic, wraparound services, including mobile trauma and addictions recovery teams. We further direct that trauma and addictions treatment programs be paired with other essential services such as mental health services and sexual exploitation and trafficking services as they relate to each individual case of First Nations, Inuit, and Métis women, girls, and 2SLGBTQQIA+ people.

Table 1. Foundational Obligations to Resource Culturally Safe, Indigenous-led Mental Health and Wellness and Substance Use Recovery Services *continued*

MMIWG[c] and 2SLGBTQQIA+ National Action Plan: 2SLGBTQQIA+ Sub-working Group Final Report	**Recommendations**: • Develop safe places for questioning 2SLGBTQQIA+. • Develop 2SLGBTQQIA+ healing supports to address historical trauma and addictions. • Develop health initiatives that lead to a positive cultural identity. • Develop holistic support and prevention services for 2SLGBTQQIA+ people.
Truth and Reconciliation Commission of Canada: Calls to Action	**Call to Action 18**: We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties. **Call to Action 22**: We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.
In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care	**Recommendation 17**: That the B.C. government and FNHA[d] demonstrate progress on commitments to increase access to culturally safe mental health and wellness and substance use services.

To fully uphold the inherent rights of Indigenous Peoples in each Provincial Health Officer report, there must be meaningful partnership and co-governance with Indigenous partners in the process of selecting report topics and developing reports. This is in line with many foundational obligations of settler colonial institutions governing BC and Canada (see Table 2). The OPHO is working toward this state but is not there yet. Limited community resources prevented First Nations and Métis community members from sharing their stories, experiences, and perspectives in several areas. The OPHO does not yet have relationships with Inuit rights-bearing bodies or collectives of Inuit living in BC, and as a result, is not yet able to uphold full distinctions-based approaches.

[c] MMIWG refers to missing and murdered Indigenous women and girls.
[d] The First Nations Health Authority.

Table 2. Foundational Obligations Related to Co-governance

Declaration on the Rights of Indigenous Peoples Act Action Plan	**Action 4.8**: In alignment with the tripartite health plans and agreements, continue to strengthen and evolve the First Nation health governance structure in B.C. to ensure First Nations are supported to participate as full and equal partners in decision-making and service delivery at local, regional and provincial levels, and engage First Nations and the Government of Canada on the need for legislation as envisioned in the tripartite health plans and agreements. **Action 4.26**: Strengthen the health and wellness partnership between Métis Nation British Columbia, the Ministry of Health, and the Ministry of Mental Health and Addictions, and support opportunities to identify and work to address shared Métis health and wellness priorities.
United Nations Declaration on the Rights of Indigenous Peoples	**Article 15(1)**: Indigenous peoples have the right to the dignity and diversity of their cultures, traditions, histories and aspirations which shall be appropriately reflected in education and public information. **Article 18**: Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions. **Article 23**: Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Funding arrangements created by settler colonial governments often result in chronic underfunding to Indigenous communities and organizations. As a result, they are often prevented from fully meeting the needs of the people they serve due to insufficient staff and resources. In addition to this, Indigenous organizations and communities are consulted on an ever-increasing number of critical projects, which adds to their workload.[4] This results in the functional exclusion of Indigenous contributions, truths, and voices. As this cycle repeats, it serves to reinforce racism and white supremacy through the absence of critical Indigenous perspectives, truths, and wisdoms in foundational policies, reports, and other resources. This phenomenon was present throughout the creation of this report. The OPHO will continue to work with the First Nations Health Authority, Métis Nation British Columbia, and other partners to prevent the functional exclusion of critical First Nations, Métis, and Inuit voices.

First Nations, Métis, and Inuit Representation Within the Alternatives to Unregulated Drugs Report

Although this report fell short of its goal of fully realized co-governance, meaningful inclusion of Indigenous partners and perspectives was sought in the following ways:

Multiple Indigenous perspectives:

1. Three members of the OPHO project team contributed unique Métis, Cree, and Eh Cho Dene perspectives throughout the development of this report.
2. The scenarios in Appendix C were reviewed and enhanced by a group of reviewers with lived and living experience of substance use, many of whom are Indigenous from across BC.
3. The Dual Model of Housing Care, also presented in Appendix C as an urban housing model with potential to integrate access to alternatives to unregulated drugs within a cultural framework, was created by and is included with permission of the Aboriginal Coalition to End Homelessness Society in Victoria.

Engagement With the First Nations Health Authority

The description of the First Nations Health Authority (FNHA) Virtual Substance Use and Psychiatry Service presented in Appendix C of this report was created in partnership with the FNHA.

Colleagues from the FNHA generously provided comments on drafts of this report.

First Nations in BC are currently working to promote cultural continuity and connection while simultaneously protecting their members from the unregulated drug emergency, the COVID-19 pandemic, anti-Indigenous racism, and climate change. Consequently, though a suggestion was made to include perspectives of rural First Nations communities, these communities did not have the additional capacity to share their perspectives on alternatives to unregulated drugs for inclusion in this report.

Engagement With Métis Nation British Columbia

The OPHO sought to include the perspectives and wisdom of Métis in BC by engaging with Métis Nation British Columbia (MNBC). In partnership, the project team hoped to highlight the perspectives of Métis community members in the form of quotations throughout the report. Métis community members have unique needs and perspectives, distinct from First Nations and Inuit, and are working to promote the health, wellness, and cultural connection of their people amidst several public health emergencies. The project team for this report did not engage with MNBC early enough in the process of creating this report, nor did it allocate sufficient time to collect and highlight the voices of Métis community members. As a result, Métis perspectives are not adequately addressed in this report.

Potential for Inuit Engagement

The OPHO recognizes that Inuit living in BC hold inherent rights to health and wellness, and to be visible within the health-care system and reporting. Currently, Inuit are largely invisible within OPHO reporting due to a lack of Inuit data governance protocols in BC, Inuit-specific data sources, and disaggregated analyses by Inuit identity in data sources that collect information based on self-identification as Inuit. The OPHO will continue to work toward building relationships with Inuit governing bodies and/or collectives to make progress toward comprehensive Inuit representation and partnerships in future work and reports.

The First Nations Health Authority, Métis Nation British Columbia, and Countless Community Champions are Finding Innovative and Culturally Relevant Ways to Support the People They Serve.

The First Nations Health Authority (FNHA) has been working to save lives through its "Framework for Action: Responding to the Toxic Drug Crisis for First Nations." The Framework sets out a system-wide response to prevent unregulated drug deaths while supporting First Nations mental health and wellness. The FNHA has also tracked and published data on the disproportionate burden of drug-related harms experienced by First Nations people in BC; provided health-care and community workers with access to harm reduction services and supplies, including nasal naloxone, through the Harm Reduction Hub; and offered culturally safe, trauma-informed services, including harm reduction, treatment, and prescribed alternatives to unregulated drugs, through the First Nations Virtual Substance Use and Psychiatry Service. The FNHA's Not Just Naloxone Program is building Indigenous harm reduction knowledge and skills within First Nations communities across BC.[5,e]

Similarly, Métis Nation British Columbia (MNBC) is supporting Métis health and wellness during the unregulated drug crisis by tracking impacts on Métis communities in BC[6] and connecting Métis people to mental health and wellness supports and other needed resources. In 2021, MNBC launched the Lifeguard overdose prevention App, designed exclusively for Métis people, which provides instant access to Métis crisis lines and resources for mental health and addictions treatments.[7]

Here, we honour Indigenous communities that are working to regain and continue their connection to their culture, language, and land while grappling with ongoing settler colonial harms that result in disproportionate substance harms.

[e] For more information, visit the Harm Reduction and the Toxic Drug Crisis page on the FNHA website: https://www.fnha.ca/what-we-do/mental-wellness-and-substance-use/harm-reduction-and-the-toxic-drug-crisis.

1

INTRODUCTION AND PURPOSE

Toxic unregulated drugs have had a devastating impact across North America, with BC among the regions most dramatically and disproportionately affected.[8] Since 2016, when the Provincial Health Officer (PHO) declared a public health emergency related to a sudden rise in drug poisonings and deaths, more than 14,000 people have died due to toxic drugs in BC, despite the rollout of multi-faceted response measures.[9] Unregulated drugs are the leading cause of unnatural death in the BC population as a whole, accounting for more deaths than suicide, accidents, and natural diseases combined.[10,11] Deaths have been increasing in BC since 2012 and have accelerated since 2015, often exponentially, with the exception of 2019, during which deaths declined compared to the previous year.[12,13] This relative respite was short-lived, however, with the COVID-19 pandemic and toxic drug crisis combining to create a scenario of dual public health emergencies in BC, and a surge in drug poisonings and deaths in 2020 that has persisted for the past four years. More than eight years into the crisis, the number of deaths is more than 2.5 times greater than when the crisis was first declared, rising from 955 in 2016 to 2,511 in 2023, the deadliest year so far.

The impacts of this crisis reach into all communities and areas of the province. A 2023 poll indicated that approximately one in five (20 per cent) BC residents personally know someone who died after using "opioid drugs," and more than one in three (36 per cent) know someone within their community who has used "opioid drugs" within the past year.[14] This is only part of the story because street opioids are only part of the unregulated drug emergency; illegally manufactured methamphetamines and

benzodiazepines are also being linked to an increasing proportion of deaths.[13]

Despite sustained efforts, resources, and effective interventions, there has been little success in reversing the rising death toll. This is not to say that the response has been in vain—from January 2015 to September 2022, 8,630 death events are estimated to have been averted due to Take Home Naloxone, overdose prevention and supervised consumption services, and opioid agonist treatment.[15,16] Without the concerted and critical efforts of first responders, clinicians, public health workers, peer support workers, substance use service providers, advocates, community groups, and people who use drugs, the death toll would be even higher.

However, to significantly impact and reduce death rates, additional tools and solutions are urgently needed.[9] Offering alternatives to unregulated drugs—also known as "safer supply"—to help people who use drugs avoid the harms of the toxic drug supply is one such tool that could be scaled up as part of the continuum of substance use supports and services.

While this report outlines some of the actions taken in BC in response to the unregulated drug emergency, it does not describe the entire response to date.[f] This report also does not provide a comprehensive assessment of prescribed alternatives to unregulated drugs (also known as prescribed safer supply), in which BC has taken initial steps following the release of policy directives and guidance to enable access to alternatives to unregulated drugs by prescription. A review of BC's approach to prescribed alternatives is available on the Office of the Provincial Health Officer (OPHO) website.[17] The review includes considerations raised by clinicians, people with lived and living experience of drug use, families and caregivers of people who use drugs, and researchers; a scan of the evidence; and an ethical analysis. In addition, it includes recommendations to improve this program, which is a key part of the unregulated drug emergency response.

The purpose of this report is to further explore the concept of enabling access to alternatives to unregulated drugs as a method of reducing drug-related poisoning deaths. It highlights the connection between drug prohibition and an increasingly toxic, unregulated supply of street drugs, and describes a range of approaches that could be considered when enabling access to alternatives, with a focus on access beyond the health-care system. Finally, this report issues an urgent recommendation to expand and improve access to alternatives to unregulated drugs for people at risk of drug poisoning and death in BC.

[f] For information about BC's response to the toxic drug crisis, see http://www.bccdc.ca/health-professionals/data-reports/substance-use-harm-reduction-dashboard and https://www2.gov.bc.ca/gov/content/overdose.

KEY TERMS DEFINED

Unregulated drugs: also referred to as illegal drugs, illicit drugs, street drugs, or prohibited drugs, "unregulated drugs" are drugs prohibited under Canada's laws for all but very limited uses, which are nonetheless made available to the public by illegal manufacturers and distributors without the benefit of quality controls or regulation, resulting in an unpredictable and often toxic supply of drugs. Although frequently referred to as "fentanyl" there is a clear difference between pharmaceutical quality fentanyl and illegally manufactured, synthetic opioid fentanyl-like street drugs (e.g., acetyl fentanyl, carfentanil, fentanyl, furanyl fentanyl) which are often adulterated with other substances.

Unregulated drug emergency: the period in BC beginning in 2016 when deaths due to the use of unregulated drugs increased dramatically, and which is characterized by the rapidly increasing detection of synthetic opioid fentanyl-like drugs and other adulterants in deaths related to the use of unregulated drugs. The Provincial Health Officer declared this situation a public health emergency in 2016.

Drug poisoning: when a person becomes ill, is injured, or dies because of the effects of a drug. This includes "overdoses," when the body is overwhelmed by a too-large dose of a drug, but also situations where harm is caused by other factors; e.g., combinations of drugs, contamination, or adulteration. "Poisoning" in this sense does not mean there was an intention to harm, and includes accidental exposure to drugs.

Alternatives to unregulated drugs: drugs of known type, quality, and composition, such as pharmaceutical drugs, that are accessed by people who would otherwise use unregulated drugs.

Prescribed alternatives to unregulated drugs: a program or policy in which participants are prescribed pharmaceutical drugs as alternatives to the unregulated drug supply. Other terms for this approach are "prescribed safer supply," "prescribed alternatives," and "medical safer supply."

Non-prescribed alternatives to unregulated drugs: a program or policy in which alternatives to the unregulated drug supply can be accessed without a prescription; also referred to as "non-prescribed alternatives" and "non-medical safer supply."

See Appendix A – Glossary for definitions of additional terms used in this report.

Context

Unregulated Drug Deaths in BC

> *"The so-called 'War on Drugs' which is conducted by the Justice System can only be regarded as an expensive failure."*
>
> J.V. Cain,
> former Chief Coroner of BC[18]

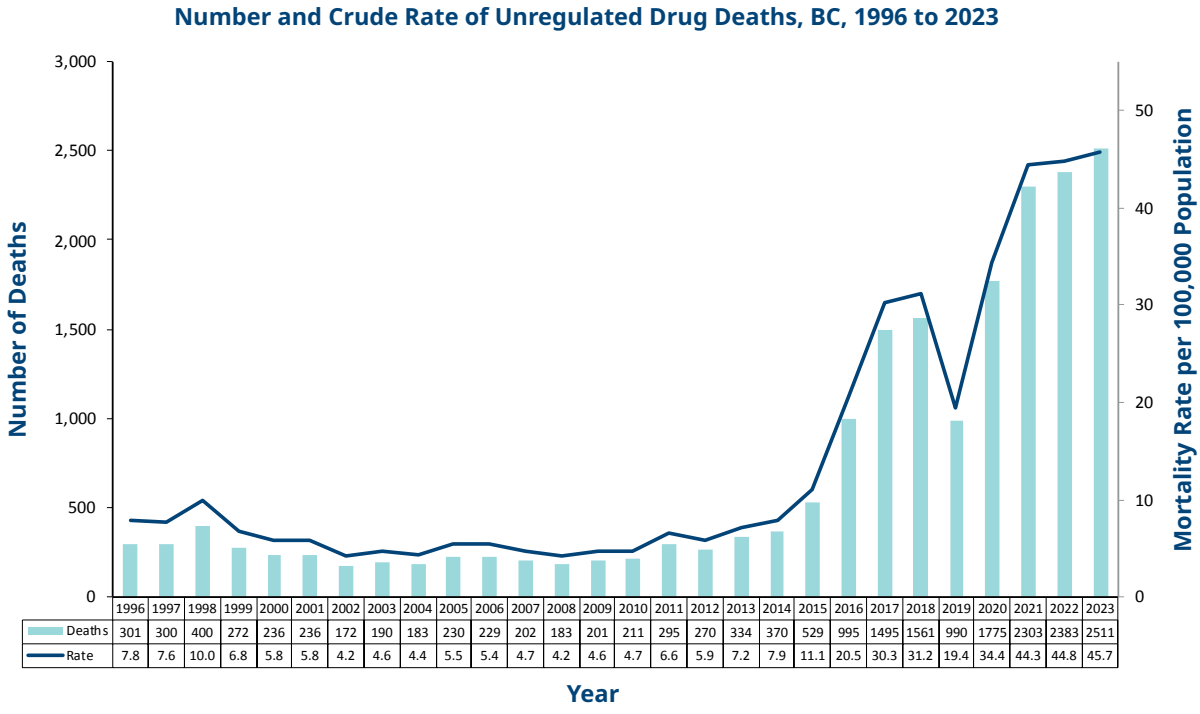
Unregulated drugs have been a cause of preventable deaths in BC for decades. In September 1994, BC's Chief Coroner released a report on "illicit narcotic overdose deaths," in response to the "inordinately high number of deaths associated with the illicit use of heroin"[18(p.iii)] observed in 1993. Between 1988 and 1993, the number of drug-related deaths in BC rose annually from 39 to 331, and reached a rate of more than 40 per 100,000 population in 1993 for men age 30–44, the most affected demographic. The report identified drug prohibition as a contributing factor and recommended, in part, that the provincial government examine existing legislation governing illicit and licit substances and make improvements.[18]

Throughout the early 2000s, the annual number of drug-related deaths in BC remained relatively stable, at approximately 200 to 250 per year. The number began to rise in 2012,[12] and by 2015, BC was experiencing a significant increase in both the number and geographic distribution of drug poisonings. At the same time, highly potent illegally manufactured synthetic fentanyl-like opioids began being detected in an increasing percentage of drug deaths.[19] In April 2016, due to the surge in drug deaths, the PHO declared BC's first provincial public health emergency under the *Public Health Act.*[20]

The emergency worsened substantially with the advent of the COVID-19 pandemic. During the pandemic, there was greater unpredictability and variability in the concentrations and potencies of fentanyl-like drugs in the unregulated drug supply; increased social isolation, anxiety, and mental distress; increased likelihood of people using drugs on their own; and reduced access to social and harm reduction services.[21,22] As a result of the intersecting impacts of these public health emergencies, during the years 2020 to 2022, a further surge in drug poisonings and deaths occurred.[12] In 2022, the rate of deaths from unregulated drugs was more than double that of 2016 at 44.8 deaths per 100,000 people.[12] These record-breaking numbers have continued, with an average of 209 unregulated drug deaths each month in 2023, or approximately seven each day, equating to a five per cent increase on 2022, occurring in all regions and communities across the province (see Figure 1).[13]

Unregulated drug deaths in BC are so impactful that they have reversed the trend of increasing life expectancy; between the years 2014 and 2016, they contributed to a measurable decrease in life expectancy at birth of 0.38 years.[23] Further analysis using data from 2019 to 2021 showed that unregulated drug deaths contributed to a decrease in life expectancy at birth of 0.93 years for men and 0.29 years for women.[24] Due to the combined impact of the COVID-19 pandemic and toxic drug public health emergency, between 2015 and 2021, life expectancy for First Nations people in BC decreased by 7.1 years, with drug poisoning accounting for the greater number of deaths and years of life lost.[25]

Figure 1.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Deaths	301	300	400	272	236	236	172	190	183	230	229	202	183	201	211	295	270	334	370	529	995	1495	1561	990	1775	2303	2383	2511
Rate	7.8	7.6	10.0	6.8	5.8	5.8	4.2	4.6	4.4	5.5	5.4	4.7	4.2	4.6	4.7	6.6	5.9	7.2	7.9	11.1	20.5	30.3	31.2	19.4	34.4	44.3	44.8	45.7

Notes: Unregulated drugs include controlled drugs (heroin, cocaine, MDMA, methamphetamine, illicit fentanyl, fentanyl analogues, etc.); medications not prescribed to the deceased, but obtained from unknown means; or combinations of the above with prescribed medications. This chart is of unintentional (accidental or undetermined) deaths and does not include intentional drug toxicity deaths or deaths due solely to one's own prescribed medications. The BC Coroners Service operates in a live database environment. Some data for more recent years are subject to change as investigations are concluded. Data are not directly comparable to published counts from previous years.
Sources: BC Coroners Service. Population estimates from the BC Stats Population Estimates Application. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, January 2024.

Size of the Population at Risk of Unregulated Drug Poisoning

Given the widespread, population-level impacts of the unregulated drug emergency, it is important to estimate the number of people at risk. This is key to better understanding the scale of response and appropriate interventions needed to reduce deaths.

It is inherently challenging to accurately estimate the number of people who are accessing unregulated drugs. Traditional population-level surveys and other tools are not effective in reaching populations that are stigmatized and criminalized. Administrative data, such as health-care records, are also limited because they only identify people connected to the health-care system, whereas many people who use unregulated drugs are not. Nevertheless, some approximate estimates can be made based on several sources:

- Canadian Alcohol and Drugs Survey data from 2019 indicate that **92,000 to 221,000** people in BC who were over the age of 15 had used at least one of six illegal drugs in the previous year.[g,26]
- Approximately **24,000** people in BC were dispensed opioid agonist treatment each month in 2023.[27]

[g] Cocaine/crack, speed/methamphetamine, ecstasy, hallucinogens, heroin, salvia.

- An estimated **42,100 to 53,000** people in BC used drugs by injection in 2016,[28] which is only a portion of all the people who are accessing the unregulated drug supply.
- While people with opioid use disorder account for only a portion of people who are accessing unregulated drugs, in 2017 the prevalence of opioid use disorder was estimated to be 1.92 per cent of the population age 12 and older in BC, or approximately **83,760** individuals.[29] More recent estimates indicate that there are approximately **104,765** people with opioid use disorder, **59,161** people with stimulant use disorder, and **142,000** with unclassified substance use disorder[h] in BC (prevalence over five years, up to August 31, 2021).[30]

  Based on these figures, which each cover different time periods, the number of people accessing the unregulated drug supply in BC over 12 months is likely at least **165,000** and could be upwards of **225,000** or higher depending on further classification of the unclassified group mentioned above.

Disproportionate Impacts of the Unregulated Drug Emergency

Unregulated drug deaths are occurring among people from all walks of life, across age groups, across the socioeconomic spectrum, and in all communities in BC. While anyone who uses unregulated drugs is at risk, not every group is equally impacted. Indigenous Peoples in BC have been disproportionately impacted by the drug poisoning emergency due to deeply embedded systems and ideologies of settler colonialism and racism (see text box: The Impacts of Racism and Colonialism). Status First Nations people in BC represent 3.4 per cent of the total BC population yet represented 17.7 per cent of all drug poisoning deaths from January to June 2023 (an increase from 15.4 per cent in 2022). In other words, First Nations people were six times more likely to die due to unregulated drugs than other BC residents in the first six months of 2023.

In the general population of BC, the emergency is disproportionately impacting men age 30–59, and most people who die from drug poisoning are using drugs alone and indoors. In 2023, there were 45.7 drug-related deaths per 100,000 people in BC; however, this rate varied by regional health authority,[i] from a low of 33.0 deaths per 100,000 people in Fraser Health to a high of 67.0 deaths per 100,000 people in Northern Health. While the death rate was highest in Northern Health in 2023, Fraser Health reported the largest number of deaths (693) in 2023, a pattern that had been identified in 2010.[12] Considerable variation also exists within health authorities, between different communities and even neighbourhoods. For example, in 2023 in the Prince George Local Health Area the death rate was 89.3 per 100,000, whereas in the neighbouring Quesnel Local Health Area the death rate was 52.2 per 100,000.[12]

[h] The unclassified group comprises people with substance use disorder for whom information was not available for them to be classified as either having opioid or stimulant use disorder. This group may also include people with alcohol, cannabis, or hallucinogen use disorder, and includes about 27,000 people with sedative use disorder (sedatives are, for example, benzodiazepines, barbiturates, and non-benzodiazepine hypnotics).

[i] BC has five regional health authorities that govern, plan, and deliver health-care services in their geographic areas. The regional health authorities are further divided into "health service delivery areas" and, within those, "local health areas." BC also has a First Nations Health Authority and Provincial Health Services Authority. For more information, see https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities.

"There's no doubt that the people of the Downtown Eastside community have suffered and continue to suffer serious harms in this unregulated drug toxicity crisis. But the Downtown Eastside is not the face of this crisis. There were 323 drug toxicity-related deaths in that community in 2022. There were 2,340 deaths provincewide. The Downtown Eastside comprised less than 14% of the deaths our province experienced last year. Eighty-six per cent of the deaths occurred in other communities—urban, rural, and suburban."

Lisa Lapointe, former Chief Coroner of BC [31]

The Impacts of Racism and Colonialism

The lands now known as British Columbia have been occupied by First Nations since time immemorial. Indigenous rightsholders who are First Nations, Métis, and Inuit from elsewhere in the lands now known as Canada also call these lands and waters home. Inherent Indigenous rights and responsibilities have never been ceded or surrendered, and are upheld in provincial, national, and international law.

The disproportionate impact of the unregulated drug emergency on Indigenous Peoples stems from known effects of colonialism and systemic racism that continue to operate in BC and in Canada.[32] Settler institutions, including the governments of BC and Canada and the BC health-care system, continue to inflict and reinforce intergenerational trauma on Indigenous Peoples through colonial laws, policies, and practices. These practices include the Indian residential school system, Indian hospitals, the Sixties Scoop, ongoing cultural dislocation, forced separation from land and waters, discriminatory child apprehensions, devaluation of women and Two-Spirit people, and culturally unsafe health care. Racism against Indigenous Peoples is widespread across the health-care system, and impedes access to primary health care and mental health and addictions services. In 2020, a survey of Indigenous people who used the health-care system found that 84 per cent of respondents had been discriminated against when receiving health care, and 26 per cent had been stereotyped by health-care professionals as being "addicts," drunk, and/or people who use drugs.[33]

Reducing substance harms for Indigenous Peoples goes hand in hand with reducing the harms of ongoing colonialism, as well as creating culturally safe, Indigenous-led, and culturally grounded healing spaces that promote cultural continuity and connection. In the *Declaration on the Rights of Indigenous Peoples Act Action Plan*, the government of BC has committed to addressing the disproportionate impact of the unregulated drug emergency on Indigenous Peoples by decriminalizing small amounts of unregulated drugs for personal use; continuing anti-stigma campaigns; expanding access to prescribed alternatives to unregulated drugs and other harm reduction measures; and ensuring accessibility of recovery beds, and evidence-based, culturally relevant and safe services.[3(Action 4.12)]

The Unregulated Drug Supply

Unregulated drugs often contain adulterants and contaminants, and their composition is subject to shifting trends and patterns in drug markets.[8] Since 2012, synthetic opioid fentanyl-like drugs have been detected in increasing amounts in BC, and as of 2024, have largely displaced heroin and other opioids from the drug supply. The rise of illegally manufactured fentanyl-like drugs in BC—which when combined with other adulterants creates an unregulated opioid product that is fundamentally distinct from pharmaceutical-grade fentanyl—is a striking example of the susceptibility of unregulated drugs to increasingly dangerous and potent adulterants. In 2012, fentanyl was detected in five per cent of drug poisoning deaths in BC.[12] By 2018, this had climbed to 86 per cent, or 1,339 of the 1,561 drug deaths that year.[12] In 2023, fentanyl continued to be detected in 83 per cent of deaths.[13] The presence of fentanyl-like drugs in BC's drug supply appears to have precipitated the ongoing emergency; the BC Coroners Service reports that the number of drug deaths excluding those due to fentanyl has remained relatively stable, averaging 297 deaths per year from 2013 to 2023.[34,13]

While the BC Coroners Service provides information about substances that are detected in cases of drug poisoning deaths, drug checking services are a source of information about the composition and potency of drugs themselves. Results from drug checking may not be generalizable across regions, and the composition of drugs in the unregulated supply is constantly shifting, but drug checking provides information about the range of substances and levels of potency that people who use drugs encounter. For example, the BC Centre on Substance Use's November 2023 drug checking report, which included data on 885 opioid samples collected from several communities in BC, showed that the median concentration of fentanyl in opioid samples was 16.7 per cent, but concentrations could be as high as 75 per cent.[35] The Vancouver Island Drug Checking Project reported a median fentanyl concentration of 12.6 per cent based on an analysis of 829 unregulated drug samples collected in November 2023.[36] Unregulated drug samples frequently contain unexpected additives or are not the drug they were sold as. On Vancouver Island, of 391 samples collected in November 2023 that were thought to be opioids, 72.1 per cent contained an unexpected additive, and 15.6 per cent contained only an unexpected additive. The fentanyl analogue fluorofentanyl was present in 70 per cent of samples and carfentanil was found in one per cent of samples.[36]

There has been increasing adulteration of drugs with benzodiazepines. They are central nervous

> *"Fentanyl remains the main and most consistent and deadly driver of this public health emergency."*
>
> Lisa Lapointe, former Chief Coroner of BC[31]

system depressants that are unresponsive to naloxone and potentiate the sedative effects of opioids. The combination of opioids and benzodiazepines makes drug poisonings more difficult to reverse and more complicated to treat,[37] and, in addition to increasing the risk of death, can result in further health complications for those who survive such events. The case of benzodiazepines underscores the volatility and unpredictability of the unregulated drug supply and the complications this presents in responding to drug poisonings: the detection rate of benzodiazepines in drug deaths increased rapidly from 15 per cent of deaths in July 2020 to 52 per cent of deaths in January 2022, then decreased to 19 per cent in December 2022.[12] In November 2023, benzodiazepines or benzodiazepine-related drugs were found in 53 per cent of opioid samples collected on Vancouver Island.[36] In other areas of BC, benzodiazepines were found in 52 per cent of samples that were expected to be opioids.[38,39] In 2023, benzodiazepines were detected in 40.2 per cent of unregulated drug deaths in BC, a substantial increase from 2022 (30 per cent) and 2020 (13.6 per cent), when benzodiazepines emerged as a significant adulterant in BC's unregulated drug supply.[13]

Another adulterant, xylazine, has been appearing with increasing frequency in unregulated drugs in Canada since 2019.[40] Xylazine is a non-opioid veterinary tranquilizer, and its effects are not reversed by naloxone. When combined with other central nervous system depressants such as fentanyl, it may increase the risk of drug poisoning and death.

Nitazines, another group of potent synthetic opioid-like drugs, are being increasingly detected.

While synthetic opioids, such as fentanyl-like drugs, have replaced plant-based opioids and are the known driver of the unregulated drug emergency, stimulant use is also increasing in Canada.[41,42] From January–June 2023, a stimulant was detected in 54 per cent of all apparent accidental opioid toxicity deaths in Canada,[43] and stimulants such as methamphetamine and cocaine sold in BC have been shown to contain fentanyl.[44] Methamphetamine or amphetamine was detected in 47 per cent of drug deaths in BC in 2023.[13]

Chapter 1
KEY MESSAGES

- The purpose of this report is to explore the concept of enabling access to alternatives to unregulated drugs, including exploring non-prescribed approaches that could expand and strengthen the continuum of services available to reduce substance use harms, and address the inherent, potentially fatal risk of the unregulated, unpredictable drug supply in BC.
- In BC, during a 12-month period, 165,000 to upwards of 225,000 people are estimated to access unregulated drugs and are therefore at risk of drug poisoning and death. Men age 30–59, people who use drugs alone and indoors, and Indigenous people are disproportionately affected.
- Drug poisoning and drug-related deaths are a longstanding issue in BC and have been a public health emergency since 2016.
- Historical and ongoing systems of colonialism and discrimination contribute to the emergency's disproportionate impacts on Indigenous Peoples.
- The unregulated drug supply is highly unpredictable and hazardous due to increasing amounts of illegally manufactured fentanyl-like drugs and adulterants such as benzodiazepines and xylazine.
- Unregulated versions of drugs such as fentanyl, heroin, methamphetamine, and cocaine, differ fundamentally from pharmaceutical-grade versions in that they are manufactured with no quality control and mixed with an unpredictable variety of adulterants and cutting agents.

2

DRIVERS OF THE UNREGULATED DRUG EMERGENCY

Factors Contributing to BC's Unregulated Drug Emergency

Prohibition and the resulting toxic unregulated drug supply are the primary drivers of unregulated drug deaths in BC. Multiple intersecting factors combine to create an inequitable distribution of these deaths across the population. From chronic health-care system gaps and housing instability to the impacts of colonialism and racism, the emergency is the culmination of policy failures, across several dimensions and over many decades. The Systems Map (Figure 2) shows how some of these factors interact with one another to influence the risk of harms associated with substance use.

Social determinants of health, such as income, housing, employment, and access to health-care services, as well as determinants of inequities such as systemic racism and discrimination, are central in influencing an individual's risk of experiencing substance harms, and of death in this public health emergency.

Prohibition of drugs, in addition to creating the unregulated drug supply, has led to stigma and discrimination against people who use drugs. This has produced many negative consequences for people who have experienced criminalization. For example, recent incarceration is associated with an increased risk of drug poisoning, especially in the two weeks following release from a correctional centre.[47,48]

Specific population groups also have unique social determinants of health that factor into how they might experience or be impacted by the unregulated drug emergency. For Indigenous people, these include self-determination and connection to culture, language, and land, as well as determinants of inequities such as colonialism and Indigenous-specific racism.[49] The overrepresentation of Indigenous people in drug poisoning deaths points to the impact of historical and ongoing colonial policies inflicted upon Indigenous Peoples by colonial governments.

Why Do People Use Drugs?

"Substance use" refers to the use of alcohol and other drugs. It occurs along a spectrum, and not all substance use is problematic—humans have used substances for millennia for social, spiritual, ceremonial, and other beneficial reasons. People use substances for their psychoactive effects: to feel good, to celebrate important occasions, or to explore psychological states and experiences. People also use substances to help them cope with emotional, physical, and mental pain or to self-medicate.[45] There is a well-acknowledged relationship between substance use and trauma. [e.g.,46] Understanding that people use substances for a variety of reasons, and that substance harms are greatly influenced by social, environmental, economic, and systemic factors, is a central principle of a public health approach to substance use.

Anti-Indigenous racism in the health-care system impedes access to culturally safe and racism-free health care, including mental health and addictions services, which increases Indigenous people's risk of experiencing substance harms.[50] For Indigenous people, reducing substance harms is inherently linked to reducing the harms of colonialism.[2]

Sex and gender also affect how people experience substance harms. Men make up a large proportion of drug poisoning deaths (77 per cent in 2023),[12] and women who use substances are more likely to experience gendered and racialized violence.[12,51,52] First Nations men and women are overrepresented in drug poisonings and deaths. First Nations women died of drug poisoning at 11.9 times the rate of other female residents in BC between January and June 2023; First Nations men died at 4.6 times the rate of other male residents in BC during the same period.[53] Women who have lost custody of a child are more likely to experience an unintended drug poisoning than those who have not; this disparity is further pronounced for First Nations women.[54] 2SLGBTQQIA+ people also experience substance harms as a result of societal attitudes toward their gender identity or sexual orientation.[55,56]

While over-prescribing of opioid pain medications has been identified as a past driver of increasing rates of opioid use disorder and opioid-related deaths in some jurisdictions, primarily the United States,[57] it is not a major contributing factor in BC's unregulated drug emergency. Prescribed opioids rarely contribute to unregulated drug deaths.[58,59] Over the past decade, opioid prescribing has decreased in BC, whereas deaths from unregulated drugs have increased. Between 2013/2014 and 2018/2019, the number of patients who were prescribed opioids in BC decreased by 12 per cent and the number of patients who received high-dose opioids decreased by 17 per cent.[60] However, the number of unregulated drug deaths that occurred annually more than quadrupled during the same time period,[13] coinciding with the decrease in prevalence of heroin and the increase in synthetic fentanyl-like opioids.

Overall, men age 30–59, Indigenous people, particularly Indigenous women, people living in poverty and with housing instability or homelessness, and people with mental health disorders or poor mental health were the most negatively affected groups in the unregulated drug emergency between 2017 and 2021.[61,62]

What Are Substance Use Disorders and How Do They Relate to Unregulated Drug Deaths?

Substance use disorders are chronic, relapsing medical conditions that are characterized by continued use of a substance despite experiencing negative impacts. The *Diagnostic and Statistical Manual of Mental Disorders* contains criteria that clinicians use to diagnose substance use disorder for a variety of substances (e.g., alcohol, opioids).[63] The criteria refer to indicators such as an individual's ability to control their substance use, social impairment, and high-risk patterns of use. If an individual meets at least two of the criteria, they can be diagnosed with a substance use disorder. Meeting a higher number of criteria indicates a higher severity of the disorder. Substance use disorders are also known as "addictions," a broader term that encompasses some compulsive behaviours, e.g., gambling addiction.

Due to a lack of regulated sources for many substances, people with a substance use disorder may use drugs from the unregulated supply and may be at a higher risk of death compared to people without a diagnosed substance use disorder.[64] However, research suggests that many people who have had a drug poisoning event did not have a substance use disorder.

In BC, from 2015-2017, 64 per cent of people who experienced a drug poisoning had been diagnosed with a substance use disorder in the previous five years.[64] The remaining 36 per cent did not have a diagnosed substance use disorder. They likely comprised both people who had a substance use disorder, but had not been diagnosed, and people who did not meet the criteria for substance use disorder (e.g., used substances intermittently without any indicators of problematic use).

In one study, most people with a history of incarceration who experienced a drug poisoning did not have an opioid or a stimulant use disorder: 72 per cent of those who had a fatal drug poisoning and 63 per cent of those who had a non-fatal drug poisoning did not have an opioid or a stimulant use disorder diagnosis.[65]

While substance use disorders may be underdiagnosed, low rates among decedents were corroborated by a 2022 BC Coroners Service death review panel.[9]

These findings indicate that a substantial proportion of the population that is at risk of drug poisoning may not have a history or diagnosis of substance use disorder. The size of the population at risk of drug poisoning due to accessing the unregulated drug supply is estimated to be 165,000 to upwards of 225,000 people; therefore tens of thousands of people at risk of drug poisoning would not have their needs met by an access model for alternatives that relies on diagnosis of substance use disorder.

Furthermore, rates of new diagnoses of opioid use disorder declined or remained relatively stable across all age groups between 2017 and 2022,[66] whereas unregulated drug deaths rose

The Systems Map

The Systems Map (Figure 2) shows many of the factors that led to the conditions for the unregulated drug emergency. These are the elements that set the stage for an exponential increase in deaths when fentanyl-like drugs were introduced into BC's unregulated drug supply. The map was created in 2017 and is one of the outcomes of a process undertaken by the Ministry of Mental Health and Addictions to understand the complexity of the factors underlying the unregulated drug emergency. The factors and their relation to each other have shifted over time, and if the process were repeated today or with a different group of people, the results would likely be different. However, this map remains relevant as it provides a sense of the range of factors that contribute to the current situation in BC: a widely available, unregulated, and adulterated supply of drugs that puts thousands of people who use drugs at constant risk of injury or death.

"In 2017, 1,451 people died of a drug overdose in B.C. The B.C. Coroners' report (published August 2, 2018) shows that about 4 out of 5 people who died were male and 9 out of 10 deaths occurred indoors, including more than half in private residences. First Nations are disproportionally affected by the crisis, with research from the First Nations Health Authority showing that First Nations people are five times more likely to experience an overdose event.

Behind these numbers, there are stories about people's lives and ideas for change. Through conversations with more than 100 people who use drugs (like heroin, cocaine, meth) and people in support provider roles, we found connections between parts of this complex problem, revealing root causes. Reframing the overdose crisis from these root causes shows the most significant leverage points for lowering overdose deaths in B.C. Collaboration among all stakeholders at these leverage points is an essential part of action and change."

Ministry of Mental Health and Addictions

How to use this map

This map shows connections between problems. Some problems have more connections than others and can be viewed as root causes.

Think about how your initiative could influence the overdose crisis in B.C. How is it connected to other problems and what impact could it have?

7 or more connections
Pink circles show problems with the most connections to other problems. Initiatives focused here could influence multiple problems at once.

4 to 6 connections
Blue circles show problems with connections to several other problems.

1 to 3 connections
Yellow circles show problems with the least connections to other problems.

Figure 2. Systems Map—Understanding the Complexity of the Overdose Crisis in B.C. and Leverage Points for Change[j]

The systems map was created in the project "Behind the Numbers: Connecting stories and ideas on Overdose and Drug Use in Private Residences in B.C." (August 2017 – March 2018, Ministry of Mental Health and Addictions). The Systems Map is part of a set of tools for understanding why people use drugs alone in Private Residences. The other artefacts are: 'Journey Map' and 'Stories Booklet'.
See: helpstartshere.gov.bc.ca

[j] Systems Map included with permission from the BC Ministry of Mental Health and Addictions.

substantially. In addition, "relapse" or return to opioid use is a cardinal feature of opioid use disorder. For this reason, treatment does not necessarily remove the risk of death due to the use of unregulated drugs. Abstinence-based treatment has been shown to increase the risk of death among people with opioid use disorder.[67] Given these findings, increasing the number of treatment spaces or "beds" for opioid or stimulant use disorder is unlikely, on its own, to substantially reduce the number of unregulated drug deaths.

In summary, the entirety of factors associated with experiencing substance harms, including the social and structural determinants of health, must be addressed alongside the primary driver of the emergency: the unregulated drug supply.

Psychoactive Substances and Their Regulation in Canada

A psychoactive substance is something that, when consumed, changes a person's mental processes; e.g., their mood, emotions, perception, or cognition.[68] Alcohol, caffeine, nicotine, cannabis, heroin, fentanyl, cocaine, and methamphetamine are all examples of psychoactive substances. In Canada, these substances are regulated or prohibited according to a variety of frameworks from legal sales (e.g., alcohol, caffeine, nicotine, cannabis, many over-the-counter medications), to availability by prescription or in hospitals only (e.g., morphine, fentanyl, heroin, cocaine, hydromorphone), to complete prohibition with legal access limited to exceptional circumstances or not at all (e.g., psilocybin, coca leaves, opium, lysergic acid diethylamide [LSD], methamphetamine).

The Unregulated Drug Supply Is a Predictable Outcome of Drug Prohibition

Canada is a signatory to international agreements on the control of certain psychoactive substances, with the foundation being the *Single Convention on Narcotic Drugs* of 1961,[69] followed by the *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* of 1988.[70] Under these conventions, activities with scheduled substances are permitted only for medical or scientific purposes. The goal of these international agreements is to protect public health and safety by prohibiting certain drugs and punishing those who possess or traffic them, but these approaches have not been effective and have caused considerable harm.[71]

Just as prohibition of alcohol created an unregulated, sometimes toxic, alcohol supply in the early 1900s, the current regulatory structure for drugs has created a multi-billion-dollar illegal global drug market with escalated drug trade violence.[71] Prohibition drives manufacturers of unregulated drugs to synthesize more potent drugs so they can be exported in smaller quantities and avoid detection—the "iron law of prohibition."[72,73]

When divided inconsistently into individual doses for street drugs, the unknown composition and potency of these substances pose a significant health risk to anyone who uses them. Health risks associated with taking drugs are compounded by the lack of information on a drug's contents and potency. This contrasts with information available on other consumer items and which is taken for granted, including pharmaceuticals, groceries,

and even potentially harmful products such as alcohol, nicotine, and cannabis. Analyses have highlighted a number of additional significant concerns and drawbacks of the "war on drugs" generated from the prohibitionist approach.[74,75,76]

In Canada, drug prohibition is codified in the federal *Controlled Drugs and Substances Act* (CDSA). The CDSA prohibits activities with controlled substances (e.g., production, distribution, export, import, sale, and possession), unless the activity is authorized by regulations or exemptions under the Act. Section 56 (1) of the CDSA sets out conditions under which the federal Minister of Mental Health and Addictions may grant an exemption to all or part of the Act. In addition, the federal *Food and Drugs Act,* as well as provincial legislation, play important roles in regulating all drugs, including controlled drugs.

While the United Nations drug control conventions would appear to preclude approaches other than prohibition, there may be some flexibility within the conventions to enable possession, purchase, and cultivation of currently illegal drugs for personal use.[77,78] United Nations positions and policies on human rights encourage countries to pursue alternatives to criminalizing personal use of controlled substances, and to identify measures to responsibly regulate drug markets to reduce the harms of the illegal drug trade.[77,78,79]

Video Supplements

The following videos provide perspectives on drug prohibition and its relationship to harms associated with drugs.

A message from Volker Türk, United Nations High Commissioner for Human Rights to the attendees of the 2023 International Drug Policy Reform Conference.[80]

https://www.youtube.com/watch?v=J3W4Qf9vwEI

"Drug use has taken many lives, but even more lives have been harmed or destroyed by poorly constructed drug control policies… We need measures that can take control of illegal drug markets, such as responsible regulation that can eliminate profits from illegal trafficking, criminality and violence."

Volker Türk [81]

An interview with John and Jennifer Hedican, who lost their son Ryan Hedican to unregulated drugs in 2017.[82]

https://www.youtube.com/watch?v=9ybAvnXEEuc

"It's a massive problem and it's a complex problem but it starts with the prohibition of drugs."

John Hedican

Racism and Drug Prohibition

Prohibition in Canada is based on a history of racism, white supremacy, paternalism, colonialism, classism, and human rights violations. Prohibition impedes public health and harm reduction initiatives and results in persistent personal, social, and structural stigma; increased incarceration of non-violent, low-level offenders; and related societal and economic costs.[83] Socioeconomically excluded populations, including women,[83] people living in poverty,[23] and Indigenous and Black people,[84] are disproportionately criminalized by drug law enforcement and the harmful impacts of the criminal justice system.

The roots of prohibition began with racist fears about non-white immigrants in Canada, and prohibition was fuelled by moral reformers. In the late 1800s, the non-white population in Canada was growing, particularly with the arrival of Chinese migrants and immigrants who joined the gold rush and worked on the Canadian Pacific Railway. At that time, the BC government's goal was a "White British Columbia."[85] The government largely favoured white immigrants and took legal and institutional measures to block Asian immigrants. Once the railway was finished, many of the Chinese workers settled in Vancouver. Race-based legislation was passed at municipal, provincial, and federal levels to restrict the movement, residences, and professions of Chinese and Japanese people. In many cities, Chinese and other racialized people were prevented from owning properties by covenants written into property deeds.[86] Chinese immigrants to Canada were forced to pay a head tax of $50 each starting in 1885, which was increased to $500 by 1903.[87] BC's 1884 *Chinese Regulation Act* included the first attempt at legal prohibition of opium in Canada and instituted a fine of up to $100 for use and possession of opium, except for medical or surgical purposes.[88,89]

The *Opium Act*

Prior to the regulation of opium under the federal 1908 *Opium Act*, white and non-white people in Canada used opium for both medicinal and recreational purposes. White people consumed opium primarily in raw form and as liquids, and some Chinese residents would smoke opium. Opium was transported legally into both white and Chinese opium factories in Canada. Britain's free trade of opium was overlooked, while the dangers of opium smoking were associated with Chinese men.[90]

The Opium Wars between Britain and China provided the opportunity for Canada to advance the narrative that opium smoking by Chinese and non-white people in colonized nations posed a moral threat to white society. In 1908, then deputy minister of the Department of Labour, William Lyon Mackenzie King was sent to Vancouver to investigate the 1907 anti-Asian riots. The Chinese Anti-opium League met with Mackenzie King in Vancouver and requested government action to address the impact of opium on the "social condition of the Chinese."[90,91] Mackenzie King returned to Ottawa and included in his report that "the Chinese with whom I converse on the subject assured me that almost as much opium was sold to white people as Chinese, and the habit of opium smoking was making headway, not only among white men and boys, but also among women and girls."[91] As a result of Mackenzie King's report, and in the context of decades of anti-Asian racism in Canada, the 1908 *Opium Act* was passed. In 1922, more than 60 per cent of all drug convictions were brought against Chinese residents, many of whom would be deported.[90] Over time, the moral panic associated with drug use expanded to target many more groups of people, including Indigenous people, Black people, women, people of colour, and people of lower socioeconomic status.

Chapter 2
KEY MESSAGES

- Prohibition has not only failed to control access to, production, and use of, controlled substances, but also created the toxic unregulated drug supply that has resulted in substantial harm to individual and public health and safety.
- Canada has had a long history of prohibition-based drug laws and drug policies that are rooted in racism, colonialism, and xenophobia.
- Racism embedded within laws, systems, and policies perpetuates colonial trauma for Indigenous Peoples.
- Many factors contribute to the risk of harm from substance use, including social determinants of health, such as income and housing, as well as determinants of inequities such as racism, white supremacy, and discrimination.
- Additional, intersecting factors that drive the unregulated drug crisis include inadequate attention to the social and structural determinants of health.

3

ALTERNATIVES TO UNREGULATED DRUGS

What is "Safer Supply"?

Alternatives to unregulated drugs and enabling access for those who need them is also known as "safer supply." It is a harm reduction-oriented public health approach for reducing drug poisonings. As an emerging concept, "safer supply" has many definitions and interpretations, and the meaning of this term will evolve over time. In this report, the phrase "alternatives to unregulated drugs" (also shortened to "alternatives") is used to describe this concept and capture both medical and non-medical models for delivering this service.

The central principle of this approach is that alternatives to unregulated drugs that are of known quality, composition, and concentration, are less likely to result in drug poisonings, and therefore are safer than unregulated drugs. Several groups and organizations have contributed to the growing understanding of this concept. The Canadian Association of People who Use Drugs defines safer supply as "a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market."[93(p.4)] In a study conducted by University of Victoria researchers, people who use drugs stated that to be effective, this approach should provide "access to a safe and

> *"[Safer supply] is an emerging intervention that expands the options on the continuum of care for people who use drugs and who are at very high risk of overdose and other harms related to using drugs from the highly unpredictable contaminated drug supply."*
>
> - National Safer Supply Community of Practice[92]

non-toxic supply that is decriminalized and legal."[94] Health Canada states that

> Safer supply refers to providing prescribed medications as a safer alternative to the toxic illegal drug supply to people who are at high risk of overdose. Safer supply services build on existing approaches that provide medications to treat substance use disorder. However, they are often more flexible and do not necessarily focus on stopping drug use. Instead, they focus on meeting the immediate needs of people who use drugs, reducing the risk of overdose by helping people to be less reliant on the toxic illegal drug supply, and providing connections to health and social services where possible and appropriate.[95]

Given the range of perspectives and definitions, what can it mean to offer alternatives as part of the response to the current emergency? Here, it is important to develop an understanding of the concept and set of approaches that are often referred to as "safer supply."

The Public Health Rationale for Enabling Access to Alternatives to Unregulated Drugs

Consuming foods and medicines of known content and purity, free from contamination or adulteration, is safer than consuming these products if their contents are unknown, or if they have been contaminated or adulterated. This is the principle upon which Canada's food and drug laws have been based since the 1800s.[96] Legislation surrounding the contents of many consumer products also follows this logic—e.g., limits to the amount of lead in toys,[97] and rules against misleading labelling and advertising. There is also a *Textile Labelling Act*,[98] which requires accurate labelling of products such as clothing or linens so that consumers can make informed decisions about what comes in contact with their bodies. Offering alternatives to unregulated drugs is the extension of this principle. Substance use always comes with some risk of harm, no matter the source of the drugs. However, it is safer to consume drugs of known quality, concentration, and composition than unregulated, adulterated drugs, which can often be much higher in potency than expected.

To prevent poisoning deaths, it is essential to reduce reliance on the unpredictable, unregulated toxic drug supply for people who use drugs. A quality-controlled supply of drugs of known concentration and composition will have predictable effects, and facilitating access to quality-controlled drugs will help prevent deaths. Conversely, failing to enable access to alternatives will result in severe risks and consequences for individual and public health. Tens of thousands of people will continue to be left vulnerable to shifting trends in and toxicity of unregulated drugs. People who use drugs will continue to be exposed to increasingly potent and dangerous contaminants in the drug supply, as occurred with the introduction of synthetic fentanyl-like opioids around 2012, that replaced plant-based opioids like heroin. Access to quality-controlled drugs that are not subject to such unpredictability, and that help separate people already using drugs from the unregulated drug supply, would result in fewer poisonings and deaths. This is a logical extension of the principle applied to other consumable products.

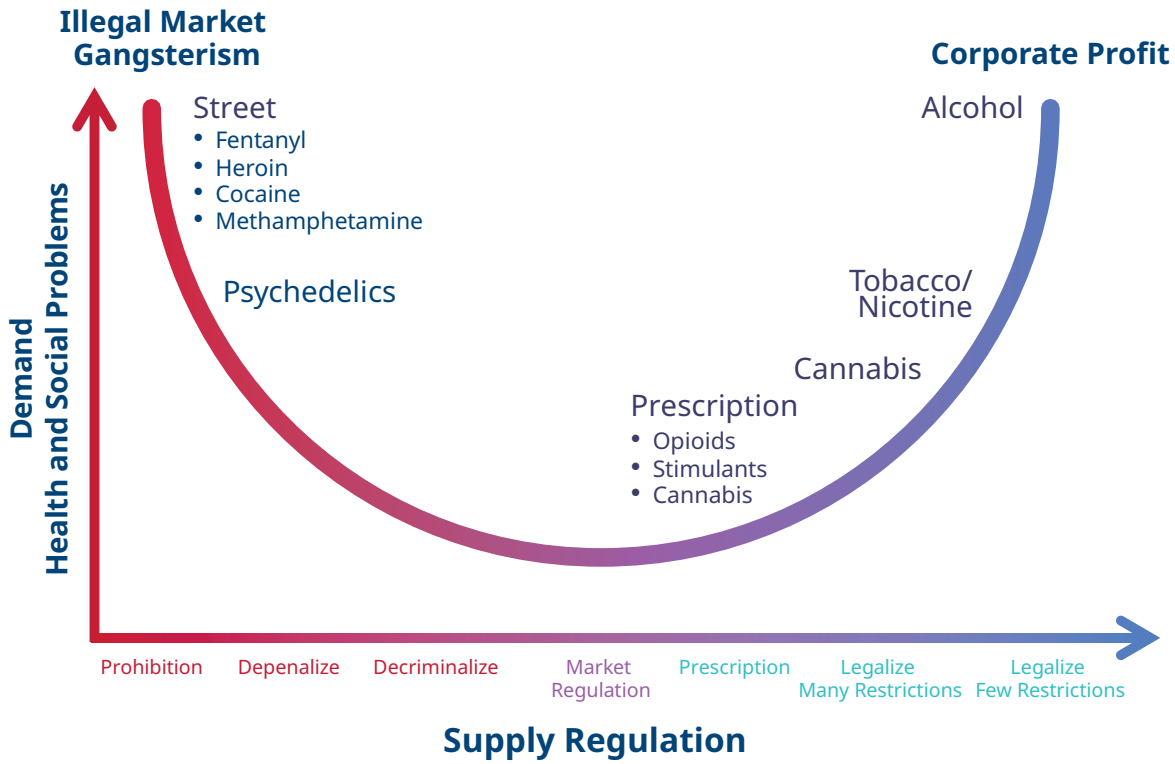
A Public Health Approach to Psychoactive Substances

Enabling access to alternatives aligns with a public health approach to psychoactive substances, which typically includes moving away from treating substance use as a criminal justice issue, considering population-level impacts of substance use, being evidence-based, and using a comprehensive range of strategies.[99,100] BC already has public health strategies that are specific to unregulated psychoactive substances. They include decriminalizing possession of small amounts of certain illegal drugs, distributing naloxone, providing prescribed alternatives to unregulated drugs, establishing overdose prevention sites, conducting drug checking, making efforts to reduce stigma against people who use drugs, and increasing access to evidence-based treatments such as opioid agonist treatment for people with opioid use disorder.

Indigenous-specific programs that are consistent with a public health approach include the First Nations Health Authority's Not Just Naloxone Program, a workshop to build harm reduction knowledge and skills within First Nations communities through a First Nations lens,[5] and Métis Nation BC's Métis-specific Lifeguard overdose prevention App, designed to honour Métis culture and tradition.[7]

A public health approach to substance use is often presented as a middle ground between prohibition and unrestricted commercialization that minimizes, but does not eliminate, harms at an individual and population level.

Figure 3. The Paradox of Prohibition[k]



[k] Adapted from: Marks J. The paradox of prohibition. In: Brewer C, editor. Treatment Options in Addiction. London: Gaskell; 1993. p. 77-85.

Figure 3 illustrates the "paradox of prohibition": while commercialization and prohibition seem to be at opposite ends of a continuum of approaches to regulating psychoactive drugs, both produce health and social harm.[101] Commercialization (promotion and sale for financial gain with few restrictions) of products like alcohol and tobacco has led to significant negative health and social impacts.[102] Drug prohibition has produced the unregulated drug market, with its associated negative impacts, but has not eliminated demand for these substances.[74,75]

A public health approach involves avoiding the harms of prohibition and the harms of commercialization while retaining limits and controls, including on availability, accessibility, and quality, and on product promotion, such as advertising, sponsorship, and product placement. The aim of a public health approach is to regulate psychoactive drugs for least harm and greatest benefit to society.

> *"We could not conceive, if we deliberately tried to do so, of a more socially destructive, individually criminalizing, health damaging, expensive and efficient way of making heroin available than we do now, under prohibition. Having no legal supply, the state abdicates, by default, the source of supply to the gangsters."*
>
> John Marks[101]

> *Members of coroners' inquests and death review panels have consistently recommended a continuum of care that includes evidence-based treatment options, access to safer supply, and other essential harm-reduction tools to end this crisis, including drug-checking, overdose prevention sites, and the need to eliminate stigma and criminalization. All of these key responses are necessary to address the tremendous and tragic loss of life our province continues to experience."*
>
> Lisa Lapointe, former Chief Coroner[10]

Options and Opportunities

There is a range of options and opportunities for how alternatives can be made available, such as the various specific programs and policies that determine how, where, and when these substances can be accessed, what substances are included, and who is eligible to receive them. There is ongoing debate about the effectiveness of various policies and programs, how to navigate existing legislation for controlled drugs, and how to avoid unintended consequences. Chapters 4 and 5 of this report describe emerging evidence about the effectiveness of enabling access to alternatives.

Alternatives to Unregulated Drugs as Part of a Continuum of Interventions

Enabling access to alternatives augments existing approaches and interventions used to reduce substance harms in BC. This is articulated in BC's *Adult Substance Use System of Care Framework*, which positions harm reduction services, including "safer supply," as one of 10 core services meant to address problematic substance use in adults.[103] BC's Overdose Emergency Response Centre includes alternatives within its "comprehensive package of essential services for overdose prevention in BC" in the "overdose prevention services" category.[27] Far from being a panacea or stand-alone approach, programs that include alternatives can be a way of connecting people with other resources, supporting opioid agonist treatment, and providing a lifesaving intervention for people who are not yet connected to, are unable, or do not want to engage with other services.

According to a 2023 poll, most BC residents agree with providing safer supply as part of a continuum of services, with 63 per cent of respondents in support of programs "where alternatives to opioids can be prescribed by health professionals," and approximately 58 per cent in support of "setting up more harm reduction strategies, such as safe injection sites."[14]

Prescribed and Non-prescribed Alternatives to Unregulated Drugs

Approaches for delivering alternatives can be categorized broadly as either prescribed or non-prescribed (see Table 3). **Prescribed alternatives** programs require people who use drugs to see a health-care provider who assesses what medication and dose should be given and writes a prescription. This can be done solely as a measure to reduce the risk of using unregulated drugs, without the expectation or requirement that the client reduces or discontinues their substance use. In BC, at the present time, physicians and nurse

practitioners can prescribe a limited variety of pharmaceutical alternatives. In September 2020, other registered nurses and registered psychiatric nurses were authorized to prescribe alternatives, including all controlled substances, through a Provincial Health Officer order.[105] To date, this order has not been fully put into practice, although registered nurses/registered psychiatric nurses are now actively prescribing opioid agonist treatment in various regions throughout BC.

Non-prescribed alternatives encompass a wide range of possible models in which alternatives could be accessed without a prescription; other control mechanisms such as access or eligibility criteria and protocols to minimize harms to individuals and the population would be established instead. These approaches are not mutually exclusive; it is possible and necessary to envision programs that would combine elements of prescribed and non-prescribed approaches.

Table 3. Comparison of Prescribed and Non-prescribed Alternatives

	Method of determining eligibility and authorizing use	Implementation under current drug laws	Present availability
Prescribed Alternatives	Requires a prescription from an authorized prescriber. Relies on availability of prescribers who are supported to provide the service.	Possible within current drug laws, via the same processes used for other Health Canada-approved prescribed medications (i.e., a *Controlled Drugs and Substances Act [CDSA]* section 56 exemption is not required).	Currently operating in BC through health authority and federally funded programs and policy that enables prescribing outside of specific programs.[44]
Non-prescribed Alternatives	Would not require a prescription or a prescriber. Other mechanisms for determining eligibility and ensuring safety to distribute and access drugs would be used.	Could be enabled by a CDSA section 56 exemption, or a revision to the CDSA, or potentially other federal or provincial actions.	Not legally operating in BC.

How Do Alternatives to Unregulated Drugs Differ From Opioid Agonist Treatment?

Opioid agonist treatment is an evidence-based treatment for opioid use disorder. Health-care providers prescribe opioid medications (e.g., methadone, buprenorphine/naloxone [Suboxone], slow-release oral morphine) to alleviate withdrawal symptoms. The patient's goal may be to eventually stop using opioids, stay on a dose that prevents withdrawal symptoms and cravings, or limit reliance on unregulated drugs. Only people with opioid use disorder are eligible to receive opioid agonist treatment.

By contrast, the purpose of enabling access to alternatives is to reduce exposure to the toxic drug supply for people at risk of drug poisoning. Anyone who uses unregulated drugs could be eligible, including people with opioid use disorder or stimulant use disorder, but also those who do not have a substance use disorder. As described in Chapter 2, many people who die from drug poisoning do not have a substance use disorder or are undiagnosed,[106] which makes meeting the needs of this population essential in reducing deaths.

The connection between opioid agonist treatment and alternatives to unregulated drugs is complex due to overlapping patient populations, similar purposes, and the frequent practice of providing opioid agonist treatment and prescribed alternatives to the same patient. Indeed, between March 2020 and May 2023, 89 per cent of people who received opioid prescribed alternatives for the first time were also on opioid agonist treatment.[107] Opioid prescribed alternatives (e.g., hydromorphone) can function as an adjunct to opioid agonist treatment to assist patients in avoiding unregulated drugs while their opioid agonist treatment dose is being established or help them avoid painful withdrawal symptoms due to missed doses and to maintain them on their opioid agonist treatment program.[108,17]

Current Policy and Guidance in BC

BC has made important steps in enabling access to alternatives to unregulated drugs. The BC Centre on Substance Use, in partnership with the provincial government, released the first version of the *Risk Mitigation in the Context of Dual Public Health Emergencies: Interim Clinical Guidance* (*Risk Mitigation Guidance*) in March 2020 (updated in January 2022).[109,110] The purpose was "to provide clinical guidance to health care providers to support patients to mitigate the compounded risks [of COVID-19 and the unregulated drug emergency]."[110] In 2021, BC began a phased approach to expanding access to prescribed alternatives independent from COVID-19, and published policy direction for prescribed safer supply in July 2021.[44] Since the release of this policy, the BC Centre on Substance Use has released several clinical protocols to support the prescribing of alternatives to unregulated drugs. These programs are closely linked to oversight by health authorities, the BC Ministry of Health, and the BC Ministry of Mental Health and Addictions, and are being independently and rigorously evaluated.[111] In 2023, the Provincial Health Officer undertook a review of implementation of prescribed alternatives in BC in an effort to understand the challenges faced by clinicians who prescribe alternatives to unregulated drugs and the people who accessed or tried to access prescribed alternatives. The review resulted in several

recommendations to government to improve prescribed alternatives programs, including retiring the current *Risk Mitigation Guidance*.[17]

Ethical Analyses of Alternatives to Unregulated Drugs

Prescribers have raised concerns about the ethics of prescribing alternatives to unregulated drugs and associated moral distress of working within a medicalized model.[112] In 2020, the BC Ministry of Mental Health and Addictions commissioned Dr. Eike Kluge, an expert in biomedical ethics, to do an ethical analysis of prescribing alternatives to unregulated drugs.[113] Based on several principles of medical ethics, Dr. Kluge concluded that it is ethically defensible to prescribe safer supply medications as alternatives to the unregulated drug supply as a public health-oriented harm reduction intervention, that is not contingent on any expectation or goal of abstinence from substance use.[113] In 2023, the Provincial Health Officer asked the Provincial Health Ethics Advisory Team to complete a further ethical analysis that considered the balance between risks and benefits to individuals who are eligible for prescribed alternatives and the risks and benefits to the broader population.[17] The team concluded, in part, based on evidence of beneficial effects of prescribed alternatives, that it is justifiable to implement effective interventions to reduce individuals' risk of harm if harm is severe and certain, even when those interventions come with uncertain risks to the broader population. It is important to emphasize that ethical analyses such as these do not compel physicians or other prescribers to provide prescribed alternatives, and these analyses did not examine the benefits and practical challenges of this type of prescribing from the perspective of prescribers.

Diversion: Concerns and Clarifications

Concerns have been raised about the sharing and selling (commonly referred to as "diversion") of medications prescribed as alternatives. Because prescribed alternatives programs in BC have focused largely on opioids that have relatively lower potency (primarily tablet hydromorphone) than that of street fentanyl-like drugs, concerns about diversion and its unintended impacts have generally been focused on hydromorphone. Motivations for diversion are varied and can include sharing prescribed alternatives with others who do not have access to them, selling them to acquire money for food, and selling or trading them to be able to purchase everyday necessities or higher potency unregulated opioids to meet individual needs.[114] Both prescribers and people who use drugs have stated that tablet hydromorphone is beneficial for some recipients.[17] However, for others, it is not a sufficient alternative to the unregulated drug supply, and a broader

> *"Diversion should be understood as indicating unmet needs for people who use drugs (both medical and social needs) and therefore efforts to mitigate diversion should begin with efforts of the health and social service system to better meet those needs."*
>
> Recommendation 1(e), *A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action*[17]

range of options is needed to effectively meet people's needs and preferences.[17,114,115] This highlights the importance of expanding the variety of medications that are available through alternatives programs, and considering approaches, including pricing structures, that address economic incentives to diversion.

Concerns have been raised about hydromorphone that is prescribed as an alternative to unregulated drugs being diverted into the unregulated market, and the risk that this would lead to new cases of opioid use disorder. This is a complex issue, to which diversion of hydromorphone and other opioids prescribed for pain also contributes. Harms could be reduced if people who buy diverted pharmaceutical medications would otherwise take unregulated drugs.[17,116] However, greater exposure of the population to diverted medications could result in increased rates of opioid use disorder. An analysis of opioid use disorder in people age 25 and under showed no increase in cases since 2020, when prescribed alternatives started becoming available.[66] The BC Coroners Service and others are monitoring trends, and while hydromorphone has been detected in a small percentage of deaths, it was not a significant factor and there is no indication that hydromorphone medications are driving unregulated drug deaths.[13,117] It is also important to acknowledge that diversion of prescribed opioids, including hydromorphone, is not a new problem.[118] Diverted as well as counterfeit or "fake" versions of pharmaceutical opioids have long been available through the unregulated drug market, and are susceptible to contamination by other drugs. For example, "fake oxy" tablets were in circulation in the first years of the current crisis and continue to be present in BC's drug market.[119,120]

The extent to which medications are being shared or sold is not known, and anecdotes may not reflect the experience of most people who are prescribed alternatives to unregulated drugs. Ongoing monitoring, evaluation, and research is required to assess the degree to which diversion is occurring, and its impacts. Experience is currently limited with respect to the prescribed tablet hydromorphone program; outcomes for different medications and program models could vary significantly. The Office of the Provincial Health Officer recently published *A Review of Prescribed Safer Supply Programs Across British Columbia*. Recommendations 3. c. (i-vii.) relate to reinforcing the existing evaluation and monitoring framework for this program with additional components. A similarly robust and comprehensive set of evaluation and monitoring systems and infrastructure would be needed for non-prescribed programs, in order to track and assess potential unintended consequences and their impacts. Balancing the risks of new substance use disorders and the benefits of saving lives will be an ongoing imperative for public health officials, agencies, and government.

Additional comments on this topic, contributed by reviewers of this report, are summarized in a companion document to this report, titled *Summary of Feedback on the Draft Report*[121] and *A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action*.[17]

Monitoring of the Unregulated Drug Market

It is important to recognize that enabling access to alternatives is both a health-based intervention with intended individual and population health and well-being outcomes, and a market intervention that could influence prices in the unregulated drug market. This involves considering economic factors such as financial incentives to diversion, whether participants should pay for the alternatives—and if so, how that price should be established—and anticipating potential impacts on illegal drug markets. Modelling and scenario planning can be used to anticipate market impacts and consequences. This also involves ensuring that evaluation plans include monitoring of retail (or "*street*") and wholesale illegal drug prices, quantities, and purity/potency,[I] and potential indirect effects such as diversion from sources of supply to other locations in and out of the province. Market monitoring will assist in understanding the drivers of diversion. This can include monitoring how BC drug prices compare within BC and to other jurisdictions that are linked to BC's unregulated markets in order to track incentives and opportunities for exploitation of alternatives programs.

For further consideration of this topic, see: *White Paper Providing an Economic Framework for Thinking Through Possible Effects of Prescribed Safer Supply*, available at: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/economic-framework-for-thinking-through-possible-effects-of-prescribed-safer-supply.pdf.

[I] This information is needed to make a direct comparison between prices of different opioid drugs by calculating their "morphine milligram equivalent" (MME) amounts. MME is an opioid drug's equivalence to morphine in terms of potency. For example, 0.1 milligrams of fentanyl is roughly equivalent to 10 milligrams of morphine – both are 10 MME. MMEs were established to help clinicians treat pain using different opioid medications.

Chapter 3
KEY MESSAGES

- Alternatives to unregulated drugs and enabling access for those who need them is also known as "safer supply."
- The central principle of this approach is that alternatives are of known quality, composition, and concentration, are less likely to result in drug poisonings, and therefore are safer than unregulated drugs.
- Enabling access to alternatives is consistent with a public health approach to substance use and follows the same logic as quality control and consumer safety protections that are in place for other products.
- Enabling access to alternatives to unregulated drugs is only one part of a continuum of interventions used to reduce harms related to substance use in BC.
- Approaches for delivering alternatives can be broadly categorized as either prescribed (made available through prescription by a health-care provider) or non-prescribed (made available outside of the health-care system), but these approaches are not mutually exclusive.
- Currently, there is a close relationship between and considerable overlap of prescribed alternatives programs and opioid agonist treatment programs. While there is potential for these two interventions to meet different needs (e.g., prescribed alternatives as a stand-alone harm reduction measure to help separate people from the unregulated drug supply, and opioid agonist treatment as a treatment for opioid use disorder), this highlights that they are connected by being part of the same continuum of necessary services for people who use drugs.
- Diversion of prescribed alternatives is an emerging concern that requires further research to understand its scale and impacts.
- Monitoring and evaluation of any new programs that are implemented will be critical to track any potential unintended consequences, including both individual and public health impacts.

4

PRESCRIBED ALTERNATIVES TO UNREGULATED DRUGS

Introduction

This chapter provides an overview of the evidence generated and experiences recounted since prescribed alternatives programs emerged in BC and Canada. It begins by outlining the range of outcomes observed in studies of prescribed alternatives programs and then describes the barriers to and facilitators of alternatives programs that have been implemented.

Prescribed Alternatives: What We Know

Literature on prescribed alternatives has been steadily emerging. Many more research projects are being conducted and papers are being written or are awaiting peer review. Information on prescribed alternatives comes from a variety of sources, including peer-reviewed articles, reports, and program evaluations that incorporate a range of research designs and systematic approaches to generate evidence as to the effectiveness of this approach.[m]

Because prescribed alternatives programs have been initiated as pilot programs, several studies mentioned in this report are evaluations of initial pilots that focus on program rather than population-level outcomes. To date, most of the research highlights findings from the perspectives of programs and program participants. While much of the published research is qualitative, it is aligned with the available quantitative findings, which consistently support similar conclusions: prescribed alternatives programs show benefits and considerable promise in reducing risk of death and improving quality of life for those enrolled in programs.

[m]Literature presented in this chapter was identified during a scoping review, which is a review methodology used to map the landscape of research for policy makers. Appendix B provides a description of the terms used to search for relevant literature.

Table 4. Summary of Literature Review Findings

Risk of death	Participants in prescribed alternatives programs reported a decreased risk of fatal and non-fatal unregulated drug events.[116,123-140] A retrospective cohort study that used linked health administrative data (March 2020 to August 2021) of individuals with opioid use disorder found that people receiving opioid prescribed alternatives under BC's *Risk Mitigation Guidance* were less likely to die from drug poisoning or other causes than those who did not receive prescribed alternatives (e.g., individuals who received four or more days of opioid prescribed alternatives in a week were 89 per cent less likely to die due to unregulated drug poisoning the following week). Furthermore, this protective effect increased with the number of days individuals received opioid prescribed alternatives. This relationship was not observed for stimulant prescribed alternatives, which did not significantly affect mortality among people with stimulant use disorders.[122]
Use of unregulated drugs	Participants who received prescribed alternatives reported that they reduced or stopped their use of unregulated, street-acquired drugs,[124-126,128-132,134,136-145] and in some cases, they reduced or stopped injection drug use.[125,126,134,137-140,143]
Retention in programs and care	Early evaluation of prescribed alternatives programs show positive rates of retention and ongoing engagement for clients, several months to a year after beginning prescribed alternatives.[131,139,146] This is important because the longer people are engaged in these programs, the more chances they have to be connected to other health and social services, and the greater the reduction in risk of experiencing an unregulated drug event. More than three-quarters (77 per cent) of a cohort of people in BC who received prescribed alternatives continued receiving these medications after 60 days.[146]
Engagement in programs and care	Prescribed alternatives programs increased access to and engagement in health care and social services,[125,126,128,130,131,137,142] including substance use disorder treatment,[114] primary health care, individual and group counselling, case management, harm reduction, and housing support.[124] This builds structure and stability for individuals and a sense of community.[140,143]

Table 4. Summary of Literature Review Findings *continued*

Physical and mental health	Participants who received prescribed alternatives reported improvements in health and well-being related to reduced withdrawal symptoms and drug cravings;[114,116,129,130-132,134,138,142] reduced exposure to unregulated drug events;[130] and improvements in areas including chronic pain and disease management,[125,126,128,131,133,134,138,143,147] nutrition and sleep,[137] access to basic needs,[125,126,128,131,136] sense of agency and autonomy,[129,143,144] sense of safety,[94,129,132,140,143,144] mental health,[125,131,137-140,143,144] and quality of life.[94,124,126,128,131,137,140,141,143]
Social and economic well-being	Participants in prescribed alternatives programs reported a reduction in involvement in criminal activities.[114,124,125,128-130,132,136,138-141,143] They also described having more time and ability to engage in personal interests, employment,[124,128,130,136,138] and family and social relationships.[125,126,128,130-132,138,140,142,143,148] In addition, they reported greater economic,[116,125,131,132,138,142,143] food,[125,126,128,131,136-138] and housing security.[124,126,131,136-140,148]
Health-care use	Enabling access to prescribed alternatives has the potential to reduce health-care system use and expenditures, though results on health-care use are mixed.[122,125,126,149,150] One study found that there was an increase in opioid-related hospitalizations in BC after the prescribed alternatives policy was implemented compared to other provinces without this policy;[150] however, the methodology and relevance of this association is questionable as this analysis did not account for differences between these provinces, such as toxicity of the unregulated drug supply and closure of harm reduction services. Another study found that recipients of stimulant prescribed alternatives had fewer acute care visits than matched controls, but the same was not observed for recipients of opioid prescribed alternatives.[122]
Health-care costs	One study of health-care costs reported lower costs for emergency department visits, inpatient hospital admissions, and mental health- and substance use-related hospital visits for participants who were receiving prescribed alternatives.[149] Primary care costs were not included in the study, but improved connections to primary care can reduce hospitalizations. For instance, primary care provides help with managing and treating infectious diseases such as HIV and hepatitis C,[149] which, if left untreated, can result in much more costly medical interventions in the future.

See also *A Targeted Scan of Evidence on Prescribed Safer Supply Programs for the Provincial Health Officer,* Appendix A in *A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action.*[17]

Enabling Access to Alternatives to the Unregulated Drug Supply: Implementation Facilitators and Barriers

Implementation of prescribed alternatives in BC has produced some insight into facilitators of and barriers to successfully achieving the goal of this service. These have been categorized into several key areas, as outlined below. While these observations relate to prescribed alternatives, many of the facilitators and some of the barriers could also be relevant to programs and models for offering alternatives beyond the health-care system.

Substantial barriers have been observed in the implementation of prescribed alternatives. These barriers impede the ability to scale-up this intervention exclusively within the health-care system to sufficiently reach the population at risk. See *A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action.*[17]

Substances Available as Prescribed Alternatives

Facilitator	Substances that can replace unregulated drugs
Barrier	Lack of available substances that can replace unregulated drugs

To be effective, programs must **enable access to substances that are effective alternatives to the unregulated drug supply**, from the perspective of the people who use drugs. This means that prescribed alternatives need to be **the right drug, in the right dose, with the right route of administration** (e.g., oral, nasal, injecting, or smoking) to not only prevent withdrawal but also provide the desired effects that are in line with client needs and goals, such as euphoria, pain relief, and improved quality of life and functioning.[94,124,128,129,138,140,141,143,144,147,151] People who access prescribed alternatives programs have indicated that the substances available are not always adequate to replace the unregulated drug supply, in some cases leading to painful withdrawal symptoms from use of street drugs, and are not always available in preferred forms for smoking, inhaling, or injecting.[114,116,129,135,143,145,148,152,153]

In surveys and interviews conducted by the BC Centre for Disease Control in 2019 and 2021, people who use drugs from across BC specifically asked for heroin and fentanyl, stating that hydromorphone is not interchangeable with these drugs and that people who use drugs are knowledgeable about what they need to improve their quality of life.[115] In addition, survey respondents identified a need for stimulants such as methamphetamine and cocaine because currently available stimulant prescription options are inadequate substitutes.[115] These results are echoed in two recent cross-sectional studies on preferred opioid and stimulant prescribed alternatives in BC.[154,155] Lastly, benzodiazepines are present in the unregulated drug supply; therefore, there is a need for benzodiazepine prescribing for people at risk of withdrawal or in need of benzodiazepines for health reasons.[115]

Some drugs that would be useful as alternatives are difficult to obtain. For example, diacetylmorphine, or pharmaceutical-grade heroin, has not been readily available, even for its currently authorized use in injectable opioid agonist treatment programs. This lack of availability extends to a diacetylmorphine

product that could be inhaled or smoked, the currently preferred methods of use, and the mode of consumption related to the highest proportion of deaths in BC's unregulated drug emergency.[61] Diacetylmorphine is currently available only in limited locations in BC, including through the injectable opioid agonist treatment program at Fraser Health Authority, the Crosstown Clinic in Vancouver, and the Lookout Medical Clinic in Surrey.[156] Stimulant alternatives are limited in availability and effect to replace unregulated stimulants, and prescriptions for cocaine and methamphetamine are not available for this program.[41]

Inclusion of People Who Use Drugs in Program Design and Delivery

Facilitator	Community centred and led by people who use drugs
Barrier	Incomplete inclusion of people who use drugs and the organizations that represent them

Having people who use drugs involved in and co-leading program design, planning, implementation,[94,129,143,146] and outreach[94,128,157] is paramount in creating accessible and welcoming programs. Safe spaces are needed that centre the perspectives and contributions of people who use drugs, and allow participants to share their needs and preferences in drug, dose, and route of administration.[40,94,115,125,128,129,143,144,147,151,155] While some efforts have been made to involve people who use drugs in program design and operation, many feel that they are not being listened to[129,144,151] or paid an adequate, living wage when employed in program delivery.[157,158]

Service User Experience

Facilitators	Respect and trust in health-care relationships Accessible, safe, and welcoming spaces; cultural safety
Barriers	Medicalization and health-care system barriers Stigma and discrimination in the health-care system Medical testing and monitoring

Positive Service User Experiences

Access to prescribed alternatives is enabled when **participants feel a sense of autonomy and are respected, trusted, and understood** by program staff.[94,144,151] Participants felt trusted when prescribers provided take-home doses (i.e., medication for one day)[94,128,135,144,151,158] and offered carries (i.e., medication for multiple days).[94,125,147] During COVID-19, the provision of take-home doses of heroin-assisted treatment in other jurisdictions reduced barriers for participants, and unintended outcomes such as diversion and overdose were not observed.[126,147,151,157] Participants enjoyed the new freedom, autonomy, and privacy, and having more time to spend on activities such as paid work and social encounters.[160] The results for participants included reduced barriers to care,[161,162] improved quality of life, and greater continuity of care.[143,160,162]

Program quality is improved when prescribed alternatives programs **create safe and accessible spaces** [94,128,135,144,151,158] and offer wraparound health care and social services.[94,125,147] In particular:

Prescription Alternatives and Peer Advocacy Program: An Example of Peer-led Harm Reduction

Jenny McDougall, a person with lived experience of substance use, founded the Prescription Alternatives and Peer Advocacy Program (PAPA) in Quesnel, BC in 2020.[n] Launched during the COVID-19 pandemic with the aim of helping people self-isolate, PAPA delivers prescribed alternatives and opioid agonist treatment medications to people who have difficulty attending pharmacies every day. Due to its success in reducing barriers to accessing alternatives to unregulated drugs, PAPA continues to provide additional services to people who use drugs in the northern BC community. PAPA's wholistic approach includes attention to social determinants of health. McDougall offers a range of assistance to clients, including delivering medications, supporting health and housing systems navigation, and helping with transportation to appointments. While the program has not been formally evaluated, client outcomes have included better retention in alternatives and opioid agonist treatment programs, reduced reliance on unregulated drugs, improved housing and employment outcomes, healthier pregnancies, better management of health conditions, and greater ability to care for family.[148,159]

[n] In this context, a "peer" is a person with lived or living experience of drug use who uses this knowledge and experience to do their work, e.g., supporting other people with lived or living experience of drug use to access services.

- Co-location of prescribed alternatives and supervised consumption services has been recommended.[126,147,151,157,163]
- Two program evaluations highlighted relational, team-based care as important for providing high-quality service.[126,128]

Information sharing between and among prescribed alternatives programs can support the expansion of access to prescribed alternatives.[151,157]

While not always addressed in the literature, **cultural safety for Indigenous people is necessary in all health and social services**, as highlighted in the 2020 report *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*.[33]

> *"There's so much stigma already in the health-care system you know, with people that are addicted trying to go and [get] help—most of them have already been traumatized in the health-care system..."*
>
> Participant from Understanding Substance Use Patterns, Preferences and Needs – Informing Safe Supply and Safer Use Services[o]

[o] Quotes from people who use drugs, gathered through the Understanding Substance Use Patterns, Preferences and Needs – Informing Safe Supply and Safer Use Services project, are included in Chapters 4 and 5 of this report. These quotes are included to highlight the perspectives of the people at risk of drug poisoning to contextualize the experience of accessing alternatives to unregulated drugs. More information on this project is available in the final publication, *Substance Use Patterns and Safer Supply Preferences Among People Who Use Drugs in British Columbia*, available online: https://towardtheheart.com/resource/substance-use-patterns-and-safer-supply-preferences-among-pwud-/open.

> *"A lot of us don't want that, we don't want people to just check up on us in the middle of our lives. That's not how we want—we want to be able to live our own kind of lives, you know—we're good. A lot of people won't think that, but we are… It makes us feel like they're being nosey, and they want to know what we're doing, if we're okay, how we're doing, what's going on in our lives. That's how we think of it… And that's not what we want… If we need help, we'll ask somebody."*
>
> Participant from Understanding Substance Use Patterns, Preferences and Needs – Informing Safe Supply and Safer Use Services

Negative Service User Experiences

"Medicalization" is the process of reframing issues that have been previously understood as non-health related as medical problems that require medical solutions, diagnosis, and mechanisms of control.[164] Making alternatives to unregulated drugs available only through the health-care system and requiring a prescription to access drugs is an example of medicalization. This means that people who wish to access alternatives must also engage with a range of practices that can feel restrictive, invasive, and stigmatizing, such as those discussed below.

Health-care services have **socio-structural barriers**, including **systemic racial and socioeconomic inequities**.[165] There are large power imbalances in the health-care system between providers and patients.[166] The limitations of prescribed alternatives programs are compounded by stigmatization within the health-care system of people who use drugs,[138] which is further compounded for some by Indigenous-specific racism.[33]

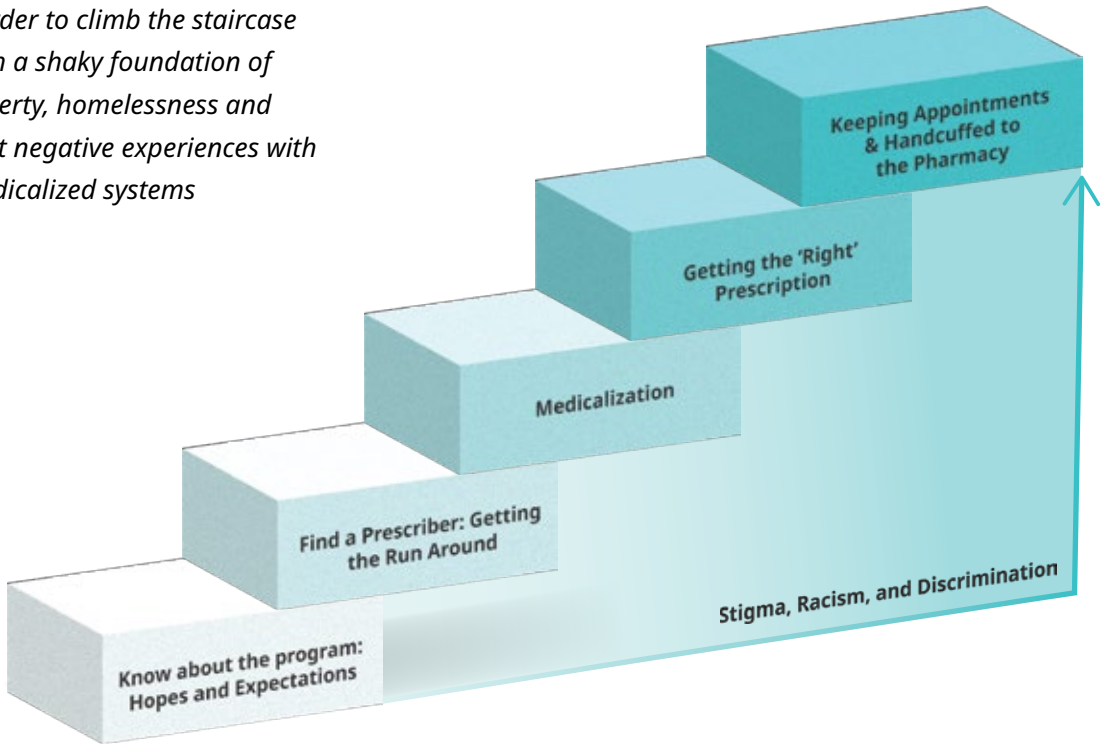
While prescribed alternatives programs can mitigate some of these barriers, they remain present in requirements including **surveillance and monitoring practices**, such as frequent check-ins with the prescriber at the program location,[94,124,128,131,140,143,148,158] urine drug screening,[94,128,147,164] witnessed ingestion of medications,[94,116,130,143,145,147,153,164] and daily pickups of short-acting medications.[124,128,130,140,143] **These practices create barriers to participation for many people who use drugs** and impede their participation in life, work, or school.[115,166-168] Moreover, surveillance can lead to participants fearing being discharged from the program or having their doses reduced.[115,116,124] As noted earlier in this chapter, in the context of a positive patient-prescriber relationship, take-home doses increase autonomy and the ability to work, and do not necessarily increase diversion.

Service Users' Perspectives

The primary purpose of BC's *Risk Mitigation Guidance* was "to provide clinical guidance to health-care providers to support patients to mitigate the compounded risks [of COVID-19 and the unregulated drug emergency],"[110] including to reduce transmission of COVID-19. Service users' experiences with access to prescribed alternatives established under BC's *Risk Mitigation Guidance* illustrate the barriers to accessing prescribed alternatives. Service users have reported that they did not always know about programs and were most likely to find out about them from a friend, family, or outreach worker, including peer workers. They often experienced a "runaround" trying to find a health-care provider who was willing to prescribe, and then encountered high levels of medicalization, systemic stigma, and discrimination in accessing a prescriber. It was challenging to get the right prescription to substitute for drugs from the unregulated market. Maintaining access to prescribed alternatives meant urine drug screens and being "handcuffed" to a pharmacy for daily pickups. Figure 4 illustrates these challenges (graphic reproduced with permission of the author).

Figure 4. Staircase to Receiving Prescribed Alternatives Under BC's Risk Mitigation Guidance: Service User Perspectives

Harder to climb the staircase with a shaky foundation of poverty, homelessness and past negative experiences with medicalized systems



Pauly B, Slaunwhite A, Nosyk B, Barker B, Urbanoski, K, and the Risk Mitigation Guidance Research Team. Mixed methods evaluation to address the public health crises of COVID-19 and overdose: Presentation to the Health Canada Expert Advisory Group on Safer Supply. 2023 Jan.

Availability, Accessibility, and Scalability

Facilitator	Positive care relationship with a prescriber
Barriers	Requirement to be in a care relationship with a prescriber Lack of capacity, training, regulatory support, and infrastructure for prescribers Navigating health system logistics and program constraints Uncertain or inadequate funding Limited availability outside of urban areas Scalability to meet need

Under current regulations, prescribers of alternatives **must be in a care relationship** with the person receiving the prescription.[128,143] This presents a barrier to people who are unable or unwilling to participate in the medical aspects of prescribed alternatives programs, those who do not have access to a primary care provider, and those who do not have a substance use disorder (e.g., people who use drugs occasionally).[115,164] In addition, not everyone at risk of an unregulated drug event requires the health and social services offered by some prescribed alternatives programs.[115] However, for those who are connected to a health-care provider, this relationship is an important facilitator of access to prescribed alternatives. Although many people who use drugs lack awareness of how to access alternatives,[133] having access to drug checking or overdose prevention services, or having received opioid agonist treatment, has been associated with increased odds of receiving prescribed alternatives.[169]

How Many Health-care Providers Prescribe Alternatives to Unregulated Drugs?

Health administrative data on prescribing by physicians and nurse practitioners show that the practice of prescribing alternatives to unregulated drugs has not been widely adopted. Between January and December 2023, an average of 786 clinicians (ranging from a low of 735 to a high of 823) in BC prescribed alternatives to unregulated drugs (including opioids, stimulants, and benzodiazepines) each month. By contrast, an average of 2,031 clinicians (ranging from a low of 1,916 to a high of 2,115) prescribed any opioid agonist treatment in each month over the same period.[27,p]

[p] The data reported here reflect the best available information at the time of writing. Future data quality improvements may result in slight adjustments to these figures.

> *"We can't prescribe our way out of this crisis. We need another pathway outside of the medical system."*
>
> Guy Felicella,
> Peer Clinical Advisor for BC Centre on Substance Use[179]

Current approaches to prescribed alternatives make prescribers the "gatekeepers" of alternatives to unregulated drugs—physicians and nurse practitioners are put in the position of controlling access.[114,115,133,144,163,164,170] Given the **shortage of primary care providers in BC**,[171] it is challenging for people who use drugs to find a primary care provider, let alone one who prescribes alternatives to unregulated drugs.[162] **Some clinicians have expressed concerns about prescribing alternatives**.[17,112,172,222] Many prescribers fear repercussions from their regulatory college,[133,144,163,164,222] feel unsupported by professional regulatory colleges as well as their peers and colleagues,[158,173] lack program infrastructure,[114,222] worry that prescribed alternatives could undermine abstinence-based treatment through the perpetuation of substance use,[147] and have expressed concerns about the negative impacts of program participants sharing or selling their medication.[114,222] These concerns are explored in more depth in the Provincial Health Officer report *A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action*.[17]

Participants are required to navigate challenges such as clinic and pharmacy hours of operation, transportation to the clinic, and lack of program capacity.[94,125,132,147,153] Programs do not always have enough space to meet the demand.[126,147,151,153,157] Alternatives programs are both difficult to find[94,111,114,115,129,130,143] and difficult to access, often because of staff shortages[153,157] and backlogs of active participants.[158] A backlog occurs when there is nowhere for the participants to be transitioned to for ongoing care. Technological issues were sometimes a barrier to timely access to medications in a program that used biometric dispensing machines.[94,128,132,144,158,163] A Personal Health Number or another form of identification, which some people do not have, is required to access prescribed alternatives. The co-location of prescribed alternatives programs with supervised consumption services has been beneficial for logistical reasons but has also been problematic for some people because of long wait times[130,147,157] and participants being exposed to unregulated drugs that are being consumed in the same space.[151]

Many of the programs operating **do not have long-term funding**, and programs are often considered pilots.[130,133,138,144,153,157,158] Moreover, lack of funding limits the number of participants that a program can take on, which limits the scale and reach of programs.[174]

Prescribed alternatives are more available in large urban centres.[115] Limited options in services and transportation to access daily dispensing become major barriers in programs that serve rural communities.[115,144,163,175] The lack of available prescribers in rural communities, especially those with harm reduction and addictions medicine training, amplifies this barrier.

> *I hate being supervised in general... I would feel kind of babied by a pharmacist"*
>
> Participant from Understanding Substance Use Patterns, Preferences and Needs – Informing Safe Supply and Safer Use Services

The unregulated drug emergency is a population-wide, public health problem. As described in Chapter 1, it is estimated that in BC, 165,000 to upwards of 225,000 individuals are accessing the unregulated drug supply during a 12-month period. An estimated 105,000 people in BC have opioid use disorder,[176] though not all of them would be accessing the unregulated market. In contrast, on average, 4,777 people[q] were dispensed prescribed alternatives (including opioids, stimulants, and benzodiazepines) each month from January 2023 to December 2023.[177] Between March 2020 and May 2023, 89 per cent of new prescriptions overlapped with an episode of opioid agonist treatment.[107] This may indicate that prescribed alternatives are currently being used as a tool to help patients begin and stay on opioid agonist treatment. A survey of harm reduction service clients conducted in 2021 and 2022 found that people who were already engaged in services were the most likely to have received prescribed alternatives, especially those who had accessed opioid agonist treatment in the past six months.[178] This indicates that most people who use unregulated drugs and could benefit from prescribed alternatives do not have access to this intervention.

In summary, while prescribed alternatives are proving effective, there are many interrelated challenges and barriers to expanding and supporting current prescribed alternatives programs. In addition to the limited number of the population at risk that are currently accessing prescribed alternatives, as well as scalability challenges, these include

- **Medicalization,** which requires a prescriber, even though the number of prescribers is limited, and which often includes intense monitoring, limited hours of operation of prescribers and pharmacies, requirements for witnessed dosing (which creates challenges with the timing of use), discomfort with the surroundings and feelings of people who use drugs of being stigmatized, mandatory dosing adjustments linked to missing doses, and dosing inadequacy.
- **Implementation challenges**—i.e., lack of support for prescribers, lack of prescriber availability, lack of needed or desired substances for people who use drugs, geographical and transportation challenges.
- **Lack of cultural appropriateness and cultural safety**.

[q] The monthly number of people dispensed prescribed alternatives ranged from 4,453 to 5,189. There was an almost continual decline in the monthly number of clients from a high of 5,189 in March 2023, to a low of 4,453 in December 2023, with one increase from 4,711 to 4,724 between July and August 2023. The data reported here reflect the best available information at the time of writing. These results may change slightly as prescription information is confirmed and data quality improvements are made.

Prescribed Alternatives: Example Scenarios

Appendix C provides example scenarios of prescribed alternatives programs. The scenarios are included to stimulate ideas and discussion about how alternatives can be made more accessible and can better meet the needs of people who use drugs—they are not recommendations. The scenarios were informed by research with, and input from, people who use drugs, and they incorporate evidence related to the barriers and facilitators outlined above. Some of the scenarios are similar to existing programs; others are hypothetical. Two scenarios describe Indigenous-led approaches, which are informed by Indigenous approaches to harm reduction.[1,180]

Chapter 4 KEY MESSAGES

- The use of prescribed alternatives programs is an emerging practice with promising early evidence of benefits for program participants, largely from program evaluations and qualitative research.
- The available evidence points to benefits such as lower risk of unregulated drug events and deaths, reduced use of unregulated drugs, better connection to health and social services, and improved health, social, and economic well-being.
- Elements that contribute to successful programs are
  - establishing respect and trust in health-care relationships;
  - having substances that can replace unregulated drugs;
  - providing accessible, safe, and welcoming spaces; and
  - involving people who use drugs.
- The main barriers to expanding access to prescribed alternatives are medicalization of the programs, lack of support for and availability of prescribers, limited range of substances available, restrictive program practices, and inability to scale-up the program to have an impact on the population-wide unregulated drug emergency.
- Prescribed alternatives programs have been implemented gradually through small-scale pilot projects and individual prescribers.
- Program evaluations and initial evidence from one large-scale retrospective cohort study point to benefits of this approach. Further research is needed to understand the impact of prescribed alternatives at a population level.

5

NON-PRESCRIBED ALTERNATIVES TO UNREGULATED DRUGS

Enabling access to alternatives to unregulated drugs beyond a medical model, and not dependent on prescribers, has the potential to reach a much greater number of people at risk of drug poisoning. Verifying the benefits of non-medical approaches and ensuring the benefits outweigh the risks will require careful consideration of appropriate regulatory models and measures for individual and public health and safety. It will also require independent research, evaluation, and ongoing monitoring.

Non-prescribed approaches would give people who use drugs the option of accessing alternatives to unregulated drugs without having to navigate the health-care system. There are no authorized non-prescribed programs in operation. While this presents some challenges due to the lack of existing operational frameworks and regulatory or program models to draw upon, it also highlights opportunities to use innovation and creativity in providing effective non-medical programs in a person- and community-centred way that builds on knowledge from other areas of substance use, such as cannabis. Innovation could be directed toward minimizing medicalized and systemic barriers, including stigma, discrimination, and racism, which can be experienced when accessing the health-care system.

Non-prescribed Alternatives: What We Know

A scan of scientific literature on non-prescribed alternatives conducted for this report revealed an unsurprising lack of published research on models that have been implemented. Public Health Ontario's 2022 research scan also found little published information on non-medical models.[181] However, a variety of publications explore potential approaches to providing access to a regulated supply of currently illegal drugs beyond the health-care system. The discussion that follows is based on qualitative articles, reports, program evaluations, a book chapter, and commentaries that explore these possible models for non-prescribed alternatives. See Appendix B for the literature search methods.

Non-prescribed Approaches

Proposed non-prescribed, or "regulated," approaches to accessing currently illegal drugs have been conceived of primarily as alternative visions for drug control, in which

a new system of regulation and access would replace prohibition. Such approaches have been proposed for illegal drugs,[182] including opioids,[183] stimulants,[184] and psychedelics.[185] While regulated approaches are based on a public health vision of drug control, which seeks to reduce the harms of prohibition and criminalization of drug use, the examples in the literature do not specifically conceive of enabling access to quality-controlled drugs as a targeted public health strategy to respond to unregulated drug events and deaths.

As such, analyses of regulated approaches differ from those that examine how to reduce harm from the unregulated drug crisis. Some elements of the various proposals would present barriers to access for people who currently use unregulated drugs. Nevertheless, as alternative visions for drug control, regulated approaches provide useful ideas and points for initiating discussion on how to make quality-controlled drugs available beyond the health-care system.

A 2009 review that explored the regulation of drugs included five general approaches: prescription, pharmacy sales, licensed sales, licensed premises, and unlicensed sales.[182] This was followed in 2020 with publication of stimulant-specific models for MDMA, amphetamines, cocaine, and coca powder, which proposed strict production, sales, marketing, and purchasing instructions using a legally regulated source of drugs,[184] and in 2023 with a psychedelic-specific proposal related to LSD, psilocybin, DMT, and mescaline.[186,r] A 2021 commentary on the regulation of opioids proposed a medical access model paired with one or more of the following three models for non-medical access to opioids:[183]

1. **Licence to purchase:** purchasers of opioids would obtain a licence by participating in training on health risks and harm reduction, and by passing a knowledge test.
2. **Purchase authorization card:** similar to the licence model, education and passing a knowledge test would both be required, but purchasers would not be tracked.
3. **General availability**: based on recognizing that most people can self-manage their use of psychoactive substances, there would be no requirements for education or tracking accompanied by public health-oriented regulation.

The commentary acknowledged that these approaches would need to be adapted to accommodate people who currently access unregulated opioids, and that other issues would need to be considered, such as privacy risks, barriers to access, level of bureaucracy, and acceptability to purchasers.

Community-led Models

Community-led models that are designed to enable access to drugs, such as compassion clubs, co-ops, and buyers' clubs, have been proposed to enable access to heroin,[172,187] tobacco and other nicotine-containing products,[188] and stimulants.[189] Community-led models are membership-driven organizations or groups whose aim is to share knowledge and/or facilitate access to medications,

[r] For readability, some substances in this list are referred to by their more commonly known initialisms instead of their full names. MDMA is 3,4-methylenedioxymethamphetamine; LSD is lysergic acid diethylamide; and DMT is dimethyltryptamine.

treatments, or substances that people are not able to receive through the health-care system due to factors such as regulatory barriers, stigma, or lack of financial resources.[190] Such community-led models emerged in Canada in the 1980s and 1990s in response to the AIDS epidemic.[187] During that time, buyers' clubs were established to provide people who faced inequities with access to lifesaving medications for illnesses such as hepatitis C and HIV/AIDS.[187,191-193] In conjunction, cannabis compassion clubs provided "persons with medical need with a safe, reliable supply of [cannabis]"[194] and a way to connect with health-care services. Compassion clubs served people with diagnoses of hepatitis C and HIV, as well as those with illnesses such as cancer, chronic pain, and epilepsy. Germany has recently joined a small but growing number of European Union countries that authorize access to cannabis through a compassion club model.[195] The BC Centre on Substance Use report on heroin compassion clubs identified several potential benefits of community-led models, including the delivery of peer-led risk mitigation and harm reduction; access to drugs of known quality and composition; determent of money from entering organized crime; and improved member agency, autonomy, and responsibility.[187]

Additional potential advantages of community-led models include the provision of access to non-prescribed alternatives that is low-barrier, and the provision of optional peer, social, and health supports for members.[188] These models can also provide opportunities for offering programming that is peer-led and peer-supported, which has shown benefits in creating spaces that are inclusive and participatory for members, and which provide an alternative option for those who mistrust or have experienced racism in the health-care system[115,188]

A critical factor identified in the literature on drug regulation and non-medical models is having access to substances of known quality and composition. It is also important for people who use drugs and the general public to be educated on all the risks and potential harms of particular drugs, doses, frequencies, and routes of administration so that they can make well-informed choices.[182]

> *"In terms of safe supply, it would be great if there was a centre... let's say you just smoked some fentanyl. There's a chill out room that you can go and hang out and play music and just chill out, if you're somebody that needs detox, we have a room. I want it to be the people healing the healing the people... Not random doctors that have had no substance issues or and it's very medical. A lot of substance users we've been through a lot of trauma and a lot of that is through the medical system or navigating the medical system."*
>
> Participant from Understanding Substance Use Patterns, Preferences and Needs – Informing Safe Supply and Safer Use Services

The Drug User Liberation Front Compassion Club

For just over one year between 2022 and 2023, the Drug User Liberation Front (DULF), a community-based organization in Vancouver, BC, operated a compassion club for non-prescribed alternatives to unregulated drugs. In 2021, DULF applied unsuccessfully for an exemption under section 56 of the federal *Controlled Drugs and Substances Act* to allow for "procurement, storage, and distribution of cocaine, methamphetamine, and heroin to compassion club members."[196] Due to being unable to access pharmaceutical drugs without a prescription, the group purchased opioids and stimulants from the unregulated supply and used drug checking to identify any contaminants or adulterants before distributing the tested drugs to members. DULF also ran an overdose prevention service. Preliminary findings from a program evaluation included self-reported improvements in the health and well-being of club members.[197] Among those improvements were significant decreases in rates of hospitalization, negative police interactions, use of the unregulated drug market, and experiences of drug-related violence. Further analysis of evaluation data confirmed that membership was associated with a reduction in the odds of having a non-fatal toxic drug poisoning. Members were almost two thirds less likely to experience a non-fatal toxic drug poisoning requiring naloxone after joining the compassion club compared to the three months before joining.[198] No fatal toxic drug poisonings were reported among members during the study. On October 25, 2023, police searched DULF premises, seized heroin, methamphetamine, and cocaine, and arrested two of the group's organizers, who were later charged and released. Though some compassion club members have commented that the service's closure has increased their risk of drug poisoning,[199] the overall impact of the service's sudden closure on the health of its 43 members is unknown.

Programs for Non-prescribed Alternatives to Unregulated Drugs: Facilitators and Barriers

A range of regulatory barriers currently prevent programs for non-prescribed alternatives from operating legally in BC. While the primary obstacle remains drug prohibition, some of the system- and service-level barriers encountered in programs for prescribed alternatives would also apply to some non-prescribed models. The facilitators identified in the previous chapter for prescribed alternatives programs could also apply to non-prescribed alternatives models, depending on the approach used.

Facilitators

- respect and trust;
- substances that can replace unregulated drugs;
- accessible, safe, dignified, and welcoming spaces; and
- involvement of people who use drugs in planning and implementation.

Barriers

Laws and Regulations: Drug Prohibition

Drug prohibition, codified in the *Controlled Drugs and Substances Act*, *Food and Drugs Act*, and related legislation, is the main barrier to implementing non-medical models. These Acts restrict access to pharmaceutical drugs that could be used to replace unregulated drugs, and make them available only in specific medical or research contexts, or not at all, as described in Chapter 2

Lack of Available Substances to Replace Unregulated Drugs

Programs for non-prescribed alternatives would face challenges sourcing the range of substances that would meet the needs of people who use drugs. If these programs accessed the same supply chains as those used for prescribed alternatives, they would likely experience the same limitations.

Availability and Accessibility: Social and Financial Capital

A potential barrier to accessing non-prescribed alternatives is an individual's lack of financial capacity to purchase available products.[115] In addition, in the case of community-led models such as buyers' clubs, knowledge of programs can be difficult to obtain for people without existing social connections to the club, which could perpetuate health and social inequities.[100] This reflects the need to have a variety of medical and non-medical access points so that eligible individuals are able to access alternatives through the model (medical or non-medical) that best meets their needs.[115]

Funding

Some non-medical models could be financially self-sustaining once established. However, some funding would likely be needed initially and perhaps ongoing. There is no current funding source for programs that enable access to non-prescribed alternatives.

Space and Program Constraints

Non-medical programs may face similar challenges as prescribed alternatives programs in securing space and hiring staff. However, without the requirement for prescribing and medical monitoring, it is possible that staff costs would be considerably lower even though appropriate oversight for programs and participants would still be provided.

Non-prescribed Alternatives: Example Scenarios

Examples of program scenarios for enabling access to non-prescribed alternatives, and a description of how those scenarios were developed, are provided in Appendix C. All scenarios are informed by the knowledge of people with lived and living experience of drug use from across the province. The scenarios are intended to inform and stimulate discussion about the range of options available for non-prescribed alternatives in BC; they are not formal recommendations. Combined with proposals from literature and experiences elsewhere in Canada and internationally, there is a body of information and ideas from which non-prescribed alternatives could be explored.

The current approach to prescribed alternatives in BC is being closely monitored, evaluated, and researched for intended and unintended impacts, health outcomes,

challenges and benefits of implementation, and accessibility, and independently evaluated for effectiveness. Similarly, programs for non-prescribed alternatives will need to be subject to rigorous monitoring, evaluation, and research to detect and respond to both their beneficial and adverse individual and population-level outcomes.

Chapter 5
KEY MESSAGES

- Many of the benefits observed for prescribed alternatives programs may be transferrable to non-prescribed models. This would need to be verified with rigorous, ongoing evaluation and monitoring.
- Due to current regulatory barriers to enabling access to non-prescribed alternatives, there has been little opportunity to implement, study, and evaluate this approach.
- Research on buyers' clubs and compassion clubs that have been established for other purposes offers some helpful information to inform implementation.
- The main barrier to enabling access to non-prescribed alternatives is the ongoing prohibition of certain substances under the *Controlled Drugs and Substances Act*, as well as challenges presented by the *Food and Drugs Act.*
- Funding challenges and the lack of long-term, secure supply chains for substances that are effective alternatives to the unregulated drug supply are also barriers.
- Rigorous monitoring, evaluation, and research is and will continue to be an important component of implementing initiatives for alternatives to unregulated drugs.
- Scenarios are presented for discussion (see Appendix C). They can provide the basis for discussions about the next phase of work that is needed to explore how to enable access to non-prescribed alternatives.

6

DISCUSSION AND RECOMMENDATIONS

Discussion

British Columbia has implemented a range of evidence-based, innovative interventions to address the unregulated drug emergency. They are saving lives; however, the crisis is ongoing and uncompromising. As of 2024, more than seven people per day in BC continued to die from the use of unregulated drugs.[13,15] This complex problem requires a comprehensive, multi-faceted, courageous, and innovative response that addresses the cause of the emergency.[71,200,201] As was seen throughout the COVID-19 pandemic, urgent, coordinated, and comprehensive approaches that challenge the status quo are possible and impactful. It is my view that in this ongoing crisis, they are also necessary.

Expanding health services and supports for people who use drugs is essential. So too is enabling access to alternatives to the unregulated drug supply so that people who use drugs will have a source of substances of a known type, quality, and concentration. The purpose is to save the lives of people who use drugs—our family members, friends, and colleagues—and to reduce the death toll of a crisis so destructive that it has shortened life expectancy in BC.

BC has established limited access to alternatives through the health-care system by individual prescription. Research to date indicates that this approach has benefits such as reduced risk of death, reduced use of drugs from the unregulated drug supply, better connection to health services, and better physical and mental health and well-being. However, prescribed alternatives programs have barriers to access and are limited in terms of reach, scalability, and impact compared to the size of the problem needing to be addressed. The health-care system is not capable, nor is it designed, to scale-up services to address the needs of the tens of thousands of people who use drugs and to replace the widespread distribution of drugs that is currently occurring through the unregulated market.

Another method of enabling access to alternatives is needed: one that has safeguards to address concerns about unintended consequences, but does not rely on the overburdened and, at times, stigmatizing and inflexible health-care system. Currently, there

is no access to alternatives to unregulated drugs beyond what is available through the health-care system. Regulatory barriers have impeded the establishment of such programs. With few programs to study, little research has been done that could speak to their effectiveness. Nonetheless, programs that do not rely on individual prescriptions present a considerable opportunity to expand access to alternatives on a scale that could bring down the number of poisonings and deaths. In the context of this emergency, that possibility alone makes this approach worth investigating. In BC, many public health experts, researchers, elected representatives, people who use drugs, and their friends and families have recommended expanding access to alternatives to unregulated drugs.[9,61,201-207]

Enabling access to alternatives beyond the health-care system does not mean discarding measures that provide protection and oversight, nor does it entail widespread, uncontrolled distribution of alternatives. Recommendations from the 2023 BC Coroners Service death review panel[9] list the types of protective measures that would need to be in place, including

- governance (oversight) structures;
- eligibility criteria;
- program access procedures;
- production and procurement processes;
- supply management and distribution system;
- staffing and training standards;
- storage and security requirements; and
- monitoring, evaluation, and research.[5]

Additional implementation considerations should include guidance on program locations, onsite/offsite consumption, and take-away policies and procedures.

This is an opportunity for thoughtful and sincere engagement on a proposal offered by multiple expert agencies and people with lived and living experience of drug use. It is also an opportunity to engage on legitimate questions about potential unintended consequences of a new approach and find ways to address those concerns.

Government commitments to expand access to substance use disorder treatment will be helpful for some people who use drugs. However, improving treatment services will not benefit the very many people who use drugs who do not have a substance use disorder, nor those who are not seeking treatment. In addition, enabling access to alternatives exclusively through the health-care system excludes people who do not interact with the health-care system. There are various reasons why people might not interact with the health-care system, including racism, stigma, and negative past experiences with the system.

Scaling up access to alternatives to unregulated drugs, alongside the current continuum of prevention, harm reduction, treatment, and recovery interventions, is essential as part of a comprehensive response that is equal to the

[5] The approach proposed in the BC Coroners Service death review panel report is summarized at the end of Appendix C.

scale of the emergency. As Provincial Health Officer, I add my voice to those calling for expanded access to alternatives to unregulated drugs, and especially emphasize the need to explore a range of models, including non-prescribed models, to ensure reach is extended across the population for those who need this service, and to all geographic areas. The following recommendations align with recommendations to government 4(c), 5(d), and 7 in my review of prescribed alternatives programs in BC.[17]

Recommendations

1. **The Province of British Columbia should explore implementing, with appropriate safeguards, and evaluating scalable programs that enable access to non-prescribed alternatives to unregulated drugs.**

   These programs would be in addition and complementary to the ongoing implementation and improvement of prescribed alternatives policies and programs. This multi-model approach is required to meet the needs, and thereby save the lives, of people who use drugs. Much depends on the details of how non-prescribed alternatives would be made available. BC has world-leading expertise that can be called upon if given enabling leadership, encouragement to explore innovative solutions, and investment by decision makers.

2. **People and organizations that represent those with lived and living experience of substance use must be engaged in planning, design, and implementation of all programs and policies that enable access to alternatives to the unregulated drug supply.**

3. **The Province of British Columbia should pursue meaningful partnership in this work through effective co-governance with Indigenous organizations and governing bodies as is required to uphold the inherent rights and title of First Nations in BC, and the inherent rights of First Nations, Métis, and Inuit people in BC.**

   Strategies must be developed to ensure that the obligations described in the Unlearning and Undoing section of this report are met in the context of alternatives to unregulated drugs. This would include increasing Indigenous communities' self-direction on matters related to psychoactive substances, addressing issues related to rural and remote communities and urban and away-from-home Indigenous populations, and determining how enabling access to alternatives can complement Indigenous harm reduction and other efforts.

Conclusion

I envision a future in which people who use drugs are not at the mercy of an unregulated supply and system that puts their lives at significant risk. This requires an urgent shift toward enabling sufficient access to alternatives to meaningfully reduce drug poisonings and deaths. This courageous, innovative, and compassionate action is needed to address the proximal cause of this emergency: the unregulated drug supply.

Important work continues to be needed in existing areas: to reduce barriers to prescribed alternatives, reduce stigma, address poverty and homelessness, expand access to Take Home Naloxone, support overdose prevention and supervised consumption services, optimize opioid agonist treatment, ramp up evidence-based substance use disorder treatment services, and prevent substance harms among youth. These services are all critically important aspects of a multi-faceted response.

Yet, to not think beyond the limits of the services and supports we have offered over the past eight years, as the death toll has continued to climb, is to accept a paradigm that has produced unacceptable, record-high rates of preventable deaths from unregulated drugs.

We have a choice: to accept that a shift and action is needed to be fully comprehensive in our response to this crisis, or to continue to implement measures that seek to improve the outcomes, but not address the proximal cause.

Appendix A: Glossary

Alternatives to unregulated drugs	drugs of known type, quality, and composition, such as pharmaceutical drugs, that people who would otherwise use unregulated drugs are able to access. Also known as "safer supply."
Benzodiazepines	a class of medications used as sedatives and tranquilizers (e.g., diazepam).
Compassion club or buyers' club	membership-driven organizations or groups whose aim is to share knowledge and/or facilitate access to medications, treatments, or substances that people are not able to receive through the health-care system due to factors such as regulatory barriers, stigma, or lack of financial resources.[190]
Controlled Drugs and Substances Act	Canada's primary piece of legislation that sets out what is legal and what is illegal in terms of the drugs listed in the schedules to this Act (i.e., controlled substances, including illegal drugs).
Criminalization	the act of making an action or behaviour criminal in nature by making it illegal; also refers to treating a person or people as criminals if they are associated with, or found to be engaging in, an illegal activity.
Decriminalization	the removal of an action or behaviour from the scope of the criminal justice system. In drug policy, decriminalization refers to a spectrum of approaches that remove criminal sanctions associated with drug possession.
Diversion	the selling, trading, sharing, or giving away of prescription medications to others. This may occur voluntarily or involuntarily.[208]
Drug checking	a service that offers a range of technologies that allow a sample of drugs to be checked to determine the contents and identify composition. The technologies are used as a harm reduction intervention to provide service users with more information about contents of illegal drugs.

Drug poisoning	when a person becomes ill, is injured, or dies because of the effects of a drug. This includes "overdoses," when the body is overwhelmed by a too-large dose of a drug, but also situations where harm is caused by other factors; e.g., combinations of drugs, contamination, or adulteration. "Poisoning" in this sense does not mean there was an intention to harm, and includes accidental exposure to drugs. See also *overdose*.
Drug prohibition	legislation and policies that restrict access to certain drugs and criminalize the sale and possession of those drugs.
Fentanyl	a synthetic opioid that is manufactured by a regulated pharmaceutical company which is available legally by prescription and in hospitals for pain management (available in several formulations). This should be distinguished from fentanyl-like products (e.g., acetyl fentanyl, carfentanil, fentanyl, furanyl fentanyl) that are illegally manufactured, adulterated with other substances, and sold illegally in the unregulated street drug market.
Food and Drugs Act	federal legislation that sets out how food, cosmetics, and pharmaceutical drugs must be manufactured, packaged, labelled, stored, imported, distributed, and sold in Canada.
Harm reduction	"policies, programs and practices that aim to minimize the negative health, social and legal impacts associated with drug use, drug policies and drug laws."[209]
Life expectancy	the estimated average years of life someone is expected to live at a given age. In BC, life expectancy is measured at birth and at age 65.
Naloxone	an opioid antagonist that blocks opioid receptors in the brain, thereby reversing the effects of opioids.
Non-prescribed alternatives to unregulated drugs	a program or policy in which alternatives to the unregulated drug supply can be accessed outside of the health-care system and without a prescription; also known as "non-prescribed alternatives," "non-prescribed safer supply," and "non-medical safer supply."

Opioid	a class of drugs that are derived from the resin of the opium poppy plant or that are synthetically manufactured and that bind to the opioid receptors in the human body (e.g., codeine, heroin, morphine, methadone, fentanyl).
Opioid agonist treatment	evidence-based treatment for opioid use disorder that includes the prescription of opioid agonists (e.g., methadone, buprenorphine) to alleviate withdrawal symptoms. Also referred to as opioid substitution treatment.
Opioid use disorder	a chronic relapsing medical condition characterized by at least two symptoms listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) criteria for opioid use disorder, including taking opioids in amounts larger or longer than intended, craving or strong desire for opioids, and persistent desire or unsuccessful efforts to cut down or control opioid use.
Overdose	when too much of a substance is taken so that the body is overwhelmed and negative health effects such as breathing suppression and unconsciousness result. Untreated overdoses can be fatal. See also *drug poisoning*.
Overdose prevention services	provincially sanctioned harm reduction sites or services that provide supervised consumption and overdose response.
Peer	a person with lived or living experience of drug use who uses that experience in their work, e.g., as a harm reduction educator.[210]
Peer review	evaluation by others working in the same field. Many academic journals require articles to be peer reviewed before they are published.
Prescribed alternatives to unregulated drugs	a program or policy in which participants are prescribed pharmaceutical drugs as alternatives to the unregulated drug supply. Other terms for this approach are “medical safer supply,” “prescribed safer supply,” and “prescribed alternatives.”

Psychoactive substance	something that, when taken, changes a person's mental processes; e.g., their mood, emotions, perception, or cognition.
Public health	"the combination of sciences, skills and beliefs that is directed to the maintenance and improvement of the health of all the people."[211] It is an organized effort by society to promote, protect, restore, and improve people's health through individual, collective, or social actions.[212]
Racism	the process by which systems and policies, actions, and attitudes create inequitable opportunities and outcomes for people based on race.
Safer supply	Health Canada states that "Safer supply refers to providing prescribed medications as a safer alternative to the toxic illegal drug supply to people who are at high risk of overdose."[95] See also: *alternatives to unregulated drugs*.
Section 56 exemption	an exemption to provisions of the *Controlled Drugs and Substances Act* granted by the federal Minister of Mental Health and Addictions under section 56 of the Act.
Settler colonialism	the process of white European societies taking control over Indigenous land and removing or eradicating Indigenous Peoples for the purpose of building an ethnically distinct national community.
Social determinants of health	The World Health Organization defines social determinants of health as the "nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems."[213]

Structural determinants of health	the "root causes" of health inequities that shape the quality of the social determinants of health experienced by people in their neighbourhoods and communities. Structural determinants of health affect whether the resources necessary for health are justly distributed in society according to race, gender, social class, geography, sexual identity, or other socially defined groups of people.
Supervised consumption services	federally approved sites that "provide clean, safe environments where people can use substances under the supervision of trained staff without the risk of arrest for drug possession."[214] Services include emergency response to toxic drug events (including administration of naloxone), sterile injecting supplies, basic health care, testing for communicable diseases, education on safer drug use, and referral to other health-care services.
Unregulated drugs	also referred to as illegal drugs, illicit drugs, street drugs, or prohibited drugs, "unregulated drugs" are drugs prohibited under Canada's laws for all but very limited uses, which are nonetheless made available to the public by illegal sellers without the benefit of quality controls or regulation, and which result in an unpredictable and often toxic supply of drugs.
Unregulated drug death	The BC Coroners Service defines an "unregulated drug death" as an unintentional death resulting from the use of unregulated street drugs, medications not prescribed to the decedent, or a combination of these with drugs prescribed to the decedent.[13]
Unregulated drug emergency	the period in BC beginning in 2012 when deaths due to the use of unregulated drugs have increased dramatically, and which is characterized by increasing detection of illegally manufactured fentanyl-like drugs and other contaminants in deaths related to the use of unregulated drugs. The Provincial Health Officer declared this situation a public health emergency on April 14, 2016.
White supremacy	the belief that white people constitute a superior race and should therefore dominate society, typically to the exclusion or detriment of other racial and ethnic groups. These beliefs permeate societal policies, practices, and norms.

Appendix B: Literature Review Methods

Scoping Review Protocol

Objective: To review prescribed and non-prescribed models of enabling access to alternatives to unregulated drugs, including opportunities, barriers, and outcomes.

The literature review was conducted October 27, 2022, and updated July 13, 2023, and January 21, 2024.

Inclusion Criteria:

- Risk Mitigation Guidance or equivalent initiatives
- Medical safer supply programs or equivalent initiatives
- Heroin-assisted treatment or injectable opioid agonist therapy or equivalent initiatives[t]
- Short-acting opioids used as a substitute for, or in addition to, street-acquired drugs
- Compassion clubs and buyers' clubs or equivalent non-medical grassroots initiatives
- Program goal is harm reduction using medication or drugs
- Indigenous-led safer supply or substitution/replacement programs

Exclusion Criteria:

- Programs that focus on harm reduction but not in relation to drug replacement
- Programs that use long-acting opioid agonist therapy exclusively

Contexts:

- Rural, urban, on-reserve, and/or off-reserve settings
- Male-only, female-only, all-gender, and/or 2SLGBTQQIA+ clients

Information Types:

- Peer-reviewed literature/journal articles
- Research reports
- Book chapters
- Government reports
- Policy documents and white papers
- Guiding documents
- Not-for-profit and community organization websites

Information Sources:

- PubMed, Medline, Embase, CINAHL, PsycINFO, Sociological Abstracts, and Social Services Abstracts
- Google Scholar
- Citation searches/reference list review
- Targeted web searches
- Not-for-profit and community organization websites

[t] The results of this search were not included in the final version of this report.

Sample Search Terms:

- Safer supply or safer opioid or Risk Mitigation Guidance
- Heroin-assisted treatment or injectable opioid agonist therapy[u]
- Opioid substitution or stimulant substitution and harm reduction
- Opioid replacement or stimulant replacement and harm reduction
- Non-prescribed or non-medicalized or compassion club or buyers' club or social club

Search Limits:

- Published in English only
- No limits to publication date in order to capture the history of non-medical safer supply

[u] The results of this search were not included in the final version of this report.

Appendix C: Alternatives to Unregulated Drugs: Example Scenarios

Development of Scenarios for Alternatives to Unregulated Drugs

The scenarios were created through a two-stage process: (1) secondary analysis of data from two studies related to alternatives to unregulated drugs to create initial draft scenarios, and (2) consultations with people who use drugs to review and provide input on the proposed scenarios.

1. Secondary Analysis

Data from two studies were used to define prospective implementation scenarios:

- **Study 1**: Understanding Substance Use Patterns, Preferences and Needs – Informing Safe Supply and Safer Use Services. This study explored preferences individuals had for accessing alternatives to unregulated drugs both within existing models and for prospective models, which were discussed in focus groups.
- **Study 2**: Risk Mitigation for People who Use Substances During Dual Public Health Emergencies. This study used the Consolidated Framework for Implementation Research[215,216] (CFIR) to guide the collection of data that focused on experiences in accessing existing models of prescribed alternatives.
- Institutional ethical approval was obtained for both studies.

Data Extraction and Model Development

- From both studies, transcripts and previously coded data on alternatives to unregulated drugs implementation and preferences were reviewed.
- Data extraction was guided by the CFIR. The CFIR is a robust framework that spans five key domains that are critical to effective implementation: individuals involved, intervention, implementation process, inner setting, and outer setting.
- Excel spreadsheets were populated with relevant ideas and concepts about implementation that corresponded with the CFIR.
- The spreadsheets were used to develop distinct model summaries.
- The summaries were further reduced to short descriptions for the purposes of this report.
- A preliminary set of models was then created.

2. Preliminary Model Review and Feedback

- Preliminary models were presented to groups of people who use drugs for review and feedback.
- Approximately 18 people were involved in three group consultations. Key information was used to enhance the scenarios for prescribed and non-prescribed alternatives to ensure they reflected a range of experiences, preferences, hopes, and ideas of people who navigate the unregulated market.

- Feedback was gathered and integrated into revised models for use in this report.

The scenarios created for this report are being further developed and used to inform a study related to modelling the effectiveness of alternatives approaches: Estimating the Value and Long-Term Impact of Implementing Risk Mitigation Guidance to Reduce the Harms of Substance Use Disorders during the COVID-19 Pandemic: A Simulation Modeling Analysis.[217]

Prescribed Alternatives: Example Scenarios

In alignment with preliminary findings from research on, and evaluations of, alternatives to unregulated drugs, as well as input from people with lived experience, the following fundamental elements are envisioned for all the prescribed alternatives scenarios:

- A full range of substances that are effective alternatives to the unregulated drug market is available by prescription. Available substances could include diacetylmorphine, fentanyl, oxycodone, benzodiazepines, slow-release oral morphine, and stimulants such as cocaine and methamphetamine. The availability of benzodiazepines could support withdrawal from benzodiazepines that are in the unregulated drug supply.
- The prescription of alternatives is not contingent upon co-prescription of other treatments.

Prescribed Alternatives in Primary Care or Addiction Medicine

In this scenario, primary care providers (physicians and nurse practitioners) and addiction medicine practitioners, at their discretion, can prescribe a range of substances to patients who are actively accessing the unregulated drug supply and are at high risk of unregulated drug death or other related harm. Dosing decisions and adjustments are based on a patient-centred care plan and ongoing prescriber–patient communication and collaboration. For medications not covered by PharmaCare, programs could make cost recovery arrangements, with clients purchasing medications directly from a pharmacy. Sliding scale and subsidy options could also be considered.

This scenario is currently authorized by the Access to Prescribed Safer Supply policy directive, and is further enabled by clinical guidelines/protocols for specific medications that have been released by the BC Centre on Substance Use.[109,110] Regional health authority programs may also have region-specific prescribing protocols to support such programs. Medication-specific protocols could be established to allow clients to quickly transition to receiving alternatives.

Further enhancements to this scenario could be pursued to reduce barriers and improve access:

- Remove existing medical monitoring requirements that are barriers to engagement and retention in prescribed alternatives programs; e.g., urine drug screens, witnessed ingestion in some cases after stabilization, daily pickups.
- For people who do not have BC PharmaCare coverage, or for substances or substance formulations that are not covered, cost recovery, sliding scale costs, or subsidies could be made available.
- Expand range of substances and formulations available.

An Innovative Example of Prescribed Alternatives

One prescribed alternatives program in the Vancouver Coastal Health region allows clients to purchase powdered fentanyl. This service is provided without any conditions of ongoing treatment once the client's dose is stabilized.

- Clients are initially seen by a physician, who performs a basic intake and eligibility assessment.
- Eligible clients receive a prescription for powdered fentanyl tablets. This formulation can be injected, inhaled, or smoked. Clients pay $25 per tablet directly to the pharmacy (a fee equal to the base cost of the medication; i.e., it is a cost recovery model).
- A nurse oversees an up to 2-day titration period to help the client find a stable dose.
- There are no requirements for ongoing medical monitoring. The physician renews the prescription based on check-ins with the pharmacy.

This program has medication-specific protocols related to dosing, titration, and daily dispensed amounts. The risk of diversion is mitigated by providing medication that meets the client's needs, and by offering a reasonable financial cost to purchase it from the pharmacy.

Prescribed Alternatives Within an Integrated Care Team

This scenario involves an integrated team of professionals, including prescribers and people with lived experience, delivering prescribed alternatives along with wraparound health and psychosocial supports. Other team members could include peers, social workers, counsellors, nurses, and pharmacists who provide support, referrals, and systems navigation in areas such as mental health, criminal justice, housing, income, and food security. Teams may be located in community health centres or housing sites, or co-located with supervised consumption or overdose prevention facilities. A peer or health-care provider (e.g., nurse) is the first point of contact.

As in the previous scenario, prescribed substances are made available to the client at the prescriber's discretion. There is no cost to the client when coverage by PharmaCare is available. For people who do not have coverage or for substances or substance formulations that are not covered, cost recovery, sliding scale costs, or subsidies could be made available. As described in the previous scenario, modifications to existing prescribing frameworks could be made to eliminate medical monitoring practices, such as urine drug screens.

Prescribing follows a patient-centred care plan, and there is ongoing prescriber/practitioner–patient communication and collaboration. There would be flexible options for accessing prescribed substances that support diverse accessibility needs and personal preferences, such as the availability of pickup, carries, and delivery.

Indigenous Models of Prescribed Alternatives

Indigenous people have inherent rights to wholistic health and wellness, self-determination, and autonomy. Settler institutions and governments continually violate these rights, which results in disproportionate impacts of the unregulated drug emergency on Indigenous Peoples. Indigenous-led, self-determined substance use services are more effective, culturally safe, and responsive to community needs than the often harmful mainstream approaches.[218,50]

All levels of government have a responsibility to uphold the rights of Indigenous communities to administer their own self-determined health and wellness services and to be actively involved in developing and determining priorities and strategies for health and wellness.[219]

The two models below describe Indigenous-led alternatives to unregulated drugs approaches: the First Nations Health Authority's First Nations Virtual Substance Use and Psychiatry Service (currently operating), and the Aboriginal Coalition to End Homelessness Society's vision for a housing-based service within a decolonized harm reduction framework (potential model). The Indigenous Housing and Decolonized Harm Reduction scenario draws on knowledge shared at the Wisdom of the Elders gathering held in Victoria in 2018.[180]

First Nations Virtual Substance Use and Psychiatry Service

The First Nations Virtual Substance Use and Psychiatry Service (FNvSUPS)[220] is offered by the First Nations Health Authority via video conferencing to all First Nations people and their family members in BC. FNvSUPS enhances First Nations community health team capacity and helps provide wholistic, wrap-around substance use and mental health care closer to home. It offers a full spectrum of culturally safe, trauma-informed care, including harm reduction, treatment, and medical safer supply. A referral is required to talk to a provider who can write a prescription; nurses and wellness liaisons support navigation, collaborative care planning, and culturally safe, trauma-informed services. Prescriptions are written at the prescriber's discretion, based on prescriber-patient communication and recognition of patient self-determination. Prescriptions are dispensed in local community pharmacies.

Indigenous Housing and Decolonized Harm Reduction Framework (Urban Indigenous Dual Model of Housing Care)

Harm reduction for Indigenous people must reduce the harms of colonization. An exemplar of this approach is the Dual Model of Housing Care (DMHC)[221] developed by the Aboriginal Coalition to End Homelessness Society (ACEHS)[v] in Victoria. The ACEHS takes a holistic approach to addressing the housing needs of Indigenous people (First Nations, Métis, and Inuit) on Vancouver Island and incorporates Indigenous alcohol harm reduction into culturally supportive housing. The ACEHS is

[v] The Aboriginal Coalition to End Homelessness Society is a not-for-profit housing provider and registered charitable organization that was established in 2016 to "lovingly provide culturally supportive affordable housing and services that end Aboriginal homelessness on Vancouver Island." See acehsociety.com for further information.

developing and operating the DMHC, "which goes beyond housing provision to provide pathways to healing from intergenerational harms rooted in colonial trauma. The DMHC strengthens Indigenous identity, builds community, (re)connects, supports healing, and leads to transformation for those previously unhoused."[221(p.8)] Within the DMHC, family members have access to physical, mental, emotional, and spiritual resources, including Elder support, Medicine Keepers, cultural mentors, native medicine gardens, traditional foods, and cultural programming. The ACEHS seeks to align Indigenous traditional health, wellness, and healing with Western approaches. The DMHC could serve as a cultural framework for alternatives to unregulated drugs programming in housing.

Alternatives to unregulated drugs for Indigenous people must be rooted in programs that are Indigenous led and culturally informed with a focus on cultural safety. Such programs must be informed by local wisdom and knowledge, and must offer pathways to health, healing, identity, community, and transformation.

Non-prescribed Alternatives: Example Scenarios

The following are examples of ways to enable access to alternatives to unregulated drugs without a prescription. Although the scenarios differ considerably from one another, all scenarios would require

- Mechanisms to determine eligibility for, and access to, alternatives to unregulated drugs (because this would not be done by prescription).
- Mechanisms to allow people to legally access alternatives.
- A supply chain to enable sourcing and safe storage of substances of known quality and composition.
- Authorization to legally operate (e.g., via a licensing system).

Community-led Models

People with lived and living experience of substance use were especially interested in the possibility of community-led alternatives models, such as compassion clubs and buyers' clubs. The following three scenarios reflect variations on a vision for providing community-led non-prescribed alternatives. While these are presented as non-medical scenarios, community-led approaches that incorporate prescribed alternatives could also be envisioned; in a separate engagement process, many people who use drugs expressed a desire for services that combine community-based and prescribed approaches.[17]

Compassion Clubs

In this scenario, a compassion club is owned and operated by its members. Operational and purchasing decisions are made democratically. Anyone who accesses drugs through this model must be a member. While prescription or diagnosis is not required, other membership criteria must be met, as determined by club members (e.g., age restrictions, income limits, a one-time payment or ongoing membership fees). This model would operate from a physical space and could be adapted to include various on-site services to reflect the needs, preferences, and goals of members. For example, members may elect to also operate

a community centre, supervised consumption space, and peer support programming. Substances of known quality and composition could be bought in bulk and made available to members at an established cost. To support access, members may offer a sliding scale cost.

Compassion Club Integrated Into a Community Centre

During the process of creating these scenarios, potential service users consistently said that a wholistic, wraparound community centre that provided alternatives to unregulated drugs as one of many available services would be ideal. In this scenario, the compassion club model would consist of a grassroots community-run space (such as a community centre or neighbourhood house) that offered a wide range of programs and services, in addition to alternatives to unregulated drugs and witnessed consumption spaces. The program would be low barrier and would provide a safe and comfortable place for people with a diversity of needs and experiences to connect, socialize, and use drugs without punitive rules. There could also be working spaces for program organizers and implementers.

Buyers' Clubs

A buyers' club is a not-for-profit, community-led, members-only organization in which members pool their resources to create collective buying power. In this scenario, the operating structure of the buyers' club is determined democratically. Collective buying can support the purchase of substances that may be challenging to source on an individual level. Bulk purchasing may also result in lower costs than purchasing individually. Substances are distributed within the network of club members and not necessarily through a physical space. As with the compassion club model, a prescription or diagnosis would not be required, but membership would be required to access substances, with membership criteria determined by the group. Sliding scale costs or subsidies could be offered, as determined by members, to support more equitable opportunities to participate.

Retail-based Approach

Regulated Retail Store

In this scenario, alternatives to unregulated drugs could be made available for purchase in either government-run or private retail spaces. A range of substances could be sold in a variety of formats and compositions. The types of substances available and retail pricing would be determined by the government to meet purchasers' needs. This model would support individual agency and offer independence from medicalized rules and surveillance. As with all models, age restrictions could be established to protect youth. Consideration would be needed regarding limitations on how often a person accessed the store or how much they may purchase. Substances purchased from the store would be consumed off-site, and options would be provided for witnessed or non-witnessed consumption. While formal connections to additional health or social supports would not be part of this model, information about harm reduction and treatment and recovery services, and access to harm reduction resources, such as naloxone, could be required to be available.

The following was not developed through the same process as the other scenarios in this appendix, but provides an additional example of a non-medical model.

Provincial Program: Central Hub and Delegated Agencies/Licensed Programs

The 2023 BC Coroners Service death review panel outlined elements of a model for enabling access to alternatives without prescription in its report *An Urgent Response to a Continuing Crisis*.[9] This model would be enabled through a *Controlled Drugs and Substances Act* section 56(1) exemption and would be overseen by the Province, with direction provided by the Ministry of Mental Health and Addictions, and with participation of all levels of government and Indigenous leadership.

This model would be based on a central provincial distribution centre and would be supported by regional programs and agencies that would provide access to non-prescribed alternatives. The central distribution centre would be responsible for operational components, such as the supply chain, security, storage, distribution, and delivery of medications, and would provide an audit function.

Programs would be required to apply for provincial licensure and delegated authority to distribute alternatives, and approval would be conditional upon meeting certain provincial requirements, including those related to the use of the central distribution resource, client eligibility criteria, and staffing and workforce training. All aspects of the model would undergo robust evaluation and monitoring to support client and public safety, which would leverage existing provincial agencies and expertise, such as the BC Centre on Substance Use and BC Centre for Disease Control.

Strategies would also be put in place to minimize the risk of diversion; e.g., potentially charging clients who wish to consume a drug off-site a price equal to that of the equivalent substance purchased from the unregulated market, while providing substances at no cost to those who consume witnessed, on-site. The model proposes that the Ministry of Mental Health and Addictions develop a detailed application process for agencies and programs that seek delegated authority to distribute substances, and outline considerations for requesting an exemption to the federal *Controlled Drugs and Substances Act* section 56(1) to enable the model.

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