

**Steppingstones Through a Raging Fire:
Safe Supply for People Who Are Unhoused in Vancouver**

by
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Abstract

In British Columbia 2,272 people died from overdose in 2022 due to escalating and unpredictable concentrations of benzodiazepines, fentanyl, and even stronger opioid analogues in the illicit drug supply (BC Coroners Service, 2022a). People who are unhoused are structurally vulnerable to overdose and dying at disproportionate rates. Safe supply is a policy intervention that seeks to replace the illicit drug supply with regulated alternatives to prevent injury or death. Through 6 qualitative interviews and a multi-criteria policy analysis, four models of delivering safe supply were assessed against the following 10 criteria: 1) provision of adequate dosages, 2) range of drug options and formulations, 3) hours in a day drugs can be obtained, 4) number and geographic distribution of access sites, 5) up-front cost for people who use drugs, 6) amount of personal data collected, 7) potential to drive population-level increases in opioid use, 8) burden of implementation, 9) cost to government, and 10) acceptability among key stakeholders. The policy options examined are: a prescribed safer supply model; a non-prescribed model delivered through supervised consumption sites; compassion clubs; and dispensaries. Each model was identified to have particular strengths, but none alone were found to provide sufficient coverage for the diverse needs of unhoused people who use drugs. Based on this analysis, it is recommended that a multiplicity of medical and non-medical safe supply options be adopted. Considerations for implementation including micro and meso logistical factors and the macro legal barrier of the *Controlled Drugs and Substances Act* are explored.

Keywords: Safe supply, people who are unhoused, harm reduction, drug policy, overdose, opioids.

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Terminology

Throughout this work I use the terms ‘unhoused’, ‘houseless’, ‘and ‘houselessness’ interchangeably to refer to the condition of lacking adequate physical shelter. This is a conscious shift in language away from the terminology of ‘homelessness’ which remains in wide use among government bodies, service providers, and academia. My choice to use ‘unhoused’ is intended to recognize that this is primarily a material condition. The concept of a ‘home’ carries deeper connotations related to belonging and community which those without housing still possess. This is their home, even when lacking a house.

As well, throughout this report I use the terms ‘illicit drug toxicity’ and ‘overdose’ interchangeably to describe the medical emergency resulting from consuming higher levels of drugs than the body can withstand. The decision to use both comes from a desire for brevity and accessibility in writing style and is not intended to suggest that everyone who have suffered from consuming toxic levels of drugs experienced this out of a failure to properly dose. In the context of an unpredictable illicit drug supply with greatly varying strengths these injuries and deaths are practically unavoidable and are fundamentally the result of an unregulated and contaminated supply.

Finally, I have also consciously decided to use the term ‘safe supply’ rather than ‘safer supply’, except in the context of BC’s policy, which uses the latter term. There is a debate among stakeholders about whether ‘safer supply’ is more appropriate at capturing the inherent dangers of drug use. I defer to organizations like Canadian Association of People Who Use Drugs [CAPUD] who choose to use ‘safe supply’, and offer the following analogy as to why:

“We can say that thrusting a hammer toward a nail in your hand is not inherently safe, but because hammering nails is legal, we can easily access hammers and nails that are “safe” and learn how to use them in safe ways. It is in this sense that legal and regulated drugs are “safe” even though there is still risk of harm. With the quality of the substance assured, people who use drugs are in a far better position to confront the risks associated with drug use.” (CAPUD, 2019, p. 14).

List of Acronyms

CDSA	Controlled Drugs and Substances Act
PWUD	People who use drugs
S.56(1)	Sec. 56(1) of the Controlled Drugs and Substances Act
VPD	Vancouver Police Department

Opening Image



"Can you imagine a world without a drug war?

Where the abused were not inconsequential and could reach their full potential.

Where laws didn't kill people.

Beautiful and loved people.

Imagine a drug war never existed." – Unknown

Photo by author

Executive Summary

Since 2016 British Columbia has been in a public health emergency due to deaths caused by an unpredictable illicit drug supply that has become increasingly contaminated with highly potent opioid analogues and benzodiazepines (BC Coroners Service Death Review Panel [BCCSDRP]. 2022). These illicit drug toxicity deaths have grown alongside increasingly expensive housing costs in the province which have generated a scarcity of affordable units (COV, 2022). COVID-19 brought a third layer of emergency to the region by further escalating the contamination of the illicit drug supply while putting unhoused people who use drugs at further risk of complications from the virus due to higher rates of comorbidities (Huggett et al., 2021; Milaney et al., 2021).

These intersecting crises opened a policy window for BC to release new Risk Mitigation Guidelines, which allowed for the scale up of prescribed pharmaceutical alternatives to the illicit drug supply throughout the pandemic (Selfridge et al., 2022). This novel harm reduction approach is called *safe supply* and builds off over a decade of evidence on the benefits of injectable opioid agonist treatments (iOAT) for those who traditional methadone options were not sufficient (Csete & Elliot, 2021). Safe supply diverges from those prior methods because it does not necessarily intend for participants to scale back or cease drug use to receive care; the primary objective is to replace the toxic illicit drug supply with regulated alternatives to reduce the risk of overdose (Klaire et al., 2022). At the time of writing at least 18 pilot programs are operating across Canada and prescribing medical alternatives to the illicit drug supply as a harm reduction method (Ontario Agency for Health Protection and Promotion [OAHPP], 2022).

Emerging evidence from these prescribed safe supply programs indicates a variety of benefits: the decreased use of illicit drugs, improved health, well-being, and/or quality of life, lower health care system costs, stabilized drug use patterns, better connections to health and social services, greater economic security, enhanced pain management, fewer wounds/abscesses, and reduced involvement in criminalized activities (McNeil et al., 2022; Ivsins et al., 2021; Ivsins et al., 2020; CATIE, 2023; Selfridge et al., 2022; Gomes et al., 2022; Ranger et al., 2021). However, these same evaluations have also indicated that prescribed safe supply programs have not been able to reduce reliance on the illicit drug supply for most participants, largely due to

access issues, insufficient dosages, and the prescription of medicalized drugs in formulations that cannot be consumed as desired (Ivsins et al., 2020; Ivisins et al., 2021). For people who are unhoused, program limitations are magnified by logistical barriers like restrictive operating hours and limited access sites (Ivsins et al., 2020).

Based on preliminary results and calls from some like the BC Coroners Service Death Review Panel for both medical and non-medical models of safe supply, this study employed qualitative expert interviews with six individuals and a multi-criteria policy analysis to gauge the strengths and limitations of different safe supply models for people who are unhoused (2022). Four policy options were explored. First, prescribed ‘safer’ supply, where medical grade drugs are prescribed by a physician to those at high risk of illicit drug toxicity death. This medicalized model of safe supply is currently being implemented across Canada, and so within this study it functions as the status-quo option among those explored. Second is a non-medical model where drugs are available without prescription and administered within a stand-alone supervised consumption site by healthcare and peer workers (Canadian Association of People Who Use Drugs [CAPUD], 2019). Third is a compassion club model where organizations of PWUD purchase, test, package, and redistribute verified safe supply to club members at a reduced price (Drug User Liberation Front [DULF], 2022). Lastly, a dispensary model is explored where drugs would be made available for purchase in publicly run shops, not unlike cannabis or alcohol (CAPUD, 2019).

Analysis of qualitative interviews generated several themes. First, interviewees described a disconnect in BC between the stated objectives for prescribed safe supply compared to its implementation. While guided by laudable goals, access to the program remains inequitable and out of reach for most. As well, the significance of providing flexible time frames for unhoused participants to access safe supply was identified as a key consideration by interviewees due to the chaotic experience of living without housing. Distrust in the medical system was also revealed as a major issue for prescriber-based models trying to reach unhoused populations, a disproportionate number of which are Indigenous peoples who have experienced racism and discrimination within the healthcare system (Turpel-Lafond¹ et al., 2021; BCNPHA,

¹ This author’s name has been included to meet APA citation guidelines; however, their views are not being referenced through this citation. This report features extensive accounts of racism within the healthcare system directly from Indigenous peoples’ firsthand experiences. It’s

2020). Interview participants also pushed back on the often-cited concern that prescribed drugs being ‘diverted’ to the general public represented a significant public health risk relative to the mass-casualty crisis currently unfolding. From their perspective, averting illicit drug toxicity deaths is prioritized above controlling who can obtain pharmaceutical-grade drugs. Lastly, interview participants emphasised the need for of a multiplicity of safe supply models to meet the diverse range of needs that unhoused people who use drugs have.

A multi-criteria policy analysis of these four safe supply models found contrasting strengths and limitations when evaluated through 10 predetermined criteria. The primary evaluative criterion was a model’s ability to end reliance on the toxic illicit drug supply; this was measured by six sub-criteria: 1) provision of adequate dosages, 2) range of drug options and formulations available, 3) hours in a day that drugs can be obtained, 4) number and geographic distribution of access sites, 5) up-front cost for PWUD, and 6) amount of personal data collected as part of accessing safe supply. An additional four criteria were measured: 7) potential to drive population-level increases in opioid use, 8) the burden of implementation, 9) cost to government, and 10) acceptability among key stakeholders including the Vancouver Police Department, general public, and groups advocating for PWUD.

Each safe supply model was found to have their own strengths and limitations. Identified strengths of the prescribed safer supply model was the ability to provide drugs at no-cost to participants and acceptability among stakeholders. However, issues related to insufficient dosages, restrictive hours for pickup, and the collection of large amounts of personal data were expected to hinder access and the overall extent to which this model could substitute unregulated toxic drugs. The un-prescribed supervised model received the most moderate ratings for indicators measuring its ability to replace unregulated illicit drugs; however, alongside compassion clubs, it was assessed to do the best at preventing a population-level increase in opioid use. Similar to prescribed safer supply, restrictive access hours and even fewer dispensing locations were identified as limitations of delivering safe supply through supervised consumption sites. Compassion clubs were assessed as well positioned to allow for flexible access to an individual’s preferred drug in its desired formulation, but this option also places a heavy

inclusion in this document is intended to highlight their lived experience and not the viewpoints of the report’s citing author.

burden on PWUD for its implementation. Finally, dispensaries allowed for autonomy and agency regarding dosages and had greater potential for varied dispensing locations but would also provide drugs at a higher cost for both government and PWUD, while likely generating backlash from the VPD and general public.

Based on this analysis and given the urgent need to replace the toxic illicit drug supply for people who are unhoused, it is recommended that prescribed and un-prescribed supervised models leverage pre-existing infrastructure to immediately scale up delivery for the most vulnerable while developing non-medical models of safe supply in the longer term. Central to this will be the replacement of the *Controlled Drugs and Substances Act* with a new regulatory framework that features human rights and public health at its center. These recommendations are consistent with what many in the literature and on the ground are saying: there will not be one single solution to the illicit drug toxicity crisis (Foreman-Mackey et al., 2022; Selfridge et al., 2022; Ivsins et al., 2021; BCCSDRP, 2022).

Chapter 1. Introduction

Since its inception, the prohibition of non-medical opioid use in Canada has been about exclusion. Initially, the exclusion of displaced Chinese migrants who had completed work on the Canadian Pacific Railway and cleared much of what is today known as Vancouver (MacKay, 2018). In 1907 the Asiatic Exclusion League, motivated by their racist fears that Chinese labourers would undercut white workers, instigated a riot that destroyed businesses throughout Chinatown (Petrasko, 2022; MacKay, 2018). Amongst the destruction were two opium manufacturers whose applications for \$600 of reparations caught the attention of then Deputy Minister of Labour William Lyon Mackenzie King (MacKay, 2018). He later told local media, “We will get some good out of this riot yet”, in reference to the government’s intention to ban the same opium trade that the British colonial empire had ironically waged two wars to force upon China in the previous century (MacKay, 2018).

Moral panic about opium use among the Chinese diaspora was wrapped in a white-supremacist double-standard that viewed opium-smoking as a ‘backward’ practice of an ‘inferior’ and ‘unassimilable’ culture to settler Canadian Christian society; meanwhile the opiate laudanum was widely used among European settlers for a variety of purposes (MacKay, 2018). Even so, a moralistic, racist, and exclusionary mindset reigned and in 1908, with little debate, the Canadian parliament passed the *Opium Act* outlawing the importation, manufacturing, and sale of non-medicinal opium (MacKay, 2018; Petrasko, 2022). Contrary to the lack of fanfare at the time, the effects of this policy decision would ripple across generations.

In 2016 British Columbia declared a public health emergency due to a drastic increase in illicit drug toxicity deaths (Ministry of Mental Health and Addictions [MMHA], 2021a). Over the following five years 1/3 of all apparent opioid toxicity deaths in Canada happened in BC – a province with only 13% of the national population (Selfridge et al., 2022). First Nations in BC have been especially impacted, with overdose mortality rates five times higher than the general population (Touesnard et al., 2022). This increase in overdose mortality is driven by the opioid fentanyl and its analogues; in 2005 fentanyl was only detected in 5% of completed illicit drug toxicity death investigations, but from 2017 - 2021 that proportion exploded to over 85% (BCCSDRP, 2022). The ‘iron law of

prohibition’ – an observation that outlawing substances incentivizes the illicit production of more potent and adulterated variations– has been in full effect with respect to opioids (Beletsky & Davis, 2017). The effects have been devastating. In 2022 alone, 2 272 died due to the contaminated illicit drug supply; in July that broke down into an average of 6.2 deaths every day (BC Coroners Service, 2022b). This trajectory of increasingly large numbers of people dying from a progressively toxic drug supply is where BC found itself in March of 2020 when a third crisis descended on the province.

Public health restrictions in response to the COVID-19 pandemic made a bad situation worse. By reducing access to harm reduction, addictions services, and other social supports for unhoused people who use drugs (PWUD), pandemic restrictions further isolated marginalized populations already at higher risk of overdose death (Palis et al., 2022; Selfridge et al., 2022). As well, border closures had a detrimental impact on the quality and cost of illicit drugs; supply chain disruptions produced unpredictable price fluctuations while illicitly manufactured benzodiazepines and the sedative xylazine began showing up in drug samples alongside extreme concentrations of fentanyl and even stronger analogues (Russell et al., 2023; Foreman-Mackey et al., 2022; Palis et al., 2022; McNeil et al., 2022). Due to higher rates of underlying illness among people who are unhoused the danger of becoming seriously ill from COVID-19 while obtaining illicit drugs or living in congregate settings posed a particular threat (Huggett et al., 2021). Moreover, complying with self-isolation requirements produced further risks of complications from withdrawals for those with heavy substance use patterns (British Columbia Centre on Substance Use [BCCSU], 2020). It’s throughout these interconnected emergencies that a policy window opened and the BC government released their Risk-Mitigation Guidelines (RMG), allowing for the scale-up of prescribed pharmaceutical alternatives to illicit drugs – i.e., a *safe supply* (BCCSU, 2020).

Over a century after Canada first legislated opiate prohibition, drug policy is being driven by decades of community organizing and compounding crises towards a new approach. Alongside moves to decriminalize the personal possession of small amounts of some illicit drugs, the province of British Columbia has also released a policy direction supporting prescribed safer supply beyond the context of the COVID-19 pandemic (MMHA, 2021a). Implicit in this shift is an understanding by many that policies criminalizing, stigmatizing, and excluding PWUD have contributed to the toxic illicit drug crisis (MMHA, 2021b). PWUD that are unhoused have been especially victimized, and

for them the harm reduction adage of 'meeting people where they're at' is especially prescient and challenging (Kerman et al., 2021; Ferguson et al., 2022). Unhoused populations must clear multiple hurdles and overcome intersecting systems of oppression and marginalization to access the life-saving drugs they need. By exploring the strengths and limitations of different safe supply models in the unhoused context policy makers can help ensure access to this life saving intervention for structurally vulnerable communities.

Chapter 2. Background

2.1.1. Indigenous Houselessness

For Indigenous peoples houselessness encompass not only a tangible lack of shelter, but also the displacement and dispossession from their land and culture as the result settler-colonialism (Bingham et al., 2019). The intergenerational cycle of trauma inflicted upon Indigenous communities through the residential school system, 60's scoop, and other genocidal policies administered through the *Indian Act*, all contributed to highly disproportionate rates of houselessness (Bingham et al., 2019). Indigenous peoples in Vancouver are 13.2 times more likely to become unhoused (BCNPHA, 2020). Research in Vancouver and Winnipeg found that compared to non-Indigenous community members, unhoused Indigenous peoples were more likely to lose housing at a younger age, for longer periods of time, and in conjunction with mental health conditions, substance-use related problems, and higher rates of health crises – particularly infectious diseases (Bingham et al., 2019).

2.1.2. Opioid Agonist Treatment (OAT) or Safe Supply?

OATs are a related intervention to safe supply primarily intended to prevent withdrawals, cravings, and overdose for PWUD that physicians have diagnoses as having an 'opioid use disorder' (OUD) (Young et al., 2022). While OATs like methadone, buprenorphine (suboxone), and injectable hydromorphone/diacetylmorphine (iOAT) similarly replace illicit drugs with pharmaceutical alternatives, they are *generally* applied as a treatment modality for OUD (Ontario Agency for Health Protection and Promotion [OAHPP], 2022). Safe supply on the other hand is not premised on ceasing or decreasing drug use (Klaire et al., 2022). At least in theory, safe supply should allow for the mind and body altering effects that people who use drugs seek to experience, while OAT is usually designed only to reduce cravings and prevent withdrawals (CAPUD, 2019; OAHPP, 2022). The basic idea is that for some, the expectation of moving towards abstinence risks redirection back to the illicit supply, which -in turn- increases the risk of overdose (McNeil et al., 2022). Prescribed safer supply as it currently exists is intended as an additional low-barrier intervention for whom OAT and other addiction recovery options are undesirable or ineffective (Giang et al., 2020; OAHPP, 2022).

2.1.3. From (i)OAT to Prescribed Safer Supply

In the summer of 2019 Health Canada announced \$25.2 million in funding through the federal Substance Use and Addictions Program for pilot projects that would increase access to pharmaceutical alternatives to the illicit drug supply (Health Canada, 2019a). Less than a year later COVID-19 prompted the federal government to issue a temporary S. 56 exemption from the CDSA to increase access to OAT, iOAT, and safe supply as a response to the pandemic (Selfridge et al., 2022). This came alongside the BC provincial government releasing “Risk Mitigation Guidelines” (RMGs) allowing physicians to prescribe some opioids, stimulants, and benzodiazepines to reduce dependence on the illicit supply and support isolation requirements (BCCSU, 2020). While a significant shift in policy, the implementation was lacking. From March 2020 – January 2021 just 3771 out of the estimated 100 000 people in BC with an OUD received prescribed opioids through the RMGs, while 1220 received pharmaceutical stimulants (MMHA, 2021a). These numbers also exclude those who sporadically use opioids and would not be considered to have an OUD. As well, a practice brief from Victoria’s SAFER implementation found that in many cases physicians framed RMG prescribing as withdrawal management rather than safe supply (Ranger et al., 2021).

However, in July of 2021 – five years after the declaration of a public health emergency related to illicit drug toxicity deaths – the province of BC officially severed their RMGs from the pandemic context and released a policy direction for “safer supply” (MMHA, 2021a). At the discretion of prescribers, individuals in BC can now be provided pharmaceutical alternatives to the toxic illicit drug supply outside a treatment context and without a diagnosed “substance use disorder” or simultaneous OAT requirement (MMHA, 2021a). As a phased approach, BC’s prescribed safer supply policy has first focused specifically on prescribing opioids already delivered through provincial and federal programs with an open-ended commitment to release a plan for stimulants beyond the RMGs at “a later date” (MMHA, 2021a, p.14).

Chapter 3. Literature Review

3.1. Overdose Among Unhoused Populations

A recent cohort study of over 60 000 adults experiencing houselessness in Boston Massachusetts found that the drug overdose mortality rate was 12 times higher than the general population and accounted for 1 in 4 deaths among people who are unhoused (Fine et al., 2022). In British Columbia, a 2017 study found that 30% of those who experienced an overdose reported unstable housing, and that those who lacked a fixed address were more likely to overdose repeatedly (Milaney et al., 2021). While illicit drug toxicity currently accounts for the 5th most common cause of death across BC (natural or unnatural), it has been the leading cause of morbidity among people who are unhoused since 2015, indicating substantial inequities compared to the broader population (BC Centre on Substance Use [BCCDC], 2022). In 2021, overdoses accounted for 79% of known deaths among people who are unhoused (BC Coroners Service, 2022a). While the proportion of deaths caused by toxic illicit drugs increased by 4% from 2020 – 2021, the absolute number of deaths jumped 75% in that year alone, driven by an unprecedented number of overall overdoses (BC Coroners Service, 2022a).

3.2. Emerging Evidence for Safe supply

3.2.1. Positive outcomes

As an emerging policy intervention, most prescribed safer supply programs have been implemented as pilot projects with limited capacity, and as such, there are few formal evaluations published at this time (OAHPP, 2022; Foreman-Mackay, 2022; Bonn et al., 2021). However, early evidence from the 18 prescribed safer supply programs currently operating across Canada found that participation led to:

- **Decreased use of illicit drugs** (McNeil et al., 2022; Ivsins et al., 2022; Ivsins et al., 2021; Ivsins et al., 2020; CATIE, 2023)
- **Improved health, well-being, and/or quality of life** (McNeil et al., 2022; Selfridge et al., 2022; Ivsins et al., 2021; Ivsins et al., 2020; Gomes et al., 2022; Ranger et al., 2021)
- **Spared health care costs** (Gomes et al., 2022).

- **Stabilized drug use patterns** (McNeil et al., 2022)
- **Better connections to health and social services** (Gomes et al., 2022; Ivsins et al., 2021; Ranger et al., 2021)
- **Greater economic security** (Ivsins et al., 2021)
- **Enhanced pain management** (Ivsins et al., 2021)
- **Fewer wounds/abscesses** (Ranger et al., 2021)
- **Reduced involvement in criminalized activities** (McNeil et al., 2022; Ivsins et al., 2022; Ranger et al., 2021).

Participants from a Vancouver tablet hydromorphone program reported finding respite from the grueling ‘hustle’ of daily criminalized and stigmatized income generation, while being able to re-direct money typically spent on illicit drugs for meeting other necessities like food, cell phones, or travel costs to visit their children (Ivsins et al., 2021). As well, those with drug debts were able to pay those down, decreasing their risk of experiencing violence or withdrawals when unable to pay drug dealers (Ivsins et al., 2021; Ivsins et al., 2022).

Most importantly, there have been no overdoses attributed to prescribed safer supply programs (McNeil et al., 2022; BC Coroners Service, 2022b; Gomes et al., 2022). While evidence also suggests that most participants continue to supplement their safe supply with illicit drugs, some participants in two studies reported an overall reduction in drug use, sometimes as the result of decreased binging (McNeil et al., 2022; Kolla et al., 2021). Participants also described how the known potency of prescribed drugs reduced their vulnerability to overdose (McNeil et al., 2022). As of 2021, fewer than 0.4% of participants in BC had died while accessing prescribed safer supply through risk mitigation guidelines, indicating a relatively low prevalence rate (Young et al., 2022). To be clear, those deaths were not attributed to taking prescribed drugs, but from the continued use of illicit supplies which McNeil et al. found occurred among 33/40 participants in their study (2022). The literature suggests this supplementation is incentivized by insufficient opioid dosages that do not account for high opioid tolerance levels and fail to reduce chronic pain or even prevent withdrawal symptoms (McNeil et al., 2022).

3.2.2. Barriers and facilitators to success

Facilitators

Early evaluations of prescribed safer supply programs in BC have underlined the importance of choice, agency, flexibility, and convenience for facilitating participant engagement (Ivsins et al., 2020). In practice, this means flexible clinic operating hours, choice over preferred drugs and consumption methods, appropriate dosages, co-prescription for other health issues, convenient locations to access prescriptions, and the ability to start or stop participation without penalty (Ivsins et al., 2020; Selfridge et al., 2022; Bonn et al., 2021). For some the co-location of dispensing sites within an overdose prevention site served as a convenient, social, and de-stigmatizing environment where those who required peer-assisted injection – oftentimes women – could access it (Ivsins et al., 2020; BCCSU, 2017). A scoping review prepared by Ontario Public Health identified door-to-door delivery, take-home dosages, the availability of prescribers, individualized treatments, avoiding denial of services through flexible accommodations, and sufficient infrastructure or human resources as further examples of facilitators for program success (Bonn et al., 2021).

Two thirds of participants accessing prescribed safer supply in Victoria continued on the program for 60 days, similar to short term retention rates for iOAT (Selfridge et al., 2022). Participants were most likely to adhere after 60 days if prescriptions were higher dosages, delivered to them, co-prescribed with mental health medications, and dispensed in tandem with continuous OAT (Selfridge et al., 2022). However, this association between the risk mitigation guidelines and OAT should not be extrapolated to suggest a causal link; those prescribed but not actively taking OAT also had low adherence rates to prescribed safer supply, likely as the result of the same external factors ending their participation to both (Selfridge et al., 2022).

Barriers

Conversely, things like limited hours of operation, insufficient dosages, and the prescription of generic hydromorphone vs. commonly used illicit opioids (particularly fentanyl) were identified as barriers to program engagement (Ivsins et al., 2020). Notably the co-location of prescribed safer supply programs within an overdose prevention site was found to also function as a barrier by requiring access through a single location

(Ivsins et al., 2020). As well, the at-times busy atmosphere of overdose prevention sites dissuaded some of those who were utilizing prescribed safer supply as a recovery mechanism from participating due to a discomfort with being around open drug consumption (Ivsins et al., 2020). Participants also pointed to the presence of police, requirements to provide urine samples, daily pharmacy visits, and witnessing of ingestion as examples of factors that would limit their access (Pauly et al., 2022).

Research from within a Vancouver supportive housing complex found that even with harm reduction services, safe consumption sites, and a prescribed safer supply program available on-site most participants reported using alone because of socio-structural factors such as a desire for discretion, avoiding stigma, restrictive guest policies, and trying to evade drug-sharing (Ivsins et al., 2022). As well, the lack of supervised smoking spaces in housing settings further increased the likelihood of using covertly, which magnifies risks in the current BC context where most overdose deaths currently occur from smoking (Lindsay, 2022). Therefore, having housing per se does not remove the risk of overdose, so long as socio-structural barriers to a sufficient safe supply persist (Ivsins et al., 2022).

3.2.3. Stakeholder and User Perspectives

As there are limited peer-reviewed studies on the outcomes of safe supply, perspectives from those delivering, designing, and potentially accessing these programs offer important insights (Bonn et al., 2021). Qualitative interviews exploring how PWUD and stakeholders (i.e. program managers, executive directors, healthcare providers, and health authority representatives) defined success found shared perspectives; both groups underlined the importance of choice, flexibility, and agency for PWUD (Pauly et al., 2022; Foreman-Mackey et al., 2022). On the program design side both groups identified facilitators like having appropriate doses, options for their preferred drug, control over consumption methods, longer-term prescription limits, flexible clinic hours, varied locations for pick-up, and access to integrated/wrap-around services as enabling success (Pauly et al., 2022; Foreman-Mackey, 2022). For PWUD, additional facilitators included 24/7 spaces for consumption, mental health supports, and access through a single window (Pauly et al., 2022). PWUD who were interviewed also sought to improve their daily functions, which meant the ability to manage chronic pain, feel 'normal' while

on their safe supply, and improve their quality of life as they defined it (Pauly et al., 2022).

In terms of delivery practices, PWUD highlighted having non-stigmatizing spaces, being trusted, and treated with respect by service providers, and the inclusion of peers and people with lived and living experience as important features of an ideal model (Pauly et al., 2022). For professional stakeholders, not living up to those expectations generated some hesitation, fearing that a failure to not listen or meet the needs and expectations of PWUD would cause further harm (Foreman-Mackey et al., 2022.) Additionally, local and meso level factors like connecting and collaborating with community, navigating precarious political landscapes, and restrictive guidance from provincial colleges of physicians were further considerations when designing safe supply programs (Foreman-Mackey et al., 2022). Other macro-level variables like the continued criminalization of possession in most jurisdictions and prevalence of stigma directed at PWUD were noted as barriers to expanding safe supply across the country (Foreman-Mackey et al., 2022).

Chapter 4. Methodology

This study explores the strengths and limitations of different safe supply models for unhoused PWUD. In particular, the unsheltered and emergency sheltered contexts are utilized as a scope through which to identify key criteria for evaluating models. The City of Vancouver is the primary geographic setting for this analysis and, where applicable, examples from comparable jurisdictions have been utilized.

4.1. Expert Interviews

To supplement the limited peer-reviewed literature on this emerging policy intervention, six qualitative expert interviews were conducted over Zoom throughout December 2022 and January 2023. Interview participants were selected based upon their professional experience related to safe supply, harm reduction programming, and/or delivering services to people who are unhoused. Known contacts were first e-mailed, and then further prospective participants were identified through a 'snowballing' recruitment technique.

Participants were sent a consent form prior to the interview date, which was either signed beforehand, or verbal consent was recorded prior to commencing interviews. Interviews lasted upwards of one hour in length, following which transcripts and audio were reviewed to pull out key themes. The interviews were facilitated by a semi-structured guide that posed questions on a variety of themes related to safe supply within the context of houselessness [see Appendix A]. This study, including its interview guide and consent form, received ethics approval from Simon Fraser University.

Interview participants were asked to focus their comments on the unhoused context and were then asked questions related to the appropriateness of BC government's goals and objectives for prescribed safer supply. Next, interviewees were asked to comment on the strengths/limitations of three models for safe supply, which were explained using language derived from the Canadian Association of People who Use Drugs (CAPUD) concept document: First, BC's prescriber model, then a non-prescribed supervised model, and finally a non-medical dispensary model. Participants were then asked questions comparing the strengths and limitations of these models for

reaching people who are unhoused. Lastly, participants were asked to expand on any missing models or aspects not covered by previous interview questions.

4.2. Multi-Criteria Policy Analysis

Four policy options were selected from CAPUD's widely *cited Safe Supply Concept Document* to represent a range of medical and non-medical models for safe supply (2019). Due to their limited real-world application, assumptions were made regarding several aspects of the models in order to ground the analysis (the limitations of which are described below). As well, this analysis is being conducted from the perspective of provincial and federal Canadian governments who are assumed to be in support of safe supply policies. As such, they are not included as explicit stakeholders within this study, however in a real-world scenario gaining their support would be fundamental. Criteria and measures were determined based on descriptions in the literature and six expert interviews who provided insights into the needs of unhoused PWUD when accessing harm reduction services. Criteria were then scored as 'poor', 'moderate', or 'good' for each policy option based on available research, interview perspectives, and intuitive projections grounded in real world examples.

4.3. Study Limitations

4.3.1. Respectful Omissions

A key objective of BC's prescribed safer supply model is to "ensure that prescribed safer supply is provided in a culturally safe manner that meets the needs of Indigenous peoples" (MMHA, 2021a, p.12). This is an important objective as Indigenous peoples are overrepresented in BC in both within illicit drug toxicity deaths and rates of houselessness (BCNPHA, 2020; BC Coroners Service Death Review Panel, 2022). As such, ensuring culturally relevant delivery of safe supply is a serious need, and ultimately one that can only be determined by Indigenous communities themselves. As a settler, a student, and uninvited guest on unceded Coast Salish territories, I recognize the burden that seeking direct input from Indigenous communities would place on them and the inability for me to develop the necessary relationships and trust in the short time of my project. It is, therefore, beyond my scope and positionality to incorporate Indigenous communities' perspectives into my analysis. As such, the key objective of

assessing whether a model is culturally safe and meets the needs of Indigenous peoples is not explored and respectfully omitted throughout this study.

4.3.2. Theoretical assumptions

Many aspects of the policy options explored in this work are presently theoretical in nature. In order to complete an analysis of non-existing policies, necessary assumptions have been made and described where relevant. As much as possible these assumptions are made based upon comparable programs or services or are based on reasonable extrapolations given the Vancouver context. In some cases, these assumptions may be based on generalizations that do not capture the many complexities of the issue or populations discussed. This analysis is not intended as a definite prescription, but rather a broad exploration and visioning of the unexplored possibilities that medical and non-medical safe supply options possess.

4.3.3. Narrow scope

Due to time and capacity limitations of this study as a student project, only six interviews were conducted. These likely represent a small fraction of the diverse opinions related to this contentious subject, and participants were not randomly selected. Further, as professional practitioners within safe supply and harm reduction spaces the opinions discussed should be interpreted as a reflection of some opinions of those closest to the subject rather than a comprehensive overview of stakeholder perspectives.

Chapter 5. Expert Interviews

This section discusses core themes derived from six one-hour interviews conducted with safe supply stakeholders throughout December 2022 and January 2023. Eligibility was determined based upon professional experience designing, delivering, and/or evaluating either safe supply programs or other services for people who are unhoused. Four participants currently worked out of Vancouver, one in Victoria, and one in Winnipeg. Participants had current and past experience in a variety of roles that included outreach, research, program design, nursing, and non-profit management.

5.1. Principle versus Practice

Interviewees were shown the following list of goals and objectives included within the MMHA's 2021 policy direction for prescribed safer supply:

- “Significantly decreasing the use of illicit drugs and reducing illicit drug toxicity injuries and deaths.
- Improving equitable access to prescribed safer supply while linking people to other health services and social supports.
- Ensure that prescribed safer supply is provided in a culturally safe manner that meets the needs of Indigenous peoples.
- Delivering services in a manner that respects the dignity and human rights of individuals who use drugs.
- Mitigating, as much as possible, the potential harms of prescribed safer supply for individuals and communities.” (MMHA, 2021, p. 12)

All participants felt that these goals, while appropriate in theory, were not being implemented in practice. Similar to findings from Gehring et al., interviewees expressed that their perspectives on safe supply were often in conflict with how the policy was applied by the provincial government. Of particular concern for most was the goal of equitable access, which two participants viewed as the most relevant for people who are unhoused; however, half of those interviewed stated that access was currently inequitable, particularly for Black and Indigenous peoples who have been marginalized by systemic racism within healthcare. One interviewee questioned whether many of the stated goals would be feasible due to the inherent barriers produced by accessing safe

supply through a prescriber. They instead suggested that goals could only be deemed appropriate only if they matched the desires of individual clients.

One participant with experience evaluating prescribed safer supply programs noted that none had been able to completely reduce reliance on the illicit drug supply, which another interviewee corroborated as the result of the limited drug options and formulations available. According to another interview participant, the goal of respecting the dignity and human rights of individuals who use drugs was not possible under the existing system which has normalized the idea that those accessing safe supply should be at or near 'rock bottom'; from their viewpoint respecting dignity and human rights would necessitate a cultural shift away from the belief that one must reach peak suffering before they are "deemed worthy of care" (Participant, #05).

5.2. Flexible Time Frames

An overarching theme across all interviews was the primacy of flexible, low-barrier access when delivering safe supply services to people who are unhoused. As one interviewee put it, "living being homeless is like a full-time job" (Participant #04).

"We've had participants who have woken up in the morning with Bylaw standing over top of them ... throwing their tents, throwing their supplies out, and of course they're not going to be able to make it into the clinic and get their safe supply that day, because their life has been turned upside down." (Participant #06)

As such, all interviewees mentioned flexible or 'atypical' time frames as a core need of people without housing when accessing safe supply. One participant described this as "authentic, client-centered driven care", as opposed to "clinician-centered" care, which is reflected by daytime operating hours suited for the schedules of providers (Participant #05). For those needing to get on wait lists for shelter beds or engage in the relentless 'hustle' to find money and drugs to hold-off withdrawals, reduced hours translated into limited access of safe supply and a redirection toward toxic illicit drugs. Because of the unpredictable experiences associated with being unhoused, some may also miss their medical appointments, which one participant noted should be accounted for in a non-punitive way. Overall, the goal when delivering safe supply should be "access that maps peoples experiences", of which flexible time frames are a key component according to interview participants (Participant #03).

5.3. Distrust in the Medical System

Another core theme among interviewees was the inherent barriers created by medicalized models for many unhoused community members who have faced stigma and discrimination within the healthcare system.

“There's so much you know racism, and stigma, and differential treatment in the health care system that just even accessing it is kind of a form of violence towards folks, especially for marginalized communities” (Participant #01)

“We literally have a [health authority] access center - which is supposed to be their low barrier access for folks [to] access health care – across the street from shelter and folks won't cross the street. They'll stay in shelter until, you know, their physical health deteriorates to the point where we're calling ambulances, because they don't trust the system”. (Participant #01)

The physician-client power dynamic, and the paternalism it can perpetuate, was cited by two participants as an obstacle to overcoming this mistrust. For another, it was less about the prescriber themselves rather than the clinical setting that kept some away. A noted effect of that unequal relationship can be an unwillingness to be forthcoming with prescribers about their drug use, which poses logistical issues for establishing appropriate dosages. One participant viewed redirecting people from institutional and clinical settings into community spaces as a way of building trust and suggested that community organizations could operate as a buffer for doing so.

5.4. Initiation and ‘Diversion’

When asked about potential unintended consequences of providing safe supply, most participants discussed an often-cited concern that drugs from prescriber programs could be ‘diverted’ to the general public and/or those who otherwise would not use drugs. Most interviewees were clear that ‘diversion’ to those who otherwise *would* be relying on the illicit drug supply did not constitute a negative consequence, and instead was a benefit from a population health perspective. While some interviewees thought that it is possible increasing access to safe supply could initiate drug use among some who otherwise wouldn't, this potential should ultimately be weighed against the high death toll mounting from the toxic illicit drug crisis.

“We're being very naïve if we're thinking replacing the unregulated drug supply with regulated drugs that are accessible to all will suddenly, you know, increase risk when the risk is already happening now before our eyes” (Participant #06)

“I think we can begin to hypothesize that there could be some people that have some overdoses or adverse effects, but then comparing them to what's happening right now, and the... amount of fatalities that are happening right now, like, is it?” (Participant #02)

“From a population-based health policy lens, I fucking promise you it would never come close to 6 humans dying a day in this province”. (Participant #05)

As one interviewee pointed out, ‘diversion’ is not an issue that is unique to safe supply programs; the same drugs given through prescribed safer supply programs are commonly provided for a variety of other health conditions (i.e., hydromorphone for pain management or methylphenidate for ADHD). Ultimately, prescribers accept the risk of ‘diversion’ as a tradeoff between providing life-saving and enhancing drugs to those who need them and the potential for those being used outside a medical context.

“Regulation is a population health approach that acknowledges there may be a small amount of unintended harms that we need to work really hard to mitigate”. (Participant #06)

On the subject of initiating drug use among the opioid naïve, these were identified by interviewees as familiar unsubstantiated claims that are also made against other harm reduction interventions like needle exchanges, but never shown to materialize. Some solutions identified by interviewees for these risks were education and appropriate regulatory policies.

“I think that the harms of opiates, or any other medication in the community, it's just labeling and making sure that things are stored in safe ways, so that only people that need access to them have access to them” (Participant #02)

“Just make it boring, like, it's just there, and some people will access it and some people won't.” (Participant #02)

5.5. “There’s no such thing as a panacea” (Participant #05)

Echoing findings from Foreman-Mackey et al.’s interviews with stakeholders discussed in Section 3.3.3, a core theme across 5 interviews was the need for a variety of co-existing models of safe supply in order to meet the needs and desires of a diverse population (2022). In other words, “it’s going to take a plurality of modalities to intervene upon an issue that is not a singular issue” (Participant #05). This was reflected in what another participant was hearing on the ground from PWUD; in their experience no one model could be universally accessible, and so “the effective model is all of the models” (Participant #06). This range of options would allow for a more equitable approach, which a cure-all method could not achieve because “when we talk about panacea, we end up alienating one group or the other and, more often than not, the group that we alienate are not people who occupy privilege” (Participant #05).

Challenging the binary of ‘prescribed versus non-prescribed’ models, one interviewee noted “de-medicalization is a spectrum, not an end point” (Participant #06). Another interview participant noted that non-prescriber models have the most room for creativity and expressed that some solutions could spring forward organically through practice. When considering alternative models, one interviewee disagreed with the tendency to rely on alcohol as a potential framework for other illicit substances. In their mind, if the goal is accessibility, tobacco would serve as a better example due to its 24/7 availability in various locations.

When asked to provide examples of ‘non-traditional’ spaces where safe supply could be made more accessible for people who are unhoused, participants had a range of ideas: drop-in centres, emergency shelters, convenience stores, pharmacies, food banks, online/ mail-order, outreach teams, emergency rooms, gas stations, or delivery through existing supervised consumption/overdose prevention infrastructure. One participant described the best location as one that aligns with where people without housing already need to go, like service centres, to avoid adding another stop in their day. MySafe vending machines, where people can access their prescribed safer supply on demand through biometric palm scans, were mentioned as a promising example by two participants. However, it was also noted that tying people’s prescriptions to a single machine limited their accessibility.

5.6. Key Takeaways

To the experts interviewed in this study the unequitable and insufficient implementation of prescribed safer supply in BC has failed to deliver for unhoused PWUD in large part due to inflexible time frames, insufficient dosages, and undesirable drug formulations. This ‘clinician-centered’ and prescriber-based system further alienates PWUD without housing from accessing safe supply as systemic racism and stigma within Canadian healthcare generates distrust between many physicians and unhoused clients. This lack of trust feeds into concerns from some physicians about the ‘diversion’ of prescribed drugs to those who have not been granted access by medical professionals. Among those interviewed, ‘diversion’ anxieties were seen as misguided and failing to appreciate the bigger picture of the toxic illicit drug crisis. As well, population level increases in opioid use could occur, the overall impact on public health and overdose mortality was thought to be minimal compared to an unregulated and increasingly toxic illicit supply. It was also suggested that negative externalities could be further managed by government through appropriate regulations, clear packaging, and public education. Overall, the shortcomings of existing prescribed programs were viewed by experts as further justification for the establishment of a variety of medical and non-medical models for safe supply that could be creatively delivered in non-traditional spaces to better meet the diverse needs of unhoused PWUD.

Chapter 6. Policy Options

In this section four medical and non-medical models of safe supply are described. Option 1 is a prescribed safer supply model similar to those currently being implemented across Canada, while options 2 – 4 are theoretical versions inspired by CAPUD’s 2019 Safe Supply Concept Document (2019). While there are few formal examples of options 2 – 4 to draw upon for analytical purposes, aspects of those models have been extrapolated from comparable programs or models for drugs where regulated safe supply currently exists (i.e., cannabis, alcohol, and tobacco). Accordingly, assumptions related to design aspects of those models are laid out in order to ground the analysis to baseline expectations.

6.1. Option 1: Prescribed Safer Supply Model

The first policy option explored represents the status-quo method of providing safe supply in Canada. As described in previous chapters, BC’s prescribed safe supply policy allows doctors to prescribe no-cost pharmaceutical grade alternatives of opioids and stimulants to those deemed to be at an elevated risk of a drug toxicity event. In this model, access to safe supply is at the discretion of prescribers, and drugs are medicalized variations – primarily tablet hydromorphone, and more recently, fentanyl – whose availability is determined by individual programs and costs are covered through Pharmacare (MMHA, 2021a). While eligibility criteria are meant to be a low barrier, in practice entry has been restricted by some programs due to limited capacity (McMurphy & Palmer, 2022).

While processes are evolving and vary across programs, this analysis will rely on examples such as the Safer Alternatives for Emergency Response (SAFER) program operating since April 2021 through PHS Community Services in the Downtown Eastside Vancouver (Klaire et al., 2022). Eligibility is determined by physicians, and custom dosage protocols are established alongside nursing staff through either a fixed dose or titration process (Klaire et al., 2022). Medical grade drugs like hydromorphone and fentanyl are available in injectable, sublingual, oral, and transdermal formulations, and are dispensed at an onsite clinic during normal operating hours (Laupacis, 2022).

6.2. Option 2: Unprescribed-Supervised Model

In this model, drugs are dispensed without prescription and administered in a supervised setting under the care of health professionals and/or peer workers (CAPUD, 2019). This option would serve to deliver safe supply to unhoused PWUD as supervised consumption services are often accessed by those who are unhoused or precariously housed, and in Vancouver are exclusively located in either Downtown or the Downtown Eastside (BCCSU, 2017; Pivot Legal Society, 2021). For the purpose of this analysis, it is assumed that these programs would offer limited medicalized drug options procured by a non-profit run supervised consumption site operating under federal exemption and with funding from local health authorities. Due to the lack of prescription, it's also assumed that drugs would not be covered by Pharmacare, and consumption would always be required on site. The establishment of these sites could follow a similar complex process to those for fixed stand-alone SCSs, where a federal exemption to *the Controlled Drugs and Substances Act* (CDSA) is required, provincial funding is often necessary, and sites must comply with municipal zoning bylaws (Manson-Singer & Allin, 2020; BCCSU, 2017). Accessibility would be limited to within operating hours, and access to the supervised consumption space would be controlled by staff and pre-determined policies laid out in the S.56(1) exemption application (Manson-Singer & Allin, 2020). For the purpose of this analysis, the operational guidance laid out by the BCSSU will be extrapolated as applying to this model (BCCSU, 2017).

This option could be similar to programs like the Molson's where hydromorphone tablets are distributed by nurses through a sliding window (Ivsins et al., 2020). PHS also has an applicable program where participants can purchase powdered fentanyl at the relatively low cost of \$10/ tenth of a gram for use through injection, smoking, snorting, or oral consumption (Wyton, 2022). For the purpose of this analysis, it's assumed that prices would be kept intentionally low in order to undercut the illicit market. It can also be expected that policies to prevent overdose from exceeding individual tolerance would be in place, and that limitations similar to those at the Molson would restrict how many doses are dispensed per hour /day to prevent running out of supplies (Ivsins et al., 2020).

6.3. Option 3: Compassion Club Model

Inspired by the cannabis and HIV medication compassion/buyer clubs of the 1980's and 90's, this model involves individuals collectively organizing in democratically controlled clubs to purchase bulk supplies of illicit drugs which are then tested, labelled, and distributed for sale to members without generating a profit (BCCSU, 2019; Drug User Liberation Front [DULF], 2022). This policy option has the potential to reach unhoused PWUD because clubs are administered through local organizations of PWUD such as VANDU whose membership is comprised of many people without housing (Jozaghi et al., 2018). As well, this option can further benefit unhoused PWUD through their ability to pool the buying power of members and bring down prices through economies of scale (BCCSU, 2019). Additionally, drug costs can be subsidized by club membership fees, fundraising, or parallel revenue streams in order to distribute supplies on a sliding scale to ensure equitable access for low-income members (BCCSU, 2019; DULF, 2022). For the purpose of this analysis, compassion clubs are assumed to run entirely independent of government bodies or public funding.

In 2021, the Drug User Liberation Front (DULF) and Vancouver Area Network of Drug Users (VANDU) – with the endorsement of Vancouver City Council - submitted a request to Health Canada for a S.56(1) exemption to establish their own club (Kulkarni, 2021). However, in the absence of that exemption, the groups have proceeded with a pilot program that involves procuring illicit drugs from the 'darknet' and double testing them: once in house, and then again by a third-party laboratory using more precise methods (DULF, 2022). Once confirmed, the safe supply is clearly packaged, sealed, and labelled before being stored in a secure fulfillment centre managed by hired staff (DULF, 2022).

In this non-medical model, access to safe supply is determined by club membership status which is granted through local organizations of PWUD who internally screen members for eligibility (DULF, 2022). All logistical aspects of procuring, testing, measuring, packaging, and storing drugs occur through a DULF fulfillment centre at an undisclosed location in the Downtown Eastside; compassion clubs formed through local organizations then operate as a point-of-contact and distributor for their members to access drugs on their own schedule (DULF, 2022).

6.4. Option 4: Dispensary Model

In this non-medical model drugs would be available for purchase without prescription in dispensaries and shops (CAPUD, 2019). This model has the least barriers to access of all policy options explored in this study, and therefore would reach unhoused PWUD by providing safe supply without the prerequisites of prescriptions, healthcare monitoring, supervised consumption, or compassion club membership. This option could operate similar to cannabis, alcohol, and tobacco dispensaries where customers are restricted by age, consumption must occur off-site, purchasing limits are relatively large, and sales are at the discretion of staff based on provincial regulations and storefront policies. Limitations on the overall strength of individual products would exist, such as with cannabis edibles where each package is limited to 10mg of THC (Shanahan & Cyrenne, 2021). While it's assumed that purchasing and possession limits would also be in place, for the sake of analysis, it's assumed that those amounts would be well over the average threshold of consumers, allowing for a multi-day supply, as is the case with cannabis' 30-gram limit (British Columbia, n.d.). Customers would be asked to provide government-issued identification in order to make a purchase, however this would be in order to verify age rather than record personal information or track purchases.

Using the example of Canada's *Cannabis Act*, the federal government would have "primary responsibility for production, cultivation, processing, analytical testing, licensing, medical sales, advertising and marketing restrictions, labelling and health warnings, and shared taxation authority" (Hammond et al., 2020, p. 1). Meanwhile provincial governments would have control over retail sale regulations, the ability to increase minimum purchasing age, decrease possession thresholds, and put limit personal cultivation and zoning laws (Hammond et al., 2020). For the purpose of this analysis, dispensaries would be publicly owned and operated, and sell variations from regulated legal sources. As such, it is assumed that drug formulations would be pharmaceutical versions of drugs in a variety of formulations, and unregulated/illicit versions, or exceptionally high concentrations like fentanyl, would remain criminalized (as is the case with cannabis and alcohol).

As a publicly owned market, prices could be controlled through different mechanisms under the government's purview, like supply-side controls and taxation

(Emerson & Haden, 2021). While the goal of this intervention is to undercut the illicit market, it is assumed that the government would aim to keep prices comparable to the illicit market. However, evidence from the legalization of cannabis has illustrated that this is not easily achieved due to how taxes and state regulations inflate prices (Childs & Stevens, 2021). Therefore, it is assumed within this analysis that prices would be higher than the illicit market.

Chapter 7. Criteria and Measures

This section lays out the criteria and measures through which the four previously described policy options will be evaluated. While many aspects of what makes an effective safe supply model will be the same for both people who are unhoused and the general public, maintaining low-threshold access, autonomy, and flexibility are particularly crucial for meeting people who are unhoused where they're at (Canham et al., 2019). For this reason, these criteria have been selected based on evidence from the published literature and expert interviews that demonstrates the salience of these considerations for providing low-barrier access to people who are unhoused. As well, considerations related to stakeholder acceptance, administrative feasibility, and cost to government are included due to the political and economic reality that issues posed from any of those factors would likely jeopardize implementation.

7.1. Objective: Significantly decrease the use of illicit drugs to reduce illicit drug toxicity injuries and deaths.

A core objective of safe supply is to reduce illicit drug toxicity injuries and deaths (MMHA, 2021). As the source of increased overdoses is the contamination of the illicit drug supply, significantly decreasing the use of *illicit* drugs is the mechanism through which to reduce illicit drug toxicity injuries and deaths. Therefore, measuring a model's ability to meet this objective will depend on how it enables unhoused PWUD to end their reliance on the illicit supply. Criteria from 7.1.1 to 7.1.6 have been selected based on what interviewees and the literature describe as key considerations when seeking to enable access to safe supply for people who are unhoused. The failure of a model to deliver on any of those criteria risks redirecting participants to the toxic illicit drug supply, and there increase the potential for overdose.

7.1.1. Sufficient dosages

This criterion measures whether a safe supply model can meet an appropriate opioid dosage threshold, as defined by PWUD. Research from BC's prescribed safer supply has shown that when programs do not supply appropriate dosages participants are more likely to supplement their safe supply with illicit drugs (McNeil et al., 2022;

Ivsins et al., 2020). Research has found that higher daily maximum dosages is correlated with participants staying on safe supply programs (Selfridge et al., 2022). As well, research indicates that ‘diversion’ – the displacement of prescribed drugs to those they are not intended for – often occurs as the partial result of insufficient dosages (Ranger et al., 2021; McMurchy & Palmer, 2022). Interviews with professional stakeholders involved in designing, implementing, and/or operating safe supply programs indicated that prescribers have not been able to keep up with progressively increasing tolerance levels due to an increasingly potent illicit drug supply (Foreman-Mackey et al., 2022).

The ability of a model to meet this criterion will be measured by the extent that participants can receive sufficient and frequent enough dosages to meet their threshold for preventing withdrawals, relieve chronic pain, and – for many – experience psychoactive effects (McNeil et al., 2022; Selfridge et al., 2022; Pauly et al., 2022; Ivsins et al., 2020). However, for others the right dose could also mean something near equilibrium where they maintain a sense of normalcy and ability to function (Pauly et al., 2022). As what qualifies as a sufficient dose will vary, dosages should be individualized to the patient (Selfridge et al., 2022). Models that allow for customized dosages that can go high enough to meet the desires of all PWUD will be scored good in this regard.

7.1.2. Preferred drug and consumption method

This criterion speaks to two interrelated factors: whether participants are able to choose their preferred drug, and whether that drug comes in a formulation that allows for their ideal consumption method. Some commonly prescribed opioids like hydromorphone - particularly the generic version utilized during a time of supply chain shortages - are not preferred by participants or ideal for injection use (Ivsins et al., 2020; McMurchy & Palmer, 2022). Alongside insufficient dosages, the inadequacy of drug formulations have been linked to ‘diversion’ (Ranger et al., 2021; McMurchy & Palmer et al., 2022). Accordingly, this criterion will also function as a measure for this possibility.

The 2019 Harm Reduction Client Survey found that only 2.7% of respondents who indicated an opioid preference chose hydromorphone as their ideal version (Ferguson et al., 2022). Heroin was preferred by most respondents (57.8%), followed by fentanyl (32.8%); morphine, oxycodone, hydromorphone, methadone, and suboxone all

polled below 3% as a preferred drug option (Ferguson et al., 2022). As well, the 2021 Harm Reduction Client Survey found that 59% of respondents in Vancouver Coastal Health identified smoking or inhalation as their preferred consumption method (BC Centre for Disease Control [BCCDC], 2021). Therefore, the ability to smoke opioids like heroin and fentanyl would facilitate program engagement, and better meet the desires of participants (Pauly et al., 2022; Ivsins et al., 2022). Safe supply models that can provide for more drug options and methods of consumption will score good for this criterion.

7.1.3. Hours of operation

The ability of PWUD to obtain their drugs on demand is highly dependent on the operational hours of where the drugs are distributed (Pauly et al., 2022; Ivsins et al., 2020; Foreman-Mackey et al., 2022). Some unstably housed participants in the Molson's hydromorphone safe supply program reported being unable to fully participate because of the inflexible schedule and limited clinic operating hours (Ivsins et al., 2020). In particular, the clinic's 1:30pm opening time meant some would risk going into withdrawals in the mornings and need to use illicit supply just to make it to the clinic (Ivsins et al., 2020). As well, the limited hours made it challenging for anyone to utilize the program to its fully potential of 5 distributions per day (Ivsins et al., 2020). As discussed in Chapter 5.2, 'atypical' and 'flexible' hours of operation were identified by interviewees as a key need for people who are unhoused. Models will score good for this criterion if drugs are available for more hours in the day.

7.1.4. Number and geographic distribution of access sites

Research indicates that the number and geographic distribution of places for accessing safe supply also matter for PWUD (Pauly et al., 2022). In the Vancouver context existing prescribed safer supply programs operate out of either the DTES or Downtown South, which creates some benefits for many experiencing housing instabilities who reside either in or nearby those neighbourhoods (COV, 2021). However, interviewees also noted that this concentration within a few neighbourhoods limited access for those who do not reside in those neighbourhoods. As well, the reason many unstably housed people reside in the DTES is the result of processes of economic and social marginalization and dislocation (i.e. gentrification) which have structurally limited neighbourhoods where low-income PWUD and unhoused communities can exist in

Vancouver (Barnes & Hutton, 2009; Burnett, 2014). Therefore, scoring good for this criterion will mean that a model could provide for more access sites across the city, thus limiting the distance that people who are unhoused need to travel to access distribution sites.

7.1.5. Upfront Cost

This criterion measures the upfront cost that an individual must pay to obtain their safe supply. The provision of no-cost safe supply through prescribed safer supply was identified as beneficial for participants because of how it reduced reliance on criminalized forms of income generation, which also decreased the risk of experiencing violence (McNeil et al., 2022; Ivsins et al., 2022). By removing the need to obtain money for illicit drugs participants were also able to avoid being caught up in ‘the hustle’ of finding enough money to avoid withdrawal sickness or payday debts (Ivsins et al., 2020). As well, no-cost options were found to increase agency over drug use which also allowed for more stabilized patterns of use, at times reducing their overall use through the lessening of bingeing (McNeil et al., 2022).

For models with upfront costs, the ability to reduce reliance on illicit drugs will also depend on to what extent they can undercut prices within the illicit market (CAPUD, 2019). PiT counts in Vancouver found that 76% relied on income assistance, and 44% relied on binning, panhandling, and or vending for their income; for most any cost savings could go a long way (COV, 2020). For those reasons, models with less or no upfront costs will be scored good.

7.1.6. Privacy and Control Over Personal Data

The privacy of participants is an important consideration when providing low-threshold services to groups who often face criminalization, discrimination, and stigma (Michaud et al., 2022). There are many examples of surveillance practices within harm reduction services like ID requirements, urine analysis, data collection, observed use from nurses, prescription monitoring by physicians, biometrics, and lateral surveillance from peers or frontline workers (Michaud et al., 2022; Pauly et al., 2022). For some within harm reduction fields these practices are viewed as trade-offs for government resources and the epidemiological tracking of health inequities (Michaud et al., 2022).

However, research from Alberta found that only 36% of potential participants said they would still access a supervised consumption service if there were ID requirements (Michaud et al., 2022). Discretion also serves as a protector against the risk of child apprehension, policing, harassment, and loss of housing or employment as the result of being exposed as a person who uses drugs (Michaud et al., 2022). In the context of service delivery, the collection of personal data functions as a further barrier to unhoused PWUD; particularly for racially and economically marginalized communities who studies have revealed are less willing to accept surveillance measures (Michaud et al., 2022).

While Health Canada has created a system for unique identifiers comprised of a combination of name letters, birth year numbers, and sometimes postal codes, recent health data breaches from cyber-attacks and the ever-improving sophistication of technology have raised concerns about re-identification (Michaud et al., 2022). Therefore, models that limit personal data collection as much as possible will be scored good for ensuring equitable access to safe supply for structurally oppressed participants, such as those experiencing houselessness, who are in turn more likely to be Indigenous, Black, or racialized people (BCNPHA, 2020).

7.2. Population-level increase in opioid use

In the context of safe supply policies, a public health method is a “reality-based approach” that acknowledges both the potentially serious harms of opioid use - such as addiction or overdose death –alongside benefits like the management of physical, psychological, and emotional pain (Emerson & Haden, 2021). While the risks of opioid use are real, research has also shown that the majority of PWUD do so in a way that is “functional, self-regulated, episodic, and non-problematic” (Steinmetz & Kohek, 2022, p. 2). For this reason, a public health approach to drug regulation acknowledges that both the overly restrictive system of prohibition and, at times, highly promotive medical prescribing of opioids have each perpetuated significant health and social harms (Emerson & Haden, 2021). In this way, many of the risks associated with opioid use are not necessarily inherent to the drugs themselves, but the way that regulatory structures – alongside other economic and social determinants – produce and/or magnify the harms of their use (Emerson & Haden, 2021; Health Officers Council of British Columbia [HOCBC], 2011). The goal of this criterion is to measure how well a model can maximize

public health by controlling access, prices, and the quantity of drugs dispensed in order to balance somewhere between the boundaries of prohibition and active promotion (Henry, 2019).

As described in Chapter 5.5, the potential for safe supply to initiate greater levels of opioid use was mentioned by some interviewees as a potential negative externality, albeit one that should be managed and weighed against the escalating death toll from toxic illicit drugs. As well, interviews conducted among PWUD in Australia also revealed some concern among participants about the effects that a legal regulated drug market could have on public health, particularly for youth (Greer & Ritter, 2020). The concern that accessible safe supply may increase population-level opioid use exists in tension with this study's primary objective of decreasing overdose deaths, as demonstrated by evidence from the United States showing that reducing the quantity of prescribed opioids was positively correlated with increased illicit fentanyl deaths (Olfson et al., 2022). As well, while providing large quantities of opioids could increase population level use, not providing enough safe supply redirects PWUD to the toxic illicit market (McNeil et al., 2022; Ivsins et al., 2020). Indeed, a challenge for safe supply policies from a public health perspective is this trade-off between providing access to regulated drugs to prevent illicit drug toxicity deaths while not suddenly inundating communities with large amounts of low-cost opioids, which could be expected to produce its own health and social harms.

For government this equilibrium can be attempted through health-centered regulations like price controls and reasonable limitations on availability and quantity (HOCBC, 2011; Crépault et al., 2023; Emerson & Haden, 2021). In order to redirect PWUD to a regulated safe supply, prices must be lesser or equal to those on the illicit market, while not so low as to incentivize re-selling or excessive use patterns (Emerson & Haden, 2021). In that way this criterion can also function as a measure for the potential of 'diverting' drugs outside of regulatory controls (i.e., to those without prescriptions under prescriber models, or to those under 19 in non-medical models). Models that can best reach stability between access and restriction will be rated good, while those that overly constrain access, potentially dispense unreasonably large quantities of opioids, or feature prices that could incentivize excessive use or diversion outside of public health regulations will be scored poorly.

7.3. Administrative Complexity

This criterion will be used to explore the complexity of implementing different models of safe supply. This will be measured by the level of macro policy changes required (i.e. amendments or exemptions from the CDSA), and additional infrastructure required to put a model into practice. Models that are easier to implement will be rated good, and those with more complexities will be rated poor.

7.4. Cost to Government

While some models of safe supply are able to generate their own revenue, and some existing prescribed programs have been shown to provide significant downstream cost-savings, their initial creation will be determined largely by the amount of up-front public monies required for its implementation and operation (Gomes et al., 2022). Models that require high up-front cost to government will be rated poor in this regard, while those that need less will be rated good.

7.5. Stakeholder Acceptance

A practical reality of Canadian democracy is that policies and programs can be jeopardized by sustained stakeholder backlash. At the time of writing, safe supply programs are facing criticism and dismissal by Official Opposition and Conservative Party of Canada leader Pierre Poilievre, whose viral video from C.R.A.B. Park has been widely shared online (Wright, 2022). With this disapproval from a major political party in mind, the following sub-criteria will gauge whether non-governmental stakeholders could foreseeably organize against a particular model and pressure allied political actors to block or repeal its implementation. The following analysis will be interpreted from the perspective of the Canadian government, and it is assumed that their support for these policy options has already been achieved, and that federal exemptions to S.56(1) of the *Controlled Drugs and Substances Act* have been granted where necessary.

7.5.1. Vancouver Police Department (VPD)

As the enforcers of drug prohibition, police play a crucial role in the potential realization of safe supply policies. While stances vary across jurisdictions, the VPD have

often stated their formal support for focusing on substance use as a health, rather than criminal justice issue (Shum, 2021). It should be cautioned that this logic may not extend to the behaviour of individual officers, whose discretionary powers are often applied differently in practice. Instead, this criterion will gauge formal support among the VPD at an institutional level.

The VPD endorse “a four pillars approach” to drug policy, which includes harm reduction, prevention, treatment, and enforcement (VPD, 2008). As part of that policy, they assert that prevention is the most important component (VPD, 2008). VPD representatives are also members of the Vancouver Community Action Team, which helped to draft the City’s approved Safe Supply Statement, and which advocates for the policy’s implementation (Spearn & Gill, 2019). From these statements one can infer a general but limited support for safe supply as a harm reduction approach.

In 2021, DULF and VANDU led a drug distribution protest where pre-tested and packaged drugs were handed out for free as an act of civil disobedience (Shum, 2021). Following a public complaint over the involvement of then city councillor Jean Swanson, the VPD released a report to the Vancouver Police Board where they reaffirmed their general endorsement of harm reduction approaches, support for decriminalizing small amounts of illicit drugs for personal use, and continued enforcement of drug trafficking laws (Shum, 2021). Key to their non-enforcement at the protest was the lack of profit motivation and DULF/VANDU’s disassociation with organized crime (Shum, 2021). However, they also noted that should a distributed sample test positive for “lethal levels of fentanyl”, they would “effect an arrest” (Shum, 2021, p. 4).

From these statements and precedent, it can be inferred that the VPD’s official support would extend to models where the profit motives and the potential for trafficking is minimal. In other words, market-based models like dispensaries are thought to score poorly while medicalized models will be scored as good.

7.5.2. General Public

Recent peer-reviewed research found that 63.5% and 56.3% of respondents in Alberta and Saskatchewan, respectively, supported the statement: “to address substance use and addiction issues, the Alberta/Saskatchewan government should:

support safer supply programs that replace illegal street drugs with pharmaceutical alternatives for those unable to stop using.” (Morris et al., 2023, pp. 3-4). Support was strongly correlated with political ideology, with agreement strongest among the “far left” (91.7%) and “centre left” (80.2%); however, a slim majority of support was also found among “centre” (54%) and “centre right” (50.3%) respondents, with support even reaching 45.3% among the “far right” in these provinces (Morris et al., 2023). Through extrapolation it is assumed that support in Vancouver could be even higher compared to Alberta and Saskatchewan due to the relatively higher support for centre-left parties in the lower mainland.

Further peer-reviewed research on public support for harm reduction approaches found that two thirds of Canadians were generally supportive of these policies, however low-threshold opioid agonist therapies and safe inhalation interventions polled below 50% (Wild et al., 2021). Notably, a belief in the ‘disease model’ – where addiction is viewed as a chronic brain disorder - correlated with stigmatizing views of PWUD and low support for harm reduction services (Wild et al., 2021). Another recent poll found that 48% supported rolling back SCSs in order to put more funding into treatment-based approaches (Bailey, 2022). Therefore, it can be assumed that those opposing safe supply programs likely do so out of concerns related to ‘enabling’ substance use, which is viewed as a disease in need of treatment (Wild et al., 2021). From these observations, medicalized models that hold more potential for connections to treatment will be less likely to experience public backlash and scored good, while those allowing for self-regulated drug use outside a medical context will be scored poor.

7.5.3. PWUD

As laid out in Section 3.3.3, the perspectives of what makes a successful safe supply model according to PWUD centered around agency, choice, flexibility, trust, respect, and ease of access (Pauly et al., 2022). The VANDU and DULF are two examples of grassroots organizations of PWUD in the lower mainland who advocate for policies from the perspective of their members. DULF and VANDU are critical of medical systems of safe supply, which they characterize as ineffective due to medicalization reducing uptake, prescriber hesitancy, and the harms of labelling PWUD as having a “substance use disorder” (DULF, 2022, p.6). In their 2021 S. 56(1) exemption request application, the two organizations agree with Health Canada’s Task Force on Substance

Use who call for a variety of programs to address the current crisis (DULF, 2022). As well, they point to a lack of any peer-led safe supply programs as a persistent gap in existing programming (DULF, 2022). Based upon these statements and the qualitative research outlined in Chapter 3.3.3, models with the lowest barrier of access and involvement of peers will be scored good, while more restrictive and medicalized models where PWUD play a passive role will be rated poor.

Objective	Criteria	Definition	Measure(s)	Data Source	Evaluation Metric
Key Objective: Significantly decrease the use of illicit drugs to reduce illicit drug toxicity injuries and deaths.	Sufficient Dosages	Degree to which safer supply drugs meet the demand from PWUD.	Ability for PWUD to obtain adequate dosages.	Qualitative research of PWUD.	More control over dosages = better Less control over dosages = worse.
	Preferred drug and consumption method	Ability for participants to choose their preferred drug and method of injection.	The number of drug options and formulations available.	Program design	More options = better Less options = worse
	Hours of operation	Amount of the time during the day that safer supply is accessible.	Hours in a day that drugs can be obtained.	Program design	Lower # = worse Higher # = better
	Access sites	Number and geographic distribution of places a participant can access their safer supply	Number of dispensing sites	Program design	Lower # = worse Higher # = better
			Number of neighbourhoods dispensing sites are located in.		Lower # = worse Higher # = better
Upfront cost	Out-of-pocket expense of receiving safer supply.	The price of drugs for PWUD	Program design	Lower price = better Higher price = worse	

Objective	Criteria	Definition	Measure(s)	Data Source	Evaluation Metric
	Privacy and control over personal data	Amount of personal data collected as part of accessing safer supply.	Intake forms, ID requirements, monitoring protocols.	Program design	Less data = better access to safer supply More data = less access to safer supply
Public health	Population-level increase in opioid use.	Potential to drive population-level increases in opioid use	Extent of restrictions on who can access safe supply.	Program design	Higher control = worse Lower control = worse
			Potential quantity of drugs dispensed.		Higher quantity = worse Lower quantity = better
			Price controls on drugs		Higher prices = better Lower prices = Worse

Objective	Criteria	Definition	Measure(s)	Data Source	Evaluation Metric
Administrative complexity	Ease of implementation	Complexity of developing and delivering a model.	Amount of new infrastructure required		More infrastructure/exemptions = worse Less infrastructure/exemptions = better
Cost to government	Upfront public investment required.	Amount of government money required to finance safer supply model's establishment and operations.	Amount of public money required to provide programs.	Comparable programs.	High upfront investment = worse Low upfront investment = better
Stakeholder Acceptance	Vancouver Police Department (VPD)	Potential of formal opposition from the VPD.	Degree that a model generates profit	VPD public statements and documents	More profit motive = worse Less profit motive = better
			Potential for trafficking/'diversion'.		More potential = worse Less potential = better

Objective	Criteria	Definition	Measure(s)	Data Source	Evaluation Metric
	General Public	Risk of public backlash from implementing safer supply models.	Proximity to medicalized and/or treatment-oriented approaches.	Qualitative research into public opinions on harm reduction.	More medicalized = better Less medicalized = worse
	PWUD	Level of support for each model among advocacy organizations representing PWUD	Involvement of peers.	VANDU/ DULF documents	More involvement = better Less involvement = worse
			Barriers to access		Higher barriers = worse Lower = better

Chapter 8. Policy Evaluations

In this section, the policy options laid out in Chapter 6 are rated good (green), moderate (orange), or poor (red), based on the criteria and measures described in Chapter 7. These ratings have been assigned in comparison to the other policy options, not necessarily as a prescription of the inherent features of any one model. It is possible that each model could be designed in a way to better meet these criteria. However, based on the assumptions laid out in Chapter 6, these evaluations are meant to generally illustrate the strengths and limitations of different approaches for providing safe supply to unhoused PWUD.

8.1. Policy Option 1: Prescribed Safer Supply

Criteria	Measure	Evaluation
Sufficient Dosage	Ability for PWUD to obtain adequate dosages.	POOR
Preferred drug and consumption method	Number of drug options and formulations available.	POOR
Hours of operation	Hours in a day that drugs can be obtained.	POOR
Access sites	Number and geographic distribution of places a participant can access their safer supply	MODERATE
Upfront cost	Price of drugs for PWUD	GOOD
Privacy and control of personal data	Amount of personal data collected as part of accessing safer supply.	POOR
Population level increase in opioid use.	Potential to drive population-level increases in opioid use.	MODERATE

Administrative complexity	The burden of implementing a particular model of safe supply.	GOOD
Cost to government	Amount of public investment required.	POOR
Stakeholder Acceptance	VPD	GOOD
	General Public	GOOD
	PWUD	MODERATE

8.1.1. Sufficient Dosage

For its ability to deliver sufficient dosages, prescribed safer supply received a rating of poor. Compared to the following three policy options, prescribed safer supply represents the most controlled when it comes to dosages (McMurchy & Palmer, 2022). These programs generally allow for flexibility in starting dosages and titration schedules, which are developed alongside participants, however the whole process is overseen and ultimately approved by either a physician or nurses who are constrained by external factors like provincial guidance and best practices (McMurchy & Palmer, 2022). Insufficient dosages – particularly regarding hydromorphone - were mentioned by three interviewees, as well as in several evaluations (McNeil et al., 2022; Ivsins et al., 2020; McMurchy & Palmer, 2022). One interviewee also described how some prescribers lacked real world knowledge about the common tolerance levels among PWUD. While dosage practices are evolving over time, this issue is entirely bypassed by non-medical models, and so prescribed safer supply still functions relatively poorly for this criterion.

8.1.2. Preferred drug and consumption method

On the question of preferred drug choice, prescribed safer supply received a rating of poor. Most programs currently dispense tablet hydromorphone alongside a supplementary slow-release methadone, Kadian, or suboxone 'backbone' (McMurchy & Palmer, 2022). Hydromorphone tablets have been reported as insufficient by published

research, this study's interviewees, and a Health Canada funded evaluation (Pauly et al, 2022; Ferguson et al., 2022; McMurchy & Palmer, 2022). While the Ministry of Mental Health and Addiction's *Prescribed Safer Supply Policy Directive* references the possible inclusion of 'other [substances] determined by programs', diacetylmorphine (heroin) is not explicitly mentioned as an option outside of iOAT treatments at this stage (MMHA, 2021; Ferguson, et al., 2022). More recently, fentanyl (a more preferred drug among youth, daily drug users, and people who were unhoused) has become available through some prescribed safer supply programs in transdermal, sublingual, injectable, and sometimes smokable forms (Ivsins et al., 2022; Ferguson et al., 2022; Klaire et al., 2022). However, the lack of widely available prescribed options for heroin, fentanyl, cocaine, smokeable opioids, and injectable stimulants (among others) are persistent limitations of prescribed safer supply (McMurchy & Palmer, 2022). Like one interviewee described,

“As a nurse I can remember I would give out oral stimulants and people just wouldn't even take them ... they don't work for people. So they would get their stimulants on the street and then come and get their [prescribed] opioids” (Participant #02).

The rating of poor is a result of the fundamental limitations of medicalized models to deliver options due to “the regulatory environment, coverage by provincial formularies, and supply interruptions” (McMurchy & Palmer, 2022, p. 75).

8.1.3. Hours of operation

For this criterion prescribed safer supply was rated poor. As mentioned earlier, having flexible hours to access drugs was identified as a central concern for people who are unhoused, and was explicitly mentioned as a weakness of prescribed safer supply by three interviewees. The struggle for unhoused participants to access the Molson's program due to the access site's restrictive schedules was also described as a limitation for those with mobility issues (Ivsins et al., 2020). As mentioned in Chapter 5.2, these limited hours are largely due to the work schedules of healthcare staff. Therefore, prescribed safer supply's inherent connection to prescriber/pharmacist schedules gives it a poor ability to reach participants outside of typical workday schedules.

8.1.4. Number and geographic distribution of access sites

For its ability to provide enough access sites to pick up prescribed safer supply, this policy was rated moderate. The need to frequently attend pharmacies/clinics is due to the limited quantities provided per visit, reduced take-away options for some options like fentanyl, witnessed-ingestion, and required urine analyses (CATIE, 2023). Broader health system capacity issues were also identified by three interviewees as a practical limitation of prescribed safer supply models as there are limited numbers of prescribers or pharmacists able to dispense drugs and perform monitoring tests when required. For instance, while delivery was initially a part of Victoria's SAFER program, this was later replaced with pharmacy/clinic pick-ups in order to redirect staffing capacity for clinic operations, except under COVID-related exceptions (CATIE, 2023). However, pick-up is offered at a neighborhood pharmacy of the participant's choosing, which provides relatively more flexible access (Ranger et al., 2021).

One interviewee explained that stringent CPS policies also restricted who can transport and deliver drugs prescribed through the program, further limiting delivery as a solution to these access issues. MySafe vending machines could be a work-around for limited access sites and operating hours, however one interviewee pointed out that individual prescriptions are still tied to one location, and another described a lack of machines as a continued barrier to implementation.

With these considerations in mind, prescribed safer supply receives a rating of moderate in comparison to the other policy options to acknowledge the existing barriers created by the prescriber-based system, while also recognizing that relatively more solutions to these issues exist compared to some of the following policy options.

8.1.5. Upfront cost

As drugs and related pharmacy costs are covered by Pharmacare, prescribed safer supply was rated good in this regard (MMHA, 2021a). The lack of out-of-pocket expense was identified by three interviewees as a strength of prescribed safer supply for people who are unhoused as it allowed for participants to avoid criminalized and/or dangerous income generation. While PHS' powdered fentanyl program does require participants purchase their safe supply, this is a novel example with prices set low to

undercut the illicit supply (Wyton, 2022). For this reason, prescribed safer supply is still rated good in comparison to the other policy options.

8.1.6. Privacy and control of personal data

prescribed safer supply was rated poor related to its large amounts of personal and biomedical information provided through the initial intake process and while picking up drugs. Urine analysis, witnessed dosing, extensive clinical charting, and monitoring for ‘diversion’ are all examples of surveillance practices in some programs that reduce autonomy (Michaud et al., 2022; McMurchy & Palmer, 2022). Lacking identification, particularly birth certificates, was identified by two interviews as a practical limitation of prescribed safer supply as it creates barriers to accessing a provincial health card. As well, the use of biometrics like palm scans for the MySafe vending machines were also mentioned as a weakness. While PHS’s SAFER program does not have any absolute conditions that disqualify someone from accessing the program, they are required to be assessed for vulnerabilities and medical conditions that could affect medications (Klaire et al., 2022). Victoria’s SAFER Initiative also involves filling out an intake form which includes health and substance use assessments, as well as requiring urine tests throughout accessing the program (CATIE, 2023; Ranger et al., 2021). As discussed in Chapter 7.1.6, these requirements for providing personal information pose a particular barrier for those who have experienced stigma or discrimination within the healthcare system, especially Black, Indigenous, and racialized peoples who are disproportionately represented among unhoused populations (Michaud et al., 2022; BCNPHA, 2020).

8.1.7. Population-level increase in opioid use

Due to eligibility restrictions within prescribed safer supply programs, the availability of drugs on a population-level would only be impacted by participants ‘diverting’ (i.e., sharing or re-selling) their prescriptions to the general public. While controls in some programs like urinalysis and witnessed consumption allow physicians and nurses to try and prevent this practice, some levels of ‘diversion’ from programs have been documented; anecdotally, PWUD are saying that there is more hydromorphone on the street, and that prices have gone down (McMurchy & Palmer, 2022). As well, interviewees pointed out that those same monitoring processes and eligibility restrictions prevent many from participating, effectively increasing demand for

'diverted' drugs among those who can't access programs legally. In this way, reducing the potential for 'diversion' requires accommodating the unmet needs of existing participants while expanding capacity within programs to allow more people to access safe supply formally (Ranger et al., 2021). The potential of 'diversion' to the general public is encouraged even further by the failure of most prescribed safer supply programs to deliver drugs in their desired formulations/dosages, as discussed in sections 8.1.2 and 8.1.3.

While the no-cost prescription of drugs represents a major benefit for unhoused PWUD, it can also produce an economic incentive to sell or trade their safe supply either out of necessity, pressure from those unable to access safe drugs, or to purchase more desirable formulations or dosages within the illicit market (McMurphy & Palmer, 2022). It is for this reason that at least one existing program has begun selling prescribed drugs at their illicit market rate (Wyton, 2022).

This criterion has been rated moderate to reflect the fact that insufficient drug formulations, no-cost prescriptions, and limited capacity within programs have all created the potential for drugs to be diverted outside of regulatory controls toward the general public. However, the limited capacity of the medical system to deliver these programs at scale and relatively small number of participants means there remains low quantity of drugs that could possibly drive a population level increase in use. As such, the risk of a prescribed safer supply – as it presently exists - driving a significant increase in population-level opioid use remains moderate so long as programs remain insufficiently able to meet the needs of their participants.

8.1.8. Administrative complexity

Compared to other policy options, prescribed safer supply leverages the most existing infrastructure and processes. In this model prescribing functions in a similar way to other medical conditions using the same drugs and pharmacies that physicians and clients are familiar with. While new prescribing and dispensing practices have needed to be developed, this is a practice that is still within the usual processes of the healthcare system. As such, this option has been rated good compared to the other options which feature relatively novel processes and functions.

8.1.9. Cost to government

While research from Gomes et al. has demonstrated significant savings for the healthcare system by providing safer supply due to a reduced reliance on emergency services, the covering of prescriptions covered by Pharmacare and the cost of administering programs (with all of their testing, monitoring, and reporting requirements) will necessitate a high upfront investment from government (2022). In recognition of these up-front and operational costs, this criterion has been rated poor.

8.1.10. Stakeholder Acceptance

Vancouver Police Department

Based on public VPD statements and reports expressing their openness to “regulated safe supply” and involvement in crafting the City’s Safe Supply Statement, the policy is rated good for its acceptability among local law enforcement compared to other policy options (Spearn & Gill, 2019, p. 24).

General Public

Based on the qualitative research described in Chapter 7.2.3, and extrapolating those findings onto the Vancouver context, prescribed safer supply is expected to be generally supported and the most acceptable model for safe supply among the public, and thus to produce relatively low risk of sustained backlash. This is in large part due to its connection to physicians, potential for concurrent treatment-based approaches, and connections to health and social services. Accordingly, it is rated good.

PWUD

For PWUD, prescribed safer supply has received a moderate rating. This is to acknowledge that it has been documented to provide several benefits for those able to access it the program, as outlined in Chapter 3.3.1.. However, statements from DULF and VANDU on its limitations alongside distrust in the medical system among many unhoused PWUD are weaknesses of this model (DULF, 2022; Canham et al., 2019). For those reasons this criterion is rated moderate to reflect the mix of benefits for some and weaknesses for others.

8.2. Option 2: Unprescribed-Supervised Model

Criteria	Measure	Evaluation
Sufficient Dosage	Ability for PWUD to obtain adequate dosages.	MODERATE
Preferred drug and consumption method	Number of drug options and formulations available.	MODERATE
Hours of operation	Hours in a day that drugs can be obtained.	POOR
Access sites	Number and geographic distribution of places a participant can access their safer supply	POOR
Upfront cost	Price of drugs for PWUD	MODERATE
Privacy and control of personal data	Amount of personal data collected as part of accessing safer supply.	MODERATE
Population-level increase in opioid use.	Potential to drive population-level increases in opioid use.	GOOD
Administrative complexity	Burden of implementation	MODERATE
Cost to government	Amount of public investment required.	MODERATE
Stakeholder Acceptance	VPD	MODERATE
	General Public	MODERATE
	PWUD	MODERATE

8.2.1. Sufficient Dosage

For its ability to deliver sufficient dosages the unprescribed-supervised model is rated moderate. This is due to the limitations of medicalized drug formulations outlined in 8.1.1., however this model is thought to function relatively better than prescribed safer supply due to the removal of prescribers from the process of determining doses. While this would allow for more control for clients at the point of consumption, dosages could still be restrained by healthcare staff providing the drugs onsite and the other assumed daily/hourly limitations on dispenses outlined in Chapter 6.2. For those reasons this model is rated moderate compared to other policies to capture the added level of individual agency within those supervised parameters.

8.2.2. Preferred drug and consumption method

As the drugs available through this model would still be the same medicalized formulations available through prescribed safer supply, this option is also rated poor for the same reasons outlined in 8.1.2.

8.2.3. Hours of operation

Similar to prescribed safer supply, this policy option has been rated as poor due to the limited hours that SCSs operate during a day and limited ability to expand those due to broader healthcare capacity and labour issues.

8.2.4. Number and geographic distribution of access sites

For the number and geographic distribution of access sites, this option is rated poor due to the many regulatory and political hurdles SCSs face for opening a new location, and the need to regularly renew S.56(1) exemptions (Mason-Singer & Allin, 2020; Pivot Legal Society, 2021). As well, municipalities have the authority to zone harm reduction service out of neighbourhoods, which in Vancouver has led to a concentration of those sites within only two neighbourhoods (Pivot Legal Society, 2021; Bernstein & Bennet, 2013).

Interviewees also noted staffing shortages, low vacancy rates, and accordingly high rents as barriers to finding spaces to open SCSs. Interviewees also described that

having to go to a supervised consumption site for witnessed ingestion functioned as a barrier, especially for two-spirit, women, trans, and gender non-conforming people who may face gendered violence, as confirmed within qualitative research by Ivisins et al. and Boyd et al., among others (2022; 2018). Some other logistical aspects of running a supervised consumption site were also mentioned by interview participants, such as the need to keep people moving through the site, storage infrastructure, and security measures within a healthcare context where those accessing services have additional rights compared to bars or clubs. All of the factors make the feasibility of having enough access sites poor.

8.2.5. Upfront cost

As described in Chapter 6.2, drugs would not be covered by Pharmacare due to their un-prescribed nature and clients would purchase drugs at a regulated price below the informal market. For those reasons this option is rated moderate compared to other policies due to its out-of-pocket, but assumed low, upfront cost.

8.2.6. Privacy and control of personal data

Compared to other options, this policy is rated moderate because of how surveillance practices embedded in supervised consumption sites are generally balanced against either the use of anonymized identifiers or pseudonyms by clients (Michaud et al., 2022). However, those policies are not always understood by those accessing services, and some have raised concerns about health system data breaches compromising participant privacy rights (Michaud et al., 2022). While possible, those remain to be unlikely scenarios; however, their risk combined with the supervision inherent to these sites positions this policy as moderate compared to others.

8.2.7. Population level increase in opioid use

A supervised consumption site model for safe supply is expected to be relatively good at preventing a population-level increase in substance use. While - similarly to prescribed safer supply - this model could incentivize the 'diversion' of drugs due to limited dosages/formulations, the market-rate price of drugs in this model would eliminate a profit incentive for doing so. These price controls, in tandem with the limited

number of supervised consumption sites and requirement of witnessed consumption, would likely function as a deterrent for 'diversion'. As one interviewee explained, based on their experience, it would also be highly unlikely that safe supply delivered within supervised consumption spaces would draw those who otherwise would not pursue it illicitly. Additionally, limitations on dispenses per hour/day would serve to reduce the potential quantity of opioids that could be redirected outside of regulatory controls and toward the uninitiated general public. With these factors in mind, and a relatively low incentive for re-sale, this model has been rated good compared to other models for its ability to prevent population-level increases in opioid use.

8.2.8. Administrative complexity

As described in Chapter 6.2, the creation of SCSs follows a complex S.56(1) federal exemption process where sites must demonstrate a variety of policies in order to receive clearance to open. As well, the operation of these sites requires a varied team of healthcare and allied-healthcare workers, including registered nurses, alongside peer staff (BCCSU, 2017). Ensuring the appropriate staff composition and spatial design has been shown to be critical steps for ensuring engagement – particularly for women, two-spirit, and gender diverse participants - and so must not be rushed (Ivisins et al., 2020; Ivisins et al., 2022). Interviewees discussed the complexity of safely managing these sites; keeping people cycling through the space, ensuring an adequate supply of drugs, and finding affordable spaces in Vancouver were all mentioned as limitations for implementation. While these are burdensome logistical hurdles for opening *new* sites, it was pointed out by another interviewee that leveraging existing supervised consumption infrastructure made the most sense for rolling out this option in the short term. As such, this criterion has been rated moderate to reflect the existing infrastructure available to launch this option relatively quickly, weighed against the complexities of scaling it up further.

8.2.9. Cost to government

Similar to prescribed safer supply, supervised consumption sites have been shown to provide downstream cost savings for the healthcare system by diverting overdose victims from hospitals while reducing the risk of overdose death and bloodborne disease (Olding et al., 2020; Khair et al., 2022). However, operations can be

costly, and the establishment of SCSs often requires provincial funding to get them up and running (Mason-Singer & Allin, 2020). However, within this model costs would be somewhat offset by participants purchasing their drugs at relatively low prices, therefore generating some revenue to support operations. To balance this modest revenue stream with the need for upfront investment, this option has been rated moderate.

8.2.10. Stakeholder Acceptance

VPD

Based upon the assumptions derived from public statements and reports, it could be expected that the VPD would moderately support a non-prescribed, supervised option, at least formally. This rating is based on assumptions of regulated dispensing, a lack of a profit-motive, and not allowing carries - which would mitigate the risk of 'diversion' or trafficking. However, one interviewee noted the police practice of lingering outside of SCSs, which in turn lowers uptake. Therefore, a cautious rating of moderate is given for this option.

General public

Based on the public attitudes described in Chapter 7.2.3., it is expected that combining safe supply within supervised consumption sites would generate a moderate level of public blowback in the Vancouver context. While a majority of respondents from a more conservative context found support for using safe supply to address substance use and addiction, the slight support for SCSs from other studies suggests some controversy remains, and that less restrictive options could expect a moderate level of pushback.

PWUD

While this model features relatively more restrictive aspects and controls compared to others, the removal of prescriber as barriers was noted as a major benefit by three interviewees. As well, the potential for peer involvement would provide some benefits from the perspective of PWUD, such as a more welcoming environment and the potential for translating their knowledge and experience around drug use practices into employment opportunities. However, the supervised setting was also noted as a barrier for some, particularly women, trans, 2-spirit, and gender non-conforming people at risk

of gendered violence (Boyd et al., 2018). For this mix of strengths and limitations, non-prescribed supervised models are considered moderately acceptable.

8.3. Option 3: Compassion Club Model

Criteria	Measure	Evaluation
Sufficient Dosage	Ability for PWUD to obtain adequate dosages.	MODERATE
Preferred drug and consumption method	Number of drug options and formulations available.	GOOD
Hours of operation	Hours in a day that drugs can be obtained.	GOOD
Access sites	Number and geographic distribution of places a participant can access safer supply.	MODERATE
Upfront cost	Price of drugs for PWUD	MODERATE
Privacy and control of personal data	Amount of personal data collected as part of accessing safer supply.	MODERATE
Population-level increase in opioid use.	Potential to drive population-level increases in opioid use.	MODERATE
Administrative complexity	Burden of implementation	POOR
Cost to government	Amount of public investment required.	GOOD
Stakeholder Acceptance	VPD	MODERATE
	General Public	MODERATE

	PWUD	GOOD
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8.3.1. Sufficient Dosage

Compassion clubs are expected to provide a moderate ability for members to access sufficient dosages. This rating is based on the described design and methods from the DULF/VANDU compassion club strategic framework where dosages are measured and packaged “according to individual needs” (DULF, 2022, p. 4). This would add a much greater level of agency among controlling dosages compared to options 1 and 2. However, as one interviewee noted, the reliance on the illicit ‘darkweb’ can be unpredictable, and that, as of yet, meeting daily needs as not been possible. Therefore, due to the unpredictable sourcing of drugs and potential for supply disruptions which could reduce available dosage sizes, this option is rated moderate.

8.3.2. Preferred drug and consumption method

Compared to other models, club members would have a good ability to access their preferred drug and consumption methods. This is due to its sourcing from the illicit market where drugs come in preferred variations and formulations. As well, in its current iteration, the DULF/VANDU framework involves distributing heroin, which remains the most desired opioid among most PWUD (Ferguson et al., 2022).

8.3.3. Hours of operation

DULF/VANDU’s framework described a flexible system where “substances will be available for collection by compassion club members depending on participant need” (2022, p.7). This is feasible due to the relatively small number of members beings served by a particular club. For its ability to provide individualized time frames for access, this option is rated good.

8.3.4. Access sites

While DULF's framework is unclear about the process through which members obtain their drugs, use of the words like "collect" and "collection" suggest that members will need to pick-up themselves from some determined place. Acknowledging the limitations involved in that process alongside previously stated commitments to meeting members individual needs, this criterion has been rated moderate to reflect that flexibility within a constrained number of options.

8.3.5. Upfront cost

In the absence of a S.56(1) exemption, DULF continue to rely on the illicit market, where prices can be unpredictable and exploitative (DULF, 2022). A benefit of this model is the lack of profit motive among the club and their ability to enhance buying power by purchasing in bulk to bring down prices from what individuals would pay (DULF, 2022). As well, additional revenue streams like donations or membership fees could help finance the club's operations (DULF, 2022). While this would make drugs cheaper than the illicit market, and there would still be the potential for a sliding-scale system of pricing, it would still place more of a financial burden on unhoused participants compared to options 1 and 2. Accordingly, this criterion and has been rated moderate.

8.3.6. Privacy and control of personal data

Access to drugs through a compassion club is only available through membership in a local drug user organization, which follow their own internally regulated eligibility screening processes. In order for a compassion club to receive drugs through the fulfillment centre they must comply with minimum safety and screening standards, including membership lists and logs of the amounts distributed to which members (DULF, 2022). The intention of these screening protocols is to ensure that members are over 19 years and currently using illicit drugs while mitigating the potential for theft or 'diversion' of safe supplies to those outside the club (DULF, 2022). It's also stated that at their fully realized potential these screening procedures could be used to help meet other needs of members, like navigating social supports and treatment options if desired (DULF, 2022).

These relatively higher barriers to entry are mitigated to an extent by the fact that they are being conducted by peers who do not hold positions of formal or institutional authority like health and social workers. While this may constitute a form of “lateral surveillance”, the democratic constitution of these organizations and clubs allows for accountability among members. In recognition of the additional personal information required alongside the self-governing nature constitution of these clubs, this criterion has been rated moderate.

8.3.7. Population-level increase in opioid use

As described above, eligibility restrictions on club membership require that a prospective member is above 19 and currently using illicit drugs (DULF, 2022). As well, the structuring of clubs through local organization of PWUD and logging of stored and dispensed drugs creates a level of lateral screening and accountability for both staff and members (DULF, 2022). While this provides some assurance that drugs are going towards those within the club, it is also a relatively informal system of control compared to other models and does not include a formal limit on the quantity dispensed beyond supply constraints. On the other hand, the sliding-scale system for prices does strike a balance between keeping drugs affordable while disincentivizing re-sale or higher levels of use than would be the case without a membership. With the compassion club model’s ability to provide drugs in the doses and formulations that PWUD desire, prices controlled near illicit market-rates, alongside their informal regulatory processes this criterion has been rated moderate.

8.4. Administrative complexity

In this model all stages of implementation are downloaded onto PWUD and their respective organizations. Procuring drugs from the dark-web is a particularly challenging and risky procedure, especially if intercepted by law enforcement. As well, the double-testing protocols, meticulous logging of drugs, and individualised dosages and distributing schedules all put a significant burden on organizers. According, this criterion has been rated poor.

8.5. Cost to government

As a self-organized model that is designed, run, and administered by organizations of PWUD, there is no inherent cost to government (BCCSU, 2019). As such this criterion is rated good.

8.6. Stakeholder Acceptance

VPD

As described in Chapter 7.2.2., the VPD have expressed a moderate level of tolerance for DULF/VANDU's practice of distributing internally regulated safe supply. However, their non-enforcement centered primarily on it being an act of protest, there being no profit motive, and assurances that distributed drugs did not contain "lethal levels" of fentanyl (Shum, 2021). As the DULF/VANDU pilot does not involve distributing fentanyl and features double testing using a mass spectrometer capable of detecting and quantifying trace amounts, this risk would be relatively low. To capture this cautious approval, compassion clubs could be expected to meet a moderate acceptability among the VPD.

General Public

Relying on the assumptions laid out in 7.2.3., the disconnection of compassion clubs from medical systems and treatment modalities is expected to generate some backlash from the general public. However, the lack of public money involved, and internally organized nature of these clubs could be expected to produce relatively more apathy among the public than other options. As this model leverages status-quo conditions towards delivering safe supply, there would be limited room for public intervention other than through law-enforcement who have stated a cautious tolerance for this approach. As such, this criterion has been rated moderate.

PWUD

As a peer-led intervention, compassion clubs are expected to maintain a good level of acceptability among PWUD. As the pilot project is being led by two of the most

established local organizations of PWUD, this is also expected to enhance the support for this model among peers and people with lived and living experience.

8.7. Option 4: Dispensary Model

Criteria	Measure	Evaluation
Sufficient Dosage	Ability for PWUD to obtain adequate dosages.	GOOD
Preferred drug and consumption method	Number of drug options and formulations available.	MODERATE
Hours of operation	Hours in a day that drugs can be obtained.	MODERATE
Access sites	Number and geographic distribution of places a participant can access safer supply.	GOOD
Upfront cost	Price of drugs for PWUD	POOR
Privacy and control of personal data	Amount of personal data collected as part of accessing safer supply.	MODERATE
Population-level increase in opioid use.	Potential to drive population-level increases in opioid use.	MODERATE
Administrative complexity	Burden of implementation	POOR
Cost to government	Amount of public investment required.	MODERATE
Stakeholder Acceptance	VPD	POOR
	General Public	POOR

	PWUD	GOOD
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8.7.1. Sufficient Dosage

Compared to other options, dispensaries would provide a good ability for PWUD to access their own dosages to meet individual thresholds as determining doses would be up to the individual after purchasing their drugs. While the limitations laid out in Chapter 6.4 would be in place, this would still likely meet individual thresholds for most. As well, there would be no barriers – other than travel – preventing someone from accessing multiple dispensaries throughout the same day, if desired.

8.7.2. Preferred drug and consumption method

Similar to other options providing pharmaceutical-grade alternatives, the ability to access drugs in their preferred formulations would be limited by this model. Particularly for stimulants and cocaine, while there are some existing medicalized options, they are often considered insufficient by PWUD, as outlined in Chapter 8.1.2. To account for the way that some of these variations do not work for everyone alongside the added agency of this model, this criterion has been rated moderate.

8.7.3. Hours of operation

As is the case with cannabis and alcohol dispensaries, the hours of operation would be limited by provincial regulations, which in BC is from 7 am – 11 pm (British Columbia, 2021). While limiting to an extent, these hours are longer relative to pharmacies, clinics, and SCSs. As such this criterion has been rated moderate.

8.7.4. Number and geographic distribution of access sites

Compared to other policy options dispensaries would have the greatest potential for a high number and geographic distribution of access sites since they are not embedded within a particular medical space, like a pharmacy, clinic, or supervised consumption site. Presumably municipal bylaws would place constraints on where these sites could open, but as a government-run shop there would be more potential for

consciously placing locations to balance community safety concerns and the need for equitable access across neighbourhoods. For those reasons this criterion has been rated good compared to other options.

8.7.5. Upfront cost

The upfront cost of accessing safe supply through a dispensary was unanimously identified by interviewees as a weakness of this model for people who are unhoused. An added difficulty noted by an interviewee was the inability to barter, trade, or exchange services to receive drugs, as is the case in the informal economy. As well, research on the effect of legalization on cannabis prices has shown a difficulty to compete with the illicit market. This failure would result in an insufficient ability for dispensaries to replace the toxic illicit drug supply for those who cannot afford the additional costs of regulation (Childs & Stevens, 2021). For those reasons, this criterion has been rated poor.

8.7.6. Privacy and control of personal data

While age-confirming identification would be required to make dispensary purchases, this information would not be recorded on a ledger or collected as data for tracking/charting, as is the case with the other policy options. However, considering research showing that being asked for ID reduces uptake for supervised consumption sites, it can be assumed that this would also be the case for people who are unhoused – who interviewees note often lack ID – when accessing dispensaries (Michaud et al., 2022). For this reason, this criterion has been rated moderate compared to other options due to ID requirements alongside lower levels of surveillance compared to other models.

8.7.7. Population level increase in opioid use

As a model with relatively lower levels of restrictions who can access safe supply, and with a greater potential for numerous access sites, the potential for dispensaries increasing population level substance use is thought to be higher than other models. A comparable scenario to draw upon could be cannabis legalization in Canada, however understanding whether this affected usage rates is imprecise due to the overlapping timing of the COVID-19 pandemic, which increased overall drug use across age groups (Fischer et al., 2021; Boury et al., 2022). With that caveat in mind,

early research has indicated that usage rates did increase following legalization, primarily among mid-older aged adults and possibly youth (Fischer et al., 2021; Boury et al., 2022).

From evidence related to cannabis use, it could be extrapolated that a dispensary model may initiate drug use among those who otherwise would not. However, comparing cannabis to other drugs like opioids is flawed, particularly as it relates to youth. Prior to legalization cannabis use was already relatively common among youth across Canadian society. For example, pre-legalization 18% of students in grades 7-12 reported using cannabis in the past year; by late 2020 (post-legalization) cannabis usage rates for those under 18 slightly increased to 19.2% (Boury et al., 2022). Comparatively, 3% of youth reported using prescribed pain killers (3% oxycodone and 0.7% fentanyl), and 4% reported recreationally using the same stimulant medications offered through safe supply (Health Canada, 2019b). Therefore, even if these drugs followed the same trajectory as cannabis (a questionable assumption given their disparate status), the impact on public health would still be manageable.

While the relatively higher prices in this model would prevent 'diversion' outside of regulatory controls or to minors, these same prices would also restrict access for many unhoused PWUD. So, while this constitutes a benefit as far as managing population-level increases in use, it should be noted that this could also increase demand for lower-cost versions through the illicit market, such as is the case with tobacco products (Gomis, 2021).

Dispensaries have been rated moderate to reflect that while there would be an increased availability of drugs being dispensed in greater quantities, higher prices and anticipated regulatory controls on promotion and formulation strengths would still function to manage impacts on public health. These assumptions, alongside the lack of economic motive to resell outside controls, and limited evidence that legal dispensaries drastically increase usage rates results in dispensaries receiving a moderate rating for their potential to increase opioid-use on a population scale.

8.7.8. Administrative complexity

As was demonstrated through the legalization of cannabis, the establishment of dispensaries is a highly complex and multi-jurisdictional endeavor. As well, it would require the extensive amendment or repeal of the *CSDA*, which itself would be a complicated political task. Also, as publicly owned shops the establishment and day-to-day operations of these dispensaries would be an added layer of complexity that cannabis dispensaries largely downloaded onto the private sector. As such, it can be anticipated that this policy option would perform poorly as it relates to administrative complexity.

8.7.9. Cost to government

While there would be revenue generated through a dispensary model, the cost of establishing publicly run store and developing a new regulatory framework combined with an urgent need to out compete the illicit market would make any potential profits slim, at least in the short term. Comparisons to cannabis related to government expenses are difficult to make due to the involvement of private sector capital and the pre-existence of a medical cannabis and grey-market dispensaries in some jurisdictions prior to legalization. However, compared to other models, dispensaries hold the highest potential for recouping upfront costs through revenue and taxation. Based on these assumptions, and the logistical complexities of implementation described above, it can be expected that this model would represent a moderate cost to government.

8.7.10. Stakeholder Acceptance

VPD

The VPD's 'four pillars' approach, with an emphasis on prevention, suggest a low level of acceptability for dispensaries, as the VPD associates drug use with community safety issues (VPD, 2008). As the least controlled model for safe supply, the risk of the opioid-naïve accessing regulated drugs would be relatively high compared to other models,

which also makes this model unfavourable from a ‘four pillars’ perspective (VPD, 2008). Based on those policy positions this option is rated poor for its acceptability among the VPD.

General Public

Three interviewees noted either a lack of political will, public-blowback, and imposition of morality as practical limitations of this model. Based on these statements and the research outlined in Chapter 7.2.3., it is assumed that drug dispensaries would be accepted poorly by the general public due to its non-medicalized design and theoretical potential for initiating higher levels of drug use. As such, a sustained backlash jeopardizing implementation could be expected at this time.

PWUD

Dispensary models were identified as preferable to PWUD by two interviewees. This is reflected in the VANDU Manifesto calls in part for “the creation of a regulated drug market where people who use drugs have access to quality-controlled drugs and can use them without fear or prejudice” (VANDU, n.d., n.p.). As described by Greer & Ritter, while shot through with skepticism about government intentions, a strong support for a legal regulated market was still determined among PWUD who were interviewed in their study (2020). As a model that provides for a the most agency and wide range of access to a regulated drug supply, this option has been rated good for its acceptability among PWUD.

8.8. Evaluation Matrix

Objective	Criteria Definitions	Prescribed Safer Supply	Un-Prescribed Supervised	Compassion Club	Dispensary
Key Objective: Significantly decrease the use of <i>illicit</i> drugs	Ability for PWUD to obtain adequate dosages	POOR	MODERATE	MODERATE	GOOD
	Number of drug options and formulations available	POOR	POOR	GOOD	MODERATE
	Hours in a day that drugs can be obtained	POOR	POOR	GOOD	MODERATE
	Number and geographic distribution of dispensing locations	MODERATE	POOR	MODERATE	GOOD
	Price PWUD pay for drugs	GOOD	MODERATE	MODERATE	POOR
	Amount of personal data collected	POOR	MODERATE	MODERATE	GOOD
Public Health	Potential to drive population-level increases in opioid use.	MODERATE	GOOD	MODERATE	MODERATE
Administrative Complexity	Burden of implementation	GOOD	MODERATE	POOR	POOR
Cost to Government	Amount of public investment required.	POOR	MODERATE	GOOD	MODERATE
Stakeholder Acceptance	Formal support of VPD	GOOD	MODERATE	MODERATE	POOR
	Potential for backlash from the general public	GOOD	MODERATE	MODERATE	POOR
	Support among advocacy organizations representing PWUD	MODERATE	MODERATE	GOOD	GOOD

Chapter 9. Recommendations

Analysis of these four particular options found that prescribed safer supply and compassion clubs scored highest based on the criteria selected for this study. However, no one model drastically surpassed the others, demonstrating the complimentary benefits of having multiple models in place – where one is limited, another has strengths, and vice versa. As well, these models should not be understood as operating in isolation; for instance, Emerson & Haden suggest a system where one can be referred through dispensaries to prescriber systems when appropriate (2021). In this way a fully integrated range of safe supply models can operate like an ecosystem where models feed into and support each other to reduce gaps and ensure reach. As reflected across expert interviewees and the published literature, there will be no panacea for the toxic illicit drug crisis for unhoused PWUD; a variety of mutually supportive medicalized and non-medicalized models are needed to ensure broad access to this lifesaving and enhancing intervention (Foreman-Mackey et al., 2022; Selfridge et al., 2022; Ivsins et al., 2021; BCCSDRP, 2022). With these considerations in mind, it is recommended that all options be pursued, divided into short, medium, and long-term steps based upon what systems are already in place.

9.1. Short term: Leverage existing infrastructure to save lives now

With year-by-year increases in illicit drug toxicity deaths, immediate action is required. In order to reach as many unhoused PWUD as quickly as possible, government should proceed with scaling up existing prescriber-based programs and adding non-prescribed options within SCSs. As both prescribed safer supply and supervised consumption sites generally service the most structurally vulnerable PWUD, including those experiencing housing insecurity, scaling up these options in the short term is a key action for reducing the risk of overdose among unhoused PWUD (BCCSU, 2017; McMurchy & Palmer. 2022).

9.1.1. Short-term implementation considerations

The greatest barrier to implementation for both prescribed safer supply and unprescribed-supervised models comes down to health system capacity issues and the complexities of designing and scaling up programs. Presently, staffing is not able to keep up with demand, particularly for those with complex needs such as unhoused PWUD (McMurphy & Palmer, 2022). These challenges indicate a need for more healthcare funding from federal and provincial governments, which at the time of writing is a major policy struggle (Tasker, 2023). However, as revealed by Gomes et al., and Khair et al., there are downstream cost-savings from pursuing these options (2022; 2022). Therefore, these up-front increases in funding will serve as investments that could free up capacity within the broader health system and allow for the re-deployment of healthcare and allied-healthcare staff towards expanding supervised consumption spaces and prescribed safe supply clinics.

Of particular concern for these options should be the expansion of operating hours within clinics and SCSs in order to suit the timelines that unhoused PWUD live within. As well, prescriber and unprescribed-supervised programs should include powdered fentanyl, if they have not already, in order to better meet the needs of participants for appropriate dosages and preferred consumption methods; doing so will help increase acceptability of these options among PWUD while also helping to address stakeholder concerns related to 'diversion'. No-cost prescriptions are a major benefit for unhoused PWUD that help to free participants from the gruelling and dangerous hustle of informal income generation, and therefore should not be abandoned. Attention should also be paid to the quantity and geographic distribution of access sites, which will require public education campaigns that can challenge the stigma of having SCSs outside of the urban core.

9.2. Medium term: Standardize processes and reduce barriers to S.56(1) exemptions for safe supply

A prevailing barrier to the scale up and expansion of non-prescribed safe supply models is the conditional, unclear, and extensive process for obtaining a S.56(1) exemption from the Controlled Drugs and Substances Act (CDSA). This clause allows the federal Minister of Health to grant exemptions for medical/scientific purposes or for

reasons “otherwise in the public interest” (City of Edmonton [COE], 2022, p.2). It was through the public interest branch that DULF and VANDU unsuccessfully applied for an exemption in order to procure, store, and distribute regulated supplies of heroin, methamphetamine, and cocaine (DULF & VANDU, 2021). Indeed, the granting of exemptions is never guaranteed, particularly should there be a change in government and/or the appointment of an unsupportive Minister of Health. This inherent uncertainty prevents S.56(1) exemption requests from being a viable long-term solution to the illicit drug toxicity crisis, however it does represent a relatively speedier way for government to expand access to safe supply while generating evidence that can persuade opponents and sceptics. Having said that, while standardizing processes will increase clarity, they will only work to reduce illicit drug toxicity deaths should more exemptions be provided, and this will only be possible if the bar for granting exemptions is lowered. In other words, applications - such as the one submitted by DULF and VANDU - should be granted in recognition of the current crisis of deaths among unhoused PWUD and the emerging evidence that safe supply can reduce the risk of overdose.

9.2.1. Medium term implementation considerations

For government, a step forward should be the creation of a streamlined, standardized, and prompt process to replace the onerous case-by-case granting of conditional S.56(1) exemptions when establishing non-medical safe supply models. For scientific research and clinical studies there are online request forms and set timelines for Health Canada to process exemption requests (Health Canada, 2022). However, as it currently stands, there is no set timelines or processes for obtaining ‘non-routine exemptions’ to the CDSA, as would be needed for non-prescribed safe supply programs (COE, 2022). Creating a standardized online application process would serve to simplify and demystify this process, and the setting of timelines would provide some accountability for regulators to handle those applications in a timely manner. These changes should be mandated by the Minister of Health and Minister of Mental Health and Addictions in order to ensure it is prioritized and achieved as soon as possible.

9.3. Long term: CDSA reform and low-barrier access to safe supply for all

The unrelenting trajectory of illicit drug toxicity deaths have rendered incrementalist and piecemeal solutions inadequate in the long term; stepping-stones will not lead everyone safely through the fire, and to substantially address this crisis government should work toward the long-term goal of low-barrier safe supply that is accessible to all who – by free choice or necessity – seek to consume presently illicit opioids outside of clinical settings. Doing so in combination with the more targeted prescribed and supervised models will ensure that as many unhoused PWUD can be reached as possible while also offering more supportive models for those who benefit from that approach.

Compassion clubs, such as the one established by VANDU and DULF, are valuable for demonstrating the viability of non-medical models and build on decades of activism by PWUD out of a necessity for survival (Jozaghi et al., 2018). Still, their limited reach and complex administration greatly limits their viability as a timely and scalable solution on their own, particularly for unhoused community members whose complex needs may limit access. Meanwhile, dispensaries represent a desirable solution for PWUD, however their operationalization will require a political struggle for which the general public and government have yet to be primed. However, early research on public attitudes towards safe supply indicate that there is possibly more support than many assume (Morris et al., 2023). Therefore, the long-term goal of replacing the CDSA with a new regulatory system should be pursued in order for widespread and low barrier access to compassion club and dispensary models for unhoused PWUD who prescriber and supervised options are not appropriate.

9.3.1. Long term implementation considerations

The greatest obstacle towards actualizing non-medical models for safe supply, like compassion clubs and dispensaries, is the continued prohibition and criminalization of non-medical opioid procurement, distribution, and consumption by the CDSA. Policy makers should build a new regulatory system that provides low barrier access while maximizing public health through mechanisms like price controls, restrictions on promotion or advertising, clear warning labels, lower risk guidelines, harm reduction

services, and the provision of accessible and voluntary mental health care and recovery options (Emerson & Haden, 2021).

9.4. Peer Engagement

Legal reforms to the CDSA must be developed in collaboration with unhoused PWUD and respect the jurisdiction of Indigenous nations over the health of their members who have been disproportionately impacted by prohibition. In the spirit of “nothing about us without us”, the lived experience and knowledge of PWUD who are or have been unhoused should be leveraged to ensure future regulatory systems meet the needs of those most impacted and make sure that policies are reflective of conditions on the ground. Peer engagement principles and practices, such as those developed by the BCCDC, should also be implemented throughout all stages of the policy process (Greer et al., 2017).

9.5. Evaluation and Monitoring

Lastly, as suggested by Emerson & Haden, all future models should have pre-determined evaluation measures in order to monitor for negative externalities and the impact of safe supply on marginalized and or vulnerable groups, such as youth (2021). Particularly as it relates to price, regulatory systems must ensure responsiveness to what is happening on the ground in order to mitigate harms associated with the increased availability of pharmaceutical opioids.

Chapter 10. Conclusion

This study has revealed the various strengths and limitations of different safe supply models with respect to unhoused PWUD. For the prescribed safer supply option, a major strength is the provision of no-cost drugs, which interviewees also identified as a key consideration for those without housing. As well, its acceptability among the VPD and general public makes the prescriber-based model more politically permissible at this time. However, this model's high up-front costs and documented failure to provide adequate dosages and drug options while also requiring large amounts of personal data creates barriers to participation for many unhoused PWUD, particularly Indigenous and Black peoples whose experiences of racism within the medical system have generated distrust.

The unprescribed-supervised model has good potential for mitigating the population-level health risks of increased opioid access while also removing the barrier of accessing drugs through a prescriber. However, accessing safe supply solely through these sites also means relatively fewer and less evenly distributed access sites that are only open for reduced hours of the day. As well, gendered-safety concerns within SCSs for women, trans, 2-spirit, and gender non-conforming PWUD have been identified by practitioners and one interviewee in this study as important considerations for this model (Boyd et al., 2018; BCCSU, 2017).

Compassion clubs can also serve to protect public health, provide flexibility and individualized programming for participants, and allow for peers to be engaged in all aspects of providing safe supply. However, downloading these complex processes of organization and administration onto peers is burdensome, particularly for unhoused PWUD who must already dedicate much of their time to survival. Finally, dispensaries represented the lowest-barrier approach that is also most desirable from the perspective of PWUD. However, for those without housing, the relatively higher cost – while necessary to manage public health – will restrict access and possibly perpetuate the existence of a lower-cost illicit market.

This report echoes calls made within the grey and academic literature and by expert interviews in this study: we need a variety of medial and non-medical options for safe supply (Foreman-Mackey et al., 2022; Ivisin et al., 2021; BCCSDRP, 2022;

CAPUD, 2019). Ultimately, what works for people who are unhoused will work for the general public who are also at risk of consuming toxic illicit drugs. For most of the aforementioned criteria their importance to unhoused PWUD is a matter of degrees. Even so, for considerations like cost and operating hours, the degree of added importance is immense compared to the broader population. CAPUD's widely cited concept document on safe supply echoes these perspectives and calls for a "low-hanging fruit" strategy where the most at-risk are targeted first (2019). The structural vulnerability of people who are unhoused to overdose death puts them at heightened risk and calls for additional attention when designing policy options that can meet them where they're at (Milaney et al., 2021).

This analysis has been largely based on assumptions derived from existing systems and comparable examples, however there are many possibilities for safe supply policies. As one interviewee described, there is ample space for creativity, particularly for non-medical models. Policy makers should not limit their imaginations based on present day circumstances. In fact, all models can be designed in such a way as to accommodate these key criteria and ensure that unhoused PWUD are provided low barrier access. Achieving this will require collaborating with peers in the design and evaluation of future programs that hold their lives in the balance.

Since its inception the prohibition of drugs has had an exclusionary function. Not far from where encampments of Chinese labourers once resided there are new tent districts populated by unhoused community members whose relegation to the margins of society is explained by moralistic judgements that suggest some lifestyles are incompatible with a 'civilized' society. The intersecting oppressions of race and class are expressed in a double standard that deems some drug use more acceptable than others, and some level of death inevitable. However, as the popular harm reduction adage goes: "every overdose is a policy failure". While a condemnation, implicit in this statement is that successful drug policy is possible, at least for governments brave enough to act.

Appendix A: Interview Guide

Preamble:

Hello, thank you for talking with me today, my name is Jonathan Northam and I hoping to speak with you today about your understandings of safer supply policies as they relate to unhoused populations. This conversation should take about 45 minutes – 1 hour of your time, and I wanted to remind you that you can choose to skip any questions, and that you can always stop the interview at anytime with no consequences.

Could you confirm that you received a copy of the consent form?

Did you have any questions about the form?

Are you comfortable proceeding based on what's laid out in the consent form?

And are you okay with me audio-recording this conversation?

For this study I'm using the term "safer supply" as defined by the Canadian Association of People Who Use Drugs, who refer to it as the "legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market". These programs are not intended as "treatments" for substance use disorders, but rather as harm reduction interventions.

As well, within this interview will be using the term 'unhoused' specifically to refer to those who currently access emergency shelters as a form of housing. Acknowledging that unhoused individuals may find themselves within multiple housing environments over time, these questions are intended to apply specifically to the context of someone relying primarily on emergency shelters as a form of housing.

Interview questions:

1. Before we proceed with questions related to safer supply, can you tell me a bit about your work and how it relates to safer supply?

Objectives of safer supply

2. What are some unique needs for people who are unhoused with respect to safer supply?

[distribute to interviewee the following list of goals/objectives]:

The BC government identifies several goals and objectives for their prescribed model of safer supply. I'll be using some of these to evaluate the current safer supply approach against two possible alternative models of safer supply. The stated goals and objectives of safer supply as articulated by the BC government include:

- Significantly decreasing the use of illicit drugs.
 - Reducing illicit drug toxicity injuries and deaths.
 - Improving equitable access to prescribed safer supply while linking people to other health services and social supports.
 - Delivering services in a manner that respects the dignity and human rights of individuals who use drugs.
 - Ensure that prescribed safer supply is provided in a culturally safe manner that meets the needs of Indigenous peoples.
 - Mitigating, as much as possible, the potential harms of prescribed safer supply for individuals and communities.
3. Do you think that these are appropriate or realistic goals for meeting the needs of people who are unhoused within shelters? Please explain why or why not.
 4. Do you think any of these goals are particularly relevant for people who are unhoused? Please explain why or why not.
 5. Are there any goals or objectives that you would add to this list?
 - a. If so, why?

Existing policy option: BC's prescribed safer supply model.

BC's prescribed safer supply policy allows doctors to prescribe no-cost pharmaceutical grade alternatives of opioids and stimulants to those who are deemed an elevated risk of drug toxicity events. Dosages, quantities, and the delivery method of prescriptions are determined by prescribers based on the client's assessed needs, clinical protocols, and government guidance.

6. What do you consider the strengths of this approach for people who are unhoused within shelters?
 - a. What are some weaknesses of this approach for people who are unhoused within shelters?
7. Are there practical limitations of implementing the current model of safer supply for people who are unhoused within shelters? If so, please describe.
 - a. How, if possible, could those limitations be mitigated?
8. Are there any unintended consequences/harms you could envision resulting from the current model of safer supply?
9. [If they answered yes to Q5]: How does this model of safer supply affect [their additional goal]?

Alternative policy option: Non-prescribed supervised model

One theoretical alternative to the current model of safer supply provided by the Canadian Association for People Who Use Drugs is to dispense drugs without prescription but administered in a supervised setting under the care of health professionals and/or peer workers.

10. What might be the strengths of this approach for people who are unhoused within shelters?
 - a. What are some weaknesses of this approach for people who are unhoused within shelters?
11. Are there practical limitations of implementing this model for people who are unhoused within shelters? If so, please describe.
 - a. How, if possible, could those limitations be mitigated?
12. Are there any unintended consequences/harms you could envision resulting from a non-prescribed supervised model of safer supply?
13. [If they answered yes to Q5]: How does this model of safer supply affect [their additional goal]?

Alternative policy options: Non-prescribed dispensary model

Another theoretical model for safer supply is to make certain drugs available for purchase without prescription in dispensaries and shops.

14. What might be the strengths of such an approach for people who are unhoused within shelters?
 - a. What are the weaknesses for this dispensary model for people within shelters?
15. Are there practical limitations of implementing a non-prescribed dispensary model for people who are unhoused within shelters? If so, please describe.
 - a. How, if possible, could those limitations be overcome?
16. Are there any unintended consequences/harms you could envision resulting from a non-prescribed dispensary model of safer supply?
17. [If they answered yes to Q5]: How does this model of safer supply affect [their additional goal]?

Comparing models for safer supply

18. Of those three options (prescribed safer supply, non-prescribed but supervised, and non-prescribed dispensary models), which do you believe would be best suited for people who are unhoused accessing shelters and why?
19. Broadly speaking, what are some trade-offs between prescribed and non-prescribed models of safer supply?
20. In your opinion, what sub-groups of people who are unhoused who use drugs might benefit most from prescribed models?
 - a. Conversely, what sub-groups of people who are unhoused benefit least from prescribed models?
21. What are some 'non-traditional' spaces where safer supplies of drugs could be administered and/or dispensed to increase accessibility for houseless people? (ex: vending machines).

Missing models

22. Are there any models of safer supply other than what I've described above that you think could be better suited to meet the needs of people who are unhoused living in shelters?
 - a. What are the strengths of this model?
 - b. What are the limitations of it?

Closing

23. To wrap up, do you have any additional thoughts, comments, or concerns that were not captured in the previous questions?

Thank you so much for taking the time to talk with me today. Just a final reminder that you can contact me via phone or email if you have any questions about today, have any information that you forgot to add and want to share, or have anything you want me to remove from my notes that you said.

Is it alright if I contact you again in a couple of weeks to ask any follow up questions I may have?

Appendix

Goals and objectives of safer supply:

- Significantly decreasing the use of illicit unregulated street drugs.

- Reducing illicit drug toxicity injuries and deaths.
- Improving equitable access to prescribed safer supply while linking people to other health services and social supports.
- Delivering services in a manner that respects the dignity and human rights of individuals who use drugs.
- Ensure that prescribed safer supply is provided in a culturally safe manner that meets the needs of Indigenous peoples.
- Mitigating, as much as possible, the potential harms of prescribed safer supply for individuals and communities.

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