A MACDONALD-LAURIER INSTITUTE PUBLICATION

LORI REGENSTREIF

How “safe supply” became Canada’s answer to the opioid crisis, why it failed, and how we can do better

MOVING THE NEEDLE

May 2025

CRDP CENTRE FOR RESPONSIBLE DRUG POLICY

15 MLI TRUE NORTH IN CANADIAN PUBLIC POLICY

BOARD OF DIRECTORS

CHAIR
Gerry Protti
Chairman, BlackSquare Inc, Calgary

VICE-CHAIR
Jacquelyn Thayer Scott
COO, Airesun Global Ltd;
President Emerita, Cape Breton University, Sydney

MANAGING DIRECTOR
Brian Lee Crowley, Ottawa

SECRETARY
Elizabeth Burke-Gaffney
Commercial Negotiator, Oil & Gas, Calgary

TREASURER
Martin MacKinnon
Lecturer (part-time),
Cape Breton University, Sydney

DIRECTORS
Richard Boudreault, CEO,
AWN Nanotech, Montreal

Wayne Critchley
Senior Associate,
Global Public Affairs, Ottawa

Colleen Mahoney
Sole Principal,
Committee Digest, Toronto

Simon Nyilassy
Founder, Marigold & Associates Limited, Toronto

Hon. Christian Paradis
Co-founder and Senior Advisor,
Global Development Solutions, Montréal

David Schneider
Senior Investment Advisor,
Aligned Capital Partners, Victoria

Veso Sobot
Former Director of Corporate Affairs,
IPEX Group of Companies, Toronto

Nigel Wright
Senior Managing Director,
Onex Partners, London, UK

ADVISORY COUNCIL

John Beck
President and CEO,
Aecon Enterprises Inc, Toronto

Aurel Braun,
Professor of International Relations and Political Science, University of Toronto, Toronto

Erin Chutter
Executive Chair, Global Energy Metals Corporation, Vancouver

Navjeet (Bob) Dhillon
President and CEO,
Mainstreet Equity Corp, Calgary

Jim Dinning
Former Treasurer of Alberta, Calgary

Richard Fadden
Former National Security Advisor to the Prime Minister, Ottawa

Brian Flemming
International lawyer, writer, and policy advisor, Halifax

Wayne Gudbranson
CEO, Branham Group Inc., Ottawa

Calvin Helin
Aboriginal author and entrepreneur, Vancouver

David Mulroney
Former Canadian Ambassador to China, Toronto

Peter John Nicholson
Inaugural President, Council of Canadian Academies, Annapolis Royal

Barry Sookman
Senior Partner,
McCarthy Tétrault, Toronto

Rob Wildeboer
Executive Chairman, Martinrea International Inc, Vaughan

Bryon Wilfert
Former Parliamentary Secretary to the Ministers of Finance and the Environment, Toronto

RESEARCH ADVISORY BOARD

Janet Ajzenstat
Professor Emeritus of Politics,
McMaster University

Brian Ferguson
Professor, Health Care Economics,
University of Guelph

Jack Granatstein
Historian and former head of the Canadian War Museum

Patrick James
Dornsife Dean's Professor,
University of Southern California

Rainer Knopff
Professor Emeritus of Politics,
University of Calgary

Larry Martin
Principal, Dr. Larry Martin and Associates and Partner, Agri-Food Management Excellence, Inc

Alexander Moens
Professor and Chair of Political Science,
Simon Fraser University, Greater Vancouver

Christopher Sands
Senior Research Professor,
Johns Hopkins University

Elliot Tepper
Senior Fellow, Norman Paterson School of International Affairs, Carleton University

William Watson
Associate Professor of Economics,
McGill University

Contents

Cover design: Renée Depocas (photo: iStock modified)

Copyright © 2025 Macdonald-Laurier Institute. May be reproduced freely for non-profit and educational purposes.

The author of this document has worked independently and is solely responsible for the views presented here. This Macdonald-Laurier Institute paper was created in partnership with the Centre For Responsible Drug Policy. The opinions are not not necessarily those of MLI, CRDP, their directors or supporters.

Executive summary | *sommaire*

Canada's opioid crisis has spiralled from relatively rare heroin usage in the 1990s to a nationwide epidemic of overdose deaths. This new epidemic is driven by synthetic fentanyl and a terribly misguided policy response: "safe supply" programs that distribute opioids in the form of Dilaudid, or hydromorphone (HM) tablets.

Because safe supply was meant to curb overdoses, health officials initially framed these programs as "harm reduction." Yet, they morphed into a social justice experiment detached from clinical evidence – epitomized by the dispensing of 8 mg Dilaudid tablets (the strongest dose available) for unsupervised use. For context, Dilaudid is as potent as heroin and – assuming most of us are "naïve" to opioids – a 1 or 2mg tablet would be enough to knock a typical adult out for several hours, say, after breaking a bone or having surgery.

Safe supply, as implemented, not only fails to reduce overdose deaths, but exacerbates the diversion of HM tablets for illicit use and undermines proven treatments like opioid agonist therapy (OAT), which rely on methadone or buprenorphine – well-known, safe, and effective medications.

The crisis demands a return to evidence-based policy. Overdose deaths in Canada surged to more than 7,328 in 2021 despite the expansion of so-called safe supply (Public Health Agency of Canada 2018; Health Canada 2023). By comparison, 3,023 Canadians died in 2016 of opioid overdoses (Health Canada 2019). Qualitative studies touting the benefits of safe supply programs – self-evaluations by program advocates – lack rigour. HM tablets are being widely diverted (sold or traded), flooding the streets at prices that compete with the street supply. Meanwhile, OAT, which is supported by decades of data showing mortality reductions, has been side-lined.

Safe supply's proponents argue that it respects user autonomy and reduces stigma, likening it to regulated alcohol. Yet opioids' acute toxicity – unlike alcohol's incremental harms – renders this analogy meaningless and fallacious.

We need a better path.

This new approach should:

- Prioritize opioid agonist therapy and a full suite of wrap-around services over the distribution of opioid tablets alone.

- Be genuinely evidence-based – in other words, "follow the science."
- Balance the well-being of individuals and communities.
- Reintegrate the "four pillars" of drug strategy – prevention, treatment, harm reduction, and enforcement – so that it addresses not only the harms of opioid use but also the root causes and contributing factors that perpetuate this crisis.

By shifting the focus back to a legitimate drug strategy model, Canada can ensure that we do not pursue harm reduction in isolation but instead link it to pathways of recovery and long-term stability. It's time to move the needle toward recovery and away from accepting the perpetual use of opioids. Only then can we hope to create a system that truly reduces harm and fosters healthier communities. **MLI**

Au Canada, la crise des opioïdes a pris des proportions telles qu'elle constitue désormais une épidémie nationale de décès par surdose, alors qu'au cours des années 1990, l'usage de l'héroïne était relativement rare. Cette récente épidémie est attribuée au fentanyl synthétique, ainsi qu'à la réponse profondément inappropriée des gouvernements, qui ont mis en place des programmes d'« approvisionnement sécuritaire » en opioïdes sous forme de comprimés de Dilaudid ou d'hydromorphone.

Ces programmes ont initialement été introduits pour « réduire les risques », dans l'espoir que leur mise en œuvre contribuerait à prévenir les surdoses en assurant un approvisionnement sécuritaire. Malgré l'intention, ils se sont métamorphosés en une initiative de justice sociale exempte de fondement clinique, concrétisée par la distribution de comprimés de Dilaudid de 8 mg (la dose la plus forte disponible) pour un usage non supervisé. Pour le contexte, le Dilaudid est aussi puissant que l'héroïne et, pour beaucoup d'entre nous très peu familiers avec le sujet, précisons qu'un simple comprimé de 1 ou 2 mg suffit pour induire chez un adulte moyen une somnolence de plusieurs heures, par exemple à la suite d'une fracture ou d'une opération chirurgicale.

L'approvisionnement sécuritaire, tel qu'il est actuellement déployé, est non seulement inefficace pour réduire le nombre de décès par surdose, il exacerbe le détournement des comprimés d'hydromorphone à des fins illégales et sape les efforts de traitement éprouvé, par le biais, notamment, des agonistes opioïdes (TAO) comme la méthadone ou la buprénorphine – des médicaments reconnus pour leur sécurité et leur efficacité.

La crise nécessite de revenir à une politique fondée sur des données probantes. Le Canada a enregistré plus de 7 328 décès par surdose en 2021 malgré l'élargissement du programme d'approvisionnement soi-disant sécuritaire (Agence de la santé publique du Canada, 2018; Santé Canada, 2023). En comparaison, en 2016, 3 023 personnes sont décédées à la suite d'une surdose (Santé Canada, 2019). Les études qualitatives

qui vantent les mérites des programmes d'approvisionnement sécuritaire – des auto-évaluations réalisées par les défenseurs des programmes – manquent de rigueur. Les comprimés d'hydromorphone sont fréquemment détournés (vendus ou troqués) et inondent nos rues à un prix avantageux par rapport au marché. Parallèlement, le TAO, appuyé sur des décennies de données qui démontrent ses effets sur la réduction de la mortalité, a été écarté.

Les défenseurs de l'approvisionnement sécuritaire soutiennent qu'il préserve l'indépendance de l'utilisateur et réduit la stigmatisation, en le comparant à l'alcool réglementé. Pourtant, la toxicité aiguë des opioïdes – contrairement aux dommages progressifs de l'alcool – rend cette analogie dénuée de sens et trompeuse.

Il nous faut une meilleure voie.

Cette nouvelle méthode doit :

- *Privilégier le recours au traitement par agonistes opioïdes et à un ensemble complet de services d'accompagnement plutôt qu'à la simple distribution de comprimés d'opioïdes.*
- *Reposer véritablement sur des preuves tangibles – en d'autres termes, « s'appuyer sur la science ».*
- *Fixer un équilibre entre le bien-être des individus et celui des collectivités.*
- *Remettre en avant les « quatre piliers » de la politique antidrogue – prévention, traitement, réduction des risques et répression – pour s'attaquer non seulement aux conséquences néfastes de la consommation d'opioïdes, mais aussi aux origines profondes de la crise actuelle et aux facteurs qui la perpétuent.*

Si le Canada se recentre sur une stratégie défendable de lutte contre les drogues, il aura la possibilité de dépasser l'approche strictement axée sur la réduction des effets néfastes en la liant aux voies de la guérison et de la stabilité à long terme. Il est temps de changer les choses en favorisant le rétablissement plutôt qu'en se résignant à accepter l'utilisation continuelle d'opioïdes. Ce n'est qu'à cette condition que nous pourrons espérer créer un système qui réduit réellement les préjudices infligés et promeut des collectivités plus saines. **MLI**

Introduction

"We provide them with access to drugs on the understanding that they choose which drugs, and they choose which doses to take, which is remarkable in any area of pharmacotherapy."

—Dr. Julian Somers, Simon Fraser University

In the late 1990s, I trained as a family medicine resident in downtown Vancouver and in rural British Columbia. At St. Paul's Hospital in Vancouver, I worked as a clinical associate on the HIV ward; at the same time, I worked on the Downtown Eastside, where I saw injection drug users navigating heroin's grip while others used oxycodone, extracted from OxyContin capsules. Health officials considered methadone a fringe treatment then – a harm reduction tool, not a cure. Doctors, seeing patients in the streets, prescribed it on the "fringes" of urban society to engage the most marginalized people and to curb HIV transmission by reducing injection drug use. Addicts injected opioids away from public view – hidden, stigmatized, and distant from mainstream medicine. But once HIV treatments became effective, the sickest population on the wards shifted from gay men to injection drug users (IDUs), as effective AIDS treatments helped the population of gay men, while missing the socially unstable IDUs who were unable to maintain the demanding medications, doctors' appointments, and follow-up regimes. We trainees barely understood methadone; no one suggested that it could be a treatment option that transformed people's lives.

Since then, opioid use has been transformed – in some people's minds – from a niche problem to an individual right, wherein advocates can demand that we "scale up the availability of safe, legal drugs to divert people from the poisoned drug supply in the illicit market" (*VICE* 2020). This change has played out against the fundamental goals of any reasonable public policy and

the pressures of strained public resources. The increasing political acceptability of applying lived experience and social justice to displace, rather than inform, public health research moved us quickly away from using objective science as a metric by which to scrutinize certain policy decisions. That we, as doctors, should turn away from objectivity and write prescriptions for opioid tablets, *ad libitum* – to be taken as often as desired – is at the crux of this moral conflict for many of us in addiction medicine.

Twenty years later, the landscape is unrecognizable. Once overprescribed, prescription opioids sparked widespread opioid dependence across North America. When doctors began pulling back on those prescriptions, patients replaced pills with heroin, then synthetic fentanyl – often contaminated and of increasing potency – which fuelled an overdose crisis (Fischer, Pang, and Jones. 2020). By then I was working in the shelters of inner-city Hamilton, Ontario, where I was seeing opioid deaths spike. Harm reduction pivoted from infection prevention to overdose prevention. Enter "safe supply" – hydromorphone tablets handed out as a "regulated" alternative to street fentanyl. What began as a pilot study morphed into national policy, branded as harm reduction but steeped in social justice rhetoric: a "right" to clean drugs.

No other country in the world has conducted such an extreme policy of advocating for unsupervised opioid pill distribution. Those who point to Switzerland, or Portugal, have it wrong. Switzerland is known for pioneering heroin-assisted treatment for people with severe heroin addiction, as a strategy to reduce needle-sharing and the consequent spread of HIV. In the Swiss program, patients inject heroin under medical supervision. Portugal is known for implementing a national strategy that redirects people who use illegal drugs away from prison and towards treatment as a healthier alternative. Drugs remain illegal, and users are required to attend dissuasion sessions that often lead to treatment. Repeated users who fail to take up treatment can face escalating consequences, like administrative fines and penalties. Both these models were relatively successful in their targeted goals – reducing the spread of HIV and decriminalizing addiction, respectively. But what Canada has chosen to do to address opioid overdose is unique in that no other country would envision a policy in which people with opioid addiction are simply given bottles of opioid pills with the assumption that this will solve their risk of overdose death.

This shift to safe supply defies comprehension. Opioids kill people – suddenly – unlike alcohol's more insidious destruction (Fischer, Pang, and

Tyndall 2019). Many addiction experts have had to sit quietly as this new drama unfolds, watching patients trade their daily supply of Dilaudid pills for a daily supply of fentanyl. Meanwhile, overdose deaths have continued to climb, despite the newly abundant supply of "safer" pills. How did we get here? Since safe supply is clearly a mistake, why keep repeating it? This paper traces the evolution of the crisis, critiques the failures of safe supply, and charts a better course – a path rooted in evidence and experience.

From heroin to fentanyl: the opioid crisis unfolds

Canada's opioid story begins with heroin – a drug originally associated with artists and outcasts, glamorized yet reviled (Lathan 2009). By the late 1990s, overzealous opioid prescribing had broadened the user base, and more people were addicted to oxycodone than heroin. By 2012, when physicians began curtailing their opioid prescriptions, many opioid-dependent people were driven to heroin, then fentanyl (Public Health Agency of Canada 2018). Fentanyl, which has a potency 50 to 100 times that of heroin, made its way across the country, and by 2021 was pushing overdose deaths to more than 7,000 annually (CDC 2022; Health Canada 2023).

By 2015, the increase in fentanyl within the North American street supply of drugs led to a surge in overdose deaths, heightening the collective desperation of drug users and health care providers; fentanyl quickly became the drug of choice as the cheaper and more potent alternative to increasingly irregular supplies of heroin and prescription pills (CDC 2022; MacMillan 2024). As patients report repeatedly, "once you've had fentanyl, you can't go back," meaning that the "high" – the speed of its onset and the potency of the drug – cannot be replaced by any other opioids. Those who have tried to use the HM tablets to replace their fentanyl invariably report that they sold or traded the pills because they were not strong enough to stop the intense withdrawal that appears within hours of a fentanyl dose.

By 2020, the landscape of addiction and the street drug supply had changed dramatically; what had worked 20 years earlier for heroin or prescription

opioid addiction – essentially methadone – now seemed ineffective in helping people stop their fentanyl use. Outcomes shifted from preventing infections to preventing overdoses.

In response to the rise in opioid deaths, overdose reduction strategies flourished, both on the ground and at the policy level. This was a welcome response, but somehow the mounting fear, compounded by COVID-19 lockdowns, saw the idea take root that harm reduction could, or should, be delinked from treatment. Perhaps harm reduction could call itself "treatment," implying that we were turning to a solution to treat the overdose problem, and therefore it was, on its own, a valid strategy for reducing overdose. But there was no evidence to back up this claim. The logic eluded many experts in addiction medicine but nonetheless gained traction with activists and policy-makers, conveying their apparent compassion for the marginalization and stigmatization of drug use. Unfortunately, there was no objective evidence that this was a good idea; even worse, we already knew where free-range opioid prescribing had gotten us before with oxycodone.

> *Sound drug policy balances on four pillars – prevention, treatment, harm reduction, and enforcement.*

We need to expand interventions that sound evidence has shown to be effective. We have no shortage of high-quality data outlining lessons learned from opioid prescribing across North America (Rao et al. 2021); we could be applying those lessons in Canada to yield better drug policy. The past 10 years of addiction medicine has seen significant improvements in accessible and effective forms of addiction treatment, including newer, easier, safer and more patient-centred treatment strategies for opioid use disorder (OUD) (Bromley et al. 2021). That Health Canada completely overlooked these advances in known, life-saving benefits (Sordo et al. 2017, Santo et al. 2021) in favour of the "novel" approach of distributing Dilaudid tablets as a "safe supply" is disconcerting to say the least.

Healthy drug policy

Sound drug policy balances on four pillars – prevention, treatment, harm reduction, and enforcement. To focus excessively on one pillar is to skew our approach. The past 20 years has seen a stigmatization of treatment and recovery. Health professionals who practiced addiction medicine before the rise of fentanyl in North America are familiar with the value of harm reduction. That's why it has been so difficult to watch resources flow into unevaluated strategies that have failed to alter the course of the fentanyl market. A more balanced approach would integrate objective findings with established policy strategies.

Prevention means educating the public about mental health and social vulnerability, and about drug and alcohol use, while addressing the psychosocial needs of vulnerable people early – preferably before they engage in substance use to "self-medicate."

Treatment of opioid use disorder means using effective approaches like oral opioid agonist treatment (OAT) – methadone, buprenorphine, or long-acting oral morphine – taken once daily. Integrating psychotherapeutic supports (Dutra 2008) into treatment is important, as is linking harm reduction and treatment services. And establishing standards for withdrawal management (Kahan, Regenstreif, and Weiss 2022a), and residential treatment (Kahan, Regenstreif, and Weiss 2022b) will help unify our fragmented approaches to care and help people build on their recovery (Cloud and Granfield 2009) to find productive and meaningful lives.

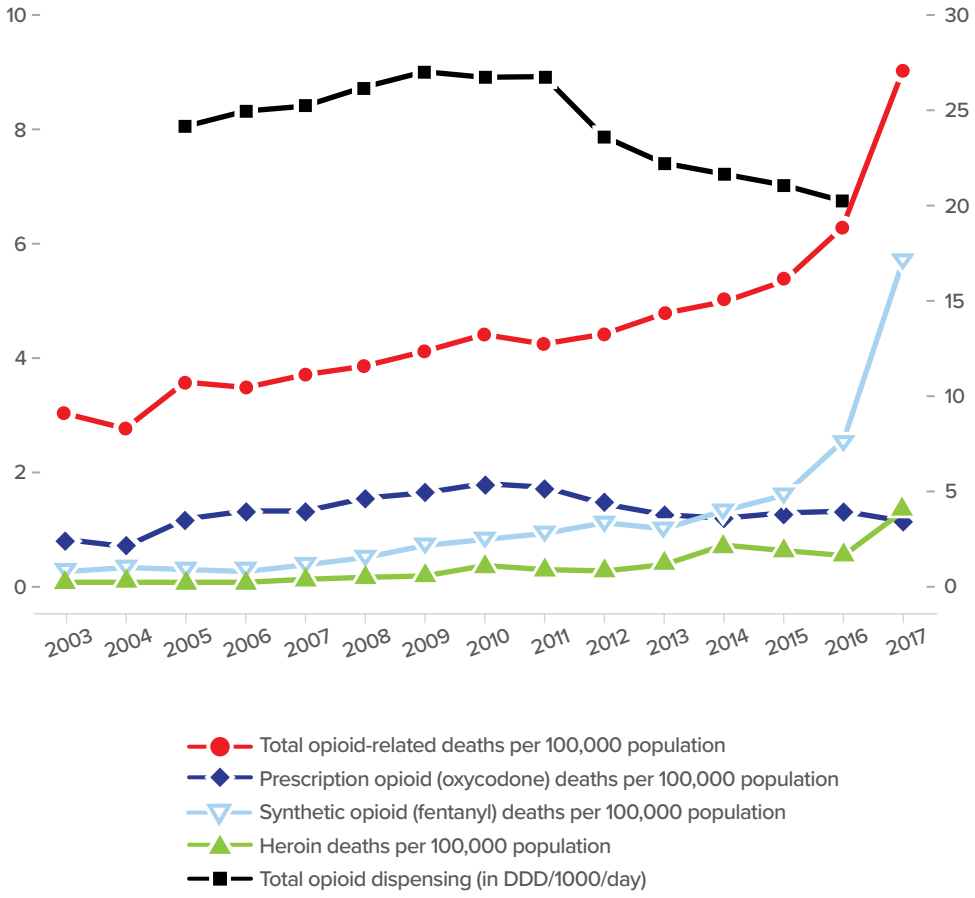
Enforcement means supporting community safety and police services while acknowledging drug use as a reflection of underlying clinical and social pathology. We can address some of that pathology without police intervention, though police play a role in ensuring community safety, especially in high-risk, low-income areas where violent crimes and drug markets are high, and the privileges of private security systems are usually out of reach. Drug use in Canada rarely leads, *prima facie*, to charges, and arrests tend to follow illegal behaviours related to untreated, unstable drug use. In recent years, there has been a growing emphasis on treating drug use as a public health rather than a criminal issue. Although we hear repeatedly about the need for "decriminalization" of drug use, and how the legal system stigmatizes people who use drugs, the reforms of Bill C-5, passed in November 2022, formally reduced this narrative (Senate of Canada 2022). While Bill C-5 did not fully

decriminalize drug possession, it made it easier for individuals to avoid prison and access treatment, prioritizing court diversion programs and reducing the use of mandatory minimum sentences. This is how we should expect successful drug strategy to function.

We know that availability, affordability, and the perception that drugs are safe, facilitate their use. The rise in the over-prescribing of oral opioids in the 1990s and into the 2010s created new cohorts of opioid users, young and old, who became physically dependent on pills, capsules, and patches, which then led to a rise in overdose deaths related to those opioids (Fischer, Jones, Urbanoski et al. 2014).

When it became clear that by adhering to this pattern medical personnel were in fact harming patients ("iatrogenic harm;" see Harvard Health Publishing 2023), prescribers pulled back, policy analysts wrote new

FIGURE 1: Opioid dispensing and opioid-related mortality in Ontario, 2003–2017



Source: Fischer, Pang, and Jones 2020.

opioid guidelines, and the street supply of prescription opioids diminished. But a mass exposure had happened; the diminished supply of opioids led to a surge in heroin and synthetic fentanyl-related mortality, initially in British Columbia and Ontario.

A sound drug policy balances the prevention, treatment, harm reduction, and enforcement pillars. Focusing too heavily on one – like harm reduction in the form of safe supply – can undermine serious efforts at mitigation of public harms. For 20 years, Canada has de-emphasized treatment, sometimes stigmatizing recovery (Humphreys et al. 2022). Clinicians like me, who are pre-fentanyl veterans, value the role that harm reduction can play against a toxic supply – but watching resources flow to untested tablet programs while deaths rise has been frustrating at best.

The hijacking of harm reduction

For unknown reasons, Canada, unlike its peer nations, decided to repeat the prescribing error of 10 years earlier, all under the guise of "harm reduction." When fentanyl appeared in the heroin supply in 2015, patients were the first to report the changes: stronger effects that knocked them out and left them with intense, sickening withdrawal. The drug they described was not the prescription-grade gel supplied in fentanyl patches that came in micrograms, but a dark, amorphous substance measured in milligrams, causing more overdoses and an escalating tolerance. People needed more and stronger opioids to stay out of withdrawal and even more to feel euphoric. The addiction and harm reduction community, public health leaders, epidemiologists, and drug policy experts became like the blind men touching the elephant, each with a partial answer to the overall problem based on their experience, but none of them able to align with each other. Author and addiction expert Dr. Vincent Lam drew this simile well (Lam 2023), except that in his description the elephant was restless and the blind men more frantic.

Canada could have used the collective urgency to collaborate; the public health sector was ideally positioned to evaluate and advise on population health and evidence. Instead, there was division. In 2016, Health Canada

established the Substance Use and Addiction Program (SUAP), ostensibly to "shift towards a more comprehensive public health approach to substance use…." But despite decades of compelling evidence for OAT, among the 92 new SUAP projects funded in 2021, only 9 per cent focused on treatment (Health Canada 2021b). This approach continued into 2024. Rather than support harm reduction programs that linked people to treatment, or that linked the four pillars to each other, funding pipelines for experimental pill prescribing grew, without ongoing evaluation.

Health Canada's SUAP-funded projects made headlines and claimed that safe supply opioids helped people at risk of overdose, but the projects made assumptions about what was actually helping. They conflated concepts around the word "safe." "Safe injection," "safe use," "safe consumption," and "safe supply" became interchangeable terms, all part of a harm reduction vernacular, yet it was unclear which were effective, which were ineffective, and which might be adding new problems to the mix. Given the number of variables at play and Health Canada's lack of commitment to evaluation, the truth was unclear. The different terms, concepts, and strategies, all identifying as harm reduction, created confusion.

Safe opioid supply quickly fit itself under the harm reduction umbrella, a bait-and-switch that almost no one noticed. After all, how many Canadians could tell the difference between safe supply and harm reduction? How many in government knew of the distinctions when the money began to flow to SUAP?

> "We provide them with access to drugs on the understanding that they choose which drugs and they choose which doses to take, which is remarkable in any area of pharmacotherapy… normally in any practice area, if you're going to… embed the word 'safe' in the title, there's a clear expectation that there is some kind of scientific evidence of safety and likely also some scientific evidence of effectiveness," noted Dr. Julian Somers of Simon Fraser University (Somers 2024).

If the primary goal of harm reduction is to reduce risk while linking people to safer options, how did the concept evolve into a social justice narrative rather than an essential clinical and public health tool? Good tools should lead to measurable population outcomes, not positive social media traffic.

Activists argue that we all have a right to use our chosen drugs safely, as if heroin and coffee are equal in their ability to destroy people's lives. Sure, we all have privileged access to a "regulated supply" of alcohol, or cannabis. But no one stands outside a liquor store and advocates for everyone to drink publicly, and with impunity, or writes documents that promote and normalize their trafficking (National Safer Supply Community of Practice 2022).

Once the idea of a "lifesaving" solution had entered the public arena, COVID lockdowns led to louder demands for an expansion of the pilot programs. The lockdowns, which suddenly restricted access to doctors' offices, pharmacies, and emergency rooms, left thousands of people – physically dependent on opioids for pain or for addiction treatment – to fend for themselves (Henderson et al. 2021). Deaths from fentanyl rose and desperation mounted.

"Activists argue that we all have a right to use our chosen drugs safely, as if heroin and coffee are equal in their ability to destroy people's lives.

Some innovations showed early benefit. To avoid methadone patients having to go to a pharmacy every day, a small group of addiction experts rapidly formed a working group in March 2020 and within a short time had developed a document that could be shared with OAT prescribers across the country that recommended new, more flexible guidelines (Bromley et al. 2021). Similar efforts started in the United States as well; these innovations all stood up well to evaluation and methadone prescribing approaches changed for the better. In Timmins, Ontario, two ER physicians trialled a novel pilot where patients rescued by EMS personnel were given buprenorphine (Suboxone®) to treat the acute withdrawal that follows a naloxone rescue dose. This made the patients comfortable quickly and gave them a chance to try this form of OAT treatment (Marion-Bellemare 2023); they could then connect with prescriber. Innovations like these garnered little attention and received minimal promotional support.

Other effective interventions such as naloxone education and distribution continued to expand and are significant factors impacting overdose death prevention outcomes at, and near, community harm reduction programs and other settings (Fisher et al. 2025; McDonald and Strang 2016).

We know that starting OAT reduces the frequency of the risk-taking behaviours around drug use and reduces all-cause mortality (Santo et al. 2021). In fact, since the emergence of fentanyl, evidence continues to point to the protective effects of methadone treatment in the fentanyl era (Stone et al. 2020; Lee et al. 2023). These are all examples of harm reduction being linked to low-barrier treatment as one of the cornerstones of drug strategy.

Meanwhile, harm reduction activism seemed to tie itself to safe injection and safe supply, as the two interventions became increasingly entwined. Though older data had shown lower infection rates when users consumed drugs at supervised injection sites (SISs), there was no data showing that distributing Dilaudid pills at these locations benefited users in any way. Staff at SISs often seemed well-meaning, but inexperienced. They appeared to not fully understand the behaviours and trajectories of untreated drug use, such as the constant pressure felt by users to acquire more drugs as well as money or other currencies to obtain them. For instance, consider the 2023 shooting incident in Toronto connected with the Parkdale Community Health Centre. In this case, a peer support worker, perhaps with naïve but good intentions, ended up on the wrong side of the law in attempting to protect a safe consumption site client involved in a shooting (*Toronto Star* 2023). Indeed, the social justice narrative has become more insistent. Today, it encourages a policy that removes medical prescribers from the equation and allows for a "non-medicalized model" in which people without experience in addiction care or opioid prescribing could take over control of opioid distribution (Kolla et al. 2024).

So, what is so wrong with this thinking? Why do addiction experts seem riled up by a policy that, one might perceive, is unrelated to their work? Where is the harm in this "harm reduction strategy?"

Patients report that the 8mg HM pills are not strong enough to stave off their cravings: "I can't dissolve more than 8 pills (about 300MEQ) in a cooker," lamented one. Understanding the simple chemistry and physiology behind the flawed concept of boiling down and injecting pills exposes the profound flaw in the "lifesaving" thinking behind this: after multiple tablets

have been boiled and dissolved into a solution, they must then be cooled back to body temperature before they can be injected. Higher concentrations mean a precipitate (solids) can form when the temperature of the solution drops, or the pH or the salinity (saltiness) changes. The result is that every time a user injects a solution of cooked tablets, solid particles can stick to blood vessels, heart valves, and the tiny capillaries in the lungs, the brain, and the spinal cord.

Drawing the solution through a filter or sponge is no guarantee against this. And if the sponge or filter is re-used after sitting at room temperature, bacteria or fungi can hitch a ride with the particles, travelling with the boiled solution through the right side of the heart, into the lungs, out the left side of the heart, and into the rest of the body, including the brain and spinal cord. This is the risk users face every time they inject a drug that they have prepared this way. "Safe" may be "safer," but infections are extremely common in people who inject drugs (See et al. 2020). A harm reduction approach that fails to help people inject less often is a failed strategy, not only because of the likelihood of acquiring a severe infection, but also because of the repeated assaults on the brain from oxygen deprivation when users experience multiple respiratory arrests followed by naloxone reversals (Xavier 2023).

When we look at the best evidence, the data is clear: link people to OAT. We have known of the effectiveness of OAT for decades (Dole and Nyswander 1965; Hser et al. 2001). Depending on how they are provided, OAT medications (buprenorphine and methadone) offer both harm reduction and treatment.

Funding streams have continued to exclude and even stigmatize treatment and recovery in favour of narratives claiming to "meet people where they are at" without imposing "oppressive" values of treatment or treatment-linked enforcement strategies. Government/health authorities denied clinicians with years of clinical experience treating opioid use disorder access to the flow of funds for pilot projects, research, or clinical guideline and policy development. The early innovations of META:PHI (i.e., Mentoring, Education, and Clinical Tools for Addiction: Primary Care-Hospital Integration), the Timmins group, and others went mostly unnoticed. This disengagement of treatment from harm reduction was perhaps the worst policy error to happen to opioid strategy in Canada. As cannabis decriminalization evolved into cannabis normalization, safe supply drugs did the same.

While opioid treatment relied on supervised dosing as a standard, the "Safer Alternatives for Emergency Response" (SAFER) program in Vancouver declared a different approach:

> "In contrast with most other existing safe supply options, SAFER participants are not required to remain on OAT concurrently. By decoupling these interventions, the focus of SAFER is on harm reduction, promotion of participant autonomy and improvement of participant–provider relationships" (Klaire et al. 2022).

Treatment was not elemental to its harm reduction program, though the provision of "safe" medications was.

Addiction psychiatrist Dr. Rob Tanguay of Calgary emphasizes an essential flaw in this thinking:

> "The fact that anybody is debating whether or not we should treat it is not only shocking but also discriminatory, racist and stigmatizing. We would never debate whether or not we'll treat someone's cancer or heart disease, but we will debate whether or not we'll treat somebody's addiction" (Open Parliament 2024).

Safe injection sites: safe supply adjacent

Vancouver was home to North America's first safe injection site, Insite (Vancouver Coastal Health 2023). In the late 1990s this program was an innovation for Canada; initially it set out to reduce the transmission of HIV and Hepatitis C in people who inject drugs (PWID). Studies show that when people inject drugs, the cleaner their injecting supplies, the lower the risk of transmission of HIV and Hepatitis C (Aspinall et al. 2014). Following the launch of Insite, researchers in BC conducted two studies: the North American Opiate Medication Initiative (NAOMI) (Oviedo-Joekes et al. 2008) and the Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) (Oviedo-Joekes et al. 2016). This was before the rise in fentanyl The studies drew attention to the objective benefits of supervised (or "safe") injection sites as a means of keeping hard-to-engage injection drug users in treatment and

linking them with health services. But when overdose deaths mounted after fentanyl appeared, the story of SISs became one of "life-saving interventions" over the prevention of infection transmission.

Dooling and Rachlis (2010) provide a concise description of the perceptible value of safe injection sites. Theirs is an excellent snapshot of where we stood in Canada on SISs 15 years ago. A 2006 study from BC had shown an increase in the uptake of detoxification services and addiction treatment after SISs were set up, and although overdose death prevention numbers were not yet compelling, it made sense that the sites could reduce overdoses by virtue of supervision – like the benefit of having lifeguards at a pool.

Canadian SISs that opened or expanded since 2016 have not consistently tracked long-term outcomes. For bean counters, every overdose tallied in an SIS can be reported as a life-saving event; they record no broader information, such as where the clients went after receiving naloxone. A dose of naloxone induces severe withdrawal symptoms so intense that it will drive a fentanyl user to find another dose as quickly as possible, literally running from paramedics, police, and emergency departments in their quest to do so. Also not accounted for: while SISs were expanding, so was the availability of naloxone kits – the increased availability of naloxone, particularly in the vicinity of harm reduction programs, also reduces overdoses.

With attention now focusing on SISs to prevent overdose for people using fentanyl, *ad hoc* "overdose prevention sites" (OPSs), later called "supervised injection (or consumption) sites" (SIS/SCSs) sprang up mainly across BC, Alberta, and Ontario. In these spaces, people trained to handle overdose could oversee drug consumption – usually via injection – give oxygen and, sometimes, naloxone if needed. Although not all were originally funded as supervised injection sites, by 2019–2020, many of the SISs were providing more than just a safe place to use drugs; they often included access to more on-site medical and social supports. In Ontario, community health centres (CHCs) applied for, and received, designated funding to house and run these programs. It seemed as if the opportunity to truly pilot a model of evidence-based harm reduction – supervised injection – was upon us. But variables changed rapidly as the idea of a "safe supply of regulated pharmaceuticals" caught on and, not long after authorities implemented lockdowns in response to the COVID pandemic, doctors and nurse-practitioners, many of them new to opioids, began prescribing "safe supply" tablets as an "overdose response" strategy.

In this way, the safe injection sites and safe supply tablets became intertwined. A new independent variable drifted in, skewing the outcome data intended to evaluate safe injection sites. Evaluation of the sites became even more muddied. Which factors were impacting overdose reduction at the sites? Which factors were improving access of patients to nursing care for wounds, thereby reducing ER usage? And which factors were neutral or even causing increasing rates of opioid addiction in the adjacent community?

Surveys of users of a safe consumption site in 2017 would have still been confounded, given that the sites also provided peer support, advice, and referral to health services. Fast forward five years and SISs were also sites where people received a tablet prescription. This created a new element of bias in the studies and self-reports coming from these programs.

We also know little about the outcomes of individuals who survive an opioid overdose or even about those who recover from the severe infections that are common to people who inject drugs, whether viral infections from shared needles, bacterial infections from simple skin germs or "vegetations" of bacteria and tissue that stick to the walls of blood vessels and heart valves. A safe consumption site cannot guarantee against these possibilities; the perpetuation of injection drug use will always come with severe consequences. A site cannot watch over people 100 per cent of the time, meaning they go home or elsewhere to use drugs as well. Without incentives to reduce or stop injecting, these risks continue.

Overdose survivors may suffer brain damage from oxygen deprivation, forever dependent on extra supports in their daily life. Others survive injection-related infections that cause spinal cord abscesses and bone infections, leaving them paralyzed or needing a limb amputation. Still others require one, or repeated, open-heart surgery for infected heart valves. Every time someone injects a solid substance such as a tablet or capsules, those solids will stick to the walls of blood vessels – including the veins and arteries leading in and out of the heart and lungs. Eventually, the voices of pro-expansion advocates drowned out the voices of concern, eclipsing harder questions from the experts thinking, "what exactly are we doing?"

Based on European programs and the Canadian data from NAOMI and SALOME, Dr. Lisa Bromley, an addiction expert based in Ottawa, launched a long and frustrating effort to get federal support for injectable opioid agonist treatment (iOAT) programs in the early days of fentanyl's rise. But after years

of advocacy, it became clear that providing iOAT was "too expensive" as it requires intensive staffing and pricey, injectable opioid solutions. For many drug users, previously adequate 10mg/mL HM ampules eventually become too weak to compete with fentanyl's potency; people would need the higher concentration, more expensive 50mg/mL ampules. Between the intensive resources and the expensive drugs needed for iOAT, officials rejected Bromley's efforts due to the prohibitive cost. By 2021, Bromley had effectively given up on asking government to support real iOAT programs in Ontario. Meanwhile, support for programs giving out cheap HM tablets ramped up. Removing the need for observed dosing was key to saving money on staffing and, at the same time, keeping patients happy.

The original term, "safe opioid supply," referred to *injectable* opioid agonist treatment – heroin and hydromorphone – provided in alignment with an SIS and linked to other health and social services. This concept emerged from small programs in a few European countries including the "heroin-assisted treatment (HAT)" program in Switzerland where individuals receive injectable or oral heroin in a supervised setting. But Canada was not doing Switzerland. Again, the term "hijack" comes to mind.

Since some officials regarded a properly run iOAT program as prohibitively expensive, why not simply give people Dilaudid tablets to crush, cook, and inject? One program in Vancouver, the Molson Overdose Prevention Site (MOPS) provided "tiOAT" (tablet OAT) with staff making a solution from tablets for supervised injection. The program, which was labour- and resource-intensive, seemed to have positive outcomes in retaining some people and linking them to other services. Up to a point, supervised injection sites were intended to watch over and engage people, "lifeguarding" their risky drug use while still reducing harm. Although there was a robust debate about whether these sites were helpful or harmful to their communities, people who used them usually had to bring their own drugs.

By 2022, self-reported evaluations of the safe supply programs by satisfied clients eclipsed objective evaluation data, and the data for the effectiveness of SISs became murkier. Cheap HM tablets had filled the gap, blurring the mission of SISs to reduce harms. Was harm, in fact, reduced? Perhaps – but it was now impossible to determine as there were more variables at play; opioid tablets had become yet another valued item on the menu in the SISs.

A "safe" supply of pills

British Columbia and Ontario increased their efforts to expand pilot programs of "prescribed safer supply" (British Columbia Centre on Substance Use 2020; CBC 2020). The term "safe supply" started out meaning "prescribed" and "supervised," as was the case in Vancouver and in Switzerland. The small "pilot safe supply" projects giving out pills in London, Ottawa, and Toronto started around 2016 to 2018 for people with apparently severe use for whom "OAT does not work." The most vocal "pioneer" of these initiatives was Dr. Andrea Sereda at the London Intercommunity Health Centre (LIHC) who, early in her career, took over a practice in which a retiring doctor had been prescribing opioids to women using drugs who reported doing sex-work in exchange for their substances. Very keen to expand this social justice concept, Sereda began promoting the concept of "safe supply" opioids, first to colleagues, then more broadly to the addiction medicine community. During this time, she even convinced the College of Physicians and Surgeons of Ontario to change their recommendations around opioid prescribing, essentially removing themselves from the responsibility of having to oversee the onerous job of advising MDs on their opioid prescribing patterns.

At the same time, Dr. Sharon Koivu, working in the hospital in London, saw striking increases in the frequency and severity of injection-related infections, particularly of heart valves. As she started to speak out within the community, expressing her concerns about the practice of giving people unobserved doses of opioids (remember that the Swiss programs and the NAOMI trials all involved only *observed dosing* of short-acting opioids). She received a swift backlash from advocates of harm reduction, many of whom refused to acknowledge that she made her objections in the context of safety concerns for people who use drugs:

> "When I came to say I'm concerned about what I'm seeing: the infections, the suffering, the encampments ... I was literally told that I was lying" (Koivu 2024).

By 2020, an unspecified number of BC, Alberta, and Ontario doctors were prescribing HM tablets for use in an unsupervised setting. These tablets were then distributed via pharmacies of "MySafe" vending machines (Health Canada 2021c). The pitch was that these tablets were a "safer" fentanyl

substitute – despite the lack of evidence that that was the case. Meanwhile, Health Canada funding drove the expansion of the National Safer Supply Community of Practice (NSSCoP) from which safe supply advocates, most with little clinical or research experience, encouraged doctors and NPs across the country to prescribe.

But fentanyl users, needing upwards of 1,500 to 3,000 morphine equivalents (MEQ) daily, would find 30 HM tablets (900 MEQ) inadequate. They had to sell or trade their pills for their more potent, preferred drug. We soon saw open street markets around pharmacies and thousands of pills appearing in police seizures, alongside crystal methamphetamines, fentanyl, and guns (Global News 2023; Hamilton Police 2024). Normalizing diversion as a type of "mutual aid" (Substance Use Health 2023) continued to defy logic, as advocates both denied and defended the diversion of tablets from the programs, calling such concerns, "an attempt to seize control of the narrative" (CBC News 2024).

In 2021, Health Canada announced another controversial safe supply initiative: the MySafe project (Health Canada 2021c), which placed hydromorphone dispensing machines in strategic locations in four Canadian cities – Vancouver, Victoria, Dartmouth, and London. According to Dr. Mark Tyndall, director of the project:

> "MySafe is designed to address the drug poisoning crisis head-on. It provides a low barrier, convenient, and secure way to access a safer drug supply for those most at risk of dying from an overdose." (Health Canada 2021c)

A related initiative, Fair Price Pharma, also launched in BC around the same time. It promoted prescription-grade opioids – heroin and fentanyl – to harm reduction programs. At some point, Sereda, who by that time was part of the federally funded hydromorphone Emergency Safer Supply substitution program, and Tyndall, were both board members of Fair Price Pharma, raising questions about potential conflicts of interest as Sereda continued to advocate for expanding access to those pharmaceutical-grade opioids (Yanor 2023).

The cheap ($0.37 each) HM tablets, prescribed, dispensed, and paid for by provincial drug formularies, quickly gained traction over the pricey iOAT programs; the tablets had found a place under the harm reduction pillar even though there was no data on their public safety. Programs even distributed

FIGURE 2: BC's fentanyl tablet program

FENTANYL TABLET PROGRAM

QUICK FACTS

WHAT IS A FENTANYL TABLET PROGRAM?

- It is designed to help reduce harms associated with the unregulated drug supply.
- Fentanyl tablets are dissolved under the tongue or on the side of your cheek.
- Some people may only want or need fentanyl tablets. Others may need the tablets with other forms of harm reduction, or the tablets on top of their methadone or Kadian treatment. **Fentanyl tablets should not be used on top of Suboxone treatment.**
- Based on real-life experience, some people have been able to reduce or stop using unregulated fentanyl once they report feeling stable on fentanyl tablets.
- Some programs are starting to offer this option, however, local accessibility may vary.
- This is not an approved treatment for opioid use disorder as there is no current research evidence to support the use of fentanyl patches in this way.

HOW DOES THE PROGRAM WORK?

- **You and your health care provider will work together** to decide if trying fentanyl tablets is right for you.
- A physician or nurse practitioner can prescribe fentanyl tablets.
- If you feel like you need a higher dose, discuss with your care provider.
- In the beginning of the program, you will need to attend a clinic or pharmacy a few times a day to receive your medication.
- During the first few doses (and after a dose increase), you will be asked to stay for 25 minutes after taking the fentanyl tablet to monitor you for sedation. After this, you do not need to stay.

Two fentanyl tablet programs are available to suit your needs:

1) Maintenance program: Adjustable dose given at least 3 hours apart. May be more suitable for people who need higher doses.

2) *As-needed program*: Fixed dose given at least 3 hours apart.

BRITISH COLUMBIA

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

phs COMMUNITY SERVICES SOCIETY

For more information, visit -------

MORE INFO NEXT PAGE

FENTANYL TABLET PROGRAM

WHAT IS A FENTANYL TABLET?

It is a tablet of fentanyl that is dissolved under the tongue or the side of your cheek.

WHY A FENTANYL TABLET PROGRAM?

Participants are prescribed fentanyl tablets to reduce their need to purchase unregulated opioids with unknown amounts of fentanyl and other unknown substances, reducing the risk of drug poisoning.

WHO IS IT FOR?

If you use unregulated fentanyl, this may be an option for you. You and a substance use care provider can discuss the appropriateness and accessibility of this intervention.

HOW MUCH DOES IT COST?

The tablets are covered under PharmaCare, including Plan G, Plan C, and Plan W for those eligible.

CAUTION!

Side effects of fentora may include: slowed breathing, nausea, vomiting, constipation, or drug poisoning resulting in death or brain injury

- Tell your care provider if you are on HIV medication, since it can interact with fentanyl tablets and increase your risk of a drug poisoning.
- Missing multiple doses may result in a reduced dose or the need to restart the program.
- Avoid using downers like alcohol and benzos, as they may interact with the fentanyl patch and increase the risk of drug toxicity (also called overdose).
- Tablets should not be chewed, sucked, swallowed, crushed, smoked, injected, or snorted because it will decrease the effectiveness.

BRITISH COLUMBIA

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

phs COMMUNITY SERVICES SOCIETY

For more information, visit -------

MORE INFO NEXT PAGE

Source: British Columbia Centre on Substance Use 2023.

prescriptions for the tablets with instructions on how to inject them (British Columbia Centre on Substance Use 2020) away from a supervised setting. Drug costs for simply prescribing, when compared to providing iOAT, were thereby significantly reduced, with no need for expensive supervision, or any therapeutic interaction.

By 2023, with it becoming clear that HM tablets were too weak for many users, the BCCSU put out guidelines for prescribing fentanyl as a safe supply (see Figure 2).

The BCCSU even went so far as to describe fentanyl prescribing for "youth under 19" (British Columbia Centre on Substance Use 2023). Not only had federal policy agreed to expand distribution of HM tablets for injection, not only had the message been manipulated from "safe injection" to "safe supply," but we were now funding a program to provide fentanyl tablets to kids.

With continued funding, those running the programs advocated that they be expanded even further, arguing that overdose deaths were still climbing

because the programs were not reaching enough people. Safe supply was now Health Canada's solution to the opioid crisis. Patients were not just still using opioids problematically but now found themselves in better organized communities of drug-using peers who provided a sense of belonging and reinforcement. With the "safe supply–harm reduction community" funded to effectively steer people away from treatment centres, the opioid landscape became competitive rather than collaborative. People asked to self-report on benefits or answer questions about diversion were unlikely to disclose concerns or suggest improvements to a program that was now providing a "currency," – a commodity to sell or trade, in order to obtain their drug of choice. The fear of losing access to this new currency was enough to bias users' responses to feedback questions about their satisfaction with the programs.

One of the worst outcomes of the safe supply movement is the rise of predatory "opioid treatment" clinic-pharmacy businesses.

One of the worst outcomes of the safe supply movement is the rise of predatory "opioid treatment" clinic-pharmacy businesses located in urban storefronts, often near hospitals. Competition among pharmacies for the business opioid patients bring with them has mounted, with little regulation or safeguarding of patients or the neighbourhoods. The prescribers are often a doctor on a video screen who may never meet the patient in person. The pharmacies manage the flow of patients while the doctors sit in a room, perhaps in their homes, with multiple screens allowing for high volumes of patient flow, simultaneously, from different sites. In Ontario at least, the monetization of safe supply, combined with the hands-off approach of the professional college, has brought a financial windfall to some mercenary prescribers and businesses (CBC 2025a).

In these so-called clinic-pharmacies, therapeutic relationships disappear. Patients walk in, see a pharmacist, who dials up a doctor who

appears remotely on a screen, who then writes a prescription or prescriptions for the pharmacist, who then bills the provincial drug formulary. The patient and prescriber never meet in person, the pharmacist dispenses the opioids, and the patient walks out the door. Dealers can take advantage of patients needing money by buying the pills they have just had dispensed to them in bulk and stockpiling them. The dealers then move the pills to regions where they can be re-sold for higher prices. From that transaction, the safe supply patient makes the $50 a day they need to buy fentanyl (or another drug of choice) until the next day, when they return to the pharmacy and pick up another bottle of tablets. Of course, safe supply advocates would claim that saying any of this aloud "stigmatizes" people who use drugs by implying they are committing a crime by selling or trading their pills for other drugs. But every patient I have asked sees these prescriptions being sold illegally outside of pharmacies. Placing opioid-addicted people into such a vulnerable position, where they are handed something of value that could be illegally sold or traded for something they desperately need – defies ethical scrutiny, says Dr. Robert Cooper of Addiction Medicine Canada:

> "It's just a made-up Canadian experiment (that)... shows a lack of experience with patients suffering from addiction disorders... the dream of every opiate addict is to have an unlimited supply of free opiates... And what safer supply did was say, 'here, here's an unlimited supply of free opiates...' They have difficulty saying no, and then they can't stop once they start. That's what addiction is" (Cooper 2024).

If you add in methadone and one or two other daily dispensed medications, a rough calculation based on 100 unstable patients using fentanyl shows that roughly $1.56 million dollars a year goes to the pharmacy alone for patients receiving three medications. By contrast, if those same 100 patients were stabilized on a once-monthly injection of extended-release buprenorphine, the annual take for that pharmacy would drop to less than $50,000 – a savings to taxpayers of about $1.5 million for every 100 patients stabilized off fentanyl and onto long-acting OAT.

The data

The often-touted "rapidly growing body of evidence" favouring safe opioid supply, in fact amounts to a few dozen qualitative studies and reports (Ledlie et al. 2024) (in which *the program evaluations were funded by the same SUAP dollars that funded the clinical programs*, amounting to an exercise in marking one's own homework (Canadian Institutes of Health Research 2023)). Most evaluations are qualitative "customer satisfaction surveys" where participants are selected non-randomly and confounding variables such as other beneficial program offerings like primary health care, food, and housing supports are overlooked or not measured. This is where things really seemed to go off the rails in terms of government policy; with a rising opioid death toll and pressure on government to do something, the emerging research was of poor quality – and yet the researchers dictated program expansion.

At no point do we have clear data demonstrating whether patients are clinically improving, nor if they are using less fentanyl, nor if there were any benefits or harms to others in their communities. Dr. Sharon Koivu, an addiction medicine consultant based in Ontario, described the basic flaw in evaluation of data on safe supply projects:

> "Essentially all of the safe supply evidence is done by safe supply providers or within the safe supply groups by people who have received often large sums of grants and funding for their programs and have been able to generate evidence to continue getting those grants, which would make the evidence just problematic. So, I would say it's low-level evidence, it's bias(ed) and problematic..." (Koivu 2024).

While promoting a perceived "life-saving" intervention, some researchers have glossed over the grotesque limitations of safe supply. For example, deep in the Interpretation section of one study, the authors of this CMAJ paper admit that:

> "... it is difficult to separate the relative impact of safer supply prescribing from the impact of the wrap-around supports provided. Emerging qualitative and program evaluation research highlights how clients in SOS [Safer Opioid Supply] programs attribute access to safer supply medications as being responsible

> for stabilizing their patterns of drug use and improving their health by reducing their use of drugs from the unregulated street supply... There is likely strong benefit to the provision of comprehensive programming that includes SOS prescribing alongside comprehensive health and social supports to a high-risk population, and the relative contribution of different program elements to client outcomes is an important topic for future research" (Gomes 2022).

Simply put, the researchers are saying that they don't know whether people used fewer emergency services because of the increased access to wrap-around services, or because they were given opioid tablets. They are hearing patients tell them it is due to the pills, but those running the SOS programs likely think it is a good idea to keep the pills and the services together so no one will be able to tell how important the opioid pills are to the success of the program. A daily injection drug user given wound care and help with housing on site is far less likely to use an emergency room. Instead of offering the same wrap-around services to OAT patients that are offered to a comparison group, they were only offered to those receiving the tablets. That the study attributed the benefits of the program to opioid tablets amounted to, well, a hill of magic beans.

And how was the MySafe hydromorphone dispensing machine project evaluated? A *Globe and Mail* headline in May 2023 claimed that "Users of opioid-dispensing machines overdosed less, reported improved health: study" (Woo 2023). The study, published in a Canadian medical journal, was a qualitative survey of 46 people who had used the machines to gain access to HM pills (Bardwell et al. 2023). Former Minister of Mental Health and Addictions Carolyn Bennett referred to this the following day in the House of Commons as an "evidence-based program... saving lives" (House of Commons 2024b). How quickly and carelessly these novel ideas became rebranded as evidence and robustly funded as a national "harm reduction" strategy.

The *British Medical Journal* published another heavily publicized paper in January 2024. Journalist Andrea Woo's *Globe and Mail* headline touted this as: "Major study finds people with opioid addictions 61% less likely to die if prescribed safer supply" (Woo 2024). The paper's authors claimed that "risk mitigation guidance (RMG)" (prescribing and dispensing opioid tablets to high-risk fentanyl users) "...were associated with reduced overdose related and

all-cause mortality among a sample of people with opioid use disorder," and, therefore "*Pharmaceutical alternatives to the illegal drug supply are promising interventions to reduce mortality in people with opioid use disorder.*" (The article attributed the quoted comments to Dr. Paxton Bach, who co-authored the study.)

On closer scrutiny of the paper's conclusion, the authors claim to show that:

> "RMG opioid dispensations of one day or more were associated with reduced all-cause mortality... and overdose related mortality [***in the subsequent week***]" (emphasis added) (Slaunwhite et al. 2024).

This paper, showing a one-week outcome, apparently provided "the strongest evidence thus far supporting this intervention," according to Bach (Woo 2024). Six years of a public experiment and this was our "strongest" evidence?

In a separate but related conversation, when asked about Health Canada agreeing to fund programs that encouraged the injection of tablets, Dr. Bromley pointed out that the (Purdue) product monograph for Dilaudid:

> "...expressly says the oral tablets are not intended for injection use. The tablets contain excipients which are harmful when injected... The way Dilaudid tablets are being used in SS programs is against the product monograph. Tablets are not sterile. If people really need to inject, there are sterile injectable medication formulations available... ask Health Canada: why are you promoting injection use of oral medications when there are safe alternatives designed for this type of use? Why did you give tens (almost 100) millions of dollars so that people could get bacterial infections of their bones, spine, or heart valves?" (Bromley 2025).

In 2022, the CDA-AMC, Canada's Drug Agency, published a report on the effectiveness of safe supply as an opioid substitution treatment (Canada's Drug Agency 2022). While stating clearly that injectable iOAT programs have some evidence of benefit when *supervised and injectable,* they point out that there was "no evidence" of clinical benefit from so-called "safe supply" prescription medications for this purpose and that the extant data was of "low quality, and many of the... reviews included the same studies."

In 2022, a Simon Fraser University team also completed a review of 19 studies of safe supply/safe consumption programs. The Province of Alberta commissioned them to conduct a rapid evidence review. They looked at studies advocating safe supply, conducted between 2019 and 2021 and published in peer-reviewed journals. The goal was to summarize key findings, appraise the quality of evidence, and assess the value of those research findings for other settings and contexts. In their conclusion, the reviewers reported finding no evidence to support either safety or effectiveness and suggested that "at present, safe supply represents a loosely defined slogan to increase the distribution of publicly funded addictive drugs to people whose life circumstances perpetuate profound addictions" (Simon Fraser University 2022).

Despite these compelling reports, the following year, then-Minister of Mental Health and Addictions Carolyn Bennett continued to promote safe supply. For instance, in 2023, she praised its importance in "saving lives" and then went on to announce more funding for these programs in the spring of 2024 (Health Canada 2023; House of Commons Canada 2024b).

According to addiction specialist Dr. Jenny Melamed:

> "'It's a trial using humans as guinea pigs... The government has never said there was evidence [supporting safe supply]. They just said we needed to do something because nothing else was working,' noting the research to be anecdotal, qualitative, and methodologically flawed" (Melamed 2024).

Meanwhile, the National Safer Supply Community of Practice, later renamed the Substance Use Health Network (SUHN) (Substance Use Health Network 2023), also funded by Health Canada, helped to brand, expand, and promote the opioid tablets.

For advocates' hammer, everything was a nail. Monthly newsletters and a national, dial-in "mentoring" call encouraged prescribers across the country – even in rural and remote communities – to prescribe Dilaudid to their patients with OUD. SUHN's website is rich in resources and advice for prescribers and allied harm reduction workers to ensure that "safe supply" opioids become entrenched in the toolbox of policy expectations for community addiction care, regardless of the lack of evidence. And its monthly newsletter offers a wide range of ways that interdisciplinary health providers can learn and promote the practice of opioid pill prescribing (Substance Use Health Network 2023).

Most recently, a new study from BC concluded that "neither the safer supply policy nor the subsequent decriminalization of drug possession appeared to alleviate the opioid crisis" (Nguyen 2025). Although it is one of very few studies, so far, to make an objective analysis, we can hope that more robust funding for more critical research will move the needle yet further.

Diversion

Alarms were going off early among addiction experts about safe supply. When *National Post* journalist Adam Zivo investigated and wrote a lengthy article about pill diversion, many doctors chose pseudonyms, afraid to speak out about their concerns (Zivo 2023). Some patients came to doctors' offices asking to be "put on the Dilaudid program," while others laughed about seeing pills being sold. As police across the country reported more drug seizures containing tens of thousands of prescription opioid pills (and as increasing numbers of addiction experts report evidence of diversion in their practices), research on diversion remained scant, low-quality, anecdotal, and disingenuous.

In her *Globe and Mail* article, Andrea Woo (2024) pointed out that "The BC Coroners Service says there is no indication that prescribed safer supply is contributing to overdose deaths, and Dr. Bach said there is continuing surveillance to examine unintended consequences." A coroner cannot determine how a 15-year-old first encountered opioids; a coroner can only determine the origin of the opioid in her system that was most likely to have killed her.

Advocates of safer supply quickly politicized suggestions that diversion was happening, accusing opponents of inciting a "moral panic... reflecting an emerging alignment among key institutional and political actors" (Michaud et al. 2024). They accused critics worried about pill diversion of "fearmongering and stigma," and claimed that diversion, if it happens at all, only occurs between fentanyl users as "caring and mutual aid." Meanwhile, another Health Canada-funded document, *Re-Framing Diversion for Health Care Providers,* attempted to normalize diversion – simultaneously denying that it was happening while also arguing that it was a positive outcome:

> "The current medical and criminal-legal framing of diversion perpetuates stigmatizing and patronizing views of people who use drugs, such as the idea that people who use drugs cannot be trusted, are manipulative, and are a threat to others. These views are harmful, inaccurate, and ultimately rooted in anti-drug and anti-euphoria prohibitionist principles" (National Safer Supply Community of Practice 2022, 4).

Many of the program reports describe how much better things are, subjectively, for participants with safer supply. Women are no longer involved in sex work; people are managing to buy food, get bills paid, or get out of debt. One research team, also using qualitative methods, argued for the apparent life-saving properties of the safer supply distribution of opioid tablets: "People need them, or they will die" (Bardwell et al. 2023). Such potent claims need more robust evaluation than small sets of semi-structured interviews.

From the perspective of those who treat OUD every day, it all makes little sense. Speaking about inexperienced safe supply prescribers, London, Ontario, addiction specialist Dr. Martyn Judson rightly points out:

> "So many of these doctors are going out into practice and they just do not understand addiction, which leads us to the development of what is called safer supply. I believe that most of the doctors who are prescribing those drugs on safer supply do not understand addiction. They've never studied it. They're not certified in it, and they just are out of their depth" (Judson 2024).

We physicians specializing in addiction medicine have sat for years with individual patients trying to help them rebuild their lives. Some of our most valuable, unpublished data comes from these encounters. Hearing them describe the lack of logic behind safe supply is almost embarrassing. One young person under 18 described walking into a Burlington, Ontario, clinic, seeing a doctor only on video, and receiving a bottle of Dilaudid; others bought their bottles of Dilaudid on the streets of Peterborough, Thunder Bay, and Windsor in Ontario, or Victoria and Nanaimo in BC. Safe supply advocates label our reports "unverified and anecdotal" (Michaud 2024) while the lived experiences of safe supply clients are somehow valid when published

as data in their reports and program evaluations; advocates simply refuse to believe this is happening.

Addiction experts Dr. Sharon Koivu in London, Ontario, and Dr. Jenny Melamed in BC tell us that the street price of hydromorphone (Dilaudid) 8mg tablets has bottomed out. Things "changed within weeks of the HM hitting the streets" stated Melamed, referring to the opioid market (Melamed 2024). The flooding of the market drove the cost of a single hydromorphone 8 mg tablet down from $15 to $20 in June 2020 to $0.50 to $1.00 by late 2021. By 2022, drug deals were increasingly occurring in the open.

A person using 3000 mg of morphine (MEQ) a day (in fentanyl) will do whatever it takes to avoid opioid withdrawal. Tolerance never levels off with these opioids; the MEQ they need will only go up over time. Tolerance and withdrawal are normal human phenomena, even for people in pain on burn units or palliative care wards. The more potent the opioid, the more intense the withdrawal. Giving people something with only some of the potency their body craves drives them to find something else – usually more fentanyl – to stay comfortable. The pharmacology is impossible to side-step using social justice arguments.

"We opponents of safe supply fear that it is now out of control and unregulated.

We opponents of safe supply fear that it is now out of control and unregulated. For instance, how many "treatment clinics" are prescribing tablets with, or without, OAT. How many pharmacies are dispensing them? How many inexperienced prescribers mistakenly believe that their actions are "saving lives" – that they are somehow mitigating a national problem – while the tide of prescription opioids continues to flow into the streets?

We also don't know how many teenagers, believing these pills to be safe and finding them cheap, will end up battling an opioid addiction. In 2023, the BC Coroners Service reported that toxic drug overdoses were the

leading cause of death among youth aged 10 to 18 in BC. Between 2017 and 2022, 142 youth in this age group died from drug overdoses, with fentanyl being a significant factor in most cases (CBC News 2023). And while the BC Coroners Service asserted that there was no evidence linking safe supply pills to overdose deaths in young people, the increasing presence of the pills in police drug seizures (CBC News 2025b; 2025c), combined with the appearance of hydromorphone in more youth opioid deaths (Azar lab 2023) has rendered this assertion incomprehensible.

A better prescription: where do we go from here?

People working with this population for the past 10 years may never have seen recovery and may be unfamiliar with treatment pathways that offer better chances of success. Newer doctors, social workers, nurses, and people with lived experience have become more familiar with the palliative mind-set – helping people to just "live another day." But effective policy must be driven by those with expertise and experience, and by those who have recovered.

Reversing the harms of safe supply will be challenging – both clinically and politically. Fentanyl addiction needs a compassionate, non-judgmental response that addresses complex needs. Those whose lives are deeply unstable – people with severed family connections, who have had long-term unemployment, who live with mental and physical disability, and who have social circles dominated by drug use – need more intensive supports. Others with healthier connections to family, non-drug-using friends, job skills, or educational achievements, may find that their path to treatment and recovery is more straightforward.

We must prioritize objective evidence and rigorous research to address, modify, and improve current interventions. Rather than ignoring signs of trouble, we must use them to mitigate poor outcomes, guide balanced evaluation, and improve societal well-being.

What would good medicine look like for people who use fentanyl?

Incorporating wrap-around services with integrated, accessible OAT care, is a recipe for success. We can structure these programs without being rigid; they can co-locate essential services including primary care, hepatitis and HIV treatment, wound care, housing support, psychosocial counselling, and residential withdrawal management and treatment options. A suite of wrap-around services, rather than dispensing tablets-as-currency, should be the "carrot" that will encourage people to become engaged "where they are at." Once patients are stabilized and engaged, we can incorporate a contingency management approach into their care that can further support recovery.

We must reframe harm reduction as a tool that links people to treatment options; opioid tablets are not a treatment option. While naloxone kits are clearly beneficial, and while clean drug use kits, when offered alongside treatment opportunities, can reduce the harms of injection drug use, people who inject frequently should be receiving an adequate dose of an oral opioid alternative (OAT) and encouraged to reduce the frequency of injecting. We should not normalize these behaviours.

We must also re-evaluate safe injection sites. Most of their data come from the pre-fentanyl era; what have been their objective benefits over the past 10 years? If we keep people relying on them for extended periods of time without promoting OAT, then we need to be honest about their palliative role. People who continue to inject drugs will remain at elevated risk of death or disability and we need to emphasize this fact.

Prioritizing individual needs and goals over political optics is paramount. When over 2,000 OAT patients in Ontario were asked what their goals were from treatment, the most frequent response was to "Stop or taper off treatment" (68.3 per cent), while studies often look to "retention in treatment" as a measurement of OAT success. The second most common treatment goal was to "Stay or get clean" (36.6 per cent). While harm reduction programs have emphasized the importance of the availability of an "alternate supply" to allow people their right to continue drug use, a priority among patients is to stop (Rosic 2021).

As a society, we can design better treatment programs. We know what needs to be done to address the root causes of addiction, and we know that early,

intensive supports will optimize people's social stability and functioning even in a challenging environment. We have extensive, Canadian research showing how social interventions can stabilize mental health in high-risk populations (Goering et al. 2011).

For inspiration and models, we can look to therapeutic communities (De Leon and Unterrainer 2020) and environments where people have opportunities to rebuild their lives over longer periods.

Destigmatizing OAT and accepting its role in long-term abstinence after years of fentanyl addiction will help more people accept treatment as an option. We now have OAT options that require patients to visit the doctor only once or twice a month – and not have to visit a pharmacy at all. Early data suggests this to be both a protective and successful option (Lee et al. 2023).

And finally, we must commit to higher quality research, building on extant evidence and moving beyond "customer satisfaction surveys" towards more rigorous methods of evaluation. We must continually re-evaluate the outcomes of our interventions, accepting criticism and making necessary revisions to ensure those interventions are, and remain, effective, sustainable, and truly safe.

Conclusion

The opioid crisis demands a comprehensive, evidence-based approach that prioritizes the well-being of individuals and communities. We must reintegrate the four pillars of drug strategy into the approach so that it addresses not only the harms of opioid use but also the root causes and contributing factors that perpetuate this crisis. To be successful, we must set aside partisan beliefs – policy-makers need to return to a science-based, objective approach to policy, funding, and evaluation. Only then can we hope to create a system that truly supports recovery, reduces harm, and fosters healthier communities.

By shifting the focus back to a legitimate drug strategy model, Canada's approach can become more balanced. It can aggressively integrate prevention, treatment, enforcement, and harm reduction, thereby ensuring that we do not pursue harm reduction in isolation but link it to pathways of recovery and long-term stability.

While addressing the root causes and social determinants of the opioid crisis is beyond the scope of this analysis, we can all agree that in order to tackle the underlying factors driving substance use, we must address the complex, expensive, and challenging issues of housing, poverty, trauma, mental illness, and lack of access to education and employment. None of this will be easy, but allowing people to continue to slide backwards will only steepen the uphill slope to recovery for more of the population. MLI

About the author

Lori Regenstreif is a family physician with a focused practice in addiction medicine working in inner-city Hamilton, Ontario, and the Sahtu region of the Northwest Territories. A contributing writer for the Macdonald-Laurier Institute, she is a national expert in addiction medicine and has co-authored guideline documents on the care of people who use fentanyl in the community, in prisons, and in hospitals, as well as guidelines for withdrawal management and residential treatment settings. She has a special interest in drug policy, particularly its impact on youth and other vulnerable populations. MLI

References

Aspinall, Esther J., Dhanya Nambiar, David J. Goldberg, et al. 2014. "Are Needle and Syringe Programmes Associated with a Reduction in HIV Transmission among People Who Inject Drugs: A Systematic Review and Meta-Analysis." *International Journal of Epidemiology* 43, 1: 235–248. Available at https://doi.org/10.1093/ije/dyt243.

Azar, P., and Nickie Matthews. 2023. Azar Lab. *CSAM Friday: Prescribing Safe Supply*. Video, 2023. Available at: https://videopress.com/embed/cddgrDB1.

Bardwell, Geoff, Andrew Ivsins, Manal Mansoor, et al. 2023. "Safer Opioid Supply via a Biometric Dispensing Machine: A Qualitative Study of Barriers, Facilitators and Associated Outcomes." *Canadian Medical Association Journal* 195, 19: E668–E676. Available at https://doi.org/10.1503/cmaj.221550.

British Columbia Centre on Substance Use [BCCSU]. 2021. "Prescribed Safer Supply: Clinical Care Guidance." BCCSU. Available at https://www.bccsu.ca/clinical-care-guidance/prescribed-safer-supply/.

British Columbia Centre on Substance Use [BCCSU]. 2020. *Safer Tablet Injection: A Resource for Clinicians Providing Care to Patients Who May Inject Oral Formulation*. BCCSU. Available at https://www.bccsu.ca/wp-content/uploads/2020/09/Resource-Safer-Tablet-Injection.pdf.

British Columbia Centre on Substance Use [BCCSU]. 2023. "Prescribed Safer Supply Protocols: Fentanyl Tablet." BCCSU. Available at https://www.bccsu.ca/clinical-care-guidance/prescribed-safer-supply/fentanyl-tablet/

British Columbia Ministry of Health. *A Review of Prescribed Safer Supply Programs Across BC*. Office of the Provincial Health Officer, December 2023. Available at: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/a-review-of-prescribed-safer-supply-programs-across-bc.pdf.

Bromley, Lisa. 2025. *Personal communication*.

Bromley, Lisa, Meldon Kahan, Leonora Regenstreif, et al. 2021. *Methadone Treatment for People Who Use Fentanyl: Recommendations*. META:PHI. Available at https://www.metaphi.ca/wp-content/uploads/Guide_MethadoneForFentanyl.pdf.

Canada's Drug Agency [CDA-AMC]. 2022. *Clinical Effectiveness of Opioid Substitution Treatment*. In Brief. CDA-AMC. Available at https://www.cda-amc.ca/brief-clinical-effectiveness-opioid-substitution-treatment.

Canadian Institutes of Health Research [CIHR]. 2023. "Evaluation of Harm Reduction Approaches to Address the Opioid Crisis in the Context of COVID-19 — Safer Supply Evaluation. Midpoint Knowledge Exchange Forum: What We Heard Report." CIHR. Available at https://cihr-irsc.gc.ca/e/53660.html.

CBC News. 2020. "London-Based Safe Opioid Supply Program Gets $6.5M Boost from the Feds." CBC News, September 21, 2020. Available at https://www.cbc.ca/news/canada/london/safe-supply-opioid-funding-1.5733327.

CBC News. 2023. "Youth Deaths Highlight Toxic Drug Crisis in British Columbia." CBC News, August 21, 2023. Available at https://www.cbc.ca/news/canada/british-columbia/youth-deaths-toxic-drug-crisis-bc-1.6950003.

CBC News. 2024. "Safe Supply Disinformation Opioids Canada." *CBC News*, April 28, 2024. https://www.cbc.ca/news/canada/london/safe-supply-disinformation-opioids-canada-1.7185767.

CBC News. 2025a. "Doctor operating safer supply clinics billed OHIP $2.5M last year." CBC News, April 28, 2025. Available at https://www.cbc.ca/news/canada/ottawa/ottawa-ottawa-safer-supply-clinic-ohip-1.7517426.

CBC News. 2025b. "Hundreds of pills seized in bust outside pharmacy in Prince George, B.C." CBC News, February 13, 2025. Available at https://www.cbc.ca/news/canada/british-columbia/pills-seized-prince-george-pharmacy-1.7458377.

CBC News. 2025c. "Winnipeg Police Uncover Drug Trafficking Operation in

Project Lowkey." CBC News, March 12, 2025. Available at https://www.cbc.ca/news/canada/manitoba/winnipeg-police-project-lowkey-drug-trafficking-investigation-1.7481399.

Centers for Disease Control [CDC]. 2022. "Provisional Data Shows U.S. Drug Overdose Deaths Top 100,000 in 2022." CDC. Available at https://blogs.cdc.gov/nchs/2023/05/18/7365/.

Cooper, Robert. 2024. Interview by Liam Hunt. September 3, 2024. Conducted for the Centre for Responsible Drug Policy

De Leon, George, and Human F. Unterrainer. 2020. "The Therapeutic Community: A Unique Social Psychological Approach to the Treatment of Addictions and Related Disorders." *Frontiers in Psychiatry* 11: 786. Available at https://doi.org/10.3389/fpsyt.2020.00786.

Dole, Vincent P., and Marie Nyswander. 1965. "A Medical Treatment for Diacetylmorphine (Heroin) Addiction: A Clinical Trial with Methadone Hydrochloride." *JAMA* 193 (8): 646–650. https://doi.org/10.1001/jama.1965.03090140034009.

Dooling, Kathleen, and Michael Rachlis. 2010. "Vancouver's Supervised Injection Facility Challenges Canada's Drug Laws." *Canadian Medical Association Journal* 182, 13: 1440–1444. Available at https://doi.org/10.1503/cmaj.100032.

Dutra, Lissa, Georgia Stathopoulou, Shawnee L. Basden, et al. 2008. "A Meta-Analytic Review of Psychosocial Interventions for Substance Use Disorders." *American Journal of Psychiatry* 165, 2: 179–187. Available at https://doi.org/10.1176/appi.ajp.2007.06111851.

Fischer, Benedikt, Michelle Pang, and Mark Tyndall. 2019. "The Opioid Death Crisis in Canada: Crucial Lessons for Public Health." *The Lancet: Public Health* 4, 2 (February): e81–e82. Available at https://doi.org/10.1016/S2468-2667(18)30232-9.

Fischer, Benedikt, Michelle Pang, and Wayne Jones. 2020. "The Opioid Mortality Epidemic in North America: Do We Understand the Supply Side Dynamics of This Unprecedented Crisis?" *Substance Abuse Treatment, Prevention, and Policy* 15, 14. Available at https://doi.org/10.1186/s13011-020-0256-8.

Fischer, Benedikt, Wayne Jones, Karen Urbanoski, et al. 2014. "Correlations between Prescription Opioid Analgesic Dispensing Levels and Related Mortality and Morbidity in Ontario, Canada, 2005–2011." *Drug and Alcohol Review* 33, 1: 19–26. Available at https://doi.org/10.1111/dar.12089.

Fischer, L.S., Asher, A., Stein, R. et al. 2025. "Effectiveness of naloxone distribution in community settings to reduce opioid overdose deaths among people who use drugs: a systematic review and meta-analysis." *BMC Public Healt*h 25, 1135 (2025). Available at https://doi.org/10.1186/s12889-025-22210-8.

Goering, P. N., Streiner, D. L., Adair, et al. 2011. "The At Home/Chez Soi trial protocol: a pragmatic, multi-site, randomised controlled trial of a Housing First intervention for homeless individuals with mental illness in five Canadian cities." *BMJ Open*, 1(2), e000323. Available at doi.org/10.1136/bmjopen-2011-000323.

Gomes, Tara, Gillian Kolla, Dustin McCormack, et al. 2022. "Clinical Outcomes and Health Care Costs among People Entering a Safer Opioid Supply Program in Ontario." *Canadian Medical Association Journal* 194, 36: E1233–E1242. Available at https://doi.org/10.1503/cmaj.220892.

Cloud, William, and Robert Granfield. 2009. "Conceptualizing Recovery Capital: Expansion of a Theoretical Construct." *Substance Use & Misuse*, Volume 43, 2008, Issue 12–13, 1971–1986 (published online July 2009). Available at https://www.tandfonline.com/doi/full/10.1080/10826080802289762.

Hamilton Police Service. 2024. "Youth Dealing Drugs Arrested in Downtown Core." News release. Hamilton Police Service, August 23, 2024. Available at https://hamiltonpolice.on.ca/news/youth-dealing-drugs-arrested-in-downtown-core/.

Harvard Health Publishing. 2023. "Iatrogenic." Harvard Medical School. Available at https://www.health.harvard.edu/d-through-i#I-terms.

Health Canada. 2019. "National Report: Apparent Opioid-related Deaths in Canada." Government of Canada, Public Health Infobase, Data Lab, Data Blog, September 2019. Available at https://health-infobase.canada.ca/datalab/national-surveillance-opioid-mortality.html?utm_source=chatgpt.com.

Health Canada. 2021a. *Horizontal Evaluation of the Canadian Drugs and Substances Strategy: Evaluation Report (heading: Substance Use and Addictions Program).* Government of Canada Available at https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/evaluation/canadian-drugs-substances-strategy.html.

Health Canada. 2021b. "Government of Canada Supports Expansion of Innovative Safer Supply Project to Operate in Four Cities Across Canada." News release. Government of Canada, March 2, 2021. Available at https://www.canada.ca/en/health-canada/news/2021/03/government-of-canada-supports-expansion-of-innovative-safer-supply-project-to-operate-in-four-cities-across-canada.html.

Health Canada. 2023. "Minister Bennett Highlights Budget 2023 Investments of $359.2 Million to Help Address the Overdose Crisis and Harms Related to Substance Use Across Canada." Government of Canada. Available at https://www.canada.ca/en/health-canada/news/2023/04/minister-bennett-highlights-budget-2023-investments-of-3592-million-to-help-address-the-overdose-crisis-and-harms-related-to-substance-use-across-c.html.

Henderson, Rita, Ashley McInnes, and Leslee Mackey, et al. 2021. "Opioid Use Disorder Treatment Disruptions During the Early COVID-19 Pandemic and Other Emergent Disasters: A Scoping Review Addressing Dual Public Health Emergencies." *BMC Public Health* 21, 1471 (2021). Available at https://doi.org/10.1186/s12889-021-11495-0

House of Commons, Standing Committee on Health, Canada 2024a. *Evidence.* Number 104, February 26, 2024, 44th Parliament, 1st Session. House of Commons, Canada. Available at https://www.ourcommons.ca/documentviewer/en/44-1/HESA/meeting-104/evidence, accessed February 22 2025.

House of Commons, Standing Committee on Health, Canada. 2024b. *Evidence.* Number 119, May 30, 2024, 44th Parliament, 1st Session. House of Commons, Canada. Available at https://www.ourcommons.ca/documentviewer/en/44-1/HESA/meeting-119/evidence, accessed February 18, 2025.

Hser Y.I., V. Hoffman, C.E. Grella, and M.D. Anglin. 2001. "A 33-Year Follow-up of Narcotics Addicts." *Archives of General Psychiatry*58, 5 (May): 503–508. Available at https://pubmed.ncbi.nlm.nih.gov/11343531/.

Humphreys, Keith, Chelsea L. Shover, Christina M. Andrews, et al. 2022. "Responding to the Opioid Crisis in North America and Beyond: Recommendations of the Stanford–*Lancet* Commission." *The Lancet* 399, 10324: 555–604. Available at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02252-2/fulltext.

Judson, Martyn. Interview with Liam Hunt. Conducted July 17, 2024, for the Centre for Responsible Drug Policy.

Kahan, Meldon, Lori Regenstreif, and Mark Weiss. 2022. "Recommendations for the provision of opioid agonist therapy in publicly funded residential addiction treatment centres in Ontario." Mentoring, Education, and Clinical Tools for Addiction: Partners in Health Integration (META:PHI), March 2022. Available at https://www.metaphi.ca/wp-content/uploads/Guide_ResidentialOATRecommendations.pdf.

Kahan, Meldon, Lori Regenstreif, and Mark Weiss. 2022a. *Recommendations for the Medical Management of Substance Use Disorders in Withdrawal Management Services in Ontario.* Mentoring, Education, and Clinical Tools for Addiction: Partners in Health Integration (META:PHI). Available at https://www.metaphi.ca/wp-content/uploads/Guide_WMSMedicalRecommendations.pdf.

Klaire, Sukhpreet, Christy Sutherland, Thomas Kerr. and Mary Clare Kennedy. 2022. "A low-barrier, flexible safe supply program to prevent deaths from overdose." *Canadian Medical Association Journal* 194, 19 (May 16): E674-E676. Available at https://www.cmaj.ca/content/194/19/e674.

Koivu, Sharon. 2024. Interview by Liam Hunt. Conducted June 3, 2024, for the Centre for Responsible Drug Policy.

Kolla, Gillian, Chowdhury N. Tarannum, Kaitlin Fajber, et al. 2024. "Substance Use Care Innovations During COVID-19: Barriers and Facilitators to the Provision of Safer Supply at a Toronto COVID-19 Isolation and Recovery Site." *Harm Reduction Journal* 21, 17. Available at https://doi.org/10.1186/s12954-024-00935-w.

Lam, Vincent. 2023. "Opioids and the Elephant in the Room." *Globe and Mail*, February 3, 2023. Available at https://www.theglobeandmail.com/opinion/article-vincent-lam-opioid-crisis/.

Lathan, S. Robert. 2009. "Celebrities and Substance Abuse." *Baylor University Medical Center Proceedings* 22, 4: 339–341. Available at https://doi.org/10.1080/08998280.2009.11928552.

Ledlie, S, Ria Garg, Clare Cheng, et al. 2024. Prescribed safer opioid supply: A scoping review of the evidence*, International Journal of Drug Policy*, Volume 125, 2024,104339, ISSN 0955-3959. Available at https://www.sciencedirect.com/science/article/pii/S0955395924000240

Lee, Kenneth, Yue Zhao, Tazmin Merali, et al. 2023. "Real-world Evidence for Impact of Opioid Agonist Therapy on Nonfatal Overdose in Patients with Opioid Use Disorder during the COVID-19 Pandemic." *Journal of Addiction Medicine* 17, 6: e374–e381. (Erratum in: *Journal of Addiction Medicine*, 2024, 18, 2 (March-April): e8.) Available at https://pubmed.ncbi.nlm.nih.gov/37934531/.

Lomas, Christopher. 2024. "Neurobiology, Psychotherapeutic Interventions, and Emerging Therapies in Addiction: A Systematic Review." *Journal of Addictive Diseases* (December 17). Available at https://doi.org/10.1080/10550887.2024.2440184.

MacMillan, Carrie. 2024. "Why Is Fentanyl Driving Overdose Deaths?" Yale Medicine. Available at https://www.yalemedicine.org/news/fentanyl-driving-overdoses.

Marion-Bellemare, Louisa, Julie Samson, and Seamus Murphy. 2023. *Scene First: Bup/Nal Treatment by EMS*. Virtual PowerPoint presentation at META:PHI Conference, Toronto, September 23, 2023. Available at www.metaphi.ca/wp-content/uploads/Conference2023_4A.pdf.

McDonald, Rebecca, and John Strang. 2016. "Are Take-Home Naloxone Programmes Effective? Systematic Review Utilizing Application of the Bradford Hill Criteria." *Addiction* 111, 7: 1177–1187. Available at https://doi.org/10.1111/add.13326.

Melamed, Jenny. Interview by Liam Hunt. May 25, 2024. Conducted for the Centre for Responsible Drug Policy.

Michaud L., G. Kolla, K. Rudzinski, and A. Guta. 2024. "Mapping a moral panic: News media narratives and medical expertise in public debates on safer supply, diversion, and youth drug use in Canada." International Journal of Drug Policy, (May 2024); Volume 127:104423. Available at https://www.sciencedirect.com/science/article/pii/S0955395924001087.

National Safer Supply Community of Practice. 2022. *Reframing Diversion for Health Care Providers*. National Safer Supply Community of Practice. Available at https://www.substanceusehealth.ca/reframing-diversion-prescribers.

National Safer Supply Community of Practice. 2021–25. "Monthly Newsletters." Available at https://www.substanceusehealth.ca/newsletters.

Nguyen, H.V., S. Mital, S. Bugden, and E.E. McGinty. "Safer Opioid Supply, Subsequent Drug Decriminalization, and Opioid Overdoses." *JAMA Health Forum* 6 (3): e250101. Available at https://doi.org/10.1001/jamahealthforum.2025.0101.

Open Parliament. 2024. "Dr. Rob Tanguay (Addiction Psychiatrist, As an Individual) at the Health Committee." Evidence of Meeting #104 for Health in the 44th Parliament, 1st session. Open Parliament, February 26, 2024. Available at https://openparliament.ca/committees/health/44-1/104/dr-rob-tanguay-1/only/.

Oviedo-Joekes, Eugenia, Bohdan Nosyk, Suzanne Brissette et al. 2008. "The North American Opiate Medication Initiative (NAOMI): Profile of Participants in North America's First Trial of Heroin-Assisted Treatment." *Journal of Urban Health* 85, 6: 812–825. Available at https://doi.org/10.1007/s11524-008-9312-9.

Oviedo-Joekes, Eugenia, Daphne Guh, Suzanne Brissette et al. 2016. "Hydromorphone Compared with Diacetylmorphine for Long-Term Opioid Dependence: A Randomized Clinical Trial." *JAMA Psychiatry* 73, 5: 447–455. Available at https://doi.org/10.1001/jamapsychiatry.2016.0109.

Public Health Agency of Canada. 2018. "Evidence Synthesis – The Opioid Crisis in Canada: A National Perspective." *Health Promotion and Chronic Disease Prevention in Canada* 38, 6. Available at https://www.canada.ca/en/public-health/services/reports-publications/health-promotion-chronic-disease-prevention-canada-research-policy-practice/vol-38-no-6-2018/evidence-synthesis-opioid-crisis-canada-national-perspective.html.

Rao, Isabelle J., Keith Humphreys, and Margaret L. Brandeau. 2021. "Effectiveness of Policies for Addressing the US Opioid Epidemic: A Model-Based Analysis from the Stanford-*Lancet* Commission on the North American Opioid Crisis." *The Lancet Regional Health – Americas*. Available at https://pubmed.ncbi.nlm.nih.gov/34790907/.

Rosic, T., L. Naji, B. Panesar et al. (2021). "Are patients' goals in treatment associated with expected treatment outcomes? Findings from a mixed-methods study on outpatient pharmacological treatment for opioid use disorder." *BMJ Open*, 11(1), e044017. Available at doi.org/10.1136/bmjopen-2020-044017.

Santo, Thomas Jr., Brodie Clark, Matt Hickman et al. 2021. "Association of Opioid Agonist Treatment with All-Cause Mortality and Specific Causes of Death Among People with Opioid Dependence: A Systematic Review and Meta-Analysis." *JAMA Psychiatry* 78, 9: 979–993. Available at https://pubmed.ncbi.nlm.nih.gov/34076676/.

See, Isaac, Runa H. Gokhale, Andrew Geller et al. 2020. "National Public Health Burden Estimates of Endocarditis and Skin and Soft-Tissue Infections Related to Injection Drug Use: A Review." *The Journal of Infectious Diseases*, Volume 222, Issue Supplement_5, October 1, 2020, Pages S429–S436. Available at https://doi.org/10.1093/infdis/jiaa149.

Senate of Canada. 2022. *Debates of the Senate*. 44th Parliament, 1st Session, vol. 151, no. 59. 17 November 2022. Available at https://sencanada.ca/en/content/sen/chamber/441/debates/081db_2022-11-17-e?language=e#59.

Simon Fraser University. 2023. *Rapid Review: Prescribed Safer Supply and Alternatives to Safer Supply Programs*. Vancouver: CARMHA, 2023. Available at https://www.sfu.ca/content/dam/sfu/carmha/resources/rapid-review/SFU_PSAD_RapidReview.pdf.

Slaunwhite A., J.E. Min, H. Palis, K. Urbanoski, B. Pauly, B. Barker, et al. "Effect of Risk Mitigation Guidance for opioid and stimulant dispensations on mortality and acute care visits during dual public health emergencies: retrospective cohort study." *British Medical Journal* 2024; 384 : e076336. Available at doi:10.1136/bmj-2023-076336.

Sordo, Luis, Gregorio Barrio, Maria J. Bravo et al. 2017. "Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-analysis of Cohort Studies." *British Medical Journal* 357 (April 26): j1550. Available at https://www.bmj.com/content/357/bmj.j1550.

Sparks, Beatrice. 1971. *Go Ask Alice*. Simon and Schuster.

Stone, Andrew C., Jennifer J. Carroll, Josiah D. Rich, and Traci C. Green. 2020. "One Year of Methadone Maintenance Treatment in a Fentanyl Endemic Area: Safety, Repeated Exposure, Retention, and Remission." *Journal of Substance Use and Addiction Treatment* 115: 108031. Available at https://pubmed.ncbi.nlm.nih.gov/32600619/.

Substance Use Health Network. 2023. "National Safer Supply Community of Practice (NSS-CoP)." Available at Available at https://www.substanceusehealth.ca/.

Toronto Star. 2023. "Health Centre Staffer Charged in Toronto Bystander's Death Released on $200,000 Bail." *Toronto Star*, August 22, 2023. Available at https://www.thestar.com/news/gta/health-centre-staffer-charged-in-toronto-bystander-s-death-is-released-on-200-000-bail/article_9f7e00d0-17d5-52f4-af93-2b4015cca772.html.

Vancouver Coastal Health [VCH]. 2023. "Supervised Consumption Service at Insite." VCH. Available at https://www.vch.ca/en/location-service/supervised-consumption-service-insite.

VICE. 2020. "Justin Trudeau Won't Decriminalize Drugs Despite Record Overdose Deaths in BC." *VICE News*, July 21, 2020. https://www.vice.com/en/article/justin-trudeau-wont-decriminalize-drugs-despite-record-overdose-deaths-in-bc-john-horgan/.

Woo, Andrea. 2023. "Users of Opioid-Dispensing Machines Overdosed Less, Reported Improved Health: Study." *Globe and Mail*, May 16, 2023. Available at https://www.theglobeandmail.com/canada/british-columbia/article-users-of-opioid-dispensing-machines-overdosed-less-reported-improved/.

Woo, Andrea. 2024. "Major Study Finds People with Opioid Addictions 61% Less Likely to Die If Prescribed Safer Supply." *Globe and Mail*, January 13, 2024. Available at https://www.theglobeandmail.com/canada/article-major-study-finds-people-with-opioid-addictions-61-less-likely-to-die/.

Xavier, C.G., M. Kuo, R. Desai et al. 2023. "Association between toxic drug events and encephalopathy in British Columbia, Canada: a cross-sectional analysis." *Substance Abuse Treatment, Prevention, and Policy* 18, 42, July 72023. Available at https://doi.org/10.1186/s13011-023-00544-z.

Yanor, Fran. 2023. "BC Government Stance on Drug Activities Odds with Reality." *Northern Beat*, November 21, 2023. Available at https://northernbeat.ca/opinion/bc-government-stance-on-drug-activities-odds-with-reality/.

Zivo, Adam. 2023. "Drug fail: The Liberal government's 'safer supply' is fuelling a new opioid crisis." *National Post,* May 9, 2023. Available at https://nationalpost.com/feature/how-the-liberal-governments-safer-supply-is-fuelling-a-new-opioid-crisis.

Appendix: Acronyms and terminology

Safe(r) opioid supply, safe supply (SOS, SS): Prescription opioids, most commonly. The preferred pills are the brand name Dilaudid® (made by Purdue Pharma). In some regions such as BC, fentanyl tablets and patches, injectable hydromorphone, and injectable fentanyl have also been included on the opioid menu. These are prescribed and dispensed for users to "take home" from a pharmacy for unsupervised dosing, in bottles of anywhere from 5 to over 100 doses. Unsupervised dosing is when the risks and dangers of pill distribution arise – sharing, selling, injecting, and enabling the purchase of other drugs.

"Prescribed alternatives (PA)," "risk mitigation guidance (RMG)," Public Supply of Addictive Drugs (PSAD)": All these terms are synonymous with the prescription drugs requested by patients and prescribed by willing prescribers. Some prescribers include other classes of drugs – benzodiazepines (i.e., diazepam (Valium®), lorazepam (Ativan®), clonazepam or alprazolam (Xanax®) in prescription form, or stimulants such as dexamphetamine (Adderall®), ritalinic acid (Concerta®), and lisdexamphetamine (Vyvanse®)). All are apparently intended to "replace the toxic street supply" of opioids, benzos, and stimulants such as crystal methamphetamine and cocaine, which can be tainted with fentanyl and lead to overdose.

"Safer Supply," "Prescribed Alternatives," and "Risk Mitigation Guidance" are all terms used by harm reduction advocates when referring to addictive prescription medications that are prescribed, at high potency doses and in larger than usual amounts, to people with an addiction.

"Public Supply of Addictive Drugs" is a term coined by the team at SFU commissioned by the government of Alberta to carry out a review of 19 peer-reviewed publications that described original research advocating for so-called safe supply. This term was intended to clarify the fact that the programs cannot be assumed to be safe, nor effective (SFU 2023).

IDU, IVDU; PWUD, PWID: Injection drug use, intravenous drug use; people who use drugs, people who inject drugs.

OAT: Opioid agonist treatment, specifically methadone and buprenorphine, slow-release oral morphine (SROM) taken once a day. Patients can receive another form of this treatment, injectable buprenorphine (Bup-XR), once every four to six weeks.

iOAT: Injectable opioid agonist treatment. Originally intended for a small sub-group of injection drug users with severe OUD who had not been able to stabilize on methadone. The subjects on the NAOMI and SALOME trials participated in iOAT as an intervention (Oviedo-Joekes 2008; Oviedo-Joekes 2016).

OUD: Opioid use disorder.

SIS, SCS, OPS: Safe injection site, safe consumption site, overdose prevention site. Often confused with iOAT when advocates insisted there was ample evidence of benefit when, in fact, the iOAT projects were highly structured and provided injectable opioids, not tablets.

TRUE NORTH
IN CANADIAN PUBLIC POLICY

> “Canada shall be the star towards which all men who love progress and freedom shall come.”
>
> **– Sir Wilfrid Laurier**

Critically acclaimed, award-winning Institute

The **Macdonald-Laurier Institute** focuses on the full range of issues that fall under Ottawa’s jurisdiction.

- Winner of the Sir Antony Fisher International Memorial Award (2011)
- Templeton Freedom Award for Special Achievement by a Young Institute (2012)
- Prospect Magazine Award for Best North America Social Think Tank (2018)
- Short-listed for the Templeton Freedom Award (2017)
- Cited by five present and former Canadian Prime Ministers, as well as by David Cameron, then British Prime Minister.
- *Hill Times* says **Brian Lee Crowley** is one of the 100 most influential people in Ottawa.
- *Wall Street Journal*, *Economist*, *Foreign Policy*, *Globe and Mail*, *National Post* and many other leading publications have quoted the Institute’s work.

WHERE YOU’VE SEEN US

CTV
cpac FOR THE RECORD
CORUS ENTERTAINMENT
CBC news
FP Foreign Policy
tvo
The Economist
WALL STREET JOURNAL
THE HILL TIMES
THE GLOBE AND MAIL
CANADA’S NATIONAL NEWSPAPER • FOUNDED 1844
NATIONAL POST

GOOD POLICY
is worth fighting for.

WHAT PEOPLE ARE SAYING ABOUT **MLI**

MLI has been active in the field of indigenous public policy, building a fine tradition of working with indigenous organizations, promoting indigenous thinkers and encouraging innovative, indigenous-led solutions to the challenges of 21st century Canada.

– The Honourable **Jody Wilson-Raybould**

I commend Brian Crowley and the team at **MLI** for your laudable work as one of the leading policy think tanks in our nation's capital. The Institute has distinguished itself as a thoughtful, empirically based and non-partisan contributor to our national public discourse.

– The Right Honourable **Stephen Harper**

May I congratulate **MLI** for a decade of exemplary leadership on national and international issues. Through high-quality research and analysis, **MLI** has made a significant contribution to Canadian public discourse and policy development. With the global resurgence of authoritarianism and illiberal populism, such work is as timely as it is important. I wish you continued success in the years to come.

– The Honourable **Irwin Cotler**

MACDONALD-LAURIER INSTITUTE

15 MLI
TRUE NORTH
IN CANADIAN PUBLIC POLICY

323 Chapel Street, Suite 300,
Ottawa, Ontario K1N 7Z2
613-482-8327
info@macdonaldlaurier.ca

macdonaldlaurier.ca