Safe Supply in Canada: Perspectives of Drug Policy Actors

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Abstract

The overdose epidemic in Canada has taken thousands of lives since 2016. The toxic drug supply which has been flooded with fentanyl and other dangerous substances has made the country's illicit drug supply the most dangerous it has ever been. Safe supply programs are being proposed to provide long-term relief to the overdose epidemic. Throughout this thesis, I look at how safe supply is being administered in Canada and how that has impacted the overdose epidemic and the safety of drug use. Through interviews with a variety of safe supply advocates from across Canada and also conducting a document analysis on documents produced on a safe supply and the overdose epidemic, this thesis intends to look at the various methods that safe supply is being carried out through, how effective it is, what problems are arising within each method, and how this is impacting the lives of drug users.

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Safe Supply in Canada: Perspectives of Drug Policy Actors

Chapter 1: Introduction

The overdose epidemic in Canada has taken thousands of lives since 2016. Between January 2016 and December 2019, 15,400 Canadians have died from opioid-related causes (Government of Canada, 2020). The toxic drug supply which has been flooded with fentanyl and its analogues, along with a concoction of other stimulants and depressants, has made the country's illicit drug supply the most dangerous it has ever been. As a result, safe supply programs are being proposed to provide long-term relief to the overdose epidemic.

Safe supply is safe and legal access to otherwise illegal drugs (Canadian Association of People who Use Drugs, 2020). These programs can operate in multiple ways, but the most prominent method is through providing pharmaceutical alternatives, which a doctor often prescribes. These programs are being argued by many harm reduction advocates, politicians, and medical practitioners to be an important way to address the overdose epidemic, as fentanyl is a potent synthetic opiate that only requires a few milligrams to be ingested to trigger a fatal overdose. Since its introduction to the drug supply in 2016, it has claimed thousands of lives in Canada (Center for Disease Control and Prevention, 2020).

With the onset of COVID-19 in early 2020, the illicit drug supply in Canada has faced a shortage due to closed borders and shipping routes being disrupted, impacting the availability of illicit drugs on the street (Government of Canada, 2021). Due to this, more drugs than ever were cut with fentanyl and other substances like benzodiazepine (benzos), causing one of the deadliest years for overdose deaths. The dire nature of the overdose epidemic has had harm reduction advocates calling on provincial governments to start taking drastic measures to stop the poisoned drug supply and keep drug users safe (Canadian Association of People who Use Drugs, 2020).

This has resulted in the conception of safe supply programs, which provide safe and legal access to pharmaceutical alternatives to the illicit and poisoned street supply.

Alongside disrupting illicit drug supply chains, the COVID-19 pandemic also led to shutting down of public spaces and encouraging people to stay home, leading to more drug users using substances alone which exasperated the rate of deadly overdoses. With the COVID-19 pandemic and the overdose epidemic happening simultaneously, many methods traditionally used by harm reduction initiatives, like overdose prevention sites, have not been able to respond to the overdose epidemic meaningfully. This has resulted in safe supply programs in Canada emerging in provinces like British Columbia through community health clinics. They provide prescriptions of pharmaceutical alternatives like hydromorphone and diacetylmorphine to opiate users in the hope of providing them with a supply that will keep them away from the poisoned street supply. In other cases, unsanctioned methods of safe supply are being used through compassion clubs and 'the dark web' where those who are not comfortable or satisfied with the medical alternatives can access a safe supply, although illegally.

These different methods of safe supply intend to provide an alternative to the poisoned drug supply, although how effectively? Throughout this thesis, I intend to look at how safe supply is being administered in Canada and how that has impacted the overdose epidemic and the safety of drug use. Through conducting interviews with a variety of safe supply advocates from across Canada and also conducting a document analysis on documents produced on a safe supply and the overdose epidemic, this thesis intends to look at the various methods that safe supply is being carried out through, how effective it is, what problems are arising within each method, and how this is impacting the lives of drug users. This research intends to provide insight into how safe supply is being conceived during the overdose epidemic and what work

needs to be done in the future to mitigate the deadly impact of the poisoned drug supply in Canada.

Research Questions

The research questions that I intended to answer through my interviews and document analysis were as follows:

1) How are safe supply programs being constructed, and what are the different methods being implemented in Canada? What impact do these different methods have on the lives of drug users?
2) Who are the current safe supply actors in Canada, what are their goals for safe supply programs, and how are they trying to achieve them?

Chapter 2: Literature review

Social Control

Drug use is something that people across the globe have been experimenting with for centuries, but only in the past a hundred years has it been assigned moral weight. In Canada, the first drug laws came into place in 1908. Before this, drug use was regular among different social groups, and despite some concerns about the health effects, drug use was generally accepted for medical or recreational use (Grayson, 2008). The subsequent criminalization of formally licit substances was not based on the drug's harmfulness but instead perceived harms and risks associated with those who use the drug. Drug laws are created based on an image of a morally corrupt drug user and a threat to the larger society's interests (Shiner and Winstock, 2015). This perception of drug users and the negative morals associated with them is seen as something that needs to be discouraged and controlled. Thus laws are created to manage those who partake in morally reprehensible behaviour.

This need to control those who participate in activities that are viewed as undesirable or harmful is described by social control theory. Donald Black (1984) defines social control as "how people define and respond to deviant behavior." Responses to deviant behaviour span from formal judicial responses like arrest and punishment; social responses such as humiliation, gossip, and scolding; and third-party intervention like mediation and arbitration (Black, 1984). The varying severity of these responses is based on the socially prescribed harm or risk associated with a deviant act. For example, in Canada, being caught cheating on your spouse could result in interpersonal conflict, gossip, and judgement to indicate discontent with your actions. On the other hand, being caught selling heroin will have a much harsher punitive response for your actions, and the social implications of your actions will be much more severe.

In other countries, though, being caught committing adultery could result in harsh penal punishment and ostracization while selling certain illicit drugs might not elicit such a harsh response. Social control varies in settings and through cultures, with responses to deviances varying even within groups.

In Canada, social control can describe the justification for many of our laws. Black (1984) describes control being practised through these channels by "the penal style of social control tends to focus of the acts, the compensatory style on its consequences, the therapeutic style on a person, and the conciliatory style on a relationship, another strategy focuses on reducing the opportunity to engage in deviant behaviour, either by altering the situation of potential deviants or by alternating the habits of potential victims" (Black, 1984). The result of social control styles is evident in the contemporary response to drug use in Canadian society. For the problem of addiction, therapeutic interventions would result in treatment, penal interventions for the issue of crime, and managerial in relation to the harm and risk associated with drug use. The role of social control in managing drug-using populations has been a cause for concern as an increasingly dire overdose epidemic is happening in Canada. The current model of either criminalizing or treating drug users has been exposed as an inadequate response. The need to control and change those who use drugs has been deeply embedded in Canada's laws, making it increasingly challenging to implement alternative methods of managing drug use.

Criminalization of illicit drugs

The emergence of prohibition in Canada

In Canada, drug use has not always been criminalized or held a negative stigma. In the late 1800s, recreational drug use was common among Canadians, and little thought was given to the health or moral implications (Grayson, 2008). During this time, Canada imported large quantities of opium to be "freely distributed by doctors, travelling medicine shows, patent medicine companies, pharmacies, general stores, and Chinese opium shops" (Solomon and Green, 1982). Along with opium, other drugs such as cocaine, heroin, and cannabis were also often prescribed freely by doctors for medical and recreational purposes among citizens (Grayson, 2008). This all changed in 1908 with the introduction of the country's first prohibitionist drug law, *The Opium Act,* which criminalized the distribution of opium, with subsequent amendments in 1911 to include the criminalization of cocaine and other opiates, such as heroin (Grayson, 2008). At the same time, the prohibitionist movements against alcohol were also sweeping across the country, and by 1929 all provinces except Prince Edward Island had laws in place to ban the sale and distribution of alcohol (Riley, 1998). Canada's illicit drug prohibitionist regime was also further expanded in 1929 with the *Opium and Narcotic Drug Act*, which policymakers utilized as the countries illicit drug policy framework for the next forty years (Levine, 2003).

The emergence of the first drug laws in Canada came to be while building the country's rail system. In the early 1900s, many Chinese immigrants were brought to Canada as a form of cheap labour to work on the railway. Opium was frequently used by the Chinese workers, with little protest given by Canadian authorities. Once the railway was complete, many Chinese immigrants stayed in the country and found work elsewhere, often willing to work for less pay than many Canadians (Solomon and Green, 1988). This caused tension between Canadians and Chinese immigrants, as Canadians believed that the Chinese were worsening their way of life,

leading to heavy scrutiny of Chinese immigrants' lifestyles being labelled as immoral and not reflecting Canadian values (McKay, 2018). This perception of Chinese immigrants' lifestyle provoked anti-Chinese racism perpetrated by the media, Canadians, and politicians alike. Rising tensions eventually led to a violent anti-Asian riot in British Columbia in which Mackenzie King, who was deputy minister of labour at the time, was sent to investigate the aftermath and report his findings to the parliament. His report took note of the popularity of opium among white men and women, the profits from the opium trade, and made a call for Canada, a Christian nation at the time, to take a stand against opium as he believed that the impact of the drug was negatively effecting Canadians (Solomon and Green, 1988). The report influenced the Canadian government, and the media started to focus on opium being the heart of Chinese immigrants' degradation of the country's morals. They labelled opium smoking immoral and un-Christian, leading to creating the country's first drug law, *The Opium Act*, banning Opium in 1908, only three weeks after King submitted his report to parliament (Solomon and Green, 1988).

Opium smoking was not banned in 1908 because of legitimate concerns surrounding the drug; it was banned because it was viewed "as a sickness that had plagued an inferior culture" (Mckay, 2018), and the only way to prevent it from spreading to the 'superior' Canadian culture was to ban it and punish those who were in possession of it (McKay, 2018). The Opium Act's impact resulted in a significant increase in the illicit drug trade, inflated the price, and led to a new form of criminal activity of importing and distributing opium (Solomon and Green, 1988). The creation of new illicit drug markets was cause for concern for Canadian lawmakers, who ushered in new and harsher drug laws in the 1920s, resulting in the *Opium and Narcotic Drug Act* in 1929. *The Opium and Narcotic Drug Act* was one of the harshest pieces of Canadian criminal legislation and intended to harshly punish those who participated in all forms of illicit

drug use (Solomon and Green, 1988). These first drug laws gave the groundwork and moral reasoning for a century of prohibition-based drug policy to come.

Prohibition and criminalization of drugs gained prominence around the world only in the last century. The breadth of drug prohibition can be explained partially by international law that has been instated by the United Nations (Levine, 2003). Harry Levine (2003) describes global drug prohibition as "a world-wide system structured by a series of international treaties supervised by the UN." Up until 1961, many countries approached drug laws by regulating substances on a case-by-case basis. The 1961 UN Single Convention on Narcotic Drugs changed that by providing a comprehensive list of narcotics deemed harmful and required strict legal control, which signified a global shift from narcotic regulation to prohibition (Taylor et al., 2016). Further treaties in 1971 and 1988 established the current global system of drug prohibition and marked the widespread criminalization of all narcotics deemed dangerous by the United Nations (Levine, 2003). To this day, most nations across the globe have either signed or made laws that abide by these treaties, resulting in the global system of drug prohibition that is seen today (Levine, 2003).

Since the first drug law in 1908, drug use has been associated with the deviant and morally corrupt, and drug laws have targeted these groups accordingly (Shiner and Winstock, 2015). This has resulted in further power granted to the state to enforce drug laws, increasingly strict and harsh punishments for those caught using or selling drugs, and models of treatment that focuses on abstinence-only programming and mitigating the harm that drug use imposes on society. Unfortunately, the actual impact of drug prohibition has been much more severe than the harms intended to mitigate. Prohibition has failed to halt the harm that illicit drugs have had on public health and public safety. It has only exacerbated those issues by creating an overdose epidemic

and the expansive black market for illicit drugs (Beauchesne, 1997). Furthermore, research has indicated that prohibition has no correlation with decreased drug use, nor has increasingly harsh penalties for drug use decreased crime (Beauchesne, 1997). Despite the well-documented failures of drug prohibition, it is still a cornerstone of Canadian drug laws because of the deeply entrenched moral belief that illict drug use is wrong and needs to be eradicated.

Canada's embracement of drug prohibition has been the cornerstone of contemporary drug laws and how they are enforced in the country. The criminalization of illicit drugs has provided police forces with extensive power to enforce drug laws, leading to mass surveillance and invasive search and seizures (Levine, 2003). Prohibition and police involvement in upholding drug laws has led to further negative consequences like "the emergence of an extensive and lucrative black market, the unpredictable quality of drugs within these unregulated markets, the criminalisation of users, the invention of new drugs and limited access to treatment" (Long, 2018). The role of police involvement in managing drug use was further highlighted in Vancouver when "a study on the effects of this massive police crackdown indicated that it did not change the price of drugs, frequency of use or enrolment in methadone programs" (Haden, 2005). The justification for enforcement is that if the police come in contact with drug users, they can divert them to other social services or refer them to treatment programs even though many drug users would prefer to avoid law enforcement due to past bad experiences and overwhelming distrust of the police (Cohen and Csete, 2005). Police involvement in managing drug use has increasingly come under scrutiny for its well-documented failures of mitigating the problems that are associated with drug use.

Overview of the evolution prohibition

The criminalization of substances in Canada did not stop at opium, cannabis, cocaine, and alcohol. The following decades after the *Opium Act* consisted of increasingly harsh sentences associated with drug use and possession, increasing police power intended to enforce drug laws, leading to racialized groups being disproportionately targeted for suspected drug crimes (Gordon, 2006). One of the most extensive changes to drug laws in Canada came in 1961 when Canada was one of the countries to sign onto the United Nation's Single Convention on Narcotic Drugs treaty, which agreed to prohibit and criminalized narcotics "like opium smoking and eating, coca leaf chewing, cannabis resin smoking, and the non-medical use of cannabis" (Sinah, 2001). Other treaties like the Convention on Psychotropic Substances and Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances placed further bans on substances like stimulants and hallucinogens (Sinah, 2001). These treaties have resulted in a stark division between socially acceptable drugs (pharmaceuticals) and illegalized drugs that carry heavy social stigma and harsh punishments.

The impact of criminalization of illicit drugs has had a lasting impact in Canada. Over a hundred years later, many of the drugs law established in the early 1900s are still in place today. The criminalization of those who use drugs has had a massive effect on Canada's criminal justice system, with police being given increased power to search and surveil those who use drugs to mitigate the perceived harm they may cause. This has resulted in policing practices that unfairly target racialized people, mass incarceration, and a still ever-growing illicit drug black market run by drug cartels (Long, 2018). The failure of prohibition is apparent, but it is still at the heart of Canadian drug policy because of the moralization of drug use that has led to the belief that anything besides prohibition could have adverse effects on public health and safety. In the face of prohibition, other models have been explored on managing drug use in Canada. For example,

in the 1970s, the medical model started to gain mainstream recognition as a valuable method to treat drug users and provided a different perspective of how society should view drug use and how to manage it.

The Medicalization of Drug Use

Medicalization

Medicalization has been defined as the "process through which phenomena that previously existed outside medical jurisdiction become constructed and handled through a medical perspective" (Anderson et al., 2010). The medicalization of drug use has gained popularity in the 1970s after the long-standing belief that those who used drugs were inherently deviant and needed to be punished. Instead, a medicalized understanding proposed the idea that those who use drugs are sick and need to be treated through medical intervention (Anderson et al., 2010). Instead of using punishment to address drug use, pathologizing addiction allowed for a biological understanding of managing drug use through providing medical intervention. These interventions sought to give drug users medication and therapies to manage their addiction, hoping that gaining control over their drug use would encourage participation in additional treatment programs. Medicalization has successfully re-framed how drug addiction is approached and has allowed for new avenues of exploring how to manage drug use and addiction. Criticism of a medical approach to drug use primarily looks at how medicalization focuses on biological factors that can be fixed by medical interventions, while often ignoring social issues impacting someone. Despite the biological- factors focus, medicalization has introduced numerous different responses to drug use that have revolutionized how we approach and manage drug use.

Methadone maintenance treatment (MMT) is one of the most prominent examples of drug treatment to come out of the medicalization of drug use. For the past three decades, MMT has been the primary treatment from opioid addictions (Fischer, 2005). The basics of MMT is that opioid addiction is a medical disorder, with one of the critical elements of the disorder being persistent and reoccurring cravings for opioids. MMT acts as an opioid substitute, helps curve cravings, halts withdrawal effects, and prevents euphoria from additional heroin use (Fischer et al., 2005). Heroin assistance treatment (HAT) has been another medical model intervention, where long-term heroin users are provided with a "provision of pharmaceutical grade heroin (diacetylmorphine) alongside other interventions that support individuals to work towards better health outcomes" (Canadian Drug Policy Coalition, 2021). These medical methods of helping manage drug use have helped drug users gain control over their substance use and be more successful in treatment programs. Although both of these interventions do not address social realities that may lead to drug use, they provide an opportunity for drug users not to be so reliant on illicit substances and explore other methods of managing their drug use and seeking out further treatment.

The role of medicalization as an approach to managing drug use is not favoured by everyone and has faced criticism for being a flawed system and as a means of social control (Frank, 2018). The need to 'treat' those who participate in activities that are perceived as morally wrong comes with problems because not everyone who does drugs believes that they need treatment. One of the most prominent criticisms of medical models is how the process is repressive and coercive, mainly focusing on expanding the medical institutions' social power and its practitioners, all while limiting one's autonomy over how they want to address their drug use habits (Kolla and Strike, 2020). The role of social control in the medicalization of drug use has

led to repressive treatments that do not focus on the needs or wants of someone; instead, it focuses on ‘treating’ a ‘sick’ person who participates in the socially disapproved activity of drug use. The medical model follows the prohibitionist belief that drug use is harmful to users and society as a whole and needs to be stopped or treated. The medical model gave a new way of framing drug use as an illness, but it ultimately does little to change how drug use is viewed or managed from how criminalization treats drug users. At the core of both of these models, the onus to change and abstain from drug use is placed on the drug user, and not doing so will either get someone labelled as ‘sick’ or as ‘deviant.’ This approach to managing drug use ultimately does little for the welfare of drug users and instead focuses on forcing changed behaviour (Kolla and Strike, 2020).

Medicalization has also faced criticism for constructing addiction as a stable entity or biological fact. At the same time, some scholars prefer to argue that drug addiction is "constituted in multiple ways, by multiple human and non-human actors, continuously shaped and reshaped in practice, and informed by policy, legal and medical discourses” (Kolla and Strike, 2020). These polarizing views of addiction indicate some contention of how medical professionals believe addiction should be managed and the social realities of drug use. The medical model's impact has resulted in treatments favouring cultural, spiritual, or community-based treatments that many drug users could find helpful and more practical than medical treatments (Järvinen, 2008). Regardless of the criticism surrounding medicalization, the model has maintained its popularity among governments and practitioners for approaching addiction-related issues due to its potential to ‘treat’ people and explain drug addiction outside of social factors.

Treatment

Treatment-focused policies have served as a core part of Canadian drug policy and have been essential in managing drug use since the 1970s (Anderson et al., 2010). These policies were developed in contention with the long-standing belief that those who used drugs were inherently deviant and needed punishment. Instead, a medicalized understanding of drug use was developed that focused on the idea that those who use drugs are sick and need to be treated through medical intervention (Anderson et al., 2010). Treatment is carried out through programs like methadone maintenance clinics, therapeutic interventions, and addressing the 'essence' of a drug users' addiction (Järvinen, 2008). Despite treatments reframing how drug addiction should be managed, treatment programs must fall in line with prohibitionist policy, which views drug use as dangerous and criminal. The goal of many contemporary treatments is to get someone to stop using drugs and stop them from engaging in public health risk behaviour, such as sharing needles and curve criminal behaviour and improving community safety (Seivewright and Perry, 2009). This has resulted in treatment programs mainly focusing on abstinence, which has brought up concerns with how effective abstinence-based treatment is, since often the goal of the program is not to get someone to stop using drugs, it is also to have them engage in behaviour that betters public health and safety. Abstinence is often used because it does not legitimize drug use and places the onus of 'getting better' on the user without considering their personal goals or ambitions (McKeganey, 2011).

Abstinence-based treatment methods have faced scrutiny as it often forces drug users into a treatment model that they are not interested in and fails to consider that many drug users do not want to be drug-free (Järvinen, 2008). Another issue arising with abstinence-based treatment is how challenging abstaining from drugs is for people who use them, with living drug-free being

an unobtainable goal for many long-term drug users (McKeganey, 2011). Although treatment can be beneficial for some, it is not a viable option for many drug users because they cannot abstain from drug use. This demonstrates a problem in Canadian drug policy of keeping those safe who use drugs without putting them into treatment that does not work for them.

The medical model has provided some solutions for treating addiction but has proven inadequate to manage the growing public health concerns surrounding drug use. With a growing overdose epidemic in Canada, the focus on abstinence and treatment in the medical model seems to be out of touch with the concern of tainted illicit drug supplies and skyrocketing rates of overdose deaths. Although the medical model supports those interested in stopping using drugs, further work needs to be done within the moedel on advocating and intervening with the health and welfare of those who currently do use drugs beyond attempting to get them to abstain. This hole in the medical model has been noted by experts and has aided in the growth of harm reduction initiatives.

Harm reduction in Canada

Overview of early developments of harm reduction

In the 1980s, harm reduction began to gain mainstream recognition in North America and Europe as a valuable tool in managing the harms associated with drug use during the HIV/AIDS epidemic. At the time, harm reduction was previously used in treatment settings with the first Methadone Maintenance Treatment programs in Europe. This early form of harm reduction primarily focused on reducing harm by providing treatments focused on abstaining from illict substance use. However, the idea of reducing harm by providing services and programs played a vital role in future harm reduction developments (Seivewright and Perry, 2009). The rise of HIV

in the 1980s had a significant negative impact on intravenous drug users who frequently shared needles, which resulted in HIV-infected needles often being shared among groups of people (Des Jarlais et al., 1993). The spread of HIV among intravenous drug users exacerbated the public health crisis as HIV was also being passed along sexually or through birth, infecting even more people. In response, needle exchange sites were developed for intravenous drug users to exchange and dispose of their used syringes and receive new ones at no cost (Des Jarais et al., 1993). Clinics that offered needle exchanges sometimes also offered methadone, pamphlets on responsible drug use, or other harm reduction supplies like condoms to attract a diverse group of drug users (O'Hare, 2007). The needle exchange was popular and had demonstrated that there was a need for a similar service. Although new harm reduction developments certainly did not halt the rise of HIV/AIDS, needle exchanges played a valuable role in lessening HIV cases among drug users and opened the possibility for further harm reduction interventions to be developed globally.

In Canada, harm reduction began to gain prominence in the 1980s as a response to HIV spreading quickly among intravenous drug users and sex workers. Policymakers started to recognize these groups as communities with specific health needs that require specialized responses (Roe, 2005). One of Canada's first harm reduction-based responses to high HIV cases was based in Vancouver, where four 'street nurses' were hired to go around the downtown core area taking blood, providing referrals, and handing out bleach bottles to disinfect needles. The bleach bottles were the prototype of needle exchanges, which were not yet allowed, and aimed to provide a solution to people sharing used needles. The bleach bottles were eventually found to be infective because intoxicated people were unlikely to take time to disinfect their needles (Blatherwick, 1989). Similar informal and peer-driven needles exchanges efforts were seen in

Montreal and Toronto as HIV cases soared (Hyshka et al., 2017). These interventions set the stage for needle exchanges being developed in Canada. They demonstrated a clear need for sterile and safe needles and syringes among drug users, especially with rapidly increasing HIV cases. Needle exchanges had notable public health benefits, but convincing policymakers and police forces was another challenge because needle exchanges were viewed as enabling drug users (Des Jarlais et al., 1993). The HIV epidemic's dire nature demanded fast action and innovative policy that the federal government appreciated at the time. The Department of Health was willing to partner with five provinces to open eight official needle exchanges across the country (Hyshka et al., 2017). The success of needle exchanges inspired further expansions of the service, with all provinces and territories across Canada currently having needle exchange programs demonstrating Canada's shifting attitude towards drug use and the emergence of harm reduction in the country.

What is harm reduction?

Harm reduction can be defined and practiced in many different ways, with many organizations and agencies relying on their personal values and goals to guide their harm reduction practices. In its simplest form, harm reduction aims to reduce harm related to drug use (Hathaway, 2001). The most targeted harms are disease transmission, overdoses, and the harms associated with drug use and drug users' lack of visibility. In order to understand how harm reduction works fully, it is imperative to look deeper into how harm can be meaningfully and realistically be reduced (Riley et al., 1999). It could be argued that the medical model has produced some harm reduction interventions, such as methadone maintenance treatment, which helps stop cravings for illicit heroin, but the focus on abstinence in many medicalization

treatments programs has proven to only work for some drug users (McKeganey, 2011). Abstinence-based programs *can* reduce the harms associated with drug use. However, it is not a catch-all response, and current data on overdoses and disease transmission among drug users indicate that other interventions must be considered. That is why scholars are moving to a definition of harm reduction that specifies that its goals are reducing the harms of drug use *without* requiring drug abstinence (Riley et al., 1999). This definition encompasses that harm reduction is not trying to get people to stop using drugs. Instead, they work with them to make it as safe as possible. This definition does not aim to take a moral standing on drug use; it has found common ground between those prohibitionists and legalizers alike (Hathaway, 2001).

Harm reduction initiatives that focus on illicit drugs carry out their goals through a variety of practices. These initiatives can be anything from needle exchanges, supervised consumption sites, naloxone distribution, drug checking, safe inhalation kit, low-threshold opioid agonist treatment, and more (Hyshka et al., 2017). One of the oldest and popular harm reduction practices is needle exchanges, where intravenous drug users exchange their used needles for sterile ones, limiting the sharing of needles and slowing the spread of any blood-borne disease, like HIV (Blatherwick, 1989). Supervised injection sites are also a critical part of harm reduction initiatives and provide intravenous drug users with a supervised place to inject drugs and directly contact health and treatment providers. The idea of supervised injection sites was conceived to address the harm associated with doing drugs in unsafe environments and conditions that were not addressed by street-level initiatives such as needle exchanges. (Hathaway and Tousaw, 2008). Supervised injection sites have been shown to positively impact public disorder, disease transmission, and overdose rates and have also provided drug users with feelings of safety while injecting (Kerr et al., 2017).

Harm reduction initiatives have not always existed and operated within the bounds of the law, with many of Canada's first harm reduction initiatives being unsanctioned. The dangers associated with illicit drug use are well known, and those who use drugs have not waited for the government to get involved in being pragmatic about their safety. Unsanctioned harm reduction initiatives typically start out of fear of criminalization for illicit drug use, fear of violence, and stigmatization associated with illicit drug use (McNeil, 2015). For example, in Vancouver in the mid-1990s, several unsanctioned supervised injection sites were established to respond to rising HIV rates and overdoses. The first site was IV Feed which provided a safer place to consume drugs, access sterile supplies, and receive emergency overdose responses (Kerr et al., 2017). IV Feed recorded over 100 people visiting the site each night, signifying an enormous need for safe places to consume drugs. The illegal nature of IV Feed had the operation shut down within a year but paved the way for future supervised consumption sites and indicated that these services were critical to safer drug use and overall public health in light of the rise of HIV in the area (Kerr et al., 2017). The creation of unsanctioned harm reduction sites has served drug users by providing them with a safer and private location for using drugs, such as compassion clubs. These necessary services have provided underground, and unsanctioned access to necessary services for drug users and have operated even in the face of criminalization.

Harm Reduction in Canada

Drug prohibition in Canada has played a significant role in the emergence of harm reduction initiatives and is vital in how services are provided. The criminalization of illicit substances has resulted in unregulated drug supplies, drug use in unsafe and non-visible locations, sharing needles due to lack of supplies, and many other problems directly related to

prohibition (Long, 2018). Harm reduction initiates have to provide services that largely mitigate the harms associated with having laws that make it illegal for people to consume safe drugs in a safe and visible location. This has led to interventions like needle exchanges, supervised consumption sites, and drug testing kits that aim to make drug use as safe as possible. Although these interventions have played a valuable role in making drug use safer, they ultimately are a bandage on much more significant issues of lack of safe drug supplies and criminalization of drug users. Many harm reduction operations are limited to what they can achieve within the current legal framework, which limits a lot of the services provided. For example, although supervised consumption sites can reverse overdoses, they cannot prevent them unless they provide drug testing to determine if someone is consuming tainted drugs that can lead to an overdose beforehand. Regardless of harm reductions limitations, it continues to contrast itself against prohibition primarily through viewing drug use as a morally neutral act, acknowledging that drug users as citizens not 'deviants,' that drug policy should be based on practice and science, not on moral judgement (Tammi and Hurme, 2007). Although harm reduction is not a perfect solution, it is increasingly bringing prohibitionist regimes under further scrutiny and providing new ways of making drug use safer.

Contemporary developments in HR

From supervised consumption to 'safe supply'

Harm reduction has come a long way since the first needle exchanges in the 1980s. In Canada, harm reduction initiatives like safe consumption sites are in operation in numerous cities like Vancouver, Montreal, and Toronto, and needle exchanges are currently operating in all thirteen provinces and territories across the country (Hyshka et al., 2017). Citizens and

politicians alike have recognized the value of harm reduction. It has influenced a change in attitudes in how Canada handles drug use in a less punitive manner. However, despite harm reductions successes in limiting the spread of disease and aiding in preventing overdoses, there is still work that needs to be done to make drug use safer that harm reduction struggles to address.

Canada is currently facing an overdose epidemic related to opioid drug use, with provinces like British Columbia and Alberta has faced a significant increase in opioid-related overdose deaths since 2016 (Hyshka et al., 2017). Even with harm reduction initiatives' best efforts, the overdose crisis shows minor signs of slowing down due to the increasing amount of fentanyl found in street drugs. Some scholars and organizations have recognized the shortcomings of harm reduction initiatives. They are now calling for "…greater focus on how to address the ongoing contamination of the drug supply with fentanyl and its analogues, the impacts of the criminalisation of drug use on overdose risk, and the intersecting influences of key social determinants of health such as poverty, homelessness, and trauma that affect many people who use drug" (Strike and Watson, 2019). Although harm reduction plays a vital role in making drug use safer, it ultimately cannot stop drug supplies from being tainted, the risks of criminalization for using drugs, or change social factors that impact drug users. These limitations desperately need to be addressed through other interventions to address dangerous and deadly issues like the overdose epidemic in Canada. Current harm reduction initiatives have proven to help manage some of the harms of drug use, but a more innovative policy for preventing overdoses needs to be implemented to keep drug users safe.

Canadian struggles towards ‘safe supply’:

The deadly impact of Canada’s overdose epidemic has inspired several drug policy experts, organizations, and drug users to call for a safe supply to be instated in Canada’s drug

policy. Safe supply is the safe and regulated access to otherwise illicit drugs (Canadian Association of People Who Use Drugs, 2020). Illicit drugs are increasingly being contaminated with lethal fentanyl and its analogues leading to one of the worst public health crises that Canada has seen. Between January 2016 and December 2019, 15,400 Canadians have died from opioid-related causes (Government of Canada, 2020). Safe supply offers a different solution to overdoses than the current approaches as it focuses on providing drug users with safe and regulated drugs and provides an alternative to illicit drugs that could potentially be laced with deadly substances. Safe supply could be an important step that Canada could take to ensure drug users' safety and health and provide a pragmatic response to the current overdose crisis.

The dangers of the poisoned drug supply in Canada can no longer be ignored. Fentanyl and its analogues, along with other dangerous substances like benzos in the drug supply are causing it to become deadlier and leading to unprecedented numbers of overdoses among long-time drug users and recreational drug users alike. Fentanyl is a highly potent synthetic opiate that is about 50 to 100 times stronger than morphine; due to its potent nature, it only requires a small amount to be (usually, unknowingly) consumed to cause an overdose (Center for Disease Control and Prevention, 2021). As a result, it has been prevalent in Canada's illicit drug supply since 2016 and has led to thousands of overdoses. The other impact of this is that fentanyl has been in drug supply for five years now; many opiate users have become accustomed to it and now prefer to use fentanyl over less potent opiates, leading to fentanyl being more in demand and found more frequently in the illicit drug supply. This has led to an already toxic drug supply becoming more dangerous, causing an overdose epidemic that has seemingly only just begun.

Harm reduction advocates and activists have identified the need for safe supply in Canada as a critical step in ensuring drug users' safety and minimizing the harms associated with

drug use. One of the most prominent issues safe supply faces is the opposite of prohibition-based frameworks that dominate Canadian drug laws. For safe supply to be meaningfully implemented, the Canadian government would have to do a complete overhaul of current drug policy and work against international treaties implemented by the United Nations, which is no small task. Regardless of the challenges associated with implementing policy, with broader international acceptance of harm reduction, safe supply is slowly being seen in a more favourable light as a pragmatic response to drug use and public health (Canadian Association of People Who Use Drugs, 2020). The social stigma surrounding drug use is another serious issue that safe supply must face. The idea of 'legalizing' drugs is uncomfortable for many Canadians, and in order to successfully implement any policy, safe supply must be made palatable for policymakers and citizens alike.

Despite the work that needs to be done to introduce safe supply across the nation, Canada has shown initiative to accommodate such a drug policy. In April 2020, during the COVID-19 pandemic, the province of British Columbia passed emergency legislation that allowed authorized prescriptions for controlled substances like hydromorphone, stimulants, benzodiazepines to support people who use drugs (Ontario HIV Network, 2020). This legislation was important as COVID-19 severely impacted the availability of illicit drugs, causing people to go into withdrawal, which can have lethal effects. People were also increasingly doing drugs alone in isolation which put them at risk of dying if they were to overdose alone (Ontario HIV Network, 2020). One of the limitations to the emergency legislation is that only substitutes to illicit drugs were available, preventing people from going into withdrawal but might not meet their tolerance. The prescriptions also ran the risk of not fully covering a drug user's needs, and the user still had to seek drugs out on the street to meet their cravings (Canadian Association of

People Who Use Drugs, 2020). This legislation demonstrated that a safe supply policy could be worked into the Canadian legislature, although more work needs to be done to ensure that adequate alternatives are available to prevent people from turning to illicit supplies off the street.

The need for a safe supply is dire. With thousands of people dying from overdoses related to fentanyl since 2016, there has been a demonstrated need for an available regulated supply. Organizations across the country are working towards safe supply initiatives in their community and making a legal and regulated drug supply a reality. As it currently stands, safe supply programs are mostly being provided by prescription through medical clinics. Some doctors and medical centers are providing hydromorphone tablets to those who use heroin in an attempt to provide them with a drug supply that will keep them away from the illicit supply on the streets (Stewart, 2020). This method of administrating safe supply works for some, but as the overdose epidemic takes more lives, there needs to be more development and options for safe supply programs across the country. Numerous harm reduction and safe supply organizations advocate for more accessible and widespread safe supply options, but the current prohibition-based drug policy and the negative stigma associated with drug use make it a challenging fight. Still, the overdose epidemic will not end until drug users have alternatives to the tainted drug supply. Meaningful action is required now, and looking into what work safe supply advocates are doing and their experiences can provide context into how the overdose epidemic is being managed and the safety of drug use in Canada.

In order to further understand the conception of safe supply in Canada, it is important to look into the work that is being done by advocates, people who use drugs, policy makers, and medical practitioners. The fight for safe supply in Canada has only just begun, but understanding the different methods of safe supply, their implications, and who is advocating for what will aid in

understanding how safe supply programs are being conceived in Canada and how they are impacting the lives of people who use drugs, and in turn the overdose epidemic. In order to conduct this research, interviews with numerous safe supply actors across Canada will be conducted, and a document analysis that looks at reports produced by the media, government bodies, and advocates will be utilized. These are both powerful research tools that will help paint a picture of the fight for safe supply in Canada today, and aid in understanding what future work needs to be done.

Chapter 3: Methodology

To conduct this research, the methods I used were qualitative interviews and document analysis. Interviews are one of the selected methodologies because they are a powerful research tool that plays a vital role in understanding an issue from an actor's perspective. Interviews can be flexible, open, and provide the opportunity for the interviewees to share their experiences and opinions, which can provide rich and in-depth data (Bryman et al, 2008). This is important because flexibility and openness allow for understanding the interviewee's perceptions and opinions on sometimes sensitive topics that may require additional questions and insight (Bariball and While, 1994). I specifically conducted semi-structured interviews, which based the interview on prepared questions and allowed the participants to share knowledge beyond the questions. The use of interviews to conduct this research was essential as the experiences and perspectives of safe supply advocates had not been explored much in discussions surrounding the overdose epidemic. This interviewing method focuses on aspects of the question that the participant deems the most important, allows for diverse perspectives, and gives the participant more say in what information they want to share and the ability to focus on how they view a topic (Brinkmann, 2013). The semi-structured interviews were conducted more like conversations where I would open with the question of asking the interviewees the same question of "Can you tell me about the work that you and your organizations are doing towards safe supply in Canada?" and asking the next question based on their response. This allowed for a natural flow of the interview where the interviewee could focus on what they deemed most important.

Since my research focuses on the experiences of drug policy actors advocating for safe supply and their thoughts on how safe supply is being implemented, the interviewees must have

the ability to freely share their experiences with me to understand their experiences advocating for safe supply fully. Safe supply is a relatively new concept, and there is currently little academic work written on it, and the actors that were interviewed are some of the first and most prominent organizations in Canada to be seriously addressing the topic. The interviews that were conducted provided the opportunity for those who directly worked on the issue to have either their experiences or thoughts on the issue be shared as the prominent voices advocating for safe supply in Canada. Interviews also provide information on current issues these organizations face and the challenges safe supply initiatives face when trying to gain legitimacy. To fully understand the topic and how safe supply is being advocated and implemented in Canada today, interviews are a necessary research method to provide new and relevant data on a previously unexplored topic.

Alongside interviews, I also conducted a document analysis of documents and articles produced on the topic of safe supply in Canada to understand how the media, government bodies, medical professionals, and advocates all discuss safe supply. This is important for my research because the interviews that were conducted can only provide me information on safe supply from the point of view of the actors working on it. A document analysis showed how various outlets discuss the topic and how safe supply is represented through these mediums. The interviews and document analysis tell separate parts of the same story. The document analysis explained how safe supply is constructed and discussed by collecting and analyzing various documents on safe supply from different sources and actors. It allowed for a more nuanced understanding of how drug use is viewed by these different bodies and gave context to many of the ideas and issues brought up throughout the interviews. Using multiple methods allows for the data to be triangulated, which is done through “convergence and corroboration through the use of

different data sources and methods" (Bowen, 2009). This provides a richer, more in-depth understanding of the topic and gives insight into numerous different actors and institutions' thoughts and processes of having safe supply programs in Canada. Through interviews and document analysis, I fully understood the issue of safe supply in Canada and what factors are working for and against its implementation. This is important because currently, little is known academically about safe supply. Utilizing multiple methods allowed various opinions and thoughts to be explored to create an in-depth and rich understanding of safe supply.

Participants

For my interviews, I interviewed eight safe supply advocates from five different organizations. These organizations were based all across Canada, and each provided a unique perspective on how they are approaching safe supply, their thoughts on how its currently being implemented, and how they would like to see safe supply be implemented across the country in the future. Three of the organizations I interviewed did national work. One of them, the Canadian Association of People Who Use Drugs, is an organization that aims to "reduce oppressive societal conditions that people who currently or formerly use drugs face and emphasize the need for their direct involvement in public policy decision making" (Canadian Association of People Who Use Drugs, 2020). They were selected because they are one of the most prominent organizations doing safe supply advocacy in Canada. They have significant insight into the fight for safe supply in Canada, how safe supply is administered, and some of the more significant challenges that are being faced in making safe supply a reality. They have worked on numerous national campaigns for safe supply and have played a key role in getting the discussion about safe supply started in Canada on a larger scale. One of the other major voices in safe supply advocacy in Canada, The Canadian Association for Safe Supply, was also selected. The

Canadian Association for Safe Supply is "focused primarily on increasing access and supply to legal, regulated substances of known potency" (Canadian Association for Safe Supply, 2020). I chose to interview them because they also have a large amount of knowledge on national fights for safe supply and some of the more significant implementation issues. They also have ample knowledge of how safe supply is being administered and the implications of those methods. They have met with various governments and politicians to discuss the importance of safe supply and do a significant amount of advocacy on the issue. Last, Moms Stop the Harm is an organization made up of mothers and family members who have lost a loved one to the overdose epidemic; their mission is "we advocate to change failed drug policies and provide peer support to grieving families and those with loved ones who use or have used substances" (Mom Stop the Harm, 2021). Moms Stop the Harm were selected because they have a countrywide presence and do significant work with local governments and local communities. They do on-the-ground work and try to connect with community members to challenge stigmas associated with drug use and advocate for more progressive drug policies such as safe supply. These organizations all provided valuable information, experience, and knowledge on how they have been advocating for safe supply across Canada and provided insight into work that has been done across the country and on national drug policy related to safe supply.

The other two interviewed organizations were BC Yukon Drug War Survivors and Coalition of Substance Users of the North. These two organizations were much more focused on making safe supply available in their cities and communities and provided insight into what on-the-ground work is being done and their experiences trying to get safe supply to be a reality in their area. BC Yukon Drug War Survivors is an organization made up of former and current drug users who advocate and "unite and empower former and current users of illegal drugs" (BC

Yukon Drug War Survivors, 2021). They provided insight into current drug users' work to access safe supply and their experiences working with or around local governments. They do a lot of local and community-based work and can provide insight into how safe supply, or lack off, impacts people who use drugs in their community. The Coalition of Substance Users of the North is a harm reduction and safe supply advocacy group based out of Quesnel, British Columbia. They are another group of former or current drug users and focus on providing harm reduction and safe supply services to Northern communities. They can give information about how they advocate for safe supply on a local level and their experiences as a smaller organization trying to make safe supply a reality. Both of these organizations provided valuable information on what is being done at a community level, opposed to larger organizations which provide insight into what is being done on a federal or provincial level. Interviews with both types of organizations are important because it allows for a complete picture to be painted of how safe supply is being advocated for on all levels.

Some challenges were faced when recruiting for the interviews. I was also hoping to interview medical professionals who were working on safe supply programs. Their views and experience would have been valuable as doctors or nurse practitioners administer many current safe supply programs through community health clinics. Unfortunately, I was not able to organize any interviews with this group. However, many medical professionals have been interviewed by various news outlets or published their experiences with administrating safe supplies. Through those, I was able to understand their experiences with safe supply through the document analysis.

For the document analysis, I looked at documents produced by organizations, government bodies, and the media related to safe supply. I collected thirty-three media reports on

safe supply, five official government reports, and ten documents put out by organizations that support safe supply. All the media and government documents collected were published after March 2020, as that is when the COVID-19 pandemic swept across North America, and the dire nature of the overdose epidemic started to be realized by these parties. All the documents collected from organizations that support safe supply were written after January 2019, as these organizations were aware of the overdose epidemic started to prepare safe supply documents well before the pandemic hit. I chose to focus on these three areas because they provide a rich and diverse understanding of how safe supply is presented and discussed in public life. Looking at the media and documents produced by government bodies specifically can provide insight into how different actors view safe supply and illuminate some of the issues safe supply faces in being implemented. Media articles can particularly provide a diverse range of opinions on safe supply and give insight into the general public's opinions on the topic.

On the other hand, government documents can provide insight into what legislative bodies are doing concerning safe supply or if different government bodies would support such policy. Finally, analyzing documents of organizations that work on drug policy can provide further information on what these actors are doing to get safe supply implemented, their goals, and how they are trying to achieve them. Thus, analyzing these three areas will provide in-depth insight into how safe supply is being constructed and how it exists in public life.

Data Collection

The semi-structured qualitative interviews were carried out with actors from various organizations that advocate for safe supply. The interviewed organizations are grassroots and focus mainly on advocating for safe supply within their communities and cities. These organizations advocate for safe supply in Canada and demonstrate an overall goal of improving

the lives of drug users and the safety of drug use. In these interviews, I asked questions that provided a solid foundational understanding of how Canada's safe supply can be implemented. The interview questions were based on how these actors advocate for safe supply, how they perceive Canada's current approach to drug policy, and what they believe needs to be changed. I also asked for insight into why safe supply is what they are advocating for and not other interventions and what impact they believe safe supply could have on the lives of drug users. The goal of the interview was to obtain a strong understanding of current challenges and issues organizations advocate for safe supply face and what problems they foresee in getting safe supply implemented in a way that helps drug users, and what problem they are seeing right now with how safe supply is being approached.

The document analysis involved collecting various documents related to safe supply in Canada, reading through them carefully, and interpreting what was being said in each document. The interpretation aspect of the document analysis is a combination of content analysis and thematic analysis. The content analysis aspect of the interpretation requires organizing the data collected through the document analysis into specific categories related to the research question (Bowen, 2009). This includes identifying important and key quotes and passages throughout the documents which describe the topic. The thematic analysis aspect of the interpretation stage requires patterns to be identified through the data. In order to do this, the key quotes and passages identified through the content analysis must be analyzed and coded and split off into categories, which will then reveal prominent themes through the documents (Bowen, 2009). For the document analysis, I looked specifically for documents based on how drug policy actors, the media, and government bodies construct Canada's current issues surrounding illicit drug use and how safe supply is constructed to respond to these issues.

The document analysis used documents, publications, and reports by the government, drug policy actors, and the media who have written on safe supply. To obtain these documents, I used internet databases and read documents related to the issue. Items used for the analysis of the documents were explicitly focused on safe supply. The analysis looked at how these documents present safe supply and frame its potential and implementation issues. From these documents, I understood how the case for safe supply is being presented, how safe supply can be integrated into current drug policy, what challenges are associated with proper implementation of safe supply, and how different actors articulate the issue. The document analysis explains how safe supply is constructed through these documents and how the current discourse on the topic may tell a different story than the one I get from my interviews. Understanding safe supply from both interviews and a document analysis allowed me to analyze whether the work done by organizations lined up with what the document analysis views as critical parts of safe supply implementation. Both methods provided different insights into the ideals, challenges, and beliefs of different actors who are a part of implementing safe supply and what this could mean going forward.

Data analysis

I utilized a thematic analysis to identify reoccurring themes and topics within my data to analyze my data. Thematic analysis is "a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail" (Braun and Clarke, 2006). A thematic analysis was chosen because it provided much flexibility in analyzing the data and allowed reoccurring themes to be recognized and deeply analyzed in how they answered the research questions and what the data says about my topic (Braun and

Clarke, 2006). I chose to do a thematic analysis for the entire data set of my interviews and document analysis because I wanted to understand how safe supply in Canada is being acted on. Looking at the data allowed for me to gain a rich understanding of multiple different aspects of safe supply advocacy, and gave a strong understanding of how safe supply initiatives are operating and the challenges they are facing, along with looking into different perspectives on safe supply and the overdose epidemic.

In order to analyze my full data set, I started by looking into frequently brought-up themes in the interviews and document analysis which allowed me to identify what was being frequently discussed and what re-occurring topics dominate the discussion surrounding safe supply. The themes that were identified through the interviews and document analysis were 1) Justifications for safe supply, 2) Medical model of safe supply, 3) Unsanctioned model of safe supply, and 4) Struggles of safe supply implementation. From within these four themes, I was able to identify numerous topics with each theme that provided a rich understanding of how safe supply programs are coming to be in Canada. To identify the themes within the interviews, I first transcribed the audio. After that, I went through the transcripts and highlighted reoccurring topics and themes within the data with an assigned colour for each topic in a process called coding. After I coded the data, I then put each identified topic into a document for closer examination. Having all the quotes of the same topic in the same document provided insight into some reoccurring thoughts on safe supply programs in Canada, how it is being adminsted, and the barriers identified in making safe supply a practical reality. After putting all the topics in their respective document, I chose the four themes above, which I felt best encapsulated the most discussed themes in the interviews.

For the document analysis, I had a similar procedure for coding the data as the interviews. I went through the relevant articles and documents put out by the media, different levels of government, and organizations on safe supply and put the relevant information and quotes into an excel document, having assigned rows for different topics that came up. This allowed me to visualize the different ways topics were being discussed, how frequently, and who were discussing what. I had four different excel sheets for articles and documents put out by the media, governing bodies, medical professionals, and safe supply advocates. The data was then analyzed, and the topics that came up most frequently that indicated to have the most impact on safe supply in Canada were selected for the themes. Most of the frequently mentioned themes in the document analysis were the same ones that came up in the interviews, allowing for four themes to be settled on that best answered my research questions and provided the most insight into how safe supply is being constructed in Canada. Using this method allowed me to look deeper into what these re-occurring themes meant about safe supply programs in Canada and what issues are frequently identified within the texts I analyzed.

Through conducting interviews and document analysis, I was able to develop an in-depth and rich understanding of how safe supply in Canada is being carried out, why it is being carried out the way it is, what alternatives there are to the current model and some limitations to complete access of Safe Supply. These methods have allowed me to have a strong understanding of the issue of safe supply in Canada and how the different programs are proposing to impact the overdose epidemic.

Chapter 4: Findings

Four themes emerged throughout my data collection from both my interviews and my document analysis. The first was the justification for safe supply, which delves into why safe supply is specifically needed in Canada. The next theme is the medicalization of safe supply, which discusses the prominent role of the medical model and the implications of this model. Third, unsanctioned safe supply methods identify how safe supply is approached outside of the legal apparatus. Last, the struggles safe supply advocates are facing in implementing safe supply programs, which discusses some of the most significant barriers identified in my data collection to get a meaningful and widespread implementation of safe supply initiatives in Canada. These four categories aim to provide insight into how safe supply is currently being approached in Canada and how these methods are addressing (or failing to address) the current overdose epidemic that has taken thousands of lives.

Justification for Safe Supply

The document analysis and interviews emphasized the need for a safe supply throughout my data collection. The current overdose epidemic is dire, with thousands of lives being lost since 2016, leaving people who use drugs and their allies desperate for alternatives. The most frequently cited reasons for the need for safe supply throughout my data collection were identified as 1) Toxic and unreliable drug supply, 2) Increasing potency of drug supply, and 3) Other policy options not adequate.

Toxic and Unreliable Drug Supply

The fight for safe supply has been going on in varying degrees for decades, but the recent influx of fentanyl, along with other dangerous substances like benzodiazepine (benzos), in the Canadian drug supplies has made the need for safe supply much more imminent since 2016.

From the document analysis, the number one identified reason for needing safe supply is how unpredictable the current drug supply is. Based on numerous media reports, illicit drugs are being increasingly contaminated with fentanyl and its analogues, along with other sometimes unidentifiable substances making it challenging to reverse overdoses. It was found in an article put out by the Globe and Mail that back in 2012, fentanyl was related to 5% of overdose deaths in B.C. In 2020, 84% of overdoses in the province were related to fentanyl. It was further found throughout the document analysis that the tainted drug supply was brought up as the primary need for safe supply by advocates, politicians, medical professionals, and government officials alike. Media reports produced by the CBC and the Globe and Mail that were analyzed throughout the document analysis claimed that fentanyl bought on the street is typically mixed with other drugs to dilute its potency, which is resulting in a lack of quality control and many drug users not being aware of what they are consuming. The lack of consistency in what is being sold on the street leads to one dose being deadlier than the next, and it is challenging for drug users to know how much to dose safely.

Further data from my document analysis found that articles published surrounding safe supply in media reports focused on largely fentanyl-contaminated illicit drug supplies, but also media outlets have acknowledged that other dangerous drugs were heightening the overdose epidemic. For example, from a report from the Globe and Mail, drugs like benzodiazepines (benzos) are being more frequently seen cut into substances sold on the street, leading to the illicit drug supply being more unpredictable. This trend in illicit drugs being cut with even more dangerous substances makes it harder for overdoses to be reversed with Naloxone and for drug users to be aware of what they are using.

In the data collected from the interviews, the interviewees focused much more on the different types of ways that the drug supply is being contaminated. Many interviewees brought up fentanyl in the drug supply but also stated that many drug users were now using fentanyl as their drug of choice, and other dangerous substances like carfentanyl and benzodiazepine's (benzos) were showing up in the drug supply, which is making illicit drug supplies as even more deadly. For example, in one interview with a member from B.C Yukon Drug War Survivors, the participant shared how benzos in the drug supply have become increasingly dangerous:

> *"Heroin is now for the elite and heroin doesn't hit the streets in the same way that it did in the past. It's really fentanyl, but there's a lot of benzos. And we just had the unfortunate incident of an absolutely amazing advocate who went to from B.C. and Alberta to do detox and was not really aware of the benzo contaminants in the substance that they had been using for some time and had a seizure and died because there was no treatment for the benzo that they had been consuming for so long, because they were not even really very aware of the supply that they were consuming."*

Increasing potency of drug supply

Throughout the document analysis, a paper put out by the BC Medical Journal stated that the rise of fentanyl and other dangerous substances in the illicit drug supply has brought up a concerning trend of drug users becoming accustomed to a very potent illicit drug supply, with many opioid users now preferring fentanyl over heroin. This was identified as an issue because the longer that drug users buy from illicit markets, the likelier they are to be not satisfied by safe supply options or the potency of pharmaceutical alternatives. This also leads to people seeking out even more potent substances than fentanyl, such as carfentanyl, which can lead to an already

toxic and deadly drug supply becoming even more dangerous with the addition of increasingly potent substances. One interviewee shared:

> *"The problem is that people's opiate levels are so high with fentanyl that they need actual fentanyl. They don't want heroin, it won't do it anymore. We give away heroin and people don't feel it. They mix it with their fentanyl to give it a little bit more legs."*

The increasing potency of the drug supply and drug users' new reliance on much stronger substances also came up in my document analysis. For example, a paper put out by the BC Medical Journal further documents how popular and in-demand potent substances like fentanyl were. This article mentioned that when someone overdosed, they would often ask who their dealer was because they knew they would get potent drugs. This preference for more potent substances is causing heroin to no longer be a desirable drug for many, leading to an illicit drug supply with high levels of fentanyl in it because that is what is being sought out.

Other policy options not adequate

The topic of decriminalization came up frequently during the data collection. From the document analysis, articles published by CBC, The Globe and Mail, and The Star all stated decriminalization of illicit drugs had been posed as a response to the overdose epidemic because the illegal nature of drugs and fear of criminalization forces people who use drugs into unsafe situations, which makes the risk of an overdose more significant. The media further argued that decriminalization could help safe supply initiatives as drug users may be more willing to seek out services, such as supervised consumption sites, and incur less stigma associated with drug use if criminalization is not a threat. From further data collected through the document analysis, it was clear that decriminalization could undoubtedly positively impact the lives of drug users.

For example, an article published by the CBC stated that the benefits of decriminalization had been outlined as taking drug possession out of the criminal sphere and reframing it as a health issue. This would ideally aim to reduce stigma, have less police intervention, and provide a way for people to feel safer and more comfortable accessing treatment services instead of being put through the justice system. It was also found through the document analysis that the Vancouver Police Department has voiced support for decriminalization, recognizing that arresting is an ineffective method of handing drug possession.

Not everyone believes that decriminalization would have that meaningful impact on the tainted drug supply and the fight for safe supply. Although decriminalization would improve the lives of drug users and no longer criminalize minor possession, it does little to address the tainted drug supply or provide a safe supply. For example, one member from the BC Yukon Drug Wars Survivor's stated:

> *"I mean, decriminalization is great for where we are now or for where we were five years ago. But it still has does nothing to address the toxic supply and it does nothing to address the exorbitant price."*

Another member of the Canadian Association of Safe Supply shared:

> *"So you can you can decriminalize things, but that doesn't save any lives. People will still be doing crime to get illicit drugs. And so those two things still remain, which are the two major factors in our opinion. And so if you had regulated drugs that people were or happy with, in the dose they needed for one, it would no longer need to go out boosting and shoplifting or stealing cars or whatever you're doing or prostituting whatever it may be."*

Another interviewee from Coalition of Substance Users of the North voiced concern about what decriminalization would mean for the lives of drug users.

> *"The difference between decriminalization and legalization is a huge jump. But I think many people who use substances don't quite understand the complexities between decriminalization and actual legalization. And that I mean, we even saw this with legalization of cannabis actually allowed them to enact even further punitive approaches to cannabis regulation. So in the long term, yes, we have access equal like regulated access, but they've also imposed more fines and potential criminal offences along with that process. And I'm fearful that if we move towards that model with this, that that would also be part of that process as well".*

Medicalization of Safe Supply

The role of medicalization in the advocacy for safe supply was one of the most prominent methods of implementation of safe supply in Canada that appeared throughout my data collection. Medicalization of safe supply relies on pharmaceutical alternatives of someone's drug of choice. Medical alternatives for popular illicit drugs include diacetylmorphine or hydromorphone for those who use heroin or other opioids, Ritalin or Dexedrine for meth and other stimulant users, among many others. This method of safe supply relies on medical professionals using their own discretion for prescriptions and doses while working with people who use drugs to meet their needs, hoping that they will not return to using drugs purchased on the street. From my document analysis and interviews, I identified multiple distinct aspects of the medicalization of safe supply. These categories are 1) Medical practitioner role in safe supply, 2) Prescribing practices, and 3) Satisfaction with pharmaceutical alternatives.

The Medical Model

The medical model of safe supply is currently the most prominent method of administrating safe supply in Canada. Through analyzing documents published by CBC, Filter Magazine, and The Globe and Mail throughout the document analysis, it was found that safe supply advocates and governments have primarily advocated for the medical model because medical professionals already have the knowledge and the ability to prescribe alternatives to the poisoned illicit drugs supply that is currently available. It was found that the federal government in Canada has put out numerous official statements in support of safe supply, which the federal health minister Patty Hajdu was voicing support for doctors providing people who use drugs with safer alternatives. These documents primarily focus on advocating for doctors to provide people who use drugs with pharmaceutical alternatives based on the circumstances to help them avoid the dangers of the drug supply. These documents do not specifically outline how medical professionals should be approaching prescribing a safe supply, but they do voice support for it and encourage medical professionals to help people who use drugs. In provinces like British Columbia and Ontario, doctors have started prescribing a safe supply to drug users. Media reports put out by Filter Magazine, Globe and Mail, and The Tyee stated that the most common drug being prescribed is hydromorphone tablets for those who use opiates. It was found that allowing pharmaceutical alternatives provides an option to the illicit supply for people who use drugs and connects them with medical practitioners who can refer them to other services if they wish.

The medical model was discussed throughout the interviews as well. One interviewee from the Canadian Association of People Who Use Drugs shared some benefits of the medical model.

> *"You know, if you give people a medical supply where they don't have to pay for it, it's going to take them out of that daily constant survival mode of, you know, getting and finding ways to get more, like that consumes people's lives. So, if we can provide a safe supply where people don't have to worry about what they're going to do to get the money for the drugs, then they can get housed. Maybe they can connect to their families, they can get employment."*

Another member of the Canadian Association for Safe Supply spoke on why safe supply through medicalization has been the primary implementation method.

> *"All of Canada's [safe supply] programs are on prescription. Right. And it's like, you know, they're all sort of medicalized right now. So, I would say that we like the quickest way, I think to get drugs to people who need them is going to be through the medical field right now."*

Medical practitioner role in safe supply

The document analysis found that most media and government documents surrounding safe supply overwhelmingly focused on medicalized safe supply and medical professionals' opinions on how the toxic drug supply should be managed. The focus on the voice of medical professionals can be attributed to changing laws surrounding prescribing practices being more accessible than making sweeping changes to prohibition-based drug laws. The legitimacy of the medical professional's work and posing drug use as a medical problem allows for initiatives like safe supply to be more palpable to politicians, police forces, and the public. Also, the medical model is already attached to pharmacies and pharmaceutical companies, making it easier for a safe supply to be distributed as the infrastructure is already there. Throughout the document analysis, the medical approaches to safe supply were described in media documents put out by

the Globe and Mail and Filter Magazine as prescribing regulated pharmaceutical alternatives, which gives people the ability to know how much they are taking and decrease their reliance on the poisoned illicit supply.

The document analysis also found that the medical model is favoured because it relies on an evidence-based approach on what substances are best substitutes for illicit drugs and often depends on the most readily available and most in-line with prescribing guidelines for safe supply. This has resulted in substances like hydromorphone being the most prescribed option. They come in an easily distributed pill format and have been supported by medical authorities as an excellent pharmaceutical alternative for heroin users. It was also found that although hydromorphone works for some, it is not the drug of choice for many. It may not be potent enough for many opiate users, which has signified a disconnect between what is being prescribed as safe supply and what drug users need.

Prescribing practices

The medical model provides a quick answer to safe supply and can be an effective alternative to toxic drugs bought on the street. From the document analysis, it was found that concerns surrounding the medical model have been arisen by safe supply advocates in relation to how medical alternatives to illicit drugs often do not provide the same level of intoxication, lack of medical professional's knowledge on what doses of drug users need, and medical professional morally objecting to providing alternatives to illicit drug supply. Despite provinces like British Columbia allowing doctors to prescribe pharmaceutical alternatives to illicit drugs, many people who use drugs are still struggling to find doctors who will provide them with a prescription that is an adequate dose and their drug of their choice.

Furthermore, the document analysis found that the medical model has widely supported by many health care professionals, politicians, and some safe supply and harm reduction advocates; despite this, there was a clear theme within discussions on safe medical supply throughout the document analysis and interviews about concerns about doctors enabling drug users' habits and flooding the street with medical-grade substances. Despite multiple official documents being produced by provinces and the federal government supporting doctors giving prescriptions to provide drug users with pharmaceutical alternatives, many health care professionals have chosen not to provide people who use drugs with a safe supply as they believed that it would enable them to keep using drugs instead of seeking treatment. As reported in The Tyee, many prescribers were also hesitant to prescribe drugs of choice. Instead, they would provide them with something less potent, leading to many drug users turning to illicit drug supplies after not being satisfied with the medical alternative.

Throughout the interviews, inconsistent prescribing practices were regularly cited as one of the most significant challenges drug users face while accessing safe supply. Many of my interviewees claimed that despite doctors having the power to prescribe drugs that better match someone’s drug of choice and the dose they are used to, many would prescribe something less potent. One member from Coalition of Substance Users of the North shared their experience of getting a proper dose for their safe supply prescription.

> *"So the direction from the College of Physicians and Surgeons needs to be way more clearer for the doctors, because like I said, we do have doctors that are that are interested, but they're scared of getting their license revoked. They're scared of seeing a suggested guideline and going over that."*

In an interview with The Canadian Association for Safe Supply, a member spoke about their encounters with doctors' hesitation to prescribe a safe supply.

> *"Health Canada, opened that up for every doctor and the country. And many of them have personal beliefs. I think that that's not right. And there's a fair share that we see, especially in northern B.C there's a lot of people out there that aren't getting access to anything like that because the pharmacies and the prescribers are not agreeing with what often said about it. And so that's a pretty big problem. And some of them that are doing it are selling the generic tablets of Dilaudid, which aren't actually Dilaudid. It's a much weaker concoction, and that's pretty common as well."*

Satisfaction with pharmaceutical alternatives

Another issue surrounding the medicalization of safe supply is that pharmaceutical alternatives can often only be consumed in a specific matter. Many drug users have preferred methods of drug consumption, whether it be smoking, snorting, injecting, or oral consumption. Pharmaceutical safe supply options must be available for each consumption method. In an interview, a member of the Canadian Association for Safe Supply spoke on the prescription of Dilaudid tablets as a pharmaceutical alternative for those who use heroin.

> *"When you took those bottles and inject them, it's quite dangerous. They're untested. They've never been fully tested. And these are what's being released as safe supply, which we don't agree with"*

A member of B.C. Yukon Drug War Survivors shared their experiences with people injecting tablets.

> *"And I mean, it's really dangerous to shoot Dilaudid because there's so much filler in them. People are getting endocarditis and flesh infections and it's just bad. Yeah, but where it is right now with the risk mitigation prescribing guidelines, it's not enough."*

Another member of the Canadian Association for Safe Supply also shared their experience with advocating for more diverse pharmaceutical alternatives.

> *"We're trying to get alternatives like Ritalin for people to do meth, and that is a huge part of what we were doing. Unfortunately, those are untested injectables. And so it's not really, in our opinion, a safe supply. It's something that can cause endocarditis and some other problems down the road. And so we're viewing it as our major problem as well as down the road. And we're also thinking about stimulants as well, quite a bit, and people that also inhale drugs. So there needs to be a compounded version of that which is currently being made domestically here. So a compounded version of heroin, which can be smokeable and injectable. And so that's what we're really after. Basically, if this isn't doing it for you, of course, you're going to go to the market, which we're trying to really avoid."*

The Coalition of the Substance Users of the North spoke on the importance of respecting drug use's ritualist nature and providing drug users with an adequate alternative to their drug of choice.

> *"But really recognizing that we need to expand safe supply or safer supply, we need to really be thinking about like heroin, heroin compassion clubs, actual*

> *cocaine, actual pharmaceutical grade methamphetamine, meeting people's needs and understanding that drug use is very ritualistic and that people who choose to smoke want to smoke in that crushing up little beaded Dexedrine is not where stimulant users want to be."*

Limits of the amount of a drug that a doctor can prescribe have also increased how safe supply is being implemented in a medical setting. However, in an interview with the Coalition of Substances Users of the North, a member highlighted how prescribing limits are harming drug users.

> *"So I think that the medications need to definitely change. The orders are not cutting it. People are having to do so many just to keep on. And we have a limit of 14 because you decided to have 14 as a recommended dose stop. So I don't know why they said 14 [tablets] because it's maybe like a point of fentanyl. So in the beginning of this, they said that four to six is equal to a point of fentanyl, which maybe, maybe some shitty fentanyl. That might be the case. But now it's the potency is so strong that people are using 10 to 14 in one smash and it's still not cutting."*

The data collected from my document analysis also found a concerning trend of insufficient pharmaceutical alternatives to qualify as an adequate safe supply. For example, in a report from the CBC, it was found that prescribing pharmaceutical alternatives to heroin-like hydromorphone did very little for people with long-term addictions who had built up strong tolerances. Further, it was found in a report from The Tyee; it was found that inadequate doses lead people to return to illicit markets to get their supply instead of relying on the pharmaceutical alternative, which ultimately does not provide an adequate safe supply for those who use drugs.

Unsanctioned Methods of Safe Supply

Unsanctioned methods of safe supply also came up frequently in my interviews. Unsanctioned models of safe supply operate outside of the legal limits of drug distribution and provide an alternative to the medical model which so many drug users struggle to trust. The two categories of unsanctioned safe supply methods identified throughout the document analysis and interviews were 1) Compassion clubs and, 2) Testing and distribution from internet sources.

Compassion Clubs

Compassion clubs came up as the most frequent unsanctioned model of safe supply that drug users use. From my document analysis, documents produced by the British Columbia Center of Substance Use (2019) on compassion clubs described them as "members-only cooperative model through which heroin could be legally obtained from a pharmaceutical manufacturer and securely stored in much the same way as it is already obtained and stored for heroin prescription programs, while also undertaking scientific evaluation". Compassion clubs can provide an opportunity for drug users to access a safe supply of their drug of choice and often a community of others who use the same substances as them. These clubs can provide access to a safe and reliable drug supply and the opportunity to build a space and community of other people who use the same substance that they do.

One member of the Coalition of Substances Users of the North spoke on why they would like compassion clubs.

> *"I would love to see compassion clubs. I would love to see that there is actual pharmaceutical grade drugs available to people to be used in the way and the mode of ingestion in which they choose, because like asking people to change*

the way that they use substances to be met by this like clinical like health care perspective is not helpful."

Compassion clubs are becoming increasingly more viable with the introduction of initiatives like Fair Price Pharma, a non-profit pharmaceutical company that provides pharmaceutical heroin (diacetylmorphine) at cost. Fair Price Pharma allows compassion clubs to get their supply from a reliable and affordable source, making access easier for those who need it. A member from the Canadian Association for Safe Supply spoke on the potential of initiatives like Fair Price Pharma.

"The other thing is like I mentioned earlier, there's like fair price pharma, which is a non-profit pharma company who does want to produce heroin for compassion clubs. So boom, right there. We need to we need to embrace non-corporate pharma and let it grow and develop, it's a new thing. But it would be really it'd be really helpful, I think, long term."

Testing and distribution from internet sources

Organizations buying, testing, and distributing drugs from 'the dark web' was another method of providing unsanctioned safe supply. This method of safe supply only came up in my interviews as it is an illegal but necessary form of safe supply for those who do not feel comfortable, safe, or satisfied with the medical approaches to safe supply. The dark web is a set of private networks that can only be accessed using specific software, providing anonymity and privacy for online transactions often made using cryptocurrency. Purchasing drugs from the dark web to provide safe supply was brought up numerous times within the interviews as to how some organizations are tackling the issue of tainted drug supplies.

One member of the Canadian Association of People Who Use Drugs said:

> *"I think could help with finding locations, different locations, different having different models and safe supply. Maybe it's a buyers club. Maybe it's through online dark web selling. Right. Like it's we really got to look at. Getting it away from that medical model, and I don't think the government's ready to do that yet, but, you know, the more that they hear from us, I think we changed their mind a little bit more and we talk to them."*

A member of the B.C and Yukon Drug War Survivors shared:

> *"And I mean, whether the government is the one doing it or whether compassion clubs or user groups like Drug User Liberation Federation are getting together and doing it on their own, buying drugs from the dark web, giving them out for free, giving them out for a reduced cost. And it's the only way forward."*

Purchasing drugs from the dark web allows drug users to access safe supply without having to through the medical model. One interviewee shared:

> *"But I also think that there's room for compassion clubs and drug user groups to get together and raise funds and buy drugs from the dark web and give those out to people, because there's you're going to have a hard time replacing things like little crack. There is no pharmaceutical replacement for crack."*

Struggles of Safe Supply Implementation

The positive impact of safe supply on people who use drugs has not been enough to implement widespread safe supply. There are still other barriers to safe supply being implemented across the country. Throughout the data collection, it was identified that 1)

Stigmatization associated with drug use, and 2) Political inaction were two of the most prominent barriers to safe supply becoming more common across Canada.

Stigma

The negative stigma associated with drug use was one of the most frequently mentioned barriers to getting a widespread safe supply. It was found throughout the data collection that stigma associated with drug use prevented meaningful policy from being put in place for safe supply; doctors are often hesitant to prescribe safe supply due to stigma, and drug users are worried about accessing harm reduction and safe supply initiatives because of stigma. A member of the Coalition of Substance Users of the North shared how negative stigma impacts their safe supply work:

> *"There's still that kind of overarching view that substance use is a moral decision and those who use drugs lack morals. The bias and stigmatizing ideals around substance use makes our work very hard, because quite often substance use is framed from what people see from entrenched or vulnerable populations that they see in community and the assumption is that everybody who uses drugs is that population of people. And we know that not to be true. We know that there are many people who have good relationships with drugs. And so it's really battling that stigmatizing ideal, certainly from federal government levels, where they just don't seem to be able or willing to be committed to what we know are effective solutions to this current inertia of a crisis that is really preventable deaths."*

Another interviewee spoke on how they struggled to promote safe supply initiatives in their community because of the stigma associated with drug use:

> *"It was very hard for us; our municipal leaders were against anything like safe supply. The community hated drug users. It's all about crime. They associate all drug users with being criminals here and the stigma is very bad."*

A member of the Canadian Association of People Who Use Drugs shared their experience with trying to get support for safe supply from the public:

> *"The general society, they don't support safe supply that much. There's a lot of pushback. We're not just going to give free drugs to drug users. Right. And it's just, you know, that it's really stigma and discrimination."*

One interviewee from Moms Stop the Harm spoke on their experience fighting stigma associated with drug use:

> *"And it was a very lengthy process, but it was very rewarding because along the way, we were able to I was able to talk to neighbors, family members, talk about stigma, talk about safe supply, talk about decorum, talk about stigma and I realized that although we have tried to address it in campaigns and literature and webinars, there is still stigma and we almost need to go back to basics and to, I guess, educate in plain language."*

The negative stigma associated with drug use must be fought for safe supply initiatives to be available and implemented across Canada. If people believe that drug use is a moral choice, there will be active resistance against safe supply and other harm reduction initiatives, limiting who has access to these initiatives and where.

Political inaction

Navigating the political landscape in Canada has posed many challenges in trying to get safe supply programs operating across the country. Since provincial governments have jurisdiction over health care, support for safe supply varies from province to province. Through my document analysis, the role of politicians in safe supply was represented differently than in my interviews. Many articles I found that focused on the medical model highlighted government support and different efforts the provincial and federal governments have made to support medical practitioners in providing a safe supply. The federal government has put out several statements about their support for safe supply initiatives. Prime Minister Justin Trudeau stated that the "government is prioritizing other options such as greater access to a safe supply of opioids" in response to the overdose epidemic (CBC News, 2020). The federal Minister of Health, Patty Hajdu, has also been vocal about Canada's need for safe supply and made a public statement encouraging doctors to provide safe supply to those who use drugs and acknowledged the toxic drug supply in Canada.

From the interviews, different organizations have had experiences with working with different levels of government. However, ultimately my data has suggested that government action towards ensuring safe supply programs are implemented has been very little, and the organizations I interviewed overwhelmingly felt very unsatisfied with interventions from federal and provincial governments.

One of my interviewees spoke on their experience working with different levels of government:

> *"We get a lot of lip service. I mean, people they want to seem like they're, you know, like they're on board. I'm sure some of them are. But it's the people who*

> *really have the power to do it are not the ones that we are meeting with. But we've met with people from all levels of government, and they all came on board and they all say that it's great and they love us and they love what we're doing. But when it comes down to providing for it in the federal or provincial budget, it's not there."*

Another interview participant shared their experience with advocating for safe supply at a federal and provincial level.

> *"Sometimes it's like this is really small and like it's the feds kind of stepping into turf. That's the provinces. And they're doing that because it's already so stigmatized in the first place. Like so the feds kind of stepped in and it just I don't know. He always illustrates to me that, like, we we can't just focus on the feds, even though the feds are giving people money, it's ultimately going to be the provinces to do it."*

One interviewee talked about their experience meeting with Prime Minister Justin Trudeau and why they believe he is hesitant to take more safe supply programs.

> *"And I understand that it's sort of like Justin Trudeau as well. Like we met him a few times down here as well. He says the right things, but he doesn't believe in those things. I can understand that when you're at a level of your life where you've reached that level and you don't want to lose and you want to be re-elected and you have to try to please everybody. However, you still have to represent everybody."*

Organizers from the group Moms Stop the Harm spoke on their feelings about the federal government's role in supporting safe supply:

> *"I mean, just the fact that the federal government continues to refuse to declare a national health emergency related to the overdose epidemic speaks to their unwillingness to really take meaningful action"*

The data collected from the interviews and document analysis has shown the many challenges and hurdles that are facing people who use drugs in their ability to access safe supply. Although there is a lot work being done by advoctes by trying to work with policy makers and medical practioners in making safe supply more accessible problems like stigma, lack of knowledge about safe supply options, political inaction, among others issues are making it difficult for safe supply to become a reality in Canada. Regardless of these hurdles, underground movements like compassion clubs are making it easier for people to access the safe drugs that they need. To further understand the fight for safe supply in Canada, it will be investigated how and why these issues are emerging and what other work is being done to make safe supply accessible to people who use drugs.

Chapter 5: Analysis

The data that has been collected indicates a need for safe supply in Canada. Drug users have been calling for a safe supply since fentanyl was introduced into the drug supply in 2016. Still, only the results of the catastrophic overdose epidemic forced a large-scale conversation of the dangers of illicit drug supplies among politicians and medical professionals. The primary way we see safe supply come to be in Canada has been through community health centers and other medical clinics. However, other unsanctioned initiatives like compassion clubs have provided more private and autonomous options for drug users. In this section, I will explore how the different methods of safe supply have impacted the overdose epidemic and analyze the impact it has had on the safeness of drug use.

Why Safe Supply?

The Toxic and Potent Drug Supply

Alongside fentanyl, other dangerous substances like benzodiazepines (benzos) are finding their way into the drug supply leading to an unpredictable supply where many drug users are unaware of what they are ingesting. As brought up in one of the interviews, "…heroin is now for the elite and heroin doesn't hit the streets in the same way that it did in the past. It's really fentanyl, but there's a lot of benzos". The unreliable drug supply has increased reliance on potent drugs like fentanyl, which has been frequently cut into opiates and other illicit drugs. It is now common for benzos to be cut into the opiate supply, often without someone's knowledge. This is leading to people becoming addicted to benzos without knowing they are. It was further highlighted in numerous interviews that situations like this only heighten the dangers of the overdose epidemic, with people unknowingly addicted to benzos dying in detox from withdrawal. As further discussed in the interviews, the current reality surrounding drug use is

that anyone who uses drugs from the poisoned illicit supply is putting themselves at an increased risk of an overdose. Furthermore, several safe supply advocates brought up through the interviews that there has only been some effort from politicians and provincial governments to make drug use safer, despite the number of deaths from the poisoned drug supply. As it currently stands, the overdose epidemic has not been declared a public health emergency, and little effort has been put forth in making a safe supply accessible in most of the country, despite the constant effort by safe supply advocates across Canada.

The lack of effort by the government in managing the poisoned drug supply has demonstrated how little effort is put towards the lives of some of the countries most vulnerable. Harm reduction initiatives have historically struggled against government inaction during health crises that have significantly impacted drug users. As seen during the HIV/AIDS epidemic during the 1990s, getting needle exchanges to be widespread and accessible was challenging due to government attitudes towards intravenous drug users and concerns about 'enabling' drug users by providing them with sterile needles. This attitude towards enabling drug users by providing them with lifesaving services can be seen in the lack of response to the overdose epidemic. The states can explain this need to control citizens through methods of social control. Since drug use is socially viewed as wrong and deviant, providing drug users with necessary services is not in the state's interest and instead is viewed as something that should be punished or denounced. Instead, the state focuses on providing services that aim to stop drug use. Treatment programs, heroin assistance treatment, and methadone maintenance treatment are examples of state-funded services intended to get drug users to stop using drugs eventually. Since safe supply programs do not intend to get drug users to stop using drugs, they do not fall in line with what is considered moral and acceptable in Canadian society. While some provincial governments are allowing for a

safe medical supply, the lack of widespread safe supply initiatives despite the clear need can be connected back to the state's need to control its citizens and prevent or punish them for engaging in behaviour that is deemed as morally reprehensible, even in the face of the deadly overdose epidemic.

Further, Canada's dedication to drug prohibition has only made it more challenging to address the overdose epidemic. The criminalization of drugs and drug use has forced drug users to rely on the illicit market for over a century. When the drug supply is so deeply entrenched in the illegal markets with no regulation of what and how much people are consuming, the negative impacts of prohibition can go largely unnoticed until a massive tragedy like the overdose epidemic happens. The illegalization and prohibition of illicit substances only make the overdose epidemic that much more challenging to address. Significant political work needs to be done to reverse laws that have been prominent in the Canadian criminal justice system for over a century.

Decriminalization

The conversation around decriminalization has been prevalent in discussions surrounding safe supply. Throughout the data collected from the document analysis, it became clear how prominent decriminalization discussions are among politicians and the media related to the overdose epidemic. Although decriminalization would improve the lives of drug users and ideally stop criminalization for a small quantity of possession, decriminalization is not a response to the overdose epidemic. Furthermore, the focus on decriminalization by politicians and the media has often detracted from the reason the overdose epidemic is happening: the tainted drug supply. Changing the laws surrounding possession does nothing to address tainted drugs, and the decriminalization becoming so intertwined with safe supply discussions is cause for concern. To

address the overdose epidemic, the safe supply initiative should be focusing on providing safe access to drugs, not on the legal ramifications of possession.

The problems with decriminalization become more apparent when it is considered that the first drug laws and the introduction of drug prohibition came to be in Canada in 1908 were based on anti-Chinese racism and concerns with the moral implications that opium use had on the Canadian population. It was not found on concern for the safety of the drug users and the health impacts. Later into the century, more drug laws that came in place were increasingly based on moral panics and concerns about what kind of people used drugs. Drug laws have never been about the health impact of drugs; it has always been about the moral issue of drugs. The focus on decriminalization in safe supply conversation can ultimately be traced back to the stigma associated with drug use and with people being uncomfortable with the idea of drug users gaining access to a legal and a safe supply of their substance choice. As a result, it is easier for politicians and lawmakers to support a motion like decriminalization as they are not providing drug users with safe substances or challenging prohibitionist policy but instead removing the penalty for them using illicit drugs. Ultimately, it is a 'hands off' decision where no meaningful relief is provided for those experiencing the overdose epidemic. As stated before, decriminalization is not a negative thing, but its prominence in safe supply discourse signals that it could be a policy scapegoat for politicians and lawmakers who do not want to make the critical step towards a safe and regulated drug supply.

The prominence of decriminalization discourse must be looked at critically within conversations about safe supply. Throughout the interviews, it was clear that advocates and current drug users felt that decriminalization would do little to make drug use safer currently or positively impact the overdose epidemic. As one interviewee from Coalition of Substance Users

from the North said, “And that I mean, we even saw this with cannabis legalization of cannabis actually allowed them to enact even further punitive approaches to cannabis regulation”. The role of social control in drug policy is further perpetuated through decriminalization. It does not allow drug users to access the necessary ‘deviant’ drugs that they need. Instead, decriminalization could lead to further surveillance and laws surrounding drug use. The hesitation by politicians to support a policy like safe supply and instead focus on decriminalization that could expand their power and ability to surveillance is in line with how drug policy and laws have always been used in Canada. Since the country’s first drug laws, police and state power have been vastly expanded and their ability to surveil and apprehend individuals who use drugs. Therefore, it is reasonable for people who use drugs to be apprehensive about the widespread support of decriminalization as a policy that has been used against them before.

The Medical Model of Safe Supply

Medical Practitioner Role

The role of medical practitioners in safe supply initiatives has been essential in how safe supply is being provided in Canada. Their relationship with people who use drugs and knowledge of pharmaceutical alternatives to illicit drugs provides an ideal situation for safe supply initiatives to grow. As found through the interviews, many safe supply advocates support aspects of the medical model because it has the infrastructure to support safe supply programs, and most illicit drugs have pharmaceutical alternatives. In addition, doctors and nurses who form a relationship with people who use drugs can monitor their drug use and refer them to other services if requested. Having safe supply programs go through medical clinics also reaffirms that

drug use and drug addiction are better off framed as a health issue, not a criminal one. In terms of the overdose epidemic, using the medical model of safe supply is the quickest and most effective way of providing drug users with safe and legal substances. However, the medical model of safe supply as it currently stands has numerous downfalls that impede its ability to be a meaningful response to the overdose epidemic and aid in overall making drug use safer.

The issues within the medical model were brought up by numerous of the interviewees, with many stating that issues start to arise when we see how medical practitioners are approaching safe supply in practice. Not every medical practitioner has the same attitude on providing a safe supply. Some are more willing to work with people who use drugs to provide a safe prescription supply than others. Historically, the medical model has been used to 'treat' people who have an addiction. The role of doctors and nurses in drug users' lives has mainly been trying to get them to stop using drugs, not providing them. For decades, the medical models focused on treating drug addiction have made it challenging for safe supply to be integrated into the medical system. Medical practitioners struggle with safe supply because they enable people who use drugs to continue their perceived harmful habit, which they view as hurting their health. This can be further connected to social control and the medical model upholding the values and norms of the state. The negative stigma surrounding drug use and history of drug use not just being considered unhealthy but also criminal has led to medical practitioners being averse to the idea that they can just provide people who use drugs with a safe supply of drugs and instead focus on socially acceptable methods of intervention, like treatment. However, medical professionals do not have to abandon encouraging people who use drugs to seek treatment while also providing them with a safe supply for their substance of choice. In the current state of the overdose epidemic, doctors

and nurses should also be aware that many drug users are dying from overdoses before they can even make it to treatment with the tainted drug supply.

Prescribing practices

Currently, hydromorphone is the most commonly prescribed opiate for safe supply. Although hydromorphone may be an appropriate drug for some, it is a relatively less potent opiate than many long-term drug users require. Based on data collected from the document analysis, those who have been long-term opiate users have reported feeling unsatisfied with their hydromorphone prescription and have found that it was not strong enough to keep them from purchasing drugs off the street. As shared in an interview with a member of Canadian Association for Safe Supply, "…especially in northern B.C there's a lot of people out there that aren't getting access to anything like that because the pharmacies and the prescribers are not agreeing with what often said about it". In some situations, those seeking out more potent options like diacetylmorphine have found it very challenging to find a doctor that would provide them with that prescription consistently, which again forced them to rely on the dangerous and poisoned drug supply the streets. The challenges with finding a consistent, safe supply for someone's drug of choice need to be overcome. Irregular and inadequate prescriptions turn those who want a safe supply back to the illicit supply because it does not meet their needs, putting them back at risk of taking poisoned drugs.

With the drug supply on the street increasingly tainted with fentanyl and other substances, more drug users are becoming used to potent opiates. Substances like hydromorphone do not even begin to meet the needs of many drug users who would likely benefit the most from having a more potent safe supply prescription. As shared by an interviewee, the increasingly potent drug supply and many people preferring fentanyl over less strong opiates cause concern when

establishing safe supply practices. Many doctors and medical professionals do not feel comfortable providing prescriptions for such potent drugs. It is easier to make a case for prescribing drugs like hydromorphone that are less dangerous and are less likely to cause an overdose than prescribing more potent substances that have much higher risks. Still, if the overdose epidemic is going to be addressed and mitigated, more potent opiates like diacetylmorphine or even fentanyl patches must be available to those who need them.

Inadequate Pharmaceutical Alternatives

One of the most prominent findings from my interviews was that many found the pharmaceutical options inadequate for their needs. Although there are pharmaceutical alternatives for most illicit drugs, doctors' hesitation to prescribe them in the dose someone needs limits how effective, safe supply initiatives are for many drug users. Another problem with the pharmaceutical supply is that there is a lack of variety of consumption methods. The dangers of this were brought up in an interview with a member of the Canadian Association for Safe Supply, "…and I mean, it's really dangerous to shoot Dilaudid because there's so much filler in them. People are getting endocarditis and flesh infections and it's just bad". Drug use is ritualistic, and there must be diverse pharmaceutical alternatives available for those who smoke, inject, snort, or orally consume their substances so that the experience is relatively the same.

Stigma perpetrated by medical professionals and governing bodies also plays a significant role in inadequate prescribing practices, likely from a century of prohibitionist policy that has engrained the dangers of drug use into generations. Medical professionals, especially those who work with people who use drugs, need to be more aware of the realities of drug use. Throughout the interviews conducted, the organizations doing safe supply work all cited that medical practitioners buying into safe supply has been challenging because of stigma. Many believe that

they are enabling drug use or feel morally conflicted about providing someone with something they believe to be harmful. Others have reported that some doctors are unwilling to provide people who use drugs with a safe supply or only prescribe them with less potent substances. Perpetuating stigma associated with drug use and not providing an adequate, or any, safe supply prescription is only prolonging the overdose epidemic and putting those who use drugs in increasing danger the longer they need to get their supply from the streets.

Unsanctioned Methods of Safe Supply

Compassion Clubs

In places where legal, safe supply is not available, people who use drugs have had to go through unsanctioned methods to access a safe supply. These methods can look like compassion clubs; purchasing drugs on the "dark web," checking and then distrusting them, or in some cases purchasing drugs off the street and checking them, and then disturbing them. Through the interviews, the importance of compassion clubs was highlighted by participants numerous times. Compassion clubs provide safe, private, and regular access to a drug of choice. They are valuable to safe supply initiatives because they provide more freedom and autonomy than clinics and pharmacies and provide an alternative to those who do not feel comfortable accessing safe supply through the medical model. By purchasing specific drugs online or through programs like Fair Price Pharma, an at-cost pharmaceutical company, compassion clubs have found ways to provide people who use drugs with safe and regulated access to a safe supply. This is important because not everyone feels comfortable accessing their safe supply through the medical model due to stigma, past bad experiences with doctors, or many other reasons. As a result, compassion clubs provide safer and more reliable access to safe drugs and can be a valuable tool in fighting the overdose epidemic.

The Dark Web

One other method of unsanctioned safe supply that came up in my data collection was purchasing drugs off the "dark web," testing them and then distributing them. I found out about this method from an organization that participated in the interviews, who told me that they did this because it was the easiest way to get a large quantity of usually reliable and safe drugs. They would purchase various drugs like heroin, cocaine, and meth from different dark web vendors and purchase them with a private and secure cryptocurrency. Once they received the drugs, they would then test them and then distribute them in a way that similarly resembles a compassion club.

Although there is significant risk associated with compassion clubs and purchasing drugs off the dark web, it may be safer than doing the tainted drugs that are currently flooding illicit markets. As it currently stands, the only other option for accessing safe supply in some provinces is going through the medical system, which presents a host of other issues, such as the amount prescribed not being enough or not getting access to your drug of choice. The unsanctioned model of safe supply indicates that there needs to be more work and dedication put into how to provide people with a safe supply. Those who are uncomfortable with the medical model or can't be tied to a clinic or pharmacy all day are often forced to turn to unsanctioned models if they want to access a safe supply, and that is only if they know how to access them.

The unsanctioned methods of safe supply have indicated that people who use drugs wont wait for safe supply initiatives to be legally allowed for them to happen. Compassion clubs and other underground distribution methods will happen whether the law allows for it or not. Similar to the unsanctioned supervised consumption sites based out of Vancouver in the 1990s, unsanctioned safe supply programs are operating out of necessity and in light of government failure to act.

With the current overdose epidemic, unsanctioned methods provide a safe and private way to access safe supply without having to go through the processes of the medical system or wait for the lawmakers to allow safe supply initiatives to operate. This method of safe supply does put those who run it and use it at risk of criminalization due to the illegal status of these operations. This is a severe limitation to unsanctioned models, as the risk of being caught accessing these initiatives could result in criminalization. This method also forces these initiatives to run underground and quietly, limiting the number of people they can reach and providing a safe supply. Still, unsanctioned models of safe supply are currently an important aspect of fighting the overdose epidemic and providing safe and clean drugs to those who need them.

Barriers to Safe Supply

Negative Stigma

As it currently stands, there is still significant hesitation by politicians and governing bodies to support and fund safe supply programs across Canada despite that indicated need by many drug policy actors and adovcates. The stigma associated with drug use is one of the most significant hurdles that safe supply advocates face when getting people on board with safe supply. Harmful stereotypes about drug users are prevalent among politicians and citizens alike, and many are not interested in problems that affect drug users. Over a century of drug prohibition has had a lasting impact on negative attitudes surrounding drug use, and the illegal nature of many drugs has made it challenging to change people's minds about drug use. The role of social control and social perceptions of drug users has perpetuated and encouraged the negative stigma associated with drug use. The overdose epidemic has taken thousands of lives in Canada, yet there has been little political action because drug use is seen as a deviant and criminal act that should be punished, and therefore drug users are not paid the same attention other health crises may receive.

Prohibitionist policy remains intact, and politicians give very little opposition despite the tragic realities of the overdose epidemic.

Safe supply programs and policies suffer because of the negative stigma associated with drug use. In the interviews, numerous interviewees stated that they struggled to get politicians and the general public on board with safe supply initiatives. On member of Moms Stop the Harm shared their experience going to local town halls trying to advocate for safe supply programs within their community and the challenges with getting people on board with what they view as "giving drug addicts drugs." Trying to change the mind of citizens and politicians on how they view drug users is challenging, and many advocates face hostile attitudes and not much support, especially in more conservative areas. In addition, the stigma associated with drug use has made it difficult for drug users to access safe supply programs through medical clinics. Many doctors and other medical professionals are hesitant to prescribe a safe supply, and the stigma that drug users face may keep them from wanting to talk to medical professionals about their drug use. This causes problems because inconsistent attitudes and approaches to safe supply make it confusing and hard to access, especially when it is not universally supported and practiced across a province.

In order to fight stigma, many harm reduction organizations are trying to change the conversation surrounding drug use. They talk to people in their communities, use their social media platforms to dispel myths and stereotypes about drug users, and challenge the public and politicians to re-think how they view drug users. This is critical work because, despite the amount of research and support that safe supply has incurred, this does not change the fact that those who have the power to make safe supply programs available across the provinces still hold onto harmful stereotypes and perpetuate negative stigma associated with drug use. The most negative stigma that is perpetuated is that everyone who uses drugs is a part of a vulnerable or

marginalized population, when in fact, many people use drugs who are not a part of these groups. When people see individuals experiencing homelessness or having a mental health crisis, they often assume that drug use is involved. Many drug users know that this is not the case, but the message that safe supply advocates are putting out must be that drug use is not a moral choice and instead something people do for various reasons. Drug use does not lead to homelessness or mental health problems for most people. Fighting stigma is critical in changing the conversation about drug use and getting buy-in from politicians and governing bodies.

Political inaction

The need for political support, primarily provincial, for safe supply is critical as politicians ultimately have the power to support initiatives and provide funding for safe supply operations. Unfortunately, from the data collection, political support for safe supply is mixed. Many interviewees claimed that when they met with politicians, they would voice support for safe supply, and some would even claim to advocate for it during election cycles. In reality, though, minimal political action has happened concerning getting safe supply programs off the ground.

Many of the interviewees had met with different levels of government to discuss safe supply policy, and while many politicians were willing to hear what they had to say and generally supported them, the different levels of government have taken minimal action to make safe supply a reality. The lack of government action on finding meaningful resolutions to the overdose epidemic can be traced back to the negative stigma associated with drug use. Although some politicians are willing to support it, many do not want to touch the issue of the overdose epidemic based on a fear that it will cause backlash from their supporters. As stated by one of the members of Mom Stop the Harm, “I mean, just the fact that the federal government continues to

refuse to declare a national health emergency related to the overdose epidemic speaks to their unwillingness to really take meaningful action."

The lack of urgency in declaring the overdose epidemic a national health emergency indicates how governments view the lives of drug users. The death toll has been massive, and yet the lack of public health campaigns or even information available on the tainted drug supply has shown how little attention or care is paid to drug users in Canada. The provinces have the most power to make safe supply a reality as they have jurisdiction over health care. This is good for some, bad for others. Provinces' like British Columbia that have a provincial government that are generally willing to try progressive harm reduction initiatives like safe supply. On the other hand, more conservative governments like Alberta have premiers who are actively resistant to harm reduction initiatives and safe supply.

Considering the tainted drug supply is a global issue, there needs to be more pressure on provinces that are hesitant to uptake safe supply initiatives to respond to the overdose epidemic. Prohibition-based drug policy is what has led us into the overdose epidemic, and a new policy that focuses on harm reduction and safe supply can get us out. Action must be taken soon by provincial governments to make safe supply a reality because the overdose epidemic will only get worse with inaction. As seen before, unsanctioned safe supply methods do prevail considering government inaction, but drug users should not have to face criminalization to access a safe supply. If we are pivoting from viewing drug use as a criminal issue to a health issue, there must be an adequate medical-based response to overdoses in the provincial health care system. Safe supply programs will happen whether governments support them or not, but providing safe and legal access to them will make them more accessible and save more lives.

Chapter 6: Conclusion

Limitations

There are some limitations to this thesis that should be noted. First, for the interviews, I would have liked to have a larger sample size. I was only able to get eight participants, and although they did provide rich and engaging data, I would have liked to have additional perspectives from other harm reduction and safe supply actors. Second, the collected data was limited because it largely came from those currently advocating for safe supply and not from those making policy or in clinics administrating safe supply. Medical practitioners were contacted, but none were available for interviews. This may not paint a complete picture of how safe medical supply works, as most of the data is based on organizations that work with drug users who may focus on specific aspects of the medical model.

Thirdly, another identified limitation was that I could not capture much data on unsanctioned safe supply. Due to the illegal nature of these methods, interviewees were understandably hesitant to talk about them and their experiences with them. Unsanctioned safe supply operations likely operate in a much more subtle manner than outlined in this thesis, but the data is just not available to understand how they work and how they provide a safe supply.

Lastly, all my data was collected in 2020 and 2021 in the context of COVID-19. Since the COVID-19 pandemic heavily impacted the drug trade and disrupted supply routes, many safe supply programs have justified their operations as necessary because the drug supply has been so compromised and limited due to closed borders. Although safe supply programs will be necessary after the COVID-19 pandemic, it would be valuable to understand how these operations will justify their necessity to provincial and local governments and other funders who may support safe supply initiatives in the context of the pandemic.

Future research directions

Safe supply in Canada is a relatively new concept, and there is much future work that can be done on the topic. One area that needs more exploration is drug users' experiences with accessing safe supplies. Since this is a vulnerable population, I could not directly seek out current drug users to interview, but they would have precious insight into how safe supply is operating in Canada. Their perspectives on how it is administered, the available drugs, the different models in which you can access safe supply, and how effective it has been at countering the overdose epidemic would be valuable information in further understanding safe supply. For future studies, building relationships and trust with those who operate unsanctioned safe supply operations is necessary for more data to be collected on how those operate. Unsanctioned safe supply operations likely play a much more significant role in providing safe supply to people who use drugs than outlined in this thesis.

It would also be interesting to explore further the experiences of medical professionals and their experiences with safe supply. Since the medical model is the more prominent method of safe supply, having more insight into how they have been administrating it and how they view some of the downfalls of the medical model, such as limited drug choices and prescription inconsistency, would be an exciting element of the safe supply discourse to explore. Medical professionals can also provide more insight into how different levels of government have supported them and perhaps provide more knowledge about how to make safe medical supply more effective and accessible.

Conclusion

The need for safe supply in Canada has never been so dire. The overdose epidemic claiming thousands of lives since 2016 has shown no sign of stopping unless serious action is taken to address the poisoned drug supply. Currently, the main methods of addressing the overdose epidemic can be seen through medical safe supply programs running out of community health clinics and doctors' offices. The medical model of safe supply does provide some relief from the tainted drug supply, but the problems of inadequate prescriptions and inappropriate pharmaceutical alternatives to illicit drugs found on the street are not proving a suitable alternative for many drug users. In addition, the stigma associated with drug use and medical practitioner attitude and willingness to provide a safe supply is currently limiting how accessible, safe supply is and who gets it. More work needs to be done on educating medical professionals about their role in safe supply prescribing and why they must work with people who use drugs to provide them with an adequate prescription to keep them away from the poisoned, tainted drug supply found on the street.

The medical model is not the only way that people have been accessing safe supply. Unsanctioned methods of obtaining safe and clean substances can be done through several operations. Two of the most common themes in the data were compassion clubs and purchasing drugs from the "dark web." These methods operate outside the bounds of the law but provide drug users with a clean and safe supply for their drug of choice and do not force people to buy from the street. Unsanctioned models of safe supply show that drug users will not wait for the government to address the overdose epidemic to keep themselves safe. However, these methods are illegal, which have been demonstrated to be necessary in light of the medical model's downfalls that alienate many drug users.

The overdose epidemic is nowhere near over. Widespread safe supply available through medical and unsanctioned methods need to become more prominent and accessible. Until the government decides to announce the overdose epidemic as a national emergency, we are unlikely to see any largescale change to access to legal and safe drugs, but that does not mean that more work cannot be done on a local level through medical clinics or community organizations to get a reliable, safe supply to those who use drugs. Safe supply initiatives are necessary to ensure the safety of those who use drugs and meaningfully address the poisoned drug supply. In the span of a few years, Canada has already seen some safe supply initiatives becoming a reality in provinces like British Columbia and Ontario, and there are reasons to be optimistic about future expansions of safe supply programs across the country. In addition, there are numerous strong and passionate safe supply advocates and organizations in Canada who are doing good work and ensuring that drug users are not being left behind or forgotten about during the overdose epidemic.

Appendix A – Interview questions

After having secured informed consent, provided an overview of my research, and clarified that the interview is meant to learn and understand their perspectives and experiences, I shall start the interview with this question:

"Can you tell me about the work that you and [name of the organization] are doing towards safe supply in Canada?"

Throughout the interview, I will ask questions related to the following themes:
- History, structure, and goals of the organization
- Perspectives on the current national drug policy
- Perspectives on safe supply as strategy/policy (e.g. rationales, compatibility with current national drug policy, articulation to other harm reduction strategies, distinction from legalization projects, etc.)
- Interactions/Articulations between national, provincial, and local governments and [name of the organization]
- Experiences with advocating for safe supply (e.g. barriers, struggles, support, etc.)
- Representations of a successful implementation of safe supply (ideal material form of the strategy)
- Representations of expected outcomes of safe supply in Canada

Before ending the interview, I shall always ask interviewees if there is any elements we discussed they would like to come back to, or anything we did not discussed they think I should learn to better understand what they communicated to me.

Appendix B – Consent Form

Informed Consent Form

Name and Contact Information of Researchers:

Julianna Petrasko, Carleton University, Department of Sociology

Email: ***juliannapetrasko@cmail.carleton.ca***
Supervisor and Contact Information: Nicolas Carrier, nicolascarrier@cunet.carleton.ca

Project Title

Safe Supply in Canada

Carleton University Project Clearance

Clearance #: 114830 Date of Clearance: 2020-11-30

Invitation

You are invited to take part in a research project based on your work and advocacy for safe supply within Canada. The information in this form is intended to help you understand what we are asking of you so that you can decide whether you agree to participate in this study. Your participation in this study is voluntary, and a decision not to participate will not be used against you in any way. As you read this form, and decide whether to participate, please ask all the questions you might have, take whatever time you need, and consult with others as you wish.

What is the purpose of the study?

Canada is currently facing a deadly overdose epidemic due to unreliable and tainted illicit drug supplies. Safe supply is a proposed policy alternative to Canada's current illicit drug prohibition framework. My study is looking at how drug policy actors in Canada are fighting to get safe supply implemented within the country, and provide safe and legal access to otherwise illegal drugs.
My research first intends to understand and analyze how and why organization and actors in Canada are currently advocating for safe supply at a national scale. Second, I aim to identify what aspects of current Canadian drug policy these actors are unsatisfied with and how integrating safe supply into drug policy could resolve those concerns.

What will I be asked to do?

If you agree to take part in the study, we will ask you to: This study involves one 30-60 minute interview that will take place using Zoom. The interview will focus on your experience advocating for safe supply policy in Canada, and what barrier have been identified with trying to get safes supply implemented. With your consent the interview will be audio-recorded. Once the recording has been transcribed, the audio-recording will be destroyed.

Risks and Inconveniences

Conversations surrounding safe supply often include talking about the current overdose epidemic Canada is facing. Some of the people I'm interviewing may have personal connections or have experienced trauma from the overdose epidemic. Talking about this may put some interviewees in an emotionally vulnerable position

Possible Benefits

You may not receive any direct benefit from your participation in this study. However, your participation may allow researchers to better understand the struggles safe supply actors are facing in getting safe supply implemented in Canada.

Compensation/Incentives

Compensation of $40 will be provided through e-transfer.

No waiver of your rights

By signing this form, you are not waiving any rights or releasing the researchers from any liability.

Withdrawing from the study

If you withdraw your consent during the course of the study, all information collected from you before your withdrawal will be discarded.
After the study, you may request that your data be removed from the study and deleted by notice given to the Principal Investigator (named above) within six weeks.

Confidentiality

We will remove all identifying information from the study data as soon as possible, which will be after all the data has been transcribed.
We will treat your personal information as confidential, although absolute privacy cannot be guaranteed. No information that discloses your identity will be released or published without your specific consent. Research records may be accessed by the Carleton University Research Ethics Board in order to ensure continuing ethics compliance.
"In-session" data, such as the audio, video and chat transcript from the interview, will be stored locally on the researcher's computer. Operation data, such as meeting and performance data, will be stored and protected by Zoom on servers located in Winnipeg, but may be disclosed via a court order or data breach.
We will password protect any research data that we store or transfer.

Data Retention

Your de-identified data will be retained for a period of one year and then securely destroyed.

New information during the study

In the event that any changes could affect your decision to continue participating in this study, you will be promptly informed.

Ethics review

This project was reviewed and cleared by the Carleton University Research Ethics Board [A or B]. If you have any ethical concerns with the study, please contact Carleton University Research Ethics Board (by phone at 613-520-2600 ext. 2517, or by email at ethics@carleton.ca.

Statement of consent – print and sign name

I voluntarily agree to participate in this study. ___Yes ___No
I agree to be (audio/video recorded/photographed …) ___Yes ___No
(Note: Please explain if recordings are optional to participation)

_____ _____
Signature of participant Date

Research team member who interacted with the participant
I have explained the study to the participant and answered any and all of their questions. The participant appeared to understand and agree. I provided a copy of the consent form to the participant for their reference.

_____ _____
Signature of researcher Date

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