Expanding Prescribed Alternatives on Vancouver Island

Practice Brief

Honouring the Land

Our work takes place in Kwakwaka'wakw, Nuu-chah-nulth, and Coast Salish territorial regions on what is colonially known as Vancouver Island. The rich and beautiful lands and waters of this Island have been home to over 50 First Nations for time immemorial; we respectfully acknowledge their past, present, and future sovereignty.

Acknowledgement

This Practice Brief would not be possible without the participation of AVI staff members who shared their knowledge and expertise as key informants. Thank you for your thoughtful contributions to harm reduction practice.

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Background

> *"...the primary driver of the drug crisis is the inherently toxic and volatile nature of the unregulated drug supply. Providing people at risk of dying with access to quality controlled, regulated alternatives is required to significantly impact the number of people dying."*
>
> *BC Coroners Service Death Review Panel, 2023* [1]

Drug prohibition and the resulting toxic, unregulated drug supply in Canada has claimed over 47,000 lives since 2016 including over 14,000 people in British Columbia (BC).[2,3] The scale of the toxic drug crisis reaches far beyond the approximately 125,000 individuals in BC who have been diagnosed with an opioid use disorder. An estimated 165,000-225,000 people access the unrelated supply in BC during any 12-month period, including up to 100,000 individuals who do not fit the criteria of substance use disorder and use drugs episodically, for example. In over 80% of opioid toxicity deaths since 2017, "fentanyl-like drugs" have been detected, with toxicology reports showing that benzodiazepines are increasingly present in the unregulated drug supply, compounding risks for respiratory depression, over-sedation and death. [4,5,6]

The COVID-19 pandemic exacerbated the toxicity of the unregulated drug supply. In March 2020, the Province of BC published a "Risk Mitigation Guidance" document to temporarily enable health care providers to prescribe medications to those at significant risk of death from the unregulated drug supply and support them to shelter-in-place. [7] AVI Health & Community Services (AVI) began focused outreach to individuals sheltering in homeless encampments in Victoria and connecting them with health care providers who were willing to prescribe using the Risk Mitigation Guidance. In June 2020, AVI was awarded funding from the Substance Use and Addictions Program (SUAP) of Health Canada to develop and implement the "Victoria Safer Alternatives for Emergency Response (SAFER) Initiative" to provide access to prescribed medications via a flexible model of harm reduction service delivery. The development and implementation of SAFER in Victoria has been documented through partnerships with the Canadian Institute for Substance Use Research and SOLID Outreach Society.[8]

Building on the acquired experience, evidence and successful outcomes of SAFER, AVI launched the SAFER Knowledge Translation and Exchange (KTE) project in 2022. SAFER KTE is an interdisciplinary team of nurses, prescribers, and pharmacists, and a program coordinator with lived experience who offer guidance and capacity building support for practitioners providing "prescribed alternatives" (PA)[9] and other harm reduction services across Canada. SAFER KTE produces clinical guidance documents, teaching resources, and offers consultation and training.

SAFER KTE supported the expansion of PA programs to communities served by AVI on Vancouver Island including Nanaimo, Courtenay and Campbell River. The Regulated Access to Drugs (RAD) program was launched at AVI's Courtney and Campbell River locations in October 2022, and the Enhanced Harm Reduction (EHR) program was launched in Nanaimo in November 2022. Each of AVI's PA programs (SAFER, RAD and EHR) work to prevent deaths and other related harms (eg. overdose events, brain injury) of the unregulated drug supply by providing regulated pharmaceuticals, connecting people who use drugs to health and social supports, and contributing to growing evidence on the implementation of PA through flexible, community-based models of care.

This practice brief highlights the early implementation of AVI's RAD and EHR programs including perspectives from program staff on program facilitators and barriers, and areas of future growth related to prescribed alternatives as an important strategy to mitigate the harms of drug prohibition.

AVI Prescribed Alternatives

AVI's PA programs were implemented to reduce the risk of death and injury from use of unregulated drugs by providing access to prescribed alternatives. The service model combines harm reduction principles and practices with the current regulatory requirements of prescribers and is grounded in emerging clinical evidence and the experiential knowledge of people who use/d drugs.

All AVI PA programs operate in community health settings that bring together an interdisciplinary staff team. Staffing at each location varies but at a minimum, all programs include nurses (RN, LPN, RPN), support workers, systems navigators, prescribers (physicians and nurse practitioners) and a medical director. As an organization, AVI centers "people with living and lived experience in ... organizational planning, program design, service provision, and evaluation" including staff in PA programs who are supported to integrate experiential perspectives and offer peer support in their relational work with service users. [10]

AVI Health and Community Services
Prescribed Alternatives
Service Model

Eligibility

At risk of drug toxicity death due to use of unregulated supply

Willing and able to participate in medical model:

- Active opioid use disorder (DSM-V)
- Unwilling or unable to engage in traditional opioid agonist treatment
- Able to attend program in-person, as required

Interdisciplinary Approach

Person-Centered

Harm Reduction Practice

Medical Care

Interdisciplinary Staff

Innovation

Guided by People Who Use/d Drugs

Evidence Based and Evidence Generating

Flexible and Iterative

Community Health Settings

Onsite Access and Outreach Support

Wraparound Care

Pharmacy Partnerships

Bridging to Other Services

Knowledge Translation & Exchange

Clinical and Practice Guidance

Community-Based Research

Capacity Building, Consultation & Education

Depending on location, resources and capacity, programs may also include assistance from medical office administrators, and a combination of clinical and program management. Partnerships with community pharmacies are an integral element for each program in dispensing medications and utilizing pharmacy expertise in clinical protocolization. The programs in Nanaimo and Campbell River have greatly benefited from co-location with their partnering pharmacies, as communication between staff teams is more direct, reducing the chance of medication errors, increasing workload efficiency for the clinical team, and optimizing integrated patient care.

Nurses provide clinical assessment, PA medication administration and witnessed dosing. As capacity allows in each location, nurses may provide wound care, referrals to external healthcare, and clinical case management in order to bridge gaps for program participants who are unattached to a primary care provider. At the Campbell River RAD program, a strong partnership with nurse practitioners at a local mental health and substance use clinic enables RAD staff to focus on PA specifically, and primary care to be delivered by partnering providers.

Systems navigators and support workers play essential roles on the interdisciplinary team and enable the programs to offer more than the singular intervention of prescribed alternatives. Both roles focus on providing psycho-social, practical and mental health care.

Systems navigators offer a wide range of support and advocacy including working with participants and the team to implement care plans, facilitating access to other health and social services, and supporting participants to apply for and maintain housing.

Support workers are compassionate, active listeners who set the tone of the programs by welcoming participants and fostering a sense of belonging. They focus on relationship-building and relate to program participants from a place of shared experience and understanding. They function as a bridge between program participants and other program staff and offer peer coaching to build self-efficacy and self-advocacy skills. Support workers are critical to providing culturally safe and accessible care, particularly within clinical settings that represent sites of trauma and disempowerment for many people who use drugs.

Knowledge translation and exchange is a key element to the AVI PA model and is a capacity-building resource in BC and across Canada. Through clinical guidance, consultation, training and dialogue, the SAFER KTE team is a leader in the expansion of access to prescribed alternatives as one of many necessary interventions to address the ongoing crisis of unregulated drug deaths (see pages 20-21 for more information on SAFER KTE).

“Regardless of the model of service provision, any model of care for providing safer supply needs to be conceptualized, designed, and must function using a harm reduction, trauma-informed, and culturally-sensitive lens.” [11]

The RAD program logo was gifted to AVI Health & Community Services by a K'ómoks First Nation community member.

Indigenous people are disproportionately impacted by the unregulated drug crisis with a death rate that is close to five times higher than other residents of Vancouver Island. [12,13,14]

Approximately 25-45% of EHR and RAD program participants self-identify as Indigenous, First Nations or Metis.

During early implementation of the RAD program in the Comox Valley, AVI included an Indigenous Liaison position as part of the interdisciplinary team. This role was pivotal in the development of the program by providing culturally-informed harm reduction support and system navigation services to program participants. The Indigenous Liaison was also integral in developing policies and protocols rooted in anti-oppressive practice and in fostering a strong partnership with the local First Nation. Given the high impact of this role, it has since evolved to AVI’s Director of Culture and Community Services, ensuring a continued commitment to decolonization, cultural care, and connection.

EHR & RAD Program Settings

The EHR and RAD programs operate in communities where the death rates from unregulated drug deaths are particularly high. For example, Greater Campbell River reported the third highest death rate (127.9 per 100,000) in the province by local health area of injury over the first 9 months of 2024. Similarly, the rate of unregulated drug deaths has been consistently higher in the Central Island region (including Nanaimo) compared to the South Island over the last 10 years. [15]

The programs are each centrally located in the downtown area of their respective communities and are adjacent to other health and social services. Program spaces generally include a small waiting area for program participants where they are greeted by staff and may access support including harm reduction supplies; simple necessities such as a warm beverage, nutritious snack, and dry clothing; peer support, advocacy and referral. Where available, participants are also able to spend time in the waiting area post-dose where they can briefly rest and connect with peers and members of their care team. Participants are ushered to a program/clinic room where nurses provide clinical assessment and care, dispense medications, apply fentanyl patches, and witness dosing as required by specific prescriptions.

Nanaimo EHR Reception & Lounge

AVI PA programs serve approximately 200 participants across four local health areas, primarily via prescribed fentanyl options such as tablets and transdermal patches. PA options are often co-prescribed with traditional, long-acting opioid agonist treatment (OAT) medications to optimize clinical effect. In addition to the stimulant and opioid options offered in all program communities, SAFER in Victoria also offers injectable sufentanil and hydromorphone injectable opioid agonist treatment (iOAT) (see Figure 3). Expanding PA options at each of the sites is dependent on several factors including prescriber and staffing availability, participant acuity, and program space, for example.

AVI Prescribed Alternatives Programs

<table>
<tr><th></th><th>Enhanced Harm Reduction (EHR)</th><th colspan="2">Regulated Access to Drugs (RAD)</th><th>Safer Alternatives for Emergency Response (SAFER)</th></tr>
<tr><td>Program Location</td><td>Nanaimo

downtown, co-located with community health centre and pharmacy

waiting area and program/clinic room</td><td>Courtenay

downtown, co-located with other AVI services

program/clinic room</td><td>Campbell River

downtown, co-located with other AVI services and pharmacy

waiting area and program/clinic room</td><td>Victoria

near downtown & other health & social services

stand-alone clinic with waiting area, clinic room and supervised consumption booths</td></tr>
<tr><td>Current PA Options</td><td colspan="3">witnessed fentanyl options: transdermal patch, tablets

OAT: buprenorphine/naloxone, buprenorphine, methadone, morphine (SROM, M-Eslon)

tablets: hydromorphone, oxycodone, dextroamphetamine, methylphenidate</td><td>same as EHR/RAD programs, plus:

sufentanil (oral, injectable)

injectable hydromorphone (iOAT)</td></tr>
<tr><td>Program Capacity</td><td>75-100 participants</td><td>30-40 participants</td><td>30-40 participants</td><td>75-100+ participants</td></tr>
<tr><td>Population by Local Health Area (2019)</td><td>Greater Nanaimo 118,654</td><td>Comox Valley 71,882</td><td>Greater Campbell River 46,382</td><td>Greater Victoria* 243,286

*does not include Saanich Peninsula or West Shore communities</td></tr>
<tr><td>Unregulated Drug Deaths by Local Health Area (Jan 1-Sept 30 2024)</td><td>86.8 per 100,000</td><td>50.0 per 100,000</td><td>127.9 per 100,000</td><td>53.7 per 100,000</td></tr>
</table>

Method

AVI’s PA programs respond to the public health crisis of unregulated drug deaths with a flexible, iterative approach that is grounded in emerging evidence and the needs of program participants. [18] In addition to publishing peer-reviewed work with academic partners and participating in third-party evaluations, AVI also regularly conducts internal evaluations to consult with program participants, continuously monitor and improve practice and programming, and to share these learnings through KTE activities.

To better understand the expansion and early implementation of AVI’s PA programs across Vancouver Island, interviews were conducted with 7 staff members from EHR and RAD programs in the communities of Nanaimo, Courtenay and Campbell River. The interview guide was informed by the inter-related domains of the Consolidated Framework for Implementation Research (CFIR: outer setting (broad, structural factors), individual characteristics (of PA program participants), inner setting (infrastructure and resources), innovation (prescribed alternatives), and implementation process (roll-out of PA programs).[19] Staff key informants included individuals working in various roles including Nurse, Support Worker, Manager and Prescriber, and the majority of key informants had been employed with their respective programs for at least 1 year.

What's Working Well

EHR and RAD staff interviewed for this Practice Brief spoke about the importance of establishing positive rapport with participants and earning their trust. This is accomplished in AVI’s PA programs by centering the experiences and perspectives of participants. For example, when the EHR program was first implemented in Nanaimo, staff hosted consultation sessions and provided food and honouraria. Feedback from participants was shared with program management and informed operational features such as clinic hours. PA staff also regularly conduct informal surveys and check-ins that allow participants to share feedback about their experiences with the program. Key informants spoke of adopting a position of empathy and curiosity when speaking with participants to build trust and support more authentic conversations:

> *“We have no expectations about abstinence - we let people lead in their own healthcare, with a balance of celebrating self-reported periods of abstinence with folks [who may be] using again. We keep it open and honest and person-centered.” (Nurse)*

A Support Worker described how providing information in an open manner and being aware of the trauma that many participants have experienced accessing healthcare is a harm reduction approach which mitigates some of the barriers of typical medical settings. For example, due to regulatory requirements of prescribers, semi-periodic urine drug testing may be required of program participants, as well as frequent connection with clinical staff. PA staff navigate this with program participants:

> *“Collecting UDS (urine samples for drug testing) doesn’t cause tension - we typically require them monthly for each participant. We remind everyone that it’s not punitive, we just need to know what’s in your system so that we know that you’re going to be safe because if you come in and test negative and are prescribed fentanyl, well then, we could potentially harm you and that’s not what we want to do. We just want to know that you have your medication, that you’re staying safe...” (Support Worker)*

Staff also described how they support participants to build self-advocacy skills regarding their prescribed alternatives by sharing what their needs are with their providers:

“We can have a conversation with them and prepare them for a conversation with their doctor - tell them there is other options, and you should bring this up with the doctor because they might be able to manage what’s not working. We can’t be the ones to prescribe but we can be the ones to make a better connection... we can kind of get an overall better view of what they’re thinking, how they’re feeling and what their needs might be. We don’t want to train people to be reliant on other people - like sometimes doing things for people is not helping them. You think you’re helping... but in the long term, they’re not able to do things for themselves. So, slowly integrating them into doing things at their own pace, by themselves, is a good model that we try to follow. And we’ll always be there for support.” (Support Worker)

Nursing staff described program prescribers as being flexible in terms of making time to connect and listen to participants and to adjust their PA options when possible:

“If [participants] report [their dose is] not enough because of their tolerance, we will go up in increments...Our doctors and team are very open to hearing feedback about dosage and trying higher dosages.” (Nurse)

Third-party program evaluations conducted in February 2023 for the RAD programs, and in November 2023 for the EHR program, both showed the majority of program participants reported their experiences with program staff, prescribers and pharmacists as positive. In Fall 2024, 89% of PA participants across the four AVI PA programs reported increased connection to healthcare services due to their participation.

Staff key informants highlighted their experiences of a positive work environment and reflected that AVI as an organization shares their values and enables them to take evidence-based action. Staff are invested in...

“...the collaboration of multiple disciplines for the purposes of learning, providing quality patient care that’s client-centered, and safety” (Nurse).

“[We have] the ability to give our all to our people. The staff are invested 100% in our clients and patients because we are working in a supportive environment, from my perspective.” (Support Worker)

Staff observe their colleagues in action and share appreciation for an interdisciplinary approach where expertise from all disciplines and lived experience is valued in order to put participants first.

“The nursing staff is incredible and do so much. Prescribers are doing a lot in the community and spread a bit thin so the nurses are really at the heart of the program, and the outreach[support] workers.” (Prescriber)

"Peer support is very important. People with lived and living experience can really help with... helping the nurses assess the level of sedation...because as someone without experience with drugs, I’m not as familiar." (Nurse)

“[The doctors] really support our program to be nurse-led, and one of our new staff was encouraged by one of our docs to make recommendations to them regarding dose changes. They are looking for nurse expertise and knowledge.” (Nurse)

In general, staff key informants observed that AVI PA programs are working as intended and yielding positive results:

"I see people: stabilizing their use, less overdoses, less intoxicated, feeling generally happier, more supported." (Prescriber)

"We have a reasonably good system in place for supply meeting the demand, and generally speaking they get what they need. We have a sufficient order to how we function in that the folks who are coming through the door get what they need: there's a pharmacy upstairs, access to medicine and we can provide wound care." (Nurse)

One respondent noted that prescribed alternatives appear to be making a significant improvement in the quality of life of participants who have been able to reduce or replace their use of the benzodiazepine-heavy, unregulated supply over a longer period:

"Most people are reporting a reduction in their use of the street [unregulated] supply. I've worked with this program for a couple of years now and I notice that participants are visibly healthier because they're using pharmaceuticals, not the contaminated supply. So they are making eye contact where they weren't before, they're not agitated, they have clarity of speech. I see them participating in their own lives and having more agency where before, the benzo's were really impairing them, making them vulnerable and sick, and really unwell." (Nurse)

These observations are reflected in outcomes noted in the 2023 third-party evaluations which indicated early successes in relation to the goals of the EHR and RAD programs to reduce death and harms related to the unregulated drug supply, and increase health and social supports. Over 85% of respondents across the EHR and RAD programs reported that using prescribed alternatives resulted in a reduction of their use of unregulated substances. Other positive outcomes included experiencing fewer overdoses, decreased withdrawal symptoms and cravings, and improvements in their health and well-being.

Barriers & Challenges

Barriers to accessing PA options have been well documented.[20] Here, the barriers identified by EHR and RAD program staff are arranged into five themes, guided by the inter-related domains of the Consolidated Framework for Implementation Research: outer setting (broad, structural factors), individual characteristics (of PA program participants), inner setting (infrastructure and resources), innovation (prescribed alternatives), and implementation process (roll-out of PA programs).[21]

Outer Setting: Stigma

A significant impact of Canada's prohibitionist drug laws, which criminalize the use of particular substances, is the persistent stigma that is inflicted upon people who use those substances, and particularly those who are racialized and living in poverty.[22] This stigma is observed and felt by AVI's PA staff who note that the presence of their program participants, as well as the harm reduction programs there to serve them, is often unwelcome in their respective communities.

EHR and RAD staff also spoke to some exceptions to the stigma enacted upon people who use drugs, and they expressed their appreciation for gestures of support, such as individuals who regularly drop off donations and local business owners who provide welcoming customer service to program participants. They highlighted families who came in to ask for naloxone training and who offered encouraging feedback. These simple gestures of support are experienced by staff as meaningful and moving.

"We see and hear a lot of the negative tensions. The current Council is quite anti-homeless and anti-drug use...[they are] trying to pass an anti-decriminalization motion..." (Nurse)

"There are quite a few people in the community that are against unhoused people, including some neighbours who blame the program for attracting unhoused people to the area." (Nurse)

"The news [reporter] has come to the street and the building many times because of NIMBYism and... it's contributed to losing many of our services and it's quite sad to see that. In this area especially, this is where people access services but it's also where the cruise ships come in and so they want to do a 'clean sweep' ... they're canceling everything for people that need the resources as opposed to people that have resources." (Support Worker)

"I grew up here and...it's very divided, and the population that have compassion for this, that can see people as just hurting human beings that need help, are very few... the masses really just don't have the capacity to understand what's going on because it would mean that they need to act." (Support Worker)

Individual Characteristics: Social and material conditions of program participants

Participants in AVI's PA programs experience significant health and social inequities, marginalization and exclusion as a result of structural drivers such as stigma, criminalization and colonialism. Beyond the life-saving intervention of prescribed alternatives, the programs work to capacity to attend to participants as whole human beings whose substance use cannot be isolated from the contexts of their lives. This includes providing outreach support whenever possible and linking participants with other health and social services to bridge care. Staff key informants spoke to the many structural barriers and poor social conditions of their program participants including lack of housing, severe food insecurity, and limited community supports to meet the full scope of unmet basic needs.

"I had one participant that told me, 'I need years of therapy to unpack what I've gone through and I don't want to be sober because I don't want to go through these things again, and I don't want to remember them, and I don't want to re-live them' and you're like, 'Ok. Yeah. I hear you on that.' And here in Campbell River, if you're referred to a psychologist it's a two-year wait. And so you start to realize maybe it's not drugs that are the problem and there's just a lot that goes into the solutions and you're just like, one tiny part of it." (Nurse)

"[Prescribed alternatives] support the physical side of the medicine wheel and this program could and should aspire to addressing all of those aspects, not just the physical side, like not being dope-sick… If someone is trying to abstain from street use and trying to use the pharmaceutical grade but they're living in wet housing because that's the only place they can go, this is so counter-productive… [or] if you start using again, you lose your housing. Wrap-around [care] is so important - it's all connected… it needs to address the whole person and have many steps and options for housing and support." (Manager)

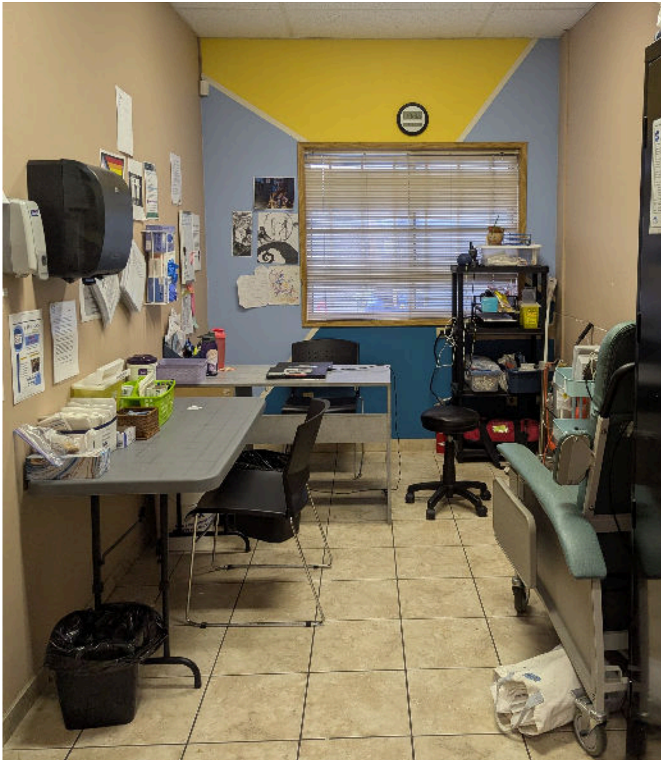
Inner Setting: Limitations of program settings

As previously noted, many PA program participants have multiple unmet needs due to structural barriers and which are linked with their need for access to regulated and safe substances. Program staff not only provide PA and support participants to navigate limited or high-barrier health and social support systems, they also must manage the limitations of the program spaces and may need to ask participants to leave when physical capacity of the space is met. It is a challenge for PA programs to find supportive landlords who understand the importance of providing space for those pushed to the social margins, as well as secure accessible and adequate spaces in which to operate. Staff reflected that stigma fractures and displaces people from being welcome in the community and significantly inhibits the potential for healing. PA programs are succeeding at keeping people alive amidst a relentless public health emergency of unregulated drug deaths, and building on this success means connecting into care and support beyond the critical intervention of a regulated supply.

"…there's a lot of beautiful work happening in this world around healing trauma… that 'we heal in community,' and it's true. But if that is true then one of the solutions to helping our client population get well is to remember that they are in community. So, we can't have a solution that necessarily isolates them from community… we're not really giving them any opportunities to experience some of the benefits of that. Like, we don't give them a way to come under shared space and share a meal together, or lie on a mat and call it yoga and let them just rest their bodies for an hour, or paint on a canvas for an hour, or make muffins for an hour, or like the kinds of things that are the reasons that we are wired to live in community." (Nurse)

"...more space would be helpful...some folks do want to just spend time with the dogs, socialize, help out by cleaning up, et cetera, and it does get crowded." (Nurse)

"If people are getting the patch or Fentora from us, that may be reducing their use but I also see the social side of things; that culture of connection and that social aspect of it, and the rituals that people have with their drug use is not taken into account or accommodated by these programs." (Manager)



Clinic Room and Lounge, Campbell River RAD Program

Meeting a broad spectrum of needs for a diversity of services users in one location can be a challenge, especially with the additional complications of finding locations that are affordable, appropriate and centrally located. The EHR and RAD programs are all co-located with other programs that serve a diversity of service users. Being able to offer PA in a variety of settings is also important for individuals who are working on personal goals of reduced use, changed use, or abstinence.

"It can be a difficult environment for people who have goals of abstinence and where the community is so small and everyone knows each other." (Manager)

Some participants identify that changing their environment is an important component of changing their patterns and substance use practices, but this may pose a challenge if they are unable to access PA providers, clinics and pharmacies in new locations.

Innovation : Limitations on Prescribed Alternatives

People who use drugs have identified that there are continued barriers to accessing medications that are appropriate and effective alternatives to the unregulated supply.[23] EHR and RAD staff shared this perspective, identifying three key challenges in particular: requirements of witnessed dosing, limitations in range of PA options, and absence of options for people who smoke as their route of administration.

Many of the PA options offered by AVI's EHR and RAD programs require witnessed dosing, meaning that participants must attend the program in-person. On the positive side, some participants benefit from the opportunity to make social connections, participate in programs, and access care. Additionally, the requirement of witnessed dosing means that program participants have access to medical attention and emergency response if required. However, the requirement of witnessed dosing can be time consuming for participants and may limit their ability to maintain employment, care for their families, and poses a particular challenge in communities where distances to travel may be longer and public transit may be limited or unavailable.

"...even in supported housing units, these regular clinic visits are too much for those services to handle in terms of getting people to us." (Support Worker)

The pharmaceutical limitations of some PA options, combined with the requirement of witnessed dosing, means that they do not always meet the needs of participants. For example, buccal fentanyl tablets (Fentora) are prescribed up to twice per day as its effects typically last 3-4 hours. This means participants may have to attend the clinic twice daily during program hours, and that this medication on its own is insufficient throughout the night. Most participants find that a combination of medications (PA, OAT, etc) is required to meet their needs over a 24-hour period.

"Fentora ties people to the clinic and also doesn't last. Folks need it when they go to sleep and they can't really go anywhere if they have to come here twice a day - they need to hang around in the area and that keeps them around other drug use, which they may be trying to avoid." (Support Worker)

"The feedback is that hydromorphone... it's short-acting and they can't get high enough pill count prescription to be able to fend off their sickness..." (Support Worker)

Staff also relayed feedback from participants about other PA options, such as prescribed benzodiazepines, that would potentially help them to reduce or eliminate their use of the unregulated supply:

"We hear from folks that are interested in cocaine, fentanyl without benzos or xylazine...we know they're already taking it in the street supply and have a tolerance for both fentanyl and benzos... They need something to address the sickness they feel from xylazine- a lot of people bring up that they still feel sick after they've taken all of their medications so they can't completely stop street use." (Support Worker)

Finally, staff key informants echoed feedback from program participants that PA that could be inhaled or smoked should be provided, particularly as this mode of consumption is related to the highest proportion of deaths due to unregulated substance use in BC.[24]

"There could be some other alternatives that people would prefer - diacetylmorphine for example, and the smokeable route. Most people don't inject anymore." (Support Worker)

Implementation : Capacity is Stretched

A limited number of PA programs have been implemented in BC, initially with short-term funding, and then expanding to a few additional communities based on successful pilot models.[25] It can be difficult to recruit and retain busy prescribers, particularly in smaller communities.

“We providers all wear many hats - hospital, clinics, belong to [Community Action Teams], speak to politicians... we are jack-of-all-trades and spread pretty thin.” (Prescriber)

“... we’ve gone through huge changes with nurse and physician leadership and... and there was a lot of... burnout and moral injury... The burnout is real and it’s cumulative and we may not really realize it.” (Nurse)

Staff spoke to challenges with scrutiny, stigma, and misinformation with regards to PA programs and harm reduction in general, particularly in smaller communities. This presents barriers to program expansion, especially as staff often must take on the difficult, dual role of being a healthcare provider and an advocate in settings that can be unsupportive and even hostile.

“You cannot surround yourself with like-minded people as much in smaller communities...you have to be a bit more brave...[this is a] very, very conservative medical community. I have walked out of meetings really shaken... I’ve been in medical meetings where we’ve been called out for making it harder for other physicians... and that we’re ‘handing out too many drugs,’ that the illicit drugs are not the problem... but just because I live in a small community doesn’t mean there are less options available to treat diabetes - it should be the same with [PA]” (Prescriber)

Reaching out, being available to engage with the broader community, and collaborating on shared client care are all activities that staff identify as important but that they feel challenged to keep up with.

“I am trying to work on this but it’s a capacity challenge and there is crisis-after-crisis and we’re spread quite thin.” (Manager)

Funding to expand PA is extremely limited and with increased moral panic about harm reduction and PA programs in particular, program staff are constantly under stress about whether funding will be continued. [26] Organizations are expected by funders to collaborate however collaboration is also hindered by the competition for funding sustainability.

“It’s colonization because that means there’s this power and control, and we’re all sitting scared and not able to collaborate authentically... Everyone holds things close to their chest and silos are created because funding is more scarce. We’re...trying to do it all ourselves because there is this fear... [we] don’t want to lose funding to somewhere else, which has happened historically.” (Manager)

Insights & Recommendations

EHR and RAD staff shared their insights and recommendations related to implementing and operating PA programs and these are arranged below into key themes: **principled practices, expanding PA options and models, knowledge translation and exchange, and policy change.**

Principled Practices

PA program staff witness the suffering of service users within contexts of structural oppression, stigma, and increasing moral panic regarding drug use, addictions and homelessness.[27] It is crucial for organizations operating PA programs to cultivate strong and principled leadership with allocated time and resources to reflect on internal practices, support staff, and counteract moral distress and injury.

"...we are doing the right thing and I know that in my heart...I'm very proud to work here. I don't know if that can make it into your report? I'm very proud of my coworkers and the things that we overcome on a daily basis, that we go through. To be able to service this community is not to be disregarded as like, 'whatever, you're just doing your job.' It's emotional, it's hard, we create connections that get severed very quickly sometimes which is not easy. We deal with youth, we deal with elderly, we deal with a very vulnerable population that... we really connect with." (Support Worker)

"We talk about 'principles before personalities' - the principles that we need to remember are what guide us. We're here because people have decided they want to live, and what does that look like...? Do your homework when it comes to setting up your team." (Nurse)

Practicing allyship with and following the expertise of people who use drugs is an ethical obligation for any group or organization that seeks to mitigate the suffering and harms enacted through unjust public policy such as prohibition. This includes advocacy within healthcare systems and actions to build partnerships and strengthen health and social safety nets. Staff key informants noted their appreciation for partnerships and collaborative efforts with pharmacists, prescribers, community healthcare providers, and hospital staff who were open and receptive to learning about prescribed alternatives and to working with AVI to collaborate on care plans for PA participants.

"We need to be able to push the envelope and that can be hard to do with the nursing and medical professions... It's important for there to be healthcare workers who can advocate within the system, like nurses, who can communicate that this is an option for treatment and should be accessible to folks with recovery goals." (Manager)

Taking the time to build relationships and advocate with other healthcare providers is necessary and has been beneficial to EHR and RAD participants. AVI has ensured access to PA for program participants when circumstances prevent them from attending their usual clinic or pharmacy.

Through relationship building, advocacy and education about PA practice, AVI staff bridge care with other healthcare providers to ensure that PA participants can access their prescribed medications in acute care and outreach settings, enabling them to successfully complete inpatient treatment and not be put at further risk upon discharge.

"We have lots of support from [the addictions medicine team] at the hospital and some of their docs work for us. People can continue on their [PA] in hospital and so that's super supportive and also is more broadly advocacy-in-action…" (Nurse)

"…we had one person in a recovery centre who was on [Fentanyl] patches and Fentora and that was a huge success…" (Manager)

"…the community building is integral, whether with potential service users or other agencies - discussing what the program is and isn't, that we're going to make mistakes and we're open to feedback, here is our goals." (Manager)

"It was rough to get going but our new pharmacist is really on-board with safe supply and has been phenomenal and reciprocal… [it took] lots of work to get there but it has been great since." (Nurse)

Expanding PA Options and Models

In order to remove some of the barriers of access to PA, options must be expanded to match the required doses, modes of consumption, and preferences of people who use drugs.[28] While there have been no significant differences of barriers identified in smaller population centres compared to larger cities, the barriers may be exacerbated where populations are less resourced. Travel distances and limited public transit combined with inclement weather make attending in-person for witnessed dosing a particular challenge. Health care providers are few and far between, and information about PA options and access may not be readily available.[29]

Staff key informants spoke to the need to expand PA delivery via outreach, pharmacies, supported housing, hospitals and overdose prevention sites.

"I'm baffled that we don't have a nurse and outreach worker pairing up for delivery - why are we only delivering the program from the fixed site? It can be hard to do this work in smaller communities because there are fewer staff available but… there [could be] more flexibility to do patch changes in the community, et cetera." (Manager)

"We should have teams of nurses supported by peers that have designated areas and communities to work with. Nurses should have a level of prescribing that is quite robust, with some physician back-up. We have nurse anesthetists, so…" (Prescriber)

"We need to expand this practice into other communities and regions - pharmacies could help with that" (Nurse).

"We need to spread things to community pharmacies; it should not be an option to provide [PA]. If you're the only pharmacy in a community, you shouldn't be allowed to decide you don't like safe supply - keep politics and views out of it." (Prescriber)

In BC, smoking has been the most common mode of consumption of unregulated drugs since 2017 and continues to be the leading mode of consumption in drug toxicity deaths.[30] People who smoke experience significant barriers to a safer supply given that current PA medications are not available in an inhalable formulation, and these must be made available to effectively stem the tide of unregulated drug deaths.

"There could be some other alternatives that people would prefer - diacetylmorphine for example, and the smokeable route. Most people don't inject anymore." (Support Worker)

Capacity Building, Knowledge Translation and Exchange

To support and advance access to PA, knowledge translation and exchange is required within programs and organizations, for external colleagues and community partners, and with the broader public. Misinformation and disinformation related to the root causes of poverty, homelessness, substance use, addictions and mental health play a significant role in the current public discourse, and this is a threat to the ability of harm reduction and other evidence-driven healthcare interventions to save lives and improve the health and well-being of individuals and communities.[31] EHR and RAD staff identified that professional development and knowledge sharing within their staff teams was important for building skills and continuing to innovate PA service delivery. They also identified the need for ongoing advocacy, training and education for their colleagues delivering care in other settings, and for the general public.

"You do feel isolated [in smaller communities] and you want to make sure you're on the cutting edge. I would like to meet more regularly with folks like this and be able to ask questions. We have [the AVI KTE team]- people whose life focus is this - but we don't have those players [in our community]... As providers we're getting more confident with our prescribing and it is so helpful to have prescribers with more experience to consult with." (Prescriber)

"People are associating the word 'harm reduction' with passing out needles and there being garbage on the street but I think if we start having conversations with people about, these are the prospects of the program, this is what we're trying to do, this is what our goals are but here are the challenges we're facing… being able to have peers come in and tell their stories and have intentional conversations with First Nations communities about what we're doing because we don't want to see anymore death." (Manager)

"How do I have conversations with especially the folks who are scared of poverty, scared of addictions, scared of the programs that are in place to support folks who live in poverty and addictions, so scared of harm reduction… it's fear, I get that. But how can I walk in this world in a way that makes it easier for people to at least turn their head a little and have a bit of curiosity?" (Nurse)

"I think at least education, starting with youth, right? Harm reduction, and not necessarily harm reduction but just basic human rights. Like I didn't know about trauma until I started dealing with my own trauma. I didn't realize that I was traumatized as a child, that vicious things that had happened to me impacted every decision that I'd made up until that point. I was 30 when I realized that, right? Like they don't teach that stuff. So maybe more education. I know we have a great educator here and [they do] all kinds of stuff, and I was fortunate to get to participate in some of that…" (Support Worker)

Spotlight on SAFER Knowledge Translation and Exchange

The SAFER Knowledge Translation and Exchange (KTE) team advances access to PA by sharing expertise, delivering training, and providing specialized consultation to AVI's PA staff, external partner organizations and individual practitioners.

The team has worked with pharmacies to protocolize pharmacy-based PA administration and has trained 5 health care providers who are now prescribing PA from their own practices. SAFER KTE supports prescribers from acute care settings to positively influence continuity of PA and iOAT care for those who transition between community and acute care settings. Through knowledge exchange and practical guidance, the team helps to build advocacy and education skills with nurses and other practitioners to grow capacity within the healthcare system to support those at risk of unregulated drug deaths.

A recent partnership between AVI and an external partner has enabled a new model for PA accessibility. Made possible by SAFER KTE, providers at the partner organization will be able to prescribe fentanyl tablets to their own patients and AVI will manage titrations through existing PA program capacity. Once a maintenance dose is achieved, participants will be transferred to a participating community pharmacy to receive their medications. This model supports non-AVI prescribers to offer fentanyl tablets, growing access to PA without tying participants to a specific site.

Policy Change

The BC Office of the Provincial Health Officer published a 2024 report that provided recommendations for expanding access to alternatives to the unregulated supply of drugs. The report notes the limitations of the current PA model that is reliant on the healthcare system as the point of access:

"...prescribed alternatives programs have barriers to access and are limited in terms of reach, scalability, and impact compared to the size of the problem needing to be addressed. The health-care system is not capable, nor is it designed, to scale-up services to address the needs of the tens of thousands of people who use drugs..." [32]

The report advocates for an expanded suite of options to mitigate the deadly impacts of drug prohibition and the unregulated supply. These options include non-prescription models in addition to the continued implementation of PA models. The PHO notes the documented benefits of PA programs, including:

"...reduced risk of death, reduced use or drugs from the unregulated supply, better connection to health services, and better physical and mental health and well-being." [33]

EHR and RAD staff witness these benefits experienced by program participants and advocate for the continued provision of PA as a life-saving and harm reduction measure.

"We need to keep [prescribed alternatives] active. If someone's not willing to go to treatment, that's their option. But we always need to have something that is 100% clean, available, of all types of drugs, medications, whatever, because people are going to acquire it whether it's legal or not. And if you don't provide a clean alternative, then they're going to get something that's going to potentially harm them. So it needs to be available..." (Support Worker)

"I mean, obviously regulate the drug supply, right? ...But this is the best that we've got right now to keep people alive. I want us to continue to learn from what we're doing, for everything to continue to progress, but until there's real commitment from a government to do full measures upon recommendations given to them, not half-measures, I think we're going to be stuck in this kind of limbo just trying to keep people alive." (Support Worker)

"Non–fatal overdoses cause a huge financial burden on our healthcare system - let's invest in prevention and provide all of the options... We're making prescribing safe supply harder than it needs to be... I just want all options on the table and I don't want people going to jail for small amounts of drugs." (Prescriber)

EHR and RAD staff also note that PA programs are a component, not a complete solution, to the ongoing structural barriers that cause suffering for people who use drugs and diminish the overall health of our society. Drivers of health inequities (eg. colonialism, ableism, and capitalism) at the root of public policy ensure that many individuals in our communities experience food insecurity, barriers to safe and affordable housing options, and unsupported impacts of trauma and violence. Health and social policy reform is required to address these inequities and to realize the transformational justice goals of harm reduction in addition to interventions and practices that keep people alive. As BC Provincial Health Officer, Bonnie Henry, concluded her 2024 report on PA: "We have a choice: to accept that a shift and action is needed to be fully comprehensive in our response to this crisis, or to continue to implement measures that seek to improve the outcomes, but not address the proximal cause." [34]

"In order for harm reduction to be an effective program, an effective offering, an effective part of the bigger picture…It is not good enough for me that for the next 30 years my clients walk to our door and lovingly receive a safe fentanyl product. I mean, if that is truly what they want, like great… but surely we can all do better, as you know as a community, as a society. At least get some stable housing and predictable food sourcing. I don't have Pollyanna images of everyone getting sober and going to school and getting jobs, but I want to be able to have reasonable ways, when it's appropriate, to talk about… other options. I want people to have access to that…" (Nurse).

"You know what? They're asking for housing.

[People tell me]: 'I live in a fucking tent. I get robbed every day. This is how I'm coping. Yes, the drugs that you're providing are saving me money, I eat more food, I have the ability to make it to more appointments because I'm more stable.'

And that's the goal, right? And if nothing else happens and that's the only thing that happens for now? That is fucking why we're here, right? But that next step… right? And that next step for almost every single person that I talk to on a regular basis, once they get stable. It's like, 'Ok where's my housing, and then I can think about long term goals.'

Who can think about long term goals when you've been tenting for three years and you're sick of getting soaking wet eight months out of the year? I've been there, I understand that." (Support Worker)

Conclusion

The perspectives and expertise shared in this practice brief affirm the successful expansion of AVI's prescribed alternatives programs over four years on Vancouver Island to include the communities of Nanaimo, Comox Valley and Campbell River. Implementation of these programs has resulted in positive outcomes for program participants, including prevention of toxic drug deaths and increased quality of life. Through flexible, community-based, harm reduction practice, AVI's interdisciplinary staff mitigate barriers of stigma, and health and social inequity, by providing access to life-saving medications, wrap-around care, and supportive linkages with other healthcare providers.

The further expansion of prescribed alternatives to reach greater numbers, broader populations and more rural communities face barriers of access, capacity and service model limitations. As noted by the 2024 Island Health Chief Medical Officer's report:

"…in the context of prohibition, interventions to support people who use substances are difficult to initiate, maintain, and evaluate, and access to these services is very limited… People who use these substances experience widespread stigma, and there has been extensive public opposition to interventions that can reduce harm associated with use…. Shifting these perceptions will require ongoing gathering and translation of evidence, and ongoing engagement…"[35]

AVI's SAFER KTE team is a critical response and resource, providing consultation, training and support for mental health and substance use practitioners, operators and frontline staff of existing and future programs, both regionally and beyond (SAFER KTE provides consultation at the national and international level as well as regional and provincial). The provision of prescribed alternatives is a key harm reduction intervention that must be included and expanded as part of a continuum of strategies to address the relentless public health emergency of toxic drug deaths.

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