Small Group Discussions

Safer Supply Project Implementation

What could safer supply access look like in your community?

Describe a pilot initiative to your ideal program.

- Suggested 5 years plan/funding from CAT – instead of yearly. Hard to get things rolling within a year – looks unstable to people, hard to find trust. Need more security with programs, to build trust within our communities. Problem with year to year programs, takes awhile to start, and then started but then gets pulled due to funding. Not helpful to communities.
- Drug dealers deliver --> dope-sick, may not want to travel. Need mobile service.
- Personal connections person/doctor.
- Talk to MLA and the community – be real.
- People who do outreach could distribute safe supply and take money and put it back into programs.
- Mobile unit with a team to distribute.
- Make a cap amount so much a day per person so things can't be sold.
- Coming from community-based organizations instead of HAs; they have better relationships and established trust with end-users.
- Funded by core funding model instead of unsustainable grant-based models.
- Trauma support and Informed from PWLLE needs!
- Expanded educational and training support for PWLLE/peers; valuing lived & living experience in recruiting for positions.
- SAFER Initiative Model; no need to 'reinvent the wheel' constantly.
- More funding for OPSs – the OPS could be a mechanism for a nurse to prescribe the safe supply (along with the pharmacist). Nurses are key as they're grounded in best practice and dosing, etc.
- Systems Dr, pharmacists, outreach staff with mobility systems.
- What about folx who are using, who we don't know about? Need anti-stigma messaging.
- Safe Supply should be affordable and accessible – If people need higher doses the cost is higher. For those experiencing poverty that can be hard.
- Consistent doses would be helpful – much different than what's on the street.
- Loved the Dr. Sutherland's approach.
- Pilot programs provide great examples that could be replicated across the province.
- Clinical, welcoming, loved the "hipster" approach, respectful supply.
- PHS's program: having patients pay for drugs (at prices tied to street prices) could reduce diversion.
- Recognizing there are different types of diversion – sharing w/ friends/family vs. organized crime interference.
- Clean needles, teach people how to use the needles properly, Narcan, drugs are currently either too weak or too strong.
- Less people are using needles – more are smoking rather than injecting.
- Langley is handing out support group information – they need a safe place to use and safe supply
- Safer supply access looks like people not having to spend the whole day looking for drugs to just get through the day, they would be able to get through the day and do activities
- Trail CAT has been operational for one year, have made good progress, but only have an Episodic-OPS, two days a month

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- SAFER Program – utilizing people with lived experience.
- Support from other medical organizations and health authorities.
- Removal of barriers including policies that prevent action.
- Protection for doctors and medical staff who may be apprehensive when it comes to working with substances.
- Trail OPS – Would love to see something like the full-time OPS in Nelson, with safe supply provided through an NP.
- Really important to have the pharmacy on-side, working with doctors, NPs and outreach workers. Transportation of drugs is fraught with legal barriers and logistical issues.
- Consideration is needed for PWUD but are not marginalized. Need more drivers, more capacity, more outreach. A mobile unit could be effective, with a health care team delivering.
- Anti-stigma work is essential to ensuring that people come forward. Often, we don't know who is using. How do we reach out to them privately? Continued outreach is needed, but
- Use existing infrastructure, existing prescribers.
- Important to have different options of medications that would work better. Ie. Hydromorphone not working the same.
- Important to have daily support by pharmacist/ Dr or NP to support when missed doses.
- Able to access medications when not able to come into pharmacy.
- Important to have privacy (especially in a small community).
- Delivery of medications or vending machine, i-OAT.
- Vancouver: Ideal is legalization and regulation. In the meantime, we are doing what we can (half measures) to get there. What do you need to know to change the policy to safe supply?
- Comox Valley: The ideal is a long way away from where we are. We currently have relatively good access to OAT and some safer supply options but there are so many barriers. Very few doctors are willing to prescribe. What is required is at the policy level- very big changes needed.
- FNHA: How many meetings/presentations do we need before the government listens to us in saying loudly yes, safer supply is what we need. OAT is medicalized half way and even then, in many rural communities it is inaccessible. Feeling of constantly playing "catch up". Coordination of all levels of government needed. The roots of drug criminalization in racism and inequality are the largest roadblocks. We need to use these numbers (bodies, coffins) to get people in the "higher up" roles to listen to us. This is de-humanizing but necessary to do in order to increase
- Cowichan Valley: There are a few doctors here willing to prescribe safer supply but it's a long way from what is needed. Interest in safer supply vending machines for rural/remote areas. Need for virtual care options (expanded) and to reach people using recreationally and alone who may not be accessing services. Expanding programs of what already work/connections already made.
- Regulated but not just by physicians – nurses, nurse practitioners.
- Outreach nurses connected to outreach teams (interprofessional).
- Broader public education and awareness – supportive information sharing.
- OPS – safe from RCMP.
- Ensuring those with lived and/or living experience with drug use are always at the table when discussing safer supply.
- Engage in anti-work/harm reduction work with youth in our communities, starting at the schools. The school boards are major barrier to this work.