

Peterborough 360 NPLC Safer Supply Program: The Participant Experience

"What's really been the best part is to see the whole program together, you know. It works. It gives us what we need to handle withdrawal, and support, and it gives us you know, a place in the community, right? Which a lot of a lot of people like me never felt we've had that before." (SSP Participant)

**Peterborough 360 Degree
Nurse Practitioner-Led Clinic**



May 2024

Acknowledgments

Report Authors: John Marris & Carolyn King

The authors would like to acknowledge and thank all those who were interviewed for this report who powerfully shared their experiences of the Safer Supply Program and their thoughts and ideas on how we can better support members of our communities who use drugs. The authors would also like to acknowledge the work of the 360 Nurse Practitioner-Led Clinic Safer Supply Program team in helping to recruit participants and in supporting those participants through the interview process and other research tasks. The work of Nancy Henderson should also be recognized in helping to establish the research project, and alongside Kirsten Woodend authoring the journal article that resulted from the first round of interviews. Kathy Hardill's work on the Electronic Medical Records which provide valuable evidence as to the success of the safer supply program has also informed this

report and forms the basis of a companion report to this document. We wish to thank Michael Fazackerley for his diligent work in transcribing interviews and recognize Gillian Kola's contribution to the project in generously sharing ideas on survey design and researching safer supply.

The artwork in this report was created by participants, staff and visitors who attended the program's monthly art drop-ins. In order to protect participant confidentiality, we are not in a position to give credit to the artists involved. However, the authors and clinic would like to offer our sincere thanks to all those who shared their creativity and agreed to have their work included in this report.

Graphic Design by John Marris

Colonialism acknowledgement

The 360 Degree NPLC recognizes that any work we do with people experiencing structural barriers to health and health care, including the impacts of colonialism, racism, poverty and homelessness must incorporate an understanding of cultural humility and the work of educating ourselves about colonization, settler treaty obligations and the Truth and Reconciliation Report. We acknowledge the pervasive health inequities created by the devastating colonial project, including intergenerational trauma and homelessness which disproportionately affects Indigenous peoples across this territory.

The 360 Degree Safer Supply Program team created, at our inception, the following

acknowledgement of our work's location in geography and in history:

The Peterborough 360 Degree NP-led Clinic is located on the traditional territory of the Michi Saagig and Chippewa Nations, collectively known as the Williams Treaties First Nations, which include Curve Lake, Hiawatha, Alderville, Scugog Island, Rama, Beausoleil, and Georgina Island First Nations. The 360 NPLC's Safer Supply Program recognizes the significant harms caused by systemic racism embedded in drug policies, health care institutions and beyond. We stand in solidarity and in gratitude for the brilliance, resilience and resistance of all communities disproportionately affected by the ongoing colonial war on drugs.

Suggested Citation:

Marris, J. & King, C., (2024). Peterborough 360 NPLC Safer Supply Program: The Participant Experience. Peterborough 360 Degree Nurse Practitioner-Led Clinic, Peterborough, ON.

<https://www.360nursepractitionerledclinic.ca/documents/>

Contents

Executive summary and key findings.....	4
The opioid poisoning crisis and safer supply	7
360 NPLC Safer Supply Program background and structure	8
Program research	9
RESULTS	10
Participant background	11
Program benefits.....	13
Positive life changes	17
Stability	19
The future	20
Positive reflections on the program	21
Program Limitations.....	26
Diversion	27
Ongoing challenges for PWUD	28
Conclusion.....	32
Recommendations	33
References	34

Glossary of key terms

360 NPLC	Peterborough 360 Degree Nurse Practitioner-Led Clinic
EMR	Electronic medical record
MMT	Methadone Maintenance Treatment
NP	Nurse Practitioner
OAT	Opioid Agonist Therapy
OD	Overdose (drug poisoning)
ODSP	Ontario Disability Support Program
PWUD	People who use drugs
SROM	Slow Release Oral Morphine
SSP	Safer supply program(s)
SUAP	Substance Use and Addictions Program (Health Canada)

Contact Information:

Peterborough 360 Degree Nurse Practitioner-Led Clinic
 info@nplc.ca
 www.360nursepractitionerledclinic.ca

Executive summary and key findings

Background

Canada is experiencing a deadly toxic drug poisoning crisis that has resulted in over 40,000 opioid related deaths since 2016.¹ The majority of these deaths have occurred in British Columbia, Alberta and Ontario. Public Health Ontario reported over 2,500 opioid related deaths in 2022 across the province.² Peterborough Public Health (PPH) reported 78 opioid related deaths between January and December 2023.³

In the context of this public health crisis the Peterborough 360 Degree Nurse Practitioner-Led Clinic (360 NPLC) started researching and developing a safer supply program (SSP) in 2021, and accepted its first participants in the spring of 2022. The program's aim is to provide a safer alternative to the toxic and unpredictable street supply through the prescribing of regulated, pharmaceutical-grade opioids for people most at risk of overdose and drug poisoning. The Canadian Association of People Who Use Drugs defines safer supply as "a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market."⁴



At the time of writing (May 2024), the program provides 41 participants with prescribed opioids, typically in the form of a daily dispensed slow-release, long-acting oral morphine (SROM, brand name Kadian) and/or methadone along with Dilaudid tablets (hydromorphone, an immediate release opioid) to take away and use, as agreed with their prescriber. As participants have stabilized on the program, a number have started to receive multi-day doses ("carries") and no longer need to attend the pharmacy daily.

In addition to prescribing safer supply, the program offers wraparound services, which includes primary health care, nursing care, social support, case management and social programming. The 360 NPLC SSP is one of 25 pilot SSP funded by Health Canada's Substance Use and Addictions Program (SUAP).⁵

Program research and evaluation

As part of the program's commitment to the funder (SUAP), and a strong wish by the 360 NPLC to understand the impact of the SSP, the program undertook a series of research and evaluation tasks that included interviews with participants, program staff, other 360 NPLC staff, and partner organization staff; assisted surveys with participants; and an audit of participant electronic medical records (EMR). The majority of data in this report is drawn from the second round of participant interviews as well as data from the participant assisted surveys. Additional sources include the first round of interviews with participants, program staff, other clinic staff, and partner organization staff. A parallel report that focuses on the EMR data and provides a guide to establishing safer supply programming in a small NP-led clinic will also be published alongside this work:

Embedding a Safer Supply Program in a Small Urban Community: Peterborough 360 Degree Safer Supply Program Evaluation May 2022 through December 2023

Key findings from EMR and assisted surveys

High retention in the program: 86% of participants have continued in our Safer Supply Program (EMR).

Reduced overdose: 79% fewer overdoses in the last 6 months of data analysis compared to the 6 months prior to enrollment (EMR).

Reduced use of unregulated drug supply: After 12 months in the program, **43%** reported a reduction in fentanyl use and **43%** reported being fentanyl abstinent, which represents **86%** of participants reporting using less fentanyl (EMR).

Reduction in criminalized activity: 71% reported a decrease in criminalized activities such as survival sex work, selling drugs and theft after 12 months in the program (assisted surveys).

Reduced injection drug use: Of participants exclusively injecting fentanyl at enrollment we saw a **50%** reduction in injecting by 12 months (EMR).

Reduced use of stimulants: 76% reported stimulant use at enrollment. This dropped to **55%** at 6 months and to less than half (**43%**) at 12 months (EMR).

Improved access to mental health and social supports: 79% of participants received counselling for mental health issues. **66%** were supported to obtain identification needed to gain access to numerous systems and benefits (EMR). **69%** of participants indicated that their mental health had improved after 12 months in the program (assisted surveys).

Improved access to primary care: 93% of participants were screened for health issues including infections, diabetes, heart disease and cancer. **66%** received preventive vaccines (EMR). **75%** of participants indicated that their physical health had improved after 12 months in the program (assisted surveys).

Improved access to the social determinants of health: 79% received health care provider interventions to increase their incomes including applications for disability benefits as well as increased access to additional income support funds for nutritional support and medical transportation (EMR).

Stability: 94% indicated that life felt more stable after 12 months in the program (assisted surveys).

Safer Use: 100% indicated using drugs more safely after 12 months in the program. Safer practices included not using alone, using new supplies every time, using filters and carrying Naloxone. **56%** indicated they had a greater access to harm reduction supplies since starting on the program (assisted surveys).

Reduced Emergency Department use: At intake **73%** of participants had visited the emergency department in the previous 4 months, at 12 months this had reduced to **31%** (assisted surveys).

Key findings from participant interviews

The majority of interview participants had a history of chronic physical and/or emotional pain. Many were historically prescribed opioid-based pain killers and when these prescriptions ended, they turned to the unregulated street supply. Participants also spoke of unresolved trauma, notably from childhood, and of a wish to relieve the pain of homelessness as being implicated in their drug use.

“I started off with prescription drugs. And then it just went from there.” (Participant 1)



Participants report that the program has given them an increased sense of security in knowing that their opioid needs are going to be met, or at least partially met, with a safer supply. The ability to disengage from higher-risk life practices that were historically used to fund street drugs was also noted. It was noted that the safer supply gave participants significant amounts of time back that could be used to make other life changes.

“It helps because I don't have to go out and do stuff that I don't want to do to get drugs.” (Participant 7)

The ability to think positively about the future and express desires and hopes for the future was noted as a new positive experience.

“Well, I want to try to go back to work. That's a new thing. I've been on disability for a long time.” (Participant 10)

Participants appreciated the sense of community that came with the program, noting the value of connecting with understanding staff who had lived experience of drug use and homelessness. Participants also noted the art and garden programming that added to their quality of life.

“I like that it's community based and, you know, trying to get people together. It's about reconnection. I guess with addiction a lot of people disconnect from the world.” (Participant 8)

Access to primary health care and the knowledge that medical professionals would not judge or penalize them for street drug use was a profoundly positive experience for almost all participants.

“I've been excited to come to the doctors [NP] rather than like "ohhh, god".” (Participant 8)

In addition to noting improvements in physical and mental health, there was a sense of a return of humanity and sense of self as time was spent in the program.

“This stabilizes a lot of stuff. You know, it's making me human again.” (Participant 11)

Aspects of the program that were seen to support these benefits included being met by staff with lived and living experience, a non-punitive approach to urine drug screening, the knowledge that underlying chronic health conditions would be addressed, a flexible approach to appointment times, and a space that participants felt comfortable dropping into between appointments.

Though the benefits of the program were the primary focus for the participants during their interviews, the challenges faced by people who use drugs was often referenced as well. These included the ongoing housing crisis that left many participants homeless, the dangerous nature of the illicit street supply of drugs, the collective trauma of seeing so many friends and family members dying of drug poisonings, and a continued sense that participants felt stigmatized and judged in other health care and social support environments.

“Yeah, actually, the housing. Everybody being depressed stuck outside with no place to go. Of course you're going to want to be high all the time.” (Participant 9)

Overall, it was clear from the interviews that the 360 NPLC SSP is having a positive impact on the lives of participants. The success of the program, including its primary health care and social supports, has been facilitated by the relational, holistic, and supportive approach taken by a staff team that looks beyond just participants' drug use.

“What's really been the best part is to see the whole program together, you know. It works. It gives us what we need to handle withdrawal, and support, and it gives us you know, a place in the community, right? Which a lot of a lot of people like me never felt we've had that before.” (Participant 1)

The opioid poisoning crisis and safer supply

Canada has reported over 40,000 opioid related deaths since 2016,¹ with the majority of these deaths occurring in British Columbia, Alberta and Ontario. In Ontario this drug poisoning crisis resulted in over 2,500 opioid related deaths in 2022 or an average of 7 deaths every day.² Though commonly referred to as overdoses, these poisoning events often result from the contamination of the street supply with potent opioids such as carfentanil, various benzodiazepines, and drugs not intended for human consumption such as the veterinary sedative xylazine. In 2023 54% of opioid toxicity related deaths included a stimulant drug and 81% of stimulant related deaths included opioids.⁶

Though the drug poisoning crisis has been worsening for many years, the COVID-19 pandemic that started in the early months of 2020 significantly added to the crisis. Public health decisions related to public gathering isolated people who use drugs (PWUD) and made drug use practices more dangerous, at the same time, border restrictions led to an increasingly toxic and unpredictable street drug supply. COVID-19 and its aftermath also exacerbated the housing supply crisis and food price inflation, thereby increasing social inequities.^{5,7}

The City of Peterborough has a population of 83,651, and combined with the surrounding County of Peterborough this rises to a population of 128,624.⁸ Between January and December 2023, Peterborough Public Health (PPH) reported 78 opioid related deaths, 377 emergency service calls for opioid poisonings, and 424 emergency department visits for drug poisonings in this area. 89% of the emergency department visits took place at Peterborough Regional Health Centre.³

Statistics on drug poisonings highlight the scale of the crisis, but it is important to remember that these deaths represent the death of parents, children, siblings, friends, and loved ones. Each of these deaths adds to the traumatization of our

communities and to the traumatization of those who are most marginalized in our current social structures.



What is safer supply?

Safer supply programs (SSPs) are one of many needed responses to the drug poisoning crisis. SSPs are rooted in harm reduction, and have the primary goal of reducing harms and consequent deaths caused by the toxic street drug supply. The fundamental aim of safer supply is not abstinence, but rather improving the safety and quality of life of PWUD. The Canadian Association of People Who Use Drugs defines safer supply as "a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market."⁴ Typically safer supply programs provide participants with a known, regulated pharmaceutical supply of opioids that can either replace, or in part replace the toxic street supply. Many, but not all, SSPs also provide primary health care, social and community supports, and other services that support the wellbeing of participants.

Safer supply programs started in Ontario in 2016 and there is an increasing body of evidence in the

form of program reports, academic research, and summary reports that indicate that safer supply reduces overdose rates, reduces emergency department admissions, and increases participants' overall wellbeing. These improvements in wellbeing include addressing long-term chronic health conditions, improved social relations and better access to housing and income security.^{5,9,10}

A word on language

Those who work with PWUD challenge the use of the word 'overdose' and prefer the term 'drug poisoning' as it correctly identifies the toxic and adulterated drug supply as the primary driver of harm rather than implying a lack of care or mistakes made by the user. Drug poisoning is therefore more reflective of what is actually

happening in our communities. However, 'overdose' will also be used in this report as it is still the most recognizable term for most readers and research participants.

At the time of this writing, Health Canada is making the change from the term 'safer supply programs' to 'prescribed alternatives programs' as a more fulsome description of the various substance use health care models offering a wide range of medications and supports for PWUD. While recognizing this change in terminology, this report will continue to use the term 'safer supply program' as it was the language that was used during data gathering and is the term familiar to participants and staff at the 360 NPLC. The two terms can be understood as interchangeable.

360 NPLC Safer Supply Program background and structure

360 NPLC Safer Supply Program

The 360 NPLC SSP is a pilot program funded through Health Canada's SUAP grant fund. The program accepted its first participants in May 2022 and completed its initial pilot period at the end of March 2023. In January 2023, the program was granted a one-year extension to the end of March 2024, and in March 2024 a further final one-year extension was granted to the end of March 2025. At the time of the first round of participant interviews, the program had **21** active participants, and at the time of the second round of interviews, the program had **41** active participants.

Program structure

Typically, participants in the program are prescribed either slow-release oral morphine (SROM, brand name Kadian) or methadone, or a combination of the two (both long-acting opioids), along with Dilaudid (hydromorphone; an immediate release opioid). A limited number of participants have also been prescribed fentanyl patches as their long-acting opioid. Participants typically receive their prescription daily at a pharmacy. They take their long-acting opioid at the pharmacy as a witnessed dose, and they get their short-acting Dilaudid tablets to take away with them. The



Dilaudid tablets can be swallowed, snorted, or injected. It is important to note that Dilaudid tablets cannot be smoked, which reflects a limitation and a gap in the medication options available for Ontario safer supply participants. As participants stabilize on the program, some were given the option of “carries” (the ability to pick up multiple days of medication from the pharmacy). This would typically mean visiting the pharmacy 3 to 4 days per week, rather than 7.

The SSP also offers wraparound supports, including primary health care, case management, and social supports for participants who are interested in these services. This includes help with obtaining identification such as birth certificates and health cards, and supporting claims for income supports

such as the Ontario Disability Support Program (ODSP). Staff also distribute snack bags and drinks to participants, and offer support with coordinating and attending other medical and social support appointments. Thanks to feedback in the first round of interviews, the SSP developed programming options that brought two monthly art-making sessions to participants, and in the summer of 2023, created a community garden that focused on Indigenous medicinal herbs and food growing practices.

At the time of this report, the 360 NPLC SSP was comprised of a nurse practitioner, case manager, nurse, three system navigators (1 full-time, 2 casual), medical office administrator, and program manager.

Program research

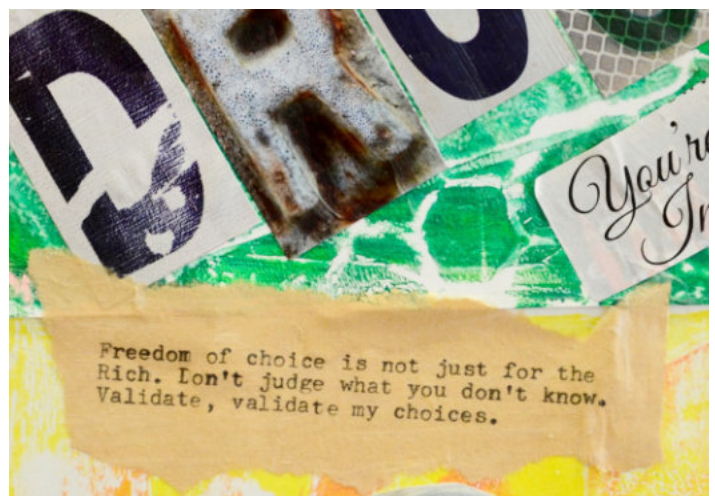
This report is primarily based on interviews with program participants and aims to provide a participant perspective on the 360 NPLC SSP. These interviews are one component of a comprehensive evaluation of the program. The evaluation tools used were:

- Intake/baseline assisted surveys* with participants
- Update assisted surveys every 4 months for participant’s first year in the program
- Update assisted surveys every 6 months after 1 year in the program
- Interviews with participants approximately every 12 months
- Interviews with SSP staff every six months
- Interviews with partner organization staff and other staff of the 360 NPLC every 12 months
- An anonymized and aggregated data set from an audit of the electronic medical records (EMR) of participants who have been in the program for 6 months or more, completed by the primary SSP Nurse Practitioner (NP)

*In assisted surveys, participants sit with a designated member of staff and can choose to fill

in a survey on a digital tablet themselves or have the member of staff ask them the questions and enter the answers.

In addition to meeting the reporting requirements of SUAP, the 360 NPLC SSP will report on the viability, successes and challenges of running an SSP in a small-sized urban community which acts as a hub for a broader region through a nurse practitioner-led clinic. This project has received approval from Trent University’s Research Ethics Board.



Notes on data sources for this report

The majority of this report draws from the second round of interviews and in part from the first round. Supporting data has also been taken from the assisted surveys that participants were invited, but not required, to take part in, and the anonymized and aggregated data set created from an audit of the EMR completed by the primary SSP NP. The audit of the EMR included **29** participants (76%) who have been in the program for 6 months or more, of which **23** had been in the program for over 12 months. Analysis of the assisted surveys was drawn from the **18** participants (47%) who had completed surveys at 4, 8 and 12 months.

Where data is available from the EMR audit, it has been used in preference to the data from the assisted surveys. Though both sets of data are based on participants' self-reports, the EMR data represents a larger sample size and data gathered more frequently being based on more regular meetings between staff and participants.

Demographic data in this report is taken from program records that include **41** participants. The source of data is identified throughout the report.

Interviews with program participants

The first round of participant interviews was conducted in November 2022, approximately 7 months after the program started. In this round, 14 of 21 program participants were interviewed. The second round of interviews was conducted in

January 2024, and 16 of 41 program participants were interviewed. Though there was some overlap of participants between the two rounds, being interviewed in the first round was not a prerequisite for a second-round interview.

Analysis approach and Reporting

For both rounds of interviews, once the interviews were transcribed, the transcripts and interviewer's notes were reviewed and coded to draw out key data points and develop themes that would inform reporting.

Reporting from the first round of interviews was in the form of an academic journal article "*And this is the life jacket, the lifeline they've been wanting": Participant perspectives on navigating challenges and successes of prescribed safer supply*" that was published in March 2024 and can be accessed at the following:

<https://doi.org/10.1371/journal.pone.0299801>

Alongside this report that focuses on the participants' perspectives, a report that focuses on the EMR data and provides a guide to others wishing to establish a comparable safer supply program is also being published in the spring of 2024:

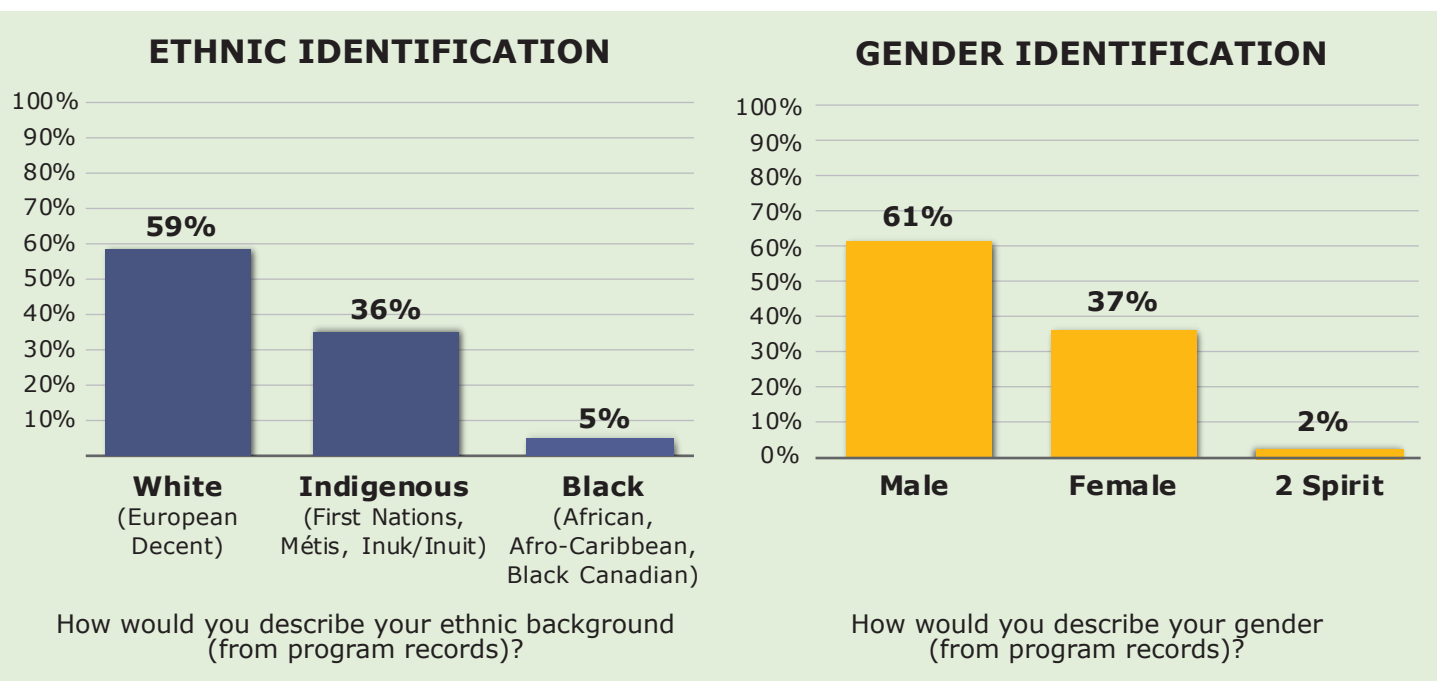
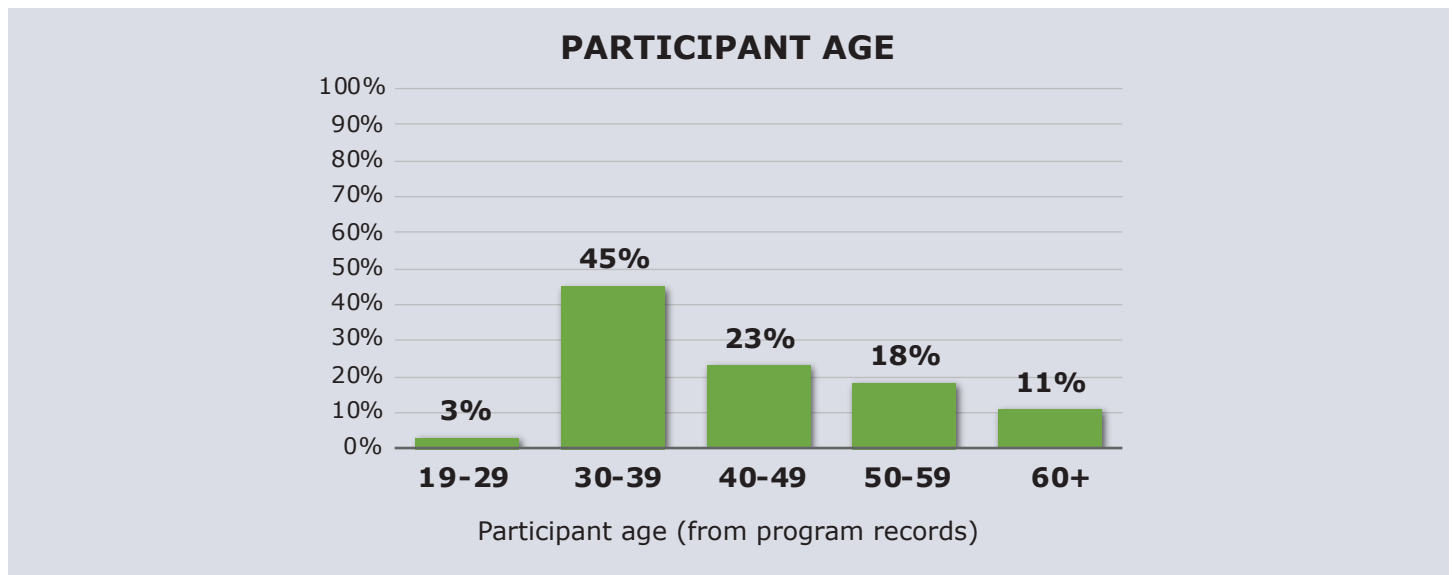
Embedding a Safer Supply Program in a Small Urban Community: Peterborough 360 Degree Safer Supply Program Evaluation May 2022 through December 2023



RESULTS

Participant background

Though demographic data for all program participants is included below, demographics for interview participants is not being shared in reports to limit the risk of participant identification.



Time in the program

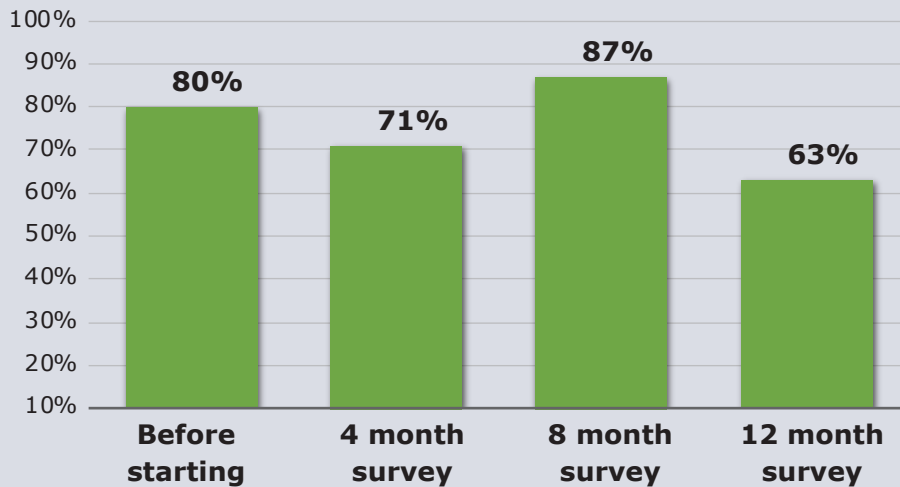
At the time of the first round of interviews in November 2022, the program had been running for 7 months, and the majority of interview participants had been in the program for between 5 and 7 months. At the time of the second round of interviews, the program had been running for 20 months, and the majority of the interview participants had been in the program for 17 to 19 months with the average time in the program being 17.25 months.

Homelessness

Participants were not directly asked about their housing situation in interviews, though some volunteered information about their current housing status. However, the participant assisted surveys do ask about experiences with being unhoused. The graph below captures participants' experiences at the end of December 2023 and illustrates that being unhoused continues to be part of many participants' experience.

Participants' reflections on experiencing homelessness will be explored in more detail in the *Ongoing Challenges* section of this report below.

EXPERIENCED HOMELESSNESS FOR AT LEAST 1 NIGHT IN THE LAST 4 MONTHS



Have you experienced homelessness for at least one night at any point in the last 4 months?
(data from participant assisted surveys)

Drug use history

With the exception of one participant who transferred from another SSP, all program participants were using fentanyl when starting the SSP (EMR data). 95% had tried other treatment-based programs to address their Opioid Use Disorder (participant assisted surveys).

painkillers and their subsequent withdrawal (mostly OxyContin and Percocet) was reported by many in the first round of interviews. In order to learn more about this pathway into illicit drug use, participants were specifically asked about any history of chronic pain and pain management in the second round of interviews.

Pain management and history of opioid use

Opioid use as a form of pain management, and a history of starting opioid use through prescription

10 of the 16 interviewees in the second round noted pain issues and a history of prescription opioids in their pathway to the use of illicit street drugs.

Participants noted various histories of injuries and careers in construction that had led to their use of prescription medication.

“I got a script for pain when I was like XX, for broken ribs... This doctor gave me like 200 a month, and it was like an endless supply. I had three rows of my mother’s medicine cabinet full of Percocets. It was insane.”
(Participant 14)

Additionally, three participants, when asked about pain, indicated that their opioid use had started with ‘emotional pain’, ‘depression’, or ‘the need to be numb.’ Childhood trauma was also noted in this context.

Of the 16 interviewees in the second round, 13 associated physical or mental pain with their start of opioid use, and 1 person declined to answer the question.

These responses challenge the idea that illicit street drug addiction typically starts with irresponsible recreational drug use.



Program benefits

Safer supply and security

A clear sense of security emerges for participants in knowing they have their safer supply and are protected from both dopesickness (withdrawal) and the many risks associated with purchasing drugs from the street supply.

“Yeah, for one I’m not fighting and spending my days just trying to feel better. I don’t have to worry about being dopesick... It’s made it so I wanted to better myself.”
(Participant 9)

“And you just have to go to pharmacy, you don’t have to go to a drug dealer. You don’t have to find money... As broke as you are, you can get them every day, right? Yeah. So, it’s like, it’s great, right.” (Participant 7)

For those who continue to use illicit street drugs, there is still a sense of security and reduction in stress from knowing their safer supply is an effective backup to their street use.

“If I have that stuff, like the Dilaudids, I know I have them. And it’s kind of like the drugs if you have them, you’re fine, and if you don’t, then you’re like, ahhh. Like it’s more of a mind thing.” (Participant 7)

Program staff also noted in their interviews this reduction in stress and the return of stability and control in the lives of participants. One staff made the point that:

“Like what’s not on the table, if you have autonomy in your life, right?” (SSP staff)

Return of time

Getting time back was a consistent theme in both rounds of interviews. This was seen as a positive experience that allowed for other activities and addressing life goals that included returning to work, going to school, and reconnecting with children.

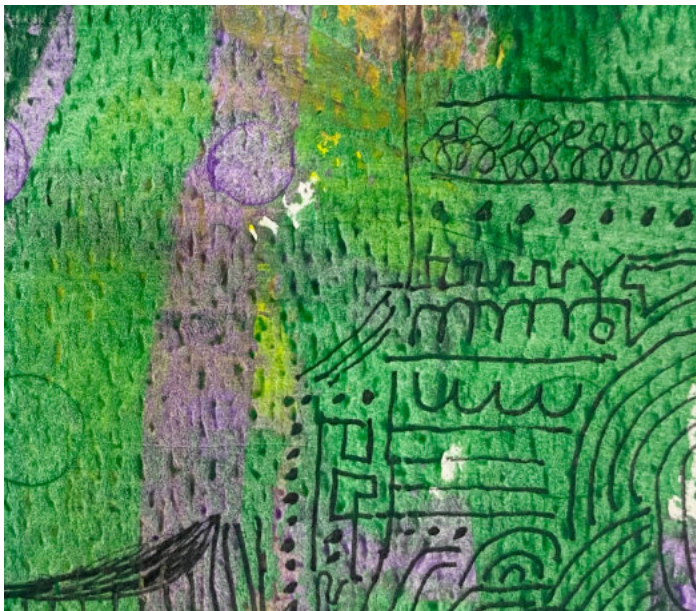
One participant reported that the SSP saved them 12 hours a day looking for street drugs

In the second round, participants spoke about the actual things that they had been able to achieve with this extra time and security.

“You know, I can hang out with the folks. Not always out hunting, searching, and worrying.” (Participant 14)

“I’m happier. My mind is clearer. I’m seeing my son every week. Now, I’ve got us all a place to live.” (Participant 15)

This return of time was also noted by program staff, who recognized the value it brought to participants’ lives, allowing them to think about things beyond sourcing their drug supply.



“So, like the gift of time in participants’ lives means that they can have lives and steer their lives in certain directions.” (SSP staff)

Overdose and drug toxicity

Participants spoke about the benefits of having access to medications of known quality, potency, and consistency that reduced the risks of overdose and the ever-present fear of dying.

“How many of us would have been dead or should be dead or would have already been dead?” (Participant 12 – first round of interviews)

“It helps me crazy amounts I used to OD all the time on stuff. Before I OD’d like 24 times. Since I was on the program I only OD’d once.” (Participant 16)

Reinforcing this increase in participant safety through a reduction in overdoses is the data from the EMR audit.

The EMR audit indicates a 79% drop in overdoses from enrollment for those in the program for 6 months or more.

While reflecting on the clear benefits of their own reduction in overdoses, participants also spoke about the collective trauma that exists within the community from seeing so many friends die and the challenge of being one of a very limited number on the SSP.

“It’s just incredible to see how like...people have passed away. You never would have expected it. Like the overdoses have been, I mean, I’ve lost so many friends due to the overdose problem.” (Participant 6 - first round of interviews)

Reports on other SSPs indicate that the 360 NPLC SSP results are consistent with reductions in overdoses seen in other programs.^{5,11,12}

Primary health care and social support

Security exists in another form for participants with access to primary health care and social support services. The knowledge that medical issues, including underlying chronic conditions, would be addressed was noted as a key benefit of the program.

**“I've had just a consistent medical attention or availability to get seen by somebody you know, for my health stuff on a regular basis; someone who actually gives a hoot.”
(Participant 14)**

Knowing that both illnesses and underlying chronic conditions could be addressed was seen as a key benefit of the program by many. This was contrasted at times to participants’ wider reception in health care environments and in drug treatment programs such as Methadone Maintenance Treatment (MMT), that in participants’ experience, did not offer primary health care.

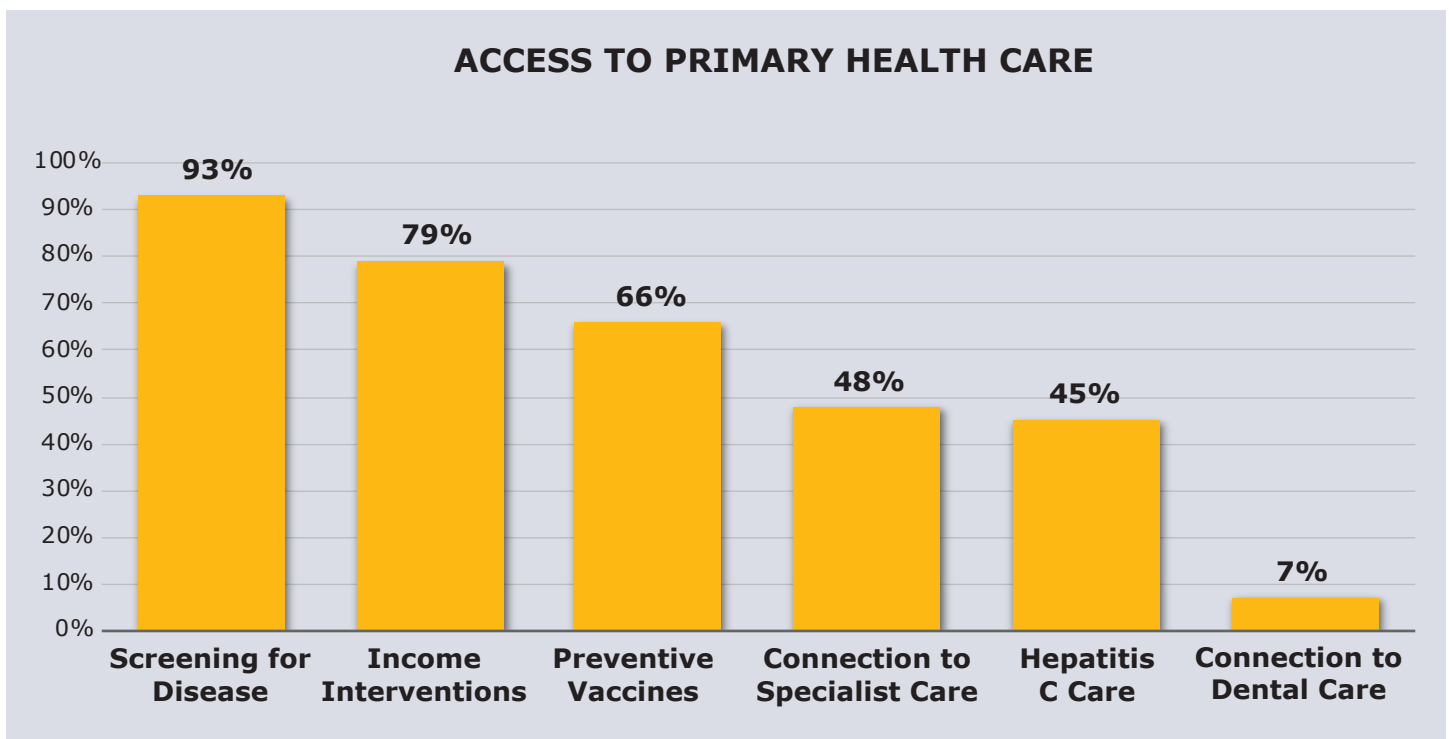
This self-reporting by participants is backed up by the audit of the EMR which show participants accessing a wide range of health care services.

Staff of the 360 NPLC not directly involved in the program also noted this uptake in primary health care, and the role of the SSP in creating the capacity for participants to focus on other priorities outside of their substance use needs.

“Until you can actually start thinking about something other than survival and where I'm going to get my next hit, then how could you possibly prioritize your own physical health needs or your own mental health needs on top of that?” (Other clinic staff)

“If I'm diabetic, but I'm also feeling really dopesick, then my priority is not going to be balancing my sugars, my priority is going to be I don't want to feel like shit...” (Other clinic staff)

Assisted surveys of participants show that 100% of participants believe they have had better access to health care since they started on the program (12-month survey)



Money

A tangible improvement in participants' financial situation was also noted by some, with money that was previously being spent on drugs now being available for basic needs such as food and shelter. Some also spoke of not having to be in so much debt.

“I don't have to owe so much at the end of the month either, which is great, because I hate owing even \$5.” (Participant 8)

“I was spending 1000 bucks a week on stuff.” (Participant 11)

The audit of the EMR noted that 79% received health care provider interventions to increase their income. This included assessments and applications for disability benefits as well as increased access to additional income support funds for nutritional support and medical transportation. Providing additional sources of income to participants is about recognizing the link



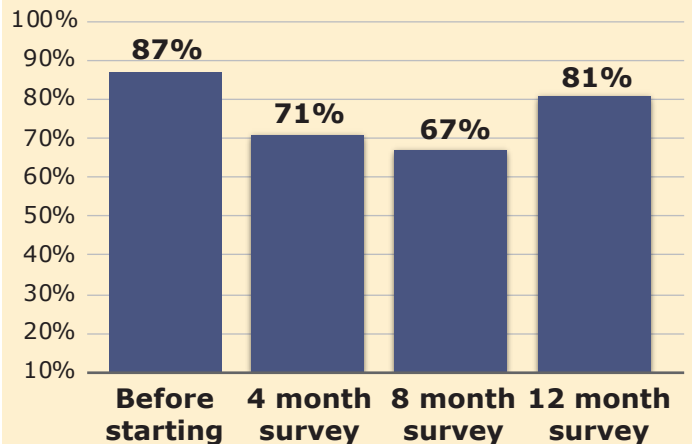
Benefits beyond the program

Other 360 NPLC clinic staff and partner organization staff noted an additional benefit of the trust that has developed between the participants and SSP staff. NPs at the clinic who are not part of the SSP, and managers of other support programs in the community noted an increasing trust, honesty and comfort from PWUD in sharing their drug use and health care needs with professionals. This increasing openness was attributed to the culture of trust and understanding that was at the heart of the SSP and the sharing of these positive experiences within the drug-using community. NPs at the clinic and other organisation staff noted that

between income and health outcomes. As Health Quality Ontario reports, “Poor people in Ontario pay for their low income with their health.”¹³

Despite these comments from participants and the data on those who have accessed additional funds, it would be misleading to see participants as financially secure as a result of participation in the program. In the participant assisted surveys, the majority continued to report that they struggle to find the money to meet their basic needs.

DIFFICULTY HAVING ENOUGH MONEY FOR BASIC NEEDS



Have you had difficulty having enough money to pay for your basic needs (food, clothing, shelter, medications) at any point in the last 4 months?
(data from participant assisted surveys)

clients were understanding that disclosing drug use did not have the negative consequences that they historically had expected, and this was attributed to the open, judgement-free culture supported by the SSP.

“One of them was in tears with one of the nurses one day because he just felt he could totally tell us the truth. And it didn't matter that he was injecting drugs. We just wanted to make sure that he was getting the right treatment based on the fact that he injects drugs, just like if he had another thing going on.” (Other clinic staff)

Positive life changes

Participants were asked what had changed in their lives since they started on the SSP. They also shared their hopes and dreams for the future and reflected on how these had changed since they started on the program.

Mental and physical health

Interview participants reflected on improvements to their physical and mental health. These improvements related to the security of having access to safer supply, the time and capacity to address underlying health issues, and the support of secure primary health care. This was in addition to the reduction in anxiety and fear associated with the toxic street supply.

“This is the best my health has been, better than in years.” (Participant 14).

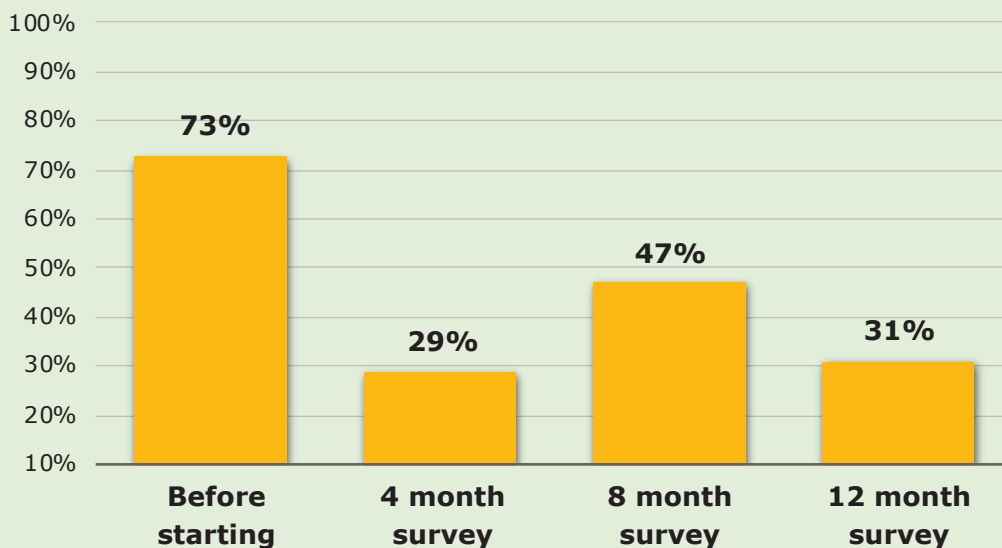
“I can function better. Let's me be more normal. Takes my body pains away. Takes away the thoughts in my head a lot of time too, right. It fills the void.” (Participant 16)

Responses to the participant assisted surveys support this picture of improving mental and physical health. Although the surveys indicate that many participants still struggle with mental and physical health issues, the majority of survey participants indicated that their health had improved since starting on the program.

After 12 months in the program, 75% indicated an improvement in physical health and 69% in mental health (data from participant assisted surveys).

Further evidence in improving health, including a reduction in overdoses, can be seen in the reduction in visits to the emergency department for program participants.

EMERGENCY DEPARTMENT VISITS IN PAST 4 MONTHS



Have you been to the emergency department for any reason in the last 4 months (regardless of whether you were hospitalized)? (data from participant assisted surveys)

Reconnection with family and children

One theme that emerged from the last round of staff interviews in October 2023 was participants starting to reconnect with family members and children. This experience was also reported in this latest round of participant interviews.

“Like I said, I got a good place to live. I make my appointments. I'm seeing my son every week. You know, I'm working at getting my son back. All areas of my life are getting better.” (Participant 15)

Reduction or elimination of street fentanyl use

The participant surveys and the program’s EMR data indicate that the majority of participants have reduced their use of illicit street drugs, in most cases this being a reduction in fentanyl use. Some participants have eliminated street-sourced drug use altogether. In the interviews, the reduction or

elimination of street fentanyl use was seen as a significant achievement by participants.

“Since I've been on the program, I've gotten off of fentanyl. And I've reduced my, my methadone and my Kadian. And, you know, it's given me chances to do more things because I wasn't headed for, I wasn't going in a good direction until I came here.” (Participant 1)

“If I can get off drugs. It's heading that way. I'm probably using like 10% of what I was when I started.” (Participant 14)

After 12 months in the program, 43% reported a reduction in fentanyl use and 43% reported being fentanyl abstinent, which represents 86% reporting a reduction in their use (EMR data).

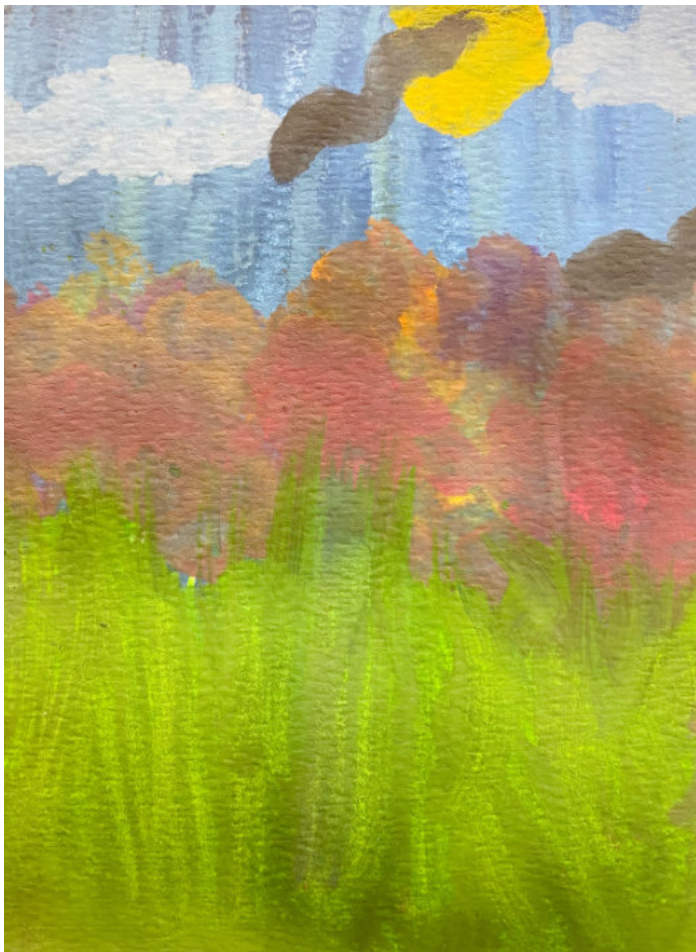
The interviews and survey responses also indicate that many participants have also reduced their use of street-acquired stimulants. For some the elimination of street drug use also meant the end of higher-risk practices such as injection.

“Oh, it's just, it's been life changing. You know? We're going to... we got rid of all the syringes and stuff now. You know, we're on a steady dose so we don't have to. I don't think we'll be doing that anymore.” (Participant 10)

For many, the ability to reduce or even contemplate reducing street fentanyl use came from the support the program provided and the encouragement received from staff in making the life changes they wanted.

“If you want to actually better yourself, they allow you, instead of feeling like you're trapped.” (Participant 9)

Results from the 360 NPLC SSP support reporting on reductions in fentanyl use found in research in other SSPs in Ontario and across Canada. ^{5,11,12,14}



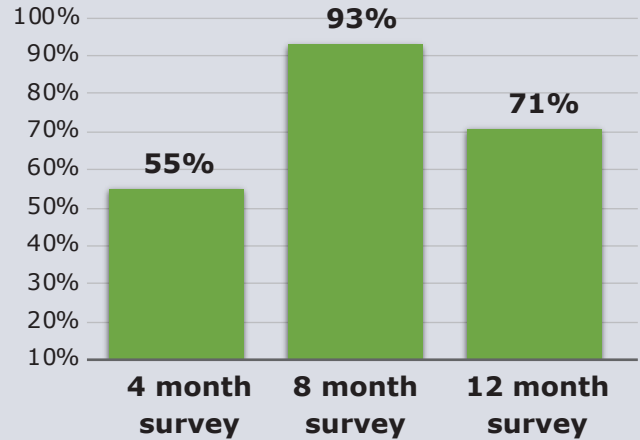
Ending higher-risk practices

Elimination or reduction in illicit street drug use and the security of the safer supply allowed some participants to end their engagement in higher-risk practices associated with their substance use. Two interviewees noted that they had been able to end their involvement in survival sex work, and others indicated that they had been able to stop other higher-risk activities thanks to the safer supply.

**“Not doing stuff you don't want to do just having your life back. Like you're not going out to do stuff to get money for drugs because you don't need them.”
(Participant 7)**

Reporting in the participant surveys also indicates a reduction in criminalized activities by Safer Supply Program participants.

SELF-REPORTED DECREASE IN CRIMINALIZED ACTIVITIES SINCE STARTING SAFER SUPPLY



Since starting Safer Supply, has involvement in criminalized activities decreased?
(data from participant assisted surveys)

Stability

All of the above life changes and benefits of the SSP lead to a picture of an emerging stability for participants. This was something that was noted by program staff in recent interviews, particularly for participants who have been in the program for a longer period of time (12 months or more).

For participants, stability meant many different things, ranging from connecting to friends and family, developing community, attending appointments, being free of the hustle of chasing money and street drugs, and a return of their sense of humanity.



Being able to hold you know, trust and family, friends, being able to show up to appointments, being welcomed into just the arms of the people around you in day to day life and not have to feel like you're an allegation to the fucking community or an outcast or you know, the black sheep, anything like that. (Participant 3)

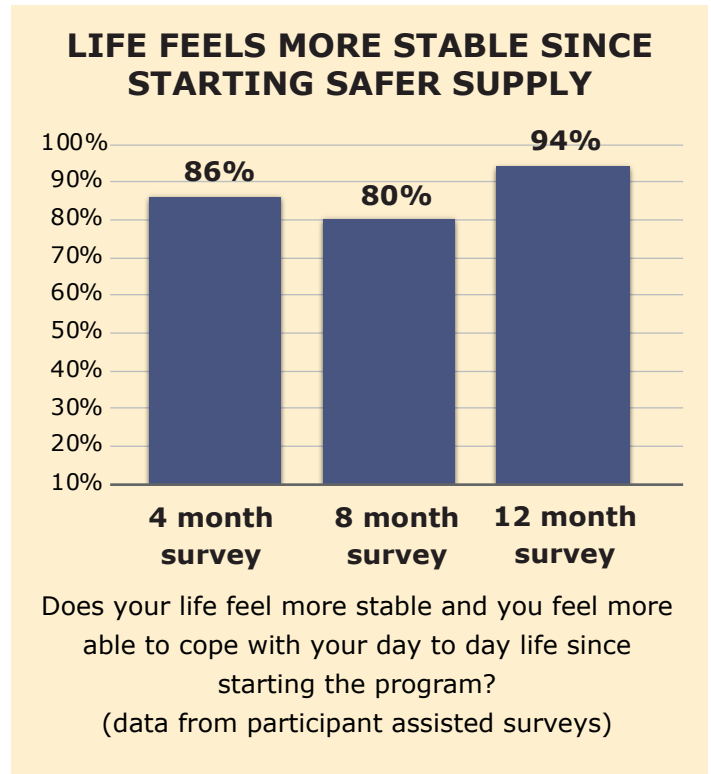
This stabilizes a lot of stuff. You know, it's making me human again. (Participant 11)

Participants gaining stability was also noted by other staff at the clinic and by staff of partner organizations. What stability meant often changed with job function, with medical staff seeing stability as attending appointments, and frontline harm reduction workers seeing stability as improving relationships in the community, and trusting support structures.

Stability is, is this idea that people can access their coping mechanisms without fear of death, or overdose. And being in a position of more security and less constant fear allows them to not be in that kind of sympathetic response throughout their lives, which allows them to make other decisions that are more beneficial for them, whether it be finding housing, volunteering, getting involved in community, finding ways of having money, to eat, addressing food insecurity.
(Other clinic staff)

Experiences reported by participants and staff of the program supports wider research on safer supply that indicates that a regulated supply of opioids not only reduces the risks of overdose but brings stability to the lives of participants.^{5,11,12,14,15}

This picture of increasing stability in participants' lives is supported by results of the assisted surveys.



The future

In both rounds of interviews, participants were asked about what they wanted next in life. In the first round, there was a focus on reducing or ending use of illicit street drugs and while this remained a significant focus in the second round of interviews, there was also the desire by some to reduce or even eliminate the need for safer supply medication.

And I have. I've cut down with those [safer supply medications] tremendously. I just want to get to the point where it's enough just to manage my arthritis, and that's it.
(Participant 9)



Though ending use of street drugs and reducing quantities of safer supply medication were desires of some participants, there was also a focus on other life goals such as work, school, and reconnection with children. In the second round of interviews, a positive future outlook was expressed more in terms of actually having the energy and agency to make changes, rather than hoping for this change.

I'm kind of thinking maybe school. I'm not sure what I want to take yet though.
(Participant 8)

Well, I want to try to go back to work. That's a new thing. I've been on disability for a long time.
(Participant 10)

Positive reflections on the program

Participants were asked to talk about what aspects of the program supported them in achieving beneficial life changes, and if there were any aspects of the program they did not like or would like to change.

Trust and an open relationship to staff

Participants often reflected that historically, attending medical appointments was a fearful experience where they felt judged and treated differently because of their addiction. These fears related to visits to the hospital, doctor's offices, and various addiction programs.

**I've been excited to come to the doctors [NP] rather than like "ohhh, god".
(Participant 8)**

In the first round of interviews there was a particular appreciation of the urine drug screening approach taken by the program, with non-observed urine tests focussing on informing participants about what was in the drugs they were using rather than a punitive approach leading to reduced medications. For many PWUD, the use of observed urine drug testing has historically been a negative, punitive, and traumatizing experience linked with systems of punishment and surveillance such as prison and child welfare systems. For others, the

experience of observed urine drug testing is a re-traumatizing experience that brings up histories of abuse and sexual trauma. The trusting and compassionate use of non-observed, non-punitive urine drug screens within the SSP builds trust and respect between participants and service providers, and fosters an environment of safety and care within the program.

You don't have to worry about the cameras looking at you. And I'm sure that you can cheat, you know what I mean? But the only person you're cheating is yourself, if you're gonna do that, you know? It's a lot less invasive. Whereas methadone, it's just, you got cameras looking at you. It's so, it's so invasive. (Participant 4 - first round of interviews)

Participants also reflected on the lack of judgement they felt from staff, which led to a more open and trusting relationship. This allowed participants to share their concerns and experiences without fear of changes in their medication or being excluded from the program.

**It makes me feel like I can come here and know I'm not going to be judged.
(Participant 7)**

Though staff having lived experience of addiction and homelessness was not directly mentioned by interviewees, there are strong indications that staff knowledge and experience is implicated in the comfort participants feel with staff.

Everybody here knows, you know, knows the lifestyle or knows somebody that's had the lifestyle so it's not like it's something that you gotta be embarrassed about. (Participant 1)



In the first round of interviews, the positive and supportive approach of the staff was often mentioned ahead of the safer supply medication as the program's primary benefit, and again participants indicated that staff had an understanding of their experiences.

Having somebody that has more of an understanding of something or a problem, and having them help. It's a lot easier than say somebody's going to school or something, doing their research, but not physically understanding what it is. (Participant 8 - first round of interviews)

The management of appointments and the waiting room

The program's understanding of the challenges of addiction and homelessness is also reflected in the structure of appointments and how the waiting room is managed. Participants are given a specific date for their appointment, but in contrast to most medical appointments, missing this time does not exclude access to medical or non-medical staff. Rather, it is understood that a time represents a guide/goal to which participants should work. For most participants, this was seen as a positive aspect of the program that contrasted to other medical appointments.

Yeah, exactly. If someone comes in, you may have to wait for the person that was here on time to go through, but you still have your appointment yeah. (Participant 14 - first round of interviews)

With administration, management and social support staff all working much of the time in the waiting room, participants can also connect with the wider SSP team while they wait to be seen by a nurse or nurse practitioner, or after appointments. These staff can supply snack bags, harm reduction supplies, check in regarding other needs, and provide reminders and support for other appointments. This has led to participants having a sense of ownership of the space and allowed for participants to drop in to the program on days

when they don't have a scheduled appointment. The majority of interviewees noted that this was something they did and many commented positively on the experience of the physical space of the program.

Oh, it's nice. It's especially one place that you feel comfortable. It's actually one of the few places around that I do feel comfortable. (Participant 9)

It's like home, it's family. Everybody. Everybody's relaxed. It's family. You come here, you just feel like home, yeah. (Participant 13)

The design of the physical space and the deliberate ease of access to staff was noted by partner staff and other non-SSP clinic staff as a key aspect of the program that contrasted with conventional medicalized spaces. This openness was seen as something of a radical departure for a health care program and something that changed the relationship between staff and participants.

Just the space that they created there, like the fact that there's the art on the wall, that it's like, it's very intentionally designed to not feel sterile and to feel like a community space where you're supposed to feel comfortable. I think that's a huge part of it, too... If you make a space where people want to congregate, then people will and then they will accept help when they need it. (Partner staff)



Access to supports

Participants regularly noted that the program offered them supports in many aspects of their lives that go beyond the safer supply. This included help with obtaining ID, negotiating with Ontario Works, court support, accompaniment to, and reminders about, medical appointments, and providing snack bags and juice boxes.

These supports were appreciated not only for their specific benefits, but also for the message this type of support conveys about how the staff relate to the participants.

Makes you feel like they got your back, you know, even the littlest thing... No one was dealing with the individuals the way you do.
(Participant 11)

Participants were specifically asked in the second round of interviews how they felt about accessing harm reduction supplies from the SSP. For some this was no longer necessary as they had stopped smoking or injecting, but for others, a non-judgemental response to requests for harm reduction supplies was appreciated and this was at times contrasted to other organizations.

It's comfortable and relaxed. You know, don't feel like you're doing something wrong.
(Participant 15)

Agency over their own health care

At the heart of a relationship-based health care model is the wish to give agency to participants in determining their own health care pathway. This sense of control and support of participant decision making was noted in the interviews.

Yeah. Cuz when you tell ____ or ____ they're like pumped for you. They encourage you. And I love that. (Participant 8)

The combination of relationship building between staff and participants, the return of time and agency to participants, and the non-judgemental approach to participants from staff all contribute to

the significant uptake in primary health care noted in program benefits above. This is a common experience with other SSPs and was also noted by partners and other clinic staff.^{5,11,12,15} The uptake in health care is also matched with an engagement in social supports.



We're seeing folks getting their foot into the door of like, all the resources available to them, because now they're walking through the door of safer supply, and like building that trusting relationship with the workers there, that now they're being connected to other agencies where they might need to use their resources. (Partner staff)

In interviews, participants also reflected on mostly positive relationships to pharmacy staff and the experiences of picking up their medications.

The pharmacy is great too. They treat you like you're at home over there too.
(Participant 13)

SSP as community and the return of humanity

Interviewees offered a number of reflections on how the SSP had developed a sense of community with them, both between participants and staff, and also between the participants themselves. This development of community was attributed to trust and lack of judgement from staff, the understanding that participants could drop in between appointments, and the programming offered by staff. Programming included twice monthly art events, ongoing drop-in activities and social space in the waiting room, and in the summer of 2023, a community garden that focused on Indigenous growing practices and medicinal plants.

Here everybody's more friendly. It's more of a little tight-knit community in a weird way. (Participant 9)



Participants also appreciated being able to drop into the clinic between appointments to access snack bags, harm reduction supplies, or just to make social connections with staff and other participants.

12 of the 16 interviewees indicated that they visited the clinic between appointments for snacks, harm reduction supplies, or just to catch up with staff.

This idea of reconnection and the development of community was also recognized by staff in their interviews where the development of community was seen as a positive benefit of the program.

So, they come in just to chat, people come in when they don't have an appointment just to hang out for a bit. Just, you know, it's a quiet space, but they like coming by. It's the sense of community and belonging, was what I did not expect. (SSP staff)

Staff noted that as participants have been in the program for longer, this emergence of connection coincided with a return of a sense of personality and humanity.

And I think that giving people that level of empowerment and seeing things in people they don't see in themselves yet, I think is a big part of that benefit. And for someone like me, going back a number of years when that I was in that position, like, I know how much that benefits that person, even if they don't say anything, like being seen, being heard, being like, engaged with, having people that are like playful and curious, and you know, want to do weird little things together, to be creative, to share food together, create those opportunities for us, because we know, in the work that the opposite of addiction is connection. (SSP staff)

For staff and participants, the development of community and trust was strongly connected to the radical way that the program's space was used. This was not only about making it clear to participants that this was their space and that they could drop in anytime the program was open, but was also connected to having staff base themselves in the waiting room for many of their day-to-day activities. For support, admin and management staff, the confidential spaces in the back of the clinic were used when necessary, but most of the time they were in a position to acknowledge the arrival and presence of participants when they walked in.

Partner staff noted this value in relation to experiences of being homeless and the constant need to be on alert while living on the streets.

[The program provides] a space where their guard can come down, you know, and they don't have to be on high alert and constantly looking over their shoulder in fight or flight mode... (Partner staff)

The deliberate, open structure of the program that provides a sense of safety for participants not only supports those participants, but also supports staff in seeing the benefit of their work.

I constantly say that like my favourite thing to ever witness is people who use drugs who felt hopeless and self-loathing and in despair and, you know, at the point where they did not care if they lived or die, see the light come on, for people. Like, gets me every time, seeing personalities come up where there was like before just a husk. Seeing people laugh for the first time in a long time, like just watching people become human when given the opportunity to do so. (SSP staff)

The value of staff with lived experience

Staff and participants noted the value of lived experience in the creation of this sense of community. Staff with lived and living experience brought a sense of joy to the space and a shared sense of humour between staff and participants that often bridged the gap between health care and



participants. Having staff with lived and living experience take part in drop-in programming also encouraged participant engagement and supported participants' forms of expression.

The value of lived experience and the ethos of the program was summed up by one program staff member as follows:

Like the grace, I don't know how to explain it because it's like... I don't know where I heard this, but it's impacted me the most in this position, in this place and spaces; like I hope if I ever lose my way and find myself somewhere that I don't come from, and people think I don't belong in, that somebody has the humanity and the grace to like, just gently pick me up and put me back in the direction of where I need to go. You know, I don't know if that makes sense. (SSP staff)

Staff also noted that the combination of staff with lived experience and the unconventional approach to space management and participant reception illustrated a radical and progressive approach to providing health care that was instructive to other health care providers and the general working of the 360 NPLC clinic.

I think it [SSP] grounds us, it makes us more aware of our community and how we can better serve it. I think that the lived experience component has been essential in changing our policy at 360 as well in terms of being more aware of, of our clientele in marginalized communities, and what they need and how to best serve them. And having people with lived experience on staff at SSP has brought that component into the 360 to a greater degree as well. (Other clinic staff)

I don't know what the effect size of planting a garden is on someone's drug usage, but just being with other people and being seen in that humanistic way and having relationships based in love and trust is incredibly important, I think, in a very long-term way... (Other clinic staff).

Program limitations

So far, this report has focused on participants' positive responses to the SSP, but participants did have some criticism of the program and noted areas they would ideally like the program to change or develop. Program changes focused on a wish for carries and different medications.

Getting carries

A small number of the participants interviewed were already getting "carries", i.e. they didn't have to go to the pharmacy every day to get their medications, but could go 3-4 times a week instead and pick up multiple days' doses in a single visit. However, the majority were attending the pharmacy every day to take their witnessed dose and then receiving that day's supply of Dilaudid. This was a point of frustration for some who noted the inconvenience of attending the pharmacy every day, and how this was both time consuming and for some an impediment to making other changes in their lives.

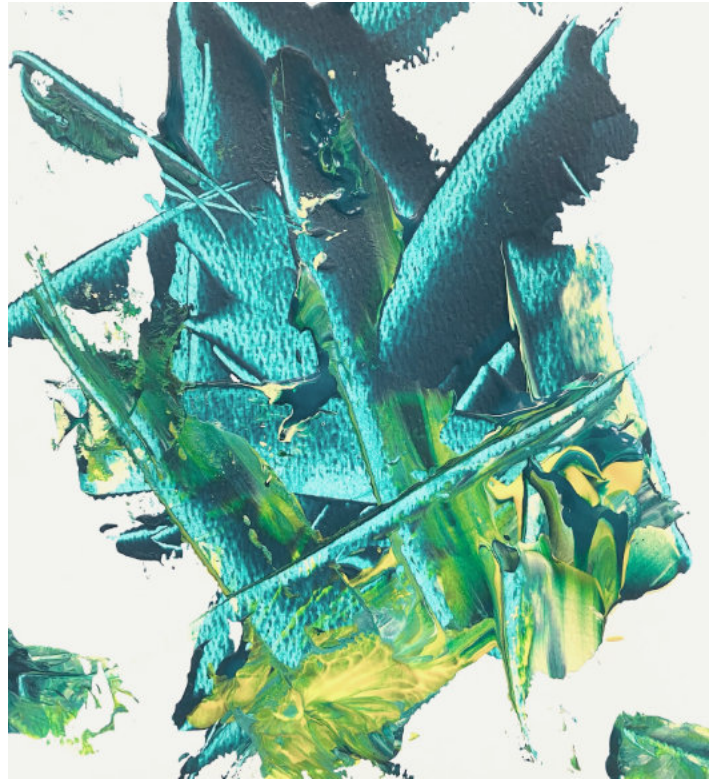
I would love having carries, because it does suck having to get up and go downtown every fucking day. (Participant 3)

Different medications

In both rounds of interviews, participants spoke of a wish for different medications, in many cases a wish for a safe prescription of fentanyl and a product that could be smoked. Others asked for heroin. In the context of different medications, people also wished for forms of legalization or decriminalization. Prescriptions for stimulants such as crystal meth or cocaine were also asked for.

I would want fentanyl. Like actual fentanyl. Like because I've had fentanyl before, and it helps me. (Participant 4)

This wish for a wider range of opioids to be available in the program was also reflected in staff and partner staff interviews. Comments were often made in the context of limitations of prescribing options in Ontario and also the inability of current



options to meet the needs of participants who had developed a high tolerance to the current street supply or wished for a smokable option.

I think we're doing the best we can given what we've got. If we were truly delivering what people are asking for, we would have smokable options in the prescriptions, we'd have fentanyl. (SSP staff)

Other research on safer supply and more broadly on the needs of PWUD indicate the need for the range of medications available on SSP to more closely match the potencies, euphoric effects, and consumption methods of street drugs. Notably, the increase in smoking as the route of consumption and the lack of provision of safer inhalation sites across Ontario, highlights the need for prescribed, fast acting opioids that can be smoked.⁵ More closely meeting the needs of program participants would also reduce the likelihood or need for participants to divert their supply in order to purchase their drugs of choice. The participant interviews and recent research also indicates the positive value of the prescription of safer stimulants.^{16,17}

Diversion

A fuller discussion of diversion and how the 360 NPLC SSP manages diversion (the practice of program participants' sharing, selling, trading, or giving away their medication), can be found in the parallel report:

Embedding a Safer Supply Program in a Small Urban Community: Peterborough 360 Degree Safer Supply Program Evaluation May 2022 through December 2023

What follows here are participant, staff and partner staff responses to being asked about diversion in interviews.

Participant perspective

Though some interview participants were critical of the practice of diversion, most expressed a neutral position, reflecting that it was not for them to judge how others used their medication. Participants noted that economic pressures, the wish to support friends, and the inadequate strength of the safer supply medications impacted decisions around diversion.

Some people have to do what they gotta do. Not gonna judge against it. Sometimes someone's hungry, or for a few extra dollars. Don't blame them one bit. (Participant 9)

The limited capacity of SSP to meet the needs of the community was noted and diversion was associated with increasing the safety of friends and an act of compassion and mutual aid. This response from participants to diversion is also seen in other research.^{5,17,18,19}

I'll take the chance of getting into trouble giving away part of my prescription, you know, rather than see that person die, and then I try and talk them into coming in and try the program themselves. (Participant 15)

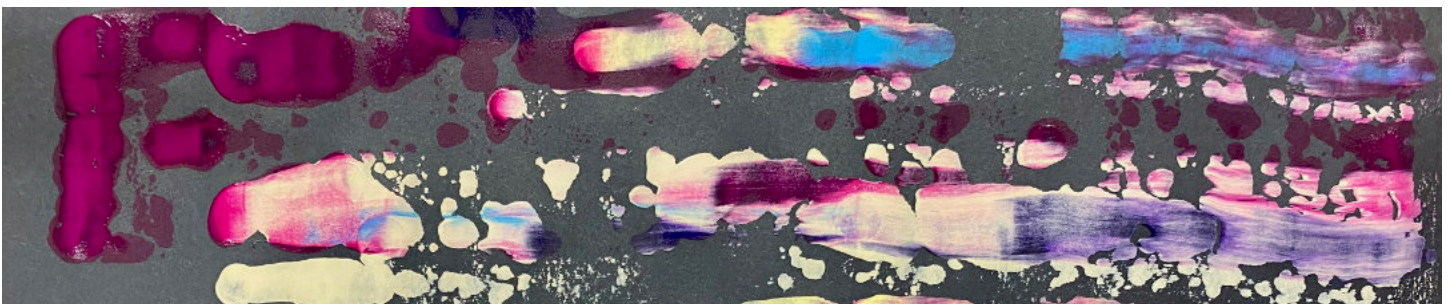
Participant interviews and other research illustrate that diversion is a complex issue and not simply a wish to profit from, or deliberately exploit, a medical program. It should also be noted that diversion is not new, or unique to SSP.^{5,9,15,17,18}

Partner staff and clinic staff perspectives

In staff interviews the issue of diversion was noted in the context of the inability to prescribe the most effective medication to meet the needs of participants. It was also suggested that looking at diversion as a failure of SSP or a moral failure on the part of individual participants was to miss underlying causes of diversion and addiction. Both histories of trauma leading to addictive behaviour and economic pressures on those marginalized by addiction were noted by other staff at the 360 NPLC.

And it's [diversion] a poverty issue, rather than necessarily being a drug issue. (Other clinic staff)

If we wanted to look at the greater context, we need to worry less about diversion and worry more about mental health resources. Because if you had somebody in childhood that didn't have trauma, or that had the resources to deal with their trauma in a timely way, then they might not need to turn off in adulthood. (Other clinic staff)



Ongoing challenges for PWUD

For all the benefits the program has brought to participants, many face significant ongoing challenges around criminalization, the toxicity of the street supply, the ongoing housing crisis in the community, the collective trauma of losing friends, and many noted continuing negative reception in other health care environments.

Criminalization

Frustration at the ongoing criminalization of addiction, poverty and homelessness was noted by a few. A history of arrests and charges that pre-date their time on the SSP have also followed a number of participants. For all the benefits of the program, as can be seen below, some participants continue to have significant police contact indicating the generalized experience of the criminalization of PWUD.

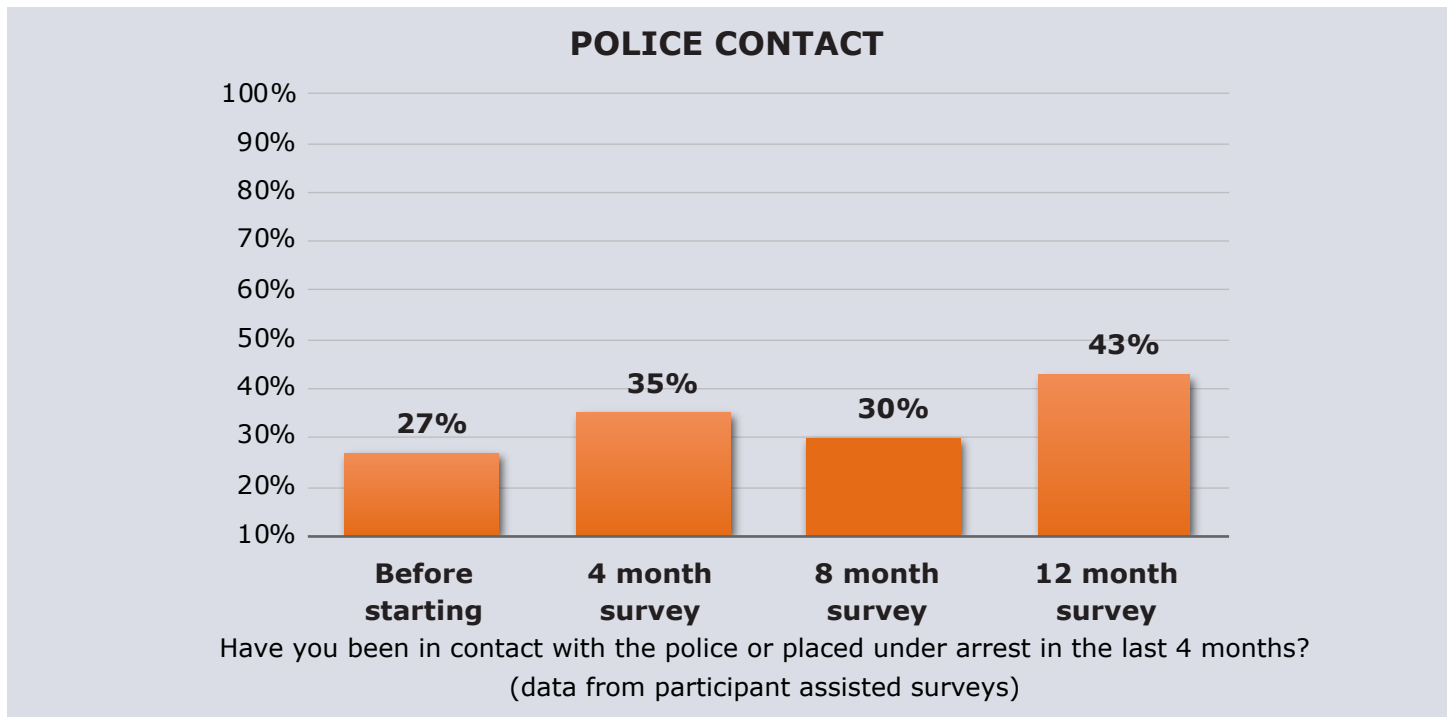
Dangerous street supply

In both rounds of interviews, participants also noted the ongoing dangers of the unregulated, illicit street supply and the threat it presented to them.

Hopefully it's fentanyl. But these days, there's Xylazine, benzos, 17 other different chemicals? I don't know. (Participant 8)

Collective trauma

In the first round of interviews, there was a sense of collective trauma expressed at the number of people who have died of drug poisonings or overdoses and the impact this has had on individuals, but also on the broader community.



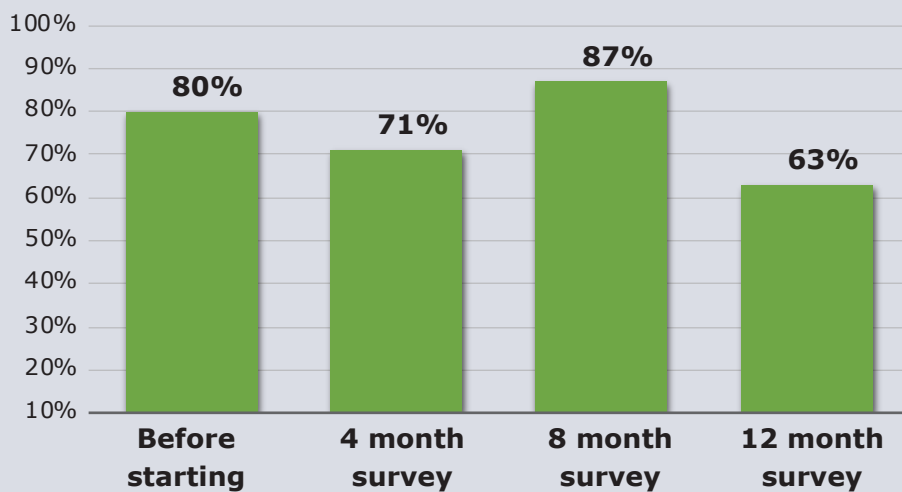
It's just incredible to see how like...people have passed away. You never would have expected it. Like the overdoses have been, I mean, I've lost so many friends due to the overdose problem. And I have three people right now in intensive care that are good friends of mine that were overdoses or our kidneys are shutting down. Whatever they're cutting the drugs with. It's definitely not good. (Participant 6 – first round of interviews)

Housing crisis

As noted, in *Participant background* above, the lack of affordable housing continues to be a challenge for the majority of participants in the

program. This is reflected in both the assisted surveys and interviews. Peterborough has an overall rental vacancy rate of 1% with median rental cost of \$1100 monthly and average rental cost of \$1235 monthly.²⁰ Given that 97% of participants have an income below the Low Income Cut-Off for a city having a population between 30,000 and 99,000 people, it is not unexpected that at any given time many participants experience housing precarity or homelessness.¹³ This data is reflected in the findings from the EMR audit and assisted surveys, both of which indicate significant housing instability. The graph from the assisted surveys on experiences of homelessness is repeated here to emphasize this point.

EXPERIENCED HOMELESSNESS FOR AT LEAST 1 NIGHT IN THE LAST 4 MONTHS



Have you experienced homelessness for at least one night at any point in the last 4 months? (data from participant assisted surveys)



Challenges associated with unstable housing and homelessness noted by participants included shelters that take an abstinence approach to drug use and exclude those who do use substances, issues of poor quality housing that are subject to landlord and drug activity-related interference such as housing unit takeovers, and the risks of victimization and physical exposure associated with sleeping outdoors.

Yeah well, for example, because of a disturbance last night which wasn't even my fault I was kicked out of the [shelter] at three o'clock in the morning and I can't go back there till nine tonight... Like all day I just got to walk around the city with no food. I mean like that's not a good way to live... I spent three years in a tent. Last winter I spent in the tent I almost died. (Participant 1)



In both rounds of interviews, participants also reflected on the the desire to use substances to provide an escape from the difficult experiences of being unhoused.

Everybody being depressed stuck outside with no place to go. Of course, you're going to want to be high all the time, when your life's miserable and you've got nothing else. Yeah, sleep couple hours away, have that bit of like...yeah, I don't blame them. I've been there myself. (Participant 9)

Reflections on the lack of affordable housing and the challenges of homelessness were also part of staff and partner interviews. It was noted by program staff and partner staff that there were limits to the stability participants can achieve while remaining unhoused and that being homeless was often a 'full-time job.' The inability to address participants' housing status was often expressed as a frustration for staff and something that placed additional stress and risk of burnout on both program, clinic, and partner staff. These challenges are also reflected in other reporting on SSP.^{5,12,15}

So, although we can listen to it, I can't make housing affordable in the City of Peterborough. (SSP staff)

Though based on a small sample size, analysis of the assisted surveys indicates that those who remain unhoused are likely to also have higher levels of police contact, are more likely to visit the emergency department, and are less likely to use new or sterile drug-use equipment each time they use.

Attending medical appointments

While many noted the benefit of being referred for medical appointments and treatments that addressed underlying health conditions, when asked specifically about how they were treated when they attended appointments, most noted that they continued to feel judged and marginalized by other community health care providers outside the SSP.

I think that they just look at me like oh, here's another fucking drug addict and just push everything else aside. (Participant 6)

Despite these uncomfortable experiences in other medical environments, participants appreciated the opportunity to address underlying medical conditions and improve their overall health; the value of having access to health care outweighed this negative reception. Further, knowing that they had a supportive primary health care provider to go back to appeared to reduce the impact of these experiences, with a number noting that they didn't care what reception they received.

I remember being in that place or like being called a druggie, like brought me to tears like. No, I'm not! (Participant 8)

Tenuous funding and small-scale programs

In both rounds of interviews, participants called for the expansion of the program so that their friends and community could also benefit from access to safer supply. Participants often noted the continued risks faced by other PWUD whose need to alleviate dopesickness left them dependent on the toxic street supply. This limitation to the program was also recognized as a source of stress for program staff.

In the middle of March 2024, the program received one more year of funding which was granted just 2 weeks before the program was due to close. Though the 360 NPLC had capped program participants at 41 in order to be in a position to integrate these participants into the main clinic,

this still placed significant stress on program staff and the wider clinic. In the run up to this expected closure, staff faced the need to balance their wish to continue to support participants and be part of the future of the program, if it had one, with their own need to seek secure employment. As was noted by the program manager, SSPs have been rightly encouraged to employ people with lived and living experience, but by the nature of late commitment annual funding, this employment always remains precarious for individuals who may already face employment challenges and marginalization.

Program staff wanted to make clear that the stress of short-term funding with short notice renewals that SSPs face has a significant negative impact on how programs retain staff, manage the stresses of the work, and support participants.

The team went through huge and really unnecessary amounts of stress in relation to the future of our funding. We had no idea if our program was continuing or not, and the uncertainty of that was not only harmful for program participants, but also hugely harmful for program staff and the clinic as a whole. The stakes are so high in this work, and it feels disempowering and even hopeless to know that our futures are held in balance by higher-ups that don't know our work, our names, or our stories.
(SSP staff)



Conclusion

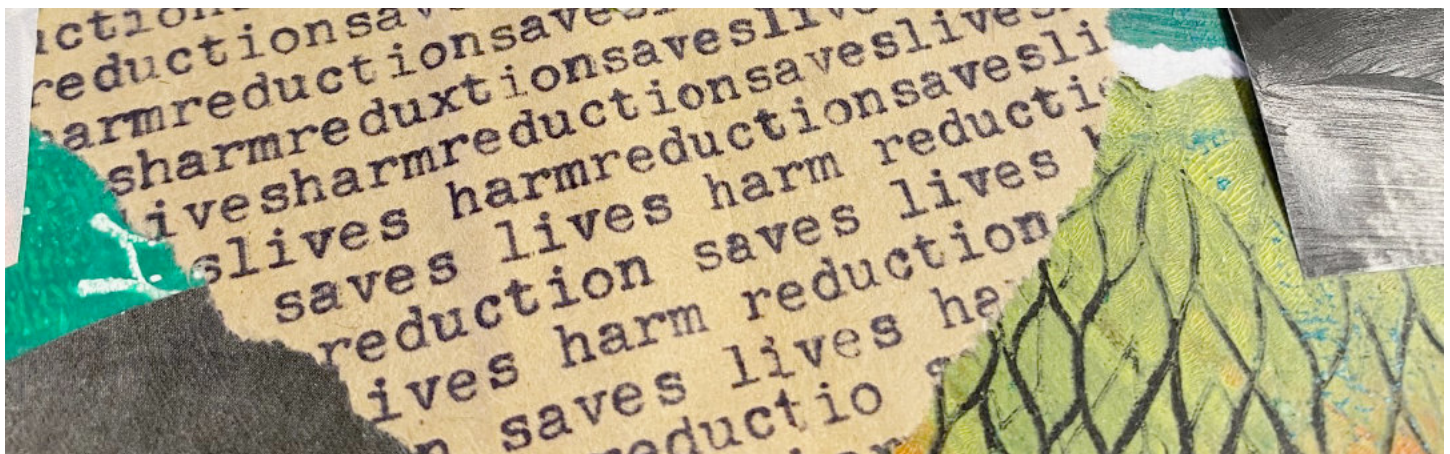
In reporting on the content of these interviews, there is a wish to reflect on the diverse stories told by participants. Some had a history of severe and chronic pain leading to a prescription for opioids that was later rescinded, others have had to deal with significant unresolved trauma. Some expressed that unregulated street drug use was part of their way to escape the pain and frustrations of being unhoused. As noted above, almost all participants had tried other approaches to manage their drug use prior to accessing the SSP. It is therefore worth reiterating that participants come to this program via complex and often very difficult experiences, and recovery or abstinence-based approaches are not always accessible, appropriate, or desired for many PWUD. This message needs to be shared with those who continue to question safer supply and other harm reduction practices as valid, pragmatic, and compassionate responses to the ongoing drug toxicity crisis.

The combination of safer supply medications, primary health care, social support, and a participant-centred approach has clearly created a structure that supports participants in their own goal setting. Even those who continue to struggle in their day to day lives while on the program and continue to deal with challenges like homelessness, have benefited from the community, health care and social supports provided. The lack of judgement participants face when things don't go to plan, and the continuing support and expressing

faith in the participants who are struggling the most is also worthy of note. From both participant and staff perspectives, critical to the success of the program has been the development of community that has come through a radical approach to managing a health care space and developing relationships with participants that empower those participants in relation to their own health care.

Despite these clear benefits, participants noted a number of frustrations and wishes for changes. Most common was the wish for different medications, in many cases a wish for a pharmaceutical grade safer supply of fentanyl. Often participants would note that other medications were available in other parts of Canada and their wish to have access to these. These comments from participants join the wider call from the safer supply community for prescribing options to more closely match the needs of PWUD, including smokable options.^{5,12,14}

Alongside this, participants, staff and advocates continue to call for the wider availability of safer supply, an approach to the drug toxicity crisis that is, where available, clearly having positive impacts. Specifically, for the provision of safer supply medications in conjunction with primary health care, social supports and ideally housing supports, these services being critical to addressing the long-term marginalization faced by people who use drugs.



Recommendations

Continue to fund and support SSPs and scale up to meet community needs: With the increasing evidence that SSPs are saving lives and changing lives, safer supply (prescribed alternatives) programs should be scaled up to meet the needs of those community members who would benefit from access to a safer supply of opioids. The development of safer stimulant supply should also be considered. While recognizing that safer supply is only one of a range of productive responses to the drug-toxicity crisis, the growing evidence supports the efficacy and validity of SSPs.

Include the provision of primary health care and social supports in SSPs to maximize participant benefit: It is clear from the review of the EMR data, interviews, and participant surveys, that access to primary health care, social support and community-building are valued and critical aspects of the SSP at the 360 NPLC. It is therefore recommended that SSPs include these provisions to maximize the benefit SSPs bring to participants.

Make steps towards addressing the housing crisis across Canada that is implicated in the marginalization of those who live in poverty and those who live with addiction: Without adequate housing provision, there is a limit to the stability that participants in SSPs can achieve. At times during the 2 years of the program, the majority of participants in the 360 NPLC SSP have experienced homelessness.

Campaign for a broader range of medications: While the current medications available for safer supply in Ontario meet the needs of some program participants, many would like to access alternative medications that more closely match the street supply. This includes options that can be smoked and access to pharmaceutical fentanyl. More closely matching the needs of participants would also reduce the need for diversion of medications in order to access street drugs.

Focus on SSPs that build community and relationships: The 360 NPLC SSP encourages the development of SSPs that include the lived and living voices of PWUD and takes into account the reality of the lives of PWUD in developing the structure of programs. This includes the provision of physical space for community building and programming, and a flexible approach to appointments and how social supports are accessed.

Continuity of care and access to safer supply for participants who are hospitalized or incarcerated: There is a need for collaboration between services to make sure SSP participants can maintain their safer supply in hospitals and prisons. Safer supply needs to be understood as essential health care, with equitable access to health care being recognized as a basic human right for all, rather than just a luxury for some.

Support safer consumption sites that include inhalation: With the clear evidence of the move away from injection to smoking, there is a greater need than ever for safe consumption sites to be maintained and supported across Ontario and Canada, and for these sites to allow for the safe smoking and inhalation of drugs and medications.

Continue education activities: SSPs need to continue and develop education and training activities for health care professionals, law enforcement, all levels of government, and the community at large on the role of safer supply as one of many needed responses to the drug poisoning crisis.

Improve the scope, quality and availability of mental health services: Governments at all levels need to recognize the unaddressed need for mental health services for all ages, that along with poverty, homelessness and marginalization are implicated in the wish to use drugs to escape the pain of childhood and adult trauma.

References

- 1 Government of Canada. Federal Actions on the Overdose Crisis, 2023. <https://www.canada.ca/en/health-canada/services/opioids/federal-actions/overview.html#a1>
- 2 Public Health Ontario. Opioid-related morbidity and mortality in Ontario. 2023. <https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool>
- 3 Peterborough Public Health. Opioid Harms Data Portal. 2023 <https://www.peterboroughpublichealth.ca/your-health/drugs-and-harm-reduction/opioids/opioids-data/>
- 4 Canadian Association of People who Use Drugs. Safe Supply Concept Document (2019) [https://www.substanceusehealth.ca/evidence-brief#:~:text=Safe%20supply%20refers%20to%20regulated,therapies%20\(CAPUD%2C%202019\)](https://www.substanceusehealth.ca/evidence-brief#:~:text=Safe%20supply%20refers%20to%20regulated,therapies%20(CAPUD%2C%202019))
- 5 Kolla, G. & Fajber, K., 2023. Safer Opioid Supply Program Evaluation: A comparison of SOS client outcomes from 2022 and 2023. London, ON: London Intercommunity Health Center.
- 6 Special Advisory Committee on the Epidemic of Opioid Overdoses. 2023. Opioid and stimulant-related harms in Canada. <https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/>
- 7 Tyndall M. Safer opioid distribution in response to the COVID-19 pandemic. International Journal of Drug Policy. 2020 Sep;83:102880.
- 8 Government of Canada, Statistics Canada, February 2022. "Profile table, Census Profile, 2021 Census of Population - Peterborough [Census metropolitan area], Ontario". www12.statcan.gc.ca.
- 9 Kolla G, Long C, Perri M, Bowra A, Penn R. Safer Opioid Supply Program: Preliminary Report. London: London Intercommunity Health Center; 2021 <https://lihc.on.ca/wp-content/uploads/2022/01/2021-SOS-Evaluation-Full.pdf>
- 10 Gomes T, Kolla G., McCormack D., Sereda A., Kitchen S., Antoniou T. Clinical outcomes and health care costs among people entering a safer opioid supply program in Ontario - Appendix 1. CMAJ. 2022 Sep 19;194(36):E1233–42.
- 11 Haines, Hill, Kerwin, Tefoglou, & O'Byrne. 2023. Safer Supply Ottawa evaluation: Fall 2023 report. <https://safersupplyottawa.com/research/>
- 12 Perri, M., Fajber, K., Guta, A., Strike, C., Kolla, G. 2023. Outcomes from the Safer Supply Program in Kitchener-Waterloo. Report 1.
- 13 Health Quality Ontario. Income and Health: Opportunities to achieve health equity in Ontario. Toronto: Queen's Printer for Ontario; 2016. <https://www.hqontario.ca/Portals/0/documents/system-performance/health-equity-report-en.pdf>

- 14 McMurchy D., Palmer R W H. Assessment of the Implementation of Safer Supply Pilot Projects. Ottawa, Ontario. 2022.
- 15 Henderson N, Marris J., Woodend K. "And this is the life jacket, the lifeline they've been wanting": Participant perspectives on navigating challenges and successes of prescribed safer supply. PLoS One. 2024 Mar 22;19(3):e0299801. doi: 10.1371/journal.pone.0299801. PMID: 38517923; PMCID: PMC10959334.
- 16 Haines, M., Tefoglou, A. & O’Byrne, P. 2023. Safer supply Ottawa evaluation. <https://safersupplyottawa.com/wp-content/uploads/SS-Ottawa-Eval-Report-Spring-2023.pdf>
- 17 Hardill, K., King, C., (2024). Embedding a Safer Supply Program in a Small Urban Community: Peterborough 360 Degree Safer Supply Program Evaluation May 2022 through December 2023. Peterborough 360 Degree Nurse Practitioner-Led Clinic, Peterborough, ON.
- 18 National Safer Supply Community of Practice. 2022. Reframing diversion for health care providers. <https://www.substanceusehealth.ca/sites/default/files/resources/ReframingDiversionForHealthCareProviders.pdf>
- 19 British Columbia Office of the Provincial Health Officer. 2023. A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action. British Columbia, Canada. <https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/a-review-of-prescribed-safer-supply-programs-across-bc.pdf>
- 20 Canadian Mortgage and Housing Corporation. 2023. Primary Rental Market Summary Statistics. <https://www.cmhc-schl.gc.ca/search#q=peterborough%20ontario>

**Peterborough 360 Degree
Nurse Practitioner-Led Clinic**



Contact Information:

Peterborough 360 Degree Nurse Practitioner-Led Clinic

705 874 3900 (phone)

info@nplc.ca

www.360nursepractitionerledclinic.ca