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Viewpoint

The Rise and Fall of Safer Supply Programs in Canada

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Since its emergence in the mid-2010s, Canada's opioid toxicity crisis has been relentless. Since 2016, more than 53 300 individuals have died due to opioid toxicity, with 2787 deaths reported in the first half of 2025 alone, 97% of which were unintentional.[1] Fentanyl and its analogues were implicated in approximately 60% of deaths and 83% involved nonpharmaceutical opioids.[1] Against this backdrop, the concept of prescribed safer supply gained traction. This novel approach provides low-barrier access to pharmaceutical-grade medications of known type, quality, and composition for individuals who would otherwise use unregulated substances. Unlike standard treatments, safer supply offers unwitnessed, flexible dispensation to prevent overdose among individuals for whom traditional therapies (eg, methadone) have failed.[2]

The first safer supply program in Canada was implemented in 2016 by the London InterCommunity Health Centre, evolving from grassroots advocacy.[3] The COVID-19 pandemic accelerated national expansion, with programs rapidly scaled up and funded primarily through the Substance Use and Addictions Program of Health Canada, the country's federal health agency. Yet just 5 years later, safer supply programs were abruptly deimplemented by the same federal government that implemented them, leaving clients and health care professionals in limbo.[4] The rise and fall of these programs offer a rare, real-world experiment in understanding the pitfalls of implementation and, crucially, deimplementation of complex health interventions during a public health emergency.

Early evaluations suggested that safer supply programs were achieving important health metrics among clients, including reduced overdose risk, improved withdrawal management, and, in some cases, stabilization of housing and employment.[2,3,5] Some models demonstrated high innovation: for instance, MySafe biometric dispensing machines enabled low-barrier access and increased autonomy, while their client-driven design fostered trust.[6] The integration of wraparound supports (ie, primary care, mental health, social work, and housing) proved critical to retention.[2,7] Programs that prioritized flexible delivery were more successful in reaching marginalized populations with complex needs, whereas rapid pandemic adaptations (eg, telehealth, take-home doses) helped maintain access during service disruptions.[7] However, these early successes masked significant implementation challenges that would ultimately threaten program sustainability.

The programs' rapid scale-up, deemed necessary in the face of a public health emergency, exposed significant implementation risks when not matched by adequate infrastructure or sustainable governmental support.[8] Many programs faced persistent organizational barriers. Staff shortages, burnout, limited physical space, and insufficient medication options constrained service delivery. Short-term pilot funding created instability, making it difficult to plan for long-term sustainability or invest in robust infrastructure.[8]

Most critically, scale-up occurred without a standardized care model, a challenge inherent to innovative interventions for which no preexisting standard exists. Rather than developing and iteratively refining a consensus-based model in parallel with expansion, variability in provincial policies created inconsistencies, with regions enacting disparately restrictive guidelines lacking clear regulatory frameworks.[8] The absence of national consensus on eligibility, dosing, and carry protocols created a fidelity gap, not to an established model, but to the minimum standards required for consistent, defensible care. This heterogeneity left health care professionals navigating ambiguous guidance, increasing administrative burden and prescriber risk aversion. Geographic disparities were

also stark, and rural and remote communities faced compounded barriers, including fewer prescribers, greater travel distances, and less outreach infrastructure.[9] Furthermore, clients frequently reported that available prescribed options, primarily hydromorphone tablets, were far less potent than unregulated fentanyl, leading to supplementation with unregulated drugs.[7] Most notably, the absence of standardized national evaluation frameworks not only hindered outcome comparison across programs but created unreasonable expectations—expecting small pilot programs with a total of a few thousand participants across the country to demonstrate population-level reductions in opioid-related mortality or housing improvements amid a national affordability crisis.

Underlying these operational challenges was a fundamental discordance between clinical and public health objectives. Although some public health leaders viewed safer supply as a structural intervention designed to saturate the drug market and displace toxic supply, individual clinicians were tasked with treating individual patients. This created an untenable tension; clinicians, bound by medical ethics and liability, prioritized individual stability and sought to minimize diversion, haunted by the legacy of the early 2010s prescription wave. Conversely, some public health advocates viewed secondary distribution (ie, diversion) as a potential mechanism for broader community protection.[10] Asking individual physicians to solve a population-level toxicity crisis using their personal medical licenses created a structural conflict that left the intervention vulnerable.

As challenges unfolded, public discourse around safer supply programs became increasingly fraught. Media coverage fixated on medication diversion, with headlines warning of prescribed opioids reaching opioid-naive youth.[10] Although diversion is a legitimate concern in any program involving controlled substances, the magnitude remained largely unquantified due to a lack of robust monitoring. Although qualitative evidence suggests that at least some diversion practices functioned as peer-based harm reduction or a survival strategy for underdosed clients,[7,10] the failure to generate real-time quantitative data to establish its scale and impacts created an evidence vacuum.[2] This made it impossible to definitively rule out iatrogenic risks, leaving the programs vulnerable to anecdotal narratives. Media reports focusing on diversion amplified public concern, fueling political polarization.[10] Safer supply programs became a flash point in the 2025 federal election, with progressive groups framing them as pragmatic, evidence-based responses, while the federal Conservative party highlighted diversion concerns and risks of public disorder. Ultimately, in March 2025, federal funding for many safer supply pilot projects was either abruptly reduced or not renewed.[4]

Regardless of the population-level impact of safer supply programs, this abrupt process diverged from established best practices for the systematic deimplementation of health interventions. Rather than following evidence-based steps designed to remove low-value care, the process functioned as a chaotic withdrawal. There was no transparent, evidence-based assessment showing safer supply programs constituted low-value care; no meaningful stakeholder engagement with clients, health care professionals, and experts; and no systematic evaluation of alternatives or mitigation strategies. This inevitably resulted in operational uncertainty, service reductions, and increased risk of overdose and withdrawal for clients who had come to rely on these programs.[4]

Several actionable lessons have emerged for future substance use–related interventions in North America. First, programs must build robust monitoring infrastructure from day one, including linked administrative health data and standardized outcome indicators, to generate real-time evidence that preempts evidence vacuums exploitable by stigmatizing narratives. Second, structured expert consensus processes involving clinicians, people with lived experience, and public health authorities are needed to develop iteratively refined clinical practice guidelines; without this, heterogeneous pilot programs cannot demonstrate the consistency required to survive political scrutiny. Third, future models must structurally decouple population-level crisis response from individual prescriber liability through institutional frameworks, such as public health authority–level exemptions under existing legislation or centralized dispensing models that shift

accountability from individual clinicians to governmental mandates. Fourth, harm reduction policy must be insulated from political cycles through legislation, cross-sectoral coalitions, and public education.

Nevertheless, evidence alone has proven insufficient to sustain harm reduction policy amid political polarization, public apathy, and reversion to punitive approaches lacking empirical support. Countering these forces demands not only robust outcome data but sustained investment in stigma-reduction research and evidence-based public communication strategies, recognizing the limitations of evidence as a policy lever when structural disinvestment and stigma prevail.

As health systems in North America continue to grapple with evolving substance use crises, the Canadian experience of safer supply offers both a cautionary tale and an actionable blueprint for the future implementation of complex substance use care interventions grounded in evidence and equity and designed for sustainability. Ultimately, any implementation and deimplementation practices must be underpinned by a commitment to patient stability, ensuring that marginalized populations do not become collateral damage in the shifting and increasingly hostile landscape of drug policy.

ARTICLE INFORMATION

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