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A continuum of disconnection: the impacts of safer supply program closures on continuity of care, transition, and total loss of service access

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Abstract

Objective In March 2025, the expiration of federal pilot funding for Safer Supply Programs (SSPs), combined with restrictive provincial legislative changes to harm reduction service provision in Ontario, disrupted care for thousands of clients at risk of toxic drug poisoning. This study examines the impacts of these changes on client health, social stability, and overdose risk across a continuum of access.

Method We conducted 30 semi-structured virtual interviews between September and November 2025 with clients who were enrolled in an SSP prior to March 31, 2025. Participants were recruited via purposive and snowball sampling. Data were analyzed using Braun and Clarke's reflexive thematic analysis to explore experiences across three distinct groups: those who maintained continuity with their prescriber or SSP, those who transitioned to a new prescriber or SSP, and those who lost access entirely.

Results Experiences of harm were directly proportional to the degree of service disconnection. Participants who maintained access ($n = 10$) retained clinical stability, but reported chronic anxiety and "survivor's guilt" regarding peers who lost care. Participants who transitioned to an alternative prescriber ($n = 13$) experienced a "medicalization of harm reduction" characterized by increased surveillance (e.g., urine screens, monitored dosing), revoked take-home doses, and the loss of trusted relationships, which undermined their autonomy and stability. Those who lost access entirely ($n = 7$) experienced significant harms, such as the loss of an entire ecosystem of care (i.e., medication, primary care, and community), an immediate return to the unregulated fentanyl market, and engagement in survival strategies that can lead to criminalization. Notably, 100% ($n = 5$) of participants who reported an overdose following the policy changes belonged to this group.

Conclusion The loss of federal funding for SSPs in Ontario did not solely reduce medication availability; it severed the structural and relational network that supported participants' reintegration into health care services that they previously felt uncomfortable accessing due to stigma, surveillance and mistreatment. Findings reveal a "continuum

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of disconnection” where the removal of wraparound supports and the reintroduction of punitive clinical practices function as forms of structural violence. Sustainable, low-barrier models are urgently needed to prevent further morbidity and mortality.

Keywords Safer Supply Program, Harm reduction, Drug-related harms, Overdose, Policy changes

Introduction

Canada continues to face an overdose crisis driven by a toxic and volatile unregulated drug supply. In Ontario, prohibitionist drug policies have contributed to an increasingly unpredictable and evolving unregulated drug supply composed of fentanyl and its analogues, often in combination with sedative adulterants, such as benzodiazepine-type compounds and xylazine [1]. The variability and unknown composition of this supply heighten the risk of overdose, prolonged sedation, withdrawal complications, unpredictable health impacts, and interfere with the efficacy of the overdose response [2]. While traditional interventions, such as opioid agonist therapy (OAT) have demonstrated clear benefits for many individuals, longstanding structural, clinical, and social barriers limit its accessibility and acceptability for a substantial proportion of people who use drugs. These barriers include criminalization, stigma within healthcare settings, adverse medication side effects, rigid program requirements, surveillance-oriented practices such as routine urine screening, and abstinence-oriented goals that may not align with individuals’ needs or circumstances [3]. Collectively, these gaps underscore the need for alternative, low-barrier approaches that prioritize autonomy, safety, and harm reduction.

Against this backdrop, Safe(r) Supply Programs (SSPs), also referred to as Prescribed Safer Supply or Prescribed Alternatives, were developed through sustained advocacy by people who use drugs, harm reduction organizations, clinicians, and community leaders as a critical harm reduction response aimed at reducing reliance on the unregulated drug supply among people at high risk of overdose [4]. SSPs are designed as low-barrier interventions that provide access to pharmaceutical-grade opioids without requiring abstinence, thereby supporting stabilization and engagement while mitigating exposure to toxic street-acquired substances. While medications prescribed varied by region, in Ontario these programs typically prescribed short-acting, take-home tablet hydromorphone (e.g., Dilaudid), frequently alongside long-acting formulations such as slow release oral morphine (e.g., Kadian) and methadone, distinguishing them from OAT, which primarily relies on methadone, buprenorphine/naloxone, or extended-release injectable formulations [3, 5–10]. While OAT medications are associated with reductions in opioid-related mortality and improved treatment outcomes for many individuals, retention rates remain variable and often

suboptimal across demographic and geographic subgroups in Ontario [11]. SSP clients frequently report challenges with OAT, including intolerable side effects or difficulty adhering to program requirements [5]. Emerging population-level evidence further suggests that individuals receiving safer supply experience lower rates of opioid toxicity events compared to those initiating methadone treatment, reinforcing the role of safer supply as a complementary component within a broader continuum of care, rather than a competing intervention [10, 12, 13].

SSPs have been associated with reductions in opioid toxicity events and acute care utilization, alongside improvements in housing stability, service engagement, and overall predictability of drug use patterns, markers commonly conceptualized as stabilization within harm reduction research [14]. These programs are frequently co-located with supervised consumption services (SCS), drug checking, sterile harm reduction supplies, primary and mental health care, case management, peer support, housing navigation, and social services [5–9], differentiating them from safer supply prescribers (often addiction medicine clinicians) which offer medications without the integrated wraparound service referrals [15]. Growing evidence demonstrates that this “one-stop-shop” model meets clients where they are, minimizes access barriers, and reduces service fragmentation [16–19]. In doing so, SSPs are associated with reduced reliance on the unregulated drug supply, fewer withdrawal episodes, decreased exposure to violence and police encounters, and reductions in emergency department (ED) visits, hospital admissions, acute care utilization, and overdose-related morbidity [14, 20, 21]. Despite strong evidence, SSPs have remained contentious, politically vulnerable and financially precarious [22]. This instability is not unprecedented. Harm reduction and opioid-based interventions in Canada have frequently been implemented as time-limited, pilot-based, or politically contested initiatives. For instance, the discontinuation of heroin-assisted treatment trials such as NAOMI and SALOME, alongside more recent restructuring and closures of supervised consumption and overdose prevention services in several provinces, illustrates how program withdrawal, and regulatory shifts have repeatedly disrupted care for people who use drugs [23, 24]. Many of the SSPs in Ontario were similarly established as pilot projects funded through Health Canada’s Substance Use and Addictions Program (SUAP), which has served as a cornerstone of federal support for innovative harm reduction initiatives nationwide

[25]. Although SUAP funding was set to end in March 2024, it was renewed for a final year [26], allowing programs to prepare for closure before the funding officially ended on March 31, 2025. This federal funding withdrawal coincided with restrictive provincial policy shifts targeted towards other harm reduction programs, such as SCS, indirectly impacting the ability of SSPs to operate. Ontario's decision to prohibit the co-location of SCS within 200 m of a designated premise such as a school or childcare centre impacted at least six SSPs across the province as they were integrated within SCS sites affected by this restriction [27]. The combined impact of federal defunding and provincial spatial restrictions of SCS dismantled multiple SSPs across the province, destabilizing the care infrastructure that many people who use drugs relied upon.

This study was designed to examine the consequences of safer supply disruptions in Ontario in the context of SSP federal funding withdrawal. Together, these changes prompted urgent questions about how clients navigated the aftermath, and whether they maintained access to safer supply, secured new providers, or lost safer supply altogether. To understand these impacts, the study focuses on the experiences of three distinct groups: (1) Individuals who maintained continuity with their original prescriber, either because their SSP secured alternative funding sources or their prescriber continued their care through another setting (e.g. primary care practice, private clinic); (2) Individuals who retained access only by transitioning to a new prescriber or SSP model; and (3) Former clients who lost access entirely due to SSP program closures and who were unable to secure an alternative prescriber. This study explores how these closures and transitions shaped participants' overall health, social stability, drug use patterns, and daily lives. It also examines the relational and structural barriers they faced and the implications of these disruptions for overdose risk and broader well-being. The study aims to generate evidence-informed insights to guide policy development, strengthen continuity-of-care mechanisms, and support the long-term sustainability, accessibility, and expansion of safer supply models across Canada.

Methods

Participant recruitment and eligibility

We used a combination of purposive and snowball sampling to recruit participants from across Ontario [28, 29]. Purposive sampling was used to reach individuals with lived experience of enrollment in a SUAP-funded SSP prior to March 31, 2025, particularly those who may have been disconnected from services following funding and policy changes. Recruitment began by identifying two "seed" participants who are members of the study's working group, and who were also associated

with SSPs in two separate cities in Ontario. Both participated in the study and supported recruitment by leveraging established community relationships and familiarity with local safer supply networks to connect with hard to reach individuals. This strategy was particularly important in a post-closure context, where some former SSP clients were no longer engaged with formal programs and could not be reached. We proceeded with snowball sampling through peer referrals which was further supported by staff at select organizations which previously housed SUAP-funded SSPs, in two other cities, where staff displayed recruitment posters and informed clients about the study. We also circulated a recruitment poster through the Substance Use Health Network (formerly the National Safer Supply Community of Practice), thereby expanding recruitment beyond immediate clinical settings. This combined approach was used to ensure representation across the three participant groups of interest and helped capture some regional experiences.

Interested participants contacted the research team via a toll-free study line or study email address. Inclusion criteria included English-speaking adults (18+), who have telephone or internet access, and have been enrolled for at least six months in a SUAP-funded SSP prior to March 31, 2025. Once eligibility was confirmed, interviews were either conducted immediately, or were scheduled for a later time.

Data collection

Interviews were conducted virtually (telephone or Webex) between September 15, 2025 and November 5, 2025, by two university-trained research team members (JMG and AS). Each session began with collecting informed e-consent via REDCap, and included a survey (~10 min) followed by an in-depth semi-structured interview (~30–60 min). The survey collected age, gender, location of residence (grouped into Central, Northern, Southeastern, and Southwestern Ontario based on the *Map of Ontario Regions*) [30], housing status, name of SUAP-funded SSP accessed prior to March 31, 2025, continuity of SSP enrollment (whether they are accessing the same prescriber or SSP, an alternative prescriber or SSP, or have no access), length of SSP enrollment, and whether or not participants had access to health and social services (e.g. primary care), harm reduction services (e.g. SCSs and harm reduction supplies), and treatment services (e.g. OAT or detox) before and following March 31, 2025. All data was entered directly into a secure web application, Research Electronic Data Capture (REDCap) [31]. The interviews explored transitions to alternative SSPs or prescribers, disruptions or continuity in medications and service access, and health and stability outcomes. See **Additional file 1** for the full semi-structured interview guide. Participants received \$50 honoraria for

their participation in the study via e-transfer or MoneyGram. Some participants provided staff email addresses for accepting the e-transfer on their behalf. For confidentiality, each participant was assigned a unique participant ID, which was linked to their data. Interviews were audio-recorded for transcription purposes.

Throughout the recruitment and interview period, the research team met regularly to debrief emerging insights, assess data quality, and evaluate thematic sufficiency. The research team brought interdisciplinary expertise in harm reduction, health policy, and qualitative research, and included members with lived and living experience of substance use. Reflexive notes were taken during and after interviews to document preliminary interpretations and contextual observations, and were used throughout analysis to support reflexive interpretation and attend to the influence of researcher positionality [31]. Recruitment was paused once the team agreed that no new conceptual insights were arising from the three distinct groups.

Data analysis

Survey data collected through REDCap were exported into Excel and examined using descriptive statistics. Frequencies and proportions were calculated for all closed-ended items to provide an overview of participants' demographic characteristics, length and location of SSP enrollment (both before and after the expiration of SUAP funding), and service use patterns.

All qualitative interviews were professionally transcribed and subsequently reviewed by a member of the research team to ensure accuracy, completeness, and the removal of any identifiable information. Transcripts were uploaded into NVivo (Version 15) for analysis.

An initial coding framework and draft codebook were developed collaboratively based on the study's research questions, early analytic patterns emerging from the interviews, and observations documented during team debriefings. To ensure experiential validity and relevance, the preliminary codebook was then reviewed by two research team members with lived and living experience (NK and AC), who assessed whether the proposed codes resonated with real-world safer supply experiences and the language used by participants. Reflecting the complexity of participants' narratives, the codebook was intentionally organized using a hierarchal, multi-level structure, grandparent, parent, and grandchild codes, to support both broad thematic mapping and fine-grained analysis [32].

Broad, overarching codes represented the highest-level of conceptual domains relevant to the study, such as experiences with safer supply access, impacts of closures, drug use patterns, service access, drug-related harms, and quality of life. These categories captured the

overarching spheres of participant experience following changes to SSP funding and policy.

More specific codes within each category, referred to as the parent code, allowed the team to examine whether an impact occurred and in what domain. For instance, changes in SSP medication access, barriers to service use, changes in overdose risk, or impact on mental and physical health.

Codes which specified the directionality, nature, or specific sub-patterns of these impacts (e.g., increased vs. decreased access to primary care, reduced dose, increased reliance on the unregulated drug supply, loss of carries, increase in EMS contact), enabled comparison across the three post-closure access groups and allowed for more nuanced distinctions in how participants were affected.

This tiered structure supported a layered analytic process, enabling the team to identify both cross-cutting structural themes and divergent experiences across participants who maintained the same prescriber, transitioned to a new prescriber, or lost access entirely.

The finalized codebook was applied to all transcripts by one research team member (JMG) to ensure consistency in coding. To assess consistency in code application, a second researcher (AS) independently coded a subset of transcripts (20%) [33]. Interrater agreement was examined using Cohen's kappa, calculated at the code level and then averaged across codes to provide an overall estimate of agreement. This process yielded a mean kappa value of 0.78, indicating substantial agreement between coders. Any discrepancies were discussed and resolved through consensus, supporting analytical rigour and shared interpretive understanding.

Two study participants engaged in a member-checking process to ensure that the analytic approach, coding structure, and interpretive language resonated with participants' lived realities [34]. They independently reviewed and coded a subset (10%) of transcripts to evaluate whether the codebook and interpretations by the research team members aligned with their own experiences. Differences in interpretation were resolved through dialogue in team meetings, deepening reflexivity and strengthening the analysis by ensuring participants' lived realities were accurately represented.

Following coding, a consolidated analytic "Master File" was created summarizing findings from all parent, child, and grandchild codes. The research team reviewed this file alongside reflexive notes taken during data collection and a preliminary themes document to identify overarching themes and patterns across the dataset. Thematic analysis was conducted iteratively, informed by Braun and Clarke's reflexive analytic approach [32], and employed both inductive and deductive strategies to explore the range of impacts. Themes were evaluated

Table 1 Participant socio-demographic characteristics

Socio-demographic characteristics	N	%
Gender		
Woman	17	57%
Man	9	30%
Non-Binary	2	7%
Two-Spirit	1	3%
Transgender	1	3%
Ethnicity		
White (European descent)	20	67%
Indigenous (First Nations/Inuit/Metis)	9	30%
Black (African/Afro-Caribbean/African-Canadian descent)	1	3%
Middle Eastern (Arab/Persian/Afghan/Egyptian/Iranian/Lebanese/Turkish)	1	3%
Other: Mixed	1	3%
Housing Status (past 30 days)		
Own home or apartment (rent/own)	25	83%
With parents, relatives, or friends (not paying rent)	4	13%
In a shelter or transitional housing program	1	3%
In a hotel or motel (paid by self or with assistance)	1	3%
On the street, in an encampment/park, in a car, or other place not meant for sleeping	1	3%
Geography		
Central Ontario	20	67%
Northern Ontario	5	17%
Southwestern Ontario	4	13%
Southeastern Ontario	1	3%

based on analytic significance and conceptual contribution rather than frequency alone. Less prevalent patterns were discussed in team meetings to determine whether they reflected idiosyncratic experiences or illuminated structurally meaningful dynamics, particularly among marginalized subgroups. Where such themes provided important insight into inequities or differential impacts, they were retained in the analysis despite lower saturation.

Analytically, the team adopted a pragmatic epistemological stance, focusing on how participants navigated real-world harms following the policy change [35]. This orientation guided our examination of the practical, social, and health-related consequences among those who (1) were able to maintain continuity of access to the same prescriber (2) were able to maintain continuity of access by transitioning to different prescribers or program models, and (3) lost access to safer supply due to program closures. Our aim was to generate findings relevant to ongoing policy debates and the design of future harm reduction and drug policy interventions.

Findings

The following descriptive survey data are presented to contextualize the qualitative findings and illustrate patterns within the sample.

Table 2 Continuity of SSP or prescriber access by location of residence

	Maintained access: Same SSP or Prescriber	Maintained access: Different SSP or Prescriber	Lost access	Total
Central	8 (40%)	11 (55%)	1 (5%)	20
Southeastern	0 (0%)	1 (100%)	0 (0%)	1
Southwestern	2 (50%)	1 (25%)	1 (25%)	4
Northern	0 (0%)	0 (0%)	5 (100%)	5

Participant characteristics and SSP access overview

Participant profiles

Participants' average age was 46.6 years. Most self-identified as women ($n = 17/30$; 57%), white/European descent ($n = 20/30$; 67%), and were stably housed ($n = 25/30$; 83%). See Table 1 for an overview of participant characteristics.

SSP enrollment information and continuity of access

At the time of the interviews, the majority of participants reported being connected to a SSP or prescriber ($n = 23/30$; 77%), while the remaining seven participants (23%) reported no longer having access. Among those who maintained access, 13 (57%) had transitioned to a different SSP or prescriber, whereas 10 (43%) continued with the same program or prescriber as before.

Patterns of continuity varied across regions within this sample (see Table 2).

Drug use patterns

Almost one-third ($n = 9/30$; 30%) of participants reported increased use of unregulated drugs, the majority ($n = 7/9$; 78%) of which were among participants who had lost access entirely. 17% ($n = 5$) reported experiencing at least one overdose after March 31, 2025, all ($n = 5/5$; 100%) of which were among those who had lost access to safer supply. A small number of participants described changes in their route of administration, including switching from smoking to injection ($n = 3$; 10%), injection to smoking ($n = 2$; 7%), and swallowing to injection ($n = 1$; 3%).

Service access

Prior to March 31, 2025, most participants reported access to harm reduction services, including SCS ($n = 25$; 83%), drug checking ($n = 24$; 80%), and harm reduction supplies ($n = 27$; 90%). Following changes to SSP funding and related policies, fewer participants reported access to these services, where 23% ($n = 7$) had access to an SCS, 40% ($n = 12$) had access to drug checking, and 70% ($n = 21$) had access to harm reduction supplies. See Appendix A for the breakdown of service access prior to and following the policy change.

Qualitative findings

Participants' experiences following the funding and policy change varied widely depending on the degree of continuity they were able to maintain. Participants were categorized into one of three distinct groups based on their continuity of care: (1) those who remained with the same prescriber, (2) those who transitioned to a new prescriber, and (3) those who lost SSP or prescriber access altogether. Across these groups, the severity and nature of impacts followed a clear gradient, shaped by different continuity in core elements of SSPs, including stability of prescribed medications (e.g. take home doses), access to wraparound services, and the preservation, or erosion, of trust in prescriber relationships.

Continuity amid uncertainty: remaining with the same prescriber

Participants who retained access through their existing prescriber represented the most stable group, describing smooth and minimal disruptions in care following the policy change.

Many participants emphasized that their prescribers shielded them from the emotional and administrative burden associated with navigating new systems. As one participant described: *"It [transition] was seamless for me in the sense that the program tried to figure everything out for me and make it as easy as possible. They took the brunt of it"* (Participant 1, Central Ontario). Others expressed relief that their prescriber continued supporting them, without which they would have faced enormous challenges securing an alternative prescriber. One participant explained:

"I would have been scrambling around like a bat out of hell if she [prescriber] had decided not to. I don't know what I would have done, but it would have been really messy for me to find a doctor that writes scripts, especially for the amount of Dilaudids that I do. No family doctor is really going to do that unless they're educated in the safe supply" (Participant 23, Central Ontario).

For this group, prescriber continuity was essential to avoiding intense emotional stress.

Seamless access to their prescriber allowed participants to maintain their daily routines and sense of safety, particularly with respect to their medication access. Many participants reported no changes in their prescriptions, continued access to take-home doses ('carries'), and no change in pharmacy pickup and in-person visits. As one participant described: *"Nothing's really changed. I go once*

every six weeks. I still get my carries because I haven't peed dirty ever. So I get my carries, and it's just a routine, right? I have a specific time, I go, and I get my script, and it's pretty much without a hitch" (Participant 23, Central Ontario). Another participant noted how this consistency provided relief, and continuing to have access to their medication was seen as 'life-saving': *"It's been a real lifesaver for me to access the medication I need and not get stuck without"* (Participant 19, Central Ontario).

Because access to prescribed medication remained intact, most participants in this group did not return to the unregulated drug market, emphasizing that their safer supply medication replaced their reliance on the unregulated drug supply, thereby mitigating overdose risk associated with an unpredictable supply. As one participant noted: *"I don't do any street drugs anymore, so there's not that danger [of overdose]. I have a set schedule. How I do my pills, I'm on a set schedule. And I'm very regimented like that. Because it's working"* (Participant 23, Central Ontario). Accordingly, participants generally did not attribute any increase in overdose risk to their SSP or prescribed medications. Several emphasized the protective effect of oral medications due to expanded options provided, such as Dilaudid, rather than injecting: *"I don't even think I have an overdose risk, because I take my medication exactly how I'm supposed to and I take it orally. I don't shoot anything. So I don't really see myself having an overdose. I don't see that in my future"* (Participant 5, Southwestern Ontario).

Despite this continuity, some participants lost access to on-site wraparound supports following the end of federal funding and provincial policy changes restricting co-located safer supply services. As a result, they described heightened overdose risk stemming from increased structural exposure to harm. This was particularly related to the lack of access to harm reduction services and supplies they once relied on as part of the integration of SSPs within larger health organizations providing multiple harm reduction services. As one participant explained, obtaining sterile equipment now required navigating unfamiliar locations, which felt stressful and burdensome: *"[My mental health] has [changed], because it's a stressful experience to go where I have to go now for the [harm reduction] equipment"* (Participant 30, Central Ontario). Heightened overdose risk was especially relevant for those that lost access to a SCS, as one participant noted: *"[My risk of overdose] changed now because there's no [SCS] anymore, where people can go use injection where it's safe, right. But they can't now. It's more overdoses happening"* (Participant 22, Central Ontario). Loss of 'one-stop-shop' access to harm reduction, primary

care, and mental health supports - core components of many SSP models - created new stressors and heightened overdose risk for some.

In addition to some participants losing access to wrap-around support and services, the majority of participants in this group carried significant emotional strain from witnessing peers lose access to their safer supply. Despite having access themselves, participants felt disappointed in the government for taking away funding from many SSPs, noting the benefits they have had on many clients: *"I'm disappointed about the whole thing, when they took it [SSP] away, there are more people who are overdosing every day. Not just that, just the bond that you have or friendships with the staff, it's just because the fact is it's safer. And the government took it away"* (Participant 22, Central Ontario). They recognized that those who lost access entirely will likely return to the unregulated drug supply and felt fearful of the outcomes: *"I think, for people that had to shift entirely into a destabilized market and illicit fucked up toxic supply. They're overdosing and they're dying"* (Participant 1, Central Ontario).

Many also described profound worry about the future and ongoing fear that their own stability could be abruptly taken away, due to the precarity of the programs. They articulated deep mistrust toward government decision-making and a sense that SSPs were perpetually under attack: *"I still have that worry about the freaking government and the power they have to say nope, it's [SSP] gone, and then just not making Dilaudid anymore, just for the hell of it. There's that fear that lingers"* (Participant 26, Southwestern Ontario).

Overall, participants who remained with the same prescriber experienced the greatest stability, but their accounts reveal that prescriber continuity alone did not eliminate the emotional and structural burdens imposed by the political instability surrounding SSPs, particularly as it relates to the withdrawn access to wraparound services and fear of loss of safer supply.

"Like starting all over again": transitioning to a new prescriber

Participants who transitioned to a new prescriber occupied a precarious middle ground, some of their experiences shaped by disrupted continuity in medication or prescriber access, resulting in a degraded form of care, while others retained access to relatively the same medication. Despite having some form of medication and prescriber access, this group often lost many key elements of SSPs, such as integrated wraparound services and take-home doses. They also experienced inconsistent clinical approaches in terms of surveillance practices and

appointment scheduling, creating a form of instability that differed qualitatively from the relative security experienced by those who kept their prescribers.

For a small portion of this group, their new prescriber maintained the same medications and dosing schedules they had previously received. These participants emphasized the relief of not having their regimen altered, as one participant explained: *"The prescription was exactly the same. I picked up right where I left off. I didn't notice any differences"* (Participant 5, Southwestern Ontario). Another noted that they also retained long-earning privileges such as take-home doses, or 'carries': *"It's [medication] pretty close to the exact same [...] He gives us our carries, he gives us take-homes, where if I had to go on vacation, he would be able to give us carries for a long period of time"* (Participant 20, Central Ontario).

However, a larger group of participants described procedural and structural barriers in the transition to new prescribers. For instance, many reported that while they maintained access to long-acting medications, their take-home privileges were reduced or revoked entirely: *"When you first change over, there's no longer what they call carries. So that made it so that you have to go [to the pharmacy] every single day"* (Participant 12, Central Ontario). Another participant discussed how drastic this change was, going from 30 Dilauids at their SSP to none under the regiment of their new prescriber: *"I had access to more of them [Dilauids], and now I can't access them at all [...] I was getting 30 of them before"* (Participant 25, Central Ontario). Participants also described an increase in in-person appointments and heightened surveillance, such as video check-ins and monitored dosing environments. As one participant explained: *"Pre-closure was great [...] then it went to twice a week to the doctor and going [to the pharmacy] every day. Now I go every two days [to the pharmacy] and see the doctor every two weeks"* (Participant 13, Central Ontario). Another highlighted complete violation of human rights, using invasive and disciplinary control and surveillance practices:

"There's a high level of surveillance there around cameras in the kind of restroom where you leave your sample. And they like to do these, sometimes do these over the phone, like Zoom-type software, at home, like, once or twice a week to see if you're having your dose. So on that end of the surveillance, that cannot be the most comfortable situation" (Participant 10, Central Ontario).

Increased appointments were especially burdensome for participants balancing work, caregiving, and other

responsibilities. Daily or unpredictable appointment schedules were incompatible with employment or family obligations, and the rigidity of new systems left little room for participants' lived realities. As one participant explained: *"I'm not someone that's homeless and can sit around all day waiting for my script [...] I have a kid, a job, a mother to take care of, and a husband. I don't have time to sit around at a doctor's office all day"* (Participant 6, Southeastern Ontario).

Changes in dosing, surveillance, and scheduled appointments were interpreted as signals of mistrust and misunderstandings about the purpose of safer supply. The majority of participants in this group emphasized that they had spent years building trust, credibility, and stability with their previous prescribers, describing the transition as a complete reset of hard-earned autonomy, as one participant expressed: *"He [prescriber] has talked about decreasing my Dilaudid since the start, which I'm like, why take on Safe Supply clients if you weren't going to do safe supply?"* (Participant 14, Central Ontario). Another participant echoed this loss of trust with their new prescriber: *"I feel like everything that I've worked towards and all of this trust that I've built... I'm right back where I started"* (Participant 3, Central Ontario).

Beyond medication changes, participants described the abrupt loss of wraparound supports that had anchored their previous SSPs. As one participant put it: *"I don't have access to a psychiatrist anymore, so if anything did happen... I wouldn't be able to go anywhere about it"* (Participant 6, Southeastern Ontario). Another participant shared how finding housing and a job was more difficult without the social supports offered at their previous SSP: *"Everything [services] was all wrapped up in a nice, pretty bow, right? If you wanted a resume or if you just needed help with housing or any of it, you could just do it all right at [previous SSP]. So right now, it's a slow process"* (Participant 12, Central Ontario). The loss or reduced access to harm reduction services, such as harm reduction supplies pushed them back into riskier drug use practices, such as needle reuse: *"I used to get a box of clean needles every time, now they give me five... I've had to reuse the same kits several times, and they get barbed and start to hurt"* (Participant 14, Central Ontario).

Participants highlighted how the closures had eliminated multiple harm reduction and drug checking sites across the city, significantly limiting options and forcing people to rely on an increasingly contaminated supply:

"The main thing is just accessibility. Before, there were several [drug checking] places that I could go to that were open and had longer hours of operation.

Obviously, because of the closures, there are just fewer places to do drug checking now, which is really unfortunate because I know there's a lot of really bad stuff out there. I'm sure that's what's causing a lot of the ODs. It's just that there's a lot of garbage. And if you can't find out what's in it, it's just – it's like Russian Roulette. You're always taking a chance" (Participant 20, Central Ontario).

Participants' experiences with the unregulated drug supply in this group were mixed but often reflected increased vulnerability. Some decreased their use due to heightened fear of contamination in the unregulated supply. As one participant explained: *"If anything, it [loss of access to drug checking] has made me decrease the amount [of drugs] that I've used because better safe than sorry type thing"* (Participant 14, Central Ontario). Others within this group described increased use in response to reduced medication doses, elevated stress, or the loss of ancillary supports: *"I use [street drugs] a lot more now. The Dilaudids really helped, right?"* (Participant 25, Central Ontario).

Collectively, these accounts illustrate that transitioning, due to a lack of choices, to a new prescriber created its own form of instability. It uprooted established relationships, reintroduced punitive and medicalized controls, fragmented previously integrated care, and increased exposure to the risks that their SSP was designed to prevent. For many, the process felt like "starting all over again," not just in their clinical regimen but in rebuilding trust, navigating services, and attempting to regain a sense of safety.

"Everything was just gone": losing access entirely

Participants who lost all access to safer supply, which included all participants residing in Northern Ontario - described the most severe and immediate harms following program closures. For these individuals, the closure of their SSP represented far more than the discontinuation of medication; it signified the loss of an entire ecosystem of care, trust, and stability. The disappearance of these programs left participants without medication, connection to health and social supports, and the sense of safety that had accompanied their engagement in care. Participants consistently described the closures as catastrophic and life-altering, marking a return to precarity, chaos, and intense vulnerability after years of progress.

Without access to a SSP, increased reliance on the unregulated drug supply was universal among this group. Participants described a rapid escalation in use and often experiences of resumed use into unregulated

fentanyl use. As one participant explained: *"I went down to not doing some carfentanil [before the closure], but I'm all back up to a half gram a day. You never know when your next blast may be your last"* (Participant 9, Northern Ontario). Others described the overwhelming pull back to daily consumption of the unregulated drug supply and the psychological distress that accompanied it: *"I just want it [drugs] more, it's like I use a lot more and I'm doing more like all the time, I guess physically or mentally, I want it all the time"* (Participant 18, Northern Ontario).

Losing access to their SSP also meant losing the structure that had kept drug use manageable and predictable. Participants described an immediate shift back to chaotic consumption patterns, risky improvisation, and unsafe practices they had worked hard to leave behind. As one participant explained: *"Using old needles, using dirty needles [...] It's really shitty and it's really painful. It's really worrisome and it's not comfortable. And it hurts, it physically hurts using old needles, and the mental anguish it causes is no fun either"* (Participant 18, Northern Ontario). The disappearance of harm reduction services alongside their SSP forced participants to rely on unknown and volatile substances, often using drugs alone. One participant summarized the lethal uncertainty of using drugs alone, but does so in order to prevent theft: *"You never know if you get something, a good batch, you're fucked. And they say 70% of people die by using alone. But sometimes it's better to use alone because when you wake up, you still got your shit"* (Participant 9, Northern Ontario).

This group also described significant increases in drug-seeking behaviors. The stabilizing effect of safer supply, where participants reported no longer needed to steal or engage in criminalized survival strategies to obtain drugs, disappeared as soon as access to the SSP ended. Participants described being pushed back into desperation: *"I'm stealing more, and I am conniving, and I'm always looking for a hustle... I robbed somebody... I don't do that. Like, I robbed. That's a big one for me because I've never done that before"* (Participant 18, Northern Ontario). Others discussed the legal consequences of this return to survival mode: *"I got arrested for selling drugs because I had a habit to support"* (Participant 21, Central Ontario). The loss of their SSP reintroduced harms not tied to drug use itself, but to the criminalized and dangerous conditions under which participants were again forced to survive due to losing access to a stable dose of pharmaceutical opioids.

Geography further magnified these harms. In Northern communities, like Thunder Bay, where services were already limited, the closure of the only SSP (where

the only SCS in the region was also forced to close) eliminated the only accessible one-stop-shop for harm reduction, primary care, and mental health supports. Participants explained that there were no alternate prescribers, no referral pathways, and no comparable services in their region: *"There isn't the safe place to use anymore [...] we're a lot more vulnerable because we don't have the access to those services or the friendships we had made with each other either"* (Participant 29, Northern Ontario). Another participant described reduced access to harm reduction supplies as a fundamental issue: *"I could get them [harm reduction supplies] at three in the morning if I needed them before. Now I can't, they're not there anymore"* (Participant 18, Northern Ontario).

As stability collapsed, participants experienced rapid and significant declines in their physical and mental health. Many shared stories of untreated infections, recurring abscesses, weight loss, and the general deterioration that comes from relying on a contaminated supply without the support of their SSP: *"I've lost a ton of weight again. The abscess on my hip is coming back"* (Participant 8, Northern Ontario). Others discussed a profound decline in their mental well-being. The sudden loss of structure, support, and connection left many feeling hopeless and alone: *"I just don't have the support in the community that I had when I was in the program"* (Participant 29, Northern Ontario). Some participants described spiraling into crisis, including incarceration directly tied to the SSPs disappearance, as they were essentially forced to make a decision, stop using altogether, or use from the unregulated supply, as described by the following participant: *"Mentally I wasn't prepared to quit... I ended up going to jail several times after the program [SSP] closure"* (Participant 21, Central Ontario).

Importantly, participants emphasized the emotional and relational rupture resulting from the loss of a safer supply. Participants described SSPs as communities, places where staff checked in on them regularly, helped coordinate appointments and ensured safety. The closures severed not only access to care but also social relationships with peers, staff, and a community of support. Losing the program meant losing this sense of connection: *"We'd have arts and crafts and stuff like that and whatnot, movies and everything. You kind of go to the laundry around there, and you drink coffee and shoot the shit with people that are basically similar, similar problems to yours [...] until it all went away. I see people once in a while, but they ain't better than they were. Actually, a couple of them died"* (Participant 9, Northern Ontario). This loss produced deep grief and a sense of being abandoned by the system: *"What the fuck am I going to do? I*

don't want to go back to what I was doing, like to what I was like before, like with the chasing the drugs to fucking getting money, buying drugs, using drugs, getting money, buying drugs. Like a 24 hour thing. I was fucking tired. I was sick and tired" (Participant 18, Northern Ontario).

Participants also described how being forced back into public, highly visible drug use heightened stigma and social hostility among the general public: *"There's definitely some [stigma] there. I see it in the way they [general public] look at me, like my hygiene and stuff [...] there's times when it gets out of hand and then I feel the stigma from the public"* (Participant 7, Northern Ontario). With fewer indoor spaces to use safely, many used in public areas, leading to increased judgement, and discrimination, as discussed by the following participant: *"I feel like we're not part of society and that they [general public] think that we're all just one way and that we choose to do drugs"* (Participant 21, Central Ontario).

Collectively, these accounts depict the SSP closures as a cascading series of losses: not only of loss of access to safer supply medications, but also loss of access to harm reduction programming and supplies, community, dignity, safety, and hope. This was not merely a policy change; it was the unraveling of the fragile stability that had allowed the participants to survive. By forcing individuals back into dangerous drug markets, survival strategies that can lead to criminalization, and profound isolation, these disruptions illustrate the catastrophic consequences of withdrawing essential health services from people already navigating multiple, overlapping inequities, by removing multiple protective layers at once.

Discussion

This study illustrates the profound social, clinical, and structural harms that follow the closures of SSPs in Ontario. While public and political debates frequently reduce SSPs to a question of medication provision, our findings demonstrate that these programs operated as complex, ecosystem-based models of care centered around flexible dosing regimens, connections to wrap-around health and social services, and trusting prescriber relationships. The closures destabilized participants' lives not merely through the loss of pharmaceutical opioids of known dose and composition, but through the dismantling of relational, structural, and environmental supports that underpinned their safety, stability, and dignity. By examining experiences within three distinct groups, from those who maintained continuity with their prescriber, to those who were forced to transition to a new prescriber, and to those who lost access entirely, our study reveals

how fragility is produced not only by drug toxicity, but by drastic policy changes, the withdrawal of services, and the erosion of trust in health and government systems.

Consistent with emerging Canadian and international research [5, 36, 37], participants in our study described their SSP as operating within, and partially buffering, the broader risk environments in which participants use drugs. Rhodes' risk environment framework conceptualizes drug-related harm as shaped by interacting social, political, economic, and institutional conditions [38]. In this study, the risk environment refers specifically to the local service ecosystems and provincial policy context in Ontario, including criminalization, funding instability, and the increasingly toxic drug supply. Interestingly, despite our diverse sample (women and Indigenous people comprising a large portion of the study population), our findings did not reveal any themes in which the risk environment was influenced by gender or ethnicity.

SSPs did not eliminate these structural conditions, however, they functioned as stabilizing infrastructures within them. By providing low-barrier medication access, supervised consumption, and harm reduction supplies, for instance, they mitigated exposure to environmental and everyday risks that otherwise heighten overdose and instability [5, 37, 39, 40]. When funding expired and policy restrictions led to program closures, these buffering mechanisms were withdrawn. In this sense, the policy shifts removed protective service infrastructures thereby amplifying vulnerability within precarious social and structural conditions [5, 41, 42].

SSPs actively modified participants' risk environments by providing low-barrier access, not only to medications, but 'one-stop-shop' access to wraparound services such as harm reduction supplies, SCSs, primary care, mental health services, and peer support. There is a substantial evidence base showing that integrated harm reduction environments improve engagement, reduce overdose mortality, enhance mental health, and strengthen trust in the healthcare systems [5–9, 43]. By integrating multiple supports into one program, they reduced the structural drivers of harm, including food insecurity, homelessness, criminalization, stigma, and the volatility of the unregulated drug supply. Importantly, these benefits arise not only from the provision of safer, prescribed medications, but from the structural supports within which they are delivered [5–9, 16–20, 37]. These accounts illustrate this clearly; even among those who maintained medication continuity, the loss of integrated wraparound care introduced new risks, burdens, and forms of instability. This shift underscores that continuity of medication does not necessarily translate into continuity of care; the broader

ecosystem of access to wraparound health and social services that made safer supply stabilizing has also been weakened among those who have had continued access to medication.

The removal of these supports can be understood as a form of structural violence, the production of preventable harm through political and institutional decisions that disproportionately impact marginalized groups [44]. Scholars have long noted that when harm reduction infrastructures are withdrawn, preventable injuries, deaths, and social suffering increase [41, 45, 46]. Our study's findings echo this pattern. The closures dismantled the very environmental conditions that allowed safer supply medications to produce stability, safety, and connection to care. In their absence, participants were pushed back into riskier patterns of use, injecting without sterile equipment and relying on the unregulated drug supply—behaviors strongly associated with increased likelihood of harm, including overdose, infection, and police interaction [47, 48]. Studies from British Columbia, Scotland, the United States, and Australia show that when services such as drug checking, peer support, mental health care, and sterile equipment distribution are detached from medication programs, the protective effect of the medication itself diminishes substantially [19, 49–51].

In addition to the loss of access to critical wraparound services, the majority of participants experienced what can be understood as policy-induced trauma. This describes the emotional, psychological, and relational harms that arise not only from service loss, but from the chronic uncertainty surrounding SSPs in Canada. Even those who retained their prescribers reported anticipatory anxiety around the precarity of SSPs, feeling simultaneously protected and distressed while witnessing peers suffer. These findings echo literature on policy precarity in harm reduction [52–54], which shows that insecure or politically contested interventions generate chronic stress and undermine the sense of safety these programs aim to cultivate. For instance, many SSPs in Canada operated under pilot program funding, such as SUAP funding, creating a sense of precarity from the beginning. Temporary, time-limited, pilot funding signalled to people who use drugs that continuity of care was never guaranteed [52]. As a result, people who use drugs were unsure of whether they would have access to their SSP as the expiration of funding approached, causing stress and anxiety, particularly over the loss of prescribed medications and a potential return to the unregulated drug supply [5]. Similarly,

harm reduction has recently been contested in Alberta, with the government banning the prescribing of safer supply and transitioning to the Narcotics Transition Services model, a limited model where access to safer supply has been dramatically reduced [55]. While this model is the only available option for safer supply in that jurisdiction; it is offered solely as a temporary, short-term bridge to OAT, and clients must have a failed OAT attempt in order to qualify for this service. It is unclear what effects this transition has had on people previously accessing SSPs; while no reports or evaluations have been made public on clients' transition to this new model of care, one former patient has launched a court challenge to the Alberta policy [55, 56].

The experiences of participants who transitioned to new prescribers following SSP closures may also reveal a deeper structural problem. For some, the fragmentation that occurred through transitions effectively reintroduced the punitive and paternalistic dynamics long critiqued within traditional drug treatment systems. The surveillance-oriented requirements described by participants, including fewer or no take-home doses, observed urine sampling, and observed dosing, reflect what previous research has identified as the “disciplinary underpinnings” of conventional treatment models, such as OAT [57, 58]. These systems often frame drug use through a lens of individual risk, deviance, and compliance, rather than as a response to structural conditions of violence, poverty, and an unregulated drug supply. Daily-witnessed dosing, unpredictable wait times, and rigid appointment requirements effectively bind people to clinical schedules in ways that undermine personal, financial, and social responsibilities, thereby posing barriers that often limit client retention and engagement [59]. Witnessed urine drug screening, experienced by some participants who transitioned to an alternative prescriber, goes against guidelines which explicitly state that this form of control violates clients trust, privacy, and respect and can be traumatizing, or re-traumatizing among those who have histories of sexual assault [60]. As such, the tightening of clinical control in these transitions represents not only a procedural change but also a philosophical retraction from the non-judgemental, low-barrier, meeting people where they are at, harm reduction ethos that safer supply embodied [61].

Critically, participants who transitioned to a new prescriber illustrate the consequences of similar surveillance-oriented requirements, whereby harm reduction programs became subsumed into risk-averse medical

models that prioritize surveillance over autonomy [57, 59]. When SSPs are relocated from integrated harm reduction environments to more conventional clinical addiction medicine settings, the intervention becomes subject to medical norms that are fundamentally at odds with core harm reduction principles (low-barrier accessibility, relational trust, and nonjudgmental engagement). The removal of take-home doses and increased surveillance demonstrates a shift toward control-oriented care that eroded stability and positioned clients as inherently risky subjects requiring constant monitoring [62]. Participants' accounts of experiencing a "complete reset" in their care relationships reflect a profound rupture in trust. This rupture is particularly concerning given evidence demonstrating that trust is one of the strongest predictors of retention, reduced overdose risk, and health system engagement among people who use drugs [63, 64]. Harm reduction scholarship further emphasizes that relationships within care environments function as enabling conditions, shaping whether services are experienced as safe, accessible, and supportive [65, 66]. In this sense, the loss of relational continuity represents more than a change in prescriber; it constitutes the erosion of social infrastructure that supports stability. Within this context, the restructuring of SSPs undermined a key protective mechanism, thereby increasing vulnerability.

Geographic inequities emerged as a particularly consequential dimension of harm. Although participants from rural Northern Ontario constituted a smaller ($n=5$) proportion of the sample, the uniformity and severity of their experiences (100% loss of access) was characterized by complete loss of safer supply access and associated services. Unlike participants in urban settings, who often retained some form of continuity or alternative pathways to care, those living in Northern communities such as Thunder Bay described the end of the only local SSP and the wraparound services embedded within it. The end of the SSP coincided with closure of the supervised consumption site, and loss of access to harm reduction supplies, and drug checking due to provincial closures of SCS that occurred concurrently with the end of federal SSP funding, with no comparable services available elsewhere in the region [67, 68]. The consequences of this loss were both immediate and compounding. Participants described being forced back into the unregulated drug market while simultaneously losing access to sterile equipment or supervised environments, a convergence of risks that dramatically heightened vulnerability to overdose, infection, and other drug-related harms. These findings align with a robust body of Canadian and international literature demonstrating that rural and northern

communities experience disproportionate harm following the withdrawal of harm reduction services, due to limited service density, lack of redundancy, and structural barriers to accessing alternative care. In these contexts, the closure of a single site does not create a service gap but eradicates the local harm reduction ecosystem entirely [3, 69].

These harms must be understood within the broader provincial policy context. Across Ontario, the loss of federal funding for SSPs and the closure of SCSs due to provincial legislation coincided with the government's introduction of Homelessness and Addiction Recovery Treatment (HART) Hubs, as an abstinence-oriented model [70]. While several harm reduction-embedded programs were banned from operating in organizations that received HART Hub funding, these hubs did not offer equivalent services, notably excluding needle exchange programs, supervised consumption, drug checking and safer supply prescribing [71]. Advocates, researchers and community organizations across Ontario have criticized this shift, and an independent auditors report substantiated these concerns, concluding that the transition away from SCSs occurred without adequate planning, consultation, or risk management [72–74]. Critically, the report found that the province proceeded with these changes despite acknowledging that people who use drugs would face increased overdose risk, a finding that was highlighted among participants in this study. While this restructuring affected communities across Ontario, its consequences were profoundly uneven. In urban centres, service density sometimes allowed for partial substitution, whereas in Northern regions, where services were already sparse, the same policy shift resulted in the near total elimination of harm reduction infrastructure. For Northern participants in particular, this policy realignment transformed an already fragile system into one of complete absence, amplifying risk, isolation, and preventable harm.

Collectively, these findings reveal that SSP closures reintroduced the same structural conditions, criminalization, unpredictability, and service fragmentation that fuel Canada's overdose crisis. In effect, the removal of safer supply re-intensified the risk environment [38], pushing participants back toward the unregulated supply and severing the relational and environmental protections that had reduced overdose risk. To address this, harm reduction service access must be scaled up, not down, especially in rural and remote regions of Ontario. Finally, even participants who maintained continuity with their prescribers discussed ongoing stress and anxiety surrounding the SSP closures. Many perceived their

programs as perpetually precarious, given the instability of SSP funding models, which caused uncertainty and fear regardless of medication continuity. This anxiety was not experienced as speculative, but as grounded in a broader history of abrupt service withdrawals and policy reversals affecting people who use drugs, reinforcing a sense of institutional unpredictability [23]. They also expressed disappointment in the government for closing such vital programs and were concerned about those who lost access, understanding the harms of returning to the unregulated drug supply. As such, funding models must be sustainable and supported by the government to mitigate the threats and uncertainties that clients of these programs often face. Without continued access, SSP clients are forced back to the unregulated market where their risk of overdose increases.

Limitations

Several limitations should be considered when interpreting these findings. First, the requirement for telephone or internet access to participate in virtual interviews likely excluded individuals experiencing most acute structural vulnerability, including those who were unhoused, street-entrenched, or without consistent access to communication technologies. Although some participants were able to access a telephone or computer with assistance from staff at a CHC, the relatively high proportion of participants reporting stable housing (83%) suggests that the severity of harms experienced by those with lower social stability may be underrepresented in this sample.

Second, the geographic distribution of participants was uneven, with the majority residing in Central Ontario (67%), where the majority of SSPs were concentrated. While the study included participants from Northern Ontario (17%), the limited sample size from rural and remote regions constrains the ability to fully capture the depth and variability of service disruptions in these settings.

Third, recruitment relied on participants' ability to proactively contact the research team. As a result, individuals who experienced the most catastrophic outcomes following SSP discontinuation or transition, such as fatal overdose, prolonged hospitalization, or incarceration, were unable to participate. This survivorship bias may lead to an underestimation of the full extent of harms associated with service withdrawal.

Finally, the study relied on self-reported, retrospective accounts of experiences before and after changes to safer supply access, which introduces the potential for recall bias. However, given the salience and emotional intensity

of program closures and transitions described by participants, these accounts nonetheless provide critical insight into the lived consequences of policy and funding changes.

Conclusion

The study illustrates that the end of pilot federal funding for safer supply that resulted in the closure of programs offering comprehensive, wrap-around services represented a reversal of many gains SSPs worked to address. Those who lost access entirely were forced back to the unregulated drug supply, resulting in destabilized drug use patterns and increased reliance on coping strategies that can lead to criminalization. Their risk of overdose also rose, revealing that the absence of safer supply is not a neutral baseline, but a harmful condition that produces predictable health, social and criminal consequences. Even those with continued access, whether through the same or an alternative prescriber, described some form of destabilization. Those who transitioned to an alternative prescriber experienced unpredictable appointment scheduling and returns to high surveillance practices which were incompatible with their lives and reflected mistrust between themselves and their prescriber. Stress and anxiety were nearly universal regardless of continuity. Even those with continued access feared that they could still lose their program due to the precarity of SSPs and expressed concern over the health and wellbeing of their peers who had lost access.

Ultimately, the dismantling of SSP funding in Ontario did not merely reduce medication availability; it destabilized the structural scaffolding that made safer supply effective in the first place. The forced removal from programs reduced access to supervised consumption, drug checking, primary care, and other health services and social services, which participants described as essential for their health and wellbeing. This highlighted the crucial protective, social, and structural infrastructure that SSPs played. This underscores a critical insight for future policy: the success of safer supply hinges not only on medication continuity, but on the preservation and expansion of the integrated, relational, and low-barrier environments that provide an expanded range of pharmaceutical medications and enable people who use drugs to survive within an increasingly lethal drug landscape.

Appendix A

See Table 3

Table 3 Wraparound Service Access Prior to and Following SSP Closures

	N	%
Supervised Consumption/Inhalation Service (SCS)		
<i>SCS Accessed Prior to SSP Closure</i>		
Yes	25	83%
No	5	17%
<i>Access to SCS elsewhere Since SSP Closure</i>		
No, but I am interested in accessing this service	13	43%
No, I am not interested in accessing this service	10	33%
Yes	7	23%
Opioid Agonist Treatment (OAT)		
<i>OAT Accessed Prior to SSP Closure</i>		
No	18	60%
Yes	12	40%
<i>Access to OAT elsewhere Since SSP Closure</i>		
No, I am not interested in accessing this service	22	73%
Yes	8	27%
Injectable Opioid Agonist Treatment (iOAT)		
<i>iOAT Accessed Prior to SSP Closure</i>		
No	28	93%
Yes	2	7%
<i>Access to iOAT elsewhere Since SSP Closure</i>		
No, I am not interested in accessing this service	25	83%
No, but I am interested in accessing this service	5	17%
Drug-checking Services		
<i>Drug-checking Accessed Prior to SSP Closure</i>		
Yes	24	80%
No	6	20%
<i>Access to Drug-checking elsewhere Since SSP Closure</i>		
Yes	12	40%
No, but I am interested in accessing this service	10	33%
No, I am not interested in accessing this service	8	27%
Substance Use Counselling (SUC)		
<i>SUC Accessed Prior to SSP Closure</i>		
No	16	53%
Yes	14	47%
<i>Access to SUC elsewhere Since SSP Closure</i>		
No, I am not interested in accessing this service	13	43%
No, but I am interested in accessing this service	11	37%
Yes	5	17%
Not sure	1	3%
Primary Care		
<i>Primary Care Accessed Prior to SSP Closure</i>		
Yes	24	80%
No	5	17%
<i>Access to Primary Care elsewhere Since SSP Closure</i>		
Yes	19	63%
No, but I am interested in accessing this service	7	23%
No, I am not interested in accessing this service	4	13%
Case Management		
<i>Case Management Accessed Prior to SSP Closure</i>		
Yes	19	63%
No	10	33%
Not sure	1	3%
<i>Access to Case Management elsewhere Since SSP Closure</i>		

Table 3 (continued)

	N	%
No, but I am interested in accessing this service	13	43%
No, I am not interested in accessing this service	11	37%
Yes	5	17%
Not sure	1	3%
Recreational/Drop-in Programming		
<i>Recreational Programming Accessed Prior to SSP Closure</i>		
Yes	16	53%
No	14	47%
<i>Access to Recreational Programming elsewhere Since SSP Closure</i>		
No, but I am interested in accessing this service	13	43%
No, I am not interested in accessing this service	12	40%
Yes	5	17%
Harm Reduction (HR) Supplies		
<i>HR Supplies Accessed Prior to SSP Closure</i>		
Yes	27	90%
No	3	10%
<i>Access to HR Supplies elsewhere Since SSP Closure</i>		
Yes	21	70%
No, but I am interested in accessing this service	5	17%
No, I am not interested in accessing this service	4	13%
Harm Reduction (HR) Education		
<i>HR Education Accessed Prior to SSP Closure</i>		
Yes	19	63%
No	11	37%
<i>Access to HR Education elsewhere Since SSP Closure</i>		
No, I am not interested in accessing this service	12	40%
No, but I am interested in accessing this service	9	30%
Yes	9	30%
Mobile Care		
<i>Mobile Care Accessed Prior to SSP Closure</i>		
Yes	16	53%
No	13	43%
Not sure	1	3%
<i>Access to Mobile Care elsewhere Since SSP Closure</i>		
No, I am not interested in accessing this service	12	40%
Yes	10	33%
No, but I am interested in accessing this service	7	23%
Not sure	1	3%
Withdrawal Management		
<i>Withdrawal Management Accessed Prior to SSP Closure</i>		
No	22	73%
Yes	8	27%
<i>Access to Withdrawal Management elsewhere Since SSP Closure</i>		
No, I am not interested in accessing this service	23	77%
Yes	5	17%
No, but I am interested in accessing this service	2	7%
Housing and Social Supports		
<i>Housing and Social Supports Accessed Prior to SSP Closure</i>		
Yes	19	63%
No	11	37%
<i>Access to Housing and Social Supports elsewhere Since SSP Closure</i>		
No, I am not interested in accessing this service	16	53%
No, but I am interested in accessing this service	7	23%

Table 3 (continued)

	N	%
Yes	6	20%
Not sure	1	3%

Abbreviations

CHC	Community Health Centre
ED	Emergency Department
HART Hubs	Homelessness and Addictions Recovery Treatment Hubs
OAT	Opioid Agonist Therapy
REDCap	Research Electronic Data Capture
SCS	Supervised Consumption Services
SSP	Safer Supply Program
SUAP	Substance Use and Addictions Program
UPHNS	Urgent Public Health Needs Sites

Supplementary Information

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Supplementary Material 1

Author contributions

All authors read and approved the final manuscript. FA developed the concept for the manuscript. FA, AS, JMG, AC, and NK procured and interpreted related data, and contributed to the writing, reviewing, and editing. MK, GK, UC, and JR contributed to the reviewing and editing. JR oversaw all aspects of the paper and acquired the funding. All authors had access to the study data and have accepted responsibility for submitting it for publication.

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Data availability

The datasets generated and/or analyzed during the current study are not publicly available to protect study participant privacy.

Declarations

Ethics approval and consent to participate

This study received research ethics approval from the Centre for Addiction and Mental Health (CAMH) (REB #2025/074). All participants provided informed consent to participate in this study.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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