0:00:01.69 -> 0:00:04.23 All right, welcome everyone.
0:00:04.23 -> 0:00:06.33 Let’s go ahead and get started.
0:00:06.33 -> 0:00:09.78 So it is my pleasure to introduce our speaker for today,
0:00:09.78 -> 0:00:12.04 Dr. Ryan McNeil.
0:00:12.04 -> 0:00:14.77 Dr. McNeil is an Assistant Professor,
0:00:14.77 -> 0:00:17.53 was joining appointments at the Yale School of Medicine
0:00:17.53 -> 0:00:20.29 and also here at the Department of Social
0:00:20.29 -> 0:00:23.1 and Behavioral Sciences at Y.S.P.H.
0:00:23.1 -> 0:00:26.6 He is teaching a course on Harm Reduction this semester
0:00:26.6 -> 0:00:28.3 which many of you might be taking.
0:00:29.73 -> 0:00:31.99 Dr. McNeil received his PhD
0:00:31.99 -> 0:00:34.19 from university of British Columbia.
0:00:34.19 -> 0:00:39.19 And he joined the Yale Faculty in December, 2019.
0:00:39.68 -> 0:00:43.18 Dr. McNeil’s research exams to Social Structural
0:00:43.18 -> 0:00:45.3 and Environmental Influences
0:00:45.3 -> 0:00:47.83 on the Implementation and Effectiveness
0:00:47.83 -> 0:00:52.24 of Harm Reduction and Addiction Treatment Interventions.
0:00:52.24 -> 0:00:54.76 He also studies the Influence of Housing
0:00:54.76 -> 0:00:56.57 and Housing Based Interventions
0:00:56.57 -> 0:00:59.223 and overdose related risk.
0:01:00.593 -> 0:01:03.93 He is the principal investigator on multiple grants,
0:01:03.93 -> 0:01:05.05 both from N.I.H
0:01:05.05 -> 0:01:08.81 and from the Canadian Institute of House Research.
0:01:08.81 -> 0:01:10.6 And he’s also the co-creator
0:01:10.6 -> 0:01:13.5 and scientific lead of Crackdown.
0:01:13.5 -> 0:01:16.49 So this was a Podcast launching January, 2019
0:01:17.797 -> 0:01:19.82 and it is designed to mobilize research
0:01:19.82 -> 0:01:23.863 and amplify The voices of people who use drugs.
0:01:24.8 -> 0:01:27.95 This media collaboration has been called a podcast
0:01:27.95 -> 0:01:29.85 most likely to save lives,
and he has received a number of awards including the Third Coast International Audio Festivals on the Radio Impact Award, the Canadian Hillman Prize and a Silver Medal from New York FestivalS Radio Awards.

So without further ado, let’s welcome Dr. McNeil. Hi everyone, Katie, thanks for very kind introduction. It always reminds me that I feel like I need to update my Faculty page. So it has like a tighter description of the things that I do ’cause it always feels a little bit much which is to say I’m just really happy to have you all here and present on both the broader concept and idea of safe supply in the context of the overdose crisis. And talk about some of the work that we’ve been doing. Looking at this, this might be new to some of you, so please don’t hesitate to ask questions. I’ll try to leave ample time at the end, and please bear with me in the clunkiest of presenting formats. I can’t be the only one who’s looking forward to doing talks in person again. Great, so a few notes as I get started, a lot of the discussion will focus on work I’ve been engaged with in Vancouver, Canada which is both where I moved here from and where I continue to run a range of different projects that are examining the Implementation of safe supply and its role in responding
I’ll spend a bit of time conceptualizing the overdose crisis as well as getting into some of the specific dynamics worth considering as we move into frankly a period of severe overdose related morbidity and mortality.

A lot of the work and thinking about safe supply really comes out of this particular space which is the Washington Needle Depot which became the Molson or the Maple Overdose Prevention Site in Vancouver, Canada’s Downtown Eastside. And really it was the beginning of 2017 as the city was grappling with a severe overdose crisis.

When you know, longstanding ideas of drug legalization and alternatives to an illegal drug supply, increasingly characterized by fentanyl and other adulterants began to really percolate in the community and become a topic of discussion as people sought out alternatives to increasingly toxic drug supply that was killing people.

So during field work in work that I do primarily as an ethnographer at this site, both people involved in operating it as well as others visiting the site began to talk a lot about the need for alternatives and the need for a safe supply. And this was very much aligned with other discussions that were happening in Circles of Drug-User Activists in the community which has a longstanding history of drug user organizing.
That’s been critical to advancing Drug Policy Reform both in Canada and globally, including the implementation of supervised consumption sites and other interventions.

Now I’ll get into this a little bit later, but that the city has also been home to several clinical trials for advanced treatment options for opioid use disorder, including a heroin prescription heroin trial and an injectable hydromorphone trial that further prime the community for discussions of alternatives.

And so this began to become more pronounced with an Activist Circles and really became a bit of a rallying cry as the community was impacted by just an incredible level of loss in the wake of a sustained overdose crisis. It really raises I think three interlocking questions, really the heart of what I wanna touch on today which is effectively, why were so many people dying? What is safe supply, and how does it address the overdose crisis? And so certainly there’s broader narratives in terms of how we think about the overdose crisis that become dominant, that in kind of relatively straightforward waves of prescription opioids, onto heroin, onto fentanyl onto now psychostimulants and other drugs.
But it’s always been a little bit messier than that. And the period I’m really gonna concentrate on is kind of this period of fentanyl and other adulterants within the supply. And certainly as folks are likely aware, fentanyl has been associated with a rapid escalation of the overdose crisis across North America as a more potent opioid that is becoming a primary driver. Well is long the primary driver of overdose deaths in North America. And really, what are my early orientations to the scope and severity of fentanyl happening alongside field work that we were doing? So running studies out of an area with really one of the most severe fentanyl driven overdose crises was certainly an experience of, you know, doing the work against the backdrop of profound loss and this grappling with what was happening as fentanyl became more prominent within the drug supply, and it became the dominant illicit opioid within the supply. First being sold kind of as heroin.
then outright displacing heroin within the local supply. And so it really struck us early on,

And so it really struck us early on, at first we were just losing people. I remember a study we were operating at that time that involve follow-up interviews with folks who had lost their housing to eviction. And, you know, effectively we quickly realized that this was happening as the shift was happening and we couldn’t find people. And then it quickly dawned on us that, you know, they were people who we were losing to this rapid spike that was happening in overdoses in the community. And it was fundamentally different.

And so we commonly encountered people who would put it really as such.

You know, with heroin you feel it coming on, you feel the intensity, you feel like you’re gonna puke. You know, keeps coming, and you know, I’m going to go down. Fentanyl, you’re sitting there waiting for something, and the next thing you know, there’s an ambulance attendant there it hits you like a Mac truck. You don’t feel it, nothing just boom, down.

You get up and swear that you didn’t even do your shot, you’re looking for it. And so this certainly for me, always perfectly summed up that this transition from, you know, a community that long been impacted by a high level of overdoses within the context
of a very kind of contained drug scene to suddenly something completely different, and, you know, the comparison of it hits you like a Mac truck really felt like what happened to the whole community. And then this certainly was consistent with what was happening across North America at this time. So in the United States, you know, you’ll notice this graph from the C.D.C that gets circulated, and I think I see in every presentation on the overdose crisis at this point. When you see this orange line, the begins to take off in, in 2015 and really becomes the dominant and still more recently further dominant cause of overdose deaths. But they’re just primarily synthetic opioids and specifically fentanyl and fentanyl adulterated drugs. So just in case folks aren’t aware fentanyl is effectively a much more potent opioid that’s associated with a much higher risk of overdose. And certainly that’s been born out by the data. The onset tends to be quicker, they tend to be more severe and it certainly becomes challenging to navigate especially transitional drug supplies wherein fentanyl is replacing heroin or other opioids, or, you know, across a lot of different contexts where, you know, one doesn’t necessarily know the potency
0:11:07.68 –> 0:11:12.68 of fentanyl from one package to the next when using.
0:11:14.84 –> 0:11:17.89 And so fentanyl, you know, certainly has become
0:11:17.89 –> 0:11:21.41 this key driver of the overdose crisis.
0:11:21.41 –> 0:11:22.86 And so if we think about Canada,
0:11:22.86 –> 0:11:25.863 where I’m gonna really kind of concentrate on a bit,
0:11:27.89 –> 0:11:30.67 you know, we similarly see, so, you know,
0:11:30.67 –> 0:11:35.67 this is a graph depicting total opioid related deaths
0:11:36.93 –> 0:11:40.78 by opioid type.
0:11:40.78 –> 0:11:42.92 And you’ll certainly notice that, you know,
0:11:42.92 –> 0:11:44.85 more and more over time,
0:11:44.85 –> 0:11:47.6 these are dominated by fentanyl
0:11:47.6 –> 0:11:50.7 and other fentanyl related analogs
0:11:50.7 –> 0:11:52.903 that can be even more potent.
0:11:55.04 –> 0:11:56.24 And then certainly
0:11:56.24 –> 0:11:58.58 because I think it bears specific attention,
0:11:58.58 –> 0:12:00.47 especially within a policy context
0:12:00.47 –> 0:12:03.28 wherein discussions of the overdose crisis
0:12:03.28 –> 0:12:06.51 still remain dominated by an emphasis on pharmaceuti-
cal
0:12:06.51 –> 0:12:07.85 or prescribed opioids
0:12:07.85 –> 0:12:09.903 which we’re gonna flip a little bit here.
0:12:11.92 –> 0:12:15.11 Did the majority of deaths in Canada has elsewhere
0:12:15.11 –> 0:12:17.67 certainly are driven by, you know,
0:12:17.67 –> 0:12:19.76 non-pharmaceutical opioids,
0:12:19.76 –> 0:12:21.543 even if used in combination.
0:12:26.4 –> 0:12:27.77 So as this has happened,
0:12:27.77 –> 0:12:30.023 and I mentioned these framing pieces,
0:12:31.95 –> 0:12:35.19 you know, early attention to the overdose crisis
0:12:35.19 –> 0:12:37.69 in North America is really emphasized
0:12:38.757 –> 0:12:40.41 and it happened alongside this period
0:12:40.41 –> 0:12:45.01 of declining life expectancy among white folks.
And certainly it became a dominant narrative. This was very much driven by, you know, the overdose crisis and deaths of what became term deaths of despair, you know. And this really configured a set of policy responses that were distinct from more traditional war on drugs approaches even as those continued to dominate.

But also frankly, is obscured the severe impact of the overdose crisis on communities of color. Certainly, you know, it’s really no longer the case that deaths among white folks and in the U.S far exceed those of other folks. And in fact, among people of color, overdose rates are rising quite dramatically and among indigenous folks remain incredibly high in fact the highest of any population. And so I think, you know, this is just a point to emphasize because we’ll cycle back to this in that when emphasizing, you know, deaths of despair, it’s to foreground that the broader range of structural inequities that certainly drove to some extent heightened overdose mortality among specifically poor white folks. These have had longstanding and severe disproportionate impacts on communities of color. So things from policing to impacts of hosing and equities and vulnerabilities, poverty, et cetera. So I mentioned the specific research context I’m gonna be focusing on is in Vancouver, Canada.
So Vancouver is located in British Columbia, Canada. And it’s commonly, you know, when you hear about Vancouver, you frankly commonly hear about, you know, two things at this point. One is frankly, a severe overdose crisis, but it’s long been characterized as one of the world’s most livable cities. Kind of nested between the Pacific ocean and the mountains and in the Pacific Northwest it’s, you know, beautiful. And that framing it’s really overlooked the extent to which it’s also a site of extreme social and structural inequalities. So the profits itself underwent a relatively rapid shift in the illicit drug supply. And it’s long had a sustained heroin scene really stretching back decades. Really stretching back decades. And, you know, effectively what we saw in really, you know, 2015, catalyzing in 2015, was the gradual replacement of heroin by fentanyl. First being sold alongside fentanyl, adulterated within fentanyl and then, you know, later becoming what one would just expect to find when purchasing illicit opioids in that context. So this rapid escalation in overdose deaths led to the declaration of a public health emergency, which later created basically a pathway for the further scale-up of overdose prevention and response interventions. So Vancouver had long been side of, you know,
I mentioned these trials looking at injectable opioids as an option for folks with opioid use disorder on through to supervise consumption or overdose prevention sites.

And this emergency situation allowed these to be further scaled up.

So these are largely clustered in the Downtown Eastside which is see this bar of people always covers what I’m trying to find.

This darken neighborhood toward the top of the map, which is about a 10 by 10 block neighborhood and the side of a lot of these interventions that I’ll be speaking of.

So this emergency order, you know, first activists began pushing for the opening or outright opening interventions including supervised consumption sites as part of the response, which are sites where people could use pre obtained drugs, which were later scaled up under the authority of the Province.

Further involved the scale up of injectable treatment options and fentanyl testing strips and drug checking technologies.

We saw the extension of these interventions into a variety of settings.

So this is a shot of an emergency shelter that had adapted supervised consumption approaches.
into its setting to increase safety for folks staying there.
And yet, even as these interventions were scaled up and, you know, public health modeling and other data showed a significant positive impact on overdose mortality.
High rates of overdose is still persistent.
Now certainly a large part of this was just the extreme shift within the drug supply and, you know, the fact that fentanyl had become the dominant opioid, later other adulterants entered the supply for sporadically and then more regularly from a tasselland.
periodically synthetic cannabinoids to occasionally Xylazine which is a tranquilizer.
So there was this complex kinda mix within the local supply.
Now, certainly a range of structural factors continued to drive overdoses in the setting, which we’ve looked at extensively.
Things like policing strategies, which rocked in place-based and displaced people from overdose prevention and response interventions, high levels of poverty, which, you know, impact people’s ability to manage drug use within the context of prohibition and can be a particularly dangerous mix in the context of a very toxic drug supply.
On through to a range of other inequities that drive overdose related mortality.
And so within this backdrop, I really cycle back
0:19:28.66 –> 0:19:30.05 to some of those early conversations
0:19:30.05 –> 0:19:31.98 that were happening within Activist Circles
0:19:31.98 –> 0:19:33.31 and in the sites where people
0:19:33.31 –> 0:19:36.47 were accessing safer places to use
0:19:36.47 –> 0:19:39.06 as the drug supply went sideways,
0:19:39.06 –> 0:19:41.67 and that was a push for safe supply.
0:19:41.67 –> 0:19:45.12 And so at its most basic level, you know,
0:19:45.12 –> 0:19:48.87 safe supplies laid out wonderfully in this concept document
0:19:48.87 –> 0:19:51.61 by the Canadian Association of People who Use Drugs
0:19:52.49 –> 0:19:54.23 which is effectively the safe supply
0:19:54.23 –> 0:19:56.9 refers to illegal unregulated supply of drugs
0:19:56.9 –> 0:19:58.6 with mind or body altering properties
0:19:58.6 –> 0:19:59.93 that traditionally have been accessible
0:19:59.93 –> 0:20:02.23 only through the illicit drug market.
0:20:02.23 –> 0:20:04.9 Drugs included are opioids such as heroin,
0:20:04.9 –> 0:20:08.063 stimulants such as cocaine and crystal metham-
phetamine,
0:20:09.36 –> 0:20:12.583 hallucinogens such as M.D.M.A and L.S.D and mari-
juana.
0:20:13.82 –> 0:20:16.53 So effectively, you know,
0:20:16.53 –> 0:20:21.53 what the concept of safe supply seeks to do
0:20:21.65 –> 0:20:24.58 is intervene mean to address overdoses
0:20:24.58 –> 0:20:28.57 driven by supply characterized by, you know,
0:20:28.57 –> 0:20:33.57 being toxic by fentanyl, high concentrations of fentanyl
0:20:34.66 –> 0:20:36.3 or other adulterants.
0:20:36.3 –> 0:20:38.36 By providing people with an alternative
0:20:38.36 –> 0:20:40.21 in a way that respects their agency
0:20:40.21 –> 0:20:42.66 and choice in relation to their drug use
0:20:42.66 –> 0:20:45.543 as well as the variety of ways in which people may use.
0:20:47.03 –> 0:20:52.03 And so this concept, you know, really came out of
0:20:52.8 –> 0:20:54.63 and I can’t emphasize this enough,
the work of Drug User Activists and Organizers.
It later got picked up so here’s a document
that we’ve worked on at a center
that I was asked slash still am affiliated with
when we pick up this idea and think about it
in the context of Compassion Club Models
that could provide people with safer access, you know,
and quickly this became part of a larger discussion
happening within the academic literature.
First as something that has a critical role
in addressing the overdose crisis,
on through to something that also could address harms
driven by escalating stimulant overdoses
that include in some cases,
those driven by fentanyl adulterated stimulants,
on through to, and I think one of the coauthors
of this is on this call.
On through to something that could play a critical role
in responding to an escalation and overdoses
that have happened under conditions imposed by COVID-19
especially wherein people are injecting alone.
And more recently on through to some,
an approach that could, you know,
rethink the ways in which Drug Policy operates globally
and could effectively trace a pathway for redressing
some of the harms caused by the war on drugs
specifically by involving folks
who have been disproportionately impacted
by this in production and export to markets
with a need for safer pharmaceutical,
alternatives and legalize options.

And so, you know, by and large,

this was really just a concept circulating within circles as people were working behind the scenes as an effort to scale these up.

But what they effectively did is extend a longstanding logic that, you know, opioids especially are part of the response to the harms of overdose.

So certainly there’s a Cochrane review. They really helps to establish the efficacy of heroin maintenance or heroin based treatment for folks who are heroin dependent, as something in this particular review as something in this particular review as a kind of add on therapy to methadone, but that cannot reduce engagement with an illicit drug supply.

On through to work that is further established its effectiveness in minimizing engagement in what often get characterized as social harms associated with drug use such as engagement in criminal activity, et cetera, and certainly further trial work that is even established it as potentially superior to methadone for the treatment of opioid use.

This trial in the New England Journal finding it effectively to be superior for folks who had not previously benefited from methadone, on through to more recent work, through a trial where they compared heroin
0:24:14.25 –> 0:24:18.113 to hydromorphone further establishing that as an Option.
0:24:19.34 –> 0:24:22.81 And so effectively, you know, people are bringing up this
0:24:22.81 –> 0:24:25.78 and pushing for this, this need for a shift
0:24:25.78 –> 0:24:30.61 toward access to better regulated safer opioids.
0:24:30.61 –> 0:24:34.87 And so, you know, eventually we saw programs implemented
0:24:34.87 –> 0:24:36.603 on a pilot level,
0:24:38.32 –> 0:24:40.63 which is partly what I’ll be focusing on
0:24:42.28 –> 0:24:43.79 based on work that we’ve been doing.
0:24:43.79 –> 0:24:47.52 So here you see a shot of an overdose prevention site,
0:24:47.52 –> 0:24:49.13 the Molson overdose prevention site
0:24:53.36 –> 0:24:55.47 And it implemented a program wherein
0:24:55.47 –> 0:24:57.18 people could be referred in through
0:24:57.18 –> 0:25:00.83 and were effectively followed through primary care,
0:25:00.83 –> 0:25:05.83 but could be effectively dispensed two mil, eight mil-
0:25:06.21 –> 0:25:10.22 tablets of hydromorphone to five times a day
0:25:10.22 –> 0:25:11.35 during the operating hours
0:25:11.35 –> 0:25:13.45 of the overdose prevention site,
0:25:13.45 –> 0:25:16.08 so as to limit their engagement
0:25:16.08 –> 0:25:18.06 with the illicit drug supply.
0:25:18.06 –> 0:25:19.94 And so you’ll notice this,
0:25:19.94 –> 0:25:21.89 I don’t know if you can see my pointer,
0:25:23.11 –> 0:25:27.55 but so folks would effectively come into the space
0:25:27.55 –> 0:25:31.09 through this door above the text box.
0:25:31.09 –> 0:25:33.68 And you know, this is an open overdose prevention site
0:25:33.68 –> 0:25:38.35 wherein folks are able to effectively ingest
0:25:38.35 –> 0:25:41.24 with the exception of by inhalation
0:25:42.36 –> 0:25:43.56 drugs that they bring in
or if registered in this program associate with the Primary Care Clinic
could effectively pick up hydromorphone dispense through this nursing window and use onsite.
Now, still later further program was implemented really just prior to COVID hitting
wherein people could similarly access effectively an equivalent amount of hydromorphone through a still lower threshold method
which was effectively, I mean, it’s basically a vending machine that takes a biometric reading wherein someone would effectively place their hand on the screen, and then they would be dispensed hydromorphone in accordance with their prescription and dosage schedule.
And so this later within the context of COVID and the serious concerns of what, I mean, frankly ended up happening with an escalation of overdose into prescribing guidance documents for the Province of British Columbia to further allow providers to outright prescribe hydromorphone and then also Dexedrine and mesocolon to folks for the purposes of still further limiting potential engagement with a drug supply that, you know, certainly in the lead up to COVID had become even more, I mean, I wanna say erratic, but there’s certainly much more direct language
I could use that to characterize what was happening.

And the deep concern about, you know, an escalation of overdose deaths that you know, frankly has subsequently born out.

And so I’m gonna really talk about some of the work we’ve done, looking at the implementation and effectiveness of these programs for folks drawing on Ethnographic Fieldwork and qualitative interviews.

And so that site, the most overdose prevention site implementing the hydromorphone distribution program. So we’ve done extensive ethnographic fieldwork at that site, including with a specific focus on the hydromorphone distribution program.

Observing its operation, spending time around it, interacting with folks, accessing or trying to access it to get a sense of how it both fits into people’s daily routines and lives and its impacts on them.

And then alongside that, we were effectively interviewing as many folks as we could enroll through that program to get a further sense of its impacts.

Now we started these interviews and then COVID hit so our followup rate certainly dropped down.

We interviewed 42 of the then 69 folks who had been enrolled in the program and I wanna say we got 16 for followup before suspending activities due to due to COVID.
And then alongside that, we’ve more recently been doing interviews with folks accessing safe supply through the risk mitigation guidelines, implemented post-COVID.

And so what really concerned with in this work is how broader factors are impacting the implementation of the program. So how dynamics within the risk environments of folks who use drugs. So this complex assemblage of social, physical, economic and policy factors that shape the situations or settings in which people use drugs including their ability to access safe supply. And then further considering differential impacts on folks who use drugs on the basis of their social position.

So how relational aspects of their identities, experiences and positions on the basis of things like age, class, sexuality, gender, race, ability, citizenship status, kind of act in relation to these broader sets of factors within the risk environment to shape their specific sets of experiences. And so I’ll be sharing some findings from the first round on the Molson risk prevention site, as well as emerging findings based on the work we’ve been doing on the Risk Mitigation Guidelines. And so the first thing and I can’t emphasize emphasize this enough.
0:30:33.1 –> 0:30:36.85 because it became certainly a thing
0:30:36.85 –> 0:30:39.74 that impacted how we thought about these programs early on.
0:30:39.74 –> 0:30:41.39 And that quite simply was the question
0:30:41.39 –> 0:30:42.63 of whether or not these programs
0:30:42.63 –> 0:30:46.083 can attract folks who use drugs.
0:30:47.04 –> 0:30:48.78 And what we effectively found
0:30:48.78 –> 0:30:51.17 is that people are highly motivated
0:30:51.17 –> 0:30:54.77 to access alternatives to the illicit drug supply.
0:30:54.77 –> 0:30:57.54 And low threshold access to pharmaceutical alternatives
0:30:57.54 –> 0:31:01.13 in particular, can reduce their potential exposure
0:31:01.13 –> 0:31:04.99 to fentanyl and other adulterants.
0:31:04.99 –> 0:31:08.73 So effectively, what we found is that people
0:31:08.73 –> 0:31:11 would often describe their motivation
0:31:11 –> 0:31:13.99 for accessing the program as being specifically driven
0:31:13.99 –> 0:31:17.77 by concerns with the illicit drug supply.
0:31:17.77 –> 0:31:20.12 So there have at times been narratives
0:31:20.12 –> 0:31:21.61 around fentanyl seeking
0:31:25.69 –> 0:31:27.3 And while people’s use of fentanyl
0:31:27.3 –> 0:31:32.01 was exceedingly complex shaped by opioid tolerance,
0:31:32.01 –> 0:31:34.553 environmental conditions and exposure,
0:31:35.56 –> 0:31:38.07 we found that people had deep concerns
0:31:38.07 –> 0:31:42.09 about potentially being exposed to drugs
0:31:42.09 –> 0:31:44.04 that contained more fentanyl
0:31:44.04 –> 0:31:46.76 than they might expect an air ago,
0:31:46.76 –> 0:31:49.49 heightening their potential risk of overdose
0:31:51.45 –> 0:31:52.995 as well as other adulterants
0:31:52.995 –> 0:31:54.823 that were showing up in the supply.
0:31:55.52 –> 0:31:59.86 And People in turn reported that they
0:31:59.86 –> 0:32:01.54 in accessing this program,
weren’t as reliant on accessing the drug supply.
Now one of our participants put it as such.
Now I’m on this hydromorphone program.
It’s changing my drug use a lot actually.
Like I went from using fentanyl five to 10 times a day
to using once a day.
So in the last month I’ve gone down to just once a day,
twice a day, and that’s good.
So certainly, and I’ll touch on this in a bit
within the context of, you know,
programs operating within a limited timeframe
around the operating hours
of the overdose prevention site,
and certainly people’s lives were complex
and would sometimes place them
in places where they couldn’t access it
when needing to use.
People nonetheless reported that they were using
illicit drugs less often because they had an alternative
and that they saw this as a chief benefit of the program.
Now, alongside this motivation that people had
to access the program, certainly we observed demand
far exceeding the ability of the site
and the attached Primary Care Group
to effectively enroll people quickly enough to,
and, you know, with sufficient capacity
to provide support in this program.
It wasn’t unusual to be doing field work at the site
and have someone show up
wanting to get on the program immediately
because they needed, you know,
something to mitigate withdrawal experiences which can cause severe pain and discomfort.

And you know, who yet weren’t able to enroll at that time.

So certainly, you know, people want it on this.

They wanted to reduce their exposure to fentanyl and the program couldn’t keep up with demand.

Now certainly we found that access to a reliable supply of pharmaceutical alternatives to the illicit drug supply, enabled people to minimize their engagement in drug scene activities.

It also helped them establish drug use routines that help them to maintain their health and well-being.

And so specifically, you know, people didn’t have to generate the income or funds that they often would have to through informal or illegal income generation so as to purchase illicit opioids within the local drugs scene.

And so people really emphasize the positive impact on their lives, both in terms of how this limited their potential exposure or engagement with police and further engagement in carceral systems.

Especially for women who are accessing the program they really emphasized in many cases that they were able to reduce or, you know, effectively stop engagement with sex work which for many was driven by their need to generate money to maintain their opioid use.
within the context of drug prohibition.

One of our participants put it quite directly, you know,
when I used to run out of money, I would do crime, right?
So that stopped.
I’m not running out of money because this hydromorphone is free, right?
That’s a big bonus for me.
I don’t have to decide between eating and doing dope, right?
I can do my dope here and then go eat, it’s working fine.
And you know, this further really hits on the point
that, you know, people talked about, you know,
the extreme time and energy
and work that goes into managing opioid use
within the context of severe poverty
and the war on drugs, you know,
effectively meant that people had to make these trade offs.
And so people were better able to attend to things
that were critical to their health and well-being
like quite simply eating.
You know, and benefit for many people,
so a number of people were what we might consider
orphan pain patients who had previously
been on long-term opioid therapies before being cut off.
And a lot of these folks would specifically
emphasize the positive impacts on pain management
to have routine access to opioids.
So this one person started accessing the program
and injecting before moving to oral ingestion.
So I was doing the injections, but now I’m doing the oral which is two pills I get of Dilaudid and it helps me with pain. The last time I was in hospital, I got some oral Dilaudid and I liked it, it helped me a lot. So I was looking forward to it. I thought I’d like the injections, but it turns out I liked the oral better. And so this was a common sentiment in that, you know, people reported severe chronic, and in some cases acute pain that they further felt that this program was critical in helping them manage. Now certainly the one thing that we found, so, you know, if we think back to that Canadian Association of People who Use Drugs, framing, you know, what we’re effectively talking about as a regulated or legal market for drugs as an alternative, and yet both in terms of this hydromorphone distribution program and still later the risk mitigation guidelines, you know, these are being delivered through Primary Care. And what we’ve effectively found is that the medicalization of approaches to safe supply has actually constrained the effectiveness of this approach. And it’s done this in a number of ways both through misaligning the intervention design and the underpinning philosophy. And, you know, subsequent to that,
And so there’s really kind of three points here. So first is that, you know, primarily opioid prescribing within the context of these programs has had an emphasis on withdrawal management. That is effectively prescribing people on amount that isn’t necessarily aligned or kind of a match for the level of illicit opioids they’re using especially within the context of fentanyl.

People often, you know, reported that what they’d received was effectively enough to mostly if not totally allow them to not experience dope sickness. But not necessarily get the high. And certainly there’s deep questions of agency and choice in the context of substance use that this raises in so far as, and especially within the context of severe social suffering, you know, the pleasure associated with drugs is something that warrants attention and, you know, maybe should prompt us to rethink our approach to prescribing, so as to allow people to have experiences that they may wish for.

Second enrollment is not meeting demands. We saw this both in the context of the hydromorphone distribution program.
wherein people were routinely showing up hoping to get on the program, you know, being in withdraw and subsequent to that at an extreme risk of purchasing illicit opioids and using within context that may heighten their potential risk of overdose, having to rush injecting or not do a test for a shot. And effectively the program needed scale up to meet the severe demand for the program. And then second, you know, within the context of the implementation of risk mitigation guidelines, you know, what we’ve effectively see is the number of people on the program is only a small fraction of the number of folks who may be eligible. And so within the context of a drug supply that’s gone further sideways, especially with the estazolam, which is a benzo showing up in addition to fentanyl within the illicit opioids supply, a rapid escalation of overdose deaths. And so enrollment, I believe is hovering around three and a half to 4,000 right now, where there’s a potentially up to 70,000 people in the Province who may be eligible for the program. And so certainly in the interviews that we’ve been doing with people about their experiences of getting on or trying to get on this program, we’re finding that people are encountering Primary Care Providers unwilling to pick up these guidance documents.
and provide them with alternatives to a toxic drug supply.

And while certainly it is important that, you know, treatment options be made available, you know, for those not wanting to go on those, you know, they’re really being put in a horrible risk.

Finally, you know, the majority of folks who’ve been accessing through the Risk Mitigation Guidelines have, you know, effectively been required to pick up their drugs in the pharmacy every day. And so this has raised concerns for people both within the context of managing potential exposure to COVID.

As you know, I think we collectively know, you know, COVID has disproportionately impacted vulnerable communities and especially folks who use drugs, grappling with multiple other structural vulnerabilities, including, you know, housing vulnerability and poverty as well as, you know, racial discrimination within a variety of systems.

And so these placed a burden on people that, you know, what’s concerning within the context of COVID but was also difficult to meet at times, given, you know, just all of the other things happening in people’s lives. And so certainly, you know, we’ve gone from a model originally envisioned it is quite flexible and low threshold to one that, you know, still while representing an advance in available interventions for
in the context of the overdose crisis
d this still might have thresholds that exceed that
which people were able to meet.
And so if folks are interested in learning more,
we published a couple of papers already
based on the work around the hydromorphone distribution program
at the Molson overdose prevention site, you know.
And just to cycle back.
So, you know, we're effectively in an era characterized by severe overdose related mortality,
driven by a toxic drug supply associated with fentanyl and other adulterants.
You know Connecticut is an example, you know, 13% of overdose deaths involved Xylazine in 2020.
And certainly this raises concerns about how can we effectively intervene.
Now, certainly the further scale up of evidence-based treatment options and medications for opioid use disorder like buprenorphine and methadone, represent an important priority.
I think we also need to start asking ourselves, you know, what are we doing for folks who aren’t able to access these
or don’t have interest in accessing these treatment options?
And effectively safe supply, you know, could be that thing.
And very much 'cause I think the Vancouver experience points to
is something that can work for people and is feasible.
And certainly, you know, rather than asking ourselves whether we should prioritize one thing over the other, you know, we're losing tens of thousands of people a year. And I think what we effectively need to reflect back on is within the context of such severe suffering and loss, you know. We need to be doing everything that we can, and, you know, this represents one potential pathway forward specifically important for folks whom if not on methadone or not on buprenorphine, you know, right now in the U.S have no other options than to to roll the dice each time they purchase and use and hope that, you know, this isn’t the time that they go down. So with that, I’m happy to answer any questions and thank you for joining and especially sitting through this with me on a zoom presentation which I know can be brutal. Any questions. I’ll ask a couple of questions then. So thank you very much, it was a very interesting presentation and an exciting place to be. I was wondering a couple of things with the kind of routinizing of the user’s day in having to go and get their hydromorphone, you know, on a regular basis, the increased womanizing of their day might empower them to perhaps aspire.
0:46:21.24 –> 0:46:25.56 to entering some kind of methadone
0:46:28.27 –> 0:46:31.23 So I was wondering, are you tracking entry
0:46:31.23 –> 0:46:34.41 into some sort of M.A.T program
0:46:34.41 –> 0:46:38.68 and kind of a sub-question to that is
0:46:38.68 –> 0:46:42.11 do they have expedited access
0:46:42.11 –> 0:46:46.87 for being, you know, in this hydromorphone program?
0:46:46.87 –> 0:46:49.44 Do they have an expedited access
0:46:49.44 –> 0:46:54.133 into M.H.E if they choose to enter?
0:46:56.24 –> 0:46:58.6 Yeah, so I’ll answer the second part first,
0:46:58.6 –> 0:47:00.53 and then jump to the first.
0:47:00.53 –> 0:47:04.54 So, you know, one of the great things about Vancouver
0:47:04.54 –> 0:47:08.09 is the settings effectively, you know,
0:47:08.09 –> 0:47:11.62 if you wanna be on methadone or Suboxone
0:47:11.62 –> 0:47:16.05 like it’s gonna happen on the spot.
0:47:16.05 –> 0:47:19.39 There’s a number of low threshold clinics
0:47:16.05 –> 0:47:18.64 that effectively someone shows up
0:47:18.64 –> 0:47:20.583 they’ll work to get them inducted.
0:47:22.93 –> 0:47:27.39 So, you know, while folks could wanna do that
0:47:27.39 –> 0:47:31.49 that wasn’t necessarily a pathway that we see
0:47:31.49 –> 0:47:33.323 now with that.
0:47:33.323 –> 0:47:36.09 You know, one of the exciting things about Canada
0:47:36.09 –> 0:47:39.31 is there’s just a greater range of treatments available
0:47:39.31 –> 0:47:41.08 for opioid use disorder.
0:47:41.08 –> 0:47:42.82 So there’s national guidelines
0:47:42.82 –> 0:47:44.92 for the treatment of opioid use disorder
0:47:44.92 –> 0:47:49.82 that include, you know, Suboxone as a first-line treat-
0:47:49.82 –> 0:47:53.98 ment, then, you know, methadone, then slow-release oral
0:47:53.98 –> 0:47:56.63 morphine,
0:47:56.63 –> 0:47:59.24 as part of a structured treatment program.
And what we would often see is less someone transitioning from a safe supply program onto Suboxone or methadone and more see them transitioning onto a slow release or morphine or moving into or quite often just between, depending on what worked for them at the time, the more structured injectable hydromorphone treatment program. And so, you know, frankly, I think it really also flips how we might think about the continuum of treatment options available to people. And so we’ve run a series of kind of interlocking longitudinal ethnographic projects, looking at these broader treatments available within the local context in Vancouver. And, you know, we effectively find that people move between them and not with the directionality assumed by the treatment guidelines wherein someone, you know, try Suboxone moves to methadone maybe tries Kadian or an injectable, but more so they’ll maybe start on a safe supply, move to injectable hydromorphone, then onto Kadian, and then, you know, maybe onto methadone at that point. But all of this is to say the people’s trajectories are just really, really diverse and shaped often by what they both hope to get out of treatment and what their preferences are around drug use itself. The key thing that tended to more drive it for people is if folks just didn’t want to be injecting anymore.
And certainly the oral therapies that weren’t just Suboxone or methadone were incredibly helpful to people in that context.

Hi, Ryan, it’s Ashley. I have two questions and they’re very different. So the first is you said a lot of really evocative statements about social suffering and pointing to some solutions that might allow for individuals to access euphoric experiences. I’m very curious to learn more about that. Can you talk a little more about some of those recommendations?

And then the second question is I’m curious to learn more about how this really powerful ethnographic and qualitative work is informing some of the more epidemiologic or more quantitative work that you’ve been doing. So if you could talk a little bit about some of the mixed methods that you’re using as well, I’d love to hear that.

We probably collectively just need to reckon with the fact that, you know, people have been getting high in some form or another for, I mean perhaps like almost the whole of human existence or at least thousands of years. And, you know, this has been a longstanding current across so much of the work that I’ve done wherein, you know
we think about people’s drug use primary lead through a lens of harm without looking at, you know,
the ways in which it can even be a positive thing for people or allow them certain experiences that are especially attractive within the context of social suffering.
And so, you know, people often spoke of in this work, you know, I want to be safer but I still want to be able to get high. And they were motivated to be engaged with programs that allowed them to be safer. And certainly this is consistent with work we’ve done on supervised consumption sites. But they still effectively wanted to have choice in terms of what they choose to do with their body, how they choose to live and so forth. And, you know, I don’t think we can separate this from the backdrop for so many folks. It was one of the few pleasurable experiences that they often had open to them within the context to, you know, perhaps managing severe chronic pain, living in conditions that Canada should be embarrassed of and the people characterized as a positive part of their lives and that many sought to continue even when engaged with treatment if that was something that they were interested in.
And so, you know, there’s probably just a much broader need to interrogate that, as we think through how we intervene in people’s lives and do so in a way that’s, you know, aligned with and sensitive to what they need or want. You know, more directly, so all of this work is operated alongside a series of other kind of more clinically or epidemiologically oriented evaluations of these interventions, which, you know, honestly things have been just really messed up by COVID, which is really frankly unfortunate. But effectively what it’s really allowed us to do is interrogate findings out of that have emerged at a preliminary epidemiological analysis, as well as, effectively flag things that have been emergent within the qualitative work to help better understand what’s happening.

And so, you know, to go back to Lauretta’s question about movement between programs certainly one of the things observed early on in our ethnographic qualitative work is that, you know, people had different trajectories within these programs than you might’ve anticipated, you know. And that’s something that’s been further built into the evaluation activities associated with the work. You know, another example would be just understanding the points.
at which people might have interruptions

in their access to these programs, which were, you know,

frankly found that were often much better able to track

through our ethnographic and qualitative work,

because we’re just a little bit more engaged with folks.

So all of this is to say that running these things

in tandem has really helped us understand

the richness of these programs in people’s lives

and interrogate emergent findings coming out

of the kind of more numbers based quantitative analysis.

Ali.

Hi, thank you so much.

This has been a wonderful experience to listen

to your work and your expertise.

I was wondering, it kind of sounds like

where you’re coming from in the experiences that you’ve had

and from Canada specifically,

there’s a completely different mindset

behind the idea of harm reduction and treatment

and like what someone’s trajectory

actually looks like from the onset

of interaction with harm reduction.

And I was just wondering,

did Canada always start out that way

or was there a big shift and how did that shift happen

and how can you see that shift happening here in the U.S

because, I mean, I’ve just been sitting here thinking,

wow, we are trash.

(laughs)

I mean, so I don’t want you to come away
from this feeling like that.
That’s like my worst outcome for the day.
In a good way, like inspired we’re trash,
we need to fix it.
So, you know, there’s been a couple of things
that have really helped in the Canadian context.
One and I can’t understate this enough,
Drug User Organizing and Activists.
And certainly the war on drugs in the U.S
and mass incarceration, I would argue
have really impeded Drug User Organizing
by frankly destroying communities
and especially communities of color
that should be central to organizing in this context.
Alongside that, you know, frankly,
a lot of other people have really stuck their neck out
around this and committed to working in allyship
with people who use drugs to advance intervention
in a way that meets their needs
to the extent that it is,
you know, I’ve been in kind of Drug Policy forums
and events in the U.S
that haven’t included folks who use drugs,
I don’t think you could do that in Canada
without probably having someone throw a shoe at you
at this point.
And all of this is to say as a challenge
to every single person here and as collectively.
If we’re not working to center folks who use drugs
in policymaking processes and interventions in this area,
what the fuck are we doing?
And we have to commit to doing that.
It’s not easy, it can be hard.
We’re more accountable in it
in ways that can be really difficult to grapple with
but you have to commit to doing it
if you wanna meaningfully intervene to address the crisis
and have policy that actually matches up
with people’s experiences
and avoid some of the unintended consequences
that we’ve seen a policy for too long.
So I think those things really need to happen together
you know, people working as allies
need to just as much work
to hold other people accountable, you know,
who were the people you’re meeting with,
who isn’t getting in those doors
and what can you do to get them there?
And especially, you know, doing so has to center folks
who are disproportionately impacted by the war on drugs.
Otherwise again, am like what are we doing?
All right, so it is actually one o’clock.
So we are out of time.
I see Mariah, you have your hand raised.
Do you want to ask your question very quickly?
Yeah, I can ask you to complete
I suppose I could also ask Ryan in class tomorrow.
But so I just sort of say shamelessly follow
a lot of like Canadian harm reduction groups
on social media and I’ve been seeing a lot of posting
0:59:14.26 –> 0:59:17.04 about the Drug Users Liberation Front
0:59:17.04 –> 0:59:22.04 giving out a safe supply of meth and heroin and cocaine
0:59:22.17 –> 0:59:26.43 that’s been tested by spectometry and immunoassay.
0:59:26.43 –> 0:59:28.255 And I just didn’t know if
0:59:28.255 –> 0:59:29.46 (inaudible)
0:59:29.46 –> 0:59:32.22 into what response around that has looked like in Canada
0:59:32.22 –> 0:59:36.29 and potential also like scale up of those tech knowledges
0:59:36.29 –> 0:59:37.853 for drug testing.
0:59:39.09 –> 0:59:40.36 Sorry, you kinda cut out on me
0:59:40.36 –> 0:59:42.243 on the last part of your question.
0:59:43.09 –> 0:59:45.71 Sure, so I was just talking about like
0:59:49.37 –> 0:59:52.56 I was just wondering what response in Canada has been like
0:59:52.56 –> 0:59:56.78 for like guard to groups, giving out safe supply
0:59:56.78 –> 1:00:00.173 and also what scale up of that tech might look like.
1:00:01.47 –> 1:00:03.75 Yeah, I mean, so, you know
1:00:03.75 –> 1:00:07.13 it’s primarily been something that’s just happened
1:00:07.13 –> 1:00:09.19 across a series of kind of events
1:00:09.19 –> 1:00:10.91 done for the purposes of drawing attention
1:00:10.91 –> 1:00:14.02 to the need for more options for people
1:00:14.02 –> 1:00:15.833 and more generally illegal market.
1:00:18.08 –> 1:00:20.45 And I would say part of it is
1:00:20.45 –> 1:00:24.44 it occupies a bit of a policy curiosity for folks
1:00:24.44 –> 1:00:29.44 more than anything at this point.
1:00:29.46 –> 1:00:32.72 And yet kind of symbolically is
1:00:32.72 –> 1:00:36.12 I think really interesting in, you know,
1:00:36.12 –> 1:00:38.993 demonstrating the further alternatives are available.
1:00:40.64 –> 1:00:42.35 You know, it certainly dovetails
1:00:42.35 –> 1:00:44.03 with the advocacy and activism
1:00:44.03 –> 1:00:47.82 being led by so many people around this.
Now with that said, you know, I think part of your question was about drug checking and you and I need to, I think separately connect about this. I mean, we’re not gonna end the overdose crisis with fentanyl test strips as an example. I just wanna say that I feel like I say this all the time. But if fentanyl is the dominant opioid in a setting and you have something that just tells you whether or not it has fentanyl in it, honestly it’s not really helpful except for people who use stimulants who are maybe worried about cross-contamination. And stimulants, like not weed. I don’t think anyone has ever found weed contaminated with fentanyl, so disclaimer, like that’s not a thing. Now with like the more advanced drug checking technologies like they can prove helpful for folks but I think we need to better locate how we understand these interventions alongside an interrogation of how people’s structural vulnerabilities and especially poverty fit into this complex calculation of how people engage with drugs in the drug supply. So sort like I’m coauthored a bunch of the drug checking studies. And like one of the early ones that gets picked up is when we did it inside that looked at people’s use of strips. You know, that found that, you know,
some folks were finding positive with fentanyl
and maybe a few of them were pitching their drugs,
but like let’s take a step back.
That was like 1% of folks who are going into insight
were using these strips to begin with.
A smaller percentage still of those folks
were disposing of their drugs
if they had something they didn’t expect to find in them.
And we were doing field work and interviews
with people at that time, and a lot of those folks
were people who were selling drugs,
who just wanted to figure out what was in their supply
and didn’t necessarily have an intention
to be using that anyways.
So drug checking is not gonna save us.
Even if available, like it’s never gonna meet the demand
for how often people are using,
the supplies really erratic.
We have all of these new adulterants
and centering the supply from Xylazine, to estazolam,
to synthetic cannabinoids to,
and we could just keep on going through them
and there will still be further ones.
So the nimbleness of this as an approach
is probably never gonna match on to what people need.
Now incredibly useful for drug surveillance, right?
Like the one place we found it helpful is like, you know
a bad package of benzo dope starts going around
and you can let people know.
But beyond that, like I think drugs,
every bit of energy spent on drug checking should just be redirected toward thinking about safe supply.

And if that doesn’t answer your question, I’ll try better tomorrow.

All right, thank you so much, Ryan, for joining us today. I think this was a very self-provoking and interesting presentation. And I hope there will be many opportunities for us to continue this conversation in the future. And thanks very much to everyone who joined us today, and for asking all these very interesting questions. So thanks everyone, thanks Ryan. Cool, thanks everyone.