THE SAFER SUPPLY TOOLKIT

DRUG POLICY ALLIANCE.

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The urgency of such a project cannot be understated.

Sadly, since hosting our community conversations with over 50 drug user activists just a few years ago, we already lost several of them – to overdose and other health issues.

These losses are immeasurable to our national movement, but also to their local communities that so desperately needed their leadership and vision.

We are deeply devastated by the loss of these incredible people who had so much passion, so much potential, and so much to offer to help us to create the world we envision where a safe supply is possible and people who use drugs can get the resources they need.

We must honor their lives with this project which could save the lives of countless more.

HOW TO USE THIS TOOLKIT

The Safer Supply Toolkit is a guide that seeks to support advocates in advancing the public conversation on safer supply and all-drug legal regulation.

It is the culmination of a collaborative exploration of safer supply as a replacement to prohibition by the Drug Policy Alliance, the Pan-American Network of Drug User Activists, the New England Users Union, the National Survivors Union (formerly the Urban Survivors Union), and the Michigan Users Union.

IT IS COMPOSED OF FOUR PARTS:

1) an executive summary,
2) a key strategies document and resource list,
3) a media guide, and
4) discussion guides for communities and healthcare professionals

The executive summary synthesizes the most important principles of safer supply from the perspectives of people who use drugs and allied advocates. These principles emerged from a series of Community Conversations held in collaboration with drug user unions across the United States. While participants differed on how to implement safer supply, all agreed that safer supply is essential to address the overdose crisis and repair the harms of the drug war. Safer supply builds upon the existing work of drug policy advocates to legally regulate marijuana and decriminalize personal drug possession. Despite political backlash stemming from deeply ingrained prohibition ideology, these policies remain largely popular among the general public. Therefore, the present moment is an important opportunity to broaden the horizons of what is considered possible.

The key strategies document outlines four specific actions that advocates can take to advance conversations about safer supply in their local communities. This includes connecting with directly impacted individuals and healthcare providers to discuss their needs and ideas for safer supply. Advocates can also educate the public on the benefits of a regulated drug supply and engage with the media to push for policy change and challenge misconceptions regarding safer supply, including perceived threats to public safety and order.

The media guide equips advocates with essential tools to further discussions on safer supply and legal regulation on a broader scale. It includes evidence-based talking points as well as tips for crafting effective op-eds, cultivating relationships with journalists, and creating compelling calls to action. Through targeted messaging and meaningful relationship-building, individuals and organizations can play a vital role in advocating for policies that prioritize public health, harm reduction, and social justice.

Lastly, **the *Safer Supply & Legal Regulation: What Comes Next?* discussion guide** is modeled off the original Community Conversations. There are two versions of the guide, each tailored to support community organizations and healthcare providers in developing policy proposals that center the autonomy and well-being of people who use drugs. Discussion participants are prompted to consider four key questions of legal regulation from a consumer standpoint:

Who should have access to a safer supply of drugs?

Where should a person be able to access it?

How much can they access?

And where can they use?

The answers to these questions — and how they're used — are up to you:

what is your vision for safer supply?

EXECUTIVE SUMMARY

> **"We are past an emergency. An emergency was yesterday. Today, we are in a global catastrophe. We know that mobilization can happen: we saw how cities and countries mobilized when it came to COVID-19. The reason why it's not happening now is because we're dealing with a population that is deemed un-human. Safe supply restores our humanity. Safe supply gives us a choice."**
>
> *– Drug User Union Representative*

Since 2000, over one million people in the United States have died from drug overdose.

The underground drug market is illegal and unregulated, leading consumers to buy drugs of unknown quality and potency. This can increase the risk of overdose and adverse effects because it is difficult to stay safe. People who use drugs also face anti-drug stigma that makes it hard to seek help and it keeps people in the shadows. Arrest for drug possession can lead to a criminal record that limits job opportunities and access to housing and social services.

After decades of harsh drug laws and enforcement, our drug supply has gotten more dangerous. We know that harm reduction, drug checking, and evidence-based treatments can help reduce the risk of overdose. But they cannot fix the underground drug supply. The only way to address the drug supply is through legal regulation and a safer supply.

The Drug Policy Alliance hosted Community Conversations with people who use drugs across the United States in 2021. The aim was to learn about safer supply preferences among people who use drugs in the US. The Community Conversations were co-hosted by the Pan-American Network of Drug User Activists, the New England Users Union, the National Survivors Union (formerly called the Urban Survivors Union), and the Michigan Users Union. Attendees explored different policy frameworks and discussed the pros and cons of different approaches.

The Safer Supply Toolkit was developed based on these Community Conversations. It aims to help engage people who use drugs, healthcare providers, and the public in conversations about safer supply. The Toolkit also includes a strategy guide, a reading list, safer supply discussion guides for communities and healthcare providers, and a media guide. This document summaries the most important principles from the Community Conversations.

During the COVID-19 pandemic, the Canadian government allowed healthcare providers to prescribe a safer supply to their patients. According to the Canadian Association of People who Use Drugs, safer supply is "a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market."

In one model of safer supply program, healthcare providers prescribe pharmaceutical alternatives to illicit drugs in medical settings. But there are also less medical models. The Drug User Liberation Front implemented the compassion club model as a more community-driven approach. There are also many other possibilities for safer supply.

People who use drugs have different ideas on how to enact safer supply. But they all can agree that access to a safer supply of drugs will save lives.

There were five key takeaways from our conversations with people who use drugs.

KEY TAKEAWAYS

Safer supply is a needed emergency response to the overdose crisis. Safer supply offers access to a known dose of a known substance without dangerous adulterants. It is the only way that people who use drugs can make informed decisions about their drug use and take steps to stay safe.

> **"Dealers don't have any control over the supply they're giving me. People who love me sold me stuff that almost killed me."**

The United States is experiencing an unprecedented overdose crisis. And most lives were lost due to an unregulated drug supply. As we funded more law enforcement and interdiction, it only made the drug supply more unpredictable. Drug supply chains were disrupted. More adulterants were added. And people who use drugs were not prepared for these changes. Safer supply will allow people to know what they are consuming. To have the most impact, safer supply programs must also be able to offer users an affordable, attractive, and practical alternative to the underground drug supply to save lives.

A safer supply, when combined with other harm reduction interventions, can keep our communities safe.

> **"Harm reduction saved my life, but safe supply would have given me a life."**

Overdose prevention centers (OPCs) and syringe service programs are essential. These programs reduce overdose and disease risk. They also provide sterile equipment, naloxone, drug checking, and harm reduction education. However, such strategies can only do so much to keep people safe; because they cannot fix the drug supply. Safer supply is a necessary component of a holistic harm reduction approach because it provides consumers with precise information about what they are consuming.

Safer supply must be available through community-based programs to reach people - especially people who have been excluded from or harmed by medical settings.

> **"The stigmatization of people who use drugs in medical facilities is visible, palpable, and killing us."**

People who use drugs report negative experiences with healthcare providers. And many avoid medical care because of mistreatment. Many people who use drugs worry about overly medical models of safer supply in the US. This is because there are so many racial and class disparities in the types and quality of treatment that are provided in our healthcare system. For example, research shows Black people are less likely to be prescribed buprenorphine, a medication for opioid use disorder, compared to white people. This is why safer supply must also be available through community models outside of healthcare. Cooperative models can build upon existing peer networks to best serve marginalized people and meet them where they're at. Cooperative models could be non-profits, avoiding profit motives and commercialization that cause harm. At the same time, healthcare providers must work to rebuild trust with patients who use drugs. Many people want better relationships with their doctors. But our current systems of care are ill-equipped to meet their complex needs.

> **"If we could get good doctors with good training who don't stigmatize people who use drugs, we could get expert input on our wellness around substance use. I would love that and need it in my life so much."**

People who use drugs prefer nonprofit and cooperative models of legal regulation. They prefer models that use existing peer networks, maximize access, and keep resources within communities most harmed by the drug war.

> **"We have to work through existing networks and community connections, rather than make people jump through hoops to get their supply."**

People who use drugs envision themselves as active participants in safer supply models. Legal regulation can shift power and resources to communities of people who already trust and care about each other. Cooperatives work for communities instead of profits. Services can be easily adapted to meet a wide range of needs. Community-based drug manufacturers and distributors are best suited to provide safe supply access to otherwise hard-to-reach populations.

Evidence-based education on drug use is necessary to improve public health and rally support for safer supply.

> **"I think there needs to be education associated with access, and everyone should be able to access that information. Ideally, people would be getting age-appropriate education on drugs throughout their lives."**

Lack of knowledge is dangerous. Educating people about drugs empowers them to make informed choices about whether or not to use drugs. It is important to get accurate information about drug effects, side effects, and potential risks. Armed with education, people can keep themselves and their communities safe. Education is also necessary to win public support for safer supply and raise awareness about the real reasons overdose deaths are so high. Education can also help to reduce stigma toward people who use drugs. Hard-won drug policy reforms and harm reduction policies are facing significant political backlash. Education can help people to see why these reforms are essential and life-saving.

The Safer Supply Toolkit is one such effort to educate the public. We need to ensure that current and future advocates have the tools to discuss safer supply with their communities. It is the only way that we can build the world we envision.

Safer supply is a needed emergency response to the overdose crisis.

Safer supply offers access to a known dose of a known substance without dangerous adulterants, so people who use drugs can make informed decisions about their drug use and take appropriate precautions to stay safe.

KEY STRATEGIES FOR ADVANCING SAFER SUPPLY

As fatal overdoses remain alarmingly high; the harms of the drug war are impossible to ignore. People who use drugs risk overdose and other adverse effects because they must rely on an unpredictable drug market. Harm reduction programs provide essential resources to people who use drugs, but can only do so much when the drug supply itself is the problem. The only solution is the legal regulation of drugs, or providing a safer supply. With a safer supply, consumers know about the quality, potency, and purity of the drugs they purchase. Safer supply is a necessary component of a holistic harm reduction approach.

This document highlights key strategies to advance safer supply. It is based on the principles of safer supply and legal regulation, outlined in the Executive Summary of the Safer Supply Toolkit. This document provides advocates with a framework to expand conversations on safer supply. The Toolkit also includes a safer supply discussion guide for communities and healthcare providers and a media guide. The media guide has tips and talking points for working with media. This Toolkit was developed by the Drug Policy Alliance in collaboration with the Pan-American Network of Drug User Activists, the New England Users Union, the National Survivors Union (formerly the Urban Survivors Union), and the Michigan Users Union.

1. BUILD RELATIONSHIPS WITH COMMUNITY LEADERS FROM DIVERSE BACKGROUNDS

Each community faces different challenges in implementing harm reduction services. Each community also has diverse stakeholders and potential allies. Get familiar with harm reduction services and other major community organizations in your area. Who are the key players? Engage with directly impacted people from the beginning for their guidance and support when developing strategies to promote safer supply. Understand your community's immediate and long-term needs by talking with people who access services for people who use drugs. Seek input from folks whose experiences differ from your own. Keep the perspectives of racially and ethnically marginalized people at the forefront of the conversation.

2. INVITE HEALTHCARE PROVIDERS TO THE DISCUSSION TABLE

Doctors, nurses, psychiatrists, and other providers must learn about harm reduction to save lives. Local harm reduction organizations likely have existing relationships with sympathetic medical professionals. It is important to engage healthcare providers in discussions about safer supply because they can be powerful allies. Many are unaware of safer supply models, especially medical safer supply models. They may be more open to safer supply when learning that other healthcare providers support the approach. They also may find the research persuasive. Introduce the concept of safer supply at conferences, seminars, and lectures. If you are a provider, start conversations with your colleagues. And use our healthcare provider discussion guide!

3. EDUCATE AND ENGAGE THE PUBLIC

Most people do not understand how the drug war has created the unpredictable and potent drug supply. And many simply believe we must focus on drug prevention and treatment to save lives. It is important to meet people where they're at. Explain how no regulation means no quality control. Explain that there are models of safer supply saving lives around the world right now. Engaging the broader public on safer supply will set the stage for revolutionary policy change that will end the drug war for all. There are many ways to do this. It can be as simple as posting about harm reduction and safer supply on social media. Talking with your friends, family, and fellow community members makes an impact too. Our media guide will help you draft an op-ed or letter to the editor. Our discussion guide could help you talk to your user union or colleagues. You could also host a webinar, organize a town hall... the sky's the limit!

4. PREPARE TO RESPOND TO MEDIA INQUIRIES

As the overdose crisis rages on, more people are interested in thinking outside of the box. Journalists are increasingly interested in discussing harm reduction and other innovative approaches. Journalists often seek new experts to get information and analysis. You may be invited to write an op-ed. It is crucial for drug policy advocates to build meaningful relationships with journalists. It can help us to keep raising awareness about safer supply as a needed response to the overdose crisis. Pay attention to the outlets that are talking about drug policy and harm reduction. Connect with the reporters who cover these issues. Reach out and make yourself available.

Check out the Safer Supply Toolkit Media Guide to learn valuable tips on working with the media and getting your message out there.

MEDIA GUIDE

Amidst alarmingly high fatal overdoses, we must explore alternatives to drug prohibition. Safer supply is a potential solution that centers social justice and public health. The Drug Policy Alliance and Drug Users Union Safer Supply Toolkit is a resource for advocates to advance the conversation on safer supply. This media guide includes evidence-based messaging that addresses common questions and concerns. The guide also offers tips for crafting effective op-eds, cultivating relationships with journalists, and creating compelling calls to action. Through thoughtful advocacy, you can play a vital role in enacting the future of drug policy.

GENERAL GUIDELINES FOR WORKING WITH THE MEDIA

Research the publication and journalist before you agree to an interview.

Has a publication or journalist covered drugs or harm reduction before? Ask colleagues who have worked with them before about their experience. Would they recommend that you do the interview?

- Positive past coverage indicates a publication or journalist might be more sympathetic. They may be more open to your message and perspective. Even so, it is still important to stick to the messages outlined below. A reporter may be missing key information you can provide with this toolkit.
- A lack of coverage might imply limited knowledge on drug policy. You can use this toolkit to give them essential information on safer supply and harm reduction.
- Past negative coverage may or may not signal bad intentions. A journalist may be interviewing you to learn more and get an alternative perspective. But there is a chance they may try to use your words to paint harm reduction in a negative light. If you are worried about this, it is okay to turn down the interview. However, this toolkit can help you stay on message if you decide to move forward.

Know the difference between "on background" vs. "on-the-record."

A background interview means any information you provide won't be attributed to you. An "on-the-record" interview means that anything you say can be quoted in the final article. Make sure you are clear about the purpose of an interview with any journalist. Never assume anything is off-the-record.

Build relationships with reporters so you can be a resource to them for future articles.

If you have a positive experience, this reporter may reach out for your perspective in a future story. They also may be open for you to contact them with ideas for stories!

Make yourself available and be prepared for interviews.

Time is of the essence when it comes to the media. Sometimes, a journalist will contact you with a deadline of a few hours. It is important to reply quickly and be flexible so you can increase your chances of getting quoted in the final piece. If you are not available, let them know and encourage them to contact you again in the future. If possible, recommend a trusted alternative source.

SPECIFIC TIPS AND ADVICE FOR BEFORE, DURING, AND AFTER AN INTERVIEW

Establish your key principles, core messages, and talking points before talking with members of the media.

Keep this guide on hand and skim it before your call! Refresh your memory before every call so you do not forget any key points.

Tailor your message to specific audiences and media outlets.

Based on your research, would this publication or journalist be more interested in a conversation or a debate?

You can ask them to send their questions in advance.

Sometimes they are willing to send questions in advance and it can help you prepare and make sure you stay on message.

You can ask them to repeat the question.

And if you do not understand, ask them to clarify or rephrase their question.

You do not have to answer any question that you do not want to answer.

And if you feel like your words may be misconstrued, you can ask to stop the interview or say you want to move to the next question. You can also just redirect the conversation to stay on message.

Stay on point and message.

Be as brief as possible. This reduces the risk of a misunderstanding or getting quoted incorrectly in the article. Often journalists do not have a lot of time, so it helps to be brief and answer the questions they ask.

Tie your messaging to current events and offer a new angle to drug or harm reduction stories.

While we should talk about safer supply every day, it is particularly important to talk about it whenever new overdose data are released. Connect safer supply to other drug and harm reduction news events during your interview.

Issue a call to action.

Tell them what our lawmakers need to change about our approach and how we must focus on saving lives first. Emphasize the urgency and significance of your message.

After the interview, thank them for the opportunity and offer to speak to them in the future.

If you like the final article, send them a message telling them they did a good job! Positive reinforcement means they may come back to you in the future!

CORE MESSAGING

What is decriminalization?

- Decriminalization removes criminal penalties for drug possession. Instead, possession is treated as a civil offense, like a speeding or parking ticket. You will not be arrested if you possess decriminalized drugs, but the officer may take your drugs or dispose of them.
- Decriminalization doesn't allow or regulate the sale or manufacture of drugs, so people continue to buy drugs on the underground market. This means that drugs may be adulterated and of unknown potency and quality.
- Decriminalization usually applies to a set amount of drugs– usually a few grams – and it varies from jurisdiction to jurisdiction.
- The state of Oregon temporarily decriminalized the personal possession of small amounts of drugs from February 2021 until August 31, 2024 and drug arrests decreased across the state.
- Drug decriminalization reduces drug arrests, but it may not have a direct impact on drug overdoses because the drug supply is still unregulated and unpredictable.

What is safer supply?

- Safer supply creates a medical-grade drug supply available from licensed sellers. Within the regulated market, the use, sale, and manufacturing of drugs are allowed. When safer supply is legally available, people who use these drugs are not criminalized or arrested for possession.
- Safer supply offers informed access to a known dose of a drug. The underground drug market cannot guarantee potency or purity. This leaves drug users vulnerable to unnecessary risk.
- Under legal regulation, drugs would be subject to rigorous quality control. This ensures their potency and purity so people never have to guess what's in their drugs.
    - *Sometimes, a safer supply is created without full regulation. In some states, access to drug checking technology has allowed people to bring their pre-obtained drugs to a harm reduction program where a small sample can be tested for adulterants. This way, people can know exactly what they're using. However, this often happens at a very small scale and it is not available in all communities.*
    - *However, this often happens at a very small scale it is not available in all communities because it is not legal, accessible, and/or funded everywhere.*
- The United States currently regulates alcohol, tobacco, and pharmaceuticals. In some states, marijuana is regulated as well. Under law, people can buy these substances without fear of contamination or criminalization.

Why safer supply?

- Safer supply saves lives. We all want our loved ones alive. Right now, we're dealing with an unregulated drug supply that is fueling the overdose crisis. People who use drugs from the underground market have no guarantee of what's in their drugs. Safer supply would reduce the risk of overdose by guaranteeing potency and purity.
    - *Drug checking services help people make safer choices. Fentanyl test strips provide quick information on whether a drug contains fentanyl. Xylazine test strips test for the presence of xylazine. Advanced chemical testing, such as FTIR and mass spectrometry, provides a full view of a drug's contents. The popularity of drug checking services shows that people want to know what's in their drugs. However, drug checking is not legal in every state.*
- The drug war drives the unpredictable underground drug supply. In an unregulated market, there are no systems to safeguard against contaminants. There are no alerts to pull drugs out of circulation or warn consumers. Instead, the responsibility lies on consumers to find a reliable supply. Too often, they have no choice or few options.
    - *Drug busts drive overdoses. A recent study found that drug seizures in Indianapolis were directly followed by a local spike in overdoses in the weeks following. This is because people lose their trusted dealers after drug busts and their tolerance for drugs goes down. When they find new dealers, they do not know the potency of the drugs they are buying and are at higher risk of overdose.*
- Safer supply complements other harm reduction strategies. It is best to combine safer supply with harm reduction strategies to keep people as safe as possible. Consumers would receive safer use equipment and instructions on how to reduce risk. This would dramatically reduce the risk of injury, infection, and disease

What's wrong with how we do things now?

- Over one million people have died of drug overdose in the United States since the beginning of the overdose crisis. We have lost over 100,000 people to overdose every year since 2021.. Our government has failed to meaningfully address the overdose crisis and save lives. Instead, another 1.1 million people are arrested every year for drug offenses. The majority of charges are for simple possession and disproportionately impact marginalized people. Meanwhile, many more are denied access to necessary pain relief and medication for opioid use disorder.
- The criminalization of people who use drugs has disproportionately devastated generations of racially and economically marginalized people. Drug charges have been the main driver of mass incarceration and criminalization since the 1990s. Despite using and selling drugs at similar rates, Black people are charged for possession twice as often as white people. The gap is even greater for sales. We grieve not only for those we've lost to overdose but also for those we've lost to the punitive justice system.
- Our friends, family members, coworkers, partners, and other community members are dying. Almost half of all people in the United States know someone who has died from an overdose. The legal regulation of a safer supply of drugs is an emergency response to this catastrophe of mass death.
- The drug war has driven the adulteration of the illicit drug supply. Crackdowns lead illicit manufacturers to create stronger drugs that are easier to hide. Fentanyl, xylazine and nitazines were all introduced to avoid law enforcement.

What does safer supply look like in practice?

- The legal regulation of a safer supply of drugs can take many different forms. Clinics in Canada and Europe have provided medical-grade alternatives to illicit drugs for years. In some parts of the United States, alcohol sales are controlled by the state. These are two models of how safer supply can be implemented in practice. Any model must balance consumer protection and ease of access.
- Safer supply must be formed in collaboration with people who use drugs. Without their insight, policymakers may overlook barriers or fail to address past injustices.
- People use drugs for many reasons, so safer supply needs to be inclusive of any reason. It could be for pleasure, medicine, spirituality, pain management or something else.
- Safer supply is complementary to medications for opioid use disorder. Some people may want to reduce their opioid use while engaging in safer stimulant use. Safer supply empowers people to meet all of their substance use goals.
- A free-market approach to legal regulation can be dangerous too. Without key safeguards, safer supply will be vulnerable to corporate capture and for-profit interests at the expense of public health. The tobacco industry is one example of how profit-driven drug markets do more harm than good.
- Safer supply needs to be founded in racial and social equity. Nonprofit organizations, cooperatives and compassion clubs are all models for consumer-centered regulation. These models limit profit incentives and keep resources within the communities they serve. Preliminary findings suggest that participants who got their drugs from the Drug User Liberation Front, a compassion club in Vancouver, had a lower risk of overdose because they had a stable supply of drugs of known potency and purity.

How will safer supply and legal regulation address the harms of the war on drugs?

- Legal regulation must repair the generational devastation wrought by the war on drugs. Racially and economically marginalized people have borne the brunt of mass criminalization. Therefore, we must take proactive measures to center and uplift affected communities.
- This includes automatic record expungement for drug-related convictions. It also includes the reservation of business licenses for justice-involved individuals. Any tax revenue should be directed back into impacted communities.
- Our drug laws punish simple possession with a lifelong criminal record. National decriminalization of drug possession alone would keep hundreds of thousands of people out of the legal system. Regulation would go even further by integrating sellers into the legal market.
  - *People often sell drugs for survival or to sustain their own supply. We must work to create pathways for underground sellers to join the legal market. This way, both sellers and buyers stand to gain from a regulated supply.*
  - *Be prepared for questions about integrating underground markets. This is often brought up in conversations around legalized marijuana. Emphasize the ineffectiveness of punitive measures and restricted access to licensing. We must make it easier to get into the legalized market or else the underground market will remain strong.*
- Safer supply could reduce contact between law enforcement and marginalized people for drug possession charges. In states and countries that have decriminalized drug possession, arrests typically decrease because policing priorities shift away from low-level drug enforcement.
- Safer supply must address health inequity. People of color are already underrepresented in medical marijuana programs and clinical trials. The cost of ketamine treatment keeps it out of reach for most people. The process of getting and staying on methadone is difficult and humiliating. If left unaddressed, these injustices would continue with legal regulation. We must provide fair access to novel treatments and medication for opioid use disorder.
- Big businesses maximize profit; safer supply prioritizes public health. Advertising bans and labeling requirements are two ways of controlling profit motives and promoting safer use.

How will safer supply and legal regulation reduce drug trade violence?

- **Drug prohibition itself is a driver of violence.** Drug prohibition destabilizes the market by regularly removing key players. New, competing players move in to capture as much profit as possible. Groups left without leaders must then settle the resulting conflict and they may use violence to establish dominance. Legal regulation would create bureaucratic procedures of resolving business disputes and keeping people in the market.
- **Drug law enforcement forces people to act out of fear.** The threat of arrest or prosecution drives many people to turn against each other. Prosecutors often offer plea bargains in exchange for information on other sellers. This sets off a domino effect of arrests and retaliation for actual or alleged snitching.
- **Drug prohibition incentivizes illicit manufacturers to produce more potent drugs.** Drug traffickers seek to transport their supply without detection or confiscation. Fentanyl, xylazine, nitazines, and other cutting agents extend a supply without compromising potency.

Alcohol and tobacco are legal, but many suffer from short- and long-term health consequences. How would safer supply prevent drug-related harms from happening with different drugs like heroin or cocaine?

- We can learn from past policy failures that put profit or punishment over public health. The history of drug laws in the United States provides endless examples of what does and doesn't work.
  - *The prohibition of alcohol was a disaster. Organized crime skyrocketed with the high demand for illicitly produced alcohol. Illicit alcohol was often contaminated, leading to poisoning, blindness, paralysis, and other harms. For 13 years, around a thousand people died annually due to tainted alcohol.*
  - *Cigarette use has plummeted among adults and youth since the 1990s. But this wasn't because we banned cigarettes. Instead, we engaged consumers in evidence-based health education. We regulated advertisements, packaging, and sales. We also raised taxes.*
- Harm reduction is a necessary component of safer supply. When we go to a bar, alcohol is prepared in front of us and served in a clean glass. When we buy alcohol from a store, it's clearly labeled with serving size and health information. These common-sense practices can be adapted to any drug and setting.
- Safer supply builds upon harm reduction services to reach more people. Overdose prevention centers and syringe service programs are important stopgaps. They serve the crucial purpose of saving lives and preventing the spread of disease. Safer supply would allow people to use in any setting without fear of adverse outcomes.
- Lack of knowledge is often as dangerous as an unregulated supply of drugs. People need fact-based, not fear-based, education on drugs. Education empowers people to make informed choices regardless of whether they ever use drugs. This means understanding drug effects, risks, safety measures, and signs of overdose.
- With legal regulation, we can focus production on less potent drugs. We can also develop formulations that pose fewer risks to consumers.

OxyContin was legally regulated and look where we ended up. How would safer supply be any different?

- Pharmaceutical companies misled us by aggressively marketing novel opioids as non-addictive. The fraudulent marketing of prescription opioids prioritized profit over people. Safer supply acknowledges and addresses addiction risks through education and harm reduction.
- The FDA failed to regulate pharmaceutical companies and protect consumers from harm. While this should give us pause, it should not deter us from pursuing better regulations that center public health when we regulate other drugs.
- Restrictions on regulated opioids exacerbated the overdose crisis. Opioid prescribers faced heavy scrutiny, and strict production quotas limited supply. These and other factors led many who relied on prescription opioids to seek illicit drugs instead.
  - *If you are asked about people diverting or selling their safe supply on the underground market, you can talk about how it is a rare occurrence and reframe the concept. Research with safe supply participants shows that when people share their safe supply, it is often for one of several reasons: safety, compassion, meeting needs, survival, or pressure.*

What can we do right now to advance safer supply and legal regulation?

- Right now, we are far away from seeing all-drug legal regulation become a reality on the federal level. Yet, we can look at the past and other nations' models to learn what's been done before.
- Evidence-based education on drug use is necessary to rally support for safer supply. We must dispel drug myths and equip people with the knowledge they need to keep themselves and their loved ones safe.
- Many progressive policies complement and make meaningful steps toward safer supply. Marijuana is now legal in half of all the United States. Personal drug possession was briefly decriminalized in Oregon. Despite its legislative rollback, this was a major win. We can continue this advocacy to include the legalization of psychedelic research and heroin-assisted treatment. In the meantime, we must also protect and expand harm reduction services as much as possible. These programs save lives while we fight for a better future.

Advocating for drug decriminalization opens up a conversation about safer supply. You can start the conversation through social media posts, talking with friends, writing op-eds, and building relationships with journalists.

The next section of the Safer Supply Toolkit aims to help you become media-savvy in your advocacy work.

TIPS FOR WORKING WITH THE MEDIA

Identifying your target audience

One of the first and most important steps of media engagement is knowing your audience. When you speak (or write), who do you want to hear your message? Are you seeking to change people's minds, or mobilize those who already support you? Is there a specific thing you want your audience to do? Answering these questions will help you prepare for any media appearance.

Potential audiences include:

- People in your local community
- Elected officials and other policymakers
- Clinicians (e.g., doctors, nurses, physician assistants, pharmacists)
- Mental health providers (e.g., psychologists, social workers, substance use counselors)
- Criminal legal actors (e.g., law enforcement, judges, attorneys, correctional officers)
- People who use drugs and their loved ones
- People in recovery from addiction or other problematic substance use

Choosing your target media outlets

Different people get their news from different sources. You must identify your target audience's preferred media outlets to best reach them.
As an example, older audiences tend to get their news from print media and cable news broadcasts. Younger audiences tend to prefer digital media and social networking platforms. Get to know people in your intended audience and ask where they learn about current events. Who do they trust and why do they trust them? Do they have specific columns or authors they follow?

After identifying your audience's preferred outlets, now it's time to research them.
You want to get a sense of an outlet's coverage on drug policy and related issues before reaching out.

Start with a general review of each outlet to get a feel for their priorities and political leanings.
For newspapers, glance over the front page and read the op-ed section. For websites, check out the most-read articles as well as opinion pieces. For television and radio broadcasts, watch or listen to their most popular shows. What topics do they focus on the most? Whose opinions are most represented? How are controversial issues addressed? This will offer insight into an outlet's approach to covering current events.

Next, dive deeper into each outlet's coverage of drug policy-related issues.
What topics have they addressed, and how have they addressed them (e.g. the overdose crisis, harm reduction, addiction)? Whose voices did they include? What were the key takeaways? If the outlet hasn't covered drug policy, have they covered similar issues? Mental health, poverty and criminal justice are all interwoven with drug policy advocacy. Don't assume a lack of coverage means a lack of interest. You could have the chance to shape an outlet's coverage by being the first to engage with them on these issues.

As a last step, find your way in.
Does the outlet invite outside contributions? If so, what kind (e.g., opinion pieces, letters to the editor, interviews)? How do you submit an opinion piece? How are interviewees chosen? Are there "beat" reporters who focus on the issues you care about? Some paths may be well-established, but others you'll have to make your own. Next, we'll talk about how to build relationships with journalists and become an expert source.

Building relationships with journalists and editors

Building relationships is one of the most important aspects of policy advocacy. Journalists and editors play major roles in shaping media coverage of our issues. While journalists write and research their stories, editors ultimately decide what gets published. Editors will sometimes assign journalists topics of personal and professional interest. So, both groups are helpful for you to target!

You've likely already come across journalists who regularly report on drug policy issues. Editors may have published supportive statements on harm reduction or medications for opioid use disorder. Take note of them as people to get to know more. Using some of the tips below, break the ice and establish yourself as an expert source on drug policy issues. Ideally, reporters will reach out to you to seek your insight when they are ready to write their next story.

- Follow them on social media and track their posts. What are they paying attention to? What are they writing about? How do their issues intersect with yours?
- Like and share their articles and posts when they do a good job of covering drug policy and related issues. Email, comment, or reply to let them know you appreciate their work. A well-thought-out message and a sincere compliment go a long way!
- Sometimes, sympathetic journalists can still get something wrong. When that happens, offer critical but friendly feedback that helps build your relationship. Thank them for covering an important issue as you offer more information.
- If your account is public, emphasize your work in harm reduction and drug policy in your bio. This will encourage journalists to follow you back and engage with your content as well.
- Send them an email and introduce yourself. Offer to set up a call and talk about your work, the overdose crisis, and how safer supply is a policy solution we need. Offer to be a source if they cover drug policy issues in the future. Let them know you can connect them to other experts in the field.
- Once you establish contact, keep them updated when a new issue comes up. Send them articles, flag new laws or bills, and keep them posted on drug policy issues. Just be mindful of how often you are contacting them!
- If you work at a harm reduction program, consider inviting respectful journalists to visit. This would let them see what you do and learn about harm reduction firsthand. Be sure to get permission from and work closely with the organization. Prepare staff and participants before they arrive and make sure that people are comfortable with a journalist coming. Be sure to tell the journalist whether they have permission to take photographs or if you agree to being "on the record" during their visit.

Being an expert source and preparing for interviews

After connecting with some journalists, you may start being contacted to speak on drug policy issues. Often, journalists will reach out to ask for background information or your perspective on an article. You may also be asked to take part in an interview, either to inform an article or for a news segment. This is an exciting opportunity, so here's what you can do to make the most out of it:

1. Respond quickly.

- Journalists work on short deadlines with tight turnaround times. If a reporter contacts you, reply to them as soon as possible so you don't miss out on an important opportunity. If you are not available, refer them to a colleague or other expert source who can respond.

2. Ask them some questions first.

- Though it's important to act fast, you should also know who you're talking to and why. If you don't know the person contacting you, take a moment to research them and their organization. Ask about the subject of their article or interview, their deadline, and their audience. For radio, podcasts, or TV, ask about the show's format. Will there be other guests? How long is the segment? Will it be live, taped, and/or edited? You can always ask a journalist to send you interview questions ahead of time. Not all journalists will do this, but many will.

3. Prepare accordingly.

- Identify your key talking points in advance. The above guide offers many messages in support of safer supply and legal regulation. Make sure to tailor these messages to the questions asked and your intended audience.

WRITING OP-EDS

An op-ed is a brief (750–800 words) article that represents a guest contributor's point of view. A good op-ed weaves together the author's perspective, research, and current events to make a compelling argument. It can be a powerful way to spark public discourse on safer supply and legal regulation. The following tips can help you craft a persuasive op-ed:

1. Choose a timely and relevant topic.

- Timing is key to maximizing the reach of your article. Op-eds often use current events as a hook to get readers interested. Did a law just get passed? Was a report recently published? Was there a recent anniversary, milestone, or remembrance day? Connect your op-ed to recent events to give your readers a concrete reason to be interested.

2. Form a strong thesis statement.

- State your main argument in the opening paragraph. Your thesis should be clear and concise, telling readers why they should care about your argument.

3. Know your audience.

- Tailor your arguments to resonate with the publication's general audience as well as your target audience.

4. Provide specific examples; tell a story.

- Stories are often more compelling than hard data. Sharing a personal anecdote or another's experience (with their permission, of course) gets readers to see how an issue impacts real people.

5. Issue a call to action.

- An effective op-ed will prompt your audience to do more than just read your article, such as vote in favor of a referendum or donate to a cause. The next section will provide more strategies to issue a powerful call to action.

6. Be clear and concise.

- Op-eds are short, quick, and to the point. Use simple language and avoid the use of jargon to keep your article brief and accessible.

7. Proofread and seek feedback from peers.

- Take the time to revise and edit your op-ed for clarity and coherence. Consider sending your draft to a couple of colleagues to get their insight.

8. Follow submission guidelines.

- Always be sure to check your target publication's rules and guidelines for op-ed submissions.

ISSUING A CALL TO ACTION

Now that your readers (or listeners) are invested, it's time to get them to take action. Issuing a call to action (CTA) is a powerful way to prompt your audience to take a specific step. In any form of persuasive communication, here are some tips on how to effectively issue a call to action:

1. Implore your audience to do one specific and relevant action.

- People often don't know where to start when it comes to advancing a cause they care about. Therefore, you can offer your audience a low-threshold way to get involved. Some examples include:
  - *Vote in favor of a drug decriminalization referendum or another piece of progressive drug policy.*
  - *Donate to a harm reduction or progressive drug policy organization.*
  - *Educate others about the dangers of the illicit supply and the benefits of safer supply and legal regulation.*
  - *Share the Safer Supply Toolkit with your friends and colleagues.*

2. Emphasize the urgency of the crisis.

- You want your audience to act yesterday. Don't let your audience procrastinate. Use action verbs and persuasive language to motivate readers & listeners to take action. Some examples include:
  - Call your representative and urge them to vote in favor of a bill.
  - Come to an upcoming town hall to support a policy proposal.
  - Sign up for a webinar before spots run out.

3. Frame the action within a larger strategy.

- One of the biggest challenges of political advocacy is getting people to keep showing up. Thus, you should always be ready to share what comes next. If you're encouraging them to vote for a referendum, highlight other states with similar laws. If you want them to donate to an organization, discuss how that money will be used to support people who use drugs. Direct them to volunteer opportunities. Provide as many occasions as possible to get involved. In doing so, you will cultivate a community of dedicated activists that will show up again and again.

FURTHER READING

POLICY DOCUMENTS

Key Principles of All-Drug Legal Regulation and Safer Supply

Drug Policy Alliance, September 2022.
Accessed here.

Heroin Compassion Clubs: A cooperative model to reduce opioid overdose deaths & disrupt organized crime's role in fentanyl, money laundering & housing unaffordability

British Columbia Centre on Substance Use, February 2019.
Accessed here.

Safe Supply Concept Document

Canadian Association of People Who Use Drugs, February 2019.
Accessed here.

Safer Supply Checklist

Canadian Institute for Substance Use Research, University of Victoria, 2022.
Accessed here.

SAFER's Top Ten: A working document by SAFER staff

Canadian Institute for Substance Use Research, University of Victoria, 2021.
Accessed here.

Decriminalizing People Who Use Drugs: A Primer for Municipal and Provincial Governments

HIV Legal Network, November 2020
Accessed here.

Drug Decriminalization: Progress or Political Red Herring? Assessing the Impact of Current Models of Decriminalisation on People Who Use Drugs

International Network of People Who Use Drugs, January 2022.
Accessed here.

CANADIAN GUIDELINES & REPORTS

National Safer Supply Community of Practice

Accessed here.

A Guideline for the Clinical Management of Opioid Use Disorder

British Columbia Centre on Substance Use, November 2023.
Accessed here.

Co/Lab Practice Brief: Implementing the Victoria SAFER Initiative

Canadian Institute for Substance Use Research, University of Victoria, 2021.
Accessed here.

Possible benefits of providing safe supply of substances to people who use drugs during public health emergencies such as the COVID-19 pandemic

Ontario HIV Treatment Network, April 2020.
Accessed here.

Early Findings from Safer Supply Pilot Projects

Health Canada, 2021.
Accessed here.

Safer Opioid Supply Programs (SOS): A Harm Reduction Informed Guiding Document for Primary Care Teams

J. Hales et al., updated April 2020.
Accessed here.

Safer Opioid Supply Program: Preliminary Report

London Intercommunity Health Centre, November 2021.
Accessed here.

JOURNAL ARTICLES

Bonn et al.
Addressing the Syndemic of HIV, Hepatitis C, Overdose, and COVID-19 Among People Who Use Drugs: The Potential Roles for Decriminalization and Safe Supply.

Journal of Studies on Alcohol and Drugs 81(5), 556–560 (2020).
Accessed here.

Bonn et al.
"The Times They Are a-Changin'": Addressing Common Misconceptions About the Role of Safe Supply in North America's Overdose Crisis.

Journal of Studies on Alcohol and Drugs 82(1), 158–60 (2021).
Accessed here.

Brothers et al.
Evaluation of an emergency safe supply drugs and managed alcohol program in COVID-19 isolation hotel shelters for people experiencing homelessness.

Drug and Alcohol Dependence 235, article 109440 (June 2022).
Accessed here.

Fischer et al. '
Safer opioid distribution' as an essential public health intervention for the opioid mortality crisis — Considerations, options and examples towards broad-based implementation.

Public Health in Practice 1, article 100016 (May 2020).
Accessed here.

Fleming et al.
Stimulant safe supply: a potential opportunity to respond to the overdose epidemic.

Harm Reduction Journal 17, article 6 (2020).
Accessed here.

Ivsins, et al.
"It's Helped Me a Lot, Just Like to Stay Alive": A Qualitative Analysis of Outcomes of a Novel Hydromorphone Tablet Distribution Program in Vancouver, Canada.

Journal of Urban Health 98, 59–69 (2021).
Accessed here.

Ivsins, et al.
Tackling the overdose crisis: The role of safe supply.

International Journal of Drug Policy 80, article 102769 (May 2020).
Accessed here.

McNeil, et al.
Implementation of Safe Supply Alternatives During Intersecting COVID-19 and Overdose Health Emergencies in British Columbia, Canada, 2021.

American Journal of Public Health 112, S151–S158 (March 2022).
Accessed here.

Pauly et al.
"A concept mapping study of service user design of safer supply as an alternative to the illicit drug market."

International Journal of Drug Policy 110. article 103849 (December 2020).
Accessed here.

DISCUSSION PARTICIPANT WORKSHEET

Welcome and thank you for participating in our Community Conversations on safer supply and legal regulation! Please use this worksheet to draft your ideal scenario for regulating different types of currently illicit drugs in your community.
You can use one model for all drugs or multiple models for specific drugs.

Circle, cross out, or fill in your own criteria to create the pathway(s) you would want to use in order to legally access various mind- and body-altering substances.

IF YOU LEGALIZED DRUGS TOMORROW: WHO CAN ACCESS?	YES	NO
People should only be allowed access to this drug by prescription.		
If yes, by prescription only **- Who can get a prescription?**		
• ~~P~~eople with dependence or substance use disorder who have not had success with medications or treatment before		
• ~~P~~eople with dependence or substance use disorder only		
• ~~A~~ny adult can get a prescription, except if incarcerated or pregnant		
• ~~A~~ny adult can get a prescription, even if incarcerated or pregnant, but no minors		
• ~~A~~ny adult but only minors with dependence or substance use disorder		
• ~~O~~ther prescribed group _____		

	YES	NO
People should only be allowed access if they register or get a special license.		
If yes, registered or licensed users only **- Who can register or get licensed?**		
• People with dependence or substance use disorder who have not had success with medications or treatment before		
• People with dependence or substance use disorder only		
• Any adult can get a prescription, except if incarcerated or pregnant		
• Any adult can get a prescription, even if incarcerated or pregnant, but no minors		
• Any adult but only minors with dependence or substance use disorder		
• Other prescribed group _____		
People should not need a prescription, license or registration.		

Other thoughts about who should be able to access drugs?

IF YOU LEGALIZED DRUGS TOMORROW: WHERE CAN ONE GET DRUGS?	YES	NO
People should only be allowed to get their drugs in medical settings.		
If yes, in medical settings only **- Which medical settings?**		
• People should only get their drugs in specialized clinics		
• People should be able to get their drugs in their general healthcare clinics		
• People should go to specialized pharmacies		
• People should be able to get them in any pharmacies by prescription		
• People should be able to get them in pharmacies over-the-counter		
• Other medical setting _____		
People should only be allowed to get their drugs in licensed specialized venues.		
If yes, in licensed specialized venues **- Which licensed specialized venues?**		
• People should only get their drugs in government-run dispensaries		
• People should only get their drugs from non-profit cooperatives		
• People should only get their drugs from for-profit dispensaries		
• Other licensed specialized venue _____		

	YES	NO
People should only be allowed to get their drugs in licensed general venues		
If yes, in licensed general venues **- Which licensed general venues?**		
• People should only be able to get their drugs in private venues (e.g. bars, clubs, coffee shops)		
• People should only be able to get their drugs in private retail (e.g. liquor store)		
• Other prescribed group _____		
People should only be allowed to get their drugs in unlicensed venues		
If yes, in licensed general venues **- Which licensed general venues?**		
• Grocery stores		
• Farmer's markets		
• Other unlicensed venue _____		
People should be allowed to get their drugs mailed or delivered to them.		

Other thoughts about where one should be able to get their drugs?

IF YOU LEGALIZED DRUGS TOMORROW: WHERE CAN ONE LEGALLY USE OR CONSUME THEIR DRUGS?	YES	NO
People should only be allowed to use/consume drugs in private spaces.		
If yes, only in private spaces **- Which private spaces?**		
• People can only use/consume in medical or health clinics		
• People can only use/consume in designated indoor spaces (e.g. supervised consumption sites)		
• People can only use/consume in private venues (e.g. bars, clubs, coffee shops)		
• People can only use at home, private residences, or private property		
• Other private spaces _____		
People should only be allowed to use/consume drugs in private spaces.		
If yes, only in private spaces **- Which private spaces?**		
• People can only use/consume in designated outdoor spaces (e.g. smoking areas)		
• People can use/consume in all outdoor areas, excl. certain areas (e.g. public parks, but not near playgrounds)		
• Everywhere		
• Other private spaces _____		

Other thoughts about where people should be allowed to use/consume drugs?

IF YOU LEGALIZED DRUGS TOMORROW: HOW MUCH CAN ONE ACQUIRE AT A TIME?	YES	NO
There should be limits upon how much of a drug one can acquire.		
If yes, there should be limits **- What types of limits should there be?**		
• There should be a standard limit *(by weight or measurement)* to how much of a drug allowed in a purchase.		
• People should only be allowed to get enough to manage their withdrawal.		
• People should only be allowed to get enough for their own personal use; not sharing.		
• Other limits _____		
There should be NO limits upon how much of a drug one can acquire.		

Other thoughts about how much one can acquire at a time?

HEALTHCARE PROVIDER DISCUSSION GUIDE

Access Powerpoint slides here

[Conversation facilitators should introduce themselves and welcome participants to the space. The facilitators should introduce the discussion topic and explain how the conversation will be documented, i.e., through written notes or audio recordings. The facilitators should inform participants of the expectations and limitations of confidentiality, outlined below. Facilitators should make sure there are enough copies of the Discussion Participant Worksheet for all attendees. Facilitators are encouraged to share with participants that this discussion guide is a part of a larger resource called the Safer Supply Toolkit, which was created by the Drug Policy Alliance, the Pan-American Network of Drug User Activists, the New England Users Union, the National Survivors Union (formerly the Urban Survivors Union), and the Michigan Users Union.]

- Notes will be anonymized to ensure confidentiality.
- Personal details will be obscured to protect participants' privacy.
- We do not recommend that you record the sessions, yet if you do – Ask for consent to record the session and be clear with participants about why they will be recorded, where recordings will be stored, and why they will be recorded. If participants do not consent to being recorded, you should not record these conversations.
- While it's expected that all participants will respect others' privacy, facilitators cannot control what participants do and do not talk about outside of the conversation.
- Only disclose personal details if you feel comfortable doing so.

[Facilitators should summarize the agenda of the conversation. Example script below.]

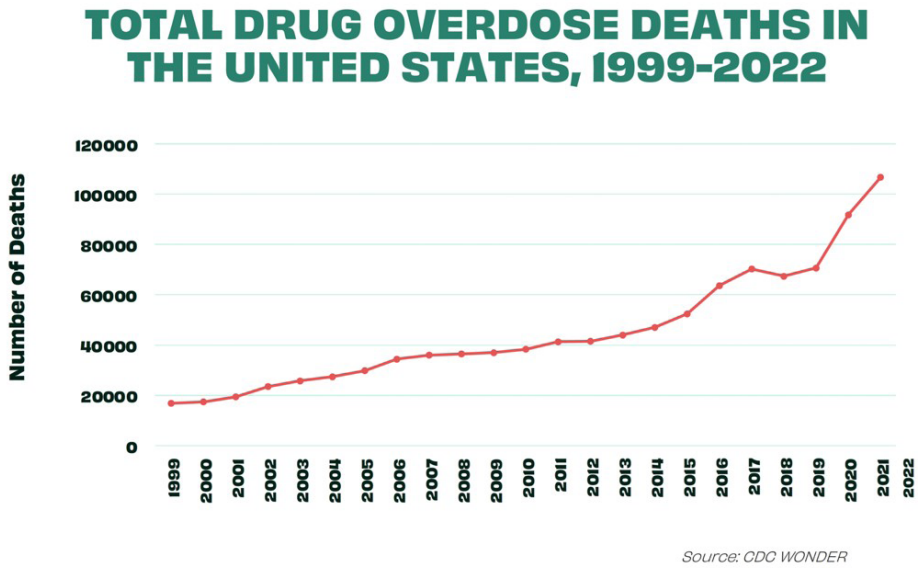
To introduce our agenda, today's conversation has two main parts: an educational section and a discussion section. The educational section will cover various models of drug policy with examples from the present day, including the Canadian model of safer supply that's emerged over the past few years. We are doing this to help make sure everyone is on the same page when it comes to the terminology and models we will be discussing later. We'll then take a fifteen-minute break before heading into the discussion section, where everyone will be encouraged to answer four key questions of legal regulation and your views about considerations for potential regulatory models informed by your experiences and expertise. Here are some components of regulatory models that we are interested in hearing your thoughts about: who can access a drug, where can one access it, where can one use it, and how much of it one can possess at once. We'll then wrap up and talk about next steps.

You've been provided a worksheet to guide your decision-making as we go through the explanatory part of the agenda. The questions in the worksheet may help you think through the various considerations of regulating drugs. You may choose to focus on one specific drug, such as psilocybin or heroin, fill out multiple worksheets for more than one drug, or use one worksheet as a framework for all drugs.

[Facilitators should describe the purpose of the conversation. The stated purpose can be customized for the particular setting in which the conversation is occurring. Example script below.]

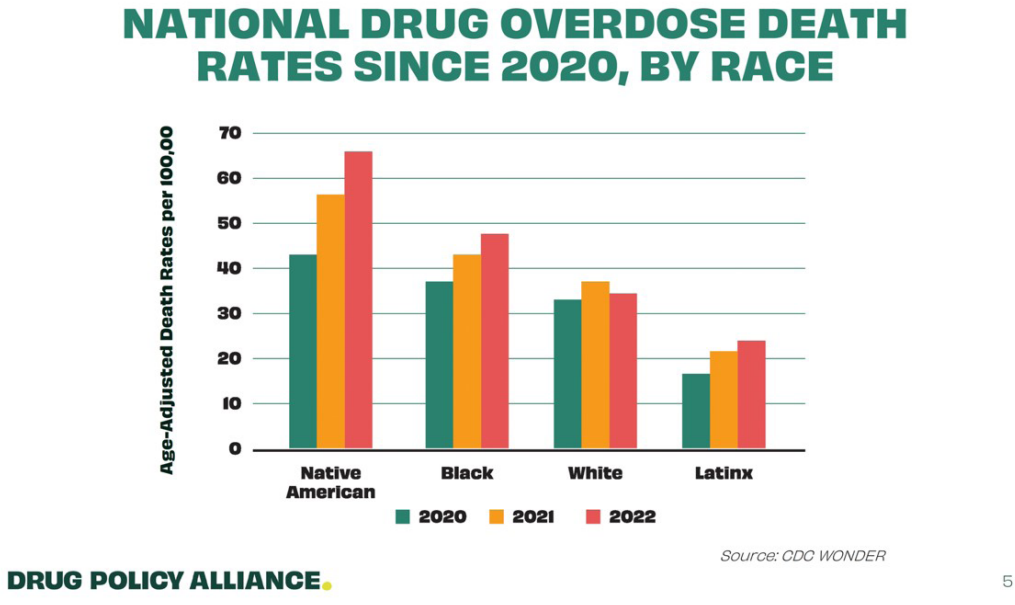
The first goal of this conversation is to come to a shared understanding of the key concepts of different models of drug policy, ranging from prohibition to legal regulation. We also want to critique these policies from a social equity standpoint, for even the most progressive of policies in the United States can still fall short of what people who use drugs need to live their lives. Some of these policies could be improved upon, or they could be scrapped and replaced with something else entirely.

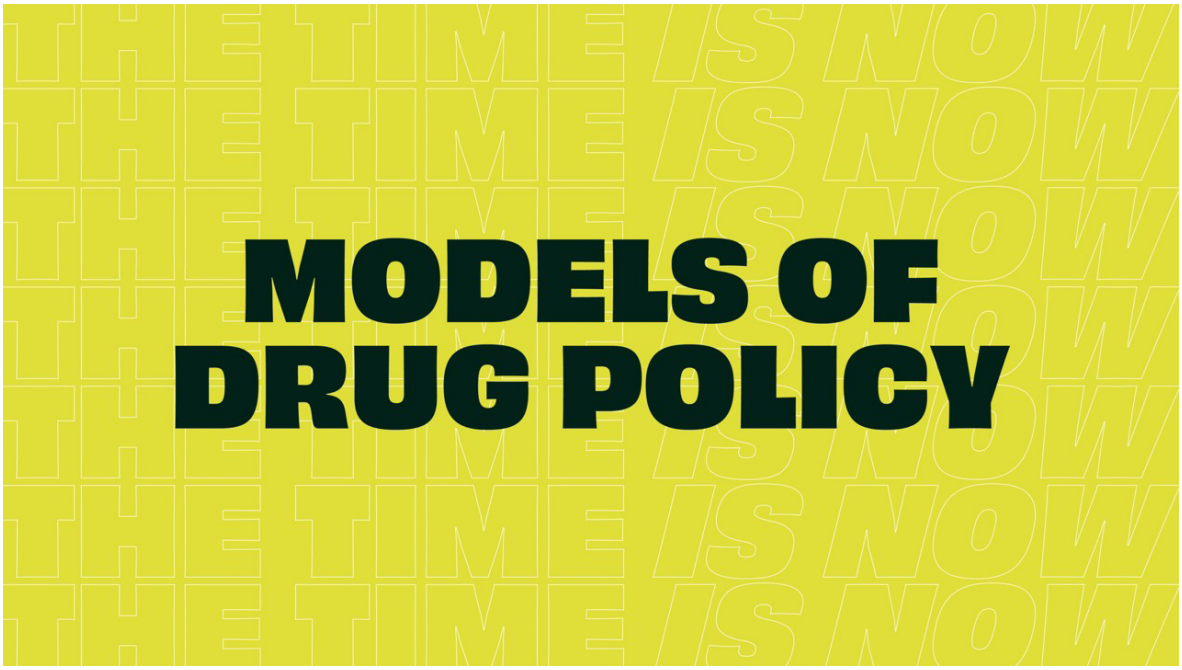
The second goal of this conversation is to establish key principles for legal regulation that draw from the expertise of healthcare providers such as YOU! In your work, you have served hundreds if not thousands of people who use drugs from diverse backgrounds — we want you to center their experiences to come up with a framework that would best serve your clients. We expect that there will be areas where you generally agree but we want to make space for dissent and nuance. We do not want you to feel silenced because your experiences and opinions do not align with the majority. The purpose of this exercise is to explore all the benefits and drawbacks of different models of legal regulation across different contexts. We do not expect that everyone will agree on a single model.

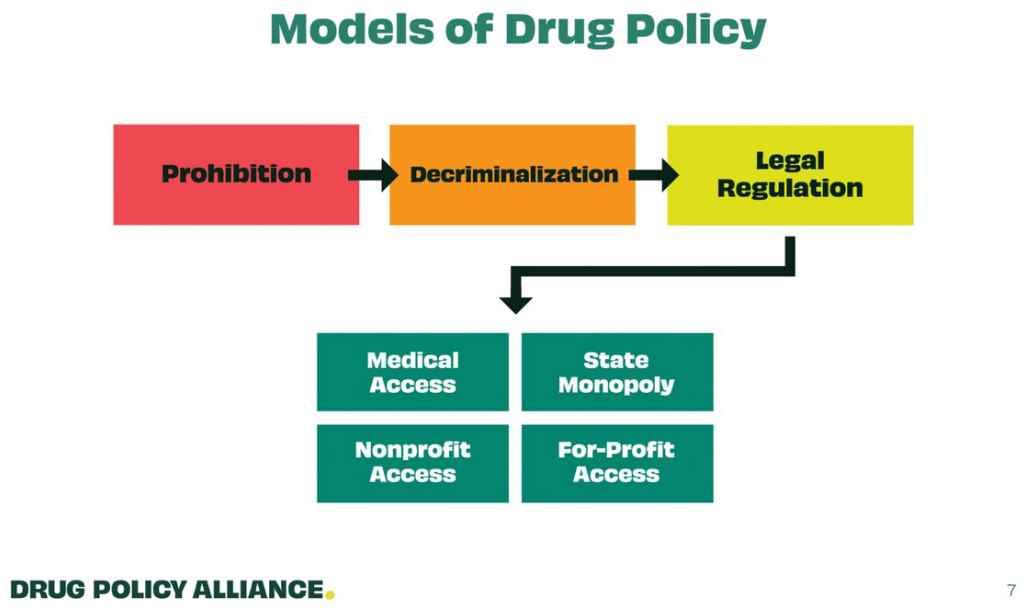


[Facilitators should frame the conversation about safer supply as a response to the overdose crisis. This can be customized for the particular setting in which the conversation is occurring. Example script below.]

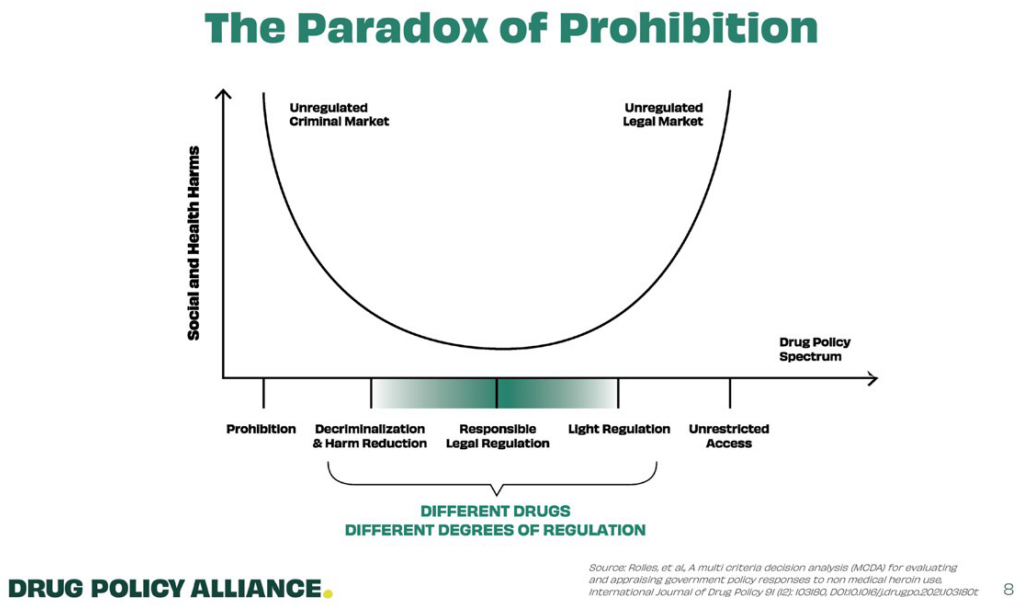
Of course, we know that there is a greater purpose to this exercise. Hundreds of thousands of people are dying every year of preventable overdoses; Black and Indigenous people of color and people from low-income communities bear the greater burden of this massive loss of life. Right now, we're dealing with an unregulated drug supply that is fueling the overdose crisis because people who use drugs from the underground market have no guarantee of what's in their drugs. Safer supply and legal regulation would guarantee consistent and reliable access to a known quantity of a known substance. Alongside other harm reduction strategies — many of which will be discussed today — safer supply is a necessary response to an overdose crisis driven by drug contamination and criminalization.







For the first segment of our discussion today, we'll be talking about the three main models of drug policy: prohibition, decriminalization, and legal regulation. Within each of these models are a wide variety of submodels, some of which can exist alongside each other, and specific policies, which can be applied to more than one model. Today, we'll focus on the submodels of legal regulation, including medicalized access, state monopoly, nonprofit and cooperative distribution, and privatized access.

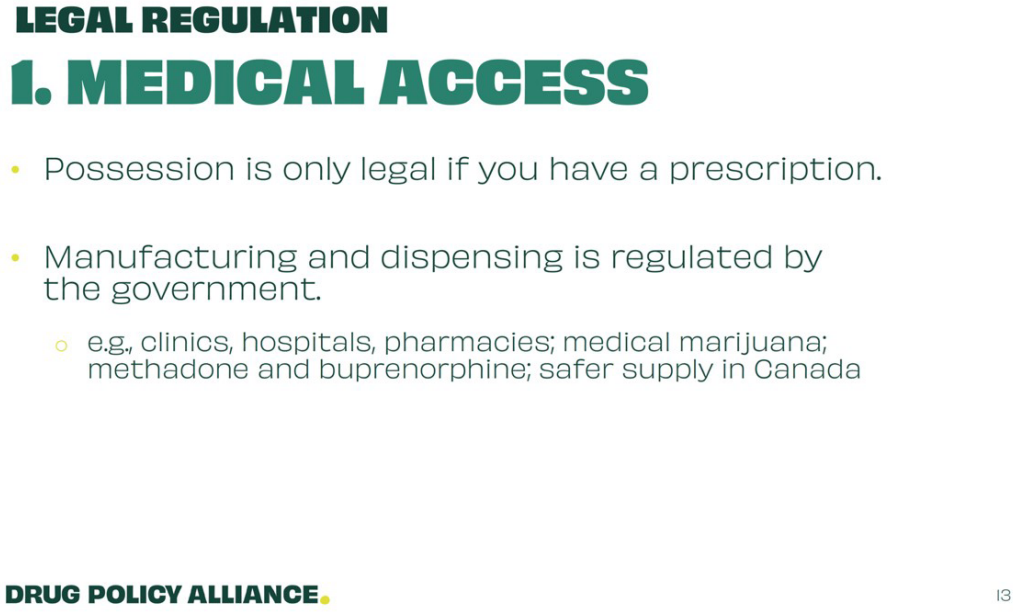


It's important to compare the different models of drug policy, as an unregulated legal market can pose just as many dangers to public health as an unregulated criminal market. The limitations of tobacco and alcohol regulation throughout the history of the United States is a good example of how ineffective regulation can prioritize corporate profit over consumer safety.

Prohibition, as the name suggests, outlaws the use, possession, sale, manufacture, and transportation of specific drugs, drug analogs, and drug precursors. The core principle of prohibition is that drug use and related harms can be reduced or eliminated by imposing (often steep) criminal sanctions, including fines, mandated treatment, or imprisonment. These sanctions appear on your criminal record and often limit a person's opportunities for employment, housing, and other basic needs. The United States has prohibited the possession, sale and manufacture of many drugs over the years, including marijuana, cocaine, heroin, and methamphetamine and these drugs still remain illegal on the federal level and in most states.

Legal regulation allows the possession, sale and manufacturing of drugs under certain rules established by law. These rules can vary widely, hence why today's conversation will dive into the minutiae of legally regulating psychoactive substances. Alcohol and tobacco products, for example have been legally regulated in the United States for decades. As of recent years, marijuana has also become increasingly available in states that have chosen to legalize and regulate it. Anyone over the age of 21 who shows proof of ID can buy alcohol and marijuana in states that legally regulate them, though there may be some restrictions on how much an establishment can sell to one person at a time or how much a person can possess.

Prescription drugs are also legally regulated, such as Adderall and Xanax. However, we know that possessing these drugs without a prescription is illegal, which leads us to the the next few slides, where we'll examine a variety of models of legal regulation using examples from the real world.



The first model we'll look at is that of medical access, or prescription access. Under this model, only qualified patients who receive a prescription can access a regulated supply of a drug. Every prescription pharmaceutical drug sold in the United States undergoes review by the Food and Drug Administration to ensure their safety and efficacy, and some drugs are subject to additional restrictions and regulations as per the Controlled Substances Act.

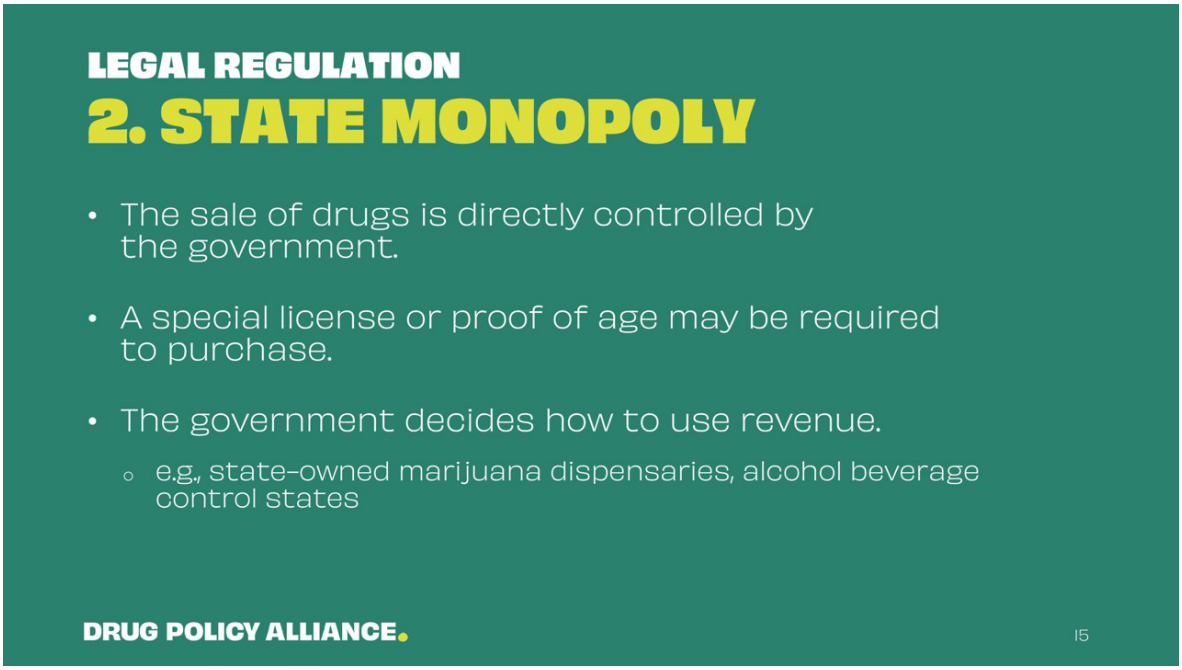
Medical marijuana, methadone, and buprenorphine are all examples of legal access through a medicalized model, though they all are administered differently under federal and state law. In the U.S., drugs are also traditionally manufactured by private companies, but may be produced by other entities, such as government contractors or nonprofit organizations.

One particularly compelling model of medical access to highlight is that of safer supply in Canada. Safer supply is an emerging idea that was put in action in light of the COVID-19 pandemic, which has significantly impacted the global drug supply and those who depend on it.

Safer supply is one form of regulation that provides prescription access to pharmaceutical alternatives to illicit substances, such as hydromorphone for heroin and fentanyl, or Adderall for cocaine or methamphetamine. The prescribed dose is determined collaboratively between prescriber and patient, but there are often legal limits to how much a person can have at once. Some programs allow participants to take home their doses, while others require observed dosing. Participants also have access to supportive services, such as counseling, referrals to housing and employment assistance programs, and harm reduction resources.

This model highlights how medical access can help connect people who use drugs to much-needed services. However, not everyone may qualify for the program, and not everyone wants to see a doctor in order to get their drugs.

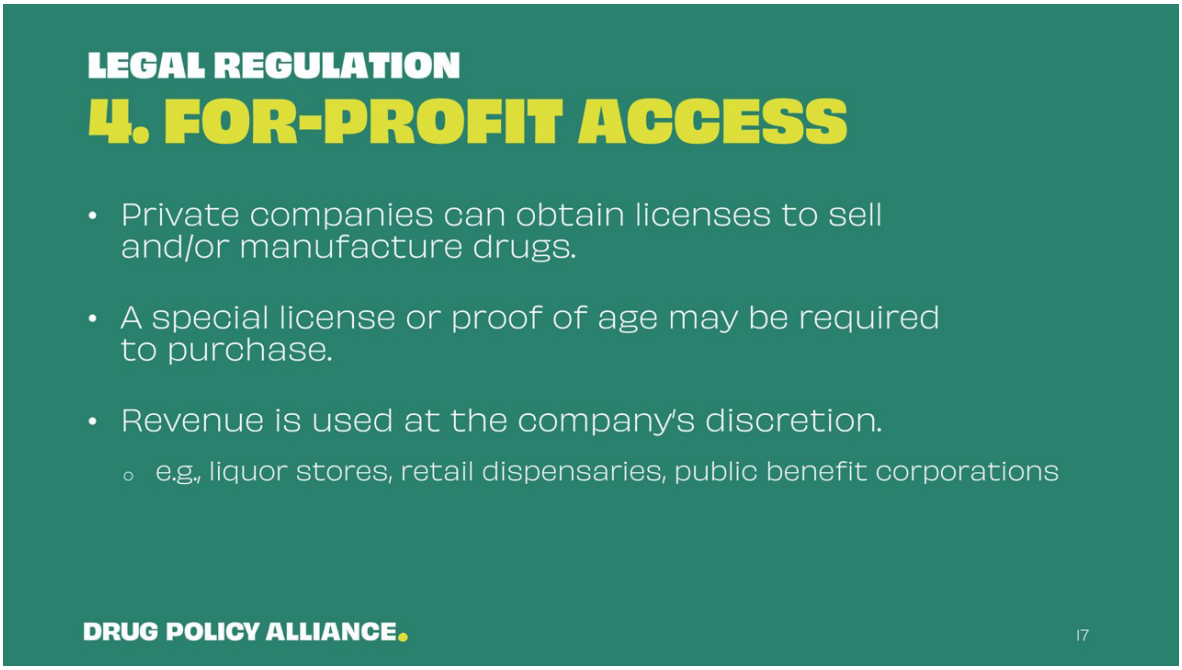
The following models can exist alongside medical access or present meaningful alternatives to it.



The next model we'll discuss is state-controlled access, or state monopoly. Under this model, drugs are made available through state-run wholesale and/or retail. In this way, the government directly controls the number and concentration of retail stores, the sale of substances, and the revenue generated as a result. This model also allows regulatory bodies to more effectively enforce proof-of-age or license requirements through direct oversight and employee training. Many people who support state-controlled access argue that a state monopoly reduces profit motive, raises revenue for the public good, and curtails consumption by deliberately making it more difficult to access a product. Examples of this model exist across the world, including in the United States, where several state governments directly control the sale of some or all alcoholic beverages. Canada has also taken an exclusively state-run approach to both alcohol and marijuana sales.

An alternative to the state monopoly model is the nonprofit or cooperative model. In this model, nonprofit organizations are licensed by the government to sell and/or manufacture different products. Similar regulations to state-controlled access can apply, such as requiring proof of age or a specialized license. Individual organizations can also choose to charge membership fees to benefit the organization and limit the amount of people who are accessing a drug. In this model, generated revenue can be used to fund a publicly available service, such as a housing assistance program. It could also be redistributed among members or put back into the organization.

This model is less commonly seen or talked about but is nonetheless appealing for folks who want to limit government oversight and eliminate the profit motive associated with privatized models. One rather new example is that of Housing Works in NYC, a longstanding nonprofit organization that serves people living with or affected by HIV/AIDS and homelessness. Housing Works launched the first legal marijuana dispensary in NYC and uses their revenue to fund harm reduction programs and other social services.



Lastly, we have the for-profit or privatized model of access. Under this model, business and companies are licensed by the government to sell and/or manufacture certain products. Like with other models, the government may require consumers to show proof of age or apply for a specialized license in order to make a purchase, as well as levy taxes. Unlike a state monopoly or nonprofit model, a privatized model allows businesses to decide how to use most or all of their revenue. However, there can still be plenty of government rules and regulations that can be put in place. For example, state liquor authorities can determine the number of bars and liquor stores that can exist within a certain distance of each other; limit the hours during which businesses can sell alcohol; how much alcohol a business can sell at a time; and to what extent businesses can advertise alcohol through physical or digital media.

Facilitators give participants roughly 10 minutes to review and complete the Discussion Participant Handout. They may think of a particular drug (e.g., methamphetamine, heroin, cocaine) or they may think of a particular drug class (e.g., stimulants, opioids). Encourage them to reflect upon the different models and examples of regulations presented earlier to think about how they may want people to be able to access their particular drug or drug class.

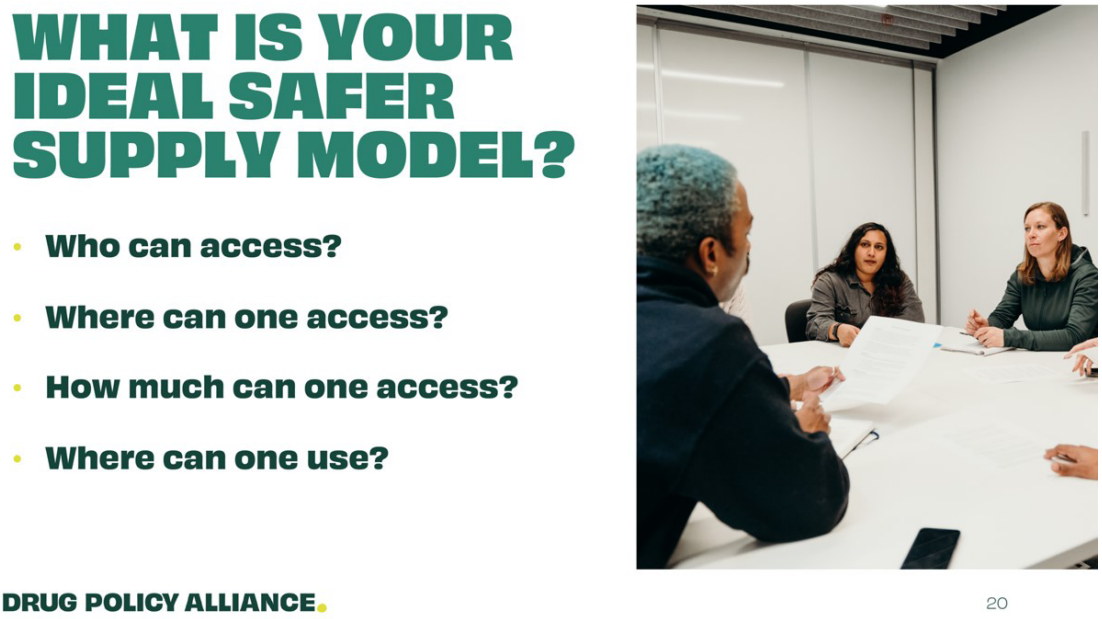
Facilitators provide attendees with a quick break and let participants know when they should return for the discussion portion.

[At the end of the break, facilitators should frame and set expectations for the following discussion. Facilitators should aspire to hear from every participant at least once for every discussion question, but some folks may not have strong opinions (or feel more comfortable typing in the chat rather than speaking out loud, if using a digital format). If a certain detail or topic is being discussed or argued repetitively, remember ELMO: Enough, Let's Move On!]

As you think about your ideal models for legalization, we want you to speak to your community's unique vulnerabilities and circumstances, rather than attempt to create one sweeping solution for all communities. What issues do urban residents face versus rural folks? What is your community's racial and ethnic makeup, and how do these factors impact access to healthcare and economic opportunities? If you were to legalize drugs tomorrow, what modes of transportation would people in your community have to use in order to go to a dispensary or a pharmacy? Does everyone have equal access to transportation? These are just a few questions that only you all can answer, as people who live, work, and organize in your communities. We are not looking for consensus around a single model: in fact, we recognize that the best model may in fact be a combination of multiple models, so people who use drugs can choose what's right for them. Therefore, please put forward your ideas even if you're unsure what others may think — this is a space to explore the options before us and imagine new possibilities for the future.

Framing the Conversation

- It's okay to disagree.
- There is no one perfect model.
- Different communities have different needs.
- We want to hear everything you have to say!



The four key questions of legal regulation from a consumer standpoint are as follows:

- Who can access?
- Where can one access?
- How much can one access?
- And where can one use?

Each of these questions will have approximately ten to fifteen minutes of dedicated discussion time.

One of the biggest questions of legally regulating drugs is deciding who can access them. While most folks would agree that young children should not have unlimited access to drugs, there's a wide variety of criteria that can be used to determine access.

Here we have listed three main frameworks of access: by prescription, by registration, and by showing proof of age (i.e. unlicensed access). Each framework can come with varying restrictions or allowances, which can be mixed and matched.

For example, adults could be able to access drugs with proof of age, while minors have to be dependent/have SUD in order to receive a prescription. Or, you could have another way of determining access altogether. What do you all think?

Probing questions:

- By prescription
    - Who should qualify for a prescription?
    - People who are already dependent? People who have "treatment-resistant" dependence?
    - Should a diagnosis be required? Which diagnoses qualify? Should diagnosis be discussed with patients?
    - Who should be able to prescribe?
    - General practitioners? Specialists? Psychiatrists? Should additional certification be required?
    - Should people be able to take their prescription home with them?
- By registering with the government or obtaining a specialized license
    - Who qualifies for a license or registration?
    - How often should the user have to renew their license?
    - Can a license be revoked? What would trigger this?
- By showing proof of age
    - What would count as proof of age?
    - Can people buy drugs even when they are visibly intoxicated?
    - Is there anyone who could not buy, even with proof of age?

The next big question of legal regulation, of course, is deciding where people can get drugs. In the Canadian safer supply model, people have to retrieve their prescriptions from the pharmacy, sometimes every day. In parts of the world that have legalized marijuana, you can go to a marijuana coffee shop or buy some to take home from a dispensary.

Now, we're going to talk about how you all would want to access drugs. We have several access points listed here, but if there's another point of access that we haven't listed, please feel free to introduce it into the conversation.

Probing questions:

- Clinics and pharmacies
  - Specialized clinics/pharmacies, or any?
  - If alongside other forms of access, should people with a prescription be able to access more than what they are prescribed?
- State-owned, non-profit or retail stores; cooperatives
  - Should there be specialized stores or other venues for different types of drugs?
  - Should there be a separation of sales for on-site and off-site consumption?
  - How should profits be used in the case of state-owned and nonprofit models?
  - How should membership be determined in the case of cooperative models?
- Home grow
  - What counts as home grow? Should people be allowed to share their home-grow? Sell it?

There are many ways to quantify amounts of drugs: by weight, by volume, by potency, by a person's tolerance (i.e. what they need to abate withdrawal, experience light/moderate/intense effects), and by a person's consumption habits (i.e. how much they consume daily/weekly/monthly on average).

You may feel that there should be strict rules on how much of a drug that people can purchase at a time, or that people should be able to have as much as they want. Or, you think people should be able to get one amount when consuming on-site, and another amount when they're taking it to go.

For this section, we'll talk about whether and how we should moderate how much of different drugs people should be able to get at a time.

Probing questions:

- For maintenance or to abate withdrawal
  - How would this be measured?
  - What about people who do not experience withdrawal? Drugs that do not induce withdrawal?
- Standard limit by weight/volume
  - What would be a reasonable limit for different types of drugs?
  - Would this limit be implemented per purchase, or per person?
  - Should there be a difference in limits for on-site vs. off-site consumption?
- For personal use (e.g. based on average daily, weekly or monthly use)
  - How would this be measured?
  - What happens if people run out before they can purchase more?
- Any amount
  - How would diversion (secondary distribution) be addressed, if at all?

Alright, so you can now legally get drugs at your venue of choice — our last question is, where can you take them? The matter of public drug use is especially a hot button issue, since we all know that not all people are able to use in the privacy of their homes.

The criminalization of public drug use (or public display of drugs) has led to thousands of people cycling in and out of local jail systems at great expense to the individual and to the public.

So, we have a variety of options at our disposal so those who own their homes are not the only people who can use drugs safely and legally.

Probing questions:

- Private spaces (e.g. clinics, supervised consumption sites, bars, lounges, residences)
  - Does a space have to be licensed to allow drug use?
  - Does a space have to have trained staff available to allow drug use?
  - Should people have to purchase their drugs on-site? Should people only be able to bring their own?
  - Should people be able to consume their drugs at public housing sites?
  - Can a venue ban drug use? e.g., a landlord of an apartment building?
- Public spaces (e.g. designated smoking areas, public parks, sidewalks)
  - Can people be publicly intoxicated?
  - If there should be restrictions on where people can use/consume in public, what should those restrictions be? (e.g. in public parks, but not playgrounds)
  - Should there be penalties for using/consuming in inappropriate places? What should those penalties be?
  - What measures should be taken to ensure the safe disposal of used supplies (e.g. pipes, syringes)?

[Facilitators should summarize the points of consensus as well as the points of dissent. Facilitators should tailor the next steps to the stated purpose or project for which the conversation's insights will be used: it is important that participants come away with a clear sense of what they can do next. Example script below.]

Thank you all so much for your insights: we have generated a variety of fantastic, innovative, and creative ideas for legally regulating drugs in the United States. As we said in the beginning, this was an exercise in the ideal: putting aside compromise and political realities in favor of envisioning a utopia. Now, as we end today's session, we want to invite you to envision your role in advancing safer supply. In the current political landscape, the decriminalization of personal drug possession is still a contentious issue: we have a long way to go before safer supply is seriously considered as a response to the overdose crisis. This conversation is just one of many being had across the country among people who use drugs, policy advocates and other healthcare providers, and we want to see more and more people getting involved and opening their minds to what a world beyond prohibition could look like. Therefore, we encourage you to take the insights from this discussion to those who haven't had it yet. This can be as simple as striking up a conversation with your colleagues: "Hey, I feel like there's something really wrong with how we treat people who use drugs. Do you ever think we could be doing something different?" You can also prepare a grand rounds presentation on safer supply, host listening sessions with people who use drugs and community leaders, or use your expertise and standing as a medical professional to write an op-ed and participate in discussion panels. Whatever your comfort or skill level, there is a place for you in the work to end the overdose crisis and punitive treatment of people who use drugs.

If you are interested in furthering your knowledge and taking the next step, the Drug Policy Alliance, the Pan-American Network of Drug User Activists, the New England Users Union, the National Survivors Union, and the Michigan Users Union. have created a comprehensive toolkit designed to support advocates in advancing the conversation on safer supply: this discussion guide is one of four parts, accompanied by an executive summary of the first community conversations off which this discussion is based; a strategy guide and list of resources for further reading; and a media guide that offers in-depth talking points, guidelines for writing an effective op-ed, and tips to build professional rapport with journalists and become an expert source. The Safer Supply Toolkit is available here: http://drugpolicy.org/SaferSupplyToolkit

Once again, thank you all so much for your participation today and your ongoing work to improve the lives of people who use drugs. Today's discussion is the foundation of a safer, freer future for all.

COMMUNITY DISCUSSION GUIDE

Access Powerpoint slides here

Conversation facilitators should introduce themselves and welcome participants to the space. The facilitators should introduce the discussion topic and explain how the conversation will be documented, i.e., through written notes or audio recordings. The facilitators should inform participants of the expectations and limitations of confidentiality, outlined below. Facilitators should make sure there are enough copies of the Discussion Participant Worksheet for all attendees. Facilitators are encouraged to share with participants that this discussion guide is a part of a larger resource called the Safer Supply Toolkit, which was created by the Drug Policy Alliance, the Pan-American Network of Drug User Activists, the New England Users Union, the National Survivors Union (formerly the Urban Survivors Union), and the Michigan Users Union.]

- Notes will be anonymized to ensure confidentiality.
- Personal details will be obscured to protect participants' privacy.
- We do not recommend that you record the sessions, yet if you do – Ask for consent to record the session and be clear with participants about why they will be recorded, where recordings will be stored, and why they will be recorded. If participants do not consent to being recorded, you should not record these conversations.
- While it's expected that all participants will respect others' privacy, facilitators cannot control what participants do and do not talk about outside of the conversation.
- Only disclose personal details if you feel comfortable doing so.

[Facilitators should summarize the agenda of the conversation. Example script below.]

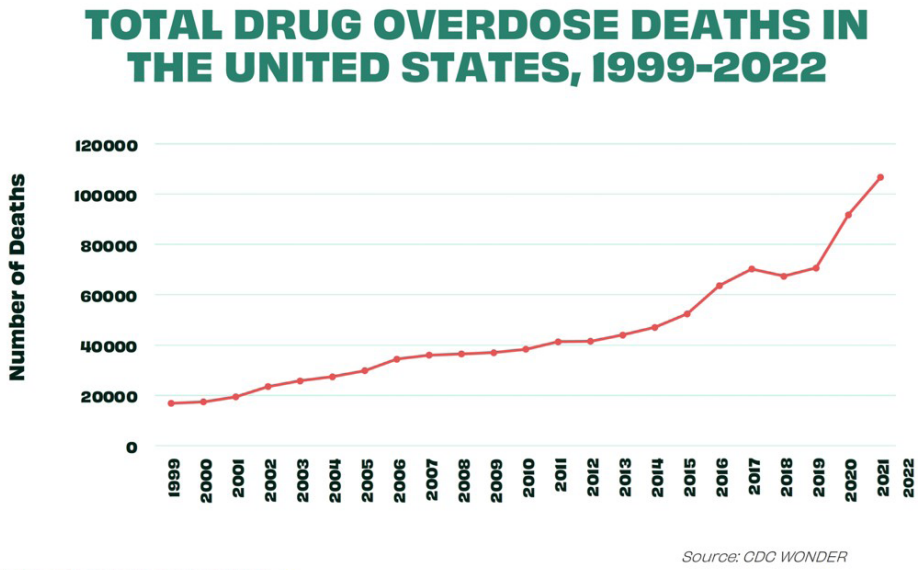
To introduce our agenda, today's conversation has two main parts: an educational section and a discussion section. The educational section will cover various models of drug policy with examples from the present day, including the Canadian model of safer supply that's emerged over the past few years. We are doing this to help make sure everyone is on the same page when it comes to the terminology and models we will be discussing later. We'll then take a fifteen-minute break before heading into the discussion section, where everyone will be encouraged to answer four key questions of legal regulation and your views about considerations for potential regulatory models informed by your experiences and expertise. Here are some components of regulatory models that we are interested in hearing your thoughts about: who can access a drug, where can you access it, where can you use it, and how much of it you can possess at once. We'll then wrap up and talk about next steps.

You've been provided a worksheet to guide your decision-making as we go through the explanatory part of the agenda. The questions in the worksheet may help you think through the various considerations of regulating drugs. You may choose to focus on one specific drug, such as psilocybin or heroin, fill out multiple worksheets for more than one drug, or use one worksheet as a framework for all drugs.

[Facilitators should describe the purpose of the conversation. The stated purpose can be customized for the particular setting in which the conversation is occurring. Example script below.]

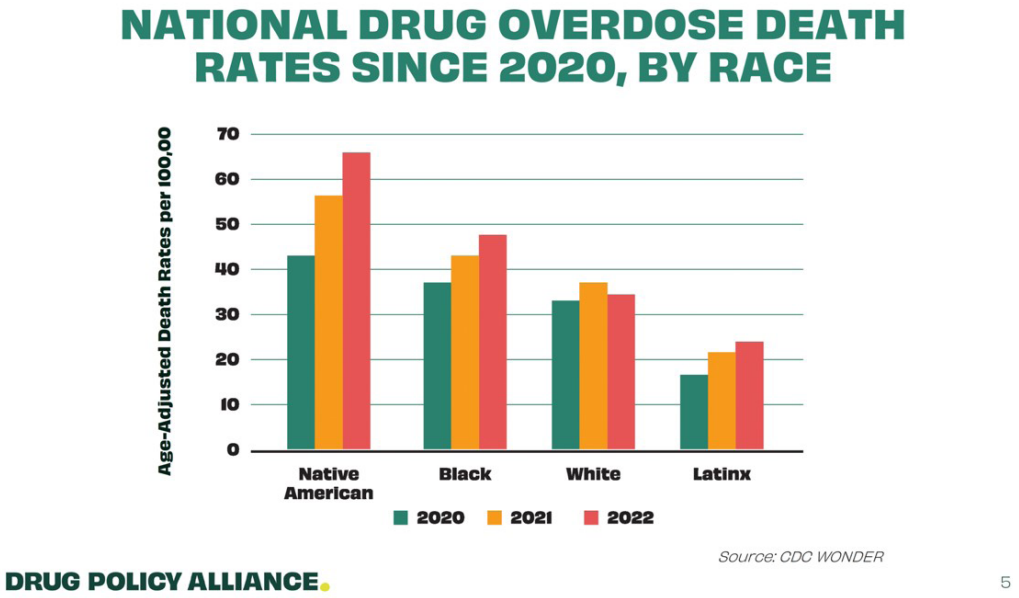
The first goal of this conversation is to come to a shared understanding of the key concepts of different models of drug policy, ranging from prohibition to legal regulation. We also want to critique these policies from a social equity standpoint, for even the most progressive of policies in the United States can still fall short of what people who use drugs need to live their lives. Some of these policies could be improved upon, or they could be scrapped and replaced with something else entirely.

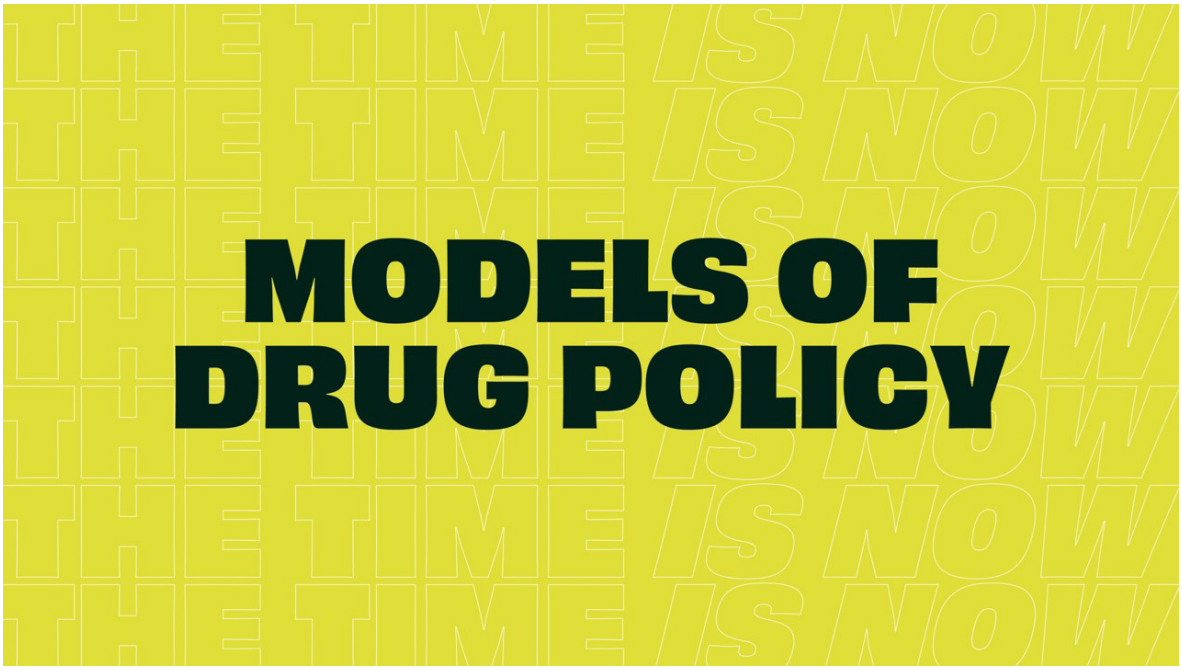
The second goal of this conversation is to establish key principles for legal regulation that center the diverse experiences and perspectives of people who use drugs — you! We expect that there will be areas where you generally agree but we want to make space for dissent and nuance. We do not want you to feel silenced because your experiences and opinions do not align with the majority. The purpose of this exercise is to explore all the benefits and drawbacks of different models of legal regulation across different contexts. We do not expect that everyone will agree on a single model.

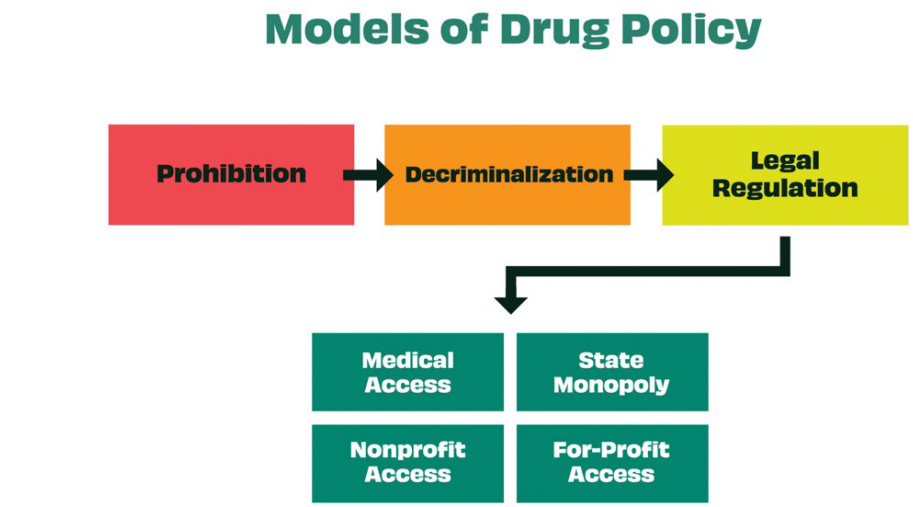


[Facilitators should frame the conversation about safer supply as a response to the overdose crisis. This can be customized for the particular setting in which the conversation is occurring. Example script below.]

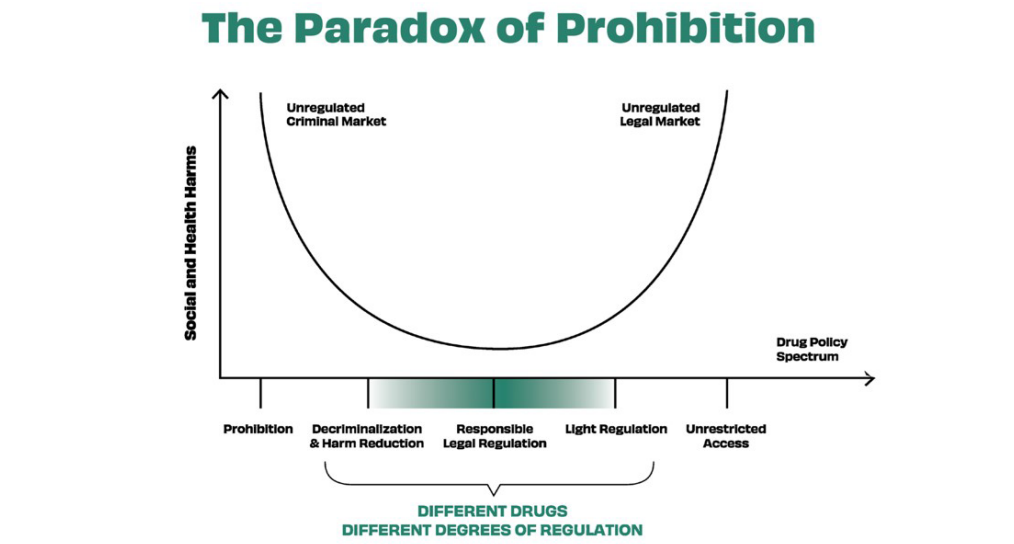
Of course, we know that there is a greater purpose to this exercise. Hundreds of thousands of people are dying every year of preventable overdoses; Black and Indigenous people of color and people from low-income communities bear the greater burden of this massive loss of life. Right now, we're dealing with an unregulated drug supply that is fueling the overdose crisis because people who use drugs from the underground market have no guarantee of what's in their drugs. Safer supply and legal regulation would guarantee consistent and reliable access to a known quantity of a known substance. Alongside other harm reduction strategies — many of which will be discussed today — safer supply is a necessary response to an overdose crisis driven by drug contamination and criminalization.





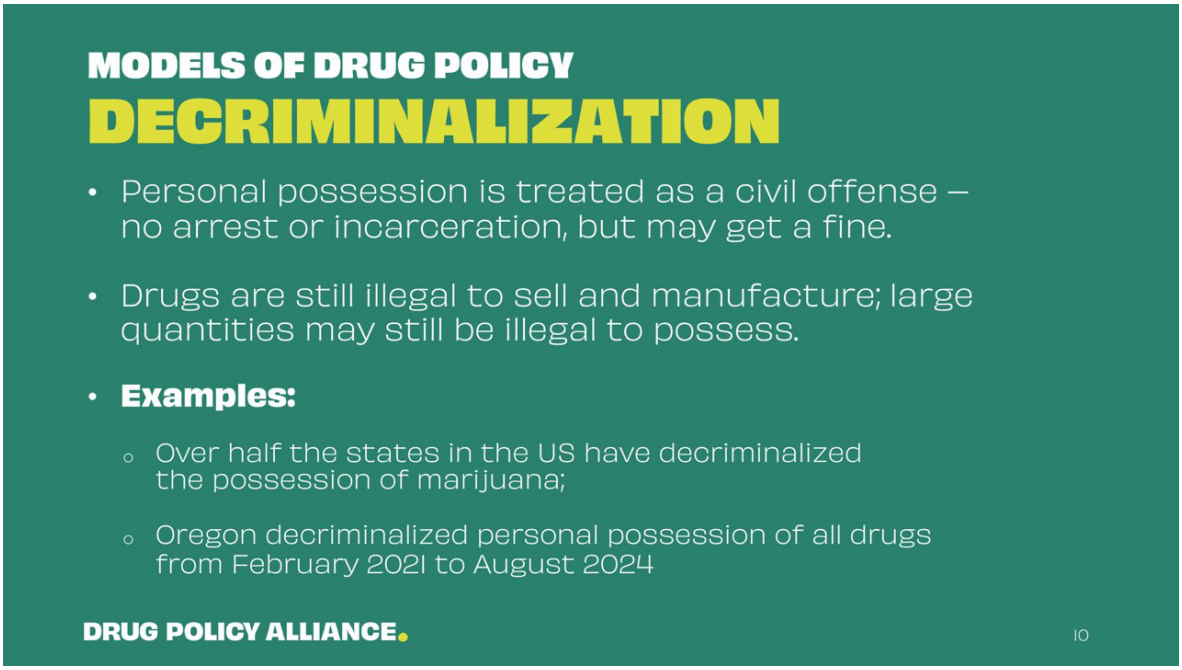


For the first segment of our discussion today, we'll be talking about the three main models of drug policy: prohibition, decriminalization, and legal regulation. Within each of these models are a wide variety of submodels, some of which can exist alongside each other, and specific policies, which can be applied to more than one model. Today, we'll focus on some of the submodels of legal regulation, including medicalized access, state monopoly, nonprofit and cooperative distribution, and privatized access.



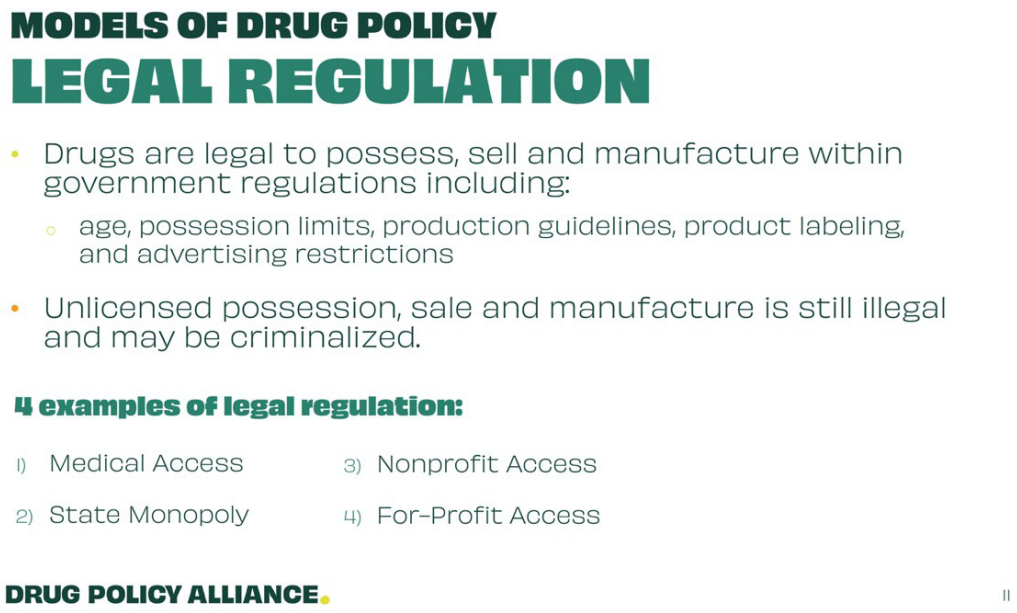
It's important to compare the different models of drug policy, as an unregulated legal market can pose just as many dangers to public health as an unregulated criminal market. The limitations of tobacco and alcohol regulation throughout the history of the United States is a good example of how ineffective regulation can prioritize corporate profit over consumer safety.

Prohibition, as the name suggests, outlaws the use, possession, sale, manufacture, and transportation of specific drugs, drug analogs, and drug precursors. The core principle of prohibition is that drug use and related harms can be reduced or eliminated by imposing (often steep) criminal sanctions, including fines, mandated treatment, or imprisonment. Drug use or sales can lead to a criminal record and often limit a person's opportunities for employment, housing, and other basic needs. The United States has prohibited the possession, sale and manufacture of many drugs over the years, including marijuana, cocaine, heroin, and methamphetamine, and these drugs still remain illegal on the federal level and in most states.



Decriminalization reduces the penal consequences of drug use and possession while continuing to pursue and prosecute people who sell drugs, seeking to eliminate the supply of illicit drugs. Civil offenses do not appear on a person's record. However, failure to pay fines for civil offenses can lead to criminal prosecution.

A key example in the United States is Oregon's decriminalization of drug possession for personal use with the passage of Measure 110. Personal possession of drugs such as heroin, methamphetamine, and cocaine was reduced from a class A misdemeanor to a new class E violation, the lowest possible penalty. Penalties are a $100 fine or a free health assessment and connection to harm reduction and treatment programs. The program also eliminates enhanced sentences based on prior convictions, so people charged with possession will never receive more than a $100 fine or assessment referral, regardless of criminal history. Unfortunately, this win faced significant political backlash and was undermined by the state legislature with the re-criminalization of personal possession in 2024. Despite decriminalization opponents' assertions that Measure 110 contributed to the continued rise in overdose deaths, no empirical study has found this to be true.



Legal regulation allows the possession, sale and manufacturing of drugs under certain rules established by law. These rules can vary widely, hence why today's conversation will dive into some of the details of legally regulating psychoactive substances. Alcohol and tobacco products, for example have been legally regulated in the United States for decades. As of recent years, legal marijuana has also become increasingly available in states that have chosen to legalize and regulate it. Anyone over the age of 21 who shows proof of ID can buy alcohol and marijuana in states that legally regulate them, though there may be some restrictions on how much an establishment can sell to one person at a time or how much a person can possess.

Prescription drugs are also legally regulated, such as Adderall and Xanax. However, we know that possessing these drugs without a prescription is illegal, which leads us to the the next few slides, where we'll examine a variety of models of legal regulation using examples from the real world.

LEGAL REGULATION

1. MEDICAL ACCESS

- Possession is only legal if you have a prescription.
- Manufacturing and dispensing is regulated by the government.
  - e.g., clinics, hospitals, pharmacies; medical marijuana; methadone and buprenorphine; safer supply in Canada

DRUG POLICY ALLIANCE. 13

The first model we'll look at is that of medical access. Under this model, only qualified patients who receive a prescription can access a regulated supply of a drug, usually through a prescription. Every prescription pharmaceutical drug sold in the United States undergoes review by the Food and Drug Administration to ensure their safety and efficacy, and some drugs are subject to additional restrictions and regulations as per the Controlled Substances Act.

Methadone and buprenorphine are all examples of legal access through a medicalized model, though they all are administered differently under federal and state law. In the U.S., drugs are also traditionally manufactured by private companies, but may be produced by other entities, such as government contractors or nonprofit organizations.

Some states have medical marijuana programs. Medical marijuana is not technically prescribed, but the programs may require the involvement of a healthcare professional, and the supply of medical marijuana is controlled and regulated.

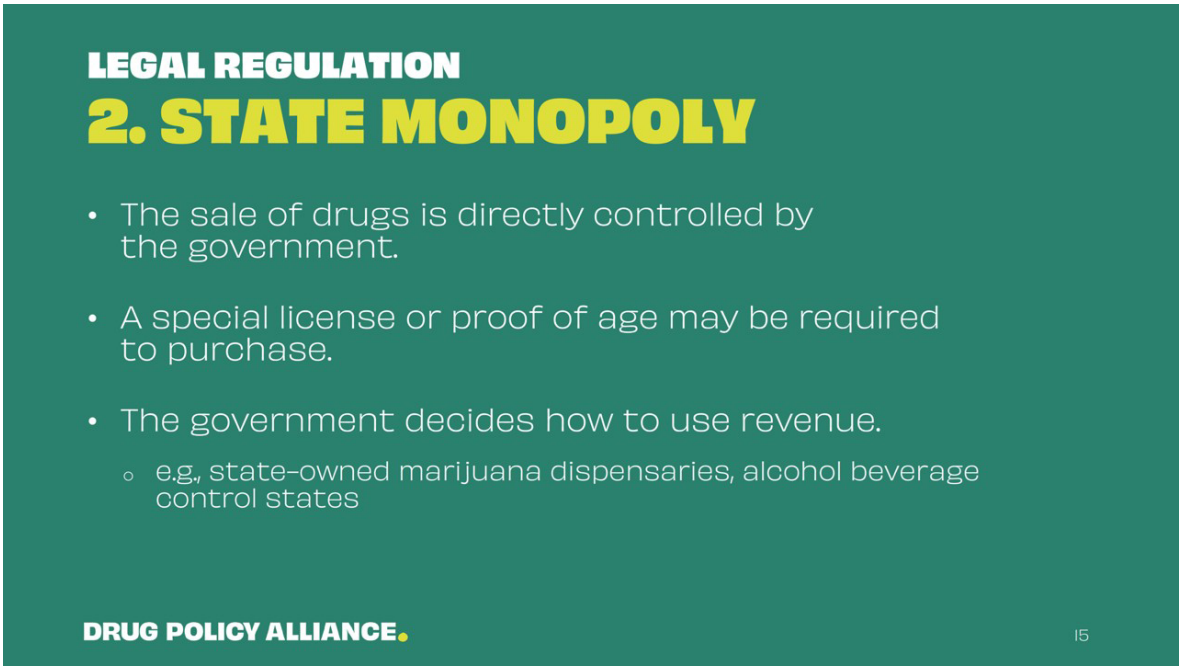
Some countries (e.g., Canada and Switzerland) have had prescription heroin programs for years, though these programs typically only reach a small number of people and have strict eligibility criteria.

One particularly compelling model of medical access to highlight is that of safer supply in Canada. Safer supply is an emerging idea that was put in action in light of the COVID-19 pandemic, which has significantly impacted the global drug supply and those who depend on it.

Safer supply is one form of regulation that provides prescription access to pharmaceutical alternatives to illicit substances, such as hydromorphone for heroin and fentanyl, or Adderall for cocaine or methamphetamine. The prescribed dose is determined collaboratively between prescriber and patient, but there are often legal limits to how much a person can have at once. Some programs allow participants to take home their doses, while others require observed dosing. Participants also have access to supportive services, such as counseling, referrals to housing and employment assistance programs, and harm reduction resources.

This model highlights how medical access can help connect people who use drugs to much-needed services. However, not everyone may qualify for the program, and not everyone wants to see a doctor in order to get their drugs.

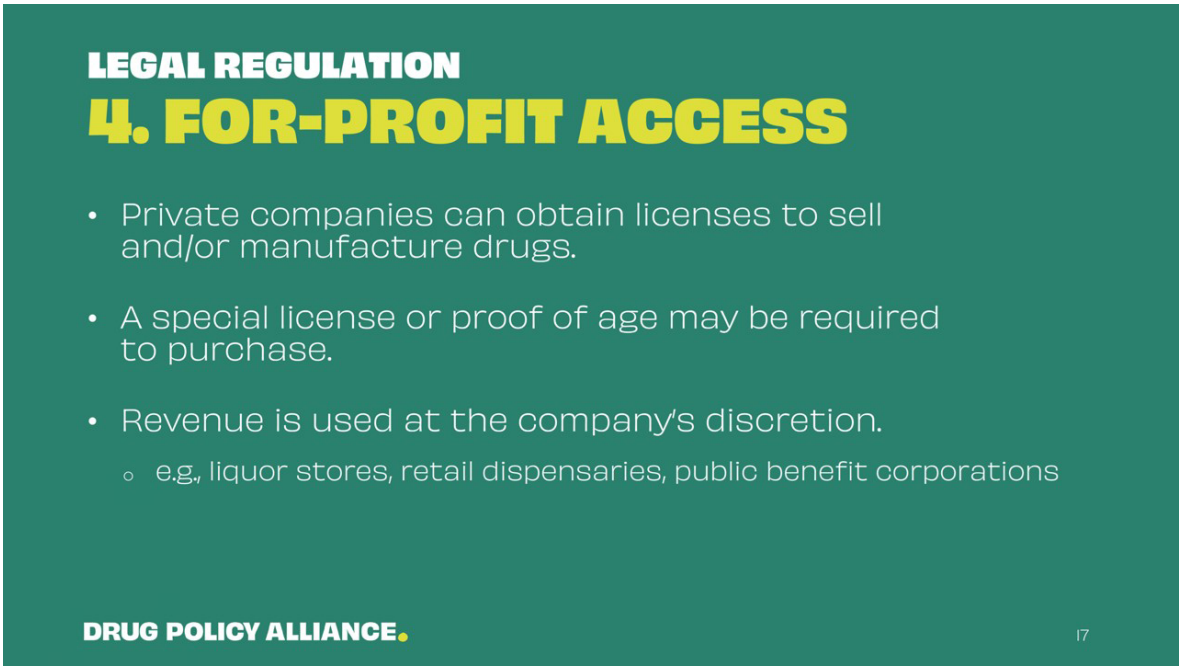
The following models can exist alongside medical access or present meaningful alternatives to it.



The next model we'll discuss is state-controlled access, or state monopoly. Under this model, drugs are made available through state-run wholesale and/or retail. In this way, the government directly controls the number and concentration of retail stores, the sale of substances, and the revenue generated as a result. This model also allows regulatory bodies to more effectively enforce proof-of-age or license requirements through direct oversight and employee training. Many people who support state-controlled access argue that a state monopoly reduces profit motive, raises revenue for the public good, and curtails consumption by deliberately making it more difficult to access a product. Examples of this model exist across the world, including in the United States, where several state governments directly control the sale of some or all alcoholic beverages. Canada has also taken an exclusively state-run approach to both alcohol and marijuana sales.

An alternative to the state monopoly model is the nonprofit or cooperative model. In this model, nonprofit organizations are licensed by the government to sell and/or manufacture different products. Similar regulations to state-controlled access can apply, such as requiring proof of age or a specialized license. Individual organizations can also choose to charge membership fees to benefit the organization and limit the amount of people who are accessing a drug. In this model, generated revenue can be used to fund a publicly available service, such as a housing assistance program. It could also be redistributed among members or put back into the organization.

This model is less commonly seen or talked about but is nonetheless appealing for folks who want to limit government oversight and eliminate the profit motive associated with privatized models. One rather new example is that of Housing Works in NYC, a longstanding nonprofit organization that serves people living with or affected by HIV/AIDS and homelessness. Housing Works launched the first legal marijuana dispensary in NYC and uses their revenue to fund harm reduction programs and other social services.



Lastly, we have the for-profit or privatized model of access. Under this model, business and companies are licensed by the government to sell and/or manufacture certain products. Like with other models, the government may require consumers to show proof of age or apply for a specialized license in order to make a purchase, as well as levy taxes. Unlike a state monopoly or nonprofit model, a privatized model allows businesses to decide how to use most or all of their revenue. However, there can still be plenty of government rules and regulations that can be put in place. For example, state liquor authorities can determine the number of bars and liquor stores that can exist within a certain distance of each other; limit the hours during which businesses can sell alcohol; how much alcohol a business can sell at a time; and to what extent businesses can advertise alcohol through physical or digital media. Some people worry that a for-profit model will create powerful economic incentives for companies to expand drug use and/or will keep people who currently sell drugs in the informal (illicit) market from participating in the new market, which could be dominated by big companies.

Facilitators give participants roughly 10 minutes to review and complete the Discussion Participant Handout. They may think of a particular drug (e.g., methamphetamine, heroin, cocaine) or they may think of a particular drug class (e.g., stimulants, opioids). Encourage them to reflect upon the different models and examples of regulations presented earlier to think about how they may want people to be able to access their particular drug or drug class.

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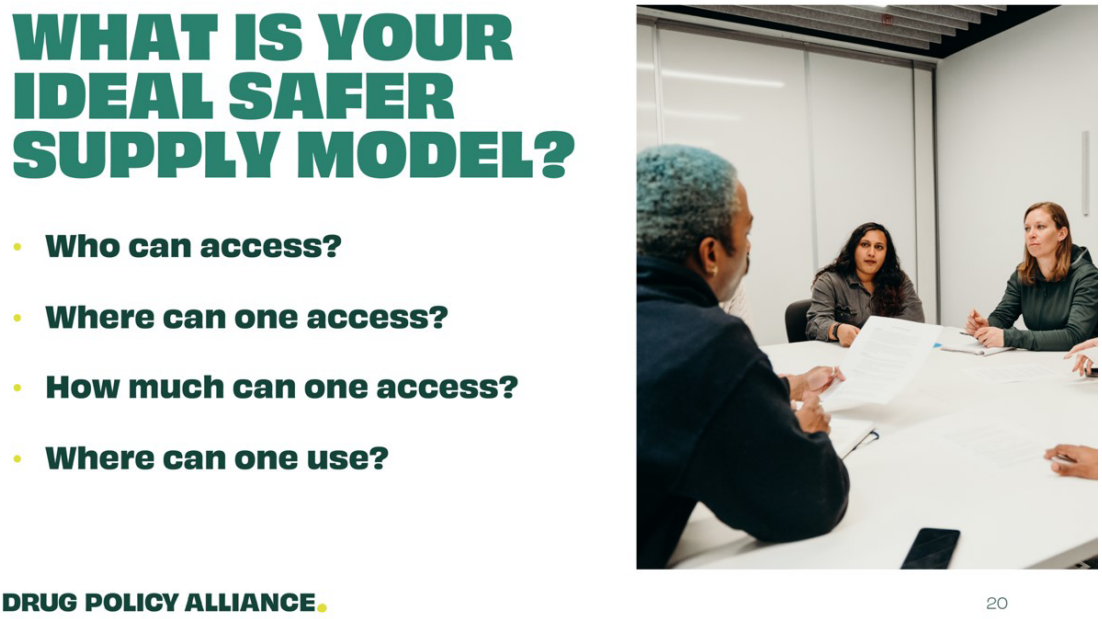

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Probing questions:

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    - Can people buy drugs even when they are visibly intoxicated?
    - Is there anyone who could not buy, even with proof of age?

The next big question of legal regulation, of course, is deciding where people can get drugs. In the Canadian safer supply model, people have to retrieve their prescriptions from the pharmacy, sometimes every day. In parts of the world that have legalized marijuana, you can go to a marijuana coffee shop or buy some to take home from a dispensary.

Now, we're going to talk about how you all would want to access drugs. We have several access points listed here, but if there's another point of access that we haven't listed, please feel free to introduce it into the conversation.

Probing questions:

- Clinics and pharmacies
    - Specialized clinics/pharmacies, or any?
    - If alongside other forms of access, should people with a prescription be able to access more than what they are prescribed?
- State-owned, non-profit or retail stores; cooperatives
    - Should there be specialized stores or other venues for different types of drugs?
    - Should there be a separation of sales for on-site and off-site consumption?
    - How should profits be used in the case of state-owned and nonprofit models?
    - How should membership be determined in the case of cooperative models?
- Home grow
    - What counts as home grow? Should people be allowed to share their home-grow? Sell it?

There are many ways to quantify amounts of drugs: by weight, by volume, by potency, by a person's tolerance (i.e. what they need to abate withdrawal, experience light/moderate/intense effects), and by a person's consumption habits (i.e. how much they consume daily/weekly/monthly on average).

You may feel that there should be strict rules on how much of a drug that people can purchase at a time, or that people should be able to have as much as they want. Or, you may think people should be able to get one amount when consuming on-site, and another amount when they're taking it to go.

For this section, we'll talk about whether and how we should moderate how much of different drugs people should be able to get at a time.

Probing questions:

- For maintenance or to abate withdrawal
  - How would this be measured?
  - What about people who do not experience withdrawal? Drugs that do not induce withdrawal?
- Standard limit by weight/volume
  - What would be a reasonable limit for different types of drugs?
  - Would this limit be implemented per purchase, or per person?
  - Should there be a difference in limits for on-site vs. off-site consumption?
- For personal use (e.g. based on average daily, weekly or monthly use)
  - How would this be measured?
  - What happens if people run out before they can purchase more?
- Any amount
  - How would diversion (secondary distribution) be addressed, if at all?

Alright, so you can now legally get drugs at your venue of choice — our last question is, where can you take them? The matter of public drug use is especially a hot button issue, since we all know that not all people are able to use in the privacy of their homes.

The criminalization of public drug use (or public display of drugs) has led to thousands of people cycling in and out of local jail systems at great expense to the individual and to the public.

So, we have a variety of options at our disposal so those who own their homes are not the only people who can use drugs safely and legally.

Probing questions:

- Private spaces (e.g. clinics, supervised consumption sites, bars, lounges, residences)
  - Does a space have to be licensed to allow drug use?
  - Does a space have to have trained staff available to allow drug use?
  - Should people have to purchase their drugs on-site? Should people only be able to bring their own?
  - Should people be able to consume their drugs at public housing sites?
  - Can a venue ban drug use? e.g., a landlord of an apartment building?
- Public spaces (e.g. designated smoking areas, public parks, sidewalks)
  - Can people be publicly intoxicated?
  - If there should be restrictions on where people can use/consume in public, what should those restrictions be? (e.g. in public parks, but not playgrounds)
  - Should there be penalties for using/consuming in inappropriate places? What should those penalties be?
  - What measures should be taken to ensure the safe disposal of used supplies (e.g. pipes, syringes)?

[Facilitators should summarize the points of consensus as well as the points of dissent. Facilitators should tailor the next steps to the stated purpose or project for which the conversation's insights will be used: it is important that participants come away with a clear sense of what they can do next. Facilitators are encouraged to refer participants to the Safer Supply Toolkit, which provides a wealth of resources to deepen their knowledge and confidence in discussing safer supply with a broader audience. Example script below.]

Thank you all so much for your insights: we have generated a variety of fantastic, innovative, and creative ideas for legally regulating drugs in the United States. As we said in the beginning, this was an exercise in the ideal: putting aside compromise and political realities in favor of envisioning a utopia. Now, as we end today's session, we want to invite you to envision your role in advancing safer supply. In the current political landscape, the decriminalization of personal drug possession is still a contentious issue: we have a long way to go before safer supply is seriously considered as a response to the overdose crisis. This conversation is just one of many being had across the country among other people who use drugs, policy advocates and healthcare providers, and we want to see more and more people getting involved and opening their minds to what a world beyond prohibition could look like. Therefore, we encourage you to take the insights from this discussion to those who haven't had it yet. This can be as simple as striking up a conversation with your friends: "If we were to legalize all drugs, how would you do it?" You can also a town hall with community leaders and healthcare providers on safer supply, post about safer supply on social media, or use your expertise and insight as an affected individual to write an op-ed and participate in discussion panels. Whatever your comfort or skill level, there is a place for you in the work to end the overdose crisis and punitive treatment of people who use drugs.

If you are interested in furthering your knowledge and taking the next step, the Drug Policy Alliance, the Pan-American Network of Drug User Activists, the New England Users Union, the National Survivors Union, and the Michigan Users Union. have created a comprehensive toolkit designed to support advocates in advancing the conversation on safer supply: this discussion guide is one of four parts, accompanied by an executive summary of the first community conversations off which this discussion is based; a strategy guide and list of resources for further reading; and a media guide that offers in-depth talking points, guidelines for writing an effective op-ed, and tips to build professional rapport with journalists and become an expert source. The Safer Supply Toolkit is available here: http://drugpolicy.org/SaferSupplyToolkit

Once again, thank you all so much for your participation today and your ongoing work to improve the lives of people who use drugs. Today's discussion is the foundation of a safer, freer future for all.