BRITISH COLUMBIA | Ministry of Health

Access to Prescribed Alternatives in British Columbia

B.C. MINISTRY OF HEALTH

December 2025

Preamble

Land Acknowledgement

The British Columbia (B.C.) Ministry of Health acknowledges with care the territories of First Nations around B.C. and is grateful to carry out our work on these lands. We acknowledge the rights, interests, priorities, and concerns of all Indigenous Peoples—First Nations, Métis, and Inuit—respecting and acknowledging their distinct cultures, histories, rights, laws, and governments. We also recognize the disproportionate impacts of the toxic drug crisis on Indigenous communities, and we are committed to addressing this injustice.

Recognition of Lives Lost

The B.C. Ministry of Health recognizes with sadness the many lives lost to the toxic drug crisis, which is devastating communities across B.C. We acknowledge the individuality and uniqueness of each of those lost, whose absence continues to be deeply felt. We also recognize the profound grief and pain experienced by bereaved loved ones as a result of the toxic drug crisis.

Rationale

British Columbia (B.C.) is experiencing an unprecedented toxic drug crisis, fuelled by a dangerous, unpredictable, and adulterated unregulated drug supply. In response to increases in fentanyl and other contaminants within the unregulated drug supply, B.C.'s provincial health officer declared the crisis a public health emergency in April of 2016. As of September 2025, we have lost more than 17,500 British Columbians due to toxic drugs. Still others are experiencing harms tied to unregulated substances, including non-fatal drug poisonings, physical injuries, HIV/Hepatitis B or C, hospitalizations for injection-related problems, and associated brain injuries.

The toxic drug crisis is also having disproportionate impacts on First Nations populations and communities in B.C. From January – June 2025, First Nations people in B.C. died of toxic drug poisoning at 5.4 times the rate of other B.C. residents. In that same period, First Nations women died at 8.5 times the rate of other female B.C. residents.[1] In recognition of this, providing appropriate and culturally safe care that is free of Indigenous-specific racism and discrimination must be a fundamental component of strategies to address the toxic drug crisis.

[1] First Nations Health Authority. (n.d.). *First Nations and the toxic drug poisoning crisis in BC.* https://www.fnha.ca/Documents/FNHA-First-Nations-and-the-Toxic-Drug-Poisoning-Crisis-in--Jan-Dec-2024.pdf

Addressing this public health emergency and its inequitable impacts requires concerted action across the full continuum of care. Prevention, early intervention, harm reduction, and treatment and recovery are all vital to saving lives, reducing harms and fostering pathways to lasting wellness.

B.C.'s prescribed alternatives (PA) program is one of several critical tools in the substance use system of care. PA is the prescription and provision of regulated, pharmaceutical-grade medications of known quality and dosage to people at high risk of harm from the unregulated drug supply. PA helps to reduce toxic drug poisoning and substance use-related harms by supporting clients to separate from the unregulated drug supply and manage their substance use and withdrawal symptoms with prescription medications. PA is delivered through a medical model to allow for thorough clinical examination, including assessing readiness for treatment and recovery services, before prescribing these types of medications. The program supports clients to stabilize their lives, transition to treatment, and connect with other social and health services. PA medications are commonly co-prescribed with opioid agonist treatment (OAT), and clinicians in B.C. report that they are effective in supporting clients to titrate onto OAT more quickly and to manage withdrawal symptoms.[2]

PA was first introduced in B.C. in March 2020 as prescribed safer supply (PSS), when the Ministry of Health (HLTH) and the B.C. Centre on Substance Use (BCCSU) partnered to release Risk Mitigation Guidance (RMG). The RMG contained guidance on prescribing select medications to support people who use drugs to isolate, reduce the transmission of COVID-19 and prevent withdrawal. In 2021, the Province released *Access to Prescribed Safer Supply in British Columbia: Policy Direction*, which expanded on the RMG to separate individuals from the toxic drug supply and reduce the risk of overdose and other harms. Both documents have now been retired. They are superseded by the present policy document.

Evidence shows that PA is helping keep people at the highest risk of drug poisoning alive, so they can stabilize their lives and connect with care and treatment.[3] However, increasing

[2] Office of the Provincial Health Officer. (2023). *A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action*. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/a-review-of-prescribed-safer-supply-programs-across-bc.pdf

[3] Slaunwhite, A., Min, J. E., Palis, H., Urbanoski, K., Pauly, B., Barker, B., Crabtree, A., Bach, P., Krebs, E., Dale, L., Meilleur, L., & Nosyk, B. (2024). Effect of Risk Mitigation Guidance opioid and stimulant dispensations on mortality and acute care visits during dual public health emergencies: retrospective cohort study. *BMJ (Clinical research ed.)*, *384*, e076336. https://doi.org/10.1136/bmj-2023-076336

reports and emerging evidence[4,5,6,7,] of diversion (*i.e.,* the displacement, unintended use, selling/trading or sharing of PA) indicate that diversion of PA medications is happening, which has the potential to result in individual- and population-level health harms. For example, two peer-reviewed studies published in the *Journal of the American Medical Association* showed an increase in opioid-related hospitalizations since the introduction of the RMG (without a corresponding increase in opioid-related deaths), suggesting some negative population-level impacts.[8,9]

Since the start of the PA program, the Province has closely monitored, implemented and enhanced safeguards to limit diversion, including extending the Provincial Evaluation of the Implementation of PA, monitoring new incidences of opioid use disorder and fatal overdose, and establishing the Diverted Prescribed Alternatives Working Group. In February 2025, the Province took another step to mitigate diversion by announcing a shift to a witnessed model of PA to ensure prescription medications are consumed by their intended recipients and reduce the risk of diversion and its related harms.

This document was developed to reflect this direction, while acknowledging the positive effects of PA on the lives of clients. It sets out key requirements and responsibilities for the operational planning and delivery of PA across B.C.

About this Document

Policy Purpose & Objectives

The purpose of this policy is to reduce the risk of diversion of PA medications while ensuring access to life-saving care for individuals at risk of harm from the toxic drug supply. The policy provides a structured framework to support health authorities, clinics, and clinicians across B.C. in planning and delivering PA-related services that are consistent and safe for individuals accessing the services and the public.

To support the overarching purpose of diversion prevention and safe service provision, this policy aims to:

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[4] Conway, B., Yi, S., Wiesmann, C., & Truong, D. (2025). Evidence of Diversion of Hydromorphone Prescribed as Safe Supply: A Pilot Study. *Canadian Journal of Addiction*, *16*(2), 11-19. https://doi.org/10.1097/CXA.0000000000000239

[5] Office of the Provincial Health Officer. (2023). *A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action*. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/a-review-of-prescribed-safer-supply-programs-across-bc.pdf

[6] Canadian Institutes of Health Research. (2025). Operating Grant: Evaluation of Harm Reduction Approaches to Address the Opioid Crisis in the Context of COVID-19 – Safer Supply. https://cihr-irsc.gc.ca/e/documents/rsu_safer-supply-eog-march-2025-en.pdf

[7] Giang, K., Charlesworth, R., Thulien, M., Mulholland, A., Barker, B., Brar, R., Pauly, B., Fast, D. (2023). Risk mitigation guidance and safer supply prescribing among young people who use drugs in the context of COVID-19 and overdose emergencies.

[8] Nguyen et al. 2024. British Columbia's Safer Opioid Supply Policy and Opioid Outcomes. JAMA Internal Medicine.

[9] Nguyen et al. 2025. Safer Opioid Supply, Subsequent Drug Decriminalization, and Opioid Overdoses. *JAMA* Health Forum.

1. Enable the provision of PA medications to separate people at risk of toxic drug-related harms from the toxic drug supply so that they can:
    - reduce unregulated substance use and harms;
    - foster and enhance engagement with other health services and substance use care, including prescriptions such as opioid agonist treatment (OAT); and
    - connect to social supports.
2. Enable clinicians to provide evidence-informed care that meets the needs of clients at risk of toxic drug-related harms while minimizing the risk of diversion.
3. Apply clear, consistent protocols to help prevent the risk of diversion and potential unintended consequences of PA for individuals and communities.
4. Ensure PA services are delivered in a culturally safe manner that acknowledges and respects the unique needs, histories, and strengths of Indigenous peoples, while working to reduce barriers within the limits of a witnessed model of PA.
5. Deliver services in a manner that acknowledges and respects the dignity, human rights, and lived experiences of people who use drugs, within a witnessed model of PA.
6. Provide access to PA clinics and services as equitably as possible, while being mindful of the varying needs, experiences, and barriers to accessing PA within a witnessed model among people who use drugs.

Scope

This policy applies to any opioid, stimulant, or benzodiazepine medication prescribed as a prescribed alternative (PA) to the unregulated drug supply.

- This policy does not cover medications prescribed for indications other than PA, including oral or injectable opioid agonist treatment (OAT, iOAT), pain management, palliative care, or medical conditions and psychiatric disorders such as attention-deficit hyperactivity disorder (ADHD), sleeping disorders, anxiety disorders, insomnia, or seizures.
- While PA medications are sometimes used to support OAT titration or maintenance, they are still considered PA even if co-prescribed with OAT and therefore fall under this policy. The OAT component of this co-prescription does not fall under this policy.

Intended Audience

The intended audience for this policy includes health authorities, physicians, pharmacists, nurse practitioners, registered nurses/registered psychiatric nurses (RN/RPN), allied health professionals, medical, nursing and pharmacy students, and people accessing the unregulated drug market and at high risk of toxic drug poisoning.

Policy Direction

1. Medications

Prescribers may prescribe a range of medication options to eligible clients with the goal of separating them from the unregulated drug supply. PA medications include the following classes:

a. Opioids
b. Stimulants
c. Benzodiazepines

- Emerging evidence[10] for PA demonstrates that hydromorphone, the most prescribed PA medication, is not effective in meeting many clients' needs as a substitute to the unregulated supply or managing withdrawal symptoms.
- Prescribers should carefully assess the clinical utility of hydromorphone to effectively manage withdrawal and reduce reliance on the toxic drug supply. For some clients, it may remain a useful intervention for limited use in specific cases (e.g., supporting OAT initiation and retention). Prescribers should exercise clinical judgment to offer substance use treatment and available PA medication options that best meet the needs of their clients.

2. Eligibility

Prescribers may use their clinical discretion to prescribe a range of PA medications to eligible clients, who include:

a. People who meet the eligibility criteria for opioid use disorder (OUD), stimulant use disorder and/or benzodiazepine use disorder; or,
b. People who have ongoing active stimulant use and are at high risk of harms

See **Appendix A** for a list of regional and provincial clinical guidance, including assessment criteria for PA medications and substance use.

3. Witnessing

PA medication consumption must be witnessed in person by a health professional, barring exceptional circumstances as outlined below.

The witnessed model of PA includes the following categories of exceptional circumstances under which prescribers may consider exemptions to witnessed dosing for PA medications

[10] Office of the Provincial Health Officer (2023). A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action

to manage the risk of destabilization for identified priority populations, while protecting communities from the risk of diversion.

a. clients who have achieved clinical stability (e.g., appropriate medication adherence, improved wellbeing, appropriate urine drug tests, psychosocial stability, absence of severe behavioural issues at clinic; refer to relevant clinical guidance listed in **Appendix A** for more information), **only to accommodate:**
    i. rural, remote[11] and Indigenous communities where routine access to a pharmacy is a barrier to patient care (*e.g.*, in areas without 7 day/week pharmacy access, provide unwitnessed doses for days of pharmacy closure); or
    ii. employment or educational obligations (*e.g.*, provide unwitnessed doses during work hours).
b. clients titrating onto OAT (only after-hours doses may be unwitnessed and only during OAT titration as per BCCSU clinical guidance regarding initiation protocols and timelines).

- Ongoing patient assessments, including regular urine drug tests, are required to confirm medication adherence for any doses that are not witnessed by a health professional.
- Prescribers should deprescribe following BCCSU clinical guidance if there is evidence of diversion (which could include, but is not limited to, urine drug tests negative for the prescribed substance; repeated inability to provide urine samples; client report; reports from other parties [e.g., pharmacists or police]; or repeated reports of lost, spilled, stolen, or vomited doses. Clinical discretion and discussion with the client should inform clinical decision-making).
- Fentanyl patch exchange regimens, when a patient exchanges their used fentanyl patches for new fentanyl patches from a health professional (e.g., physician, nurse, pharmacist), constitutes witnessed dosing.

4. Authorized Prescribers

PA medications may be prescribed by:

a. Physicians and nurse practitioners practicing within specialized PA programs that are directly operated or funded by and subject to the oversight of health authorities, and in line with provincial clinical guidance from the BCCSU;

[11] Rural and remote communities are defined as Community Health Service Areas (CHSAs) with a Rural Urban Classification of 6 (Rural, at least 50% of the population resides outside of a population centre and the weighted remoteness index is less than 0.5) or 7 (Remote, at least 50% of the population resides outside of a population centre and the remoteness index is 0.5 or higher).

b. Physicians and nurse practitioners practicing independently of health authorities, and in line with provincial clinical guidance from the BCCSU.

5. Intervention Codes

PharmaNet intervention codes (SA & VS) are used for monitoring and evaluation purposes and help to improve data quality and collection for the PA program.

PA prescribers must:

a. Add the 'Safer Alternative (SA)' code to PA prescriptions in the "Directions for Use" field of the B.C. Controlled Prescription Form to clearly indicate that the medication is being prescribed as an alternative to the unregulated drug supply, to distinguish the indication from other prescriptions (e.g., chronic pain prescriptions, ADHD treatment prescriptions), and for monitoring and evaluation purposes.
b. Outline instructions for witnessing in the "Directions for Use" section of the prescription form, including the specific dates, times and days of the week for each witnessed dose or non-witnessed dose, and indicate the corresponding exceptional circumstance category that enables any unwitnessed doses.
c. Clearly document in the patient's medical record any rationale for exemptions as they align with the policy.

Pharmacists dispensing PA must follow the instructions provided on PharmaCare's Prescribed Alternatives webpage.

6. Evaluation & Monitoring

PA prescribers and programs must become a part of any provincial evaluation.

- All PA prescribing will be captured in the health administrative data from PharmaNet, which will be used to support provincial evaluation and monitoring efforts.
- Programs, prescribers and clients will be invited to engage in additional types of evaluation as appropriate.

7. Additional Supports

PA are expected to be prescribed alongside appropriate health and social services aligned with client goals.

8. Health Authority Programs

Health authorities are expected to develop and/or refine protocols, clinical workflows, and other resources as needed to support prescribing and witnessing and meet clinical practice needs.

9. Care Approach

PA services are expected to be free from stigma and discrimination.

10. Culturally Safe Care

PA services and supports are expected to follow principles of cultural safety and humility in accordance with the BC Cultural Safety and Humility Standard and the Prescriber's College's practice standards on Indigenous Cultural Safety, Cultural Humility, and Anti-Racism (BC College of Nurses and Midwives, BC College of Physicians and Surgeons)

Implementation Timeline

All PA programs, services, and service providers are expected to begin implementation activities to transition existing PA clients to the witnessed model of PA, in alignment with policy directives, immediately upon policy release. All PA clients must be fully transitioned to the witnessed model of PA (including fully witnessed dosing or partially witnessed dosing for people that qualify for exemptions), in accordance with this policy by **December 30, 2025**.

Performance Metrics

1. Monthly number of clients dispensed PA medications.
2. Monthly number of new clients dispensed PA medications.
3. Monthly number of PA doses dispensed.
4. Monthly proportion of PA doses that are coded as witnessed.
5. Monthly number of prescribers of PA.

Compliance and Oversight

Roles and Responsibilities

- **Ministry of Health:** Responsible for providing policy direction, strategic leadership, and oversight of policy implementation. Responsible for facilitating implementation activities, including engagements as appropriate, via established governance structures for PA.
- **Regional Health Authorities:** Accountable for ensuring that PA programs and services operated or funded by their health authority comply with this policy. Senior health authority executives are accountable for their health authority's compliance with this policy.

- **Service Providers:** Responsible for integrating this policy into day-to-day PA practices and delivering services in accordance with the policy.
- **Regulatory Colleges:** Responsible for ensuring registrants provide safe care to their patients.

Policy Monitoring & Evaluation

- The Ministry of Health will track progress against identified performance metrics, assess fidelity to the policy, and identify areas of success as well as areas for improvement.

Compliance Mechanisms

- Adherence to the policy will be monitored. In the case of significant or repeated non-adherence, compliance measures will be implemented by the Province.

Review

This policy is subject to periodic reviews and updates as required.

Appendix A: Clinical Resources

The following list of clinical resources and consensus guiding documents are available for clinicians supporting people who use drugs. This section will be updated as new resources are developed:

- B.C. Centre on Substance Use Resources:
  - The BCSSU has published the *Bulletin: Updated Prescribed Alternatives Policy—Implications for Clinical Practice* as a companion document to the PA Policy to answer clinical questions not directly answered by the policy itself. The Bulletin provides practical information for transitioning PA clients to witnessed dosing and replaces the Interim Clinical Resource previously published on April 29, 2025.
  - The BCCSU has developed and released three medication protocols to support the implementation of emerging approaches for prescribed alternatives in B.C. These protocols include the Fentanyl Patch Protocol, Fentanyl Tablet Protocol, and the Sufentanil Protocol. They are targeted towards health authorities seeking to implement PA programs in their regions, as well as clinicians seeking to prescribe PA.
  - The BCCSU provides a variety of up-to-date and evidence-based and evidence-informed guidance documents, clinical guidelines, practice updates, practice support tools and bulletins. Refer to https://www.bccsu.ca/opioid-use-disorder/ for documents that may be relevant for the provision of OUD care and to https://www.bccsu.ca/clinical-care-

guidance/prescribed-alternatives/ for the provision of medications to reduce harms associated with unregulated opioid use.

  - The BCCSU has published the Stimulant Disorder Practice Update to provide an overview of evidence-based treatment options and introduce new evidence and approaches relevant for those providing care for individuals who use illicit stimulants.
  - The BCCSU 24/7 Addiction Medicine Clinician Support Line is available to provide case-based support to physicians, nurse practitioners, nurses, and pharmacists who are engaged in prescribed alternatives. Refer to https://www.bccsu.ca/24-7/ (778-945-7619).

- The Rapid Access to Consultative Expertise (RACE) Line is an innovative model of shared care that connects B.C.-based physicians, nurse practitioners, and midwives with their specialist colleagues to help streamline the patient journey with timely advice provided within two hours. Refer to RACEConnect (RACE@providencehealth.bc.ca).
- Harm reduction resources can be found on the B.C. Centre for Disease Control website: http://www.bccdc.ca/health-professionals/clinical-resources/harm-reduction.