Perspectives on Safer Supply:
Insights from people who use substances in British Columbia

Presentation developed by

Jane Buxton MBBS, MHSc, FRCPC[1,2] Principal Investigator

Jessica Xavier MPH[1] research coordinator, Patterns & Preferences project

[1]BC Centre for Disease Control (BCCDC), Vancouver, BC, Canada

[2]School of Population and Public Health, University of BC, Vancouver, BC

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ACKNOWLEDGEMENTS

- We respectfully acknowledge that this work was conducted across the unceded, ancestral and traditional territories of more than 200 First Nations across what we call British Columbia; and that BCCDC is situated on the territories of the xʷməθkʷəy̓əm (Musqueam), skwxwú7mesh (Squamish), and sel̓íl̓witulh (Tsleil-waututh) nations
- We are grateful to the peer research assistants many of whom are members of PEEP (Professionals for Ethical Engagement of Peers) who assisted in developing the survey and question guide, facilitated interviews & focus groups, and assisted in interpretation of findings. Thanks also to the participants for sharing their knowledge and insights

BC Centre for Disease Control

PEEP Professionals for Ethical Engagement of Peers

Photo JB: April 14, 2022
6.5yrs after declaration of the overdose Public Health Emergency
>10,000 toxic drug deaths have occurred in BC

CONFLICT OF INTEREST & FUNDING

- We have no conflict of interest to declare; the opinions expressed are those of the presentation authors. Some data is unpublished/in review
- Funding for data collection and analysis:

Quantitative data was obtained from 2019 & 2021 **BC Harm Reduction Client Survey,** funded by Health Canada *Substance Use and Addiction Program.* Administered to people aged 19 and over attending harm reduction sites across BC

Qualitative data was obtained through interviews and focus groups led by peer research assistants under the ***Understanding substance use patterns, preferences and needs: Informing safer supply and safer use services*** (Patterns and Preferences) study funded by BC Ministry of Health *Community Crisis Innovation Fund.*

- The funders had no input into the data collection, analysis or interpretation in this presentation

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Health Canada Santé Canada

British Columbia Ministry of Health

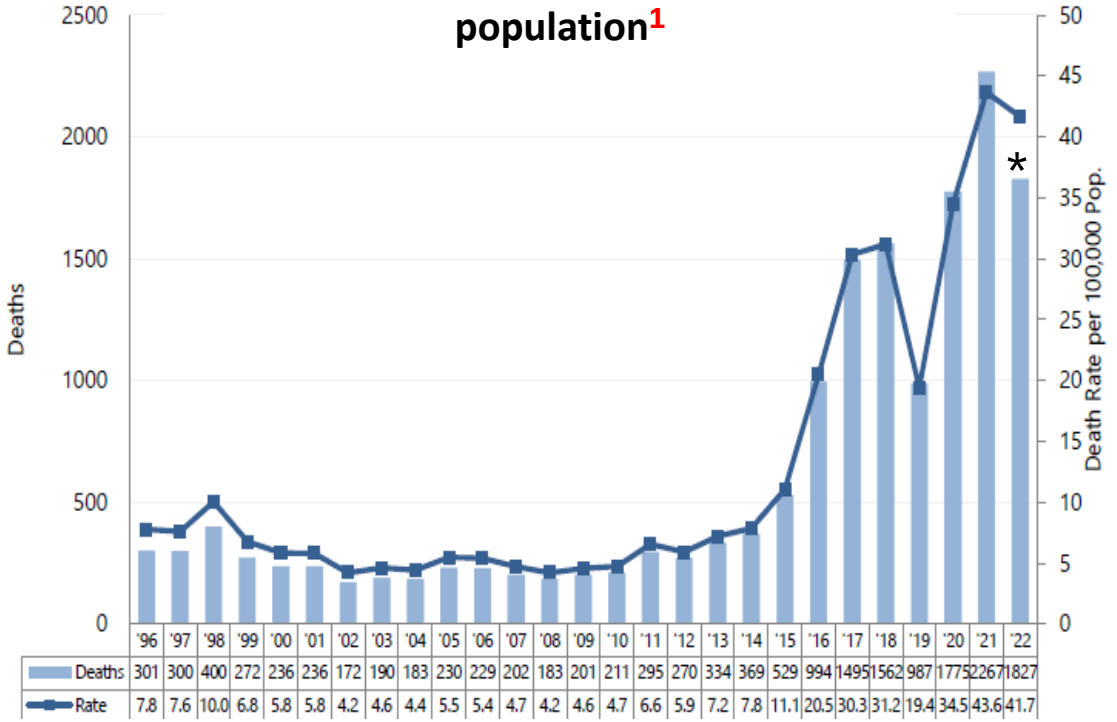
OVERVIEW

- **Background**
  - BC drug toxicity deaths
  - Study rationale and aims
- **Methods**
- **Findings reported:**
  - trends in opioid & stimulant use
  - current mode of opioid use
  - reason prefer to smoke opioids
  - preferences of safe supply options (opioids and stimulants) and mode of use,
  - experiences with risk mitigation guidance/pandemic prescribing
  - trends and concerns re benzodiazepines in opioid supply
  - access to prescribed safer supply prescription (risk mitigation guidance (pandemic) prescribing)
- **Policy and practice implications:**

BACKGROUND – BC OVERDOSE DEATHS

1. 2021 annual illicit drug toxicity deaths in BC were highest ever reported (n = 2267)[1] (2000-2010 < 250 deaths/year)

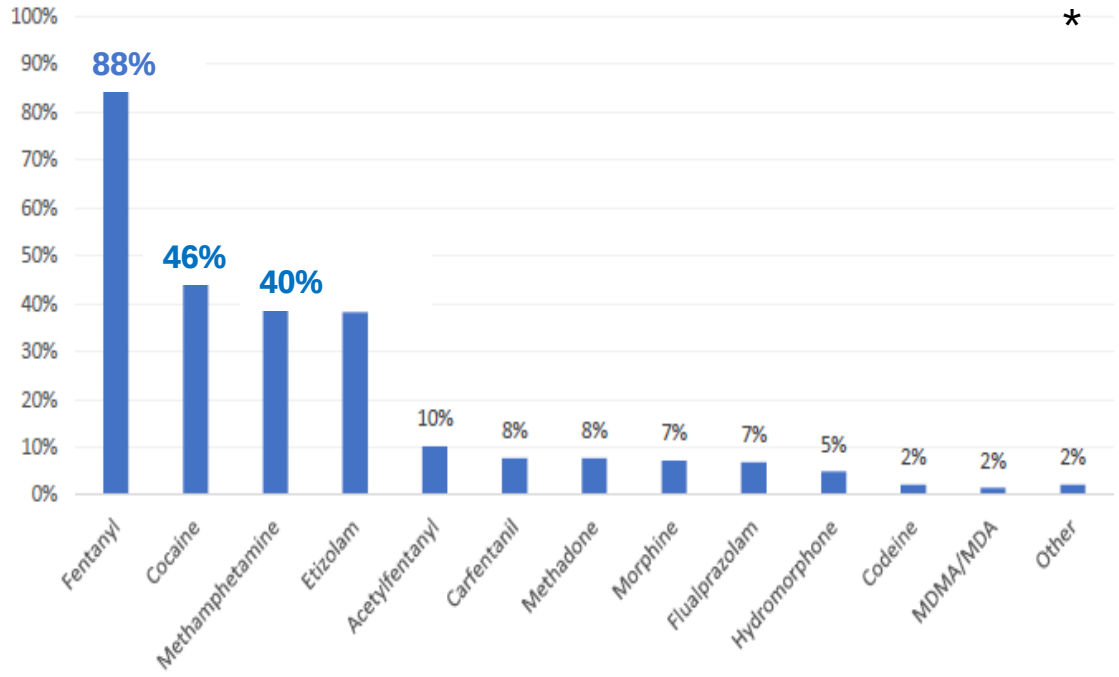
Illicit drug toxicity deaths & rate/100,000 population[1]



*2022 data are to Oct 31st

2. Polysubstance use is common in BC decedents

Substances detected in expedited toxicology among illicit drug toxicity deaths (Jul 2020-Aug 2022)[2]



STUDY RATIONALE

- The unregulated (illegal) drug market in BC is becoming increasingly toxic. Despite increasing availability of interventions e.g. opioid agonist therapy, supervised consumption and overdose prevention sites and take home naloxone, overdose events and deaths continue to rise.
  - Fentanyl is the main opioid available in the unregulated (illegal) market and cause of deaths
  - Methamphetamine use has increased
  - Polysubstance use is frequent
  - Benzodiazepines are frequently detected in illegal opioids

- Prescribed safer supply prescribing (pandemic prescribing (risk mitigation guidance)prescribing) in BC at the time of the study included:[3]
  - oral opioids - but not fentanyl or diacetylmorphine (heroin)
  - only oral stimulants dextroamphetamine (Dexedrine) and methylphenidate (Ritalin)

STUDY AIMS

The overarching aim of this project was to understand the needs and preferences of people who use illegal opioids and/or stimulants who can benefit from access to safer supply and safer use services. Specifically, we were interested in understanding:

If people who use opioids and/or stimulants were prescribed a continuous supply of pharmaceutical grade alternatives, which one(s) would they choose? Why?

What are people's experiences with concurrent substance use? What substances do they use concurrently and why?

How would people choose to use their preferred pharmaceutical alternative? Why?

As roughly half of illegal opioids currently contain benzodiazepine-like substances, are there concerns about benzodiazepine withdrawal upon a potential transition to safe(r) supply and opioid agonist treatment?

METHODS:

MULTI-METHODS: USING QUANTITATIVE & QUALITATIVE APPROACHES

Our methodology is informed by previous British Columbia surveys and research findings

People who use substances provided input at all stages of this research including methods, data collection and interpretation

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MULTI-METHODS: QUANTITATIVE

Cross-sectional surveys of people who use drugs attending harm reduction sites across BC[4]

2019	**22** sites	**621** participants	
2021	**17** sites	**537** participants	of these **365** gave preferred opioid safe supply option, **330** gave preferred stimulant safe supply option

Analysis: Descriptive & multivariate logistic regression to understand preferences and associations

SUMMARY OF QUANTITATIVE FINDINGS

(FROM 2019 & 2021 HARM REDUCTION CLIENT SURVEYS)

- **Opioids:**
  - (2019) Preferred opioid: 58% prefer diacetylmorphine (heroin); 33% fentanyl (2019)
  - (2019) Mode of use: 68% smoke opioids. Smoking more likely if younger and also use methamphetamine
  - (2021) Reasons given for smoking opioids often associated with safety
  - (2021) If had safe opioid supply, 62% would prefer to smoke it (73% currently smoke opioids)
- **Stimulants:**
  - (2021) Preferred stimulant safe supply: 59% methamphetamine; 26% cocaine; <11% currently available/prescribed oral stimulants (Dexedrine and Ritalin)
  - (2021) Preference for methamphetamine (vs. other stimulants): if younger; men; frequent drug use
- **Access to prescribed safer supply prescribing** (risk mitigation guidance (pandemic) prescribing)
  - (2021) 16.5% received a prescribed safer supply;
    - of these: 68% received an opioid; 33% a stimulants and 10% a benzodiazepine

MULTI METHODS: QUALITATIVE

One-on-one interviews and focus groups with people who use drugs across BC in 2021/22
Interviews & focus groups were led by peer research assistants, audio recorded and transcribed


47 interviews


six focus groups with 40 participants

Total participants n=87

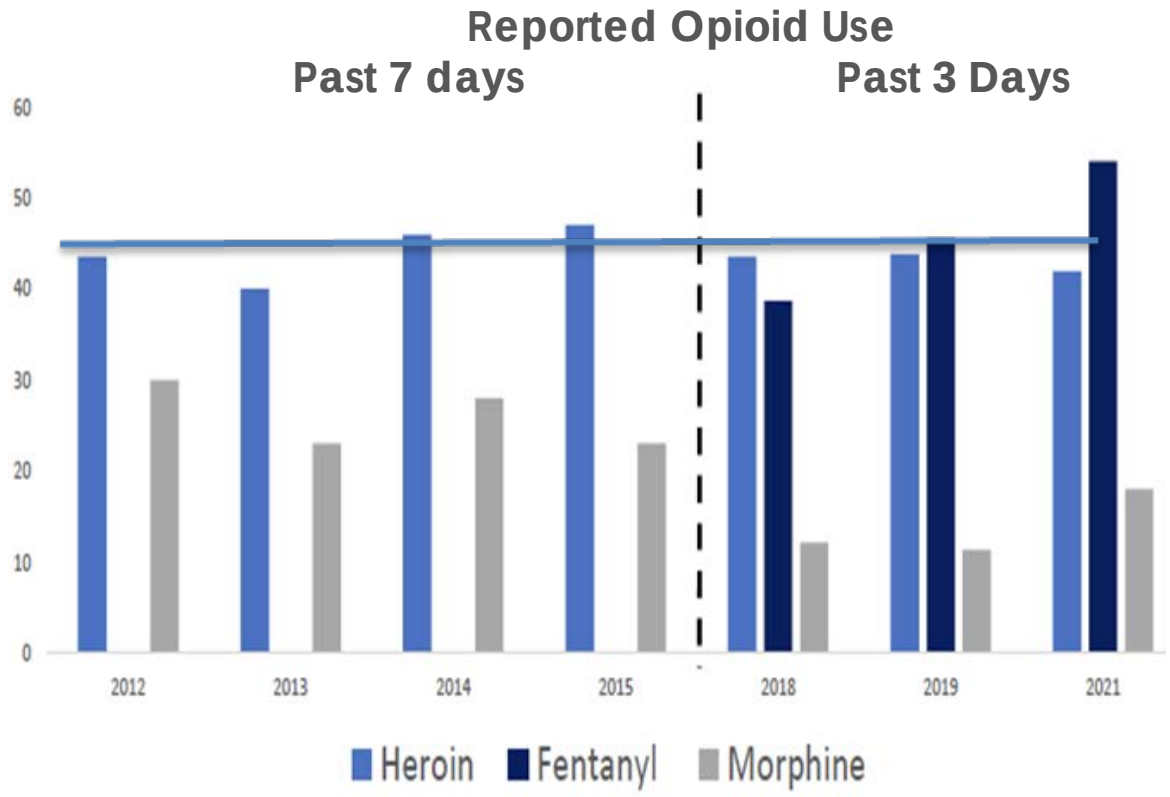
Of these:

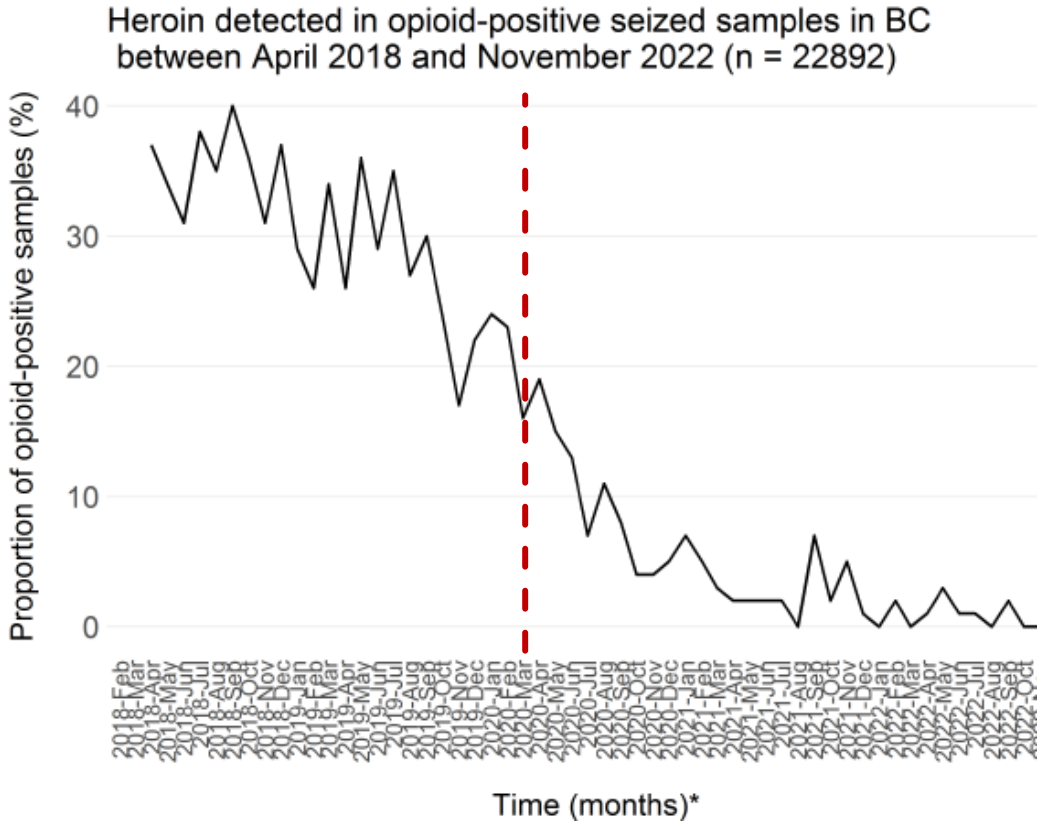
61 reported any **opioid use in past month;**
73 reported any **stimulant use in past month;**

Analysis: Thematic analysis was used to identify patterns and outliers.

OPIOID TRENDS

BC HARM REDUCTION CLIENT SURVEY & DRUG ANALYSIS SERVICE





In 2021 survey: 54% of participants reported using fentanyl; 42% report using heroin[4]

However, **heroin** in opioid-positive enforcement samples tested by Health Canada lab **less than 5%**

PREFERRED OPIOID (2019 SURVEY)

FERGUSON ET AL 2022[5]

Research objective: To identify opioid preferences across BC and associated variables

Overall reported preference:

57.8% heroin (diacetylmorphine)

32.8% fentanyl

9.4% prescription opioids e.g. morphine, oxycodone, hydromorphone, methadone, Suboxone

Older ages more likely to prefer heroin; preference also differed by geography

Age Group	Heroin (n=234)	Fentanyl (n = 133)	Total (n = 367)
≤29	46 (54.8%)	38 (42.5%)	84 (23.5%)
30-39	75 (58.1%)	54 (41.9%)	129 (36.1%)
40-49	54 (66.7%)	27 (33.3%)	81 (22.7%)
≥50	52 (82.5%)	11 (17.5%)	63 (17.6%)

OPIOID SAFER SUPPLY PREFERENCE
QUALITATIVE FINDINGS:

Many participants expressed a preference for a pharmaceutical supply of heroin and/or fentanyl as they met an individual's needs and objectives

> *"They [heroin, fentanyl] have the strongest analgesic effect and the strongest euphoric effect. I find that when I was prescribed Kadian morphine it was helpful in terms of mitigating withdrawal symptoms. But it's more of a safety or stabilizing sort of function..."* (Oscar, Vancouver)

Participants shared that existing safer supply options were limited, and did not reduce their reliance on the street supply

> *"Somebody using fentanyl, trying to replace that with dilaudid or hydromorph - they're using their whole supply in one shot in the morning and they're screwed by noon."* (Thomas, Quesnel)

> *"I'm on four M-Eslon 100's and 14 dilaudids....– I use probably - if I'm being honest, three, four points a day of heroin too– or fentanyl on top of that ...I don't get high from it. I just feel normal."* (FG4 Participant)

QUALITATIVE FINDINGS:
PREFERENCE FOR OPIOID SAFER SUPPLY

Many participants were interested in **heroin safe supply.**

Reasons given: a longer lasting high & fewer undesirable side effects compared to other opioids; behavioral and physiological effects (e.g. higher functioning, less sleepy), unique euphoric properties.

> *"I don't like dope with fentanyl…I don't want to get high to go to sleep."* (FG1 Participant)

> *"Heroin, you can do a little bit of heroin and get lots of energy…yeah, you can work a job…if you're just going to do fentanyl than you're going to have to be willing to…do what you have to do to get money every 10 minutes."* (FG3 Participant)

Some participants were interested in **fentanyl safe supply**

Reasons given: fentanyl perceived as providing better pain management compared to heroin; concerns that heroin was not strong enough given peoples' increased tolerance from ftheir entanyl use, familiarity with fentanyl - some don't remember using or have never used heroin.

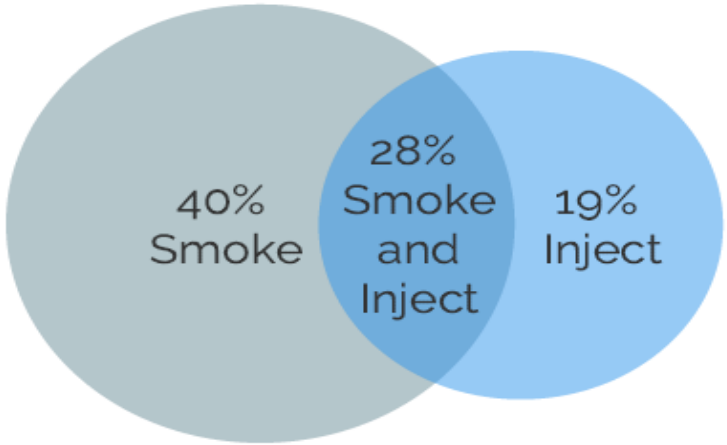
> *"Heroin's not the biggest pain medication where fentanyl is. You can use more heroin where fentanyl if you get a good decent supply of fentanyl you're [snaps fingers] up out of bed just like that.And whistling and doing dishes…"* (FG5 Participant)

MODE OF OPIOIDS USE HRCS 2019

MOST PEOPLE SMOKE OPIOIDS - *PARENT ET AL*[6]

Mode of opioid use:

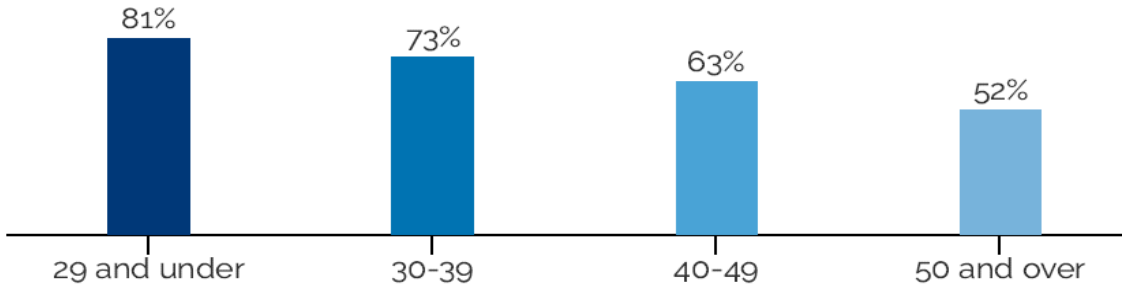
68% smoked opioids; 32% did not smoke



13% other mode

Younger more likely to smoke

81% aged <30; 52% aged 50+



% reported smoking opioids by age

More likely smoke if also use methamphetamine (MA) in past 3 days

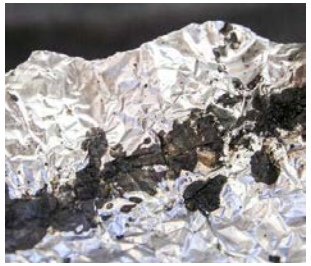
88% of those who smoked opioids used MA in past 3 days

56% of those who did not smoke opioids used MA in past 3 days

REASONS GIVEN FOR PREFERRING TO SMOKE OPIOIDS/DOWN COMPARED TO OTHER METHODS HRCS 2021 *KAMAL ET AL*[7]

Participants asked to select all that apply or specify other[1], thus could select >1 response
161 participants provided 349 responses.

Reasons:		N	(%)[2]
Safety reasons **47.6%** of all reasons	Less likely to overdose	49	(14.0%)
	Less likely to get blood borne disease e.g. HIV/HCV	44	(12.6%)
	Less likely to get other infections e.g. abscess	39	(11.2%)
	Better able to control dosage	34	(9.7%)
Effect and practice of smoking **26.6%** of all reasons	Prefer the effects from smoking	45	(12.9%)
	Smoking is more social	25	(7.2%)
	Able to smoke with stimulants e.g. crystal meth	20	(5.7%)
	Prefer the practice of smoking	3	(0.9%)
Do not Inject **25.8%** of all reasons	I don't like injecting	40	(11.5%)
	Never injected	27	(7.7%)
	Can no longer inject/cannot find vein	23	(6.6%)



[1] Other reasons given were allocated to categories
[2] % is percent of 349 responses **Almost half of reasons given for smoking opioids were for safety reasons**

PREFERRED MODE OF USE OPIOID SAFE SUPPLY [7] HRCS 2021

Reported smoking opioids in last 3/7 = **73%**

Preferred mode of opioid safer supply consumption	N (%)
Smoking	**176 (62%)**
Injecting	56 (20%)
Swallowing	33 (12%)
Snorting	9 (3%)
Other	8 (3%)

To reduce peoples' reliance on the toxic, unregulated supply, **safe supply options need to be expanded to include inhalable forms**

Low-barrier and accessible models

"I could quite happily get heroin and get carries and you wouldn't see me. I'd pick up my carries. I'd be out working, doing whatever I wanted to do to get out of here…Like right now I take morphine, dillies and-- and diacetylmorphine and fentanyl simply because I don't want to go to the fucking clinic three times a day anymore. (FG3 Participant)

STIMULANT TRENDS AND POLYSUBSTANCE USE

BC HARM REDUCTION CLIENT SURVEY

3. Changes in specific stimulant use[4, 8]

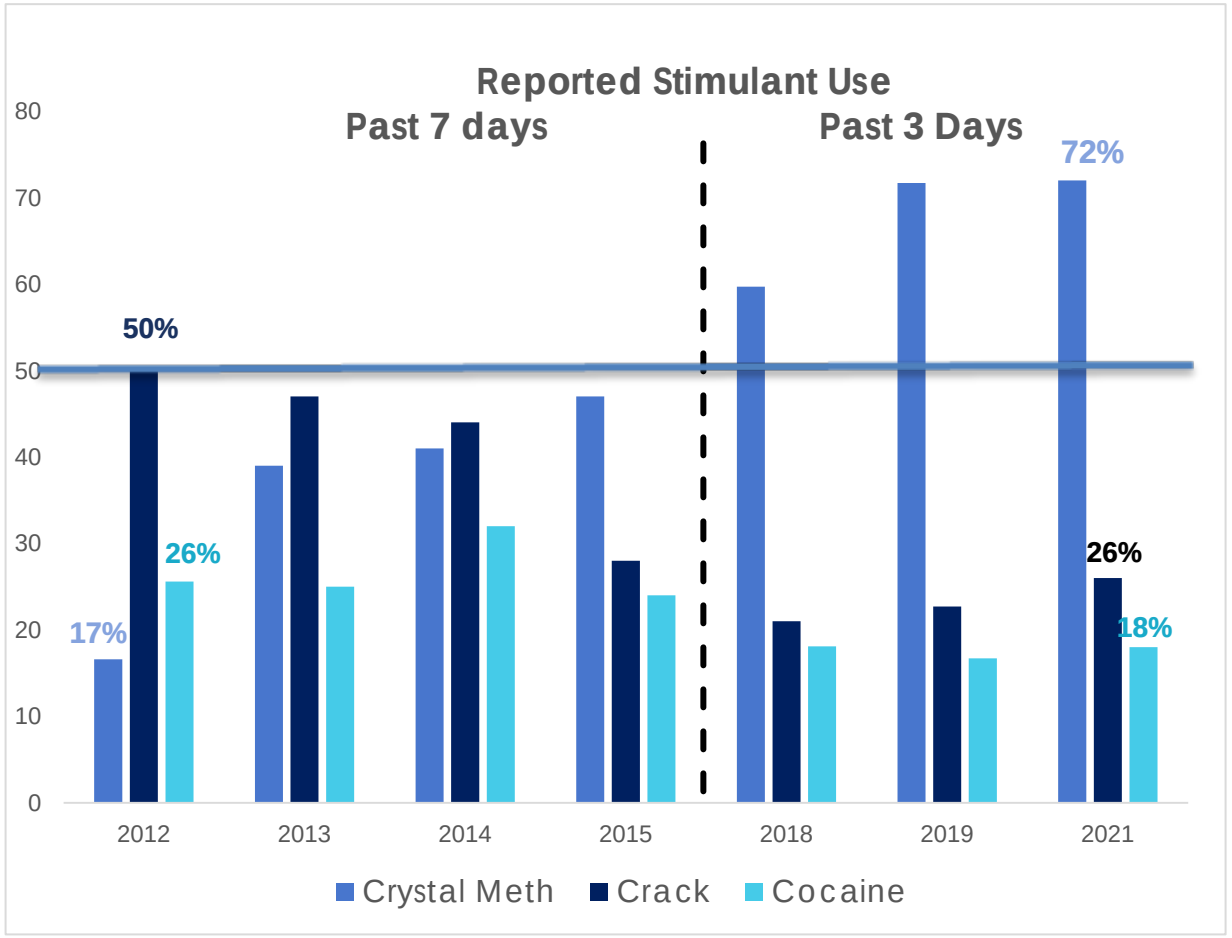
- **MA use increased** (from 17% in 2012 to 72% in 2019 & 2021)
- **Crack and powdered cocaine decreased**

4. Motivation for using uppers with downers[9]

- **Self-medication**
  - ➢ e.g. ADHD, physical dependence, avoid OD
- **Availability and preference**
- **Drug effects and properties**
  - ➢ desire for specific high, to balance & level out
- **Funds and life situation**
  - ➢ cost, environmental factors

5. People who are opioid naïve (use stimulants only)

are at high OD risk if stimulants contaminated by opioids in production or distribution e.g. baggies, scales; or in use e.g. contaminated pipes



FINDINGS: QUANTITATIVE – 2021 HR CLIENT SURVEY
PREFERRED STIMULANT

Among the 330 participants who reported one preferred stimulant safe supply option:

- **58.5%** chose **methamphetamine** (n = 193)
- **25.5%** chose **cocaine** (n=84)
  - **Crack cocaine 13%** (n=43); **powder cocaine 12.4%** (n=41)
- **Prescribed stimulants 10.9%** (*RMG/Pandemic prescribing)*
  - 6.4% dextroamphetamine (Dexedrine) (n=21) ; 4.5% methylphenidate (Ritalin) (n=15)
- **MDMA** (Ecstasy) 4% (n=12); Other 1.5% (n=5)

Higher odds preferring methamphetamine compared to other stimulants

Younger age <30y (AOR: **3.38**, 95% CI [1.46-7.80] vs. those ≥50y; p=0.01

Gender: **Cis men** (AOR: **1.80**, 95% CI[1.75-2.97] vs. cis women; p=0.04

Frequency of drug use: Compared to those who use a few times/month,
- those who use drugs **every day** (AOR: **15.43**, 95% CI[3.38-70.51], p: <0.01)
- those who use **a few times a week** (AOR: **8.90**, 95% CI[1.78-44.44], p: 0.01)

REASONS FOR USING/PREFERRING ILLEGAL **STIMULANTS**: **SELF-MEDICATION**

Many report self-medicating to improve daily functioning, provide energy & productivity, and to manage physical, cognitive & mental health-related disabilities i.e. pain, ADHD, mental health issues

> *'I know because of my illness, I lack energy a lot of times. So when I used to smoke the crystal meth or the crack I would have the energy to do the things I couldn't do normally'* (FG2 Participant, Quesnel)

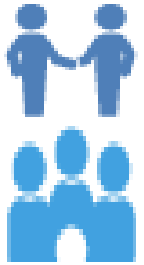
Many who self-medicate report prescribed stimulants (e.g. Dexedrine/Ritalin) are not comparable to stimulants from the illegal supply and don't provide the effects some seek

> *'I found it [Dexedrine] kept me awake a lot longer and it's really different than the meth. I would prefer the meth …I definitely don't like the way Dexedrine helps me 'cause it's not even close to the same'* (FG4 Participant, Cranbrook)

Currently, stimulants are used to address some of the effects of fentanyl

i.e. extend period of well-being, cost saving, balance/level out, and some perceive concurrent use of stimulants with opioids will reduce the risk of opioid OD.

REASONS FOR USING/PREFERRING ILLEGAL **STIMULANTS: AVAILABILITY AND COST**



Some who preferred Dexedrine/Ritalin continued to use illegal stimulants as access to prescribed stimulants was restricted by prescribers e.g. denied due to mental health

> *'I was on Dexedrine and Ritalin my whole life, … They won't put me on back again, but I need it… apparently I'm going schizophrenic because I smoke too much meth. …. He [prescriber] said no to multiple clients…* (FG2 Participant, Quesnel)

Different stimulants have different effects; people experience the same stimulant in different ways; thus stimulants were sought based on the effects a person required

> *'When it comes to cocaine I want cocaine right now. …. I don't want no-- prescribed alternative.'* (FG 1 Participant, Vancouver)

Current stimulant use may reflect availability and cost, not necessarily preference e.g. cocaine was preferred over meth if the quality was *'what it used to be*' and *'affordable*'

REASONS FOR USING/PREFERRING ILLEGAL **STIMULANTS: MODE OF USE**

Current prescribed stimulant alternatives are only offered in oral form.[3] Thus people may inject oral forms or continue to use from the illegal supply. Some participants smoked as perceived smoking as more social, associated with less stigma, and easier to set and clean up.

> *'Like I still smoke even though I don't get high, as a social thing, you know. Everybody else is smoking so--'* (FG6 Participant, Nanaimo)

> *'Smoking is just a quicker, easier method'* (Samuel, Victoria)

Others transitioned to smoking as developed issues with other modes of use (e.g., poor vein health for people who inject their substances or damaged nasal septum for people who snort their substances).

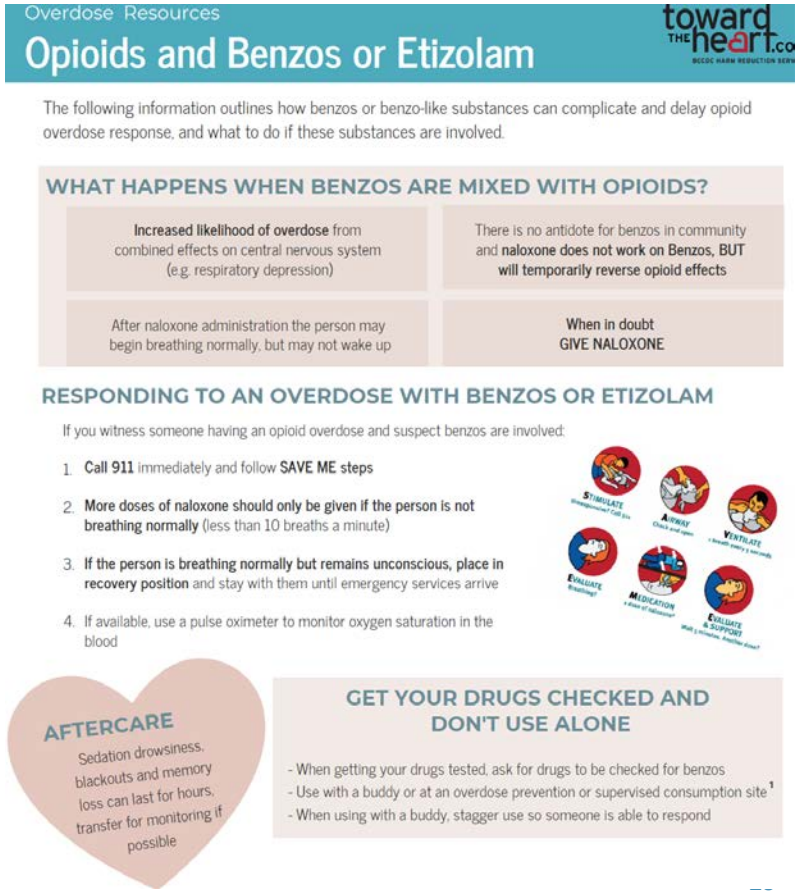
> *'I ended up having to start smoking because I just fucked up my nose so much that I literally couldn't snort anymore'* (FG6 Participant, Nanaimo)

TRENDS OF BENZODIAZEPINE-LIKE SUBSTANCES IN ILLICIT OPIOIDS

- People who use opioids and OPS staff reported concerns re prolonged sedation - benzo-like substances identified 2020
- Information sheets developed about benzo withdrawal, responding to an overdose with benzos/etizolam etc. posted on towardtheheart.com Jan 2021

Data sources:

- People who use opioids commonly report benzo use, often unintentional (HRCS and interviews)
- Biologic samples from Coroners and LifeLabs
- Drug testing – enforcement samples and community drug checking programs
    - NB: **Benzo test strips have limited sensitivity** as benzos/etizolam are not water soluble. Vigorous shaking may help but maybe negative result despite being present


Overdose Resources

Opioids and Benzos or Etizolam

toward the heart.co

The following information outlines how benzos or benzo-like substances can complicate and delay opioid overdose response, and what to do if these substances are involved.

WHAT HAPPENS WHEN BENZOS ARE MIXED WITH OPIOIDS?

Increased likelihood of overdose from combined effects on central nervous system (e.g. respiratory depression)

There is no antidote for benzos in community and **naloxone does not work on Benzos, BUT will temporarily reverse opioid effects**

After naloxone administration the person may begin breathing normally, but may not wake up

When in doubt GIVE NALOXONE

RESPONDING TO AN OVERDOSE WITH BENZOS OR ETIZOLAM

If you witness someone having an opioid overdose and suspect benzos are involved:

1. **Call 911** immediately and follow **SAVE ME steps**
2. **More doses of naloxone should only be given if the person is not breathing normally** (less than 10 breaths a minute)
3. **If the person is breathing normally but remains unconscious, place in recovery position** and stay with them until emergency services arrive
4. If available, use a pulse oximeter to monitor oxygen saturation in the blood

AFTERCARE

Sedation drowsiness, blackouts and memory loss can last for hours. transfer for monitoring if possible

GET YOUR DRUGS CHECKED AND DON'T USE ALONE

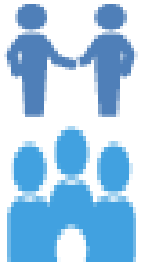
- When getting your drugs tested, ask for drugs to be checked for benzos
- Use with a buddy or at an overdose prevention or supervised consumption site
- When using with a buddy, stagger use so someone is able to respond

https://towardtheheart.com/resource/how-to-respond-to-a-opioid-overdose-with-benzos/open

BENZODIAZEPINE-LIKE SUBSTANCES (INCLUDING ETIZOLAM) REPORTED USED AND DETECTED IN OPIOIDS

Data source	Date	Benzo-like substances reported used or detected
Harm reduction client survey[4]	2019 & 2021	Reported use benzodiazepine (other than Xanax) in past 3 days 9.5% & 20.7%
Interview & focus group participants	2021/2022	36% report any benzo use (intentional or perceived exposure to benzo-like substances in illegal opioid supply) in past month
Coroners data[2]	July 2020 Jan 2021-Jan 2022 Feb 2022 onwards	Detected in 15% of decedents Detected in about 50% of decedents Declined to about 25%
Life Labs data	Jul 2020-Nov 2021	>50% of benzo-like substances in urine screens were etizolam
Enforcement testing Drug Analysis Service	Jan 2021-Sep 2022	20-30% of opioid positive samples were positive for benzodiazepines
Drug checking Vancouver Island Drug Checking Project[10]	Nov 2021 Dec 2021-Oct 2022	Expected opioid/down containing benzo &/or etizolam >75% continued at about 50%

CONCERNS REGARDING BENZODIAZEPINE-LIKE SUBSTANCES CONTAMINATING OPIOIDS



Interview and focus group participants raised concerns about illegal opioids being contaminated with benzodiazepines:

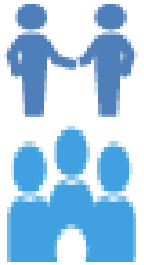
1. Benzodiazepines are ubiquitous in opioid supply

   "So I would say that I also have a benzo addiction. Because — it's really hard to get stuff down on the streets that does not have benzos in it' (Ariel, Kelowna)

2. Severe risks associated with benzodiazepine withdrawal

   ' 'Once someone is dependent there's also the danger of them quitting cold turkey because quitting the benzos cold turkey can cause seizures' (Taylor, Maple Ridge)

CONCERNS REGARDING BENZODIAZEPINE-LIKE SUBSTANCES CONTAMINATING OPIOIDS



Interview and focus group participants raised concerns about illegal opioids being contaminated with benzodiazepines:

3. Increased risk of overdose and sedative effects of benzodiazepines: Loss of memory and consciousness, and being victimized (e.g. theft, physical or sexual violence)

'You have these little glimpses of the memory of what happened. And then you're… on a mat in a holding cell. It's, like, oh, that's not something that I think anybody intends to do when they're picking up any substance, right' (Evan, Kelowna)

'… if you do the benzos you're out and people can do anything with you when you're out on benzos' (Gabrielle, Victoria)

ACCESS TO PRESCRIBED SAFER SUPPLY

(RISK MITIGATION GUIDANCE (PANDEMIC) PRESCRIBING)[11]

- Of HRCS respondents who reported using any illicit opioids, illicit stimulants or benzodiazepines in last 3 days (N=491), overall a small proportion (N=81) **16.5%received a prescribed opioid, stimulant or benzodiazepine through prescribed safer supply (PSS).**
  - Among those who received PSS, 68% (N=55) received an opioid, 33.3% (N=27) received a stimulant, and 10% (N=8) received a benzodiazepine.
- Compared to people who did not receive PSS, PSS recipients were:
  - Significantly more likely to both smoke and inject drugs in the last six months (46.9% vs 24.9%, p=0.001)
  - Significantly more likely to use substances daily (86.5% vs. 73.5%, p=0.043)
  - Younger (17% ≥ 50 years old vs. 35% <50 years old, p=0.003)

ACCESS TO PRESCRIBED SAFER SUPPLY

(RISK MITIGATION GUIDANCE (PANDEMIC) PRESCRIBING)[11]

- In logistic regression models controlling for demographics (age, sex, urbanicity), people already most engaged in services were the most likely to receive PSS.
- People who reported accessing the following services in the prior six months had significantly higher odds of PSS receipt compared to people who did not:
  - Drug checking services (OR:1.67 (95%CI: 1.00-2.79))
  - Overdose prevention sites (OR: 2.08 (95%CI: 1.20-3.60))
  - Opioid agonist treatment (OR: 4.48(95% CI: 2.13-9.40)

POLICY & PRACTICE IMPLICATIONS FOR SAFER SUPPLY

Safe supply aims to provides people who use drugs with substances of known content as an alternative to the toxic illegal drug supply. For people to use safer supply it needs to meet their needs, and be acceptable and accessible

> *"Because I know that for most people ….the existing options, the range of options, doesn't really satisfy most people's needs. Most users I know are still using some form of street drug or another."* (Oscar, Vancouver)

Current safer supply options don't meet the needs of people who use drugs in their effect, the prescribed doses and the preferred mode of use; therefore people continue to use substances from the toxic illegal street supply

Diverse opioid and stimulant options are needed to accommodate preferred substance and mode of use, and be available in appropriate doses. Options should be accessible through models outside of physician prescribing

POLICY & PRACTICE IMPLICATIONS FOR SAFER SUPPLY

- Expand the substances offered to include
  - Opioids: diacetylmorphine (heroin) and fentanyl
  - Stimulants: methamphetamine and cocaine
- Include inhalable forms
- One size does not fit all
  - Preferences vary by age, gender, geography, and frequency of use
- Challenges of access – explore non-prescriber models
- Engage people who use substances to ensure diverse needs are identified and met i.e. options are appropriate, acceptable & accessible. Ongoing input necessary to identify shifts
  - Substance and mode of use preference may change as safer supply options become available e.g.
    - smoke for safety reasons, if safer supply available may prefer other modes
    - stimulants are used to address effects of fentanyl; may change if heroin available

13 RECOMMENDATIONS BASED ON STUDY FINDINGS

1. Include diacetylmorphine (heroin) in the Safer Supply Policy Directive. Implement and expand safer supply programs offering heroin.
2. Safer supply programs should offer various forms of fentanyl, including fentanyl powder.
3. Provide a regulated supply of stimulants people are accessing from the illegal supply (e.g. methamphetamine, cocaine, desoxyn), in addition to currently available prescribed alternatives (e.g. Dexedrine, Ritalin).
4. Safer supply programs need to include benzodiazepines and prescribers should consider providing a safer supply of benzodiazepines to those at risk of benzodiazepine withdrawal or health concerns that can be addressed with benzodiazepines.
5. Make injectable alternatives to oral forms of safer supply available.
6. Make inhalable forms of heroin and fentanyl, as well as other safer supply options (e.g. stimulants), available.
7. Expand existing overdose prevention sites to allow for supervised inhalation both indoors and outdoors.

13 RECOMMENDATIONS BASED ON STUDY FINDINGS

8 Regulatory bodies, such as the College of Physicians and Surgeons of BC, should be transparent about audit processes and guidelines in place to monitor and detect harms resulting from the absence of safer supply prescribing.

9 Public health and harm reduction organizations should develop educational and advocacy tools to empower people who use drugs to seek out and advocate for the substances and modes of use they need, particularly when confronted with prescriber hesitancy.

10 Clarify the role of the provincial government in addressing prescriber hesitancy.

11 Provide low-barrier models, that include virtual and mobile options, take-home dose options and flexible and appropriate policies around missed doses, to ensure access to safer supply programs.

12 Seek section 56 exemption from the federal government to legally develop, implement and evaluate non-prescriber safer supply models. Provincial governments have a role in supporting the implementation of non-prescriber safer supply models, including compassion clubs and co-op models.

13 Involve people with lived and living experience of substance use in the design and operation of safer supply programs to ensure programs are aligned with peoples' preferences and needs and increase access.

FOR FURTHER INFORMATION

- Please see full report available soon on https://towardtheheart.com/research-projects

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- For questions or concerns please contact
  - Jane Buxton: jane.buxton@bccdc.ca
  - Jessica Xavier: jessica.xavier@bccdc.ca

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