

Substance Use Patterns and Safer Supply Preferences Among People Who Use Drugs in British Columbia



March 2023

Xavier J, McGreevy PB, McDougall J, Lamb J, Streukens A, Haywood B, Scott T, Lock K, Ackermann E, Loyal J, Ferguson M, Liu L, Kamal A, Greer A, Butler A, Iammarino S, Palis H, Slaunwhite A & Buxton JA



BC Centre for Disease Control
Provincial Health Services Authority



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ETHICS APPROVAL

The *Harm Reduction Client Survey* was approved by the University of British Columbia Office of Behavioural Research Ethics (#H07-00570). The '*Substance Use Patterns and Safer Supply Preferences...*' study was approved by the University of British Columbia Office of Behavioural Research Ethics (#H21-02494).

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Executive Summary

Background and objective

British Columbia (BC) has implemented a variety of measures to reduce injury and death arising from the ongoing unregulated drug poisoning emergency. However, many stakeholders including people who use drugs, advocates, and researchers have highlighted how these measures do not adequately address the underlying issue. The illegal market is unregulated and consequently unpredictable. Indeed, the addition of fentanyl to the illegal supply has been associated with the large increase of drug-related harms and deaths observed from 2016 to present in BC, due to variable concentrations of fentanyl in the illegal supply and issues of cross-contamination.

Safer supply has been advocated in response to the limitations of current measures aimed at addressing the unregulated drug poisoning emergency. Broadly defined, safer supply refers to a legal and regulated

This report presents the findings of a multiyear study which aimed to understand the needs and preferences of people who use drugs from the illegal market and safer supply.

supply of drugs and pharmaceutical alternatives to drugs that have been traditionally criminalized, such as diacetylmorphine (heroin) or methamphetamines. This report presents the findings of a multiyear study which aimed to understand the needs and preferences of people who use drugs from the illegal market and safer supply. To successfully separate people from the illegal supply, consultation with people who use drugs is paramount. These findings can inform policy recommendations for the effective design of safer supply models and programs that will be acceptable, desirable, and accessible to people who use drugs.

Methods

The study was comprised of two components: the *Harm Reduction Client Survey*, and interviews and focus groups with people who use drugs. The *Harm Reduction Client Survey* was administered at harm reduction distribution sites across BC to assess peoples' patterns of drug use, and peoples' preferences for safer supply substances and modes of use. Interviews and focus groups were conducted to identify the strengths and challenges with safer supply as currently implemented in BC, and to better understand the preferences and expectations for future models of safer supply.

Key Findings

Expand opioid and stimulant safer supply options to encourage acceptability and access and reduce barriers to current opioid, stimulant, and benzodiazepine safer supply options (Recommendations 1-4)

RECOMMENDATION 1: Include diacetylmorphine (heroin) in the Safer Supply Policy Directive. Implement and expand safer supply programs offering heroin.

Many people interested in or accessing a safer supply of opioids continue to use from the illegal supply because they are unable to access their preferred opioid and/or a sufficient dose. Our findings suggest that most people who use opioids report a preference for diacetylmorphine (heroin) (Ferguson et al., 2022). Research has demonstrated that providing a safer supply of heroin is effective at reducing peoples' use of illegal opioids and risk of overdose (Ferri et al., 2011; Oviedo-Joekes et al., 2016; Smart, 2018; Strang et al., 2012). While injectable heroin is approved by Health Canada (Government of Canada, 2022a), heroin is currently only available at a few injectable opioid agonist treatment clinics across BC (Eyd et al., 2021; Maghsoudi et al., 2020).

RECOMMENDATION 2: Safer supply programs should offer various forms of fentanyl, including fentanyl powder.

After heroin, fentanyl is the next (or second) most preferred opioid by people who reported interest in accessing a safer supply of opioids (Ferguson et al., 2022). Fentanyl is included in the 2021 Safer Supply Policy Directive (BC Ministry of Mental Health and Addictions & BC Ministry of Health, 2021), however, it is currently only prescribed by a small number of prescribers and programs across the province (McMurchy & Palmer, 2022). Fentanyl patches and injectable fentanyl are approved by Health Canada, however, inhalable forms of fentanyl are not (Government of Canada, 2022a).

RECOMMENDATION 3: Provide a regulated supply of stimulants people are accessing from the illegal supply (e.g. methamphetamine (e.g. Desoxyn), cocaine), in addition to currently available prescribed alternatives (e.g. Dexedrine, Ritalin).

People who use stimulants exclusively or concurrently with opioids are at considerable risk of overdose (BC Coroners Service, 2022; Lukac et al., 2022; Ministry of Public Safety and Solicitor General, 2018; Tupper et al., 2018). Currently, there are very limited safer supply options for people who use stimulants (i.e., dextroamphetamine (Dexedrine), methylphenidate (Ritalin)) (BC Ministry of Mental Health and

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These findings can inform policy recommendations for the effective design of safer supply models and programs that will be acceptable, desirable, and accessible to people who use drugs.

Addictions & BC Ministry of Health, 2021; Fleming et al., 2020; Government of British Columbia & BC Centre on Substance Use, 2020). Many participants noted that current options do not provide the desired medicinal and/or non-medicinal effects, contributing to widespread continued use of stimulants from the illegal supply. A regulated supply of peoples' preferred stimulants (e.g., methamphetamine (e.g. Desoxyn), powdered cocaine, crack cocaine) can reduce peoples' exposure to stimulants that may be contaminated with opioids and other contaminants.

RECOMMENDATION 4: Safer supply programs need to include benzodiazepines and prescribers should consider, on a case-by-case basis, providing a safer supply of benzodiazepines to those at risk of benzodiazepine withdrawal or experiencing health concerns that can be addressed with benzodiazepines. Policies and guidance that account for the relative risk of not prescribing benzodiazepines leading to peoples' continued reliance on an unregulated, contaminated supply are needed.

Benzodiazepines are frequently detected in the illegal supply of opioids (Vancouver Island Drug Checking Project, 2021). Participants shared common experiences of benzodiazepine dependency and exposure and concerns around the severe risks associated with benzodiazepine withdrawal. Moreover, participants shared experiences of being denied or cut-off benzodiazepine prescriptions — leading them to use from the illegal supply to meet their benzodiazepine needs and to reduce risks associated with sudden withdrawal.

Expand safer supply mode of use options to encourage access and make overdose response services more equitable based on preferred mode of drug use (Recommendations 5-7)

RECOMMENDATION 5: Make injectable alternatives to oral forms of safer supply available.

Many people prefer injecting their substances and will continue to do so using safer supply intended for oral consumption. At the time of this study, many of the safer supply options (e.g. Dilaudid, M-Eslon, Dexedrine, Ritalin) were meant for oral consumption. However, as we heard from many participants, people were injecting these substances. Injecting tablets not meant for injection can cause serious health issues due to additives in tablets that can cause infection. While some safer supply programs offer injectable

formulations (e.g. injectable (diacetylmorphine (heroin), injectable hydromorphone), these programs are not accessible to all across BC.

RECOMMENDATION 6: Make inhalable forms of heroin and fentanyl, as well as other safer supply options (e.g. stimulants), available.

Many people primarily smoke their substances and a considerable number of people report a preference for inhalable forms of safer supply (Kamal et al., 2023). However, at the time of this study, there were no inhalable safer supply options available. Inhalable versions of heroin are not available anywhere in BC but could be, under provincial legislation (Government of Canada, 2022a). Injectable fentanyl is approved by Health Canada, however, inhalable forms of fentanyl are not approved by Health Canada (Government of Canada, 2022a). Some programs have made inhalable forms of fentanyl available through the provincial compounding regulatory framework, a framework that allows for the provision of drugs that have not been approved for manufacture by Health Canada (Government of Canada, 2009). Participants related stories of people sharing or re-using smoking equipment and being exposed to residual substances of unknown potency and content, including opioids among persons who were opioid naïve, resulting in overdose. Indeed, smoking was the most common mode of consumption among people who died of illicit drug toxicity between August 2017 and July 2021 (BC Coroners Service, 2022).

RECOMMENDATION 7: Expand existing overdose prevention sites to allow for supervised inhalation (indoor and outdoors).

Beyond acceptable safer supply options for the many who smoke their substances, participants expressed concerns that there is inequitable access to safer supply and overdose prevention sites for people who smoke their drugs. While there are a number of overdose prevention sites across BC where people can inject their substances, there are few sites that allow for inhalation.

Removing barriers associated with prescribed safer supply and prescriber hesitancy (Recommendations 8-10)

RECOMMENDATION 8: Regulatory bodies, such as the College of Physicians and Surgeons of BC, should be transparent about audit processes and guidelines in place to not only detect harmful prescribing practices among healthcare providers but to monitor and detect harms resulting from the absence of safer supply prescribing.

RECOMMENDATION 9: Public health and harm reduction organizations should develop educational and advocacy tools that can 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.

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

Participants emphasized how safer supply prescribers and programs are distributed unequally across the province, in part, due to prescriber attitudes and discretionary power leading to inequitable implementation and access. As others have pointed out, prescriber hesitancy is a major barrier to implementation and equitable access to safer supply (McMurchy & Palmer, 2022). Participants also demonstrated gaps in awareness and knowledge around the different options that are available under opioid agonist treatment and safer supply — contributing to a limited capacity to seek out and/or advocate for their preferred option.

Improving access to safer supply across BC (Recommendations 11,12,13)

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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. Engage peer workers in the operation of safer supply programs to improve access by increasing awareness of programs through peer networks and develop trust and connection to create comfortable safe, environments.

Our findings demonstrate that for many people who use drugs, existing safer supply programs are not meeting their needs in terms of the substances and modes of use offered and the models and program requirements. Participants shared perspectives around rural considerations for safer supply programs, access for people with mobility constraints, policies and practices around missed or take-home doses. Survey findings demonstrated that of those who used illegal opioids, stimulants and/or benzodiazepines in the last 3 days (and thus would have been eligible for safer supply) (n=491), only 16.5% (n=81) were receiving a prescription for a Risk Mitigation Guidance (Pandemic Prescribing) substance (i.e. the main safer supply clinical guidance at the time of the survey) (Palis & Slaunwhite, N.D.). Moreover, of the participants who responded to the question 'have you heard of pandemic prescribing/risk mitigation guidance' (n=469), only 38.3% (n=180) had heard of it and of these only 19% (n=89) were receiving a prescribed supply. 9% (n=15) of participants, among the 167 who had tried Risk Mitigation Guidance (Pandemic Prescribing)

reported trying but physicians would not prescribe (Liu & Buxton, N.D.). We heard from participants that, in many cases, their preferences were not reflected under current legislation and services. In order to improve access and use of safer supply, there is an urgent need to improve engagement with people with lived and living experience and prioritize their voices at decision-making tables.

Future Research

Targeted research that focuses on the experiences of different groups of people who use drugs accessing safer supply is needed to address specific needs and service gaps. For example, research that focuses on the unique barriers and challenges faced by Indigenous communities and youth accessing safer supply. Research that examines prescriber attitudes and relationships with service-users in the context of safer supply could help identify implementation issues and areas that would benefit from clinical and/or policy guidance. Finally, ongoing evaluations are needed to monitor safer supply initiatives as they evolve.

Conclusions

Current measures aimed at addressing the unregulated drug poisoning emergency have helped reduce drug-related injury and deaths, however they do not address the core issue of the unregulated and unpredictable illegal supply. While there have been important steps made to acknowledge the need for a regulated safer supply of substances, existing safer supply options are limited in terms of the substances provided, the modes of use available, and the diversity and the flexibility of programs offered. The findings from this report demonstrate the value of engaging with people who use drugs to inform the design and implementation of programs that successfully meet their needs. If the regulated supply of psychoactive substances is not acceptable, desirable, and accessible to people who use drugs, people will continue to use from the illegal supply and drug-related injuries and deaths will continue.

The findings from this report demonstrate the value of engaging with people who use drugs to design and implement programs that successfully meet their needs. If the regulated supply of psychoactive substances is not acceptable, desirable, and accessible to people who use drugs, people will continue to use from the illicit supply and drug-related injuries and deaths will continue.

Glossary of terms

Benzos	Benzodiazepines
Bubble	A type of pipe used to smoke drugs
Bump	A small amount of a drug taken by snorting
Carries	A supply of a regulated drug that can be taken home in specific doses and does not have to be observed being taken at a pharmacy, clinic, center, etc. under supervision
Cisgender i.e., cis man, cis woman	Person whose gender identity aligns with their sex assigned at birth
“Clean”^a	Used by some to refer to abstaining from using substances
Concurrent use	Using substances simultaneously/at the same time
Cross-contamination	Substances unintentionally introduced to other substances causing unexpected, and at times, harmful effects
Dailies or daily dispensing	A prescribed or regulated supply such as opioid agonist treatment or safer supply that requires people to pick up their supply in increments once or multiple times a day and, in some cases, under supervision
Dillies; Hydromorph	Hydromorphone (Dilaudid) i.e., a prescribed opioid
Decriminalization	Decriminalization refers to eliminating criminal sanctions for the possession of illegal drugs. Broadly speaking, it does not refer to a single model but rather a concept that can form the basis for a variety of models. Decriminalization is not the same as legalization or providing a regulated supply because people must still access the unregulated supply to acquire substances

^a We acknowledge that the term “clean” has been identified by many as stigmatizing because it suggests that not pursuing sobriety is improper or not clean. We have chosen not to change any of the language used by participants to describe their lived experiences.

Doing a dragon/ chasing the dragon	An opioid (typically heroin) is placed on aluminum foil and heated from below (often with a flame such as a lighter). The vapour produced is inhaled through a straw or tube-like object
Dope	Term used to refer to drugs that have traditionally been illegal
Down	Opioid
Drug checking services	Services that people can access to test their drugs to see what specific substances, contaminants and concentrations they contain
Euphoria/euphoric properties	Experience of pleasure or excitement and intense feelings of well-being and happiness that are part of the effects associated with certain drugs
Hard	Crack cocaine
Hoot/blast	A small amount of a drug taken by smoking
Injectable opioid agonist treatment (iOAT)/ heroin-assisted treatment	Injectable forms of regulated substances, such as diacetylmorphine (heroin) and hydromorphone, provided to reduce risks associated with using unregulated substances
Junkie^b	A term that some people who use drugs and specifically people who inject drugs self-identify with
Medicinal properties	Properties of substances that can be used to relieve pain or treat symptoms associated with illness
Naloxone	An opioid antagonist medication used to reverse the effects of an opioid overdose. In BC, take-home naloxone kits are available to the public at no cost
Nodding off/on the nod	An effect that can be associated with consuming particular substances, such as opioids, that involves falling asleep, briefly or unintentionally
OD	Overdose

^b We acknowledge that the term “junkie” has been identified by many as an outcome of intrapersonal, interpersonal or institutional stigma due to its’ historical use. However, some people who use drugs may self-identify with the term and use it in an act of reclamation. We have chosen not to change any of the language used by participants to describe their lived experiences.

Opioid agonist treatment (OAT)	An opioid agonist (i.e. methadone [Methadose, Methadol], buprenorphine/naloxone [Suboxone, injectable Sublocade], slow release morphine [Kadian]) that is meant to prevent withdrawal and reduce cravings associated with opioid dependence. Opioid agonist treatment generally does not provide non-medical properties such as euphoria or a “high”
Overdose prevention sites or services (OPS)	Overdose prevention <i>services</i> were introduced in Dec 2016 in BC by a Ministerial Order (M488) under the public health (overdose) emergency. Health Canada subsequently issued an exemption under section 56.1 of the Controlled Drugs and Substances Act to authorize Ministers of Health across Canada to approve temporary overdose prevention <i>sites</i> in areas of need. The term overdose prevention <i>site</i> is commonly used to include both and will be used throughout this report to refer to sites where people are provided with sterile, new supplies to use pre-obtained drugs under the observation of staff in order to have access to a timely response in the event of an overdose.
“Point” of a drug	0.1 grams of a drug
Powder	Cocaine
Prescriber gatekeeping	Prescriber attitudes and practices that contribute to restricting access to services such as safer supply
Regulated supply or pharmaceutical grade	Term used to refer to drugs acquired through a supply that is regulated for quality control
Risk Mitigation Guidance (also referred to as Pandemic Prescribing)	Guidance that was put in place at the start of the COVID-19 pandemic in March 2020 that encouraged prescribers to prescribe alternatives to toxic illegal drugs for persons at risk of COVID-19 and/or overdose. The rationale for pandemic prescribing was to encourage physical distancing and address overdoses. This guidance refers to alcohol, benzodiazepines, opioids (including hydromorphone and M-Eslon), and stimulants (including Dexedrine and Methylphenidate)
Safer supply	A legal and regulated supply of drugs with non-medical mind/body altering properties that typically have only been accessible on the illegal drug market

Safer Supply Policy Directive	In 2021 BC’s Ministry of Mental Health and Addictions and Ministry of Health released <i>Access to Prescribed Safer Supply in British Columbia: Policy Direction</i> , encouraging the expansion of pharmaceutical alternatives to illegal drugs
Sick/dope sick	Being in withdrawal from opioids, opioid agonist treatment, or benzodiazepines and experiencing symptoms as a result
Side/meth	Methamphetamines
Smash/shoot a drug/poking	To inject a drug
Street supply or street grade	Terms used to refer to drugs acquired through the illegal, unregulated market
Supervised consumption sites (SCS)	These sites operate under a Health Canada exemption from prosecution under federal drug laws (Section 56.1) following an official application and community consultation process. People bring pre-obtained substances to use under the supervision of trained health professionals.
Supervised inhalation sites or services	Sub-category of Supervised Consumption Sites (SCS) or Overdose Prevention Sites (OPS) where people are provided with sterile, new smoking supplies to smoke pre-obtained drugs under the supervision of staff to have access to a timely response in the event of an overdose
Tablet injectable opioid agonist treatment (tiOAT)	Tablet forms of regulated substances, such as hydromorphone, provided to reduce risks associated with using unregulated substances
Unregulated drug poisoning emergency	Term used to describe the public health emergency declared in 2016 in BC that is ongoing, due to an unregulated, toxic supply of drugs. Also referred to as: overdose crisis or drug toxicity crisis
Up/upper	Stimulant such as cocaine and crack
Wired	Term used to refer to being dependent on a substance

Background

Unregulated drug poisoning emergency

British Columbia (BC), and the rest of Canada, have been experiencing an unregulated drug poisoning emergency for nearly a decade (Government of British Columbia, 2016; Public Health Agency of Canada, 2022b). BC declared a public health emergency in 2016 due to the increasing number of overdose deaths. In 2021, the number of annual illicit drug toxicity deaths in BC were the highest on record with 2,236 lives lost and data suggest that the annual number of deaths for 2022 is likely to exceed 2000 (BC Coroners Service, 2022).

Different terminology has been used to name crises declared in BC, Canada and the US, including the ‘overdose crisis’, the ‘illegal drug toxicity crisis’ and the ‘opioid epidemic’. In this report, we use the term ‘unregulated drug poisoning emergency’.

In 2021, the number of annual illicit drug toxicity deaths in BC were the highest on record with 2,236 lives lost and data suggest that the annual number of deaths for 2022 is likely to exceed 2021.

Following consultation with people with lived and living experience, and public health and toxicology specialists, this term was chosen because it clearly indicates the source of the emergency: drugs of unknown contents and potencies, as well as unreliable and inconsistent supply networks. We will be referring to deaths from the unregulated drug poisoning emergency as ‘overdose deaths’ for the purpose of brevity and clarity. We recognize that this term may include a small number of intentional overdose deaths.

The addition of the synthetic opioid, fentanyl (and its’ analogues), to the illegal drug supply has directly contributed to an increase in overdose deaths. Fentanyl is 100 times more potent than morphine and 50 times more potent than diacetylmorphine (heroin) (Centers for Disease Control and Prevention, 2022). The potency and the high variability of fentanyl concentrations in the illegal drug supply create a context where people are unsure about the presence and amount of fentanyl in the substances they are using. This is shown through BC Coroner’s Service data which indicate the detection of extreme concentrations of fentanyl (>50ug/L) (21% of cases between November 2021 to February 2022) (BC Coroners Service, 2022). Another example is the cross-contamination of stimulants with opioids, at the stage of distribution (e.g. contamination of scales or baggies) and/or consumption (e.g. smoking stimulants using a pipe that contains opioid residue), that puts people who use stimulants,

especially those who are opioid naïve, at considerable risk of overdose (Fleming et al., 2020; Public Health Agency of Canada, 2022a).

In response, BC and other Canadian jurisdictions implemented a number of initiatives with the intention of reducing overdose deaths, including but not limited to (Strike & Watson, 2019; Wallace et al., 2019):

- Increasing distribution and access to take-home naloxone
- Implementing overdose prevention sites and supervised consumption sites
- Implementing and expanding access to drug checking services
- Increasing opioid agonist treatment availability

However, these programs and services do not address the underlying issue of the unpredictable and toxic drug supply, resulting from particular substances being illegal and unregulated. Interventions aimed at responding to overdose and testing illegal drugs, like the ones listed above, are reactive rather than preventative solutions. Opioid agonist treatment may be effective at reducing the use of illegal substances and overdose risk for some but not for all (Bahji et al., 2019; Fairbairn et al., 2019; Krawczyk et al., 2020; Mattick et al., 2009, 2014; Santo et al., 2021). Retention is highly variable and oftentimes low (Kurz et al., 2022; Nosyk et al., 2010; Socias et al., 2018) and research in BC suggests that a considerable number of people who receive opioid agonist treatment, particularly those accessing harm reduction services, continue to regularly use drugs from the illegal supply because opioid agonist treatment does not meet all of their needs (Lukac et al., 2022). Key limitations associated with opioid agonist treatment access and continuation include inadequate dosages (Termorshuizen et al., 2005; Fairbairn et al., 2019), opioid agonist treatment not providing non-medicinal or psychoactive properties some are seeking (Fairbairn et al., 2019), undesirable side effects (Fairbairn et al., 2019; Schwartz et al., 2008), and strict program requirements that are onerous for clients (Bao et al., 2009). These findings in combination with increasing overdose deaths, highlight the need for a regulated supply of substances beyond opioid agonist treatment.

Simple possession of some illegal substances for personal use will be decriminalized in BC starting January 31st, 2023 (Government of British Columbia, 2022) and is hoped to reduce stigma and allow people who use drugs to participate more fully in society without fear of persecution. However, it will not achieve the implementation and expansion of an acceptable regulated

Interventions aimed at responding to overdose and testing illegal drugs, like the ones listed above, are reactive rather than preventative solutions.

supply of drugs in order to reduce overdose deaths. Within a decriminalized context people are still dependent on accessing drugs from the unregulated toxic supply.

Defining the safer supply landscape in BC and existing gaps

The term ‘safer supply’ was introduced to highlight that access to a supply of drugs of known content is possible by regulating the production and distribution of substances that currently or traditionally have only been accessible through the illegal market. The term safer supply gained more formal recognition in 2019 when Health Canada released a report titled: *‘Toolkit for Substance Use Addictions Program Applications – Increasing Access to Pharmaceutical-Grade Medications’* (Health Canada, 2019). In the context of the COVID-19 pandemic, the Government of BC and BC Centre on Substance Use released Risk Mitigation Guidance (also referred to as Pandemic Prescribing) titled *‘Risk Mitigation: In the Context of Dual Public Health Emergencies’* with the dual aims of increasing access to prescribed alternatives to illegal substances for persons at risk of overdose and reducing COVID-19 transmission (Government of British Columbia & BC Centre on Substance Use, 2020). In July 2021, BC’s Ministry of Mental Health and Addictions and Ministry of Health released safer supply guidance titled *‘Access to Prescribed Safer Supply in British Columbia: Policy Direction’*, that decoupled safer supply from the COVID-19 pandemic. The Policy Directive encourages the expansion of pharmaceutical grade alternatives to illegal drugs (BC Ministry of Mental Health and Addictions & BC Ministry of Health, 2021). These developments have led to discussions around the definition of safer supply as the term has been used to define a range of models. For the purpose of this report, we define safer supply based on the 2019 report released by the Canadian Association of People who Use Drugs, which states:

‘Safer supply refers to a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market’

To note, some people use the term ‘safer supply’ and others use the term ‘safe supply’. While ‘safe’ is contested because there is no such thing as a guaranteed ‘safe’ supply (i.e. even with a regulated supply, there are risks) many people who use drugs will use the term ‘safe’ to acknowledge that, as the Canadian Association of People who Use Drugs’ explains: ‘with the quality of the substance assured people who use drugs are in a far better position to confront the risks’ (Canadian Association of People who Use Drugs, 2019). In this report, we will use the term ‘safer supply’ and avoid changing participants’ use of the term ‘safe supply’ to acknowledge the complexities in coining an appropriate term and respect terminology used by many participants and people who use drugs.

The definition of safer supply included from the 2019 report from the Canadian Association of People who Use Drugs emphasizes the need to a) systematically regulate substances for quality control and safety purposes and b) regulate and provide access to substances that provide non-medicinal properties, recognizing that many people who use from the illegal supply are seeking non-medicinal and/or euphoric

properties. Indeed, safer supply accepts that people will use substances to experience psychoactive or mind altering effects and does not aim to decrease or limit substance use. Based on this definition, safer supply does not include opioid agonist treatment, such as methadone and buprenorphine/naloxone, as these substances are typically not sought for purposes other than treatment or withdrawal management given their low psychoactive or mind altering properties (Government of Canada, 2022b; National Institute on Drug Abuse, 2018; Whelan & Remski, 2012). In this report we align our approach with that of the Canadian Association of People who use Drugs, that recognizes safer supply as a term that is inclusive of:

- Tablet injectable opioid agonist treatment (also referred to as tiOAT)
- Injectable opioid agonist treatment and heroin-assisted treatment (also referred to as iOAT)
- Risk Mitigation Guidance (also referred to as Pandemic Prescribing)
- Other models that provide a regulated supply of substances with psychoactive or mind altering properties (e.g. compassion clubs, cannabis dispensaries)

In the context of this report, safer supply is an umbrella term for various models through which a variety of substances are made accessible. Models may differ by what substances they offer, in what form they are offered (e.g. oral and/or injectable), and their eligibility, dispensing and regulatory requirements (for example, requirements for supervision, the setting in which substances are delivered, or requirements to get a prescription). While some variations exist, the options remain limited as the current landscape of safer supply is in its infancy. Preliminary evidence shows that most people who use drugs are not having their needs met by current safer supply options and/or do not have access to safer supply (Bonn et al., 2020; Kolla et al., 2021; McNeil et al., 2022).

Our research approach is based on the premise that people who use drugs must be involved in creating drug policy. Consultation with people who use drugs enables us to understand their needs and preferences for safer supply, and the rationale behind these preferences. Thus, consultation ensures safer supply will be designed practically to increase access, and better positions programs to anticipate and account for potential shifts in needs and preferences. To successfully separate people from the unregulated and unpredictable supply, safer supply options need to be acceptable and desirable to those expected to access them. Otherwise, people will continue to use from the unregulated supply and the objectives of safer supply will not be met.

While some variations exist, the options remain limited as the current landscape of safer supply is in its infancy. Preliminary evidence shows that most people who use drugs are not having their needs met by current safer supply options and/or do not have access to safer supply.

Our study

Scope

Our study entitled ‘Substance Use Patterns and Safer Supply Preferences among People Who Use Drugs in British Columbia’ uses data collected between 2019 and 2022. 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:

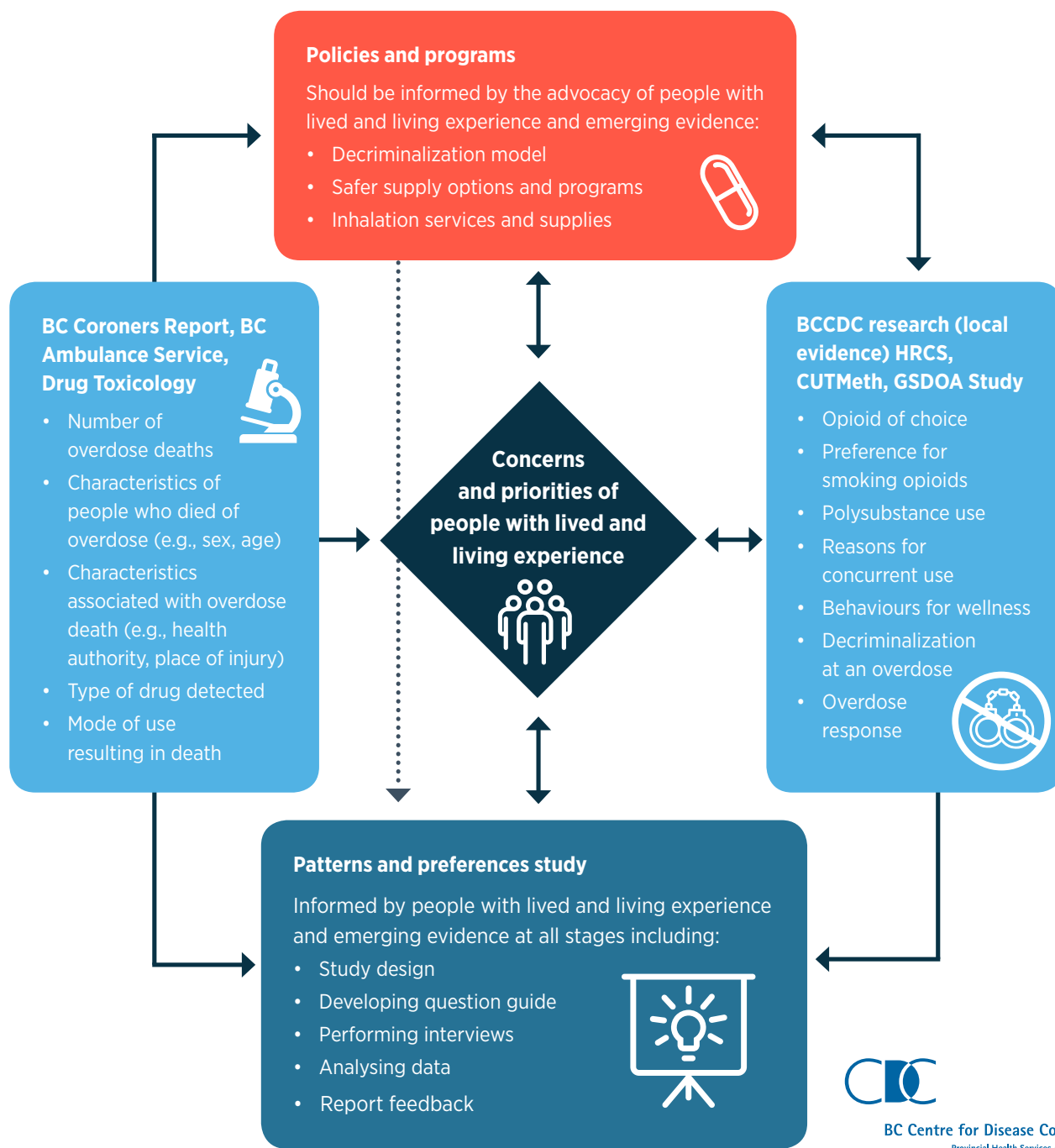
- If people who use opioids and/or stimulants were prescribed a continuous supply of pharmaceutical grade alternatives, which one(s) would they choose? Why?
- How would people choose to use their preferred pharmaceutical alternative? Why?
- As roughly half of illegal opioids currently contain benzodiazepine-like substances, are there concerns about benzodiazepine withdrawal upon a potential transition to safer supply and opioid agonist treatment?
- What are people’s experiences with concurrent substance use? What substances do they use concurrently and why?

This study and the research questions above were informed at all stages by concerns and priorities identified by people with lived and living experience as well as by emerging evidence available from the BC Coroners Service, BC Ambulance Service, drug checking services and BCCDC research. Figure 1 on the following page demonstrates the motivating forces and knowledge sources behind this study.

Below is a brief snapshot of our data sources and methods. Some findings sections are preceded by additional data from BC Centre for Disease Control opioid agonist treatment indicator and safer supply indicator dashboards. ***Data from these dashboards are provided to contextualize this study’s findings – these data are not a product of this study.***

FIGURE 1: INFORMATION SOURCES CONTRIBUTING TO OUR STUDY

■ Policies and programs
 ■ Evidence sources
 ■ Patterns and preferences study



Methods, data sources and analyses

We used a mix of quantitative and qualitative research methods. Data collection and analyses of quantitative and qualitative components were conducted separately and findings were integrated at the interpretation stage to report on intersections and validate the data across different sources. A breakdown of participant demographics and drug use characteristics can be found in *Appendix I*.

Harm Reduction Client Survey data

The quantitative component drew from two surveys, completed in 2019 and 2021, with people who use drugs accessing harm reduction sites across BC. While some participants reported accessing safer supply, this was not an eligibility requirement and as such few participants had experience accessing safer supply. This is an annual cross-sectional survey conducted by the BC Centre for Disease Control, titled the *Harm Reduction Client Survey*. Eligibility criteria include being 19 years and older, self-reporting using illegal drugs in the past 6 months and ability to provide informed consent. Survey questions were developed with input from the Professionals for the Ethical Engagement of Peers (PEEP)¹ and the Vancouver Area Network of Drug Users (VANDU).² A copy of both the 2019 and 2021 surveys are available on the BCCDC website: Harm Reduction Client Survey (bccdc.ca). In total, 621 and 537 people responded to the 2019 and 2021 surveys, respectively. Analyses were conducted with the 2019 survey to determine peoples' most commonly used substances and modes of use. A further analysis was conducted with the 2021 survey to examine safer supply opioid and stimulant preferences and safer supply mode of use preferences.

Interview and focus group data

The qualitative component drew on data from one-on-one interviews and focus groups. We conducted individual interviews with 47 participants, and six focus groups with 40 participants (copy of question guides available upon request). Participants were eligible to participate if they: were 16 years or older, used illegal or prescribed opioids and/or stimulants in the past month, spoke English, and were able to provide informed consent. While some participants reported accessing safer supply, this was not an eligibility requirement and as such not all participants had experience accessing safer supply. Six peer research assistants from across the province recruited participants through their networks and harm

1 Professionals for the Ethical Engagement of Peers is an advisory and consultation group made up of people with lived or living experience of substance use who work with the BC Centre for Disease Control and are comprised of regional representation in British Columbia.

2 The Vancouver Area Network of Drug Users is a grassroots organization of people who use drugs that works to impact public policy and practice related to the use of illegal drugs.

reduction organizations. An analysis was conducted where analysts paid special attention to common threads throughout participants' narratives to identify the strengths and challenges with safer supply as currently practiced in BC, and highlight preferences and expectations for future models of safer supply. Pseudonyms (i.e., fake names) were assigned to interview participants to protect their privacy and identity, and are included alongside excerpts in this report. Focus group participants were not identified individually in the transcripts and are thus identified by focus group number. A glossary of terms used by participants can be found on pages 10–13. A peer advisory, including members of PEEP and Peer2Peer,³ was consulted at various stages from study design to knowledge translation to ensure processes, study tools, and interpretations were representative of individual and community experiences.

In total, 621 and 537 people responded to the 2019 and 2021 surveys, respectively.

³ Peer2Peer is an advisory group that aims to develop, implement, and evaluate models and strategies to support peers/experiential workers who are working in BC overdose response settings. For more information, visit towardtheheart.com/peer2peer-project.

Findings: Themes and Sub-themes

Two major themes and related sub-themes emerged from an analysis of our survey responses and a parallel analysis of our interviews and focus groups. Table 1 summarizes the themes and sub-themes that follow.

Table 1: Summary of themes and sub-themes

THEMES	SUB-THEMES
<p>1. 'I was hopeful it would be better than it was': Summarizing <i>common perceptions</i> of current safer supply options with respect to substance and modes of use options, as well as considerations for improving access and service delivery</p>	<ul style="list-style-type: none"> a. Safer supply substance options <ul style="list-style-type: none"> i. Opioid safer supply options ii. Stimulant safer supply options iii. Benzodiazepine safer supply options
	<ul style="list-style-type: none"> b. Mode of use options <ul style="list-style-type: none"> i. Injectable safer supply options ii. Inhalable formulations for safer supply and safer use services
	<ul style="list-style-type: none"> c. Model considerations <ul style="list-style-type: none"> i. Perceptions of prescriber practices ii. Constraints for rural communities iii. Policies and practices around missed doses iv. Perceptions of take-home doses
<p>2. 'No one size fits all': Reflecting on <i>unique and personal</i> substance use preferences and safer supply needs to inform the design and implementation of safer supply programs</p>	<ul style="list-style-type: none"> a. Case-by-case risk assessments
	<ul style="list-style-type: none"> b. Virtual and mobile prescribing and delivery
	<ul style="list-style-type: none"> c. Financial costs
	<ul style="list-style-type: none"> d. Integrated and wrap-around services
	<ul style="list-style-type: none"> e. Eligibility requirements
	<ul style="list-style-type: none"> f. Staff characteristics
	<ul style="list-style-type: none"> g. Prescribing and program flexibility

A snapshot of the current opioid agonist treatment and prescribed safer supply context in BC

Table 2 summarizes the substances included in BC's Safer Supply Policy Directive document, approved by Health Canada, and available for prescription-based distribution, as well as information about access to and prescribing of these substances to-date, in various formulations. The table also includes psychoactive substances that are not included in BC's Safer Supply Policy Directive for informational purposes.

Table 2. Regulatory, prescribing and accessibility differences across opioid agonist treatment, psychoactive substances and prescribed alternatives in various formulations

Substance	Included in safer supply policy directive	Approved by Health Canada for prescribing	Formulation currently available in BC	Number of people accessing a regulated supply in BC, June 2022*	Number of prescribers prescribing a regulated supply in BC, June 2022*
Opioids					
Fentanyl	Y	Y	Patch, injectable, oral	Data not available	Data not available
Diacetylmorphine (Heroin)	N	Y	Injectable	115	13
Hydromorphone (e.g. Dilaudid)	Y	Y	Oral Injectable	Oral: 194 Injectable: 30	Oral: 46 Injectable: 13
Morphine (e.g. Kadian, M-Eslon)	Y	Y	Oral	3,326	672
Methadone	Y	Y	Oral	14,627	1,046
Buprenorphine/naloxone (Suboxone)	Y	Y	Oral	7,604	1,527
Stimulants					
Amphetamines	N	N	N/A	N/A	N/A
Cocaine	N	N	N/A	N/A	N/A
Crack cocaine	N	N	N/A	N/A	N/A
Dextroamphetamine (Dexedrine)	Y	Y	Oral	Data not available	Data not available
Methylphenidate (Ritalin)	Y	Y	Oral	Data not available	Data not available
Benzodiazepines	Y	Y	Oral	Data not available	Data not available

*These numbers are based on the BC Centre for Disease Control opioid agonist treatment indicators dashboard. These indicators represent the number of clients being dispensed opioid agonist treatment in BC in June 2022. This dashboard can be accessed at: [Unregulated Drug Poisoning Emergency Dashboard \(bccdc.ca\)](https://www.bccdc.ca)

THEME 1.

‘I was hopeful it would be better than it was’

Summarizing common perceptions of current safer supply options with respect to substance and modes of use options, as well as considerations for improving access and service delivery

Overwhelmingly, participants described existing safer supply options as ‘a step in the right direction’ but with substantial limitations, stating that *‘if there’s going to be options for one person – then there should be options for everyone’* (Jacob, Cranbrook). Key challenges such as limited opioid, stimulant, and benzodiazepine safer supply options, lack of inhalable forms of safer supply, dogmatic prescriber practices, inequities for rural communities, and high-barrier program elements (e.g., strict policies around missed doses, mandatory supervision), repeatedly occurred throughout participants’ narratives.



SUB-THEME A

Safer supply substance options

FEW PEOPLE REPORTED that the current opioid agonist treatment and safer supply options were adequate for them to considerably reduce or eliminate their use of drugs from the illegal supply. Of those who were satisfied, most were living in urban centers (e.g. Vancouver) where they could access unique and specialized programs not available in other regions of BC (e.g. Cranbrook, Nelson, Quesnel). However, for most, current options were seen as falling short in terms of available substances, potency and comparability to the substances participants commonly used from the illegal supply:

'There's a lot of people that don't like any of the options that are out there – or they just don't find that they work for them.' (Focus Group 4 Participant, Cranbrook)

'Cause I haven't done any, like, prescribed drugs that actually give you the same, like, give you the feeling that street drugs do, right.' (Jack, Quesnel)

And so people continued to use from the illegal supply *'Most users are still using some form of street drug or another.'* (Oscar, Vancouver)

One participant summarized the current state of safer supply substances offered, saying:

'Yeah, there's still a lot, a lot, a lot of problems. It's a small – yeah, it's a step in the right direction and to a lot of people outside of this thing, probably it's a huge step. And it is a big deal. But there's still a lot of, yeah, it's still very restrictive. I mean, all the substances, even for obvious things like opiates, stimulants are still, you know, just sort of like close to what people need and want.' (Kelly, Victoria)

i. Opioid safer supply options

Of the 2019 survey participants who reported an opioid preference (n=405), 57.8% (n=234) preferred heroin and 32.8% (n=133) preferred fentanyl. Preference for heroin was identified in all age groups but the proportion who preferred heroin over fentanyl increased with age and differed between geographic regions (Ferguson et al., 2022).

Of 2021 survey participants who reported any illegal opioid use (n=347), 15.3% (n=53) were receiving a prescribed supply of opioids (Palis & Slaunwhite, N.D.). Of the 2021 survey participants who were interested in accessing opioid agonist treatment and/or a safer supply of opioids (n=355), heroin (46.5%, n=165)

and fentanyl powder (22.5%, n=80) were most commonly preferred. Differences in preferences were observed between geographic regions, genders and sexual orientations (Ferguson & Buxton, N.D.-a).

These data are further substantiated by qualitative findings from interviews and focus groups where participants emphasized the reasons why many believed it was important to have heroin and fentanyl as accessible safer supply options. Of the interview and focus group participants, 80.3% (n=61) reported any opioid use in the last month (not including opioid agonist treatment). Many participants shared that heroin and fentanyl were not interchangeable with other opioids as people use them for their unique medicinal, euphoric, and other properties. As one participant explained:

'You won't find one guy out there saying... I'm using fentanyl 'cause that's the wrong drug for me... They're using fentanyl because it's the right fucking drug to use... You know what, we're using fentanyl whether you like it or not, whether we're on safe supply or not... Give me fentanyl. We're off the street.' (Focus Group 5 Participant, Nelson)

Several participants suggested the preference for heroin and/or fentanyl was known to policy makers but ignored:

'Cause so many years I've used down or fentanyl or heroin or whatever, street grade. Which is pretty strong. The hydromorph — it's just not strong enough. It's pharmaceutical grade. It's meant for pain. But it's not — it doesn't adequately address the person's cravings for their heroin or their opioid that they want. They want that rush... To me — they're going halfway with it... they just go halfway then they draw the line and say, no, no, no. Well, then why do you have it?' (Elliot, Quesnel)

Many participants emphasized that not only are heroin and fentanyl preferred but they are necessary options for safer supply to reach its goal of reducing peoples' reliance on the toxic, unregulated supply. Without these options, minimum needs are not being met with respect to potency and sought-after effects and people will continue to use from the illegal supply while being on prescribed alternatives. This may limit the potential for safer supply to reduce overdose deaths if people continue to use from the toxic, illegal supply.

'People need to feel they get something that's the equivalent of what they were using. Not like five, six steps down from it. Yeah, like somebody using fentanyl, trying to replace that with Dilaudid or hydromorph is — they're using their whole supply in one shot in the morning and they're screwed by noon.' (Thomas, Quesnel)

'The safe supply options are just not strong enough opiates... it seems ridiculous and I know there's stronger opiates available.' (Isabelle, Cranbrook)

Current safer supply options were being used as a harm reduction measure by many participants, to supplement and stabilize their use of illegal drugs. However, because of the limited options – they were not able to use safer supply as an alternative to unregulated drugs:

'Yeah, hydromorphone doesn't work for me. And – yeah, it's – better than being sick, but it's not, you know, I enjoy or want to do... There's not anything besides heroin that really works for me.' (Tristan, Vancouver)

'...Kadian, morphine... it's more of a safety or stabilizing sort of function rather than a personal choice.' (Oscar, Vancouver)

Interview and focus group participants provided nuanced responses about why other opioids, such as hydromorphone (e.g. Dilaudid), were not interchangeable with heroin and fentanyl. As an example, one participant spoke to the negative effects they experienced from a particular opioid, sharing that *'I was [using] a lot more morphine but it was starting to upset my stomach'* and *'I'm fairly allergic to morphine. I get away with it, but it really does affect my body in an ugly way'* (Focus Group 5 Participant, Nelson). Our findings suggest, people are knowledgeable about the substances they are using and combinations of substances (prescribed or illegal) that improve or reduce their quality of life.

Participants specified why they reported a preference for either heroin or fentanyl in the context of safer supply. Participants who preferred heroin shared that their preference was based on heroin producing a longer lasting high, unique euphoric properties, fewer undesirable effects (including a reduced risk of overdose relative to fentanyl), and better behavioural and physiological effects (e.g. higher functioning, less sleepy).

'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 either be rich or be willing to fucking go out and do what you have to do to get money every 10 minutes.' (Focus Group 3 Participant, Vancouver)

'...I still prefer heroin so my friends don't die, right.' (Focus Group 1 Participant, Vancouver)

'So I've done heroin, you know, here and there in the past. It's hard to get now. But it was always the drug that I found the

Many participants emphasized that not only are heroin and fentanyl preferred but they are necessary options for safer supply to reach its goal of reducing peoples' reliance on the toxic, unregulated supply.

‘People need to feel they get something that’s the equivalent of what they were using. Not like five, six steps down from it. Yeah, like somebody using fentanyl, trying to replace that with Dilaudid or hydromorph is — they’re using their whole supply in one shot in the morning and they’re screwed by noon.’ (Thomas, Quesnel)

most pleasurable and the most easily able to function on.’ (Oscar, Vancouver)

For participants who preferred fentanyl, there were perceptions of fentanyl being more effective for pain management than heroin. There were concerns that heroin would not be strong enough given peoples’ increased tolerance from using fentanyl.

‘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...’ and ‘fentanyl is the only thing that gives me a quality of life. Without it, there is no quality and I might as well just fucking die’ (Focus Group 5 Participant, Nelson)

People also developed a sense of familiarity with fentanyl, as participants often shared that they had not used or could not remember ever using pure heroin: *‘I don’t think I’ve never done pure fent or heroin’ (Jack, Quesnel).*

RECOMMENDATION 1: Include diacetylmorphine (heroin) in the Safer Supply Policy Directive. Implement and expand safer supply programs offering heroin.

RECOMMENDATION 2: Safer supply programs should offer various forms of fentanyl, including fentanyl powder.

ii. Stimulant safer supply options

Findings from the 2019 and 2021 surveys show that methamphetamine was the most commonly reported used substance in the past 3 days (71.7% in both 2019 and 2021) compared to other stimulants such as cocaine and crack. Differences in stimulants used were observed based on age, use of opioids, housing and employment (Papamihali et al., 2021). A majority of interview and focus group participants also reported using methamphetamine (81%, n=51) in comparison to other stimulants (crack cocaine (48%, n=30), powder cocaine (29%, n=18), MDMA (10%, n=6), other (22%, n=14)).

Among 2021 survey participants who were interested in a safer supply of stimulants (n=330), the most frequently selected one was methamphetamine (58%, n=193), followed by cocaine (powder cocaine: 12.4%, n=41, crack cocaine: 13%, n=43). Fewer people reported a preference for currently prescribed stimulants dextroamphetamine (Dexedrine) (n=21, 6.4%) and methylphenidate (Ritalin) (n=15, 4.5%). Differences in preference were observed across age ranges, gender and different frequencies of drug use (Ferguson & Buxton, N.D.-c).

Of the interview and focus group participants, 96.1% (n=73) reported any stimulant use in the past month. When asked about stimulant safer supply options, many interview and focus group participants shared that the current options available, dextroamphetamine (Dexedrine) and methylphenidate (Ritalin), could not be compared to stimulants people are commonly using from the illegal supply, as the prescribed options do not provide the effects some are seeking.

'I found it [Dexedrine] kept me awake a lot longer and it's really different than the meth. I would prefer the meth over the actual dextroamphetamine itself...I definitely don't like the way Dexedrine helps me 'cause it's not even close to the same.' (Focus Group 4 Participant, Cranbrook)

'People are going to do what they're going to do regardless. I'm going to smoke meth at some point despite or regardless of this conversation or what happens in – whatever, right. So why not make it safe?' (Ryan, Nelson)

'When it comes to cocaine I want cocaine right now. And it can be done, I'm sure the government can – I don't want no – prescribed alternative.' (Focus Group 1 Participant, Vancouver)

While some reported a preference for a safer supply of the illegal stimulant they were currently using, others noted that people may not be using their preferred stimulant due to barriers such as financial constraints.

'I'd do a lot more cocaine than I would do meth. But cocaine is more expensive than meth on the street.' (Ariel, Kelowna)

‘So I’ve done heroin, you know, here and there in the past. It’s hard to get now. But it was always the drug that I found the most pleasurable and the most easily able to function on.’
(Oscar, Vancouver)

Similar to opioid use, many people reported continued use of illegal stimulants due to dextroamphetamine (Dexedrine) and methylphenidate (Ritalin) not having the desired effect or meeting peoples’ needs:

‘But the meth has — it became a replacement for Dexedrine ‘cause I didn’t want to be on Dexedrine anymore.’ (Kyle, Sooke)

However, even among those whose preferred stimulant safer supply was dextroamphetamine (Dexedrine) and methylphenidate (Ritalin), some disclosed that they continued to use illegal stimulants as they found access to prescribed stimulants was restricted by prescribers. For example, some participants shared requesting a prescription for dextroamphetamine (Dexedrine) or methylphenidate (Ritalin) and being denied due to mental health or other diagnoses. BC Centre for Substance Use prescribing guidelines recommend that prescribers be cautious of risks, including stimulant-induced psychosis, when deciding whether or not to prescribe stimulants to someone at risk of overdose or other drug-related harms (BC Centre on Substance Use, 2022). For some, these concerns were based on inaccurate perceptions of their experience with stimulants:

‘I was on Dexedrine and Ritalin my whole life, right... They won’t put me on back again, but I need it... because apparently I’m going schizophrenic because I smoke too much meth. But that’s not why. He [prescriber] said no to multiple clients... The thing is I just got off the Mental Health Act.⁴ So I don’t have to take my schizophrenic pills anymore. So legally he should be able to put me back on Dexedrine.’ (Focus Group 2 Participant, Quesnel)

Several interview and focus group participants emphasized the need for stimulant safer supply options that were comparable or equivalent to illegal stimulants, particularly given the experiences of opioid overdose among people who use stimulants and those who do not typically use opioids.

Many participants shared experiences of overdose due to contamination of stimulants with opioids or cross-contamination within networks of people who use drugs (for example, sharing equipment that contains opioid residue). This is discussed in more detail in sub-theme B: mode of use options, in the context of sharing inhalation equipment.

4 The Mental Health Act is a law that aims to determine when a person becomes an involuntary patient, due to mental health conditions and a ruling that the person is at risk of harming themselves or others. Under the Mental Health Act, a person cannot refuse treatment, including medication (Mental Health Act, 1996).

'I don't like doing opioids. I don't knowingly do them or — but I've been, I call it, poisoned three different times maybe in the last four years by them.' (Focus Group 1 Participant, Vancouver)

Beyond reducing the risk of overdose, our quantitative data and qualitative findings provide insight into the different reasons people use particular stimulants and, for some, in combination with particular opioids. As interview and focus group participants articulated, stimulants are central to the lives, functioning, and well being of some and this needs to be recognized to support access to and expansion of stimulant safer supply options. As results from the 2021 survey suggest, there continues to be limited access to a safer supply of stimulants. Of those who reported any illegal stimulant use (n=437), only 6% (n=26) received a prescription for stimulants (Palis & Slaunwhite, N.D.).

Findings from the 2019 survey indicate that over half (59.9%) of participants reported using opioids and stimulants together. Open-ended survey answers revealed that, of these participants, the majority (62%) used stimulants together with opioids to access the unique drug properties and effects of stimulants (i.e. desire for a specific type of high) (Steinberg et al., 2022).

From our qualitative findings, some reported using methamphetamine for managing physical pain and/or illness and/or their emotional and mental wellness. For many, methamphetamine allowed them to manage attention deficit hyperactivity disorders (ADHD) and/or mental health issues, such as depression.

'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.' (Focus Group 2 Participant, Quesnel)

'Stimulants provide me motivation and focus. I'm severely ADHD. I suffer from adult ADHD. It manifested at approximately the age of 26. My symptomology has worsened over the course of time... I was unable to seek the medications that I needed through the medical system.' (Morgan, North Vancouver)

As some disclosed, self-medicating with illegal stimulants improved their daily functioning, and as a result, their quality of life (for example, increased alertness and energy, better performance at work, chores, ability to socialize, and balancing the sedative effects of opioids and/or lengthening the effects of opioids).

'It's like — you got your upper and it keeps you up and you have that mellow feeling from, like, the body pain goes away when I mix it with the down. So it's like I'm awake and my pain's gone and then I can stay awake.' (Focus Group 4 Participant, Cranbrook)

'Positive impacts would just be the elevation in mood and the elevation in my energy so that I'm able to do a bunch of loads of laundry and household chores and mopping and very exciting stuff like that.' (Charlotte, Victoria)

As participants explained, not all stimulants produced the same effects and people sought out particular stimulants based on the effects they needed. In addition, different people could experience the same stimulant in different ways. For example, some participants shared that particular stimulants were not

effective for self-medicating or improving daily functioning and could cause negative side effects such as psychosis or paranoia:

'The side effects are all different – depending upon people... [Some] go into, like, immediate psychosis whereas others can, you know, go through it for two weeks, even three weeks.' (Focus Group 6 Participant, Nanaimo)

Participant responses highlight the need for safer supply options given that individuals react differently to substances.

RECOMMENDATION 3: Provide a regulated supply of stimulants people are accessing from the illegal supply (e.g. methamphetamine (e.g. Desoxyn), cocaine), in addition to currently available prescribed alternatives (e.g. Dexedrine, Ritalin).

iii. Benzodiazepine safer supply options

Survey findings indicate that the percentage of participants who reported using benzodiazepines (other than Xanax) in the past 3 days increased from 9.5% in 2019, to 20.7% in 2021 (Ferguson & Buxton, N.D.-b). However, access to a safer supply of benzodiazepines is limited. As the 2021 survey findings show, of participants who reported any benzodiazepine use (n=125), only 4.8% (n=6) reported receiving a prescribed supply of benzodiazepines (Palis & Slaunwhite, N.D.).

Of the interview and focus group participants, 36% (n=27) reported any benzodiazepine use (intentional or due to exposure to a benzodiazepine contaminated opioid supply) in the last month. Many concerns regarding contamination of the illegal opioid supply with benzodiazepines were raised by interview and focus group participants, including the severe risks associated with benzodiazepine withdrawal, increased risk of overdose, naloxone not reversing the sedative effects of benzodiazepines, as well as loss of memory and consciousness and being victimized (e.g. theft, physical or sexual violence).

'Benzos... even Narcan [naloxone] can't really help you.' (Ariel, Kelowna)

'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)

Participants discussed that many have developed benzodiazepine dependencies from being exposed to it in the illegal supply, putting them at risk of severe symptoms (e.g. seizures) associated with abrupt benzodiazepine withdrawal, which can be especially dangerous if a person is withdrawing without support and supervision.

'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)

'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)

In addition to participants wanting benzodiazepines to manage their benzodiazepine withdrawal symptoms, some sought benzodiazepines for their unique properties and effects when combined with opioids.

'Usually when there's benzos in it you get more of the effect that you want. You're trying to get high... Makes it stronger, right.' (Jack, Quesnel)

In light of this, there was an emphasis on the need for safer supply to include benzodiazepine prescribing. As participants shared, people with a benzodiazepine dependency or persons who use benzodiazepines to self-medicate will continue to access the toxic illegal supply to meet their needs even if they are on opioid agonist treatment or safer supply, if their benzodiazepine needs are not being addressed.

'I have to take benzos otherwise I'd die.' (Cameron, Maple Ridge)

'The methadone does nothing for the benzo withdrawal.' (Focus Group 2 Participant, Quesnel)

'A lot of people are wired to the benzos... If they get fentanyl without benzos in it, they're still sick.' (Focus Group 3 Participant, Vancouver)

RECOMMENDATION 4: Safer supply programs need to include benzodiazepines and prescribers should consider, on a case-by-case basis, providing a safer supply of benzodiazepines to those at risk of benzodiazepine withdrawal or experiencing health concerns that can be addressed with benzodiazepines. Policies and guidance that account for the relative risk of not prescribing benzodiazepines leading to peoples' continued reliance on an unregulated, contaminated supply are needed.

Many interview and focus group participants shared that the current options available, dextroamphetamine (Dexedrine) and methylphenidate (Ritalin), could not be compared to stimulants people are commonly using from the illegal supply, as the prescribed options do not provide the effects some are seeking.

Mode of use options

Currently, safer supply are mostly offered in oral forms. There are limited injectable forms and no inhalable forms of safer supply in BC. Evidence suggests that tablet formulations are not acceptable to many people leading them to injecting tablets not meant for injection (McLean et al., 2017; Roy et al., 2011; Wurcel et al., 2015) or continuing to use from the illegal supply in order to inject or smoke their drugs. Moreover, there is a large evidence base demonstrating the effectiveness of injectable forms of safer supply (Meyer et al., 2022; Oviedo-Joekes et al., 2021).

Our findings demonstrated that for many the formulation or mode of use of available safer supply substances was also very important in determining safer supply acceptability and access. Participants provided in-depth insights into the reasons they chose particular modes of use and why restricted mode of use options for safer supply was a limiting factor to safer supply's effectiveness. As one participant shared:

'They need all the tools in the toolbox. You can't just have a limited supply, really. 'Cause a true safe supply got to be safe supply for all. Yeah, we definitely should have, you know, a safe supply of fentanyl for people to inject or smoke, whatever they want.' (Focus Group 3 Participant, Vancouver)

i. Injectable safer supply options

Findings from the 2019 survey indicated that among people who reported using opioids in the last 3 days (n=369), people commonly smoke or inject their substances (39.8% (n=147) exclusively smoke, 18.4% (n=68) exclusively inject, 28.2% (n=104) smoke and inject). Differences were observed based on geographic region, gender, age, using drugs alone, owning a take-home naloxone kit and using methamphetamines. Only 14.9% (n=55) of participants reported regularly using opioids by snorting, swallowing or 'other' (Parent et al., 2021).

Findings from the 2021 survey suggest that, among people who indicated a preferred mode of use for a safer supply of opioids (n=282), roughly 1/5 of participants (19.9%, n=56) would prefer to inject their safer supply of opioids (to note, modes of use were not mutually exclusive and thus participants could indicate more than one preferred mode of use for a safer supply of opioids) (Kamal et al., 2023).

Our qualitative findings provide insights into peoples' reasons for choosing to smoke and/or inject their substances and why, for many, oral prescribed alternatives do not meet their needs and may deter them

from accessing safer supply. Mirroring the quantitative data, many participants described injecting sometimes and smoking other times and making this decision based on a number of circumstantial factors: *'Sometimes I smoke it and it's better and sometimes I inject and it's better'* (Focus Group 3 Participant, Vancouver). People injected for different reasons, such as to achieve a more intense high, to have the effects of a substance kick in faster and last longer, to conserve more of their supply and resources as people discussed injecting requiring people to use less at one time than other modes (e.g. smoking):

'Injecting seems to hit faster and last longer. And then smoking it takes a bit – little bit longer to hit you, I guess, but not – get you the high that you want.' (Hailey, Quesnel)

'It's like you have to smoke a lot of it to get the high thing. But when you inject it, you only have to inject small amounts to get really high—' (Lucy, Kelowna)

As these participants pointed out, mode of use may depend on the source they are accessing. Hence, more people may be interested in injectable forms of a regulated supply than the number currently, primarily injecting in the context of a toxic unregulated supply.

Among those accessing safer supply, many participants discussed tablet formulations being inadequate in terms of dosage and strength—leading to most injecting their safer supply tablets and injecting large quantities at one time:

'I could take my entire scripts at once, inject it, and I'm still not feeling very well.' (Isabelle, Cranbrook)

These findings emphasize the need for safer supply substances and dosages that meet peoples' needs:

'I think that they should offer more than just the dilaudid. That they should be offering safe injectable heroin.' (Focus Group 2 Participant, Quesnel).

However, increasing dosages and expanding safer supply substances, while maintaining tablet formulations, is not sufficient. As our findings suggest, people have important reasons for injecting, some of which are tied to their preferences and rituals when using substances: *'it's just more so what people are used to'* (Focus Group 6 Participant, Nanaimo) and are *'familiar with'* (Sarah, Nelson). By failing to acknowledge this and having limited injectable

'They need all the tools in the toolbox. You can't just have a limited supply, really. 'Cause a true safe supply got to be safe supply for all. Yeah, we definitely should have, you know, a safe supply of fentanyl for people to inject or smoke, whatever they want.' (Focus Group 3 Participant, Vancouver)

safer supply options, people will continue to inject large numbers of tablets, which can cause health-related issues (Strike et al., 2021), or not access safer supply.

ii. Inhalable formulations for safer supply and safer use services

Quantitative and qualitative findings suggest that smoking is increasingly the most common mode of use among people who use opioids in BC. As one participant articulated *'I smoke nowadays — most people do'* (Focus Group 1 Participant, Vancouver).

Findings from the 2019 survey showed that 68% (n=251) of participants who used opioids in the past 3 days reported smoking opioids and, of those that reported experiencing an overdose in the past 6 months (n=109), 72.5% (n=79) reported smoking opioids in the past 3 days. Other factors that were associated with smoking opioids was gender, age, and using drugs alone (Parent et al., 2021).

Interview and focus group participants reported that the needs of people who smoke opioids and/or stimulants were not being met as there are only a few supervised inhalation sites across BC and currently there are no inhalable forms of safer supply being offered.

'Inhalation — people are not — we're not being appropriately serviced. It's all being for people mainly on opiates and opioids and injectors.' (Focus Group 1 Participant, Vancouver)

"Cause there was quite a bit of people that wanted to switch to smoking but we haven't had that option yet [due to there being no accessible supervised inhalation site]." (Chloe, Victoria)

'You can't put a pill of Dilaudid or hydromorph on a tinfoil. You can't blow out a smoke cloud of Dilaudid.' (Focus Group 6 Participant, Nanaimo)

Qualitative findings provided insights into why smoking may be more common than injection among people who use opioids in BC, as well as, in some aspects, how this may relate to the toxic, illegal supply that increasingly contains extreme concentrations of fentanyl.

Many interview and focus group participants discussed reducing the risk of overdose as a major reason for choosing to smoke their substances. Of concern, people may overestimate the capacity to reduce overdose risk by smoking. This was also reflected in findings from the 2021 survey where, of participants who provided an open-ended answer to why they preferred to smoke their opioids in the past month (n=165), 13.3% (n=47) indicated that they preferred to smoke due to a perception that it reduced their risk of overdose (Kamal et al., 2023). As BC Coroners data indicates, smoking was the leading mode of use among people who died from an illicit drug toxicity death in 2021 (BC Coroners Service, 2022). Thus our findings point to an urgent need for harm reduction communication to provide accurate information around risks of smoking and the measures people adopt to reduce their overdose risk when they have little control over the contaminated supply they are accessing.

'I'm pretty safe and I make sure my girlfriend's pretty safe... Yeah, she doesn't inject without me being there. She'll smoke a couple dragons but she won't do a shot unless I'm there.' (Tristan, Vancouver)

'Because I only smoke it, I'm not concerned about overdosing on it.' (Amber, Vancouver)

Some other reasons 2021 survey participants indicated for why they preferred to smoke opioids in the past month (n=165) included less risk of injection or blood borne disease (23.9%, n=84), prefer not to inject (20.7%, n=73), preference for the effects and practice of smoking (13.1%, n=46), better able to control dosage (9.3%, n=33), smoking is more social (7.1%, n=25) and can no longer inject (5.7%, n=20) (Kamal et al., 2023). As interview and focus group participants shared, some primarily or exclusively smoked their substances, as it was associated with a less intense and more manageable 'high', particularly when using potent substances such as fentanyl or substances with unknown contents.

'If you've got enough in your system maybe smoking it's okay. But to get it in your system sometimes injecting it or other ways are better to get it in your system enough that you actually feel the effects properly.' (Focus Group 5 Participant, Nelson)

Smoking substances was perceived as more social for some, associated with less stigma than other modes, and easier to set up 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 — when I leave — going to smash more.' (Focus Group 6 Participant, Nanaimo)

'Smoking is just a quicker, easier method' (Samuel, Victoria) and *'when you're doing needles it's a big fucking procedure, holy moly, man'* (Theodore, Victoria)

Some people transitioned to smoking due to developing issues with other modes of use (e.g., poor vein health for people who commonly injected their substances or damaged nasal septum/passages for people who snorted 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.' (Focus Group 6 Participant, Nanaimo)

'Inhalation — people are not — we're not being appropriately serviced. It's all being for people mainly on opiates and opioids and injectors' (Focus Group 1 Participant, Vancouver)

Our findings emphasized that many chose or preferred to smoke instead of inject because they perceived smoking to be an effective way to considerably reduce or eliminate their risk of overdose (despite there being significant risks of overdose associated with smoking substances). With this in mind, peoples' preferred ways of using drugs may evolve and change if they are provided with a safer supply that presents considerably less risk of overdose. For example, some may choose to inject if they had a regulated supply that reduced their concerns around overdosing. This variable relationship between mode of use, particular substance, and substance potency was evident in participants' explanations of their decisions to smoke or inject. As one participant shared, even contaminants could influence ones' common mode of use:

'I've watched a lot of guys, like, who were poking at the shit before [injecting] — start smoking it a little more rather than shooting it because of the benzos.' (Focus Group 4 Participant, Cranbrook)

Findings from the 2021 survey indicate that, of those who reported a preferred mode of use for a safer supply of opioids (n=282), 73% (n=206) reported smoking opioids in the last 3 days, whereas when asked about preferred mode of use for a safer supply of opioids, 62.4% (n=176) reported a preference for smoking (Kamal et al., 2023). These findings show that over half of people would prefer to smoke their safer supply of opioids, suggesting that inhalable forms of safer supply should be made available. In addition, inferences about substance use preferences cannot be made based on current patterns as people who use drugs have adapted and continue to adapt their substance use practices to reduce harms associated with drug prohibition and the toxic, illegal supply.

Not all participants believed that smoking their drugs reduced the risk of overdose—and for these participants, their own experiences of overdose via smoking or experiences of those around them formed the basis for the urgent need for safer supply options for people who smoke opioids.

'Yeah, I'd like to be able to have smokable and injectable — of heroin and fentanyl, right.' (Focus Group 2 Participant, Quesnel)

In addition to inhalable forms of safer supply, our data suggests that a common factor that appears to be contributing to overdoses is people sharing smoking supplies and being exposed to substances and dosages that they are not expecting or accustomed to. Access to smoking supplies was not flagged as a major issue by most as participants reported that smoking supplies were relatively easy to access in BC. However, many called for supervised inhalation sites:

'And there needs to be a place where people can actually — doing inhalant things and be able to be safe too. 'Cause a lot of people die—from fucking doing—dragons.' (Focus Group 1 Participant, Vancouver)

'I think they should have one for the OPS but their excuse is there's not enough proper ventilation in the — which is bullshit because all they got to do — the place is small enough...Or let the people smoke outside. Like stop fucking chasing them away and calling the cops 'cause they're smoking outside. They want to be somewhere where they can be found if they—.' (Focus Group 6 Participant, Nanaimo)

Supervised inhalation sites can reduce adverse overdose outcomes by supporting people to use in a supervised/observed setting, providing a space to reduce rushed use, and enabling a timely overdose response. Similar to supervised injection sites, they can also provide people with harm reduction education such as the risks associated with sharing smoking supplies, particularly in the context of a toxic illegal supply:

“Cause people use pipes for meth and for down, right. So now that they’re free [pipes in interior BC are now free of cost whereas there was initially a fee when they became available], people are less likely to share them and then get, like, a pipe full of down when they’re trying to smoke side and die ‘cause, like, that’s happened in our community.’ (Focus Group 4 Participant, Cranbrook)

‘I can’t just look at it and see, like, oh, yeah, I know what that is. Like sometimes pipes are — you can’t even see in the pipes, right. They’re so caked with this or that. You don’t know what’s all in there.’ (Jacob, Cranbrook)

Peoples’ preferred ways of using drugs may evolve and change if they are provided with a safer supply that presents considerably less risk of overdose.

RECOMMENDATION 5: Make injectable alternatives to oral forms of safer supply available.

RECOMMENDATION 6: Make inhalable forms of heroin and fentanyl, as well as other safer supply options (e.g. stimulants), available.

RECOMMENDATION 7: Expand existing overdose prevention sites to allow for supervised inhalation (indoor and outdoors).

Model considerations

IN ADDITION TO CURRENT SUBSTANCE AND MODE OF USE OPTIONS not addressing the needs of many, participants communicated that existing safer supply programs are difficult to access. Reasons for this included constraints around prescribers, rural communities, policies and practices around missed doses and requirements of being supervised and on-site for daily dispensing. These barriers increase the likelihood of people not accessing or discontinuing use of safer supply programs.

While this report is focused on safer supply, some findings related to opioid agonist treatment are included in the following section where they are applicable to safer supply. For example, many existing prescribed safer supply programs are modelled after opioid agonist treatment models and as such the

While this report is focused on safer supply, some findings related to opioid agonist treatment are included where they are transferrable to safer supply.

barriers to accessing opioid agonist treatment participants discussed, including prescriber practices, missed doses and take-home doses, were applicable. Additionally, when discussing model considerations and barriers to access, it was common for participants to discuss opioid agonist treatment and prescribed safer supply program constraints interchangeably or in parallel. Below, references to opioid agonist treatment are clearly differentiated from safer supply, where possible.

i. Perceptions of prescriber practices

Findings from the 2021 survey indicate that, of those who used illegal opioids, stimulants and/or benzodiazepines in the last 3 days (and thus would have been eligible for safer supply) (n=491), only 16.5% (n=81) were receiving a prescription for a Risk Mitigation Guidance (Pandemic Prescribing) substance (i.e. the main safer supply clinical guidance at the time of the survey) (Palis & Slaunwhite, N.D.). Moreover, of the participants who responded to the question 'have you heard of pandemic prescribing/risk mitigation guidance' (n=469), only 38.3% (n=180) had heard of it and of these only 19% (n=89) were receiving a prescribed supply. 9% (n=15) of participants, among the 167 who had tried Risk Mitigation Guidance (Pandemic Prescribing) reported trying but physicians would not prescribe (Liu & Buxton, N.D.). This data demonstrates that despite BC's Risk Mitigation Guidance (Pandemic Prescribing) and Safer Supply Policy Directive, there is limited awareness and knowledge among people who may benefit from prescribed

alternatives. As demonstrated by our quantitative and qualitative data, some of this may be related to prescriber practices and challenges associated with the therapeutic relationship between prescribers and people who use drugs.

Among interview and focus group participants, many had limited awareness or knowledge of definitions and distinctions between opioid agonist treatment, Risk Mitigation Guidance (Pandemic Prescribing), and safer supply.

'Well, it'd be nice to kind of have a list of other options too. 'Cause a lot of people aren't knowledgeable to exactly know what they have.' (Focus Group 6 Participant, Nanaimo)

"Cause I didn't really know anything – well, I didn't know there was different fentanyl's. I didn't know there was different ways to take it.' (Chloe, Victoria)

When asked where they had heard about various options, it became clear that many were reliant on prescribers for learning about the objective of safer supply and what options were available to them. In some cases, prescribers would only share information about the options they recommend (e.g. opioid agonist treatment) rather than providing information about the complete range of options available in order for people to make an independent and informed decision.

'I should have gone on Kadian instead. 'Cause that's what my doctor also gave me the option of. But he never gave me the option of the other ones. Only Kadian and methadone.' (Ariel, Kelowna)

'They suggested that program and I was, like, yeah, okay... And then they basically said, well, you don't have to stop using but, like, that's kind of the goal' (Evan, Kelowna)

Prescriber practices, or as some people who use drugs referred to it as, 'prescriber gatekeeping', influenced different stages of the prescribing process, from providing information to providing access to certain programs. As some participants shared, prescribers reserved the right to deny someone access to safer supply options and opioid agonist treatment or to make access to one option conditional (e.g. requirement to be on opioid agonist treatment to receive prescribed safer supply or requirement to be on one or the other).

'So we're still trying to get doctors to prescribe the dillies [Dilaudid] here in town. So that's kind of where we're at.' (Focus Group 4 Participant, Cranbrook)

'Q: Have you tried to get drugs through Pandemic Prescribing? A: No. Because my doctor is not keen... Kadian I would prefer but my doctor has never let me on it.' (Samuel, Victoria)

'Dr. [identifier removed] cut me off benzos and that's when it started my fentanyl journey, right. So I got cut off benzos and, yeah, I was really, really sick. And he didn't really give a reason other than because I was on methadone already and I was on it for years. And my general health practitioner was prescribing it with psychiatrists. And the psychiatrists were good with giving it to me, but Dr. [identifier removed] wasn't. So he made me choose between either methadone or clonazepam [benzodiazepines].' (Focus Group 5 Participant, Nelson)

Prescriber discretion resulted in considerable variation between regions as the landscape of safer supply in a municipality and region was determined by prescriber attitudes:

'Yeah, it also depends though — literally where you're at in B.C. 'Cause, like, I found — came to notice that literally here in Nanaimo everybody is quite limited to what they can get. Even though, like, you could literally go to a different city and be given, like, anything — opposed to, you know — what we have available here. And it doesn't make any sense whatsoever.' (Focus Group 6 Participant, Nanaimo)

The reasons behind prescribers' choice to share or restrict access to particular information or prescribed alternatives were not clear to participants. Many expressed concerns around prescribers using their discretionary power provided to them under the Safer Supply Policy Directive and Risk Mitigation Guidance, to push ideals around abstinence or opioid agonist treatment, and implicit biases and stigma towards people who use drugs (for example perceptions around the autonomy of people who use drugs).

'Because when you get multiple doctors and you're trying to talk to multiple doctors about your situation, things get lost in translation. And you end up missing, like, they'll prescribe it [methadone] in a certain way and you get carries or whatever. And then the next week your carries are taken away because it's another doctor who doesn't believe that you should have carries.' (Focus Group 2 Participant, Quesnel)

'They're [health care providers, prescribers] letting their personal — judgement interfere with their professional. And that's not right' (Focus Group 6 Participant, Nanaimo) and *'The stigma that we're dealing with comes from, in my observation, the professionals themselves more than anyone else.'* (Christina, Vancouver)

Participants also pointed out that prescribers may not be in touch with the nuances of peoples' substance use preferences and needs (e.g., differences between substances and their effects, necessary dosages) leading to prescribing practices, both around safer supply and opioid agonist treatment, that may not be meeting peoples' base needs:

'My old lady is maxxed out taking, like, no longer legally prescribe her any more milligrams [of Ritalin]. But the stuff only lasts four hours in her system or five hours or whatever, right. So half the day she's, you know, got her wits about her and whatever. Then the rest of the day she's frantic. Like, oh, the puzzle pieces don't fit together... If the day was four hours long, bingo, right. We got it. Good job pharmaceutical company and doctors and everything...But it's not...' (Ryan, Nelson)

'They wouldn't up me and they wouldn't lower me and they just kept me at the same one [methadone dosage] and it just wasn't working.' (Eleanor, Victoria)

Participants expressed concerns around prescribers relying heavily on prescribing guidelines and not considering unique and distinct needs, particularly around dosages, that make a 'one size fits all' approach ineffective:

'It should be based on what a person needs and not by what the regulations. Some people may need more, some may need less.' (Focus Group 6 Participant, Nanaimo)

Beyond not meeting peoples' needs, participants spoke to the harms that can arise when people are concurrently using from the illegal supply and safer supply and/or opioid agonist treatment programs. As the participant below articulates, due to the constraints of current safer supply and opioid agonist treatment programs that prevent many people from using these programs as alternatives to the illegal supply, many are using safer supply and/or opioid agonist treatment for stabilizing purposes or to supplement their use. This can lead to increasing peoples' tolerance, which then causes people to need to use more from the illegal supply:

'So when I had to stop going to the clinic and stop receiving those substances [methadone and morphine] from the government I discovered that my tolerance had been jacked way the fuck up. I was maintaining on heroin a point a day for a year and a half by myself no problem. After just a few months with the government supply, my tolerance had been jacked up to the point where I literally needed five or six points a day to get by... I would have never gone to them. I would have never ingested those substances that I didn't want anyway in the first place. I would have continued on doing it on my own way if able. Because now I'm really trapped. They've got me a position where I can't even afford to leave them alone now.' (Christina, Vancouver)

Contrary to what some prescribers and policy makers may believe, expanding safer supply to offer higher doses and substances that meet peoples' needs in terms of potency and effects can increase overall safety from overdoses and other substance-related harms by reducing or eliminating peoples' use of the unregulated supply and peoples' engagement with the illegal market and associated risks. Moreover, a safer supply that reflects peoples' use of substances from the illegal supply can contribute to minimizing concurrent use of prescribed substances and substances that have historically only been available through the street supply and complications associated with needless polysubstance use.

RECOMMENDATION 8: Regulatory bodies, such as the College of Physicians and Surgeons of BC, should be transparent about audit processes and guidelines in place to not only detect harmful prescribing practices among healthcare providers but to monitor and detect harms resulting from the absence of safer supply prescribing.

RECOMMENDATION 9: Public health and harm reduction organizations should develop educational and advocacy tools that can 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

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

'It should be based on what a person needs and not by what the regulations. Some people may need more, some may need less' (Focus Group 6 Participant, Nanaimo)

ii. Constraints for rural communities

Our qualitative research included rural municipalities, such as Quesnel, Cranbrook, and Nelson. Interviews and focus groups revealed key concerns around prescriber models of safer supply in these communities. As one participant put it: *'I was going to say that Vancouver has lots of options, we don't.'* (Focus Group 4 Participant, Cranbrook).

Many people in rural areas were reliant on one or two prescribers for safer supply and opioid agonist treatment, making people exceedingly dependant on prescribers' perceptions and practices as well as their availability. Limited prescriber availability was informed and compounded by limited healthcare and social service resources in rural communities.

'Like two weeks ago it [safer supply prescriber hours] was on a Thursday, and now, this past week, it was on a Monday. And just kind of been shifting because he's been working up at the hospital for another doctor. Taking shifts.' (Focus Group 5 Participant, Nelson)

'He told the old lady that he wants everyone on the methadone in his form of – it's under his thumb now. He's the prescribing doctor in this area so now, wah, hah, hah, he's got all this power. He runs your life. You miss one pickup of your dailies, and I'll kick you off and now you're going to be sick.' (Ryan, Nelson)

Rural areas tend to have limited service and transportation options, meaning that people were required to travel farther to access services or prescribers that dispense safer supply and opioid agonist treatment. Given this, traditional, inflexible hours of operations and supervised, daily dispensing models posed a number of challenges.

'I know that it can be problematic when it's not reaching people that are not able to get it in town to get on it. Or that are too sick to come out of their house to come down to visit a doctor. I'd like to see something that would be accessible...' (Focus Group 2 Participant, Quesnel)

'I continue to do – my fentanyl, because if I miss a Saturday [of their prescribed Kadian] and my drugstore's closed on Sunday, so I pick up Sunday's on Saturday... But if it's on a long weekend and I end up missing Saturday, they take Sunday, Monday off. If I miss, then Tuesday I'm out. I've been shut right off.' (Focus Group 5 Participant, Nelson)

iii. Policies and practices around missed doses

When sharing experiences of accessing safer supply or opioid agonist treatment, a persistent theme was being ‘cut-off’ by prescribers due to missing a few days of their prescribed supply. This practice around missed doses was perceived as a major barrier, as many people ceased enrolment in the program altogether due to being ‘cut-off’.

‘But for me, like, using the safe supply would be having that safe supply there all the time. But it’s not there all the time because – doctors shut you down after two days. And take you all the way back down to zero and build you back up again. To me, that’s a dangerous supply... why am I even on safe supply? The biggest safe supply I have is right there and called fentanyl on the street. It’s there seven days a week whether I miss it or I don’t miss it and nobody’s ridiculing me if I do.’ (Focus Group 5 Participant, Nelson)

‘If you miss two pickups or something, he cuts you in half or cuts you right off of your [methadone] – and it’s like, you know – you’re putting unrealistic expectations on these people. You’re setting them up for failure. You’re supposed to be helping.’ (Ryan, Nelson)

Our findings also point to the circumstances and barriers that some people who use drugs encounter such as precarious housing and employment that make missing a dose fairly common.

‘Not having the motivation to go get up and get a fucking prescription for something [in this participants’ case – Dialudid] that takes fucking two months to be able to notice a difference in my day-to-day fucking life. When I’m already dope sick all fucking day it’s hard to drag my ass to a fucking clinic when it’s not going to work with me and my hours when I fucking barely am able to manage getting dope enough to be un-dope sick most of the time... That’s eleven weeks to get to a stable dose. It’s impossible if your medication isn’t delivered. Do you know how many times I’ve had to reset because I’ve fucked up and, like, you’re running around trying to figure out how to make money in a place where you can’t get a fucking job. You don’t have a place to sleep. You’re forced to stay outside. You can’t have any sort of fucking personal belongings because it fucking – it gets stolen all day by people who are in the same fucking shitty desperate situation you’re in.’ (Parker, Quesnel)

With this in mind, participants called on prescribers to be aware of and practice in a way that took into account their circumstances and the barriers they face.

As some participants emphasized, cutting someone off of their safer supply or opioid agonist treatment is not necessarily protective because people are at greater risk if they access the illegal supply to replace their prescribed supply to avoid withdrawal symptoms. This can place them at greater risk as they may potentially have a reduced tolerance and are accessing a supply of unknown contents and potency.

‘Your chance of overdose...like, they [healthcare providers, prescribers] think it’s high if you miss two days [of prescribed supply] in a row. But, like, it doesn’t even touch fentanyl anyways, like,

I'm not going to friggin' overdose. Give me a break, you know what I mean.' (Focus Group 2 Participant, Quesnel)

Being cut-off is de-stabilizing as participants reported that access to a safer supply or opioid agonist treatment factored into their budgets and schedules. Losing access can have serious consequences on peoples' housing, mental health, relationships, and employment.

'I was going to say that Vancouver has lots of options, we don't' (Focus Group 4 Participant, Cranbrook).

'With me I had a prescription for M-Eslon the past two years...I was an assistant manager at a recovery house... And I moved back here [Nelson] and I managed to get kicked out of the house that I was staying in and was kind of homeless looking for a place. And in that time...started using again because I ran out of my prescription and missed my appointment with Dr. [identifier removed]. So they cut me off and I haven't been able to get in to see a doctor in the past couple weeks...And, of course, fentanyl went boof.' (Focus Group 5 Participant, Nelson)

'I was sort of sick. I'm a heart patient and stuff. And I've had my back broken. I couldn't get up and come down to the clinic. So Dr. [identifier removed] cut me off. I was down to 190 mls [on] methadone. And he cut me off cold turkey while I was living in a camper. So after that I decided never to go back on it again so — and went back onto fentanyl off the street.' (Focus Group 5 Participant, Nelson)

Missed doses signal the need for more support and low-barrier services that are easier to access. Cutting people off from their safer supply or opioid agonist treatment does not address the issues behind missed doses.

'I just get carried away with my day and then the next thing you know, I go, oh, shit. It's eight o'clock. I missed the pharmacy, right. And then if it's been a crazy week, next thing you know I've missed three days and they're cutting me off. And now all hell is going to break loose 'cause I'm — got to get — I'm going to get better one way or another, right.' (Focus Group 2 Participant, Quesnel)

iv. Perception of take-home doses

Participants provided thoughtful recommendations around take-home doses, suggesting that while precautions and measured action would be needed around safety, take-home doses are necessary for promoting access to safer supply or opioid agonist treatment. Moreover, take-home doses can contribute to autonomy and participation in various aspects of life including employment.

'The carries and the wasting of money... Making people go every single day [for their safer supply or opioid agonist treatment] in this open-air jail. I think that's a disgrace...' (Arthur, Vancouver)

Take-home doses were perceived as necessary as many people accessing safer supply or opioid agonist treatment continued to use from the illegal supply because there were not able to use at their desired times and in their social or preferred contexts.

'And at the beginning [of being on identifier removed – safer supply program] I was getting a vein but it was pretty high doses... So I brought them down actually, and I just go once a day now as opposed to three times a day. And a lot of that is because I like to get high at home and my tolerance was through the roof. I know it sounds a little silly but it's true.' (Amber, Vancouver)

Models requiring supervision and daily dispensing limited employment and social opportunities for people and was not realistic for people with personal or professional obligations (for example, people working full-time who did not have accommodating employers).

'I already have a full-time job. I don't need another one going back and forth to the clinic.' (Tristan, Vancouver)

'I think I would like a prescription without supervision. So having carries. But – just 'cause it allows the most flexibility and freedom in my day-to-day life.' (Oscar, Vancouver)

In addition, supervision was a deterrent altogether for some people interested in accessing safer supply.

'Because who likes getting supervised, right. Makes me like want to go sneak it or something instead. You know what I mean?' (Hailey, Quesnel)

'I want it to be just like alcohol. That's it. Bottomline. I am so sick of being treated like a toddler. Why does somebody supervise me... it gives them a lovely opportunity to treat me like shit on a daily...' (Christina, Vancouver)

‘No one size fits all’

Reflecting on unique and personal substance use preferences and safer supply needs to inform the design and implementation of safer supply programs

INTERVIEW AND FOCUS GROUP DISCUSSIONS often revolved around the concept of ‘no one size fits all’ when it comes to peoples’ substance use preferences and patterns and resulting needs in the context of safer supply. Various aspects of choice and constraints that are unique from person to person were raised as important considerations in the design and implementation of safer supply programs. It became clear that many safer supply models are needed to successfully reach people who use drugs. Key considerations highlighted by participants are included below.



SUB-THEME A: Case-by-case risk assessments

Not all people who use drugs are equally at risk of overdose. Precautionary and safety measures around safer supply should be determined on a case-by-case basis, accounting for individual mental health conditions, circumstances, and access to supports. For example, the benefit-risk ratio for take-home doses will not be the same for all people who use drugs. As the participants below indicate, supervised programs may be necessary to support some in taking precautions or, on the other hand, supervised programs may be desired by some who draw benefits from being on-site and interacting with others. For others, supervised programs are not needed or desired.

'I think both supervised, non-supervised would be good for – depending on how you're able to use...And then unsupervised for people that don't really need to be supervised... there's a lot of different variables around that, you know...' (Focus Group 6 Participant, Nanaimo)

'That's how I get my exercise. I go down there [to safer supply clinic] on my bike and – you know, sometimes I get – I don't get out a whole lot. I just, you know, cabin fever, whatever.' (Amber, Vancouver)

As participants explained, risk behaviors differ from one person who uses drugs to the next and thus creating highly restrictive programs based on a sub-group of people who use drugs who may engage in unsafe use could, rather than contributing to increasing overall safety, compromise the well-being of more people who use drugs who could benefit from low-barrier safer supply programs but may continue to use from the unregulated supply due to restrictive policies.

SUB-THEME B: Virtual and mobile prescribing and delivery

Participants reported that mobility and other logistical constraints need to be accounted for and should inform virtual and/or mobile safer supply programs. This is especially important to make safer supply feasible and accessible in rural communities but also applies to other groups. For example, people who have been involved with the justice system may face barriers to obtaining safer supply models that require supervision and/or daily dispensing due to conditions of release such as red-zone restrictions, house arrests requirements, or other court-imposed conditions.

'And maybe they should take into account that some people can't – they need people to help them get their stuff. So maybe you need to get enough to make sure that the people in your building that have mobility problems, that you can help them get their stuff too. So you should be able to access that.' (Focus Group 1 Participant, Vancouver)

'It'd be nice to, you know, have someone deliver out to, like, where I am. Or people that aren't mobile, like, for his dad, for instance. He's, you know, for them to get safe supply is pretty much

impossible. Yeah, 'cause he doesn't have a vehicle and he's too sick to actually hitchhike in or get a ride in from someone. Doesn't have the money to pay somebody to drive him in every day.' (Focus Group 5 Participant, Nelson)

'Q: What are some of the challenges you might face getting a prescription? A: Well, right now I'm under house arrest.' (Jordan, Quesnel)

Considerations for virtual and mobile prescribing and delivery were closely linked to considerations for case-by-case risk assessments and supervised delivery. As participants suggested, alternatives to daily dispensing that can offer support to people at risk of overdosing should be explored in the context of rural communities and persons with mobility constraints.

SUB-THEME C: Financial costs

People who use drugs are a heterogeneous group composed of people with varying incomes and different financial situations. As participants shared, safer supply programs would benefit from developing and implementing a payment system that reflects different financial situations (e.g. free supply, subsidized supply, full price...) while being within a reasonable range that is comparable to the illegal supply.

'So if I was on, you know, disability or social assistance I think it would have to be the government paying. But if I was working, you know, I think it would — if it was just, you know, gauged towards my income level, then I'd be willing to pay somewhat out of pocket.' (Oscar, Vancouver)

'Yeah, that's one main thing that always kind of is everybody's ultimate concern is cost value. You look at the stores down in the States, for instance, just at the cannabis stores, you know, all the taxes that they have thrown in. You can buy like a gram and, you know, it'd be 10 bucks. But now just because they got so many stupid little tax things that they're going to throw on — you're basically paying three times the amount.' (Focus Group 6 Participant, Nanaimo)

As participants noted, they are having to pay for their substances when acquiring from the illegal supply and many would consider it acceptable to have to pay for a regulated supply: *'Well, I pay for them now, right. I mean, if I pay for them now, I'm still willing to pay for them then'* (Morgan, North Vancouver). However, as several indicated, pay models will not work if people are not able to access the substance and mode of use program of their choice.

'If I had been — successfully off it [illegal supply as a result of a safer supply that is working for them] for a while, yeah, I would pay for it [safer supply]. For sure.' (Cole, Quesnel)

These findings suggest that, in a sense, the illegal market is functional because it responds to the needs and preferences of the purchasers. Safer supply programs will need to achieve this for pay models to be feasible.

SUB-THEME D: Integrated and wrap-around services

Models that combine a regulated supply with housing, social service, and healthcare services should be made available for those interested. However, it is important that safer supply programs are not coercive and do not require using these additional services. As our findings indicate, there is no consensus among people who use drugs around their purpose for accessing safer supply and additional services they would be interested in accessing. For example, some perceived safer supply as an opportunity to be connected with a health care provider:

'I think safer supply programs are definitely — have a lot of value for both a harm reduction context and for a, you know, a bridging sort of health service that helps people through the transition in their lives from illegal drug use through to whatever it is they envision for themselves in the future.' (Oscar, Vancouver)

'Q: How do you think it would impact your life if you had access to a safer supply? A: More convenient, cheaper, less chance of overdose... Having an actual professional to check in with you instead of, you know, your drug dealer buddy like — you can actually get a doctor to make sure you're okay.' (Kiara, Cranbrook)

On the other hand, others reported that they would be satisfied with solely accessing a regulated supply of drugs and did not express interest in integrated or wraparound services. As one participant explained, for some an ideal safer supply would exist separately from healthcare and social services as not to assume that people using substances included under safer supply all identify with problematic substance use — much like the sale and regulated distribution of alcohol is not intertwined with healthcare and social services for those purchasing alcohol:

'No, yeah, not just to keep the sickness at bay. Yeah, like, definitely to get high occasionally, for sure. Yeah, just like when people are having a rough day and have some drinks and whatever, similar kind of thing.' (Kelly, Victoria)

Peoples' level of interest in additional services and interacting with healthcare providers is highly personal and informed by several factors including a person's goals or vision for their substance use, their perception of how current services are meeting their needs, and their perceptions of and experiences with systems of care. Several participants discussed negative

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and traumatic experiences with healthcare services and providers and how that informed their mistrust and hesitancy around accessing health and social services including safer supply. As one participant suggested, integrating safer supply with wraparound services could discourage people from accessing safer supply programs given widespread mistrust in systems that, despite being aimed at providing care, have harmed many people who use drugs:

'I think most of it for that is, you know, some people just don't want to talk about, you know, it's not everybody's business, right. So that's one of the challenges is that, you know, you're on file. You know what I mean? And you don't know who's going to get their hands on that information.'
(Ash, Maple Ridge)

These findings point to the importance of different models that suit different needs. Participants' accounts emphasize the importance of non-coercive integrated and wrap-around services as well as relationship and trust building between safer supply staff and people accessing these programs to overcome deep-rooted mistrust resulting from decades of people being criminalized.

SUB-THEME E: Eligibility requirements

Our findings suggest that requiring a substance use disorder diagnosis to be eligible for safer supply should be evaluated. Current safer supply models exclude many who are at risk of overdose but do not have a diagnosis of substance use disorder. People who use drugs recreationally and not necessarily daily, are at risk of overdose and, in fact, face unique risks due to lower tolerance, not having a reliable source and being opioid naïve (for recreational stimulant users):

"...people who are out doing things that are a little lessor or — they don't have as much of a problem with it... It's not considered as much of a big deal... But then at that point what do you do, because there's — you're not going to get into — the safe use programs... And then there's a group of people in the middle who dabble in everything who there's no actual, like, safe way to do that. Especially if you're doing a bunch of things. Or trying things. It's a lot more safe if you've got your same person you're going to all the time and you've been doing it a long time. And so just in terms of, like, contamination and trying things or whatever for the first time, it's a lot more dangerous. And I think that leaves a lot of people vulnerable." (Jasmine, Nelson)

As this participant shared, if the aim of safer supply is to reduce the risk of overdose, it is important that all people who use drugs at risk of overdose be considered in the design and implementation of safer supply (e.g. recreational users, young people).

SUB-THEME F: Staff characteristics

Participants emphasized the importance of providing non-stigmatizing and compassionate care. Those who received their safer supply through a peer-led delivery model highlighted the success of this model. They noted that peer-led models reduced barriers related to accessing medications, and overcame issues related to a lack of trust or rapport with providers who do not have lived or living experience and/or are not embedded in the community. Anonymity was also an essential safer supply program element highlighted by some participants:

'You don't want to have to go somewhere where you're feeling uncomfortable, stigmatized.' (Focus Group 1 Participant, Vancouver)

'I think privacy is another obstacle, like, that should be available either way. Be able to get your drugs — just I guess how the dillies are done or through mail or something, you know, just having that option of being able to do it privately. Yeah, I don't think everybody likes the social scene.' (Focus Group 6 Participant, Nanaimo)

'Depends on what you mean by supervised. Like, is it going to be one of the security foot patrol people saying hey, you know, you can't be doing that here, you know. Then that — no, I don't want that. Supervised by, like, hey, yeah, just someone there making sure no one's overdosing, making sure everyone's okay, then, yeah. I don't want an authority or anything like that, no.' (Nathan, Nanaimo)

SUB-THEME G: Prescribing flexibility

Participants spoke about the need for prescribers to be adaptable and flexible. As some participants shared peoples' tolerance is likely to change and waiver over time and, as such, there is a need for continuous communication between prescribers and people accessing safer supply to adapt dosages to ensure it is meeting their needs, whether that be pain relief, withdrawal management or experiencing mind altering and euphoric effects:

'I've been on it [safer supply] now for ten years. And for the first two years I got nicely buzzed off it. And for the last eight years, I do it and all's it does is stops my pain. I get no feeling from it.' (Focus Group 1 Participant, Vancouver)

'If they find out they don't want that, okay. Give them something else. People change. Their minds change. I do believe, though, a person knows best for themselves.'
(Ryan, Nelson)

To encourage long-term access of safer supply and reduce discontinuation and return to the illegal supply, safer supply programs need to accommodate these changes.

Similarly, participant narratives underlined that substance and mode of use preferences often evolve in a person's life. To encourage long-term access of safer supply and reduce discontinuation and return to the illegal supply, safer supply programs need to accommodate these changes:

'Well, at one time the hydromorph with Dilaudid was the thing I would love to have a prescription — finally I got it. Now it's not the thing that interests me anymore. Now I want to go back to getting M-Eslon which I was prescribed before from my doctor. Which I got cut off from that and put on the Dilaudid.' (Elliot, Quesnel)

As participants suggested, ensuring prescribed safer supply programs are flexible and accommodating will require prescribers to listen and trust people when they voice their needs:

'If they find out they don't want that, okay. Give them something else. People change. Their minds change. I do believe, though, a person knows best for themselves.' (Ryan, Nelson)

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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. Engage peer workers in the operation of safer supply programs to improve access by increasing awareness of programs through peer networks and develop trust and connection to create comfortable safe, environments.

Conclusion and Future Research Directions

Conclusion

There have been important steps made to acknowledge the harms of an unregulated, contaminated supply and urgent need for a regulated safer supply of substances. However, existing safer supply options are limited in terms of the substances offered, the modes of use available, and the diversity and the flexibility of programs offered. This research demonstrates the value of clarifying the needs of people who use drugs to inform the design and implementation of programs that successfully meet the needs of the population(s) they are intended for. If a regulated supply of psychoactive substances is not available through programs that are accessible and acceptable to people who use drugs, people will continue to use from the illegal supply and the unregulated drug poisoning emergency will persist.

Future research directions

There is a need for more research that is focused on the unique experiences of particular groups of people who use drugs accessing safer supply. For example, research that focuses on the unique barriers and challenges to accessing safer supply faced by Indigenous communities and youth could help identify important needs and gaps. In addition, studies observing prescriber-service-user interactions and experiences in the context of safer supply could help illuminate implementation issues and potential areas that would benefit from clinical and/or policy guidance. Finally, ongoing evaluations are needed to monitor safer supply initiatives as they evolve.

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APPENDIX: SUPPLEMENTARY TABLES

The following tables provide information about who our survey, interview and focus group participants were as well as information about their drug use.

SUPPLEMENTARY TABLE I:

Participant demographics (surveys, interview and focus group participants)

	Harm Reduction Client Survey 2019		Harm Reduction Client Survey 2021		Qualitative Interviews and Focus groups	
	Yes (N = 621)		Yes (N = 537)		Yes (N = 76) ^a	
	N	%	N	%	n	%
Gender						
Man	392	63.1%	333	62.0%	46	60.5%
Woman	213	34.3%	186	34.6%	28	36.8%
Trans man	1	0.2%	1	0.2%	0	0.0%
Trans woman	1	0.2%	3	0.6%	0	0.0%
Two-Spirit			3	0.6%	1	1.3%
Gender non-conforming	6	1.0%	2	0.4%	0	0.0%
Other	2	0.3%	4	0.7%	1	1.3%
Prefer not to say	1	0.2%	2	0.4%	1	1.3%
Self-reported Indigeneity						
Yes (First Nations)	177	28.5%	166	30.9%	22	28.9%
Yes (Métis)	75	12.1%	61	11.4%	10	13.2%
Yes (Inuit)	2	0.3%	1	0.2%	0	0.0%
No	324	52.2%	270	50.3%	39	51.3%
Prefer not to say	17	2.7%	23	4.3%	4	5.3%
						<i>continued</i>

	Harm Reduction Client Survey 2019		Harm Reduction Client Survey 2021		Qualitative Interviews and Focus groups	
	Yes (N = 621)		Yes (N = 537)		Yes (N = 76) ^a	
	N	%	N	%	n	%
Age						
<29	117	18.8%	71	13.2%	10	13.0%
30-39	182	29.3%	137	25.5%	26	33.8%
40-49	162	26.1%	140	26.1%	16	20.8%
50-59	121	19.5%	120	22.3%	14	18.2%
60+	26	4.2%	52	9.7%	8	10.4%
Prefer not to say	6	1.0%	7	1.3%	3	3.9%
Health Authority						
Vancouver Coastal Health	138	22.2%	70	13.0%	22	27.2%
Fraser Health	196	31.6%	108	20.1%	5	6.2%
Northern Health	117	18.8%	92	17.1%	10	12.3%
Island Health	58	9.3%	119	22.2%	21	25.9%
Interior Health	112	18.0%	148	27.6%	23	28.4%

^a Demographic and drug use questionnaires were collected from 76 of the 87 interview and focus group participants.

SUPPLEMENTARY TABLE II:

Harm Reduction Client Survey (2019, 2021) participant drug use characteristics

	HRCS 2019		HRCS 2021	
	Yes (N = 621)		Yes (N = 537)	
	N	%	N	%
OPIOIDS				
Used opioids (including OAT) in the last 3 days			374	69.6%
Type (among participants who use opioids)^a				
Methadone	139		157	42.0%
Buprenorphine/Naloxone (Suboxone)	25		30	8.0%
Hydromorphone	17		141	37.7%
Oxycodone	6		37	9.9%
Morphine	70		99	26.5%
Heroin ^b	272		225	60.2%
Fentanyl	283		290	77.5%
Method of consumption (among participants who use opioids)^a				
Smoke			272	72.7%
Snort			33	8.8%
Inject			135	36.1%
Swallow			179	47.9%
Other			9	2.4%
STIMULANTS				
Used stimulants in the last 3 days			439	81.8%
Type (among participants who use stimulants)^a				
Methamphetamine	445		385	87.7%
Cocaine (powder)	104		99	22.6%
Crack cocaine	141		140	31.9%
MDMA	28		30	6.8%
Other	42		43	9.8%

continued

	HRCS 2019		HRCS 2021	
	Yes (N = 621)		Yes (N = 537)	
	N	%	N	%
Method of consumption (among participants who use stimulants)^a				
Smoke			358	81.5%
Snort			95	21.6%
Inject			130	29.6%
Swallow			50	11.4%
Other			3	0.7%
Used benzodiazepines in the last 3 days^c			123	22.9%
Used OAT (methadone/ [buprenorphine/naloxone (suboxone)]) in the last 3 days	159	25.6%	177	33.0%
Used both OAT (methadone/ [buprenorphine/naloxone (suboxone)]) and any illegal drug in the last 3 days (among those who use OAT)	140	88.1%	167	94.4%

^a Participants could select all answers that applied.

^b Data is self-reported. The content of opioids in the illegal supply is unknown, and thus some participants who reported using heroin may be unknowingly primarily using fentanyl.

^c Data is self-reported and may not be accurate if participants are using benzodiazepines unknowingly from the contaminated supply.

SUPPLEMENTARY TABLE III

Interview and focus group participant drug use characteristics

	Yes (N = 76) ^a	
	n	%
OPIOIDS		
Used opioids (not including OAT) in the last month	61	80.3%
Type (among participants who used opioids)^b		
Hydromorphone	28	45.9%
Oxycodone	6	9.8%
Morphine	28	45.9%
Heroin ^c	39	63.9%
Fentanyl	52	85.2%
Method of consumption (among participants who used opioids)^b		
Smoke	43	70.5%
Snort	7	11.5%
Inject	35	57.4%
Swallow	40	65.6%
Other	4	6.6%
Had a prescription for at least one opioid (among participants who used opioids)	29	47.5%
STIMULANTS		
Used stimulants in the last month	73	96.1%
Type (among participants who used stimulants)^b		
Methamphetamine	61	83.6%
Cocaine (powder)	24	32.9%
Crack cocaine	39	53.4%
MDMA	7	9.6%
Other	14	19.2%

continued

	Yes (N = 76) ^a	
	n	%
Method of consumption (among participants who used stimulants)		
Smoke	61	83.6%
Snort	17	23.3%
Inject	35	47.9%
Swallow	14	19.2%
Other	4	5.5%
Had a prescription for at least one stimulant (among participants who used stimulants)	6	8.2%
Used both stimulants and opioids in the last month	59	77.6%
Used benzodiazepines in the last month^d	27	36.0%
Had a prescription for benzodiazepines (among participants who used benzodiazepines)	4	14.8%
Used OAT (methadone/[buprenorphine/naloxone (suboxone)]) in the last month	26	34.2%
Used both OAT (methadone/[buprenorphine/naloxone (suboxone)]) and any other drug without a prescription in the last month (among participants who use OAT)	25	96.2%

^a Demographic and drug use questionnaires were collected from 76 of the 87 interview and focus group participants.

^b Participants could select all answers that applied.

^c Data is self-reported. The content of opioids in the illegal supply is unknown, and thus some participants who reported using heroin may be unknowingly primarily using fentanyl.

^d Data is self-reported and may not be accurate if participants are using benzodiazepines unknowingly from the contaminated supply.



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