

Introduction

One response to the opioid poisoning crisis has been to expand the prescribing of pharmaceutical grade opioids (e.g., sufentanil, diacetylmorphine, hydromorphone, slow-release oral morphine) as a substitute for unregulated drugs. These drugs are prescribed with the recognition that people may experience psychotropic effects, unlike conventional opioid agonist therapy (OAT) with methadone or buprenorphine, which aims to suppress cravings and avert withdrawal. While conventional OAT has been widely accepted and implemented in Canada, programs that offer prescribed alternatives to opioids remain controversial.

Multiple programs that offer prescribed alternatives to opioids have been considered and some implemented, including safer opioid supply and injectable opioid agonist therapy (iOAT). These programs differ in terms of drug, formulation, amount of supervision, and degree of integration with other health or social programs or settings. Programs also vary in terms of hours of operation, staffing, and rules. Client preferences will likely determine uptake of, and satisfaction with, these programs but have not been fully studied to date.

In this study, we examined which features of programs that provide prescribed alternatives to opioids are important from the perspectives of people who use drugs in Toronto, Canada.

Methods

We conducted 8 focus groups with 65 participants who have a history of injecting opioids. Two focus groups were conducted with participants who self-identified as women and one with participants who self-identified as men; non-binary individuals were invited to attend either. Focus groups took place at 4 supervised injection sites in Toronto between January and March of 2020. Focus groups lasted approximately 60 minutes, were co-facilitated by a researcher with lived experience of drug use and other members of the research team and were digitally recorded and professionally transcribed. We used Nvivo 12 for coding and thematic analysis of qualitative data. Participants also completed a questionnaire, analyzed using descriptive statistics with Stata 17. Participants were reimbursed \$25. This study received approval from St. Michael’s Hospital and Toronto Public Health Research Ethics Boards.

Results

Among the 65 participants, 31 (50%) identified as men, 29 (47%) as women, and 2 (3%) as non-binary or another gender. The median age was 38 (Interquartile Interval [IQI] 30 to 52), and the median age at first opioid injection was 22 (IQI 17 to 28). Fentanyl had been injected at least once in the past month by 44 (68%) participants, among whom the median number of fentanyl injecting days in the past month was 28 (IQI 24 to 30). At the time of the focus group, 18 (28%) participants reported being prescribed methadone and 3 (5%) buprenorphine. Of the 62 participants who responded to questions regarding safer opioid supply, 13 (20%) were enrolled a safer opioid supply program at the time of the focus groups and 3 (5%) were previously enrolled.

Preferences for Program Models

- Participants wanted diverse models (e.g., standalone, integrated) and emphasized that programs should be available wherever people who use drugs access services (e.g., supervised injection sites, health centers, doctor’s offices, shelters) and in institutional settings like jails, prisons, and hospitals to ensure continuity of care.
- There was a strong preference for 24/7 access, especially overnight. While some participants indicated they were willing to travel, long distances and related costs were seen as barriers.
- Several participants felt strongly that prescribed opioids should be dispensed daily with observed consumption—at least initially, for titration and to establish trust. However, many recommended take-home doses subsequently be made available to give clients more flexibility. For several participants, daily dispensing and multiple daily visits to the clinic was a drawback of OAT. At the same time, there was concern that lost or stolen take-home doses would not be replaced, putting clients at risk of withdrawal.

Flexibility to Meet Individuals’ Opioid Needs

- Many participants felt that current programs, including those that offered hydromorphone, did not fully meet their needs. Participants expressed that programs should support the goals of each individual client, whether that includes having access to doses that are high enough to produce pleasurable effects, avert withdrawal, or taper. To achieve this, participants asserted that programs need to have a range of drug options and formulations available; however, some expressed they would be willing to switch from their usual drug to one offered by a program if the alternative provided the desired effect.
- Many participants identified fentanyl as their preferred drug and explained it would be very difficult to transition from fentanyl to hydromorphone. Failure to account for individual needs can result in clients continuing to use drugs from the unregulated drug supply, compromising safety.

Look, me being addicted to fentanyl, going in there and getting prescribed Dilauidids is not gonna help me. All I’m going to do is go and sell my Dilauidids to get heroin or fetty [fentanyl]. So, if I’m addicted to heroin or fentanyl, that’s what they should be prescribing me. [Man]

- As everyone will have a different tolerance to opioids, participants emphasized the importance of prescribers working with clients to find a suitable starting dose. Many worried that a starting dose that is too low could discourage those who are accustomed to higher doses from enrolling or lead clients to compensate with opioids from unregulated sources. Several participants found supervised titration acceptable to establish a safe starting dose.

Results (Continued)

Maximizing Access

- Participants expressed that anyone who relies on the unregulated drug supply should be eligible and that programs should consider current risk in addition to past experience when assessing eligibility. Specifically, participants asserted eligibility should not be restricted to clients who have experienced an overdose.

The first time I tried fentanyl I overdosed, and it was very bad, and I almost died... Do people have to... risk dying before they get on safe supply? Do I have to risk my life before I get on safe supply? [Woman]

- Furthermore, participants emphasized the importance of making programs accessible to those without prior OAT experience as well as those looking to transition from OAT to better meet their needs and goals.
- Some participants also supported access for youth. Several suggested a separate program tailored to youth, with additional supports to meet their unique needs.

I would want the program to build on a foundation where all those pre-teens and youths have the same kind of support... So they can build a foundation for younger generations to not go through what we’re going through. [Woman]

- The suggestion of including pregnant people in programs offering prescribed opioids elicited strong disapproval from some participants, often due to concerns about fetal risk. However, others argued that denying access could lead to greater harm.

That’s a hard one for me, because my first reaction, my first response when I said it was, no, like, that’s fucked up. But after hearing [others], I’m like, wait a minute, there are pregnant women that are still addicted to dope using dope, active street dope. So yes, my mind is now flipped to hell yeah, let anybody, at any stage, at whatever point, access the program... It should be better to put them on a program where it’s cleaner, safer, regulated. [Man]

Importance of Trust, Especially for Women

- Trust emerged as a cross-cutting theme but was most salient with women. One recommended way of improving trust between clients and programs was to staff programs with workers with lived experience of drug use.
- Some women expressed a preference for using alone and thus may not be able to benefit from program models that require supervised administration.

I don’t use those [supervised consumption] sites. Don’t get me wrong guys, I totally support it, but it’s not for me. I consider IDU [injection drug use] use, it’s such as a personal thing for me as a woman. You know what I mean. I don’t feel comfortable going into sites to do that. I don’t even feel comfortable doing it in front of my husband. I do it all in private. [Woman]

- Participants explained that being prescribed a safer opioid supply of drugs can reduce women’s exposure to violence, which is especially urgent for trans and racialized women. Several women reported that their experiences with oral hydromorphone programs led to decreased involvement in sex work and criminal activities.

Now they have the safe supply program, so people aren’t searching for drugs on the street. People aren’t having to do sex work or boosting, robbing and stuff. Personally, before I had my job, I was turning to sex work, I was escorting, I was stealing from stores and stuff... and then going and trading that stuff for drugs. I’m risking my freedom, I’m risking my health, I’m risking my sanity, just so I can get better. This is why I completely agree with safe supply programs, because then that really does eliminate a lot of risks. [Woman]

Limitations

1. It may be difficult to generalize our findings to the wider population of people who use drugs in Toronto and beyond, including in contexts where access to harm reduction services and OAT is very different.
2. Our results may be subject to both volunteer bias, as participants self-selected to take part in the study, and social desirability bias, as participants may have been hesitant to discuss behaviors that can lead to stigmatization.
3. Our results do not explicitly explore concerns for some groups, such as people living in poverty, racialized individuals, and Indigenous peoples.
4. Our focus groups were conducted just before the declaration of emergency related to the COVID-19 pandemic, during which the prescribing of pharmaceutical grade opioids increased; respondents' preferences may have changed with greater exposure to such programs.

Conclusion

This study provides a qualitative exploration of potential clients’ preferences for program models and features offering prescribed alternatives to opioids. Overall, study participants favored program models that are highly accessible, flexible, and client-centred. Our findings offer clarity around which features are important to people who are at high risk for overdose and death, and for whom conventional treatment offers limited benefits; addressing their concerns may help enhance uptake and client experience. Our findings also emphasize the importance of considering the needs of specific groups of people who use drugs during implementation, such as women and youths. More broadly, the study’s focus on potential client preferences reaffirms the need to include client preferences, such as through client advisory committees, to inform client-based program design, implementation, and evaluation.