Prescribed Safer Supply: Emerging Evidence

National Safer Supply Community of Practice

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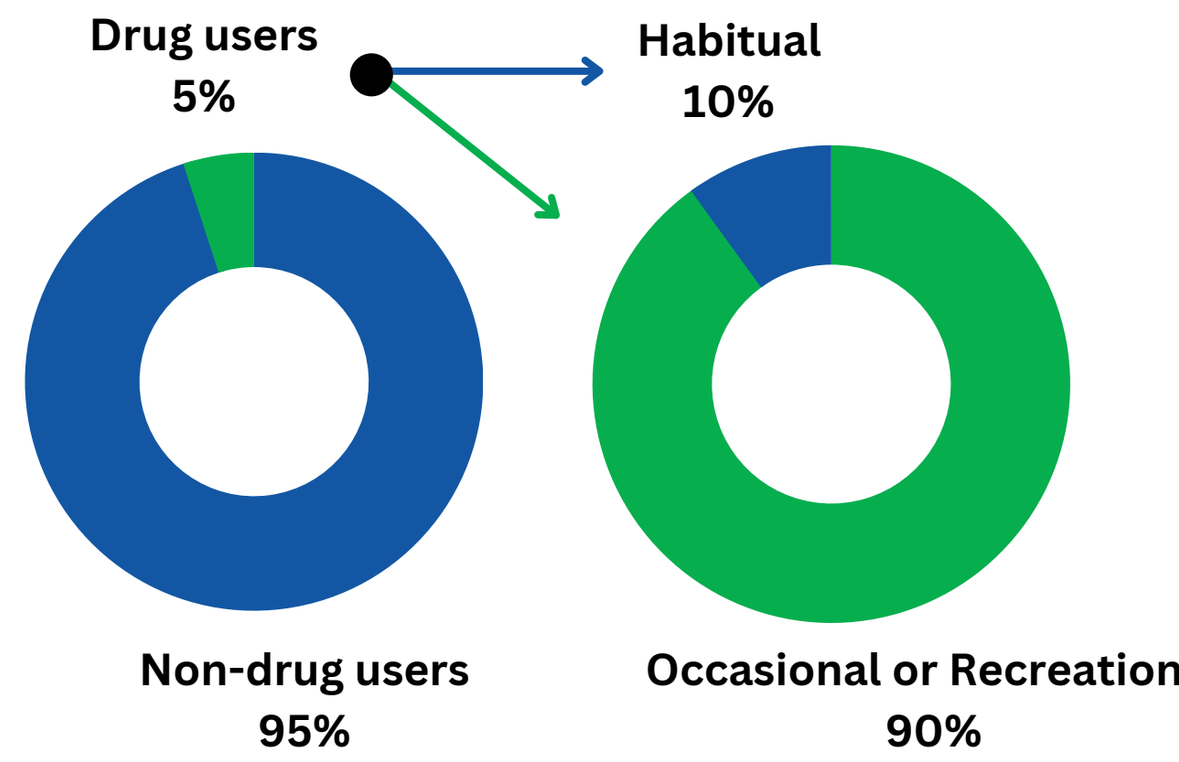
Context

Around **5%** of adults around the world **use illegal drugs**, and nearly **90%** of them are occasional or recreational users (1). The appearance of **fentanyl** in the **unregulated drug supply** has made the illegal drug supply increasingly unpredictable and toxic. As a result, there were **34,455 opioid toxicity related deaths** in Canada between January 2016 and September 2022 (2).



People who use drugs have been calling for a safe supply of drugs for **decades**. **Safe supply** refers to **regulated pharmaceutical drugs** of **known content**, **quantity**, **quality**, and **potency** that provide the mind/body altering properties of drugs that are currently only available through illegal markets and not available through traditional opioid agonist therapies (OAT) (3).

> [Prescribed] safe opioid supply programs are a promising intervention to address North America's ongoing overdose crisis by providing people at high risk of fatal overdose an alternative to the toxic drug supply. (4)

Health Canada funds **26 pilot programs** which use **prescribed models** of safer supply. The most common settings for prescribed safer supply are **community health settings**, such as community health centres, primary care clinics, and onsite pharmacies (5).

26 Prescribed Safer Supply Pilot Programs

Methods

We draw on **findings** from **peer-reviewed research articles** and **commentaries** on prescribed safer supply, as well as **all program evaluation reports** published to date.

Who can access prescribed safer supply?

Although anyone who uses opioids from the illegal drug supply – either recreationally or routinely – needs access to safer supply, safer supply is **only available through medicalized programs** ("**prescribed safer supply**") due to the **current legislative** and **regulatory context** in Canada. Prescribed safer supply programs are **not accessible** to those who use opioids recreationally.

Typical prescribed safer supply **inclusion criteria** include **DSM-V defined opioid use disorder** and **previous unsuccessful experience(s)** with methadone, buprenorphine or slow-release oral morphine (SROM), **or disinterest** in methadone, buprenorphine, or SROM (12).

Programs currently **prioritize** those who are:

- at the **highest risk of death** from overdose (6)
- experiencing **serious medical complications** from their drug use (7,8,9,10), and
- **marginalized** from health care services, including traditional OAT (11).

> [N]ot all people who use opioids are interested in treatment, nor is conventional treatment suitable for all people who use opioids. (13)

What does the evidence show?

Peer-reviewed scientific studies and evaluations of prescribed safer supply programs show:

Retention rates in prescribed safer supply programs are very high: Program evaluations show retention rates exceeding 80% (8,9,11,14,15,16).

Prescribed hydromorphone is not contributing to drug-related deaths: Data from coroners in BC and Ontario have found no link between prescribed hydromorphone and drug-related overdose deaths. In Ontario, despite the increasing use of immediate-release hydromorphone during the early pandemic period, both the percentage and overall number of hydromorphone-related deaths decreased (17).

> There is no indication that prescribed safe supply is contributing to illicit drug deaths. (18)

What does the evidence show? (cont'd)

Peer-reviewed scientific studies and evaluations of prescribed safer supply programs show:

Reduced risk of death and/or overdose: Both drug-related deaths and deaths from any cause among people receiving prescribed safer supply were rare (6,7) and they had fewer overdoses (8,10,11,14,19,20).

> I haven't had an overdose since I've been on the program. I had a couple shortly before where I had to be defibrillated. (14)

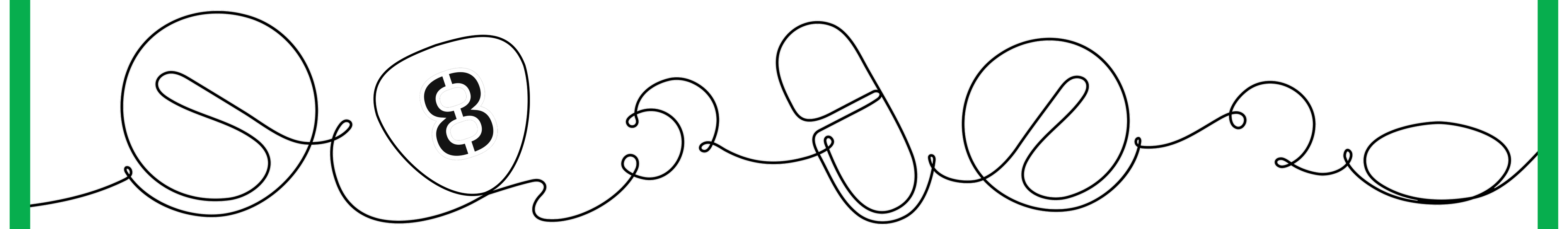
Engagement and retention in programs and care: Increased access to health and social services, including primary care, COVID-19 quarantine, OAT, counselling, and housing support; and improved relationships with providers (9,10,14,15,16,21,22).

Improvements in physical and mental health: Improved chronic and/or infectious disease management, medication adherence, pain management, sleep, nutrition, and energy level (7,8,9,10,15,22,23,24).

Fewer emergency department visits and hospitalizations: Significantly fewer Emergency Department visits and inpatient hospital admissions after entering the prescribed safer supply program compared to the year prior, with no change in these outcomes among a matched group unexposed to prescribed safer supply in the same time period (7).

Decreased hospitalizations for infectious complications: In the year after beginning a prescribed safer supply program, there was a significant decrease in hospitalizations for infectious complications among clients; hospitalizations dropped from 26 in the year before program entry to 13 in the year following entry to a prescribed safer supply program (7). There was no change in these outcomes among a matched group unexposed to prescribed safer supply in the same time period (7). Increasing infection rates overall among people who inject drugs since 2016 align with the shifts in the unregulated drug market towards non-prescription fentanyl (25).

Reduced use of drugs from the unregulated street supply: (thereby reducing overdose risk) and, in some cases, reducing overall drug use or ceasing the use of drugs by injection (4,8,10,11,14,15,19,20).



> I don't use street drugs anymore. I never thought it was possible. (9)

> There are people that are on this program that started off in tents and now they've actually got themselves to a position where they're renting an apartment. That doesn't happen without safer supply. (8)

Improved control over drug use: The flexibility and autonomy of prescribed safer supply programs, coupled with certainty about dose strength, enabled participants to avoid withdrawal symptoms and manage pain (4,10,19,20,22).

Improvements in social well-being and stability: Economic improvements (4,8,10), reduced inequities stemming from the intersection of drug use and social inequality (24), better control over time leading to engagement in employment, hobbies, and interests (8,9,14), decreased involvement in and exposure to violence, criminal activities and legal issues (4,8,9,15,22), improved general social stability (11), improved housing access (8,14), and improved relationships with family members and friends (9,10,15).

Decline in health care costs: Participants had lower costs for healthcare not related to primary care or outpatient medications in the year after program initiation, with no corresponding change observed in a matched group of individuals who did not access the program (7).

Success factors for prescribed safer supply programs

> The overarching approach to providing safer supply services should be grounded in the community and centred on input from people with lived experience in program co-design, planning and implementation. (9)

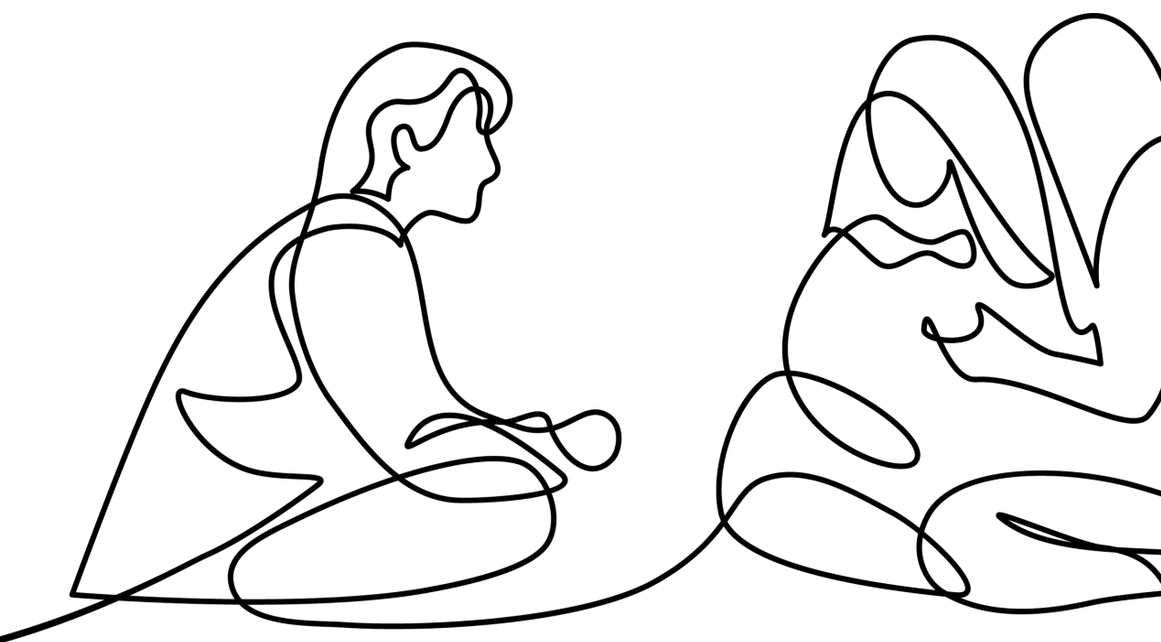
- **Comprehensive ancillary services**: populations served by prescribed safer supply benefit from **wraparound health** and **social supports** delivered alongside safer supply (7,8,10).
- **Program flexibility** (4,8,9,19) and **adaptability** (5,9)
- **Low-barrier**, **client-centred** design (4,9)
- Ability to **provide pharmaceuticals** that **meet people's needs** (dose, formulation, type) (16)
- **Community-centred** approach, foregrounding the **leadership** and **engagement** of **people who use drugs** (22,26).

Conclusions

The emerging **evidence supports prescribed safer supply** as a **critical option** on the **continuum of harm reduction** and **treatment services** for people who have not been successful with traditional approaches to care and who are at high risk of drug poisoning.

Research involving **health administrative data** provides reassurance about the **safety** of prescribed safer supply programs: Gomes, Kolla et al. (7) found a **significant decline in health services utilization** among clients on prescribed safer supply alongside no change in infection rates, opioid-related deaths, or all-cause mortality.

More research is needed, including **longitudinal studies** to monitor changes in access to and delivery of prescribed safer supply across the country, determine which models are most **effective**, and identify the **impact** of programs on the **health**, **well-being**, and **safety** of individuals and communities.



> It's not yet perfect, but it saved my life. (9)

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