

FOCUS ON: SAFE SUPPLY

FINDINGS FROM FOCUS
GROUPS WITH PEOPLE WHO
USE UNREGULATED DRUGS



Focus On: Safe Supply

Acknowledgements

We are grateful for the participation of people who use unregulated drugs, without whom this study would not exist. Their time and effort to inform aspects of a potential 'safe supply' initiative will greatly assist local efforts. We sincerely hope their contributions will establish new opportunities for preventing deaths and injuries due to accidental poisoning.

A special thank you is due to Andrew Childerhose of The Working Centre, who assisted in many aspects of the focus group study.

A special thank you is also due to the Inner City Health Alliance for their collaborative efforts to advance initiatives grounded in equity.

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Table of Contents

Executive Summary	iii
Background	1
Methodology	2
Limitations	3
Findings: Concept	4
Findings: Operational Design Considerations	11
Conclusion	19
Appendix A: Focus Group Guide	20



Executive Summary

This qualitative report follows from focus groups held with people using opioids from the unregulated market to assess the concept of safe supply, and provide operational design and delivery guidance. Safe supply initiatives provide pharmaceutical equivalents to contaminated and unregulated substances such as opioids, stimulants, and benzodiazepines. The focus groups revealed several themes.

Pervasive throughout the focus groups was a sense of limited time before participants or their friends faces another overdose emergency. Every participant had experienced multiple and escalating losses and trauma due to overdose poisoning, and all participants fear it is now the new normal.

Participants were overwhelmingly enthusiastic about the opportunity for a safe supply program, and anticipated strong demand. Such a program was thought to have very positive impacts on both individual and community health, safety and well-being. By stabilizing and decriminalizing the withdrawal – acquisition – purchase – use – withdrawal cycle, participants suggested other opportunities would become possible. Key to “settling the noise and chaos” was obtaining the optimal dose and formulation, and ensuring people who use unregulated drugs are involved in program design and delivery to avoid initiation and perpetuation of structural barriers.



Background

Opioid-related deaths in Ontario have risen from 111 fatalities in 2000 to 1,475 victims in 2018. While prescription opioids were previously a substance of concern following their addition to the Ontario Drug Benefits Plan, the presence of the bootleg fentanyls has been the leading contributor to escalating fatalities since 2015-16. The Waterloo Region Crime Prevention highlighted the potential for market contamination by bootleg fentanyls in 2008, and advised of the threat to public health and safety in 2013 and 2016.

The unregulated marketplace for opioids remains toxic and contaminated with a variety of bootleg fentanyls, benzodiazepine analogues (novel, unregulated, derivative substances), synthetic cannabinoids and dozens of potentially harmful bulking substances that affect weight and toxicity. There is little to no chance the unregulated market will become safer for consumers over time.

The Government of Canada announced an opportunity in August 2019 that would permit stakeholders to apply for funds to create 'safe supply' programs. Safe supply initiatives eliminate the individual and community harms associated with the unregulated market by providing prescription opioids (among other classes of drugs) such as hydromorphone, morphine, diacetylmorphine, etc. to people currently using unregulated opioids. Following evidence from injectable opioid programs in a therapeutic context, a safe supply approach is likely to reduce death and injuries, and improve both individual and community health and safety.

In September 2019, focus groups were held in Kitchener with people actively using opioids from the unregulated market. Participants were asked if a safe supply program would be appropriate locally and if so, what that program might look like.

We are grateful for those who were able to participate, and remember those who have passed away prematurely. Based on the feedback from people in the focus groups, and contributions from medical, safety and health practitioners, the Working Centre will lead a collaborative application through the Inner City Health Alliance to seek funds from Health Canada for a safe supply initiative.





“NOTHING ABOUT THIS PROGRAM
IS GOING TO KILL ME TODAY.”

Methodology

Two focus groups held in 2019 on September 5 and September 10, for male identified persons, and for female and trans-identified persons, followed the question framework found in Appendix A. A third focus group was envisioned for people who work in direct service with people who use drugs however this focus group has been deferred. Outreach workers and others in direct service to people lacking stable housing, however, have previously identified the provision of a safe supply as a priority locally.

Invitations were limited to people currently and regularly using opioids from the unregulated market. Persons were invited through networks of people who use drugs and/or through persons in direct service holding relationships with people who use drugs.

Invitations included the following information:

- A funding application is being considered for a new program
- The applicants are requesting 90 minutes of your time and expertise to assist with shaping the program
- The focus groups are confidential
- A cash payment of \$25 will be available after each focus group to each participant

In total, 8 people who use drugs participated in these focus groups, 5 who identified as men and 3 who identified as women, ranging in age from early 20s to mid 60s. Focus group participants met at a downtown location. There was a facilitator and a recorder at each session. The recorder did not use names in the notes. A BSW student observed the second session.

A series of questions were verbally asked of the participants. Sometimes a discussion ensued, and those comments are included here. The main themes are summarized with direct quotes from participants. Persons or organizations named by participants are identified as XXX.



Limitations

This small study is the first in Waterloo Region to assess the potential impact of providing pharmaceutical equivalents to people using opioids from the local unregulated market in the Waterloo Region area. Participant selection grew from existing relationships and availability rather than from a random pool. Participants lived in downtown Kitchener and were primarily injecting opioids. The number of participants is low relative to the estimated number of people who use opioids from the unregulated market, and thus could provide input into a safe supply program. Opioid formulations such as pharmaceutical fentanyl and diacetylmorphine were not considered but should have been given escalating tolerance levels and despite the structural barriers imposed by the Ontario Drug Formulary (and thus drug benefit coverage and guidance). Safe supply for stimulants and benzodiazepines were not the subject of these focus groups but should be considered in any safe supply initiative. The findings provide unique insights but caution is advised given the scale and diversity of people who use unregulated drugs.



Findings: Concept

Overall impact



The nature of the project was briefly shared with participants, who were then asked if they had any questions.

“With methadone there are so many constraints, how clinical is it going to be? Will you have to go 3 times a day? These are some constraints.”

“I do feel positive as long as people don’t take advantage of it. Methadone people just keep going up & up & up. And I don’t know how that would look. What would the maximum (dosage) be?”

“People need more personal attention – we’re getting all kinds of negative attention. But to hear something other than that, that would be great.”

“Why is it hydromorphone?”

“Do more beyond saving lives.”

Impact on safe supply participants



Thinking of yourself and people who use opioids regularly, would you expect the impact of an initiative like this to be positive? Negative? Neutral?

All participants thought the impact of a safe supply initiative would be very positive, both for participants and for the community at large. Participants repeatedly noted the high risks and uncertainty of purchasing substances from the unregulated market, and shared the negative impacts arising from the craving – acquisition – use – withdrawal cycle.

“It’s hard to say something bad about something so good.”

“Nothing about this program is going to kill me today.”



“...YEAH, BECAUSE THEY CUT IT WITH EVERYTHING... AND YOU NEVER KNOW WHAT IT’S CUT WITH.”



“I think it’s a great idea. It can keep you from working, from sex work.”

“The community, you’re taking addicts and giving them drugs, and people don’t realize there’s a process to sobriety. I think the worst crime is neglect, abuse isn’t as bad. I would say, just the attention in itself, getting attention on the subject, so they are depicted as people, damaged goods in some cases, and the most important, (for some people) there is no hope and we don’t expect to get better. There are some folks that are lifers.”

“The end point isn’t to get off drugs, it’s not about getting off drugs, that’s not the end goal.”

“Yeah, personally I have had to use fentanyl, but prefer prescription. Prescription takes away the risk, always the same thing. I do it by myself, and with fentanyl you never know if you’re taking too much. For that reason I’d rather smoke.”

“If you’re scared enough to switch to smoking, you know there’s something wrong.”

“At the moment you’re putting your life in the hands of your dealer.”

“...yeah, because they cut it with everything... and you never know what it’s cut with.”

“Alprazolam – all of the shit that happens. Every terrible conceivable thing happens.”

“Importers – they bulk it up, dye it, sell it. They don’t know what it is. You don’t just have the toxic supply, you have a bunch of other shit in it.”

“I’m just worried about turning blue, like a smurf. And it’s toxic in two ways. One, with carfentanyl, it’s easy to have a hotspot and then you die. And that’s the thing – it’s less than 1 percent drug, cut with everything. And two, there’s a whole generation will die of endocarditis. It’s something that will kill us in one of two ways. And with pharmaceuticals, they are made in sterile conditions. When you’re buying drugs from China, sometimes they send the wrong chemical. That’s pretty terrifying when you’re buying stuff to inject.”

“...synthetic cannabinoids, fentanyls, and benzos. Nobody is gonna come back to that.”

“Benzo’s used to pop up when there was a heroin drought years ago, every couple summers, you used to expect it would happen at some point. Now every third batch will put you out for 12 hours.”

“We got some stuff that was over half benzos, was that the green?” (Discussion about how it would put people out for hours.)





Demand: After 6 months using a safe supply initiative, what might the impact on the use of opioid and non-opioid substances be?

“Older people would probably stabilize and consider reducing. Younger people would probably just keep going.”

“After 6 months, not much change for most but for those that change their dose, it would be a lot.”

“Definitely slow down – optimal dose is key. Few people will want more.”

“Once optimal dose, it wouldn’t change.”

“If someone started the program using stimulants...well, not sure there would be any change. Maybe free opioids would free up time to not do non-opioids.”

“If you can get what you need for free, why use more?”

“A lot of people over 45....more of the old age group...seems to be a lot of older people... we’re tired, and just want to stop. The really young they would experiment with going up and down.”

“Depends on if they used stimulant or not, if they didn’t use them already they wouldn’t go seek them out. It’s such a hard question to answer, because it’s so personal. It completely depends on the person. If they’re getting what they need from the opiates, they aren’t hustling for the fix as much and then they are looking for a job, they wouldn’t need the drugs as much, it depends if someone would even do that.”

“Stimulants, if they are use to that. If somebody does speedballs, that could be hard, because you don’t have stimulants, you don’t have that. Have you looked into a synthetic stimulant? Because I’m so productive on stimulants, you can do a bunch. With stimulants your body is on high, and with opioids it’s slower, I get less done. Carries would fix this.”

**“DEFINITELY SLOW
DOWN — OPTIMAL DOSE IS
KEY. FEW PEOPLE WILL
WANT MORE.”**





What might be the impact on people receiving methadone or Suboxone®? Or on people not receiving methadone or Suboxone?

“Methadone, people only use it as a safety net. Less than 10 percent of people use it as designed. People would go for this, they wouldn’t commit crimes, or for women, they don’t need to sell themselves if they don’t want to. People end up taking their lives over it.”

“I know a few people on methadone. It just doesn’t scratch the itch. I’ve tried to lower my dose, but I start to use again. If I had a steady supply, in terms of keeping me well, and the mental jonzes, and could shoot up—that’s half the addiction. It’s the process, it’s the ritual. I might actually have a chance. You can get use to it, bit by bit by bit. With methadone, it’s not what I actually want to be using. No safety net, it’s what I actually want.”

“There wouldn’t be intermingling between people wanting to stay clean at a methadone clinic, and those just using it as a safety net, those still using.”

“You had to go through hell (to obtain Suboxone®), you can’t get up to anything that works. All it takes is one thing.”

“My reason, methadone puts me on a permanent nod. Heroin gives me a get up and go. Yeah, methadone makes me sluggish, sweaty, all kinds of shit.”

“I’m on methadone, we still use drugs a lot. The methadone isn’t working for me. I don’t get high, all the methadone does is gets me from not getting sick. Hydro would give me euphoria, or something close, at least a release from anxiety.”

“Methadone fried my mom’s brain, illegally.”

“I would be curious about the process, [from methadone to hydro] I have no idea what that would look like.”

“It’s really hard (for methadone) to come out of your system.”

“I would quit the drugs, once the void has been met. I know what it looks like, a business, kids, a house, a partner. I was clean. I had important relationships, kids, mortgages, things to fill my life. Once those things weren’t there I used drugs. I would like something else to fill my life.”

Impact on crime and victimization

“Big time - people don’t have to go out to get what they need.”

“I can’t think of anything that would be safer.”

“My dad retired 3 years later because I injected his retirement fund.”



“There would be less car hopping, b&e, robberies, violent crimes. There’d be less sex workers, less people dealing, wouldn’t need to get it from their dealer, from this program instead.”

“Crime would go down, for sure. You don’t have to be on the grind for 12, or 24 hours a day. It takes all your money. Three days dope sick, you’d do things you never wanted to do in your life.”

“You don’t break into houses, or cars for fun. It’s the desperation. Crime would drop off in a massive way. You’ll still have tweakers stealing bikes. “

“Alternative to the grind and hustle all day long everyday. Once you get the money, then you gotta find the shit.”

“By taking 12-24 hours out of someone’s life, they will have time to do things.” (Like housing, income, health care, social services, etc.)
[Emphatically affirmed by a second person]

“You take the criminal aspect out of it, you make everyone healthier and happier.”

“I am sick of being sick.”

“This would take the least flack. If they legalized drugs. It would change. It takes the criminal aspect out of it. That’s how you make communities out of it. If you legalize it, it takes the criminal aspect out of it.”

“Most people think of the crime associated with drugs. But with this, everything gets paid. Rent gets paid, bills get paid, the idea of being able to live like a human being that isn’t impoverished is so tempting. I do dope because it’s my medicine. I can’t talk to people without opioids, and various drugs in my system. I can’t imagine going out in the day without not having to spend every cent on drugs. What would I even spend my money on? Buy records, or whatever people do – that’s the dream.”

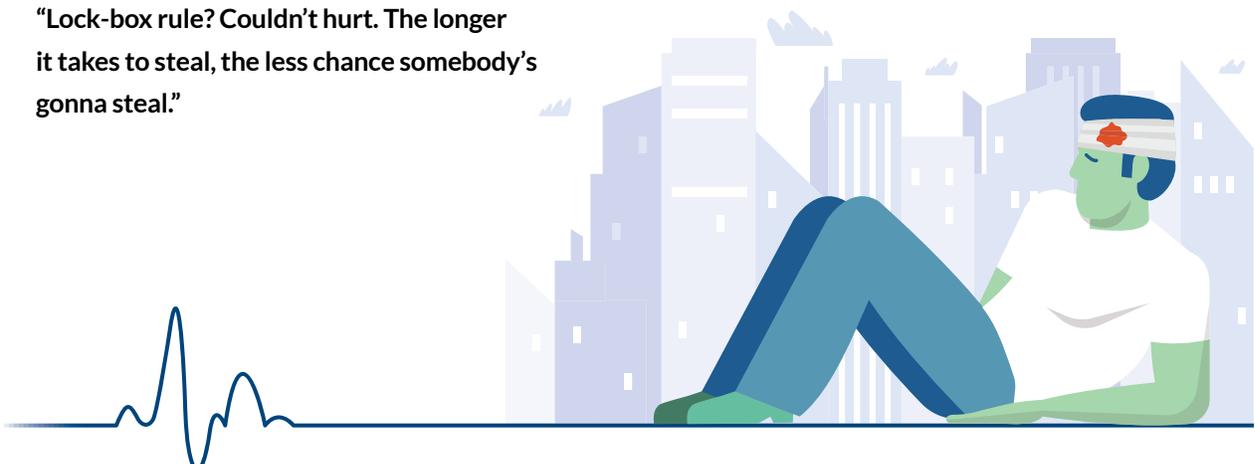
Potential risks of safe supply to women or vulnerable persons

“It’s not as dangerous as having to buy fentanyl. I don’t think it’s an issue.”

“Daily carries (take-home prescriptions) – the chance of getting robbed. Women? People who are small?”

“Lock-box rule? Couldn’t hurt. The longer it takes to steal, the less chance somebody’s gonna steal.”

“Women might be at risk of getting robbed. The intimate partners of women might be jealous.”



“YOU TAKE THE CRIMINAL ASPECT OUT OF IT, YOU MAKE EVERYONE HEALTHIER AND HAPPIER.”



“Partners being resentful, got more shots. If they are with someone...an ex, an abusive partner...they might not feel comfortable going there.”

“Clients would often come at similar times, women who were uncomfortable leaving (could use a buddy system). Just the fact that people aren’t leaving at the same time. I’d be more worried about people leaving alone.”

“I’m more worried about the people [using] on their own.”

“Jealousy could be a big thing [if not everyone gets into the program].”

“A one day carry probably wouldn’t get you robbed. But it’s possibly a concern.”



Safety: the changing cultural landscape

Participants talked about how culture has changed over the last few years. Trust is declining and violence, and the threat of violence appears to be increasing.

“Robberies, being jumped - we need to watch our own friends. It’s more violent than it was before. I will shaft someone in a heartbeat, I am so ready. It’s because people have gotten so goddam greedy with rent, keep it to a decent price. I can afford a place, I’m on ODSP, but there’s nowhere to rent. They say it’s because their costs are so much.”

“In terms of greed, it’s desperation. They are desperate to get their fix. I’ve seen so many people fuck over their so called friends.”

“Yeah, it’s worse than it was before. Like at the XXX you can’t leave your knapsack unattended. Before I could leave stuff and come back to it. Now if I want to nap, I need to sleep with it under my head, or hold onto it. Your phone is never safe, I would never be able to plug it in and go a table away.”



Impact on area surrounding fixed site location(s)



In a fixed site model – not the only model available – participants thought the impact on surrounding neighbours would be positive given the expected decline in crimes committed to acquire opioids by a subset of people who use unregulated drugs and survive on low or no income. Some participants thought nuisance issues are more accurately attributable to the behaviours of some people who use stimulants, due to issues of psychosis, sleep deprivation, etc.

“It will make the neighbourhood happy, it will give them peace of mind.”

“[It would] improve the lives of users, and the way people look at addiction in community. People would feel safer, not about to steal their cars. Some people would say you’re getting dope for free. But it’s about hope, not just saving lives, but making the connections where you can change your life.”

“Impact on surrounding neighbours – a lot of it is perceived. In reality, it lowers the crime rate. If the neighbours actually notice. They will be hyper-vigilant. A bunch of calls given the nature of the program. Not the same kind of desperation (for participants). None of us act like freaks. You don’t want to lose the program.”

“I think people will think negative [impacts] but it will be positive.”

“People will be on their best behaviour. Will lower crime, negative impacts.”

“It would be good to connect with neighbours.”

“Use existing research. Surrounding neighborhood would be positive, fewer people breaking into cars.”

“Needs to be a connection – community and mental health. How is there going to be anything that comes from it? Connection at least. If there is connection it starts somewhere and goes from there.”

“I was thinking more like security cameras, things like that.”

**“IT WILL MAKE THE
NEIGHBOURHOOD HAPPY, IT WILL
GIVE THEM PEACE OF MIND.”**



Findings: Operational Design Considerations

Unmet Demand



Demand: How many people might use a safe supply program?

We attempted to gauge participant's perceptions about what kind of demand exists for a program like this, since no evidence of prevalence exists. Potentially thousands of people across Waterloo Region are using unregulated opioids regularly however the demand for a safe supply program is unknown, and it is likely an early initiative that will not be able to serve all who could benefit. Participants sensed structural limits to funding and program capacity.

"300-400 people."

"250? 500?"

"Every serious user in the tri-cities."

"For people who can't use methadone, they would choose this. It's a different kind of stability."

"I couldn't even guess. People would drive in from the suburbs. Now they're going to (methadone/Suboxone® clinics). They are all packed. To be fair, not all of those methadone folks are gonna jump in from a 12 step program to this."

"Don't just serve the hardest of the hard to serve."



**“DON’T JUST SERVE THE HARDEST
OF THE HARD TO SERVE.”**



What kind of qualities in staff would you like to see?

There was a clear consensus that focus group participants are deeply affected by stigmatization, stereotyping and discrimination emanating from service providers, governments, the labour and housing markets, and the public discourse generally. Participants spoke about the need for staff to be tolerant and non-judgemental.

“Yeah, a couple years ago my dad told me to watch a TED Talk, and it was about addiction. The opposite of addiction is attention, relationship. That’s what we need. The staff should have to watch that.”

“Acceptance, no judgement in the eyes of the workers. Like when XXX first started the XXX [a program], just love and acceptance. With food you do not limit them, you give them as much as they want, they will stop when they need to. But like a dog that’s been abandoned, they will be starving and we need to expect that. The first couple months they will overeat, but when they know they are safe they will eat less, and less. Behaviours, manners, having an open mind (are good staff qualities).”

“Something similar to XXX, or whoever is involved in their community, so their outreach worker goes with them, so there is no judgement.”

“Yeah, judgement is a huge issue, like at XXX hospital. If you’ve had past use, years and years ago, they still judge you, and that affects the care that you get.”

“People need some sort of... common sense. These people, this is what you’re going to get, worst case, eyes wide open. If you can’t handle this then don’t take the jobs. There’s going to be a high burnout.”

“Something like peers? The kind of staff at the SIS (safe injection site) is supposed to have-non-judgmental.”

“No staff should be 12-steppers.”



Demand: What kind of hours would you recommend for a fixed site?

“24 hours? Early enough to go to work... opening at 6 would be better, or maybe 7 or 8 am.”

“6 am – 6 pm would be super.”

“8 am until late, or a carry, then 5 pm.”

“There are a lot of working people. Open till 9 pm or 10 pm. If you have carries (several days of take-home medication) it’s different.”

“7 am - 10 pm. 6 am is early.”

“9-9. Sick people start work early, you’re on the roof until your done, sometimes you don’t get off work til 8. I don’t think it takes an hour to get downtown.”

“12 hours, it all depends on funding. Wouldn’t want to miss shift workers.”

“8 am till midnight. They would show up for sure.”



Demand: Estimated frequency of site visits at initiation

There was general agreement that participants would visit 3-4 times per day at initiation. In addition to the specific prescriptions offered, options such as carries, or providing an overnight dose, or permission to take the wash (residue) home are variables affecting the frequency of visits.

“Bare minimum 2 visits, probably 3. Are you allowed to take your wash [with you]?”

“Could I have one carry for the night?”

“I don’t know many junkies to hold onto the morning dose.”

“Are you allowed to take your wash home?”

“We would max it out. I would show up as many times as you would let me, until I filled the void. When I was safe, and then I would move on to something else.”

“People would come back a bunch because it isn’t high enough. We would need to find the perfect dose.”

“I grew up in group homes - 32. They are pretty clear and desperate in their ways. Different then when you’ve had safety and been loved. Once kids left and got three meals and love, then they got proper. They felt safe quickly. And they tried to teach their loved ones. Once people feel safe, and it’s not something they have to sell their soul for. They would want to do more.”



“From my perspective, it depends on the day. Work day – once during my day. I could maybe go three times. If I had the times, I’d go on three times on the weekend. If I was off methadone, (I would ask) is it holding me long-enough?”

“It depends, without three, I’m hesitant. It’s annoying to go back, and back. That’s why carries would be great. If you had the 8-12. If they could travel. Carries would be much better.”

“I was thinking people that don’t have a lot to do, they would go more often. People that do would go less often. If someone wants to stop - it will kill me, it’s killing my family - they would go.”

“This is a dream come-true for me. An outreach program that could bring people their doses if they were far away, or couldn’t make it. My pharmacist is willing to deliver.”



Pharmacy Pick Up

Involving pharmacies had unanimous support in both focus groups. Participants raised no concerns. Some people reported great relationships with their pharmacist and noted it would be convenient to pick up with other prescriptions.

Pharmaceutical considerations, mode of use, urine drug screens



Drug Formulations

There was a unanimous preference for brand name vs. generic brands, and a clear preference for powder vs. tablets or liquid formulations. Participants also talked about the high importance of preparing their substances for consumption. The availability of other formulations would break that habit but participants indicated the trade off would be worth it. Participants raised concerns about the risks of endocarditis associated with bulking or filler materials used in tablets throughout the focus group discussions.

“I don’t want fillers.” [endocarditis]

“Tablets—I’d rather make it myself.”

[Some formulations] “...gets them away from the ritual of addict.”



“Tablets unless the formula is concentrated enough. So much is the ritual.”

“Some of us are more addicted to the process. To the ritual.”

“Dilaudid is as close to the heroin as you can get.”



Modes of Consumption

Most participants preferred injection for themselves. For the most part, it was thought that most other program participants would prefer injection but accounts of a significant number of smokers were noted throughout the discussion. Participants anticipate that the prevalence of use by oral or snorting methods would be low to non-existent.

Thinking of other people who use substances, how do people prefer to consume their opioids? Would program participants switch their consumption methods over time?

“50% smoke, 50% bang.”

“Orally it takes too long to kick in.”

“Maybe 60:40 in terms of smoking to injection – a little more (smoking) for folks using fentanyl. Some people are scared of needles.”

“Would a nurse administer (inject) it? If it’s a nurse doing it... they don’t know how.”

If a safe supply initiative cannot offer a supervised smoking, would that be a problem?

“Some smokers would switch, but not every smoker is going to switch to IV. It’s the ritual.”

“And smoking stops working for them. And then they turn to banging (injecting) it.”

“It would be a challenge. From accessing, they don’t want to go to the next point. And then go onto the next point.”





Urine Screens

Participants were generally accepting of urine screens if required, and opportunities for research that would inform the program. Two of eight participants expressed deep reservation about observed urine screens.

“I can’t have cameras and people watch me. I have issues where I can’t have someone actively watch me. I can’t imagine being penalized.”

“I can pee on demand!”

Criteria of Participants



Should any requirements or criteria be added before allowing people to take home their substances? If so, what requirements would you suggest?

“I kinda feel like people should feel like there should be a small amount of time that you should be there. Consistency. To show that you’re committed but at the same time you want as few barriers as possible.”

“Figure out the optimal dose.”

“Develop relationships. Observe.”

“Do a mental health check up first.”

Should there be any criteria for removing people from a program like this? If so, what might that be?

Most participants thought that violence onsite, towards other participants or staff should not be tolerated.

“Threats towards staff.”

“I wouldn’t want there to be a lot of things to get people kicked off. If something comes up, you should have the chance to explain yourself.”

“I could end up using meth because I’m camping. I don’t want to be kicked out for that.”

“Maybe selling doses.”

“Stealing from the pharmacy.”

“I wouldn’t sell if it’s helping you get better.”



“...GOING DOWN A PATH, OF WHO WE ARE, WHO WE COULD BE...”



Additional Services



What other programs/services would be helpful?

In both focus groups, a housing discussion ensued, particularly around aspects of affordability, suitability, and gentrification. Participants indicated that the provision of safe opioids would free up significant time to take care of other basic needs, other services and opportunities.

“Services for single people.”

“Services and referrals for housing, identification, income, addiction treatment.”

“Peer support groups, lobby groups.”

“Art therapy, music therapy, other therapeutic groups.”

“A letter for carries/take-home prescription (in case of questioning by a physician or by police). The person’s name on the script bottle.”

“A night shift if you need it.”

“Rehab for anyone that wants it.”

“What has been listed for the CTS/SCS/SIS/OPS (supervised consumption site): OW/ODSP support, income, housing....just having things more streamlined.”

“Serious counselling. A lot of counsellors are judgmental. I accessed XXX for 12 years. Staff come and go. XXX is now a probation officer, I can’t talk to her anymore. It’s hard when it comes to that. Shouldn’t be a place where people are trained, should be where they stay.”

“A simple way - get involved in the clinic to cause an activity in the brain. Alarm clock to get some sort of idea on what they want to do. Using and using and using. Going down a path, of who we are, who we could be. I’m so sleepwalking myself. I would like someone wide awake.”



Advisory Committee



Would you be willing to assist with an advisory group, paid or unpaid?

Participants unanimously expressed a desire to assist in program development and possibly, program delivery should funding materialize. The preference was to be paid for their time and expertise however volunteering was seen as an option. Two advisory groups – one for men, one for women only – are recommended by participants.

“Volunteer for sure but less hours are available than if I was paid.”

“Paid is better, a bonus.”



Conclusion

There was clear support for establishing a low-barrier safe supply program. Participants and their peers expressed being terrified of the unregulated opioid market but also saw a lack options. Participants identified significant benefits in health, safety, and well-being for people regularly using unregulated opioids, and for the community at large. While the results are not generalizable to all people using unregulated opioids, participants provided key insights that may be common to many potential participants.

The focus groups provided key considerations for program design and delivery. Qualitative evidence of individual and community benefits in health and safety align with international findings from studies of similar initiatives in a therapeutic context. Participants repeatedly emphasized that achieving the optimal dose is critical to success. Potential participants are willing, and should be, involved in both program design and delivery to avoid the initiation and perpetuation of structural barriers that limit access.



Appendix A:

Oral Questionnaire Template Guide

Date: _____ # of participants: _____

Facilitator copy: _____

Focus Group Outline

1. (5-10m)

Introduction to the session, facilitators

Thanks for coming out to share your time and expertise. My name is _____ and I am _____.

Together, we want to ask some questions we really need your help with.

- This session is 1 of 3(?) that will inform a funding application for a new program.
- These are confidential sessions.
- What is said in this room stays in this room.
- Notes will be taken but no names will be attached or shared outside of this room. Notes will be a summary, not who said what.
- Cash at end of session.
- Thanks for coming out – it matters, a lot.

Reportable statements

- Harm to self, others

Happy to share final report back with you – just need a way to get it back to you.

Any questions?



2. (5-10m)

Could we quickly introduce ourselves to each other? (First name/alias fine)

Before we describe the project and get into the conversation, we want to be clear about our hopes for our short time together:

- Aim is for an open and honest conversation, without judgement or fear of judgement. We may have to cut you off if we are running out of time or to give others a chance to speak.
- Everyone gets to participate. Be patient, allow others to speak, do not interrupt.
- What is said in this room stays in this room.
- There are no wrong answers!
- My job is to keep time – we only have so much of it and lots to get through.
- Any other suggestions for an open and respectful conversation you would like to add?

Program Description:

A local group is interested in applying for funding to support an initiative that would provide pharmaceutical hydromorphone free of charge to people who currently use opioids purchased from the unregulated market. There is no guarantee of funding.

The program aims to have as few barriers to participation as possible. Briefly, the idea is people who are regularly using opioids would meet with a medical practitioner at a downtown location to be assessed for suitability for the program. If accepted into the program, participants would then work with medical professionals to be provided optimal doses of hydromorphone. At the beginning of the program, participants would obtain and use the hydromorphone on site under supervision of a medical practitioner. It is possible that 'carries' or 'take-home hydromorphone' will be permitted after a period of time.

There are many details still to be worked out, and the deadline for applications is just a few weeks away. We want your honest opinions and perspectives as your comments will very much help shape the application.



Qualitative assessment and demand for MOP (20-25m)

Q1 (10m)

1. Before we begin with our questions, are there any questions or impressions come to your mind about a program like this?
(Brainstorm questions, and not necessary to provide answers. Hearing what questions people have is the goal. Use flipchart.)

Q2 (10-15m)

- 2a. Thinking of yourself and people who use opioids regularly, would you expect the impact of a program like this to be:
Positive or mostly positive?
____ Why ?
Negative or mostly negative?
____ Why ?
If neutral, why neutral
____ Why ?
- 2b. Can you think of any benefits or negative impacts not yet mentioned?
Probe for impact on people currently receiving mmt or suboxone AND people not on mmt or suboxone.
- 2c. Would a program like this have any impact on people currently receiving mmt or suboxone?
If so, what might the impact be?
- 2d. Would a program like this have any impact on people NOT currently receiving mmt or suboxone? If so, what might the impact be?
- 2e. If crime and victimization impact has not been substantially discussed, ask: Would a program like this have any impact on crime and victimization?
- 2f. How many people do you think would want to use a program like this if it were in downtown Kitchener?



- 2g. Do you think people would travel to downtown from the suburbs to use a program like this?
- 2h. The program, if funded, would be open 7 days a week all year long. What daily hours should the program be open?
- 2i. How frequently do you think people would use the site each day?
- 2j. Infrequent urine screens might be a requirement. Do you see this as a major barrier to the program?

Opioids and consumption (15m)

- 3. Hydromorphone comes in a variety of formulations. In thinking of yourself and other people who use opioids, what formulation would people prefer? (Rank or percentage):

Brand name or generic? Long acting or short acting? Pills or powder or liquid?

- _____ Short acting generic hydro
- _____ Long acting generic hydro
- _____ Short acting brand name hydro tabs - Dilaudid 8mg
- _____ Long acting brand name hydro tabs - Dilaudid
- _____ Powdered hydro
- _____ Pre-loaded injectable liquid hydro - 10mg

- 4a. In thinking about how people consume opioids, what % of people using a program like this would prefer to mostly:

- _____ Snort
- _____ Inject
- _____ Oral
- _____ Smoke

- 4b. When you are or were using opioids, what is your preference?

- _____ Snort
- _____ Inject
- _____ Oral
- _____ Smoke



4c. Smoking presents program challenges. Given the availability of a safer and free supply of hydromorphone, do you think smokers would switch to other methods if smoking was not permitted onsite?

4d. Given the availability of a safer and free supply of hydromorphone, do you think people might switch from injecting to other methods of consumption?

4e. On a scale of 1-5, with 5 being the most important, how important do you think it is for people to prepare their own opioids vs someone else doing the preparation?

1

2

3

4

5

(Not important someone prepares their own)

(Very important)

4f. After 6 months or so, do you think people participating in the program would:

- Increase their use of MOP hydromorphone
- Decrease their use of MOP hydromorphone
- Maintain their use of MOP hydromorphone
- Not sure

4g. After 6 months or so, do you think people participating in the program would:

- Continue to seek fentanyl and/or other opioids from unregulated market
- Stop seeking fentanyl and/or other opioids from unregulated market
- Seek less fentanyl and/or other opioids from unregulated market
- Not sure

4h. After 6 months or so, do you think people participating in the program would:

- Increase their use of non-opioid substances
- Decrease their use of non-opioid substances
- Maintain their use of non-opioid substances
- Not sure



Location (15m)

5a. Should people be allowed to take the substances off site or pick up from a pharmacy to use later?

Yes: _____ No: _____ Unsure: _____

(Possible probe: any concerns with pharmacy pick up?)

5b. Should any requirements or criteria be added before allowing people to take home their substances? If so, what requirements would you suggest?

5c. Should there be any criteria for removing people from a program like this? If so, what might that be?

5d. In thinking about surrounding neighbourhood, can you think of any negative impacts on neighbours?

5e. Can you think of any ways to minimize negative impacts on neighbours?

5f. Do you see any health and/or safety risks for people participating in this kind of program? (Testing for theft of drugs here, potential for diversion)

5g. Do you see any health and/or safety risks to women and/or 'vulnerable' people participating in this kind of program? (Testing for theft of drugs here, potential for diversion, abuse of person)

Additional services (15m)

6. What programs/services would be most needed to provide additional service to participants of this kind of program?

7a. Would you be willing to join an Advisory Group for a project like this?

7b. Would you be willing to volunteer or is payment required?

8. Any other questions, comments, concerns, advice or reflections about a Managed Opioid Program?

9. Any other questions or comments?





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For more information please contact 519.575.4400 ext. 3474.

www.preventingcrime.ca | www.overdoseprevention.ca

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