

Adam Zivo: New study shows a quarter of safer supply patients diverting opioids

Program appears to be failing to incentivize addicts to move away from toxic illegal street drugs

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Drug addicts are selling the free hydromorphone opioids they get through government "safer supply" programs in order to buy even harder drugs such as fentanyl, an Ottawa addictions worker says. PHOTO BY POSTMEDIA NEWS

A new Vancouver-based study suggests that many "safer supply" patients are diverting their taxpayer-funded opioids to the black market and are possibly being dishonest to researchers about defrauding the system. Worse yet, it appears that safer supply may not be as effective at separating addicts from street drugs as advocates claim, even though the entire point of the program, as described by Health Canada, is to provide "a safer alternative to the toxic illegal drug supply"

The study was produced by Dr. Brian Conway, director of Vancouver's Infectious Disease Centre, whose research team administered anonymized questionnaires and urine tests to 50 of their safer supply patients this spring. They wanted to understand whether these patients were actually using their hydromorphone — a heroin-strength opioid distributed through safer supply — as intended.

It seems that many were not.

Nearly a quarter of the patients self-reported diverting their prescribed hydromorphone: 20 per cent claimed that they used only some of their pills and sold or traded the rest, while four per cent claimed that they diverted all of them.

However, the urine tests found that 24 per cent of patients had absolutely no hydromorphone in their system, which suggests that as much as a quarter of them — not just four per cent, as indicated in the questionnaires — may have diverted all of their hydromorphone. This suggests that a significant portion of the questionnaire responses (at least 20 per cent) may be false, and that diversion was more prevalent than patients were willing to admit.

It should be noted that urine tests in Canada are notoriously easy to cheat, as they typically only measure the presence or absence of a drug, not its quantity. Over the past two years, several physicians and former addicts have told me that safer supply patients are well-aware of this, and that many pass their tests by consuming one or two hydromorphone pills just before giving their samples.

Conway's study, though unpublished, was presented at the Canadian Society of Addiction Medicine's Annual Scientific Conference earlier this month, where I was in attendance. When I brought up the limits of urine testing to Conway during the event, he conceded that this was a legitimate issue and that the actual diversion rate among his subjects was likely higher than 24 per cent.

During his conference presentation, Conway explained that his research was designed so that partnering pharmacies confirmed that patients had picked up their daily safer supply in the morning, and that patients were then asked, later in the afternoon, to enroll in the study and give their urine. To reduce sample bias, patients were told that their results would not impact their prescription renewals.

I asked whether some of the patients simply hadn't had a chance to use their hydromorphone during this window, which could explain the drug's absence in some cases, but Conway said that previous qualitative studies suggest that safer supply patients, when presumably not engaging in diversion, consume at least some of their hydromorphone pills almost immediately upon receipt. This, combined with the high sensitivity of the tests used by his clinic, meant that the risk of false negatives for hydromorphone was low.

In his presentation, Conway stressed that, unlike other drug users, none of the studied patients died or had "medically significant" overdoses while on safer supply. In a follow-up phone interview, he clarified that this benefit was present regardless if patients were co-prescribed traditional addiction medications, such as methadone, which are proven to reduce overdoses and deaths.

However, some conference attendees, such as Dr. Launette Rieb, pushed back and noted that reduced mortality could be explained by the extra income generated by diversion, which allows for improved lifestyles, or by the fact that safer supply patients are given access to higher-quality, better-funded health care than other addicts.

Conway accepted that safer supply is "not completely safe," but argued that the program may have value in incentivizing engagement with the health-care system. Yet, if safer supply essentially bribes addicts into connecting with doctors, simply giving them cash might be less reckless at this point: at least we wouldn't be flooding communities with dangerous opioids.

Several audience members seemed unconvinced by Conway's defence of the program. "Isn't this very clear that we should probably be shutting this down?" asked one audience member, who raised the issue of youth using safer supply drugs. Conway acknowledged that youth are accessing diverted safer supply.

Although the studied patients were on safer supply for a median period of 15 months, street drugs were still found in all of their urine samples: 84 per cent tested positive for fentanyl, and 72 per cent for amphetamines.

The very purpose of safer supply is to separate recipients from riskier illicit substances, so it is concerning that the program appears to be failing in this regard.

When asked whether there was any evidence, aside from patient self-reports, that safer supply reduced (without eliminating) fentanyl use among his patients, Conway referred back to the reduced overdose numbers. He emphasized that safer supply is "not all good and all bad," and that it needs to be "fine tuned" after being misrepresented as a "silver bullet" for solving the addiction crisis.

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