London InterCommunity Health Centre

Safer Opioid Supply Program

PRELIMINARY REPORT

Acknowledgements

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Project Team

Gillian Kolla developed the facilitation guide with input from staff at London Intercommunity Health Centre, and conducted the focus groups. Gillian Kolla, Cathy Long, and Andrea Bowra conducted analysis of the data, and contributed to writing initial drafts of the report. Gillian Kolla, Melissa Perri and Rebecca Penn contributed to editing this report. Graphic design by Ryan White, R.G.D. Cover Art by Pirkko Saari, used with permission.

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Executive Summary

The Safer Opioid Supply (SOS) Program was started in 2016 at the London Intercommunity Health Centre (LIHC). The development of this program was informed by the recognition that traditional substance use and addiction treatment programs were not meeting the needs of some LIHC clients, particularly people who use drugs who were experiencing homelessness, street-involved, or disconnected from traditional models of healthcare delivery.

The main objective of the SOS program is to use a harm reduction approach to reduce some of the health risks associated with substance use, particularly overdose deaths related to fentanyl contamination within the unregulated opioid supply. In the SOS program, clients are provided with a prescription for pharmaceutical opioids to replace street-acquired substances from the unregulated drug market. SOS medications are generally provided as a daily-dispensed prescription for take-home dosing by clients. In addition to the provision of pharmaceutical medications, all SOS program clients are also offered comprehensive health and social services by an interdisciplinary team consisting of primary care physicians, nurse practitioners, nurses, systems navigators, outreach workers, and care facilitators.

This report details the findings from a mixed methods evaluation of the Safer Opioid Supply program at London Intercommunity Health Centre from 2020 to 2021. The goal of this evaluation was to examine the scale-up of the SOS program after Substance Use and Addictions Program (SUAP) funding was received from Health Canada in March 2020, in order to identify what was working well and what could be improved as part of an ongoing quality improvement and SOS program evaluation plan.

The main objective of the SOS program is to use a harm reduction approach to reduce some of the health risks associated with substance use, particularly overdose deaths related to fentanyl contamination within the unregulated opioid supply.

Summary of Main Findings

Clients in the SOS program overwhelmingly appreciated the program, finding that it was reducing their overdose risk by providing a known dose of a pharmaceutical medication. They also felt that it was helping them to stabilize their health, improve their social functioning and well-being. When speaking about staff members, SOS clients referred to feeling that they are treated with respect and being provided with compassionate care that meets their health needs. LIHC staff also observed positive impacts of the SOS program on clients. However, staff also addressed the continuing negative impacts of the homelessness crisis in London on SOS clients, highlighting how this creates difficulties finding appropriate sheltering options for people living on the street and contributing to negative health and social impacts.

SOS program benefits

Health and social impacts of the SOS Program: Clients reported numerous health and social benefits of being on the SOS program, including reductions in overdose risk and improvements in health and social wellbeing.

- 59.6% of SOS clients stated their physical health improved since starting Safer Supply

“If it wasn’t for this program, I really don’t think I’d be here right now... and feeling as healthy as I do.”

(FOCUS GROUP 2 WITH SOS CLIENTS)

Increased access to health and social services: The SOS program allowed for increased access to health and social services, including primary care, counselling, and housing support.

“I got my Hep C taken care of...now I can walk with my head held high.”

(FOCUS GROUP 2 WITH SOS CLIENTS)

Reduction in criminal activities: Access to the SOS program helped clients reduce involvement in criminal activity and in sex work as a means to obtain substances.

- 47.4% of SOS clients reported decreased involvement in criminal activities as a means to obtain substances since starting Safer Supply

“We don’t have to go to the streets anymore to make our habit, to make money to pay for our pills. Since I’ve been on it [the SOS program], I haven’t gone to jail in three and a half years. So, that’s a good thing. I’m pretty much not working [in sex work] at all anymore, so. It saved my life.”

(FOCUS GROUP 2 WITH SOS CLIENTS)

Improved relationships with family members and friends: The SOS program provided clients with stability and safety which led to improved relationships with family members and friends.

> *For myself, it's helped my relationship with my family now. I can go take my daughter's kids out, which she wouldn't let me before. I've been on the program – almost 4 years, 3 and a half years. For me, it's the relationships I've gotten with people that I haven't had before.*

(FOCUS GROUP 2 WITH SOS CLIENTS)

Reasons for wanting to be part of the SOS program among people who use drugs on the waitlist for the SOS program

To avoid overdose and criminalization: One of the prime motivations for wanting to be on the SOS program was to reduce the risk of overdose. Participants also noted a desire to reduce involvement in sex work, street hustles and criminal activities.

> *I'm afraid that if I don't get some help soon, I'm going to have to go to that fentanyl, and I don't want to because I've seen too many people die, and I don't really want to die yet.*

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

To improve health and stability: A desire to inject less fentanyl—or to avoid using fentanyl altogether—was a key driver for wanting to be on the program. Many of those attempting to access the SOS program (as well as those on the SOS program) had current or previous experience with opioid agonist therapies (OAT) such as methadone or buprenorphine, and it had not been effective for them.

> *I'm on methadone and I've been put up to 100 ml of meth, and it's not helping anything.*

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Clients in the SOS program overwhelmingly appreciated the program, finding that it was reducing their overdose risk by providing a known dose of a pharmaceutical medication.

Challenges faced by SOS program clients

High demand for the SOS program: Clients and people wanting to be on the program reported frustration with the lack of expansion of SOS programs more broadly in other settings and the lack of prescribers given the high levels of community need.

> *I think the problem is that all the people that need the program, there's not enough doctors that are doing it. That's the problem.*

(FOCUS GROUP 2 WITH SOS CLIENTS)

Lack of information about SOS program admission and eligibility criteria: Participants expressed frustration over the lengthy wait-times to access the program and unclear eligibility criteria.

> *It's almost like, I have to literally, I'm breaking through a wall – nobody's telling me anything. I just want to know how to I get on the damn program...*

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Lack of pharmaceutical medication options available: Clients described the importance of having a wider variety of prescription opioids available on the provincial formulary, given the diversity of needs that exist and the high tolerance due to exposure to fentanyl from the street market.

> *If we had it, if we had heroin, people would give up the Dilaudids for the heroin.*

(FOCUS GROUP 1 WITH SOS CLIENTS)

Negative experiences within the healthcare system: Negative perceptions about substance use in the health system and during hospitalization resulted in patients receiving sub-optimal pain control and withdrawal management, and influenced continuity of care during hospitalization.

> *I had major surgery, and they didn't agree with the program, so I went through withdrawals right after major surgery.*

(FOCUS GROUP 2 WITH SOS CLIENTS)

Safety concerns: Other challenges identified by participants included safety concerns related to pharmacy pick-ups, gender-based violence, and sharing and selling of medications.

> *Like you can't be on it and not expect to be splitting with your spouse. That's just common sense. You're not going to be sitting there doing your dope and watching your spouse sick. That's not happening.*

(FOCUS GROUP 2 WITH SOS CLIENTS)

Program features and design considerations

Need for onsite supervised consumption service: Participants noted that having an SCS located at LIHC or very close by would be useful, as this was an area where people are already gathering to use substances. They reported feeling safe using in London's SCS, but that distance made access difficult.

> ***For me it's safe, it's safety. I feel comfortable there. Nothing's going to happen to me. I can do my hit and relax for a bit.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Staffing considerations: Participants emphasized the need for more staff to increase the capacity of the SOS program. COVID-19 related restrictions continue to severely affect SOS clients, whose complex health and social needs have intensified in the last year and a half, leading to high workloads for staff.

> ***We need more staff, we need more prescribing providers, and more space. Right now, we're running them off their feet.***
>
> (FOCUS GROUP WITH SOS STAFF)

Recommendations

Based on feedback from staff, SOS clients, and people who were on the program waitlist, there are several program and health-system level recommendations that arise from this evaluation.

Program-level recommendations

Increase the number of prescribers: Unanimously, participants felt there was a strong need to increase the capacity of the SOS program so that it would be able to meet community demand.

Provide clear information about waitlist and triage criteria: Clearer communication of program details, such as program eligibility and timelines, is needed.

Continue to expand wraparound services: Participants expressed a desire for additional wrap-around services, including integrating people with lived or living experience as staff members, to meet community need.

Offer supervised consumption services: Clients stressed a need for a supervised consumption service (including supervised smoking/inhalation services) at or near LIHC to ensure easy access.

Emphasize harm reduction strategies through education campaigns: Continued harm reduction education campaigns regarding the importance of safe substance consumption practices (e.g., heating drug solutions prior to injection) is necessary.

Provide accompaniment for pharmacy pick-up: Safety concerns raised by some clients when getting their prescriptions may be addressed by having a LIHC staff member available during busy periods at the pharmacy.

Advocate for program expansion and increased pharmaceutical options: In order to meet broader community needs that may be driving sharing and selling of medications, expanding program capacity and pharmaceutical options should be pursued

Systems-level recommendations

Expand coverage for high-dose injectable opioid formulations on the Ontario Formulary: The lack of high-dose opioid formulations covered by the Ontario formulary is a major challenge in meeting the needs of SOS program clients.

Expand access to diacetylmorphine: Clients highlighted that heroin (diacetylmorphine) would be the most useful opioid medication to have available, and an additional benefit is that diacetylmorphine holds potential as a safer supply option for people who smoke fentanyl.

Address stigma and discrimination within the healthcare system: Stigma and discrimination towards people who use drugs and people on the SOS program were commonly reported and are impeding access to care.

Provide continuity of care and improve pain and withdrawal management for hospitalized SOS clients: Inadequate and often stigmatizing treatment in hospitals led to disruptions in continuity of care for SOS clients when hospitalized. Greater understanding of withdrawal management and pain control for people who use drugs is essential.

Background

The overdose crisis in Canada and in Ontario

Canada is facing a devastating overdose crisis; over 21,174 people have died from opioid-related overdose between January 2016 and December 2020[1]. In 2019, Ontario became the province with the highest number of deaths with 1,512 opioid toxicity deaths recorded. This was the first year that Ontario surpassed the province of British Columbia, which has been considered the epicentre of the overdose crisis in Canada. Unfortunately, the COVID-19 pandemic has worsened the rates of opioid-overdose related deaths across the country; with 2,426 people who died from opioid-overdose in Ontario in 2020[2]. There was a 79.2% increase in overdose-related deaths across the province of Ontario during the COVID-19 pandemic period[2].

The overdose crisis is driven primarily by unregulated, illicitly-produced fentanyl (and fentanyl analogues) that have supplanted heroin in the unregulated opioid supply in many parts of the country, including Ontario. In 2018, the presence of fentanyl was detected in 74% of opioid-related deaths in Ontario[1], and this percentage has continued to rise. Since the beginning of the COVID-19 pandemic in March 2020, fentanyl was a direct contributor to 87% of all opioid-related deaths in Ontario[2]. Additionally, there is volatility in the composition of the unregulated drug supply; carfentanil and other extremely potent fentanyl analogues are frequently detected, and there has been a worrying increase in benzodiazepine class drugs (such as etizolam, flualprazolam and flubromazolam) in fentanyl samples over the last 2 years[3]. An urgent expansion of strategies is necessary to both prevent and respond to opioid-related overdose.

Harm reduction and treatment interventions to address the overdose crisis

There are several treatment and harm reduction interventions that were in operation prior to the onset of the overdose crisis that have been adapted or scaled-up in response to the growing number of opioid-related deaths. These include the distribution of naloxone kits[4], supervised consumption services (SCS) and overdose prevention sites[5,6], opioid agonist therapy (OAT)[7,8,9] (i.e. methadone, buprenorphine/naloxone and slow release oral morphine), and injectable OAT programs (iOAT) (i.e. diacetylmorphine (heroin) or hydromorphone)[10,11,12]. Encouragingly, there is evidence that the expansion of harm reduction interventions such as naloxone distribution, SCS and OAT across Canada since 2016 has been responsible for averting overdose-related deaths[13]. However, issues with slow scale-up of these interventions and equitable access across the country remain major impediments to a comprehensive response to the overdose crisis.

While the programs listed above are necessary and lifesaving, these programs do not fully address the drivers of the overdose crisis: criminalization and the volatility of the unregulated drug supply. Additionally, there continue to be access barriers for the harm reduction and treatment programs listed above, as they are not available in all communities (and particularly rural and remote areas) or accessible for all community members (such as women, gender-diverse people, or members of racialized communities). These factors are particularly relevant for newer treatment modalities such as iOAT, where access barriers persist due to lack of programs in most of the country, with limited geographical reach and limited hours of operation even in areas with iOAT programs [6,14]. While treatment with methadone and buprenorphine is associated with reductions in overdose[15,16], retention in traditional OAT programs is poor [17,18]. For example, retention of first-time methadone patients at one year was found to be just under 50% in Northern Ontario and 40% in Southern Ontario, with a median time to discontinuation in the southern part of the province of around 6 months[17].

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SOS programs aim to reduce overdose by giving clients access to legal, pharmaceutical drugs of known potency and consistency. It is important to recognize that the call for 'Safer Supply' comes from people who use drugs and applies to all currently unregulated substances.

Additionally, current data shows that during the COVID-19 pandemic, 75.3% of overdose deaths occurred in a private residence, with 72.6% of people being alone at the time of death with no one present to intervene[2.] These findings suggest a strong need for harm reduction and overdose prevention strategies that aim to prevent overdoses from occurring in the first place, in addition to strategies that intervene after an overdose has occurred. Novel measures are rapidly needed to address the overdose crisis and the contamination of the unregulated opioid supply across Canada[19,20].

Rationale for Safer Opioid Supply programs

One of the novel measures aimed at addressing the overdose crisis are Safer Opioid Supply (SOS) programs. In SOS programs, physicians prescribe short-acting opioids (usually hydromorphone tablets) to clients to replace the unregulated opioids they rely on from the street-acquired drug supply[21, 22, 23,24,25]. These medications are generally provided as a daily-dispensed prescription for take-home dosing by clients. In some of the SOS program models, clients are also engaged in comprehensive primary care if they desire as part of an interdisciplinary client-centered, team-based, and comprehensive approach to the provision of care within a community health centre model[21]. It is important to recognize that the call for 'Safer Supply' comes from people who use drugs, and applies to all currently unregulated substances[14]. Medicalized safer supply programs - where prescriptions for pharmaceutical alternatives are provided as a harm reduction measure – are an attempt by some prescribers to address the crisis of overdose deaths from an unregulated drug supply that is now predominantly illicitly-produced fentanyl in many parts of Canada. In 2020, the number of these programs began to increase across Canada, as a form of 'risk mitigation' prescribing to address the intersection of the overdose crisis and the COVID-19 pandemic[23,24,25].

SOS programs aim to reduce overdose by giving clients access to legal, pharmaceutical drugs of known potency and consistency. They are informed by research on the efficacy of Heroin Assisted Treatment programs that have been part of substance use treatment in Europe since the 1970's[26,27]. Clinical trials of diacetylmorphine (pharmaceutical heroin) for opioid dependence - including the NAOMI study in Canada - have shown good evidence for safety, retention in treatment, reduced use of illicit drugs, and sustained health and social benefits [10,11]. Furthermore, the Study to Assess Long-term Opioid Maintenance Effectiveness (SALOME) clinical trial found that high dose injectable hydromorphone was non-inferior when compared to diacetylmorphine[10]. In the SALOME trial, hydromorphone was found to have a similar profile of adverse events as diacetylmorphine and was also associated with fewer seizures[28]. Demonstrated outcomes from these studies included: increased and sustained engagement in healthcare, improvements in self-reported mental and physical health, a decline in money spent on drugs and activities to acquire drugs, and decreased overdose [10,11,26,27]. National clinical and operational guidelines have been developed for iOAT programs that are based on the experience of service delivery and published research studies [29-31].

These studies demonstrate the efficacy of Heroin Assisted Treatment and iOAT. However, these strategies generally require supervision of all doses of injectable medications, where clients must attend a clinic multiple times a day to take doses of their medications under observation. This service delivery model is costly and difficult to scale-up to address needs across Canada, particularly in smaller cities, and in rural and remote areas. The SOS program developed by London InterCommunity Health Centre (LIHC) provides a prescription for daily-dispensed, take-home doses of short-acting hydromorphone tablets (primarily Dilaudid brand, due to this tablet's ease of dissolution into solution), with or without slow-release oral morphine (Kadian) as a long-acting opioid backbone co-prescribed for witnessed dosing at the pharmacy.

How does the Safer Opioid Supply program at London Intercommunity Health Centre work?

LIHC has been operating since 1989, when it was opened as the first community health centre in London, Ontario. The LIHC model focuses on keeping people – and the communities where they live – in good health by providing comprehensive primary health care services, health promotion, and community development.

The SOS Program was started in 2016 by Dr. Andrea Sereda as an extension of the harm reduction model at the Health Centre. It was informed by the recognition that traditional substance use and addiction treatment programs were not meeting the needs of some LIHC clients, particularly those who were experiencing homelessness, street-involved, and disconnected from traditional models of healthcare delivery. The primary goals of the SOS program were to reduce some of the health risks associated with injection drug use, particularly the rapid increase in overdose deaths related to fentanyl contamination within the unregulated, street-based opioid supply in London, Ontario and across Canada.

The SOS program at LIHC began slowly and was initially offered to people who physicians believed to be at high risk of imminent death due to unmanaged health conditions (e.g. infective endocarditis, untreated HIV), and to those who were having difficulty engaging with the health system because their drug use could not be accommodated within a traditional healthcare delivery model. The program started with three clients who were heavily street-involved, and who were in a cycle of frequent hospital admissions due to overdose and infectious complications from injection drug use. They had not been successful in engaging in traditional substance use treatment options like methadone. These patients were often released from hospital on a 'weaning' prescription of hydromorphone, and Dr. Sereda observed that while on this weaning prescription they stabilized, were able to engage with healthcare, and were not buying from the street supply of opioids. However, when their weaning prescriptions ran out, they would be forced to return to buying unregulated opioids on the street, and their health would deteriorate again. So, Dr. Sereda began continuing their opioid prescriptions. By providing them with a prescription for pharmaceutical opioids like hydromorphone, they stopped buying opioids from the street supply, were able to re-engage with healthcare, and their hospital admissions stopped. This was congruent with results from the NAOMI and SALOME research studies in Vancouver[10, 11], where people were provided with pharmaceutical injectable heroin and hydromorphone. However, neither of these pharmaceutical options were available in Ontario, so a different approach was taken. Short-acting hydromorphone tablets were prescribed as a daily-dispensed, take-home prescription, with the dosage determined on an individual basis, taking into account individual tolerance and medical conditions. Clients were seen in clinic frequently as their medications were titrated to a stable dose, and then weekly thereafter for close monitoring. Ongoing monitoring includes clinical assessment and primary care, as well as access to an interdisciplinary team providing harm reduction education and wrap-around allied healthcare including connection to outreach workers, psychiatric support, intensive HIV case management, onsite HCV treatment team, support with finding housing, and an intensive case management program for street-involved women engaged in sex work.

As the program slowly expanded, a decision was made that the SOS program would focus on harm reduction as the guiding philosophy of care, and that the program would be firmly rooted in the voices of people who use drugs and developed with their guidance. An important part of the SOS program is that it is embedded in a community health centre that provides low barrier primary care. Every client in the SOS program becomes a family practice patient at the community health centre, and comprehensive primary care is provided for all SOS clients alongside their SOS prescriptions. This means that every patient has the option of receiving wrap-around harm reduction services and primary care as part of the SOS program model.

As the program slowly expanded, a decision was made that the SOS program would focus on harm reduction as the guiding philosophy of care, and that the program would be firmly rooted in the voices of people who use drugs and developed with their guidance.

All SOS program clients are offered a broad array of wrap-around health and social care by an interdisciplinary team consisting of primary care physicians, nurse practitioners, nurses, systems navigators, outreach workers and care facilitators, who use a social determinants of health and harm reduction approach to address clients' health and social needs.

Program description: The SOS program at LIHC

The SOS program is part of the broader Health Outreach programming offered by LIHC that provides support for people experiencing homelessness or who are heavily street-involved in London, Ontario. All SOS program clients are offered a broad array of wrap-around health and social care by an interdisciplinary team consisting of primary care physicians, nurse practitioners, nurses, systems navigators, outreach workers and care facilitators, who use a social determinants of health and harm reduction approach to address clients' health and social needs.

During the intake process, all SOS program clients meet with the systems navigator, who helps to assess their individual needs and circumstances. Once their individual needs are identified, clients are referred to both health (HIV or hepatitis C education, diabetes education, nutrition services, harm reduction education) and social services (housing support, assistance applying for social programs, and counseling).

The health care team for the SOS program consists of family physicians, nurse practitioners and nurses. In addition to SOS prescribing, the health care team works with clients to address their primary health care needs, which includes treating conditions like asthma, diabetes, HIV, hepatitis C, providing comprehensive sexual health care and screenings, and regular preventative health care (for example, cancer screenings and vaccinations). More specialized medical care is also available by referral.

The social care team consists of system navigators, social workers, outreach workers and care facilitators. This team engages with SOS program clients to provide direct supports as well as linkages to services within LIHC or in the community that meet the needs that clients have identified. This can include assisting with harm reduction education and access to equipment and supplies, assisting clients to access food security as well as other basic needs (e.g., hygiene supplies, clothes), working with clients to find housing or to prevent housing loss (for those in precarious housing), assistance with transportation to and accompaniment for appointments, engaging in advocacy with clients (on issues like accessing income, housing, or in the justice system), community outreach, and supportive listening for clients. Health Canada's Substance Use and Addictions Program (SUAP) funding also allowed the SOS program to add two care facilitators in January 2021 to further assist SOS program clients address their needs.

Program description: By the numbers

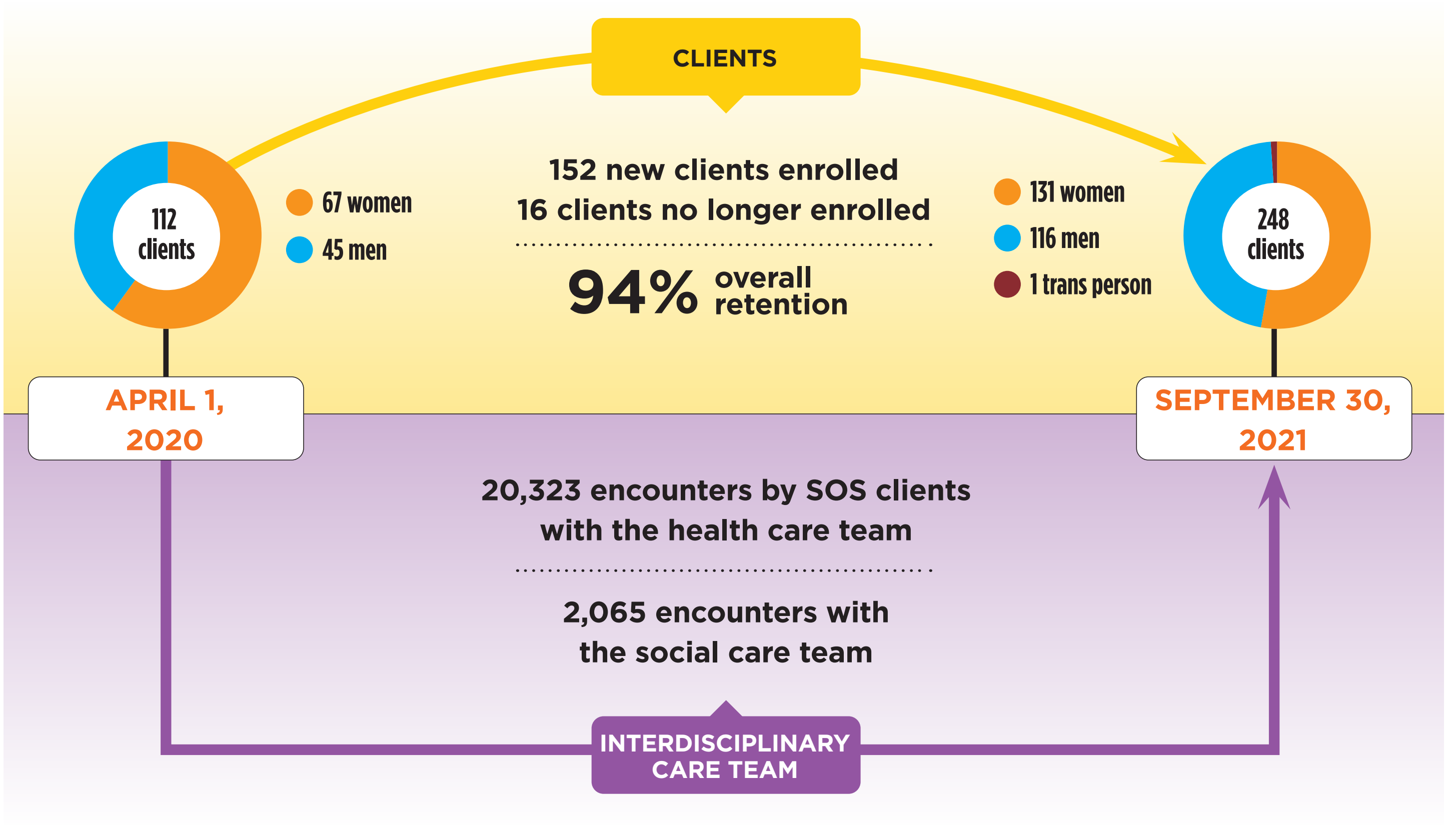
In the spring of 2020, the SOS program at LIHC received funding from SUAP to expand their program operations. On April 1st, 2020, when SUAP funding began, there were a total of 112 clients enrolled in the SOS program (67 women and 45 men).

As of September 30th, 2021, there are a total of 248 active clients enrolled in the SOS program (131 women, 116 men and 1 person who is trans, non-binary or gender non-conforming).

Between April 1st, 2020 and September 30th, 2021, there have been 152 new clients enrolled in the SOS program, and 16 clients who are no longer part of the program. The overall retention for the program is 94% in this period.

Between April 1st, 2020 and September 30th, 2021, there have been a total of 20,323 health care encounters by SOS clients with health care team (LIHC physicians, nurse practitioners and nurses), and 2,065 encounters with the social care team (system navigators, outreach workers and care facilitators).

In the last 6 months (April 1st, 2021 to September 30th, 2021), there were 7,772 encounters with members of the health care team, and 846 encounters with the social care team.



Impacts of the SOS program on clients

This report was produced from data gathered using a mixed methods approach. Both focus groups and survey data was gathered from clients on the SOS program. Additional focus groups were also held with SOS program staff and individuals on the wait list for the program. More methodological details are available in the Methods Appendix at the end of the report. In this section, survey data will be presented. Beginning in the next section, major themes emerging from analysis of data from focus groups will be explored.

Survey with SOS clients

As part of the quality improvement and program evaluation goals for the SOS program, two surveys were developed to monitor the impacts of the SOS program on clients. Below, we report on the results of this survey, which was conducted from April to October 2021.

Surveys were conducted with two separate groups:

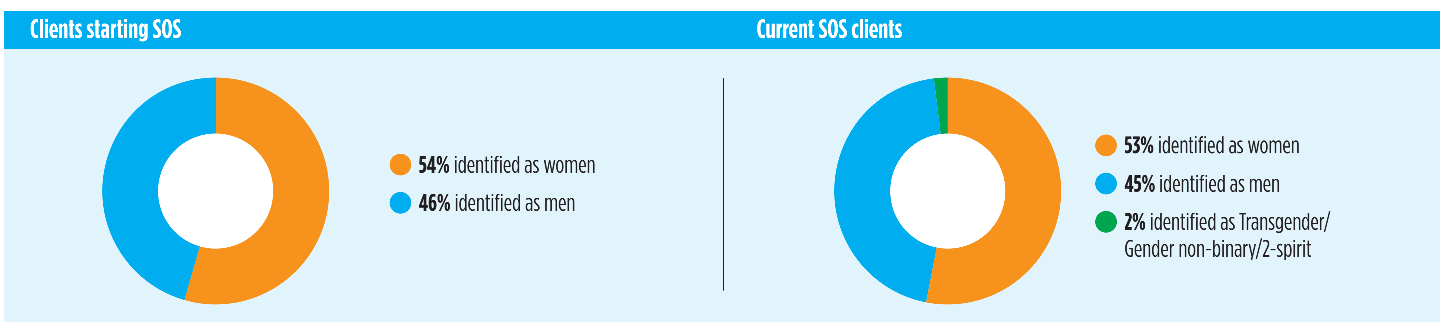
- 19 people who were admitted to the SOS program being initiating onto treatment, at intake. These surveys were conducted from April to October 2021.
- 59 people who were current SOS clients and who had been in the program at least four weeks when they completed the survey. These surveys were completed from June to October 2021.

Both surveys asked questions about drug use and social situation.

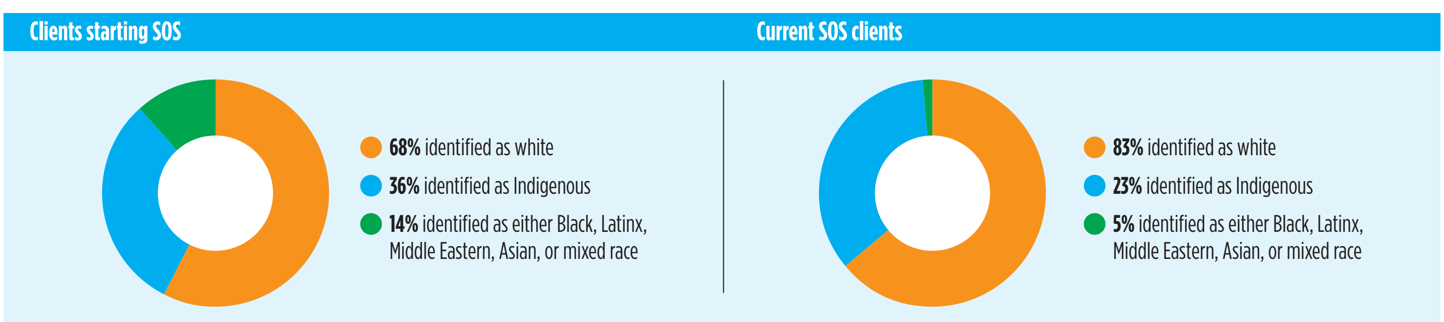
It is important to be cautious in interpreting these data, due to the small sample sizes in both groups and the lack of random sampling. This is descriptive data from a convenience sample of clients available and willing to complete the survey on days when data collection was occurring. As these data reflect two separate groups sampled at one point in time, the use of this sampling methodology means that we cannot make causal inferences from this data.

Demographics

GENDER

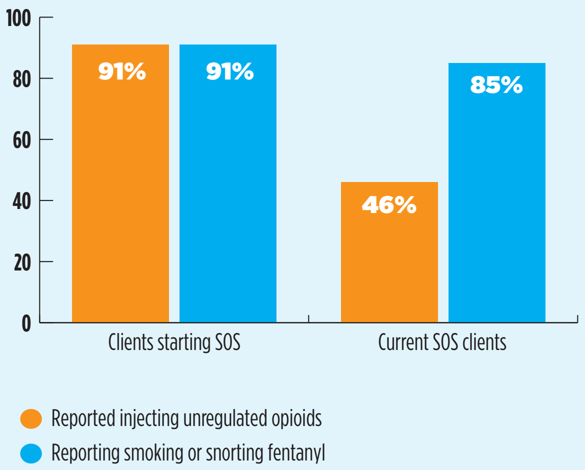


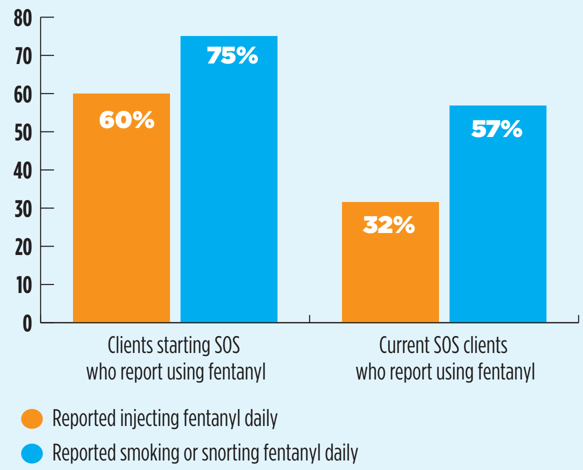
RACIAL AND ETHNIC BACKGROUND

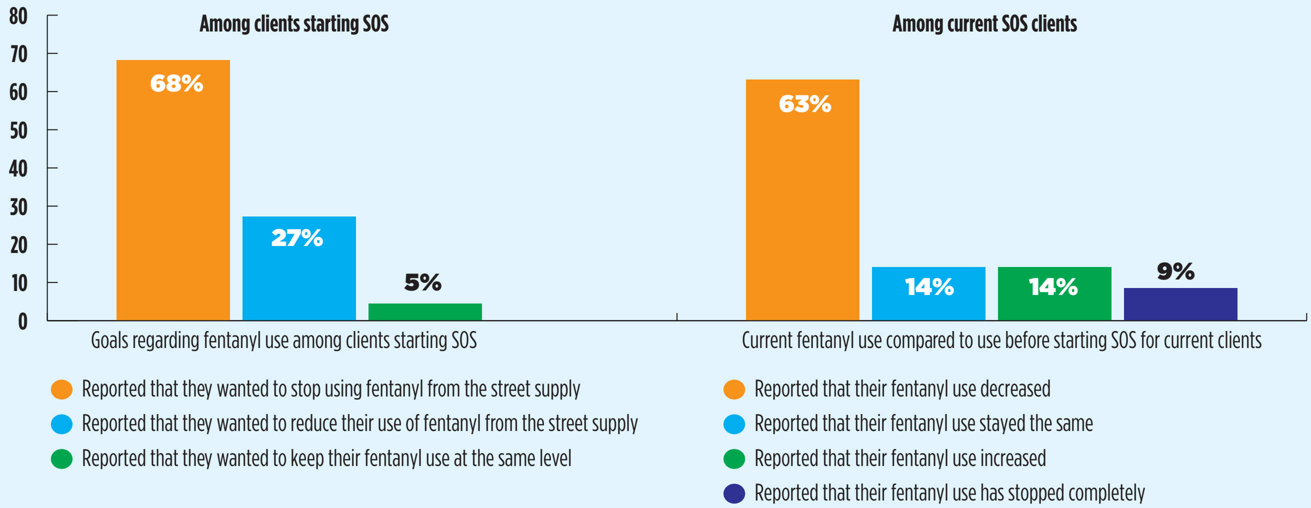


DRUG USE

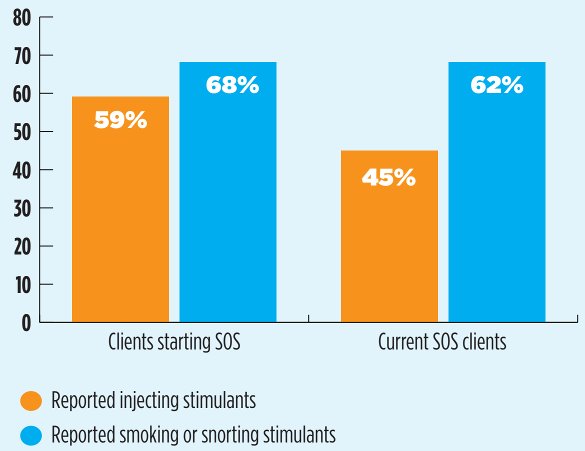
Use of unregulated opioids (fentanyl or opioids not prescribed to them)

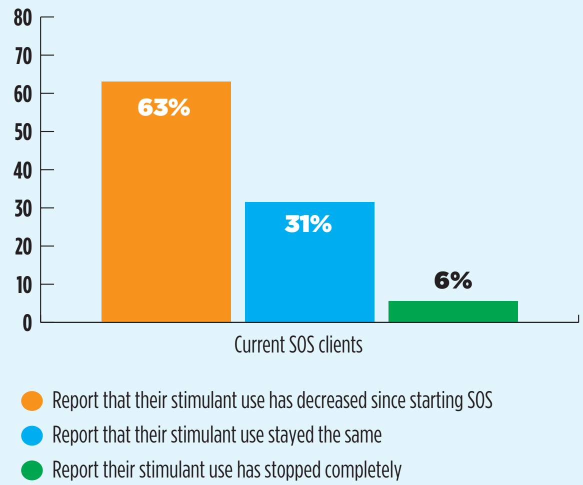






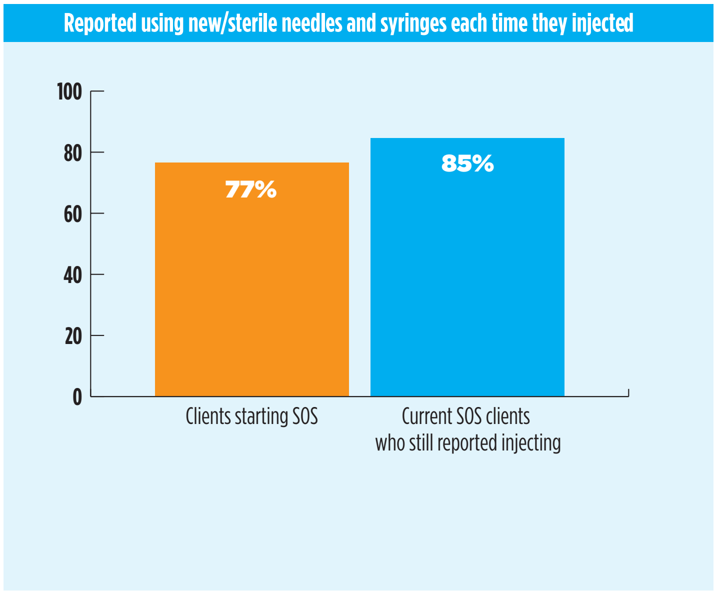
Use of unregulated stimulants (crystal methamphetamine, cocaine, crack, stimulant pills not prescribed to them)

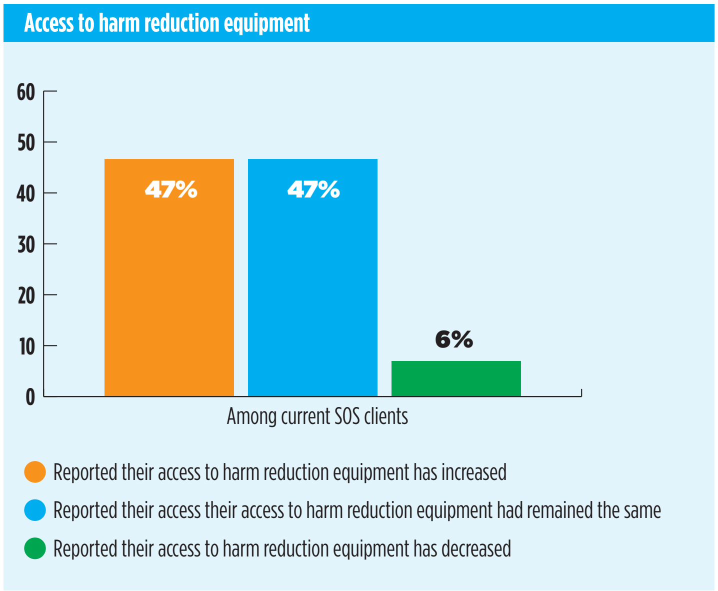




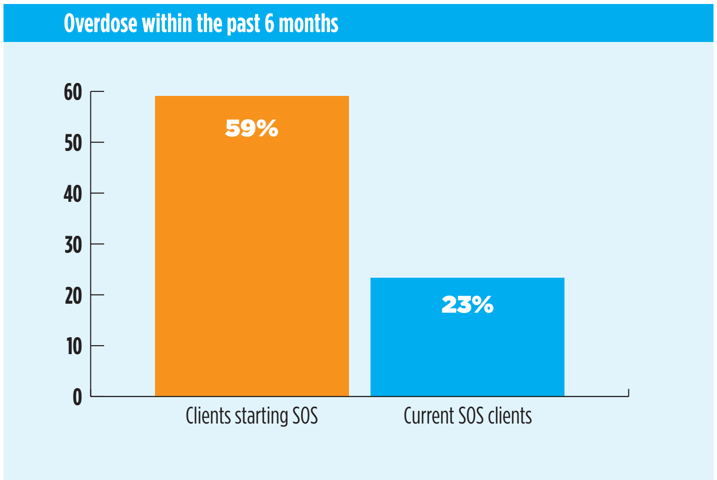
35% **of current SOS clients reported they were no longer injecting drugs at all.**

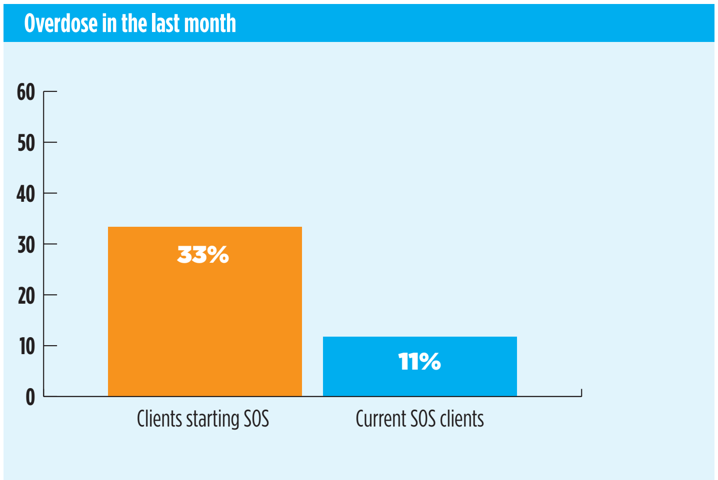
HARM REDUCTION EQUIPMENT USE



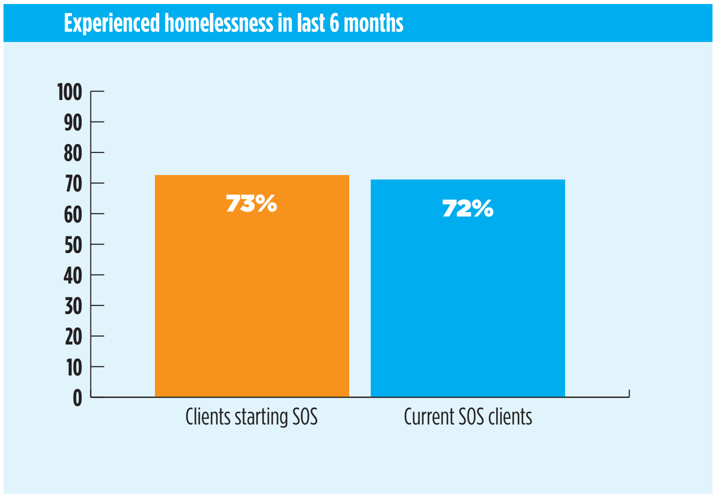


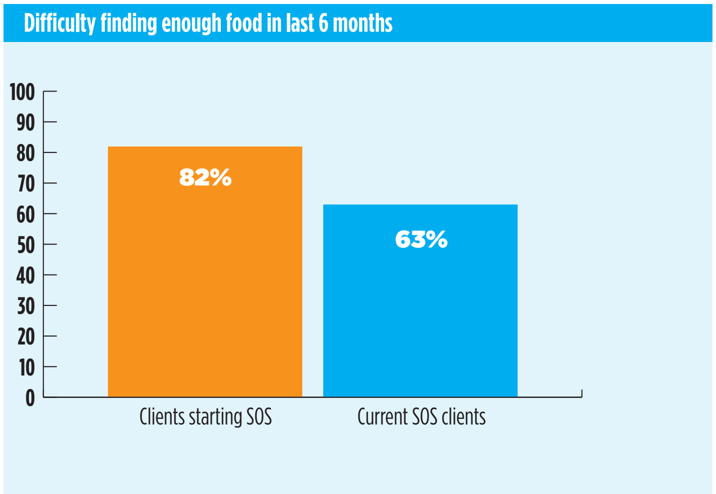
OVERDOSE

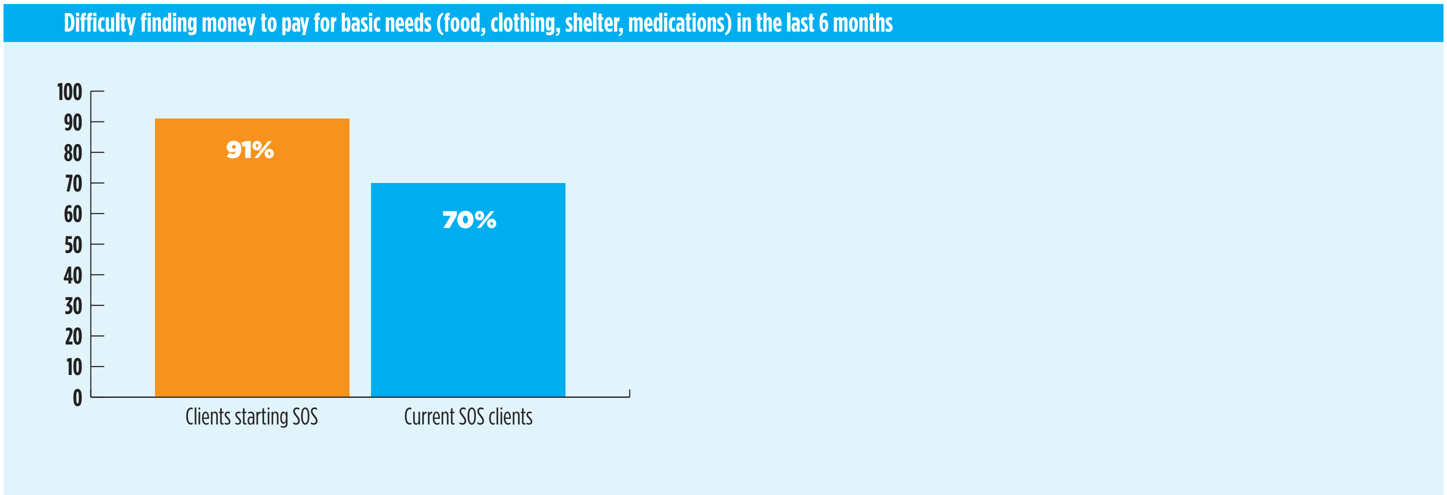




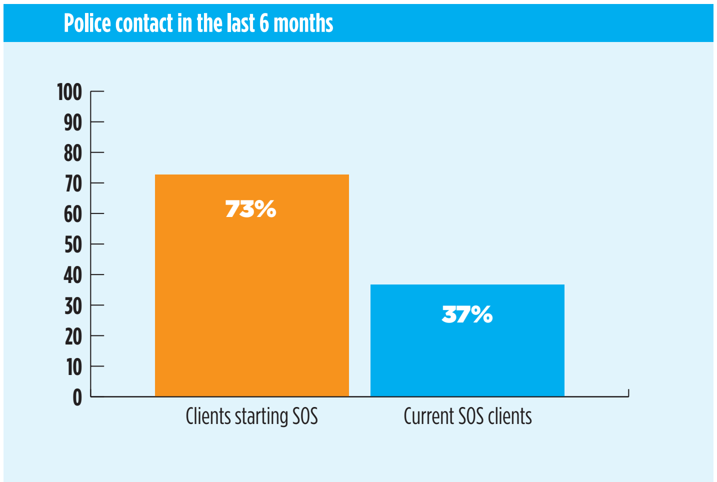
HOMELESSNESS, FOOD INSECURITY AND DIFFICULTY PAYING FOR BASIC NEEDS

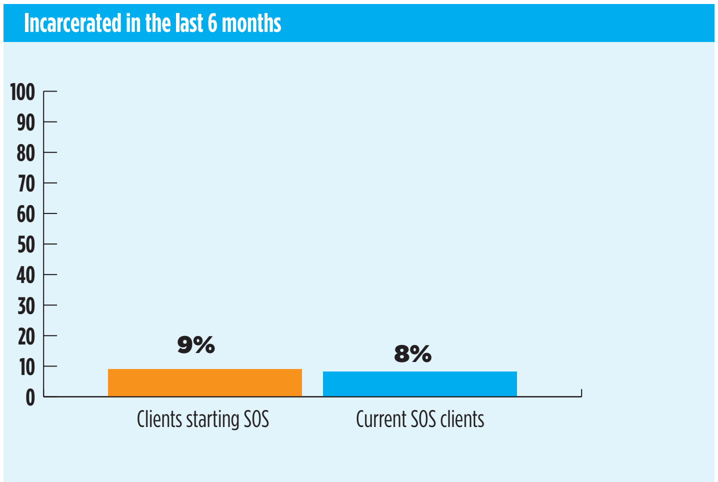






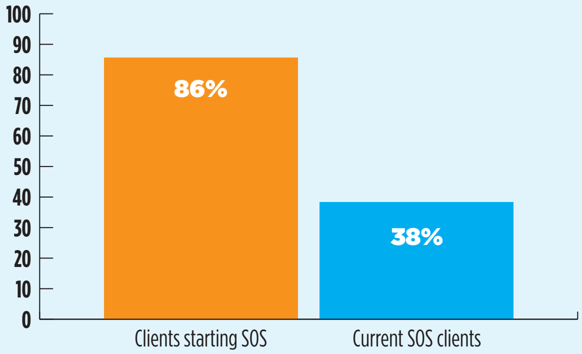
CONTACT WITH POLICE AND INCARCERATION

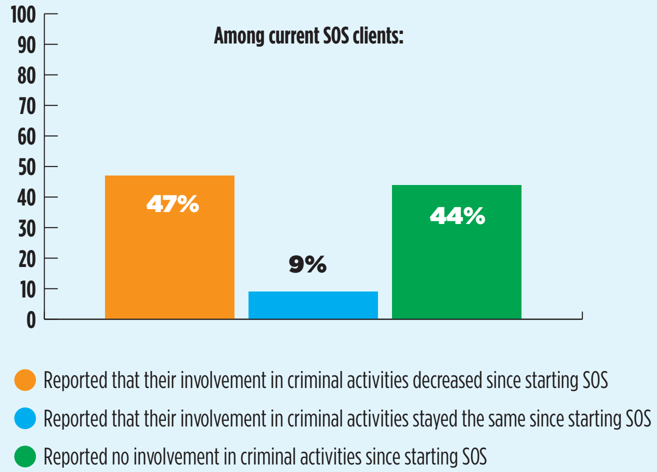




INVOLVEMENT IN CRIMINAL ACTIVITIES

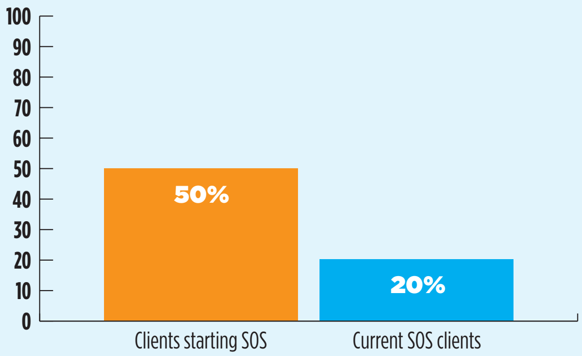
Involvement in criminal activities to pay for or get drugs in the last 6 months

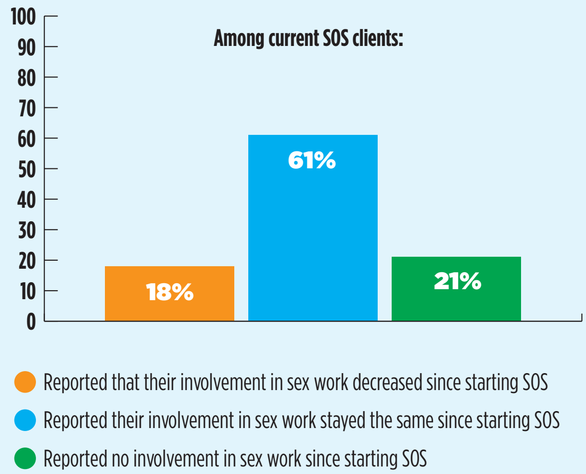




INVOLVEMENT IN SEX WORK

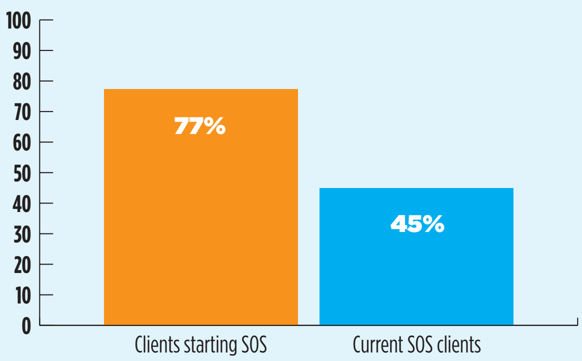
Involvement in sex work to pay for or get drugs in the last 6 months



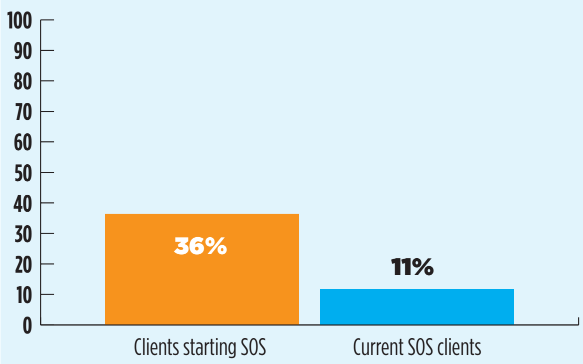


HEALTH SERVICES USE

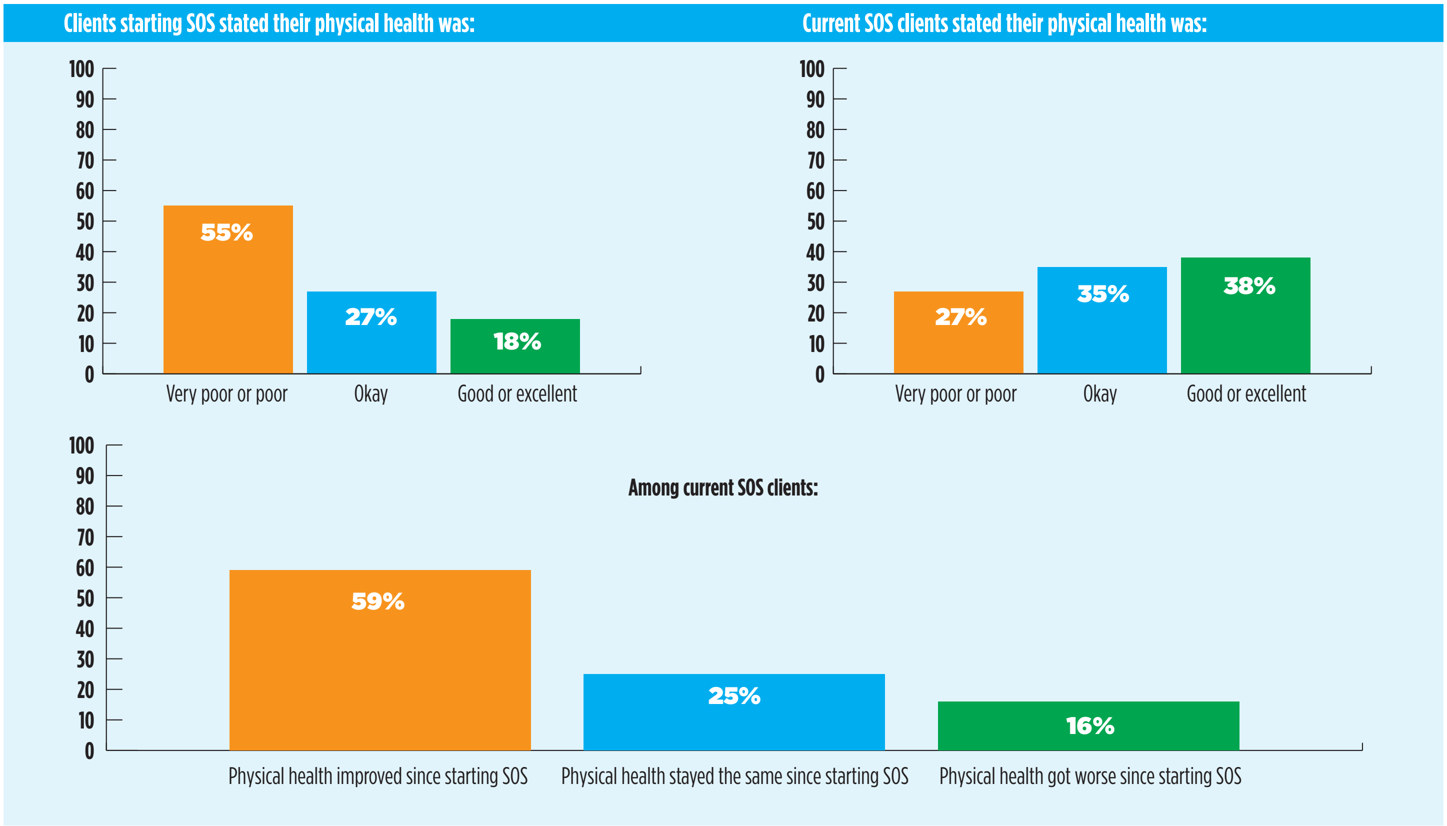
Emergency department visit in the last 6 months



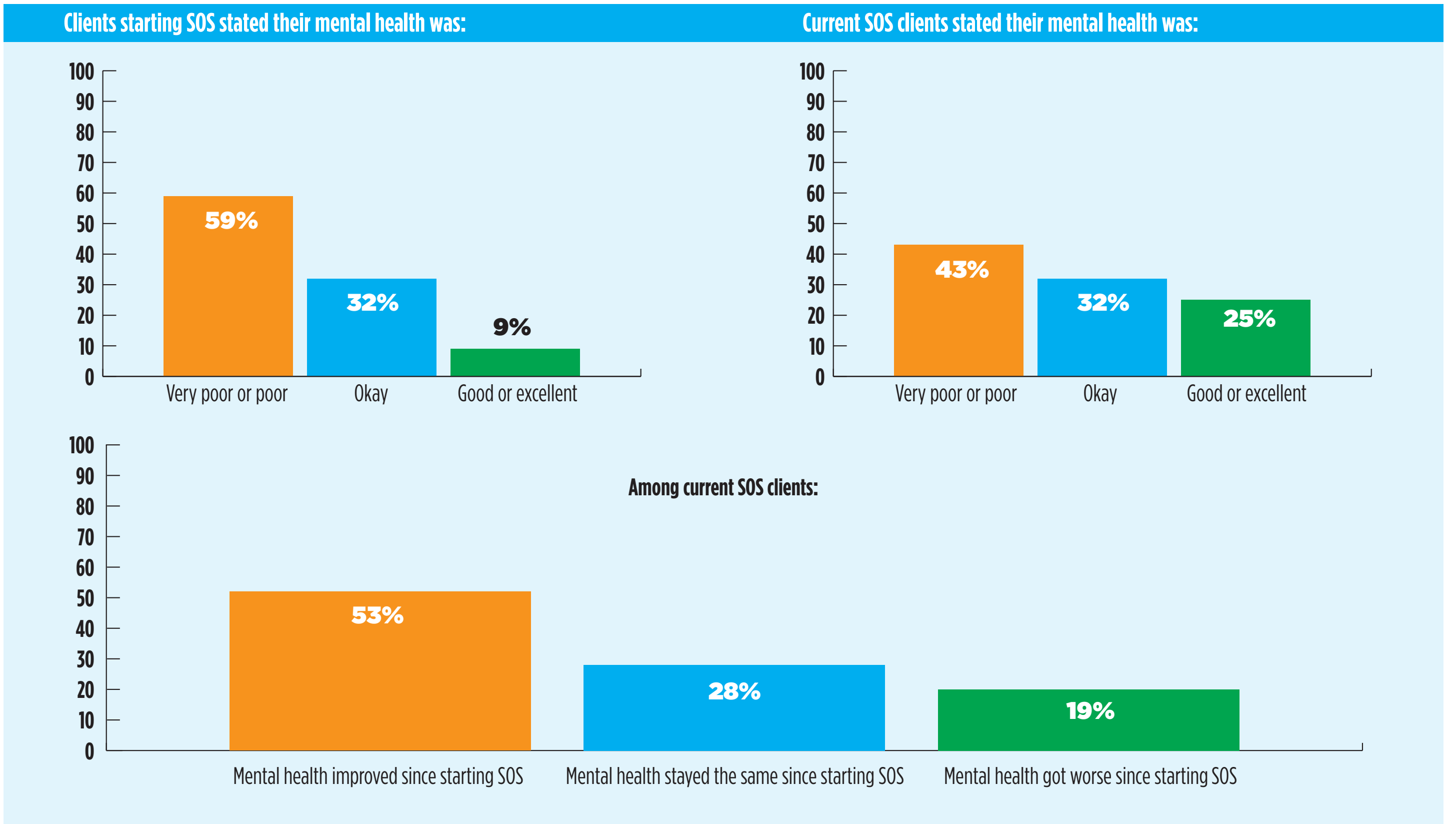
Hospitalized for at least one night in last 6 months



PHYSICAL HEALTH



MENTAL HEALTH



SOS Program Benefits

This program evaluation included two focus groups with current SOS program clients and a focus group with SOS program staff, where they were asked about the benefits and challenges of the SOS program, their feedback surrounding program operations and ideas about which program aspects could be improved. These data are presented in the following sections, with a focus on the perspectives of clients as they are receiving program services. An additional focus group was also held with people who use drugs who were on the wait list for admission into the SOS program. Their feedback is integrated throughout the report and reflects the number one challenge that all respondents discuss as critical to the program: the inability to meet the high level of need for SOS in the community.

Improvements in overall health and social wellbeing

Clients reported significant improvements to their overall health as a result of being in the SOS program. They attributed these improvements to their increased engagement in primary care, as well as due to the stability that having access to SOS has brought to their lives.

> ***“If it wasn’t for this program, I really don’t think I’d be here right now... and feeling as healthy as I do.”***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Clients reported that prior to accessing the SOS program, they were experiencing a range of medical conditions linked to their drug use, such as overdoses and infectious complications that required frequent hospital and emergency department visits. The frequency of these hospital and emergency department visits was reduced for clients as the program addressed certain ongoing health concerns.

> ***“The amount of hospital visits I’ve had... a billion – I was in the hospital all the time. Like blood infections and abscesses...”***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

In addition to experiencing fewer infection-related complications of injection drug use, clients reported being able to more easily access early treatment for infections when they did occur, since they engaged with primary care on a weekly basis as part of their participation in the SOS program.

In the focus groups with both clients in the SOS program and people who were on the wait list for the program, participants reported significant chronic health conditions, including chronic pain and pain from previous traumatic injuries. The experience of high levels of unmanaged pain prior to being clients in the SOS program was common and prevented many clients from engaging in their regular activities. Clients reported that the access to medications they receive through the SOS program has allowed them to engage in schooling and work activities.

> ***“Me, pain wouldn’t even... I’d been knocked in the head so many goddamn times, I just didn’t give a shit about... if a bone was sticking out, I’d sit on it, you know, I didn’t give a shit. I just wanted to get friggin’ high. But now, I’ve gone back to school, I took part in of a PSW course.”***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

The experience recounted by the client above, of having their pain properly controlled so they could engage in school, is in contrast to the experience of a participant who was on the waiting list for the SOS program, whose pain was not properly controlled and who was unable to find a primary care provider:

> ***“Cause of my spinal injury, I just want to get my pain managed. I don’t care if it’s through physio, through anything, like, marijuana, I’ll do whatever it takes. It’s not necessarily about the Dilaudid program, having opioids or whatever, it’s just I’m sick of being in pain, and I can’t even get a flipping doctor.”***
>
> (FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

In addition to health benefits, access to primary care, and reduced pain from chronic health conditions, clients also reported other positive impacts on their health and overall wellbeing as a result of engaging with the program. One client, who recounted having been severely underweight prior to being on the SOS program, stated that:

> ***“I’ve gained weight. I’ve gained like 50 lbs!”***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Additionally, several clients identified improvements in their ability to take care of themselves, with one client stating:

> ***“I’ve started to look after myself a hell of a lot more than what I used to.”***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Several clients also identified benefits to their overall well-being and reported positive improvements in their social situation and functioning.

> ***I have interests now. Things I used to like to do – that I didn't know I liked to do because I never had time to do anything I liked to do. I like helping people, and walk around and I find myself doing that, and having more time to be myself, instead of this guy who hustled and robbed everybody.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

By easing the burden of having to 'hustle' to acquire drugs, the program allowed clients more time to take care of themselves and to explore other goals and interests, including hobbies and work/volunteer opportunities.

Reductions in overdose risk

One of the major motivations that participants reported for wanting to be in the SOS program was that they felt that using a pharmaceutical source of opioids of known dose put them at less risk of overdose than when they were using fentanyl.

> ***You guys are also kind of keeping it monitored, whereas me, I'm gonna go out and I'm gonna buy fentanyl and then I'm gonna buy way too much, or I'm gonna buy whatever. This is you putting me at a safe dose, so that I'm not gonna go and overdose on whatever.***
>
> (FOCUS GROUP 1 WITH SOS CLIENTS)

The volatility of the unregulated drug supply, particularly the varying potency of street-acquired fentanyl and inability to know the concentration and amount taken was likened to a deadly game of chance.

> ***Cause every time you're doing fetty [fentanyl], you're doing Russian roulette, and you don't know when your time is up, when your ticket's there, your ticket's there, right?***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Increased access to other health or social services

In addition to receiving access to a safer, regulated supply of pharmaceutical opioids, when people become clients in the SOS program, they receive comprehensive primary care as patients of the community health centre, and receive services from an interdisciplinary team of health and social care professionals. Several clients reported that being on the SOS program had allowed them to access and engage in HIV and hepatitis C management, which is part of the interdisciplinary care provided by the Health Outreach Team at LIHC.

> ***I got my Hep C taken care of...now I can walk with my head held high.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Additionally, clients were able to build relationships with staff and access much needed social and emotional supports. This included attention to basic needs and access to supports such as finding and maintaining housing and accessing food and/or income support programs.

> ***It's done nothing but been good for me. I've got my family, I've been housed for first time in 10 years, I'm volunteering at [organization]. I'm doing things that I just, didn't care about, had no motivation to before.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Staff also noted these benefits among clients of the SOS program, with staff members highlighting that the major benefits were that as clients began to receive safer supply, along with medical attention and primary care, they began to stabilize. They also noted the benefits to the interdisciplinary care model:

> ***What is working well is that clients are receiving much needed emotional support and attention to basic needs. They are engaging and learning they have a support system here.***
>
> (FOCUS GROUP WITH SOS STAFF)

Clients also reported that that the program provided for coordination of different services that they did not have access to prior to being part of the program.

> ***Because there's a health worker who watches your hospital stays, then there's a housing worker who watches your homelessness, then there's people who goes in and out of prisons to help you out, you know, so there's, nobody's really combining that all to look into one scope of a whole lifestyle. It's all little blocks, and everybody's taking a little piece of you, but nobody's putting you all together into one until you get into this program.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Reductions in use of fentanyl and other street acquired drugs

Many clients reported that they were using less fentanyl from the unregulated (street-acquired) market since starting the SOS program. All SOS clients interviewed during this evaluation had previously been on methadone and many also had been on buprenorphine, but had not had success with reducing their use of street-acquired fentanyl on these medications. The financial implications of spending so much money acquiring fentanyl each day were often highlighted by clients, who attributed the stabilization they've experienced since beginning the SOS program to knowing they had a stable dose of opioids available to them.

> ***"I was spending $500 and $600 dollars a day on fentanyl, but now that I'm on the D [Dilaudid] program, I can maintain with my D's and I can get away with getting one point [of fentanyl] a day, so $40 a day instead of $500 to $600 dollars."***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Some clients attributed a decrease in injection of fentanyl to the SOS program. Knowing they had a dependable supply, clients described experiencing less anxiety about going into withdrawal.

> ***"You don't have to think, 'Okay, I have to go sell this, to go do that, or go do this to get that'. You know it's gonna be there [your prescription] at 8 o'clock when the pharmacy opens."***

(FOCUS GROUP 2 WITH SOS CLIENTS)

In one example, a client explained they were using less opioids overall because they no longer had to worry about how they were going to acquire drugs due to being on the program.

> ***"My overall intake in a day isn't as high as it used to be. I wanted – because I know that I get these pills everyday, so it's not a hurry up and get as much in you as you can because you don't know if you're gonna get it tomorrow, you know what I mean?"***

(FOCUS GROUP 2 WITH SOS CLIENTS)

All SOS clients receive extensive harm reduction education as part of the program. Even though reducing or stopping use of drugs by injection is not a goal of the SOS program, many participants reported a reduction in their use of drugs by injection.

> ***"I chew or snort, I haven't banged in a long time! Cause my veins are so screwy, so if my husband's not there to help, I'll spend an hour trying to find this vein."***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Other clients reported that they would alternate between injection and taking their medications orally, with injection preferred if they were in withdrawal (such as in the morning).

> ***"Well, the beginning of the day, I inject them, and then the rest of the day until bedtime, I take them by mouth. Just because I'm so sick - like I'm sick now - because I haven't had my pills yet today."***

(FOCUS GROUP 1 WITH SOS CLIENTS)

Reduced criminalization and reduced involvement in sex work

By providing a reliable supply of pharmaceutical opioids, the SOS program reduced the pressure of having to generate income in order to acquire drugs. This allowed many clients to decrease their involvement in sex work, street hustles, and criminal activities.

> ***"We don't have to go to the streets anymore to make our habit, to make money to pay for our pills. Since I've been on it [the SOS program], I haven't gone to jail in three and a half years. So, that's a good thing. I'm pretty much not working [in sex work] at all anymore, so. It saved my life."***

(FOCUS GROUP 2 WITH SOS CLIENTS)

As some clients very openly explained, this has led to reduced involvement with criminal activities, as well as fewer interactions with law enforcement and the criminal justice system. It has also improved their relationships with members of the larger community.

> ***"I haven't broken the law since I've been on it [the SOS program], and you know, haven't robbed anybody, or people aren't afraid of me right now, and that kind of feels good. There's a lot of people look at me and be afraid because they knew they're getting robbed. Yeah, this program really helped that way. I haven't been to jail, and my record's looking better."***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Increased safety

Some clients, particularly women, described being in unsafe situations in order to acquire drugs from the unregulated street market prior to being part of the SOS program. They described how the SOS program provides an alternative and safer way to have access to a consistent supply of opioid medications, without compromising their personal safety.

> ***“So, one of my safety issues that I have right now, the reason why I had to get on the Dilaudid program, was the person I go to for fentanyl is somebody that is not a safe person, so that's what I'm trying to withdraw from and get away from.”***

(FOCUS GROUP 1 WITH SOS CLIENTS)

Safety concerns were more commonly voiced by women who participated in focus groups; however, a majority of clients of all genders described an increased feeling of safety since being part of the SOS program.

> ***“And, it has kept me from the cops knocking at my door! Where's your whereabouts, or, whatever, you know. Having this done like this is taken me out of a lot of really dangerous situations.”***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Increased access to housing and food security

Clients also noted that being on the SOS program allowed them to focus on accessing housing and improving their access to nutritious food. A number of clients were able to acquire housing following enrollment in the program.

> ***“And being housed...when I was on the street, I was malnourished, I was like 95 pounds. I was constantly in the hospital getting IV fluids and everything. I'm still underweight but at least I'm getting nutrition, I'm getting food. She's got me on Ensures and everything. Before, if I got 14 cases of Ensure, where was I gonna put them?”***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Since clients no longer had to worry about acquiring opioids on a daily basis, SOS provided an opportunity for them to undertake steps to stabilize various elements of their lives.

> ***“People who are hustling all day. Before I got on the program, that's all I did, I hustled. I didn't have time to get a home because I was hustling. I didn't have time to do anything. All my money went to opiates, every second of every day went to opiates. No time for anything else.”***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Improved relationships with family and community members

Clients described improvements to their relationships with family, including children and grandchildren, following enrollment in the program, with one participant stating:

> ***“I've got more of a family life with my grandkids and a better relationship with my daughter”***

(FOCUS GROUP 1 WITH SOS CLIENTS)

In fact, several clients described a major, unanticipated benefit of the SOS program was the improved relationships with family members and more frequent interactions with them compared to when they were actively using the unregulated street supply of drugs.

> ***“For myself, it's helped my relationship with my family now. I can go take my daughter's kids out, which she wouldn't let me before. I've been on the program – almost 4 years, 3 and a half years. For me, it's the relationships I've gotten with people that I haven't had before.”***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Reasons for wanting to be part of the SOS program among people who are not clients

As part of this program evaluation, a focus group was held with people who use drugs who are not part of the SOS program but were on the wait list and wished to be part of the program. A major reason for including this group in the evaluation was to obtain information on program eligibility criteria, the admission process, and the program wait list experience. These themes will be addressed in the next section, which addresses challenges facing the SOS program. This section presents the major reasons that people not currently part of the SOS program gave for wanting admission to the program.

Desire to avoid overdose

People who were currently not part of the program stated that a primary reason for wanting to be on SOS was to reduce their risk of fatal overdose.

> ***I actually have the perspective that fentanyl is killing people, it's killing people in huge numbers. It's killed four of my best friends.***

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Some participants noted that the unregulated drug market in London, prior to the arrival of fentanyl, had been composed primarily of diverted prescription opioids: "The oxys were the big thing" (Focus group with people on the waitlist for the SOS program). They noted both that several different types of prescription opioids had always been readily available in the London unregulated drug market, and that heroin had rare. However, fentanyl arrived in London in approximately 2017/2018 and has led to devastatingly high rates of overdose.

> ***See, with London and heroin, something happened where we were able to keep it out, right, but with the fentanyl, for some reason, when it came, it just ravaged London like unbelievable.***

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Despite the current predominance of fentanyl in London's unregulated opioid market, there are still some people who have been able to secure pharmaceutical opioids and have managed to not transition to fentanyl. They want access to prescribed hydromorphone through the SOS program so that they can avoid having to start using street-acquired fentanyl in the face of decreased availability of pharmaceutical options through the unregulated street supply. Transitioning to street-acquired fentanyl would place them at increased risk of overdose and other harms, due to fentanyl's potency as well as the unpredictability and volatility of the composition of fentanyl (due to the presence of fentanyl analogues and unregulated benzodiazepines, which are frequent contaminants in the unregulated opioid supply).

> ***I'm afraid that if I don't get some help soon, I'm going to have to go to that fentanyl, and I don't want to because I've seen too many people die, and I don't really want to die yet.***

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Desire to reduce involvement in sex work, street hustles, and criminal activities

Reduced reliance on sex work and crime to generate income was a key reason those who were not clients discussed as to why they wanted to be on the program. Several women described experiencing gender-based violence, and wanted to be part of the SOS program to avoid having to put themselves in unsafe situations in order to generate income to acquire drugs.

> ***I'm a prostitute, and I've been doing it for about five years now, and I do it to fund my drug habit, and the fentanyl scares me because so many people even in front of me have died. And also, I'm tired of getting raped, and I'm tired of being abused, I'm tired of being taken advantage of just for drugs. With that being said, if I didn't have to go and put my body out there and had a program that could help me with my addiction, I would so appreciate it, because I don't want to put my body out there no more. I'm tired of getting hurt and I really need a program like this to help me.***

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Desire for improved health and stability

Among those who were not clients, a desire to inject less fentanyl—or to avoid using fentanyl altogether—was a key driver for wanting to be on the program. Many of those attempting to access the SOS program (as well as clients of the SOS program) had current or previous experience with opioid agonist therapies (OAT) such as methadone or buprenorphine, and explained that it had not been effective for them.

> ***I'm on methadone and I've been put up to 100 ml of meth, and it's not helping anything.***
>
> (FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Participants frequently described their previous experiences with OAT as ineffective or unsuitable. Due to their previous lack of success with OAT or trying to stop using opioids completely, the SOS program offered another opportunity for stabilizing their drug use.

> ***I've tried methadone and I've tried, I'm allergic to it, and I had ana...- where your throat closes? And so, that doesn't work for me. I've tried cold turkey. Oh, try that – that's how...and then it just doesn't work. So, this program would be great just to even let me be me and to get better.***
>
> (FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Participants in this focus group also described how being able to access a program that provided comprehensive, wrap-around supports, in addition to providing them with a prescription for opioid medications, was appealing. Access to housing was also seen as a key need for participants.

> ***I think that we need maybe housing, maybe life skills programs, programs to rehabilitate us into the community and into our own homes that are back behind the program.***
>
> **(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)**

Challenges faced by the SOS program

The three major types of challenges for the SOS program identified by participants include: the high level of demand for the program, health policy and system-level challenges, and safety concerns. Current clients and people waitlisted for the program noted that not everyone needing safer supply had access to it due to high levels of demand. They also identified challenges that arise from the current health system, such as the lack of pharmaceutical options available for prescription, negative perceptions from health-care providers who were not part of the SOS program, and barriers relating to continuity of care during hospital admissions. Safety concerns related to pharmacy pick-ups, gender-based violence, and sharing and selling of medications were other challenges identified by participants.

Major challenge: High levels of demand for the SOS program

Clients reported few issues with the structure of and/or participation in the SOS program. This is important to highlight because clients were asked repeatedly in the focus groups to reflect on drawbacks of being on the SOS program and issues with program operations. Clients repeatedly highlighted that they receive excellent care from the SOS program.

> Interviewer: ***"If you could change anything about the safer supply program, what would you change?"***
>
> Participant 1: ***"Personally, I wouldn't change anything."***
>
> Participant 2: ***"Absolutely nothing."***
>
> (Focus group 1 with SOS clients)

However, both clients and people on the program waitlist highlighted that the major issue with the SOS program is the unmet demand for the program within the community. It was explained that the demand was so great that it was impossible for only one program in London to meet all community member needs.

> ***" I think the problem is that all the people that need the program, there's not enough doctors that are doing it. That's the problem. "***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

The high level of demand means that people who use drugs are unable to access the program in a timely manner – if at all. Participants pointed to both barriers to access and communication gaps regarding program entrance requirements and program access processes.

> ***" It took me a good 2 years to get on the program and that was me coming in here once a week at least, begging to get on the program. I think I would change that, make it a little easier to get on the program for people who need it. "***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

The general consensus among the focus groups was that the high program demand created barriers to access, with many people experiencing long wait times for program enrollment. In the focus group with people who were not current SOS program clients, some participants reported that they had been on the wait list for as long as two years. This led to high levels of frustration among people who were currently on the waitlist for the program:

> Participant 1: ***"When I started asking about this program almost 2 years ago, I was told I am a prime candidate for the program."***
>
> Participant 2: ***"I've been told that still to this day but yet I'm not on it."***
>
> (Focus group with people on the waitlist for the SOS program)

The impact of long wait periods was further amplified during the COVID-19 pandemic, as some were informed that enrolment had been paused due to the impacts of the pandemic on service operations and the need to redeploy staff to pandemic-related duties.

> ***" The doctor's been telling me that frigging they haven't been putting anybody on during the COVID. "***
>
> (FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Lack of information about program admission and eligibility criteria

People not yet on the SOS program expressed frustration over the wait-time to access the program and a lack of clarity about how to get on the program.

It's almost like, I have to literally, I'm breaking through a wall – nobody's telling me anything. I just want to know how to I get on the damn program... Like, I know where the doctors are, but I can't talk to them. I can't have an appointment. Like, how the hell am I supposed to get on it?

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

For this reason, participants stressed the need for better communication about program eligibility criteria and the intake process.

Having set stipulations of who can, or like, or maybe like even putting out there, like more knowledge about what are the requirements to be on the program. There's not enough knowledge of what we actually need to be, like what we have to do, to get on the program, what is needed of us, or what group we have to fall in.

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Confusion over eligibility was further compounded by the circulation of incorrect or outdated information about the program. Part of this confusion stems from the overlap in SOS program clientele with a specialized medical outreach program for street-involved women working in sex work that is also run by the primary doctor for the SOS program.

Apparently, it's like, you explain that you're a working girl, and then they want to sit down and talk with you. It's like, if you say no...I feel like if you say no to them that you're not given the chance for the program, or you have to lie to say you're a prostitute to get on the program. I've heard a lot of that.

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

The lack of ability to ensure access to the SOS program was also difficult for staff members to reconcile. While they recognized the need to triage people who were experiencing major medical issues, they experienced moral distress at not being able to assist everyone who needed access.

And we often use safe supply as a gateway into addressing other major problems. So, I recognize that you're someone with non-controlled HIV, I'm going to take you before this other person...which is totally unfair, and doesn't reflect the need for decriminalization and where we'd like to be.

(FOCUS GROUP WITH SOS STAFF)

A number of people on the waitlist for the SOS program perceived the process to get on the program to be unfair and spoke about feeling frustrated over seeing other individuals fast-tracked while still having to wait themselves.

I feel because I don't run the streets and I don't hang out in front of this place, that I'm not seen, and I don't do anything bad or wrong, so therefore I just don't deserve to be on it.

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

People unable to access the program felt that eligibility criteria that prioritized those who were injecting fentanyl, experiencing frequent overdoses or multiple medical conditions, experiencing homelessness, or involved in sex work were unfair. Due to their own feelings of vulnerability, it was difficult for them to reconcile that the SOS program was triaging people with the highest level of medical or social need and the highest risk patterns of drug use to access the program. Even though many recognized that the SOS program was attempting to meet the high level of need in the community and that demand exceeds program capacity, they also voiced feelings that it was unfair that they had to wait to become 'sicker' before gaining access to the program.

Health System Challenges – Lack of medications available as prescription options

Staff and clients described the importance of having a wider variety of prescribing options available given the diversity of needs that exist within the community. Prescription heroin was frequently proposed as the main medication alternative that clients would like to have access to in an SOS program:

If we had it, if we had heroin, people would give up the Dilaudids for the heroin.

(FOCUS GROUP 1 WITH SOS CLIENTS)

Participants also noted that heroin would be a good option in order to reduce the pill volume for people on high doses of Dilaudid:

I think it would be better if we got the heroin, because if you're doing 30 Dilaudids a day, that's tough on your intake and system, eh? And if you wouldn't need that much if we were doing the heroin, you know what I'm saying?

(FOCUS GROUP 2 WITH SOS CLIENTS)

Participants described high tolerance to opioids brought on by years of opioid use and exposure to fentanyl from the unregulated market. The high tolerances meant there was a near universal experience of multiple failed attempts at opioid agonist treatment options like methadone and buprenorphine. Many SOS clients were currently receiving a combination of long acting opioids (frequently slow release oral morphine, brand name Kadian) as well as the immediate release hydromorphone tablets (brand name Dilaudid).

“No, but like say for people like us that have very high tolerance or whatever? Yeah. Like me, I get 5 Kadians and 18 Dilaudid 8's a day, so people say, "Holy fuck, that's a big script that you got!" But to me, it's nothing, because all it does is just keeps my pain at a tolerant level, you know what I mean?”

(FOCUS GROUP 2 WITH SOS CLIENTS)

In the SOS program, the name brand version of hydromorphone – Dilaudid – was prescribed rather than the generic versions of hydromorphone. This is because for people who chose to inject their medications, Dilaudid brand tablets dissolve into solution very easily, and with almost no residue remaining once in solution. However, due to this ease of dissolution, some clients do not heat the solution (as heating is not necessary to dissolve the tablets).

“They dissolve in the water, so, if I know that I'm going to make a hit, I will literally put my water and my Dilaudid in the thing, and I can set it aside and leave it there for a little bit, and it'll dissolve, I shake it, and it's done. Sometimes I don't bother even heating, especially when I'm on the go all day.”

(FOCUS GROUP 1 WITH SOS CLIENTS)

Heating a drug solution that is going to be injected – even for a short amount of time – has been found to be an important harm reduction strategy. This is because heating kills bacteria that may be in the solution, which may reduce the risk of infective endocarditis and other infectious complications[32,33]. Similarly, research has shown that short periods of heating can be effective at significantly reducing the presence of detectable virus in the solution - such as HIV - which may reduce HIV transmission[34]. Many clients recognized the importance of heating due to continued campaigns by LIHC staff to emphasize the importance of heating, with one client stating:

“A lot of people are getting abscesses because of the not heating, right?”

(FOCUS GROUP 2 WITH SOS CLIENTS)

This emphasizes the importance of continued harm reduction education campaigns with clients on the importance of short periods of heating to reduce the risk of bacterial and viral infection.

Many clients also reported that they were continuing to use fentanyl from the unregulated street supply while on the SOS program. The main reasons given for this was that people preferred the more potent high from fentanyl, compared to the medications available in the SOS program. For example, one participant noted that with fentanyl:

“I like it better, I get a better buzz from it.”

(FOCUS GROUP 2 WITH SOS CLIENTS)

When considering medication options for SOS programs, client feedback suggests that access to a greater variety of pharmaceutical opioids – in particular heroin (which is known as diacetylmorphine when used as a pharmaceutical medication) would be helpful. For people who continue to use fentanyl (in addition to safer supply) for a more potent high, access to prescription formulations of fentanyl and fentanyl analogues (such as sufentanil) should be considered. Currently in Ontario, there are no high-dose injectable opioids (hydromorphone, diacetylmorphine, or fentanyl) covered by the provincial formulary and available for prescription use in the doses needed. This has repeatedly been identified as a barrier to expanding the treatment options available for people dependent on street-acquired fentanyl. There is an increasing recognition that the prescription of fentanyl may be necessary for people who have become accustomed to using it from the unregulated market and have high levels of tolerance[35,36]. One program in BC is piloting this as an option.

Health System Challenges – Negative experiences with other healthcare providers

Clients recounted negative experiences with healthcare providers outside of LIHC due to being in the SOS program. In some cases, the negative experiences consisted of healthcare providers voicing disapproval of the SOS program to clients:

> ***I've noticed that most people that know that I'm on it don't necessarily attack me, they attack [name of SOS doctor], call her a pill pusher. And I defend her, I say, "Man, there would be a lot of fucking dead people if it wasn't for her, or the jails would be way overfull. The hospital beds would be way overfull. How many people would be way in the street?***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Many of the negative comments reported by clients were directed at the physicians and staff involved in the SOS program, rather than at clients themselves. However, these comments had the effect of undermining therapeutic relationships with clients, as they felt that healthcare providers did not understand their realities or appreciate the positive impact that the program was having on them.

> ***I've had doctors say, 'I don't agree with what she's doing.' And it's like, you guys don't understand what we go through on the streets. You know what I mean? If she wasn't helping me, I'd be in jail right now, you know what I mean?***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Multiple clients felt they were being negatively judged when discussing their involvement in the SOS program with other doctors and healthcare providers.

> Interviewer: ***"Were there any negative impacts from being on the program that you didn't anticipate?"***
>
> Participant: ***"We got judged!" [Multiple voices agreeing]***
>
> Interviewer: ***"Tell me about that."***
>
> Participant: ***"Like they said, the doctors call [name of SOS physician] a joke – the pill pusher."***
>
> (Focus group 2 with SOS clients)

Health System Challenges – Continuity of care during hospital admission

Negative perceptions of safer supply and the SOS program from other healthcare providers translated into sub-optimal care for clients when requiring hospital admission. This included multiple clients reporting that their pain was undertreated and that they experiencing withdrawal following surgery.

> ***I had major surgery, and they didn't agree with the program, so I went through withdrawals right after major surgery.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Clients also related that they believed their negative treatment in hospital was due to stigma and discrimination surrounding their drug use or status as people dependant on opioids:

> ***They classify us as junkies once we go into the hospital.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

The most frequent way that this manifested was as underdosing of pain medications while in hospital. This client provides an example of this by describing how their regular dose of 8 mg of medication was reduced to 2 mg, leaving them in pain.

> ***I'm on [Dilaudid] 8's and when I got out of surgery, all they were giving me was Dilaudid 2's.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

This was particularly problematic as clients described both feeling like they needed to leave the hospital early due to undertreated pain, as well as making them extremely reluctant to go to hospital when necessary due to fear that negative treatment would result. As one staff member summarized:

> ***We have fairly consistent wretched interactions with hospital, and getting people into hospital.***
>
> (FOCUS GROUP WITH SOS STAFF)

In the focus group with LIHC staff members, the perception that clients experienced stigma and discrimination during their encounters with other medical providers and particularly during hospital admissions was strongly echoed. Staff also recounted other negative interactions, including a failure to include clients in decisions regarding their care.

"A lot of folks have been traumatized by their hospital experiences, with things happening, they feel behind their back, not fully consenting to the procedures that they're getting."

(FOCUS GROUP WITH SOS STAFF)

Despite attempts by LIHC staff members to advocate on behalf of their clients, the result was a lack of continuity of care for clients of the SOS program across healthcare settings.

Issues accessing prescriptions at pharmacies

Some clients described issues when accessing their prescriptions at the pharmacy. As knowledge of the program has spread through the community, there are sometimes people gathering outside of the pharmacy each morning who are looking for opportunities to secure access to medications.

"When I first started going to [pharmacy], there was only three of us out back there. There was only the three of us. And then someone went telling a bunch of people, and then there was a whole show of people back there."

(FOCUS GROUP 2 WITH SOS CLIENTS)

This issue may stem from the lack of capacity within the SOS program. Clients described how many of the people attempting to access pills are visibly unwell and in withdrawal.

"They're so sick and they need the pills, and say 'Just pop me one, or pop me two'."

(FOCUS GROUP 2 WITH SOS CLIENTS)

This has caused a safety issue for some clients; they described being harassed to share their prescriptions with those who are not on the program. Some clients have chosen to switch to a different pharmacy in order to pick up their prescription to avoid the worry that they will be asked to share their medications.

"That's why people have changed pharmacies, too, right? To go somewhere out of the way. But I feel glad to be on the program."

(FOCUS GROUP 2 WITH SOS CLIENTS)

Another solution proposed by clients was to have a staff member, preferably an outreach worker who is well-known in the community and familiar with community dynamics, available outside the pharmacy at the popular times for pick-up (particularly first thing in the morning) to assist clients.

"Get a staff member to go there at 8 o'clock. [Staff name]'s here every day early, like 8 o'clock, if he could just go there until they got their stuff and be on their way."

(FOCUS GROUP 2 WITH SOS CLIENTS)

Safety issues – Gender-based violence

Issues related to gender-based violence were also raised by participants. Both clients of the SOS program and people not on the program described situations where women in abusive or coercive relationships were forced to give portions of their prescriptions to their partners.

"He [boyfriend] takes half of her script every day, and then if he's not happy with that, he takes more."

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

A frequent theme in research on substance use is the gendered nature of the vulnerability of women and gender-diverse people who use drugs, and the way this manifests in substance use related safety issues and the experience of gender-based violence. Due to the fact that the SOS program's primary doctor is also heavily involved in a program that provides low barrier healthcare to women who are street-involved and engaged in sex work, a high number of women experiencing vulnerability to gender-based violence are clients of the SOS program. While the needs of these groups were a focus of the Health Outreach Program prior to the development of the SOS program, participants expressed the need for continued attention to these issues as they emerge within the unique dynamics of safer supply provision.

Even in cases where gendered violence was not described, one participant – a woman – described the difficulty of being part of the SOS program while her partner was not:

"I met the girls from the working girl program [the specialized medical outreach program] in jail. I got out of jail, I get on the program. I don't have no wait time or nothing right, but my ex, he was with me for three years when I was on the program, but he wasn't accepted on the program once."

(FOCUS GROUP 2 WITH SOS CLIENTS)

Participants in the focus groups highlighted how this could create tensions within couples, especially in the context of a highly volatile drug market where overdose was a common experience. Participants disclosed that it is not uncommon for family members (such as spouses) to assist a loved one experiencing withdrawal by sharing their medications, due to the difficulty watching someone suffer. They argued that if a family member also uses drugs, they should have priority access to the SOS program:

"I think family members first, your spouse, like you can't be on it and not expect to be splitting with your spouse. That's just common sense. You're not going to be sitting there doing your dope and watching your spouse sick. That's not happening."

(FOCUS GROUP 2 WITH SOS CLIENTS)

Sharing and selling medications

The discussion above regarding the sharing of medications with family members highlights the more general issue of concerns regarding the sharing and/or selling of prescription medications. Clients were concerned that the program could be stopped or cancelled all together as a result of people sharing or selling portions of their SOS prescription:

"They get their medication and just trade it for what they need and want. Basically, that's the bottom line, that's all it is, and those are the people that are taking it to an advantage, and it's giving us who need it a bad name."

(FOCUS GROUP 2 WITH SOS CLIENTS)

Due to the methods used for this evaluation, it's not possible to estimate the frequency with which the sharing and selling of medications is occurring. Many participants spoke of it being a very rare occurrence:

"I'm greedy with my stuff. It is very rare that I will share my meds with anybody, and I'm like, you know what, I'm sorry, I need this."

(FOCUS GROUP 1 WITH SOS CLIENTS)

When asked to describe the reasons why people might be sharing, trading, or selling their prescriptions, two major reasons emerged. The first reason described by participants stemmed from the lack of fentanyl as one of the pharmaceutical options available by prescription through the SOS program. Participants described how many people were now highly tolerant to fentanyl and found that other opioids were no longer effective for them.

"Depending on the person. Depending on how bad their fetty [fentanyl] intake is in a day. If they need, say, a half a gram of fetty, they'll get rid of their script to get as much fetty as they can, you know what I mean?"

(FOCUS GROUP 2 WITH SOS CLIENTS)

The second reason described by participants was the capacity limits for the program, leaving many people unable to access a safer supply through the program. The lack of access resulted not only in structural inequity in access to the program, but also positions clients who want to be able to help out community members at high risk of overdose in a difficult place. This led some clients began to question and examine notions of who was most deserving of care:

"You can't really pick out who needs it and who doesn't. We all need it, it's just who needs it more, because there is people out there that do need it a hell of a lot more than others."

(FOCUS GROUP 2 WITH SOS CLIENTS)

Research that has examined the diversion of methadone and buprenorphine can be instructive in assessing the rationale for sharing and selling of medication in the SOS program. This research has documented how social ties and practices of mutual aid between people who use drugs can be protective when people are experiencing withdrawal and unable to secure an adequate supply of drugs for themselves[37,38]. In cases where medical care is inaccessible, the social ties among people who use drugs facilitate the sharing or buying of methadone that is used to avoid or treat withdrawal[38]. Interestingly, staff members highlighted that the sharing and selling of methadone was also a common occurrence in London:

"Yeah, I think there's greater acknowledgement that methadone did not work for people on fentanyl really well, and there's greater acknowledgement that there needs to be an alternative. But I think the loss of control, this is my perception of it, the loss of control around the substance that the client is using is scary for addiction medicine doctors, I think. And there's also not an acknowledgement that people trade methadone. I just don't understand that. People still sell methadone."

(FOCUS GROUP WITH SOS STAFF)

In addition to highlighting the ways in which people who use drugs attempt to assist members of their communities, the research examining the diversion of methadone and buprenorphine also points to contextual and structural factors, where the need for sharing or selling is driven by a lack of easy accessible and flexible medical treatment options when people need them[39,40,41]. Additionally, there is research examining the ways in which people use diverted buprenorphine to transition away from other unregulated opioids and stabilize themselves outside of the medical system[39]. Emerging research findings has detailed how some people who use drugs attempt to secure pharmaceutical medications over street-acquired fentanyl. This is due to perceptions that the known dose of diverted pharmaceutical medications have a lower overdose risk than using street-acquired fentanyl of unknown dose and potency[41,42]. This is not dissimilar to how participants in this evaluation described that sharing or selling their SOS prescriptions was not always negative because it meant that someone else now had access to pharmaceutical medication of a known and consistent dose:

> ***“In the grand scheme of things, diversion can be seen as a good thing, because it means more people have access to pharmaceutical-grade medication. However, we know that because we don’t have a decent social income support system, anywhere, people are gonna use their prescriptions as currency. We know it. So we need to somehow figure out how to provide the proper social supports, including income to people, and then you know, increase the safer supply to the point where there is no market for illegal substances, or, sorry, for contaminated substances.”***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

As captured in the quote above, sharing and selling of medications can reflect unmet needs (e.g., food, housing) and barriers to access to comprehensive health and social services and a range of pharmaceutical medications to meet people’s needs. The lack of multiple pharmaceutical treatment options available through the SOS program - particularly the unavailability of fentanyl for people with high tolerance - leaves people reliant on the unregulated fentanyl market to meet their needs. This highlights why it is critical to increase the medication options available, including options for high-dose injectable hydromorphone, diacetylmorphine (heroin), and fentanyl. In addition, the high demand for the SOS program and the restricted capacity created due to LIHC being the only local SOS program results in a situation in which many people meet the eligibility criteria but are still not able to access this essential services. A three-pronged strategy that includes full access to SOS for all who require it, ensuring that a full-range of medications are available within SOS programs to meet people’s needs, and comprehensive, wrap-around health, social and income supports are required in order to address the root causes of sharing and selling.

Program features and design considerations

Need for onsite supervised consumption service

Currently, there is no supervised consumption service (SCS) available at LIHC. There is one SCS that is operated by another agency at a site that is a considerable distance from LIHC. During the focus groups, clients were asked about utilization of that SCS, and reported positive experiences using at the site, with one client stating that:

> ***For me it's safe, it's safety. I feel comfortable there. Nothing's going to happen to me. I can do my hit and relax for a bit.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Two issues that were reported by clients are the distance from LIHC and the hours of operation of the SCS. One participant commented on these issues after they were found using drugs in another community agency:

> ***We got kicked out from the [agency] for using, and they'd be like, go down to the site in the morning. I'm like, how are you gonna do that? It doesn't even open until 10, and then you gotta go all the way.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Participants spoke of how it would be very useful to have an additional SCS in London located at LIHC or very close by, as this was an area where people are already gathering to use substances. While clients noted that the community of people who use drugs watch over each other and intervene when overdose occurs in the outdoor areas close to LIHC, having an SCS would be preferrable.

> ***It would be nice to have a place like behind the [outdoor area where people gather to use] that was actually a legal place to go to, you know what I mean? To shoot, to do our thing, right? Because it's safer, there's no using alone, and we do look out for each other. Someone goes down, there's always someone there with Narcan or whatever, lives have been saved from being together.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Clients also expressed that access to drug checking services would be a strong benefit for those who are continuing to use some street drugs, including occasional fentanyl use. Being able to test drugs proactively would allow them to know the contents of their drugs before consuming them.

> ***That's really positive – I think we should be able to test like, should be able to bring in and know if this is fetty or not, can we test this?***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Observed dosing

Establishing a SCS at LIHC would enable an observed dosing arm of the SOS program. An observed dosing arm may be useful for new clients during the titration period, or for clients who have medical or substance use patterns (e.g. concomitant use of large amounts of alcohol) that may render then ineligible for take-home doses. A few participants stated they would be willing to engage in observed dosing, particularly during the titration period if the goal was to stabilize and then transition them to take-home dosing. However, they also brought forward multiple potential barriers related to observed dosing. First, they discussed how the need to attend a clinic multiple times a day for observed dosing would interfere with school or work-related activities, including for those involved in sex work, leaving them to have to choose between their work, school or access to safer supply.

> ***You can't go to school, you can't hold down a job...***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Participants also highlighted how observed dosing would essentially tie them to the clinic or the area around the clinic all day long:

> ***See, I don't like that idea, because I can't be running around all day trying to chase this.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Observed dosing would also be a barrier for those with mobility challenges or who live further from the site. They would face difficulty having to travel to a set location multiple times per day.

> ***Seeing as she's you know, in a wheelchair. So for her to have to go there every single day in a wheelchair, that would be bothersome. I'm not meaning to speak for you, but [laughs] I'm just saying, people that would be in a wheelchair, or people that have a hard time with mobility...***

(FOCUS GROUP 1 WITH SOS CLIENTS)

The final challenge that clients discussed was hours of operation that do not consider the individual considerations and personal needs surrounding dosing schedules. For example, people may need night time doses to avoid going into withdrawal.

> ***See, no, because, I always get sick in the middle of the night.***

(FOCUS GROUP WITH PEOPLE ON THE SOS PROGRAM WAITLIST)

Comments from clients regarding the issues and barriers with observed dosing closely correspond to barriers that have been raised in research from Vancouver examining programs where observed dosing of either injectable or tablet hydromorphone is required for clients[43,44]. This suggests that having a supervised consumption site available onsite for clients who wished to use it would be useful for them and to the program. However, while some clients would be willing in some circumstances to have their doses observed at the clinic (for example, during titration), clients raised numerous issues and barriers with requiring the supervision of all doses.

Urine Screening

One aspect of the program that elicited a wide range of feedback from both clients and program staff was the urine screening process. During point of care urine drug screening, clients provide a urine sample that is tested for prescribed and unregulated drugs. Results are available immediately. This can be followed up by sending the urine sample for more detailed screening at a laboratory. Currently, urine screening results are used to ensure that prescribed medications are being taken. There are no consequences for use of cannabis, prescribed medications that the client does not have a prescription for or use of unregulated drugs like fentanyl or stimulants. Because there is no drug screening in London, urine screening also functions as a form of drug checking, where adulterants or contaminants in unregulated substances are detected.

Clients found that the general process of urine screening was being done in a respectful manner.

> ***You can go pee and the only thing they ask is leave your bags and stuff outside. So, that is completely totally, okay with me.***

(FOCUS GROUP 1 WITH SOS CLIENTS)

However, some clients perceived the process to lack transparency around what exactly is being tested for in the urine screening, and felt concerned there may be consequences associated with the results.

> ***I think because they're screening for everything, you feel like you're being picked out of different things, you know what I mean? If they were saying, okay, we're only going to screen for fentanyl, and I know that it's only being screened for fetty, I'd be a lot more comfortable. But being screened for a total of like 10 different things, it's kind of... you know? I kind of want to be like, oh shit, I can't do nothing because I gotta go do my piss test today.***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Most staff members found that clients appreciated being informed of and involved in the full urine screening process. Staff were aiming for an open and collaborative approach to urine drug screening, where the urine testing was performed directly in front of clients. In this way, clients can be immediately informed of the potentially unknown contents of the drugs they are using. This also helped staff in communicating to clients that the urine screening process is not used as a punitive measure or a method of surveillance.

> ***So what we've started trying to do is I'll test the urine right in the room, and the clients have really been valuing that. They've been saying, 'Can I see?' And then, it's been really helpful because I have said, 'This is not about punishment, this is about knowledge is power'. So I've been telling people, 'These are the things that are in your urine, including benzos.' And they're like, 'I don't take benzos'. And I say, well, it must have been cut into your crystal or into your fentanyl.***

(FOCUS GROUP WITH SOS STAFF)

When involved in these aspects of their care, clients remarked that they appreciated having this information so that they could make more informed decisions about the substances they use.

> ***Because if you're buying off the street like I say, running fucking low, then if you're getting something that you don't know, then it's showing up in your system and at least then you know what's happening to you.***

(FOCUS GROUP 2 WITH SOS CLIENTS)

Staffing considerations

Consistently, participants emphasized the need for more staff to increase the capacity of the SOS program. It should be noted that the focus groups for this evaluation occurred during the COVID-19 pandemic, when some staff members had to be re-deployed to other positions within the health centre and when some aspects of the SOS program had not been scaled-up as planned due to the pandemic-related restrictions in place. While participants noted that staff had been very successful at limiting the impacts of COVID-19 restrictions on service provision, it is likely that pandemic-related disruptions nonetheless had an impact.

In terms of medical staff, the need for more prescribers was emphasized, as the current demand for the program is beyond the capacity of a single prescriber.

> ***We need more staff, we need more prescribing providers, and more space. Right now, we're running them off their feet.***
>
> (FOCUS GROUP WITH SOS STAFF)

The need for more prescribers was felt by staff, as well as by clients:

> ***I think the problem is that all the people that need the program, there's not enough doctors that are doing it. That's the problem.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

Beyond prescribers, the staff expressed that more interdisciplinary team members, including nurses, outreach workers, system navigators and care facilitators were needed in order to provide immediate services to clients.

> ***Just obviously the staffing issue within that. If we get more staff, we can get more people, we can expand the program, and help more people, right?***
>
> (FOCUS GROUP WITH SOS STAFF)

One advantage of increased staffing described by participants is that it would enhance the capacity of staff to respond to the health and social-related needs of clients immediately, rather than having to rebook people to come back at a later time to have their issue addressed.

> ***We've got clients who need to have their heart function assessed or their mental health assessed, and we don't have the time. And it's unrealistic in my opinion to say, we'll do their safe supply stuff here, and we'll book them at a later time, like another day in the week to do that, because they don't come back. And we need to catch them in the moment, and then once we've been able to build some of that, then they will start coming back.***
>
> (FOCUS GROUP WITH SOS STAFF)

Given the complex social needs of many SOS program clients, the ability to have staff available to provide counselling and punctual assistance with basic needs is vital:

> ***A lot of times, people come in and most of their issues, a lot of their issues, is social, and if they had somebody to talk to or had the opportunity to speak to somebody, making sure that we have somebody for them to talk to in that time.***
>
> (FOCUS GROUP WITH SOS STAFF)

Outreach workers, system navigators and care facilitators

Clients and staff also highlighted the need for more outreach workers, system navigators and care facilitators to assist clients in attending appointments and programs outside of LIHC. This is of particular importance due to the stigma and discrimination that many clients experience in hospital settings, which can interfere with clients' willingness to seek out diagnostic testing or other medical services.

> ***The one thing I'd like to add to that is we need more outreach workers who - if they need an echocardiogram or they need to go to a different appointment and they're terrified of the hospital, that we will go and support them.***
>
> (FOCUS GROUP WITH SOS STAFF)

Clients also commented on the need for more outreach workers, given community demand and the lack of services adapted to the realities of people who use drugs and are street-involved. The increase in service demands during the COVID-19 pandemic period, as well as the increase in homelessness in London and the increased disruptions due to the instability in the sheltering situation for people experiencing homelessness in London during the last year and a half has created a very strong need for outreach services, in particular.

> ***More outreach. It needs more outreach. There's nothing out there if you're stuck on the street, who do you talk to, right? If you're having a bad time.***
>
> (FOCUS GROUP 2 WITH SOS CLIENTS)

It is important to note that staff members in the focus group strongly highlighted that the situation regarding homelessness in London had reached crisis levels during the COVID-19 pandemic. They spoke about their difficulties in finding appropriate sheltering options for people living on the street, as well as the near-impossibility of finding long-term or permanent housing options for people experiencing homelessness.

"We need appropriate housing for people. No barriers, 24 hour access, come and go as you please, be given what you require in order to maintain your hierarchy of needs, whatever that looks like for you. Food. Clothing. Access to showers. Safety."

(FOCUS GROUP WITH SOS STAFF)

Workers with lived/living experience of drug use

Workers with lived and/or living experience of drug use (often called 'peer workers') were described as an essential component in coordinating clients' care across health and social settings and ensuring that the care provided is client-centered and client-driven. Employing people with lived and/or living experience was also described as a means of addressing client mistrust in medical settings and with medical professionals.

"We gotta have peer workers. All of these things about having a client – so if a client is leading their care plan, they want to be able to talk to somebody they trust whenever they need to. What worked for you, what didn't work for you, this is my experience, this is what my experience has been. So if we had a team of peers to support clients new in the program where that trust could be built, and care coordination, right, maybe even peers could lead part of that, provide shared coordination."

(FOCUS GROUP WITH SOS STAFF)

Workers with lived experience were described as beneficial given the experiential knowledge and expertise they bring to the role. One client proposed pairing a worker with expertise as a person who uses drugs with a LIHC staff member as a way to improve outreach within the community.

"I feel like a combination of say a person that works here in at intercommunity [LIHC] to go with somebody like one of us and walk out into the community, because we know everybody. We know everybody on the street. We are the street. So, like, if you combine us with you, I'm sure it would get a lot better."

(FOCUS GROUP 2 WITH SOS CLIENTS)

Overall program philosophy

In the focus groups with staff members, the importance of a program philosophy that centred a harm reduction approach to working with people who use drugs was emphasized. This includes the importance of recognizing and respecting the autonomy of the people they were working with:

"I'd like us to have an overarching philosophy of people's autonomy, getting away from the practice of trying to fix people or making their lives the way that we want our lives to look. So, acknowledging that people get to live the way they choose to live."

(FOCUS GROUP WITH SOS STAFF)

Staff emphasized that this philosophy needed to be coupled with the provision of holistic, interdisciplinary care that includes mental health supports and attention to social determinants of health, in addition to the provision of safer supply and medical care.

"Well, that's cause we want to provide primary care, too, because that's how – it's not all just about physical health, it's about mental health, it's about having the time to identify the social determinants of health, and dispatch them to the right part of the team, but we want to make sure they're being cared for, their entire body, not just one aspect of it."

(FOCUS GROUP WITH SOS STAFF)

Major findings and recommendations

Findings

Clients in the SOS program overwhelmingly appreciated the program, finding that it was reducing their overdose risk by providing known doses of pharmaceutical medications. They felt that the program was lifesaving, and that in addition to helping them to stabilize their health, it was improving their social functioning and well-being. These observations were echoed by SOS program staff; however staff also highlighted the continuing negative impacts of the housing crisis and the difficulties in finding sheltering options or permanent housing for SOS clients experiencing homelessness. Clients had limited recommendations for program delivery, and also expressed that SOS program staff were providing respectful, compassionate care that meets their needs.

For people who use drugs on the waitlist, motivations for wanting to be on the SOS program include wanting to reduce overdose risk, and reduce involvement in sex work, street hustles and criminal activities. Many of those attempting to access the SOS program (as well as current clients) had current or previous experience with opioid agonist therapies such as methadone or buprenorphine, and these medications had not been effective. The SOS program offered a novel option for them.

Participants also described challenges faced by the SOS program, including high demand for the program driven by lack of prescribers and a lack of expansion of SOS programs more broadly, as well as difficulty in obtaining information about program eligibility criteria and wait-times to access the program. The lack of medication options available for prescription on the provincial formulary was also identified as a major limitation. Participants described the need for high-dose injectable hydromorphone, heroin and fentanyl to address high levels of tolerance due to exposure to fentanyl in the street-acquired opioid supply. Major challenges at the level of the health system were also identified, where negative perceptions about substance use and the SOS program in the health system and during hospitalization resulted in patients receiving sub-optimal pain control and withdrawal management. This created barriers relating to continuity of care during hospital admissions. Other challenges identified by participants included safety concerns related to pharmacy pick-ups, gender-based violence, and sharing and selling of medications.

Based on feedback from staff, SOS clients, and people who were on the program waitlist, there are several program and health-system level recommendations that arise from this evaluation.

Program-level recommendations

- **Increase the number of prescribers:** Unanimously, staff, clients, and people on the waitlist felt there was a strong need to increase the capacity of the SOS program so that it would be available to more people in the community who are desperately seeking safer supply. To increase capacity to meet this demand, the SOS program requires additional prescribers, as well as the expansion of the SOS programs model beyond LIHC more broadly.

- **Provide clear information about waitlist and triage criteria:** A number of people on the waitlist asked for clearer communication of program details, including program eligibility and timelines. Providing information for how long clients might expect to be on the waitlist and communicating how decisions about who is prioritized for program admission may help to address misconceptions.

- **Continue to expand wraparound services:** Both staff and clients noted a need for additional wrap-around services, including linkages to health and social services offered by other agencies in the community. Some clients expressed a need for additional outreach workers or care facilitators to accompany and support clients attending appointments offsite. Integration of people with lived or living experience as staff members should also be prioritized.

- **Emphasize harm reduction strategies through education campaigns:** Continued harm reduction education campaigns regarding the importance of heating drug solutions prior to injection is necessary. While clients recognized that not heating drug solutions could contribute to bacterial infections, the ease of dissolution of Dilaudid brand pills led some to skip this step.

- **Provide accompaniment for pharmacy pick-up:** Some clients reported experiencing harassment at the pharmacy when getting their prescriptions and suggested having a LIHC staff member waiting at the pharmacy with clients who would like accompaniment picking up their prescriptions.

- **Offer supervised consumption services at LIHC:** Clients stressed a need for a supervised consumption service (SCS) at or near LIHC to ensure easy access to SCS services. The smoking of street-acquired fentanyl was reported by many SOS clients, suggesting that an SCS should incorporate supervised smoking/inhalation services as well as supervised injection. Relatedly, many felt there was a need for a drug testing service.

- **Advocate for program expansion and increased pharmaceutical options**: While it is not possible to estimate the extent of sharing and selling of medications occurring, it is clear that it is driven by structural and systemic issues such as a lack of program capacity, a lack of access to a range of high-dose opioids for people with high tolerance, and a desire by clients to assist community members suffering from withdrawal or at high risk of overdose. Addressing these systemic factors by expanding program capacity and pharmaceutical options available should be pursued. Continued consultations with the SOS advisory group will also help to ensure that measures to address sharing and selling are properly targeted and proportionate.

Systems-level recommendations

- **Expand coverage for high-dose injectable opioid formulations on the Ontario formular**y: The lack of coverage for high-dose opioid formulations on the Ontario formulary is a major challenge in meeting the needs of SOS program clients. The listing of high-dose injectable opioids (including injectable hydromorphone, diacetylmorphine and prescription fentanyl formulations) on the formulary is within the jurisdiction of the provincial government, and is urgently needed.

- **Expand access to diacetylmorphine:** Clients highlighted that heroin (diacetylmorphine) would be the most useful opioid medication to have available. Provincial and federal governments and regulators need to urgently act to expand access to diacetylmorphine in Canada. Our data shows high rates of fentanyl smoking among people entering the SOS program, and there are currently no smokeable opioid options available for prescription. Diacetylmorphine has potential as a smokeable option for safer supply programs, which should be pursued urgently due to indications that overdose by smoking is an increasingly common occurrence in Ontario[2].

- **Address stigma and discrimination within the healthcare system:** Negative experiences with healthcare providers outside of LIHC due to being in the SOS program were recounted by SOS clients. Stigma and discrimination towards people who use drugs and people on the SOS program were commonly reported and are impeding access to care. Health systems actors such as hospitals must act urgently to address this issue.

- **Provide continuity of care and improve pain and withdrawal management for hospitalized SOS clients:** SOS clients reported receiving sub-optimal pain control when in hospital. They also report negative comments and treatment when attempting to access care in hospital setting. Staff reported this frequently persisted despite their attempts to advocate for clients. Negative treatment led to a lack in continuity of care from the community to the hospital setting when hospitalization occurred for SOS clients, and is a missed opportunity to provide comprehensive care for a population who frequently delay care until they are very ill due to experiences of stigma and discrimination. Health systems actors such as hospitals must act urgently to address this issue.

Clients in the SOS program overwhelmingly appreciated the program, finding that it was reducing their overdose risk by providing known doses of pharmaceutical medications. They felt that the program was lifesaving, and that in addition to helping them to stabilize their health, it was improving their social functioning and well-being.

Methods Appendix

Mixed methods were used to conduct an evaluation of the Safer Opioid Supply program at London Intercommunity Health Centre in 2020-2021. The goal of this evaluation was to examine the scale-up of the SOS program after SUAP funding was received from Health Canada in March 2020, and examine what was working well and what could be improved in the SOS program as part of an ongoing quality improvement and program evaluation plan.

The evaluation plan was developed in consultation with representatives from London Intercommunity Health Centre, including both staff who were responsible for front-line service delivery, clinical staff, and program management. The main priority in the evaluation process was to ensure that the perspectives of clients of the SOS program were highlighted. Additionally, staff members involved in the delivery of different aspects of front-line services in the SOS program were also engaged. These two groups were specifically prioritized to draw upon the first-hand, experiential knowledge and expertise that they possess, and to have this reflected in the evaluation. Finally, a focus group was also held with people who use drugs who were on the wait list for admission into the SOS program. Their perspectives were included to ensure that questions around barriers to admission and program access were reflected in the report.

Data Collection

Data collection included 4 qualitative focus groups with 3 different stakeholder groups, a review of program statistics, and quantitative surveys with SOS program clients.

1) Focus groups

- Focus groups were conducted in September & October 2020
- All focus groups were held in-person at London Intercommunity Health Centre
- There were two focus groups held with current SOS clients; a total of five women and four men participated in these two groups
- One focus group was held with people who use drugs who were on the wait list for admission into the SOS program; there were three men and three women in this focus group
- One focus group with SOS program staff was held; there were four men and ten women in this focus group

2) Review of program statistics

- De-identified aggregate program statistics from March 31, 2020 to September 30, 2021 were compiled by LIHC and reviewed by the evaluation team

3) Surveys

- Surveys were completed with two distinct groups of people: clients starting SOS and current SOS clients.

For clients starting SOS:

- A baseline survey was conducted with clients who were starting SOS, at their intake into the program. This survey provides information on their drug use and social situation prior to beginning the SOS program.
- A total of 19 clients entering the SOS program for the first time completed the baseline survey from April to October 2021.

For current SOS clients:

- A survey was conducted with current SOS clients who have been in the SOS program for at least four weeks and includes clients who have been part of the program for varying lengths of time. It provides information on their drug use and social situation while they are receiving SOS.
- A total of 59 current SOS clients completed the survey from June to October 2021.

Analysis & Synthesis

With the consent of participants, focus groups were audio-recorded and transcribed. Iterative and thematic analytic methods were used to identify key themes that emerged in the discussions. The project team coded and analysed all transcripts, and themes were mapped onto the key areas that were identified in the evaluation framework. Once initial themes were identified, they were compared (between the different groups of participants) to ensure consistency.

Survey data were analysed using descriptive methods. It is important to be cautious in interpreting the survey data, due to the limitations involved in having small sample sizes in both groups and the lack of random sampling. Survey data was drawn from a convenience sample of clients available and willing to complete the survey on days when data collection was occurring, which may introduce sampling bias. As these data reflect two separate groups sampled at one point in time, the use of this methodology means that we cannot make causal inferences from this data.

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