National Safer Supply
Community of Practice

Reframing Diversion

for Health Care Providers

Frequently Asked Questions

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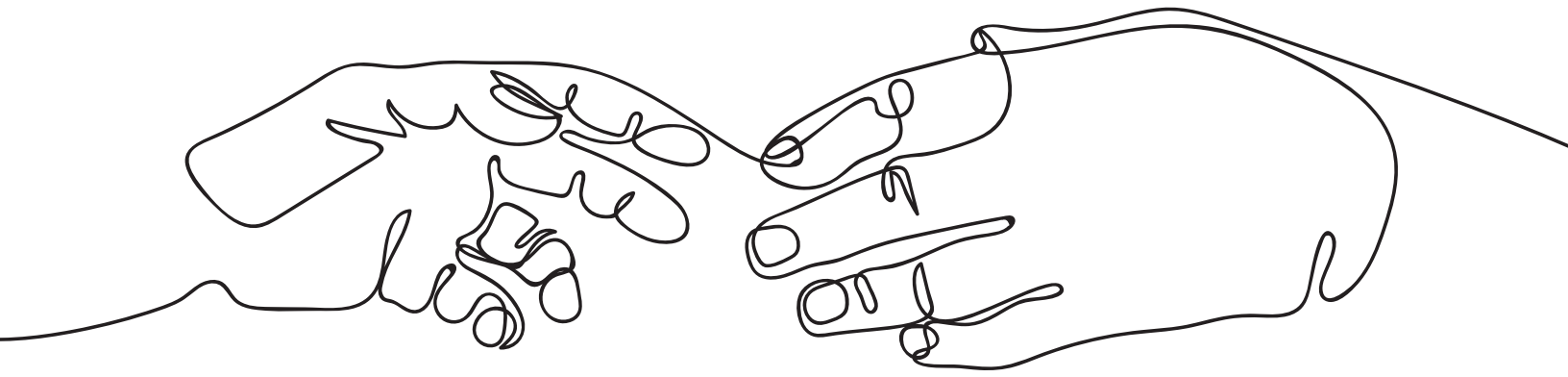
Who and what is this document for?

Are you a clinician who is:

- Currently prescribing safer supply, or considering it?
- Wondering about the possible diversion of safer supply medications?
- Worried that the safer supply medications you prescribe may be used for purposes other than you intend, by people you did not prescribe them to?
- Interested in learning more about diversion and how you can compassionately navigate diversion in your practice?

This document is intended to answer your questions and offer you helpful ways to orient your practices and navigate the diversion of prescribed safer supply medications.

This FAQ was developed by the collaborative Reframing Diversion Working Group of the National Safer Supply Community of Practice (NSS-CoP). The working group members hold diverse roles as stakeholders in health and social service provision, including physicians, physician assistants, nurse practitioners, nurses, people who use(d) drugs, researchers, program coordinators, and activists. The working group aims to define, critique, and shape emerging discourses of diversion, to educate healthcare providers on the different community practices of diversion, and to promote a person-centered care approach to risk mitigation.



What is diversion?

Diversion has been defined as:

- "...A practice whereby an individual redirects their prescribed drugs to another party for illicit use." (Bardwell et al., 2021b, quoting the American Pharmacists Association [2014]).
- "Displacement or unintended use" of prescribed safer supply medications (Ranger et al., 2021, p. 3).
- "The selling/trading, sharing or giving away of prescription medications to others. This may occur voluntarily or involuntarily." (Larance et al., 2011)

Diversion exists in the space of tension between rule-based medical compliance and meeting the needs of people who use drugs, whether they are safer supply participants or not.

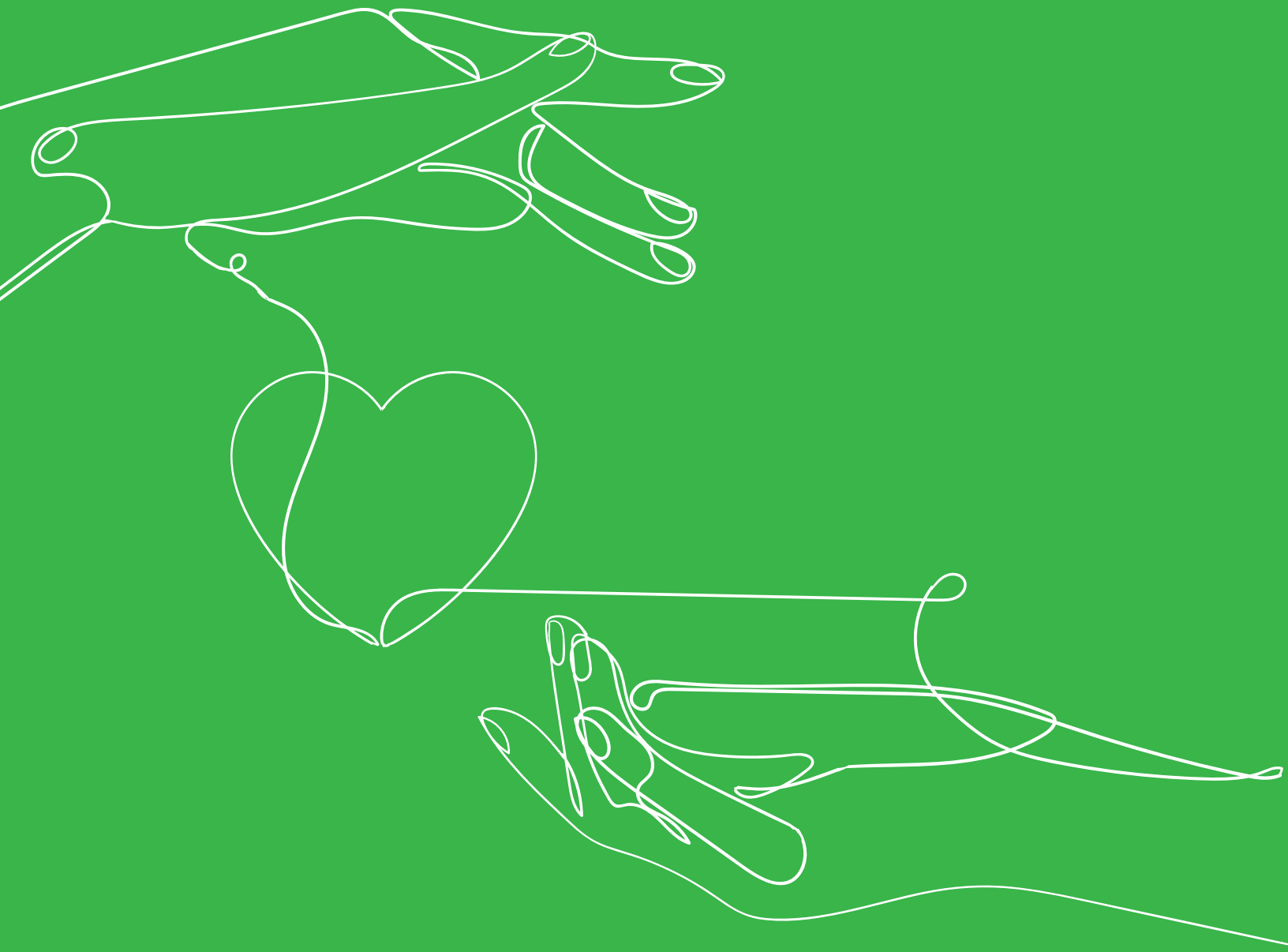
Why redefine and reframe diversion?

> "'Diversion', as this term is conventionally used, is not typically understood as practices of giving and helping, but may nevertheless be perceived as such by those who undertake them." (Havnes et al., 2013)

Diversion is a single term typically used by people working in health care, social services, and law enforcement to describe a variety of different phenomena in communities of people who use drugs. Diversion of safer supply and/or Opioid Agonist Treatment (OAT) medications occurs in many contexts and for many reasons.

The current medical and criminal-legal framing of diversion perpetuates stigmatizing and patronizing views of people who use drugs, such as the idea that people who use drugs cannot be trusted, are manipulative, and are a threat to others. These views are harmful, inaccurate, and ultimately rooted in anti-drug and anti-euphoria prohibitionist principles[1]. These views make it more difficult for clinicians to see the many reasons safer supply participants might redirect prescribed medications to other people.

[1] Anti-drug and anti-euphoria perspectives place moral judgment on substance use. Anti-euphoria sees the pursuit of euphoria (feeling "high", intense pleasure, and/or well-being) or altered consciousness through mind- or mood-altering drugs as inherently wrong, and an insufficient or indefensible reason to use drugs. (Canadian Drug Policy Coalition, 2022; Medrano, 2022, February 8)



Breaking down the social and economic context around diversion moves us towards more shared, accurate, and compassionate understandings of diversion practices.

What social and structural contexts motivate diversion?

> “Criminalization, coupled with negative framings of drug selling as predatory, contributes to the difficulty in examining acts of mutual aid and care that surround drug selling as practices of care.” (Kolla & Strike, 2020)

Social and structural conditions shape diversion practices.

- **Prohibition, criminalization, and medicalization:** Legal and medical systems exert strict control and/or prohibit access to safer, regulated drugs. This is rooted in anti-drug and anti-euphoria prohibitionist principles — the idea that illicit drugs are inherently bad, and it is possible to stop humans from using drugs through making them illegal.
- **Structural and systemic discrimination:** Structural and systemic discrimination, including racism, capitalism, colonialism, criminalization, sexism, ableism, classism, and transphobia perpetuate the inequitable conditions in which people who use drugs must strive to survive.
- **Neoliberalism and austerity:** Budget cuts to health and social services over the past 30+ years have resulted in the widespread lack of access to care services. In the absence of robust and well-resourced safer supply programs, people who use drugs experience extreme difficulties in accessing regulated drug supplies (lack of availability and capacity of safer supply prescribers[2], limited program capacity, program waitlists, inadequate pharmaceutical dosages, etc.).
- **Capitalism and financial motivations:** Diversion practices are shaped by capitalism, poverty, structural discrimination, and housing insecurity. To survive under these conditions, some people who use drugs may have no other choice but to generate income via diversion practices, to purchase the drugs they need to feel well, and/or to provide mutual aid to other people who use drugs in their communities.

[2] We use the word prescriber to encompass the doctors and nurse practitioners who have prescribing privileges.

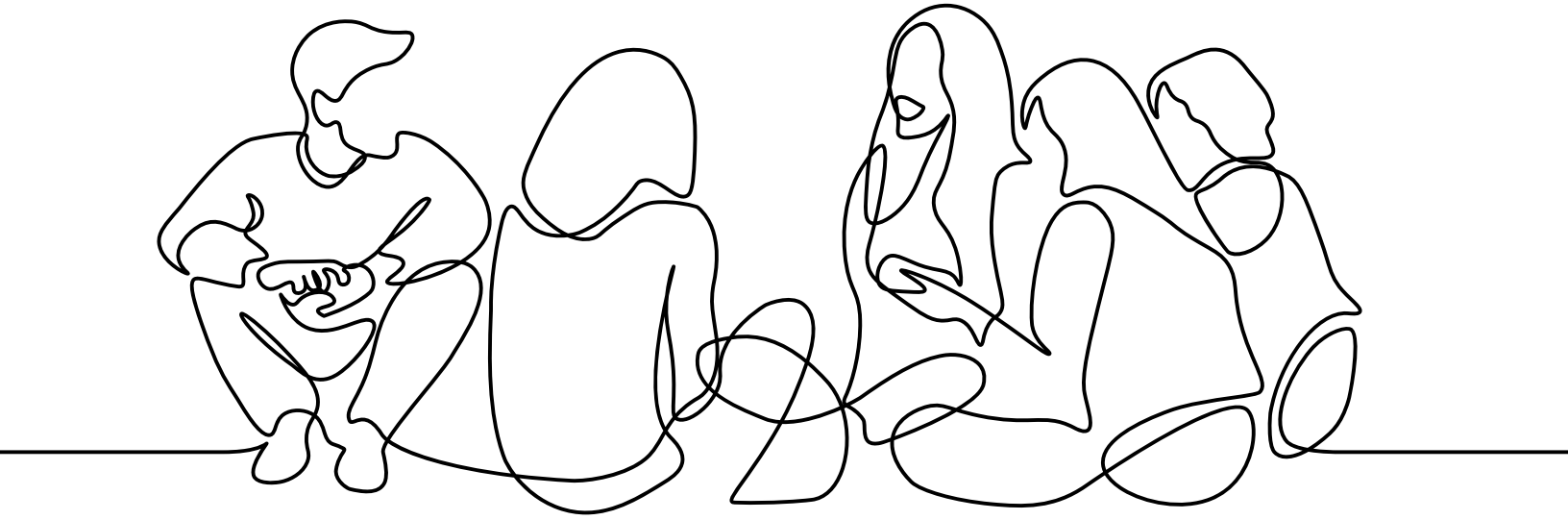
What are the types of diversion?

> “Instances of possible diversion of safe supply medications should be approached with empathy and understanding of the complex reasons that people may divert to have their needs met.” (Victoria SAFER Initiative, 2021, September 8, Appendix 2)

Why does diversion occur within the current context of prohibitionist drug policy? How does it happen? How do people understand it?

Breaking down the social and economic context around diversion moves us towards more shared, accurate, and compassionate understandings of diversion practices.

- **Compassionate sharing:** Sharing doses with partners, friends, and community members who need pain relief and/or withdrawal symptom relief.
- **Survival or subsistence sharing:** Sharing, exchanging, and/or selling doses as a way to meet needs such as a place to sleep, basic physical necessities (food, water, showers, more adequate medications/substances etc.), and/or a safe place to store doses.
- **Coerced or forced diversion:** Sharing, exchanging, and/or selling doses in response to threats of violence, theft, conflict, etc.
- **Unintentional or inadvertent diversion:** Diverting doses to others accidentally or involuntarily because of loss, violence, theft, lack of safe places to store doses, etc.



What are the benefits of diversion?

> “Both the provision and purchase of diverted buprenorphine support user-defined risk minimization strategies to avoid withdrawal, reduce heroin use, and satiate opioid cravings in periods of lowered tolerance.” (Kavanaugh & McLean, 2020)

There are many benefits and advantages to diversion practices among people who use drugs. Naming these benefits allows us to develop more accurate, shared and compassionate understandings of diversion.

Experiencing the advantages of accessing the drugs of one’s choosing:

- Decreasing risk of drug poisoning from using drugs of unknown potency and composition
- Addressing and preventing withdrawal symptoms
- Getting high and feeling euphoria
- Managing physical and emotional pain
- Assisting with relaxation and sleep
- Moderating effects from other prescription and/or illegal drug use

Having money, resources, and/or social connections to address one’s needs:

- Enabling choice around daily priorities for spending and earning money
- Being able to replace missed doses (due to missed appointments, restrictive pharmacy pick-up times, etc.) by accessing diverted medications
- Allowing for preparation for possible reduced access to safer supply medications through the safe storage of doses for later use. Fear, uncertainty, lack of trust in the healthcare system, and program limitations may motivate people who use drugs to plan for future needs (program cut-offs or limitations, theft, etc.)
- Cementing social relationships and mutual aid within communities of people who use drugs

Having a quick, barrier-free way to provide safer supply to more people:

- Facilitating more people to access safer supply in the context of a dangerous drug supply and closed, inaccessible, and rare safer supply programs
- Making medication available when prescribers are significantly limited in number and when gate-keeping occurs
- Allowing people to avoid potentially stigmatizing encounters with the healthcare system or safer supply programs
- Normalizing and destigmatizing drug use within and around communities of people who use drugs
- Inadvertently protecting against Hepatitis C and HIV transmission in communities of people who use drugs

What are the challenges around diversion?

What are the concerns? Who is concerned? Why are they concerned?

There is a perceived tension between diversion's identified public health benefits and potential public health risks. This plays out differently across regions and across the identities, roles, and responsibilities of those involved in safer supply programs. Naming these concerns and tensions cultivates more shared and compassionate understandings of diversion.

Prescribers of Safer Supply Programs:

> "Restrictive prescribing practices may increase harms and risks to people in custody as they attempt to self-medicate with other more harmful illicit substances or diverted medication [in the prison drugs market]. The preoccupation with diversion can create distrust, damage patient-doctor relationships and result in disengagement from healthcare services." (Duke & Trebilcock, 2022)

Some prescribers struggle with the perceived tensions between the known risks of prescribing opioids versus the known risks of diversion.

Some prescribers may be concerned that:

- **Prescribed medications may not be staying with the participants of safer supply programs,** potentially resulting in the misdirected use of services, restricted access for participants on waitlists because of limited capacity, and distrust between prescribers and participants.
- **Participants may share, sell, or exchange their doses for different drugs** (particularly those with a higher potency or strength), and/or for other goods and services.
- **Prescribed medications may be consumed by people with lower and/or different drug tolerance levels.**
- **Doses may be accidentally consumed by youth or children.**
- **Prescribers may risk audits** if they have knowledge that diversion is occurring and fail to address it.
- The inherent power imbalances and focus on stopping diversion in current medical models of safer supply programs can create **tension and conflict between prescribers and participants,** which interferes with care and access.

Participants of Safer Supply Programs:

> “Because you don’t give people the right dosing to begin with, so they sell what they have so that they can buy what they need. Because you don’t give them an adequate amount to address their needs. So what are people supposed to do, just sit happily in withdrawal, taking medication that doesn’t work?” (safer supply participant, as recorded in LeBlanc et al., 2021)

Prescriber concerns about diversion significantly affect participants of safer supply programs. In the current medical model, prescribers have substantial power over safer supply participants. This imbalance can create tension and conflict, which negatively affects care and access.

Safer supply participants may be concerned that:

- **They may not be able to access their prescribed medications** if they share, sell, and/or exchange their doses, potentially resulting in lack of access to safer supply, increased pain and discomfort, and greater risk due to increased reliance on toxic drug supplies.
- Prescribers’ concerns about diversion may **impede participants’ ability to be honest with them,** potentially risking their eligibility to be in the program and access other types of care.
- **Their partners and friends who are seeking relief from pain and withdrawal symptoms may be unable to access non-toxic drug supplies** through informal diversion networks, and, therefore, must risk consuming a toxic drug supply.
- If doses are restricted due to “suspected” diversion, this may significantly **limit (or render impossible) their freedom and agency to self-regulate their own consumption,** as well as their ability to safeguard doses (i.e. storing doses for later use if needed) and access life-saving safer supply services.
- Narratives of certain participants “deserving” safer supply versus others who are deemed “undeserving” may result in **lateral and horizontal violence among people who use drugs**[3].

[3] Lateral violence is a form of bullying, and can often be called horizontal violence, which has been defined as “organized, harmful behaviors that we do to each other collectively as part of an oppressed group, within our families, within our organizations and within our communities.” (Coalition to Stop Violence Against Native Women, 2022)

What is emerging research telling us?

> “In decision-making consider the following: Initiatives should be grounded in the best evidence and clinical practices. Precaution: There may be an obligation to act before we have perfect knowledge about a potentially devastating threat.”
> (BC Ministry of Health, 2017)

At this point, the majority of relevant research has been conducted with participants of OATs, such as prescribed methadone and buprenorphine. Research from OAT programs and emerging research from safer supply programs are demonstrating that:

We have an obligation to evaluate internal and external sources of evidence and information, to determine whether we have accurate information about options and their effects in the short and long term, and to act on the best information available.

- The diversion of prescribed OAT and safer supply medications is a **harm reduction practice** rooted in **mutual aid**.
- Diversion of prescribed OAT and safer supply medications **saves lives and improves quality of life** for both the person for whom safer supply is prescribed and for those who use diverted medications.
- Many **social and structural contexts motivate diversion** practices among people who use drugs.
- **Punitive approaches to diversion are counterproductive, restrictive, and stigmatizing.** These approaches create barriers to safer supply program access and put people who use drugs at greater risk of drug poisoning from the toxic illegal supply.
- **Barriers to medicalized safer supply programs necessitate diversion practices** among people who use drugs.

Evidence-based research on the successes and challenges of safer supply programs is now underway. Emerging research on the diversion of prescribed medications has highlighted key insights.

Diversion is a harm reduction practice rooted in mutual aid that saves lives and improves quality of life:

- The diversion, sharing, exchanging, and selling of prescribed drugs must be **reframed as protective practices of caring and mutual aid** in communities of people who use(d) drugs. (Bardwell et al., 2021c; Kolla & Strike, 2020)
- The **benefits of providing pharmaceutical alternatives that may be diverted far outweigh the risks** and harms associated with diversion and accessing toxic and volatile illicit drug supplies. (Bardwell et al. 2021b; Bardwell et al., 2021c; Kolla & Strike, 2020; Socias et al., 2021, Sud et al., 2021)
- Both the provision and purchase of diverted prescribed medications support **user-defined risk reduction strategies** to avoid withdrawal, reduce heroin use, and satiate opioid cravings in periods of lowered tolerance. (Kavanaugh & McLean, 2020)
- Higher frequency of diverted buprenorphine use is associated with **lower risk of drug overdose.** (Carlson et al., 2020)
- **Giving one's prescription opioids to an individual in withdrawal was indeed seen as an act of helping,** something that takes on particular significance for couples in which only one partner is included in Opioid Maintenance Treatment and the other is using illicit heroin. (Havnes et al., 2013)
- Diverted buprenorphine serves **a variety of functions for people who do not have access to prescribed buprenorphine:** "To get high, manage withdrawal sickness, as a substitute for more preferred drugs, to treat pain, manage psychiatric issues and as a self-directed effort to wean themselves off opioids." (Cicero et al., 2014)
- Diverted and prescribed safer supply medications may both serve as a **means of overdose prophylaxis** during the COVID-19 pandemic, allowing people to self-isolate and use drugs alone without resorting to the illicit drug supply. (del Pozo & Rich, 2020)

Social and structural contexts and motivators of diversion:

- Diversion is **not a homogenous practice** and occurs for a variety of complex and valid reasons. Social and structural contexts frame diversion practices. People who use(d) drugs have divergent perspectives on diversion practices. (Bardwell et al., 2021b; Bardwell et al., 2021c; Kolla & Strike, 2020; Harris & Rhodes, 2013; Havnes et al., 2013; Sud et al., 2021)
- Diversion **may indicate that the medications being prescribed are not the adequate medications or doses for the participant.** For some, the safer supply medications that are currently permitted do not adequately or appropriately address the expressed needs of people who use drugs. In their current forms, **safer supply programs are not adequate replacements for legal and regulated drug supplies.** (Bardwell et al., 2021a; Bardwell et al. 2021b; Bardwell et al., 2021c; LeBlanc et al., 2021)
- Participants of a research study on the use of diverted buprenorphine noted **four main motivators for their diversion practices:** perceived demands of formal treatment, the desire to utilize non-prescribed buprenorphine in combination with a geographic relocation, to self-initiate treatment while preparing for formal services, and to bolster a sense of self-determination and agency in their recovery trajectory. (Silverstein et al., 2020)

Punitive approaches to diversion are counterproductive:

- **Punitive measures used against safer supply participants suspected of diversion are contraindicated** and can increase risks of overdosing and other drug use-related harms (McLean & Kavanaugh, 2022; Ranger et al., 2021; Victoria SAFER Initiative, 2021, September 8, Appendix 2)
- Market demand in the form of **unmet needs for buprenorphine was the major driver of diversion,** suggesting that 'supply-side interventions' intended to again limit access to buprenorphine may be counterproductive. (McLean & Kavanaugh, 2022)
- Restrictive prescribing practices may **increase harms and risks to people who use drugs who are incarcerated** as they attempt to self-medicate with other potentially harmful illicit substances or diverted medications in the prison drugs market. (Duke & Trebilcock, 2022)
- **Less restrictive prescribing practices for buprenorphine-naloxone have not been a major driver of diversion practices** for non-prescribed use among cohorts of people who use drugs. (Bach et al., 2022)

Barriers to medicalized safer supply programs necessitate diversion practices:

- **Barriers related to availability, accessibility, and acceptability** may explain low rates of prescribed buprenorphine use among certain groups of people who use drugs. (McLean & Kavanaugh, 2019)
- Even as most participants expressed an interest in the utilization of buprenorphine to stop heroin and/or prescription opioid misuse, **geographic, temporal, financial, and institutional barriers deterred formal entry into or retention in buprenorphine treatment.** (McLean & Kavanaugh, 2019)
- Barriers and **lack of access to healthcare providers who are able and willing to prescribe buprenorphine increases the likelihood of diversion practices** among people who use drugs. (Cicero et al., 2018)

What are some helpful approaches to diversion for prescribers?

Reframing Diversion as a Concept:

> "Taken together, these findings identify a need to move beyond the tension of harm-reducing versus harm-producing effects toward forms of health care and promotion that focus on the needs, perspectives, and priorities of people who use drugs." (Sud et al., 2021)

- **Perceptions of diversion are heavily reliant on perceptions of people who use drugs as a whole.** All prescribed medications, including methadone, suboxone, and other OAT medications, can be and frequently are diverted in a variety of contexts and for many reasons. Focusing on the humanity and logic behind diversion practices may help build understanding of diversion.
- The context of drug prohibition, combined with the current medical model of safe supply, has forced undue focus on the potential harms of diversion and ignored the demonstrated benefits. **Diversion is an issue because prescribers and participants are forced to work within a medical model,** under the broader context of criminalization.
- **Prescriber preoccupations with diversion practices can create distrust, damage patient-doctor relationships, and result in disengagement from healthcare services.** (Duke & Trebilcock, 2022)
- Challenge conceptualizations that perpetually frame diversion as harmful, dangerous, and/or reckless and **reframe the diversion, sharing, exchanging, and selling of prescribed drugs as protective practices** of caring and mutual aid in communities of people who use(d) drugs. (Bardwell et al., 2021c; Kolla & Strike, 2020; McLean, 2018)
- Prescribers and service providers must move beyond the tensions concerning diversion and its harm-reducing versus harm-producing effects toward **forms of health care and promotion that focus on the needs, perspectives, and priorities of people who use drugs.** (Sud et al., 2021)

Navigating Diversion in a Medicalized Model as Prescribers and Clients:

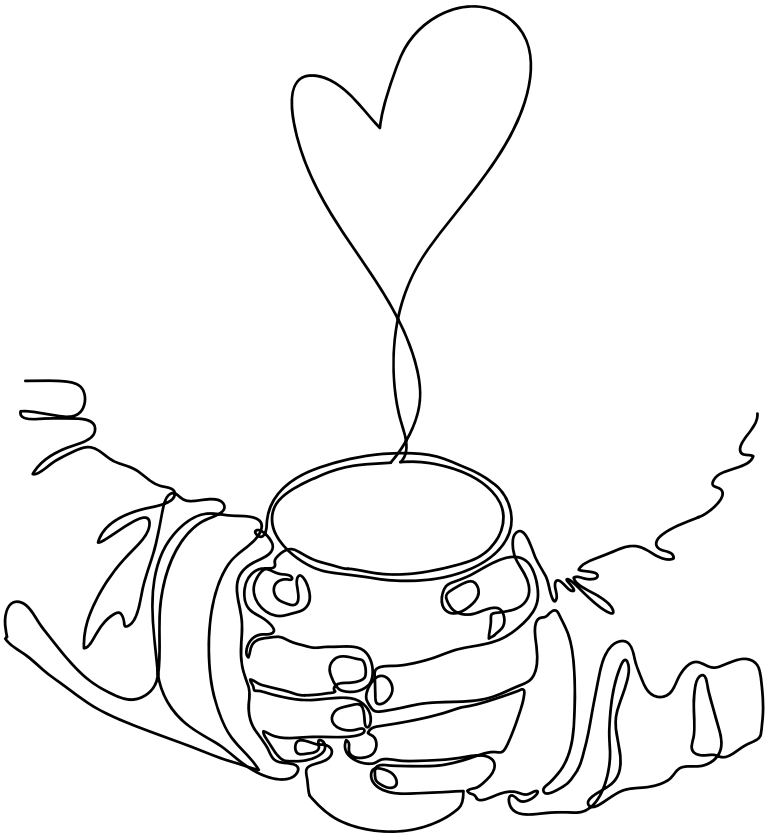
> “Having more options is a displacement prevention practice. Rather than deeming a participant a ‘poor fit’ for a program, prescribers and teams should be striving to develop a continuum of options within their services rather than hoping for a one-size-fits all approach.” (Ranger et al., 2021)

- **Safer supply programs should include a variety of drug types and dispensing models** that meet people where they are at. (Bardwell et al., 2021a)
- Instances of **possible diversion should be approached in non-punitive, supportive, and compassionate ways** that focus on the participant’s needs, the role of diversion in fulfilling those needs, and how prescriber(s) can better meet their needs through potential changes to their safer supply plan. (Victoria SAFER Initiative, 2021, September 8, Appendix 2)
- Have **open discussions with safer supply participants** about their needs, social contexts, and community.
- **Address other unmet needs** that may motivate a need for diversion, such as food, shelter/housing, access to health/social care, and financial support.
- Acknowledge the social and structural contexts and motivators of diversion, and **appreciate the benefits of diverting prescribed medications.**
- Acknowledge and accept that diversion will happen regardless, and **develop policies and practices that reflect the realities of diversion and mitigate any potential harms.** (Bardwell et al., 2021a)
- **Approach safer supply dosages with “generous constraints”** that reflect the identified and expressed needs of participants. (Harris & Rhodes, 2013)
- Discuss the importance of **information sharing surrounding non-punitive urine drug screenings** (UDS) with participants.

Organization-Level and Systems-Level Advocacy for Prescribers:

> “Given that drug policy, criminalization, and poverty created challenges, our findings demonstrate the need for strategies that engender greater safety, reduce harm, and alleviate the effects of these constraints, including through policies promoting safer drug supplies, decriminalization, and employment.” (Bardwell et al., 2021c)

- **Provide training** for prescribers about the importance of information sharing surrounding non-punitive urine drug screenings (UDS) with participants.
- **Advocate** for other formulary options, policy changes, and systemic transformations within regulatory colleges
- **Support research and evaluation** to better understand the needs of safer supply participants and the social and structural motivators of diversion practices
- **Advocate** for non-medicalized forms of safer supply, compassion clubs, and decriminalization
- **Advocate** for government resources dedicated to addressing the social determinants of health of people who use drugs and their communities (e.g. food, housing, health and social care, guaranteed basic income, employment)



Where can I find support as a prescriber?

The National Safer Supply Community of Practice operates a consultation hotline exclusively for safer supply prescribers. If you are a physician or nurse practitioner who works with people who use drugs and want to learn more about safer supply and how you can best support the people you work with, join our community of practice and email us for details about the prescriber consultation hotline.

Where can I find more information?

Looking for more information or resources to help guide your safer supply prescribing practices? Here is a brief list of information, resources, and research. For additional resources and research, please visit the National Safer Supply Community of Practice Resource Library.

Information and Resources

- National Safer Supply Community of Practice
  - Resources
  - Webinars

- Canadian Association of People Who Use Drugs
  - Safe Supply Concept Document

- Health Canada
  - Safer Supply Toolkit

- Canadian Drug Policy Coalition
  - Safe Supply Information and Resources

- Hales et al.
  - Safer Opioid Supply Programs Guiding Document

Research

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National Safer Supply
Community of Practice

This FAQ was developed by the collaborative Reframing Diversion Working Group, as part of the National Safer Supply Community of Practice (NSS-CoP).

Please visit www.nss-aps.ca **to learn more.**

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