Knowledge Update

BC Centre for Disease Control
Provincial Health Services Authority

Topic	Receipt and access of opioid agonist treatment and prescribed alternatives among respondents from the 2023 Harm Reduction Client Survey
Date	February 14, 2025
Data source	Harm Reduction Client Survey
Authors	Katie Fajber, Heather Palis, Mieke Fraser, Chloé G. Xavier, Roshni Desai, Christie Wall, Brooke Kinniburgh, Alexis Crabtree

Key messages

- In the 2023 Harm Reduction Client Survey, 38% (165/433) of survey respondents reported receiving opioid agonist treatment (OAT) and/or prescribed alternatives (PA) in the last six months. Reported access to OAT and/or PA varied by sociodemographic factors such as gender, age, health region, and community size.
- Among all participants who reported receiving a prescription (N=196), 63% indicated OAT, 52% indicated a PA opioid, and 7% indicated a PA stimulant.
- Co-prescription of OAT and PA is common. Among respondents who reported a prescription of one or more of these medications (n=162), 39% reported receiving OAT only, 30% reported receiving OAT and PA, and 31% reported receiving PA only.
- Among respondents who reported an interruption to their prescription and a reason for that interruption (N=60), the most reported reasons were as follows: 53% reported being cut off by their provider or being unable to renew their prescription, 25% reported services were too hard to access, 22% reported they could not get carries (take-home doses), and 22% reported it was easier to buy street drugs.

Introduction

This knowledge update provides insight on experiences of prescription medication use by people who use drugs who are attempting to avoid the unregulated drug supply, with the intent to inform policy and better support people who use substances.

The primary objectives are to: 1) describe the proportion of 2023 Harm Reduction Client Survey (HRCS) respondents who received a prescription for opioid agonist treatment (OAT) and/or prescribed alternatives (PA); and 2) describe the proportion of respondents who experienced an interruption to their prescription for at least seven days and present the self-reported reasons for interruption.

- The public health emergency in BC is driven by an unregulated, increasingly toxic supply of fentanyl, fentanyl analogs and other contaminants. Prescription medications, including OAT and PA, are used to attempt to reduce or replace a person's reliance on the unregulated toxic drug supply.

- OAT is prescribed to individuals with opioid use disorder (OUD) to prevent withdrawal, reduce cravings, and promote stabilization (British Columbia Centre on Substance Use et al., 2023). OAT is a form of treatment that is widely available in BC; however, has limitations in reach and retention (Paul et al., 2023; Piske et al., 2020).

- 'Prescribed Alternatives to the toxic supply' (also referred to as PA) is the term recommended by BC's Office of the Provincial Health Officer to replace the term Prescribed Safer Supply (PSS), and refers to pharmaceutical medications including opioids, stimulants, and benzodiazepines. In July 2022, the Government of BC released *Access to Prescribed Safer Supply in British Columbia: Policy Direction* which supports the use of prescription medications for people who are at high risk of drug poisoning due to use of the unregulated supply (British Columbia Ministry of Mental Health and Addictions, 2021). In December 2023, the Provincial Health Officer released a review of Prescribed Safer Supply (PSS) including recommendations that the PSS policy continue and that changes be made including increased monitoring of potential harms and increased integration of services within a holistic approach to health care which also addresses the social determinants of health (British Columbia Office of the Provincial Health Order, 2023).

- Safe supply is a concept originating from people who use substances who have called for a regulated supply of substances to uphold human rights and prevent death from the unregulated supply (Canadian Association of People who Use Drugs, 2019). Prescribed Alternatives (PA) is a medicalized model for safer supply that has been implemented and evaluated in BC (British Columbia Office of the Provincial Health Order, 2023). There is overlap in the objectives and use of PA and OAT. OAT has been available in BC for longer and has a more comprehensive evidence base compared to PA. PA is intended to contribute to the spectrum of harm reduction services by offering additional prescribing options and flexibility with the aim of reducing an individual's reliance on the unregulated market (Government of Canada, 2023).

- For additional reports related to the HRCS, please see the Harm Reduction Client Survey webpage and Harm Reduction Reports pages.

Definitions

In the 2023 HRCS, prescribed alternatives were defined as "prescription medications [that] act as substitute for opioids/down, stimulants, or benzos that people get from the street (this includes Opioid Agonist Therapy (OAT) and Prescribed Safer Supply (PSS)". Participants were asked if they had tried to get prescription medication(s) from a doctor or nurse as a substitute for street drugs.

During analysis, we categorized medications using the definitions below.

Type	Definition
Opioid Agonist Treatment	Any reported prescription for methadone (Methadose, Metadol), buprenorphine, buprenorphine/naloxone (suboxone, Sublocade), diacetylmorphine (heroin) injectable, or Kadian (morphine) in the last six months.
Prescribed Alternative Opioid	Any reported prescription for hydromorphone (Dilaudid), oxycodone (OxyNeo)[1], M-Eslon (morphine)[2], or fentanyl (fentanyl patch, Sufentanil, Sufenta, Fentora) in the last six months.
Prescribed Alternative Stimulant	Any reported prescription for dextroamphetamine (Dexedrine), methylphenidate (Ritalin), Lixdexamfetamine (Vyvanse), or mixed amphetamine (Adderall) in the last six months.
Prescribed Alternative Benzodiazepine	Any reported prescription for diazepam (Valium), clonazepam (Klonopin), alprazolam (Xanax), or lorazepam (Ativan) in the last six months.
Unspecified	Any prescription for morphine not specified as Kadian or M-Eslon; anyone who reported receipt of PA/OAT but did not specify medication type(s).

[1] Oxycodone was a later addition to the list of PA because prescribers commonly labelled it as such in provincial surveillance of PA.
[2] In clinical practice, some OAT clients may receive M-Eslon when Kadian is unavailable. This detail is beyond what was collected in the HRCS.

Study Design and Methods

- The 2023 HRCS includes responses from 433 eligible respondents at 23 harm reduction supply distribution sites in BC. Eligible respondents were 19 years or older and reported use of unregulated substances in the last six months on a self-reported, anonymous survey collected between December 5, 2023 and March 8, 2024. Surveys took approximately 30 minutes to complete, and respondents received a $20 honorarium for completing the survey (see Appendix I for further details on methods).

- This knowledge update provides an update to a prior analysis: Receipt and access of prescribed alternatives and opioid agonist treatment among respondents from the 2022 Harm Reduction Client Survey (Xavier et al., 2023).

- Interpretation of results were done in collaboration with the Professionals for the Ethical Engagement of Peers (PEEP), a consulting and advisory board comprised of people with lived and living experience of substance use.

Findings

Receipt of PA and/or OAT

- In the 2023 HRCS, 38% (165/433) of survey respondents reported having a prescription for OAT and/or PA in the last six months. Among respondents who reported a prescription (N=165): 39% reported it was for OAT only; 30% reported receiving PA and OAT; and 31% reported receiving PA only (Table 1). Comparatively, in 2022 (N=187), 32% reported OAT only; 51% reported PA and OAT; and 18% reported PA only.
    - Among all respondents who reported a prescription in the 2023 HRCS (N=165), 28% were aged 50 or older. While 17% of OAT only respondents were aged 50 or older, 41% of PA-only respondents were in this age group.
    - Among all respondents who reported a prescription (N=165), 29% identified as women. In comparison, 38% of OAT respondents identified as women and 16% of PA only respondents identified as women.
- Among all respondents who reported a prescription (N=165), 87% reported using unregulated substances daily; 57% reported injection drug use in the last six months; 95% reported inhalation drug

use in the last six months; and 72% reported substance use at an overdose prevention site (OPS) or supervised consumption site (SCS) in the last six months.

Receipt of specific medications

- Among all respondents with a prescription for PA and/or OAT in the last six months (including benzodiazepines and unspecified medications) (N=196), 63% reported an OAT medication; 52% reported a PA opioid; 7% reported a PA stimulant; and 1% reported a PA benzodiazepine. Some respondents did not specify which medication they received (Table 2). In the 2022 HRCS, 82% reported an OAT medication; 63% reported a PA opioid; 15% reported a PA stimulant; and 9% reported a PA benzodiazepine.
- Within their medication categories, the most reported prescriptions were:
    - Among those who received OAT (N=124), 59% received methadone.
    - Among those who received a PA opioid (N=102), 52% received hydromorphone (e.g,. Dilaudid).
    - Among those who received a PA stimulant (N=15), 60% received dextroamphetamine (e.g., Dexedrine).
    - Receipt of PA benzodiazepine among respondents was rarely reported (N=3).

Co-Prescription of OAT and PA

- Among all respondents who reported a prescription of OAT and/or PA, excluding benzodiazepines (N=162), 38% reported receiving OAT only; 30% OAT and PA; and 31% PA only (Table 3). This varies slightly from 2022 HRCS findings in which 35% reported receiving OAT, 47% reported OAT and PA, and 18% reported PA only.[3]

[3] There are notable differences in how the questions were asked in the 2022 and 2023 HRCS. In 2022, participants were asked if they had tried to get a prescription for 'prescribed safer supply (PSS)' and if yes, were asked to indicate whether they were prescribed specific medications as OAT or PSS. In 2023, participants were asked if they had tried to get 'prescription medications to substitute for use of street drugs (this includes opioid agonist therapy (OAT) and Prescribed Safer Supply (PSS))'. Participants were prompted to write in the names of medications received. Medications were categorized as OAT or PA during data cleaning.

- Among recipients who reported PA, receipt of PA opioids was more common than receipt of PA stimulants or a combination of both.
    - Among respondents who reported receiving PA only (n=49): 80% received opioid(s) only, 12% received stimulant(s) only, and 8% received both.
    - Among respondents who reported receiving PA and OAT (n=50): 92% received opioid(s) only, 4% received stimulant(s) only, 4% received both.

Interruptions to prescriptions

- Among respondents who reported receiving a prescription (n=196), 31% (n=60) of respondents indicated they took a break or stopped their medications for at least seven days when they did not want to, and provided at least one reason (Table 4).[4]
- The most common reasons that respondents took a break from or stopped their medication for at least seven days (n=60) were:
    - 53% of respondents reported they were cut off or couldn't get prescription renewed;
    - 25% reported services were too hard to access;
    - 22% reported they couldn’t get carries (take-home medication); and
    - 22% reported it was easier to get street drugs than a prescription.
- The reasons respondents stopped taking medications were grouped into broader categories during analysis: 75% of respondents reported a clinic or program barrier; 32% reported a medication-related reason; 15% reported a stigma-related reason; and 27% reported other reasons. Comparatively, in the 2022 HRCS (n=74), 51% reported a clinic or program barrier, 45% reported a medication-related reason, 12% reported a stigma-related reason, 26% reported another reason.

[4] Question wording may have introduced bias into responses. In the 2023 HRCS, the question 13 was worded as “If you took a break or stopped taking the medication(s) you wrote above for at least 7 days, what were the reasons?” This language implies that people had a choice; however, the response options reflected reasons outside of a person’s control.

Interpretation

- **Access to OAT and PA varies across BC and across populations**. Our findings suggest that access to OAT and/or PA only may vary according to sociodemographic factors such as gender, age, health region and community size. Some difference may be ascribed to individual interpretation and uptake of the PSS policy directive among providers, as well as varying local and regional contexts (Karamouzian et al., 2023; Pauly et al., 2024). In both the 2022 and 2023 HRCS results, there was variation in which medications were received (OAT only, OAT and PA, PA only) across different age groups and gender identities. Gender may influence a person's access to different medications, such as which medications are offered and which medications they choose. People with greater exposure to the unregulated toxic drug supply (i.e., used substances daily) and with greater engagement with other harm reduction services (i.e., used an OPS or SCS in the last 6 months) represented a high proportion of respondents receiving a prescription. This finding is similar to past analysis of HRCS which found an association between using drug checking services or using an OPS or SCS and receiving PSS (Palis et al., 2024). Improving patient outcomes from OAT and PA requires attention to equity and the barriers that different populations face when accessing substance use care and harm reduction services (Urbanoski et al., 2024).

- **Co-prescription of OAT and prescribed alternatives is common, albeit was not required in the guidance at the time of survey.**[5] Among respondents who indicated receipt of a prescription, a slightly higher proportion indicated receiving OAT only (39%) compared to OAT and PA (30%) or PA only (31%). In the 2022 HRCS findings, co-prescription of OAT and PA was notably higher (47%). These findings suggest how OAT may be a pathway to receiving PA, the overlap between OAT and PA providers, and how PA and OAT may be provided with the intention that they be complementary prescriptions (Selfridge et al., 2022). People with lived and/or living experience have observed in their communities that people who use substances are sometimes required to access OAT as a precursor for accessing PA. Similarly, studies have found that OAT prescribers were over three times more likely to prescribe PA (Kurz et al., 2024; Pauly et al., 2024). In another study, opioid Risk Mitigation Guidance (RMG) receipt in a week was associated with increased probability of OAT receipt in the next week (Min et al., 2024).

- **Receipt of OAT was reported more than PA, and among those who reported PA, PA opioids were reported notably more than PA stimulants or a combination of both.** These trends are also reflected

[5] The BC Prescribed Safer Supply Policy Directive is not available online, as of the time of publishing these results.

in the 2022 HRCS findings, as well as provincial surveillance data (British Columbia Centre for Disease Control, 2025). Prescription of PA opioids has been declining since 2023 (British Columbia Centre for Disease Control, 2025). Stimulant users may face different barriers to PA than opioid users, and there remains a need for improved stimulant medication options that are appropriate as an alternative to the unregulated supply (Fleming et al., 2024; Palis & MacDonald, 2023). People with lived and/or living experience reflected how in some communities the only PA prescribers worked at the OAT clinic which did not take on people who used stimulants only – creating a major barrier for people who use stimulants to access medical care.

- **Improving outcomes from OAT and PA requires sustaining programs and policies so that individuals can maintain their medical care and stay well.** Among respondents who reported an interruption to their prescription, over half indicated being 'cut off' by their provider or being unable to renew their prescription. Given the limitations of this survey, we are unable to further contextualize the driving factors – including programmatic or clinical factors– that may have led to a person having medication discontinued.[6] People with lived and/or living experience of substance use noted seeing individuals being involuntarily deprescribed in their communities and emphasized that people require individualized prescriptions (i.e., appropriate medications, dose, delivery) to meet each person's specific needs. In academic literature, commonly noted barriers to PA programs include medications not being adequate substitutes for the unregulated supply, limited program capacity and related lack of program funding, and lack of resources and regulatory support for providers (Barker et al., 2025; Foreman-Mackey et al., 2022; Karamouzian et al., 2023; Pauly et al., 2024).

Limitations

- Respondents in the 2023 HRCS are a convenience sample of clients who visited a participating harm reduction supply distribution site in BC. These results are not generalizable to the experience of all people who use harm reduction services or to all people who use substances in BC.

- Survey responses are self-reported, and the accuracy of responses cannot be assessed. Many sites had someone available to support people to complete the survey in recognition that literacy may otherwise be a limiting factor in participation; however, the presence of a support person may have affected how respondents answered. BCCDC continues to look for new ways to support people completing the

[6] The response option was worded as "I got cut off / couldn't get my prescription renewed." The full 2023 survey can be found here: http://www.bccdc.ca/Health-Professionals-Site/Documents/HRCS%202023%20survey%20final.pdf

survey and help them provide honest responses that can be used to improve services and supports for people who use harm reduction services.

- Respondents in the HRCS are anonymous, thus it is not possible to determine if respondents are the same in the 2022 and 2023 survey. This limits the ability to do statistical tests. There is noted variability in how the questions were asked between years. Comparisons between results from the 2023 and 2022 HRCS presented in this knowledge update should be interpreted with caution.

- Some respondents indicated they received a medication, but did not specify what medication. As such we were unable to categorize those respondents as receiving OAT and/or PA and they were left out of some analyses. This missing information could indicate difficulties completing the survey, not knowing medication names, not wanting to disclose medication names or something else. Additionally, respondents may use varying language to refer to their medications (i.e., OAT, PSS, PA) which could bias the results and limit the interpretation. These results should be interpreted alongside other data sources to support accurate interpretation.

- Consistent with BCCDC policies to reduce the risk of survey respondents being identified, subgroup results are only presented when there are at least 20 respondents.

Supporting Information

Document citation

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Tables and Figures

Table 1: Demographic and substance use characteristics of respondents who received Prescribed Alternative (PA) medications and/or, Opioid Agonist Treatment (OAT) in the last six months.

Characteristic [1,2]	Overall receipt of PA and/or OAT, N = 165	OAT only, N = 64	PA and OAT,[3] N = 50	PA only,[4] N = 51
Health Authority (survey site)				
Interior	29 (18%)	14 (22%)	4 (8%)	11 (22%)
Fraser	22 (13%)	17 (27%)	1 (2%)	4 (8%)
Vancouver Coastal	31 (19%)	12 (19%)	7 (14%)	12 (24%)
Island	39 (24%)	10 (16%)	11 (22%)	18 (35%)
Northern	44 (27%)	11 (17%)	27 (54%)	6 (12%)
Community size (2021 Census Population Centre)				
Small population centre (1,000 to 29,999)	78 (47%)	30 (47%)	30 (60%)	18 (35%)
Medium population centre (30,000 to 99,999)	25 (15%)	4 (6.3%)	9 (18%)	12 (24%)
Large urban population centre (100,000 or more)	62 (38%)	30 (47%)	11 (22%)	21 (41%)
Type of current residence				
Private or band owned residence	34 (21%)	17 (27%)	5 (10%)	12 (24%)
Another residence (e.g., hotel/motel, SRO, supportive housing)	37 (23%)	8 (13%)	18 (36%)	11 (22%)
Shelter	41 (25%)	16 (26%)	11 (22%)	14 (29%)
No regular place to stay (homeless, tent, couch-surf)	49 (30%)	21 (34%)	16 (32%)	12 (24%)
Age group				
19 to 29	15 (9%)	-	-	-
30 to 39	53 (33%)	20 (32%)	20 (40%)	13 (27%)
40 to 49	49 (30%)	19 (30%)	15 (30%)	15 (31%)
50 or older	45 (28%)	17 (27%)	8 (16%)	20 (41%)
Gender [2]				
Man	106 (65%)	37 (59%)	33 (66%)	36 (72%)
Woman	47 (29%)	24 (38%)	15 (30%)	8 (16%)

Characteristic [1,2]	Overall receipt of PA and/or OAT, N = 165	OAT only, N = 64	PA and OAT,[3] N = 50	PA only,[4] N = 51
Sexual orientation				
Heterosexual or straight	130 (82%)	53 (87%)	40 (83%)	37 (74%)
Gay, Lesbian, Bisexual/Pansexual, Queer, Asexual, Unsure/questioning	29 (18%)	8 (13%)	8 (17%)	13 (26%)
Employment				
Full time or part time	32 (20%)	14 (22%)	9 (19%)	9 (19%)
No employment or volunteer work	127 (80%)	50 (78%)	39 (81%)	38 (81%)
Used substances daily, last 30 days	140 (87%)	54 (84%)	45 (90%)	41 (87%)
Injection drug use, last 6 months	91 (57%)	32 (53%)	31 (62%)	28 (56%)
Inhalation drug use, last 6 months	150 (95%)	58 (95%)	48 (98%)	44 (92%)
Drug use at overdose prevention site (OPS)/ supervised consumption site (SCS), last 6 months	113 (72%)	44 (70%)	37 (77%)	32 (70%)
Used opioids in last 3 days (fentanyl, heroin)	143 (87%)	55 (86%)	44 (88%)	44 (86%)
Used stimulants in last 3 days (meth, coke, crack)	121 (73%)	45 (70%)	40 (80%)	36 (71%)

1) *Missingness of data varies for each question and is not included in these tables. 'Prefer not to say' and 'unsure' responses were excluded on a case-by-case basis depending on the question.*
2) *Subgroup results are only presented when there are at least 20 respondents, as per BCCDC policy. As such, respondents who identified as transgender, non-binary, agender or gender creative have been removed from these results to maintain confidentiality.*
3) *Only PA opioid(s) and PA stimulant(s) included.*
4) *Among those receiving PA only, 39 receiving PA opioid only, 4 receiving PA stimulant only, 2 received both an opioid and stimulant, 2 received PA without specifying medication type (i.e., opioid, stimulant, benzodiazepine). See Table 3 for the type(s) of PA prescriptions reported.*

Table 2: Type of medication reported by respondents who received Prescribed Alternatives and/or Opioid Agonist Treatment in the last 6 months by medication type.

Medication type	2023		2022	
	N = 196 [1,6] N (%)	Proportion within each medication type	N = 187 N (%)	Proportion within each medication type
Any OAT [2]	**124 (58%)**	**N = 124**	**154 (82%)**	**N = 154**
Methadone (Methadose, Metadol)	73 (37%)	59%	108 (58%)	70%
Buprenorphine or buprenorhpine/naloxone (Suboxone, Sublocade)	25 (13%)	20%	27 (14%)	32%
Kadian (morphine)	26 (13%)	21%	49 (26%)	18%
Heroin (diacetylmorphine, DAM)	-	-	22 (12%)	14%
Any prescribed alternative opioids	**102 (52%)**	**N = 102**	**117 (63%)**	**N = 117**
Hydromorphone (Dilaudid, 'Dillies')	65 (33%)	64%	88 (47%)	75%
Oxycodone, OxyNeo	20 (10%)	20%	22 (12%)	25%
Fentanyl (Fentora), sufentanil (Sufenta)	15 (8%)	15%	29 (16%)	19%
M-eslon (morphine)	2 (1%)	2%	17 (9%)	15%
Any prescribed alternative stimulants [3]	**15 (7%)**	**-**	**28 (15%)**	**-**
Any prescribed alternative benzodiazepines [4]	**3 (2%)**	**-**	**16 (9%)**	**-**
Unspecified OAT or prescribed alternative [5]	**28 (14%)**	**-**	**-**	**-**

5) *Includes respondents who reported having a prescription for prescribed alternatives or OAT in the last 6 months. Respondents may have reported medication received either alone or in combination with other medications.*
6) *OAT medications include methadone, buprenorphine, morphine (Kadian), or diacetylmorphine.*
7) *PA stimulants include dextroamphetamine (Dexedrine) and methylphenidate (Ritalin). The breakdown of prescriptions are not shown due to small cell counts.*
8) *PA benzodiazepines include diazepam (Valium), Lorazepam (Ativan), and unspecified benzodiazepines. The breakdown of prescriptions are not shown due to small cell counts.*
9) *Unspecified OAT or prescribed alternatives includes anyone who did not name any medication or indicated receiving morphine but did not name the medication.*
10) *As some respondents indicated receiving multiple medications, the percentages total to over 100%.*

Table 3: Prescription type and drug type reported by respondents who received prescribed alternatives and/or OAT in the last 6 months.

Receipt of PA, excluding benzodiazepines	2023 N = 162	2022 N = 171
OAT only [1]	**63 (39%)**	**59 (35%)**
PA opioids or stimulants only [2,3]	**49 (30%)**	**31 (18%)**
Opioids only	39 (80%)	24 (14%)
Stimulants only	6 (12%)	6 (4%)
Opioids and stimulants	4 (8%)	1 (0.6%)
PA opioids or stimulants and OAT	**50 (31%)**	**81 (47%)**
Opioids only	46 (92%)	65 (38%)
Stimulants only	2 (4%)	3 (2%)
Opioids and stimulants	2 (4%)	13 (8%)

1) *OAT includes Methadone, Buprenorphine, Heroin (diacetylmorphine), and Kadian (Morphine).*
2) *Prescribed alternative opioids includes Hydromorphone, Oxycodone, M-Eslon (Morphine), Fentanyl.*
3) *Prescribed alternative stimulants includes Dextroamphetamine, Methylphenidate.*

Table 4: Reasons for taking a break or stopping to take prescribed alternatives or OAT medications for at least 7 days.

Characteristic [1]	2023 N = 60 [2]	2022 N = 74
Clinic or program barrier	**45 (75%)**	**38 (51%)**
I got cut off / couldn't get my prescription renewed	32 (53%)	17 (23%)
Services were too hard to access (hours, wait time, distance)	15 (25%)	11 (15%)
It was easier to buy street drugs	13 (22%)	19 (26%)
I couldn't get carries	13 (22%)	-
I had a negative urine test for the medication I was prescribed	6 (10%)	-
The clinic charged me a fee to be a patient	1 (2%)	6 (8%)
Medication-related reason	**19 (32%)**	**33 (45%)**
The medication dose was too low	11 (18%)	12 (16%)
I couldn't get the medication I wanted	9 (15%)	12 (16%)
I didn't want to take that medication anymore	6 (10%)	12 (16%)
I couldn't get the medication in the form I wanted (e.g. injection, tablet, etc.)	5 (8%)	7 (9%)
Stigma-related reason	**9 (15%)**	**9 (12%)**
I didn't like how I was treated by pharmacy or clinic staff	9 (15%)	9 (12%)
Other reasons	**16 (27%)**	**19 (26%)**
I went to jail or prison	8 (13%)	-
Something else	9 (15%)	-

1) *Response options in varied between survey years which may have impacted results. The 2023 version used the word 'medication' as opposed to 'drugs' in all response options. The 2023 version also added two options ('I couldn't get carries' and 'I had a negative urine test for the medication I was prescribed) and removed two options ('I was worried about being treated badly by police, family services, etc.' and 'I decided I didn't want to take that drug anymore').*
2) *Respondents who received medication (OAT, prescribed alternative opioids, stimulants, or benzodiazepines, or unspecified) and who both a) said yes to Question 12 ("Was the dose for any of the medication(s) you wrote above reduced or stopped when you didn't want it to be?") and b) responded to Question 13 ("If you took a break or stopped taking the medication(s) you wrote above for the least 7 days, what were the reasons?"). Excludes respondents that did not answer or did not stop medication for 7 days.*

Appendix I - Methods

Additional details about the methods used for completing and analysing 2023 Harm Reduction Site Client Survey data:

- The 2023 HRCS included questions on substance use, barriers to accessing prescribed alternatives to the toxic supply, BC's decriminalization policy, experiences with overdose, and interactions with law enforcement. Questions about social and demographic characteristics of respondents were also included.
- Harm reduction supply distribution sites across BC were invited to participate based on geographical representation, site capacity, and interest of the site and its clients. Quantitative surveys were distributed at 23 harm reduction distribution sites in small, medium, and large population centres across the five regional health authorities (Interior: 4 sites, Fraser: 4 sites, Vancouver Coastal: 5 sites, Island: 4 sites, Northern: 6 sites). Each participating site completed between 10 and 30 surveys.
- People are eligible to participate in the survey if they:
    - Are 19 years of age or older; and
    - Used a drug that is illegal or from the unregulated market (for example: opioids/down, heroin, fentanyl, powder cocaine, crack cocaine, methamphetamine, hallucinogens, etc.) in the previous six months.
- BCCDC received 447 completed surveys. We excluded fourteen ineligible surveys, resulting in a total of 433 eligible surveys.
- The HRCS is a paper survey, and BCCDC shares additional information with sites to help individuals understand and respond to questions. BCCDC recommends that site staff assist respondents to complete the survey, but this was not possible in all locations.
- Respondents received a $20 cash honorarium for their time to do the survey. Sites were provided with $5 per respondent to cover any small costs for administering the survey (e.g., snacks, pens).
- For more HRCS reports and outputs see the Harm Reduction Client Survey webpage and Harm Reduction Reports pages.