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## “PEOPLE NEED THEM OR ELSE THEY’RE GOING TO TAKE FENTANYL AND DIE”: A QUALITATIVE STUDY EXAMINING THE ‘PROBLEM’ OF PRESCRIPTION OPIOID DIVERSION DURING AN OVERDOSE EPIDEMIC

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### Abstract

The practice of prescription opioid (PO) diversion remains highly controversial and has been characterized as a source of significant drug-related harm by physicians and public health officials. We critically analyze the “problem” of diversion through an examination of the perspectives of people who divert POs during an overdose epidemic to better understand the practice, including benefits and challenges, as well as how diversion is shaped by structural contexts. Qualitative semi-structured interviews were conducted with 21 participants recruited from ongoing cohort studies involving people who use drugs in Vancouver, Canada. Prohibitive prescribing policies made accessing POs difficult, leading some to smuggle drugs out of clinics. Others would buy POs in bulk or do trades to acquire them. Participants risked having their prescriptions terminated, but rationalized this risk as a protective measure that allows them to provide safer drugs to others (e.g., to prevent overdose or treat withdrawal). Poverty also framed diversion, with some participants diverting their POs to generate income to pay for expenses including food and sometimes illicit fentanyl (perceived as a stronger alternative). However, diversion was shaped by other constraints, including criminalization, negative health impacts from not consistently consuming POs, and supplies running out, which led some participants to rely on other illegal means to generate income. This study highlights the intricate means by which POs are acquired and diverted and

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how environmental contexts frame how participants negotiated risk and rationalized diversion. Our study provides an alternative perspective on the “problem” of diversion and demonstrate a positive effect in providing a safer drug supply to others during an overdose crisis. 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.

## Keywords

prescription opioid diversion; drug dealing; contextual factors; situated rationality; critical drug policy; safer supply

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## 1. INTRODUCTION

### 1.1. Background

North America continues to face an ongoing opioid overdose epidemic. The origins of this epidemic have been linked to the use and diversion of prescription drugs (Khan et al., 2019; King et al., 2014; Powell et al., 2020). More recently, the epidemic has been driven by the increasing presence of illicitly-manufactured fentanyl and its related analogs contaminating drug markets (Ciccarone, 2017; Frank and Pollack, 2017). For example, in 2017, 42% of overdose deaths in the United States were attributed to fentanyl use (National Institute on Drug Abuse, 2018). In the Canadian context, fentanyl was detected in 85% of overdose deaths in 2019 in the province of British Columbia (British Columbia Coroners Service, 2020). While illicitly manufactured fentanyl continues to present public health challenges across North America, diversion and prescription opioid (PO) use continue to be framed as a significant concern among physicians and public health officials (Compton and Wargo, 2018; National Institute on Drug Abuse, 2020; Substance Abuse and Mental Health Services Administration, 2017; Van Zee, 2009).

Prescription drug diversion is a practice whereby an individual redirects their prescribed drugs to another party for illicit use (American Pharmacists Association, 2014). PO diversion, specifically, is a common practice within numerous jurisdictions (Davis and Johnson, 2008; Launonen et al., 2015; McCabe et al., 2007; Winstock et al., 2008). For example, a national study among methadone and buprenorphine patients in Finland reported that 7% of participants sold their POs and 12% gave them away to others (Launonen et al., 2015). Another study among street-entrenched people who use drugs (PWUD) in New York City found that almost 40% of participants reported lifetime experience of diverting POs (Davis and Johnson, 2008). Given the prevalence of PO diversion, various stakeholders in the medical community, including pharmacists and nurses, have identified diversion as a practice that needs to be addressed via ongoing educational efforts and regulatory frameworks (American Pharmacists Association, 2014; Carlson et al., 2020).

Critical substance use scholars have utilized a Bacchian approach to assess drug policy frameworks (Boyd and Kerr, 2016; Duke, 2020; Fomiatti, 2020; Fraser and Moore, 2011; Fraser et al., 2014; Lancaster et al., 2017; Weier and Farrugia, 2020). Through a

series of interrogative questions, Bacchi's approach to assessing public policy attempts to unpack preconceived notions that underly the premise of the "problem," including: understanding where it arose from; what effects these proposed policies may produce; how the "problem" may be considered from a different perspective; and how it might be disrupted, questioned, or replaced (Bacchi, 2009, 2012). One Australian study utilizes some of Bacchi's policy questions to understand the "problem" of amphetamine-type stimulant use (Fraser and Moore, 2011). This study focuses on the underlying assumptions, silences, and their effects within several national policy documents. In short, they identify how despite the fact that there is a lack of clarity and conclusiveness regarding the short- and long-term harms caused by methamphetamine, decisive law and order measures are nevertheless recommended to address this problem (Fraser and Moore, 2011). Another study from Canada, employs a Bacchian approach to examine a variety of Vancouver Police Department policy reports on the city's "mental health crisis" in the Downtown Eastside, a neighbourhood disproportionately affected by poverty, mental health, and public drug use issues (Boyd and Kerr, 2016). Boyd and Kerr argue that these reports use selective sources, including anecdotal narratives, to frame those with mental health issues through a negative lens. The effects of this framing could contribute to the continued stigmatization of residents of this neighbourhood. Further, the assumed policy recommendations include justifications for larger policing budgets for additional neighbourhood surveillance and make recommendations for re-institutionalization, despite the fact that intensified police surveillance can produce harmful effects among neighbourhood residents (Boyd and Kerr, 2016). Bacchi's approach allows for "[opportunities] to question taken-for-granted assumptions" regarding policy "problems" (Bacchi, 2009). Given existing tensions between controls on prescribing, anti-diversion discourses, and calls for safer supply programs, we employ Bacchi's theory to reconsider diversion from another perspective, one that is informed by the experiences of those who divert POs.

Applying a Bacchian approach to diversion, then, we can see how constructs of diversion are framed through medical and criminal justice lenses. Diversion is assumed to be a "problem" and that PWUD do it, presumably for nefarious reasons. This "problem" arose from the context of assumed over-prescribing, leading to drug "abuse" and overdose mortality (Compton et al., 2015). As a result, multiple jurisdictions have established regulations or prescription drug monitoring programs as a way to control and monitor physician prescribing practices, reduce prescribing rates, and increase safety for patients (Haffajee et al., 2015; Haffajee et al., 2018; Rhodes et al., 2019). Existing prescribing standards in Vancouver at the time of our study, for example, are based on an assumption that prescribing has led to the current public health crisis, and as a result, a number of recommendations have been made to physicians, including advising patients that long-term opioid treatments are not appropriate for most conditions (e.g., non-cancer pain, fibromyalgia); ordering random urine drug tests or pill counts to assess compliance; terminating prescriptions for patients who show no evidence of POs in their urine tests; and recommending POs be dispensed in small amounts to prevent diversion (College of Physicians and Surgeons of British Columbia, 2016a, 2016b). However, some studies have suggested that the effects of prohibition on POs have led to the initiation of illicit opioid use (Beletsky and Davis, 2017; Kanouse and Compton, 2015; Voon et al., 2015), and that these monitoring programs

have not led to reductions in overdose (Rhodes et al., 2019). Additionally, methadone programs have strict regulations requiring daily dispensing of prescriptions, regular urine drug screening, and supervised ingestion to prevent diversion and thus prevent patients from taking too large of a dose (Bourgois, 2000; McNeil et al., 2015), though the unintended effects of these policies have included negative impacts on initiation of and retention in treatment (Reisinger et al., 2009) and the re-initiation of heroin use (McNeil et al., 2015). These regulatory prescribing frameworks demonstrate both the complexity and contradictions of such prohibitive policy measures.

Considering the “problem” of diversion from differing perspectives, in ways that may disrupt or replace problematic policies, warrants further investigation (Bacchi, 2012), particularly in our study setting, which has seen a significant number of overdose deaths since the province declared a public health emergency in 2016 (BC Coroners Service, 2021), and while various overdose prevention services have been implemented, more is needed to sufficiently address the epidemic. Rather than endorsing prohibitive policy approaches to the current overdose epidemic (the larger policy problem), including those focused on ending diversion, grassroots organizations comprised of PWUD in the Canadian context have been calling on all levels of governments to implement various harm reduction measures, including safer supply strategies. In brief, a safer supply can be defined as access to pharmaceutical-grade opioids prescribed by physicians as a safer alternative to the toxic illicit drug supply (Ivsins et al., 2020a). The Canadian Association of People who Use Drugs, for example, identifies a regulated drug supply as a necessary harm reduction strategy to mitigate the risks associated with using potentially toxic drugs from an unregulated market (Canadian Association of People who Use Drugs, 2019). Drug policy researchers have also identified the need for PWUD to easily and consistently access a regulated supply of unadulterated opioids to improve health outcomes (Ivsins et al., 2020a; Ivsins et al., 2020b; Tyndall, 2020). As scientists and grassroots organizations alike continue to emphasize the need for alternative policy frameworks that support a legal and regulated supply of drugs for PWUD, many individuals are already providing others with pharmaceutical-grade opioids through the practice of PO diversion – which remains a criminalized practice.

There are a small number of studies that have identified motivations for diverting from the perspective of diverters, including: financial incentives (Johnson & Richert, 2015a, 2015b, 2015b; Spunt et al., 1986); wanting to share with known parties and/or help out friends (Duffy and Baldwin, 2012; Harris and Rhodes, 2013; Havnes et al., 2013; Johnson and Richert, 2015b), including diverting to those who were either cut off from their prescriptions or were ineligible to enrol in opioid agonist treatments (OAT; Johnson and Richert, 2015a); and acquiring a surplus of POs (Johnson and Richert, 2015a). Importantly, not all studies described financial incentives as motivations for diversion; some reported more altruistic motivators. For example, a qualitative study among methadone patients in London, England, described how participants diverted their methadone to help others out of potentially risky situations (e.g., procuring drugs from an unknown source), and diversion was discussed more so as a “gift” for someone else rather than influenced by economic benefits (Harris and Rhodes, 2013). While these studies illuminate some motivations for diverting POs, they focus exclusively on methadone and buprenorphine and were undertaken outside of

the current North American opioid overdose epidemic context. Our study objective was to examine the perspectives of people who divert a wider range of POs (e.g., hydromorphone, morphine) during an epidemic involving a contaminated drug supply in order to understand any challenges, benefits, as well as any contextual factors that shape this practice.

## 1.2. Conceptual framework

A Bacchian analysis does not just critique drug policy frameworks, but also invites the consideration of alternative perspectives of the “problem” at hand and how these may impact the materiality of people’s lives (Bacchi, 2009, 2012). Drug policies to address diversion, as we have illustrated above, are top-down prohibitive measures. Thus, the perspectives of those who divert POs should also be considered as a means to understand and assess the “problem” of diversion. Drug policy researchers have increasingly identified how the day-to-day experiences of PWUD and the delivery of public health interventions have been framed by macro level contextual factors, including economic, social, structural, and environmental factors (McNeil and Small, 2014; Rhodes et al., 2012). Our understanding of the material effects of these contextual factors on PO diversion is framed by situated rationality theory, which posits that an individual’s perceptions and decisions do not occur in a context-free vacuum but rather are framed by social environments (Lawson, 1997; Pound and Campbell, 2015; Rhodes, 1997; Rhodes et al., 2003). Risk-taking among PWUD is often understood as an irrational behaviour; however, within the context of a particular drug-using environment (e.g., public injection spaces) these “risks” are perceived in relation to other dangers that PWUD may consider a greater threat (Bayat et al., 2020; Bourgois, 1998; Connors, 1992; Moore, 2004; Rhodes, 1997). For example, in examining how overdose prevention messaging may be at odds with the daily realities of drug use, Moore demonstrates that while PWUD are acutely aware of overdose risk factors, “risky” practices are still common and accepted, in part due to the presence of structural and economic constraints that may be perceived as more threatening than the risky practice itself (Moore, 2004). This is not because PWUD do not have concerns, but rather that these “risks” must be weighed against a multitude of other “potential risks” such as avoiding arrest and drug withdrawal, acquiring accommodations, and generating income, demonstrating how autonomy is affected by structural constraints (Moore, 2004). Rhodes describes this as a hierarchy of “risk priorities” whereby PWUD will prioritize some risks over others depending on the particular situation (Rhodes, 1997). This theoretical understanding will aid us in illuminating the situated contexts that affect how participants perceived and negotiated particular practices in relation to PO diversion. It also will allow us to further contextual the “problem” of diversion and propose alternative approaches, as appropriate, with the goal of lessening the negative effects of more prohibitive drug policies and increase the autonomy of PWUD.

In this article, we demonstrate that there is a strong public health case for establishing a safer supply of opioids. There does not currently exist a safer supply standard of care nor have existing programs in our study setting been sufficiently scaled up. As a result of existing policy and programmatic structures, PWUD are at risk of overdose from using toxic drugs and some experience barriers in accessing prescriptions, so participants rationalized PO diversion as a measure that responds to the needs of a community. However, diversion

is also framed by several competing priorities. More progressive policies are needed to meet the safer supply demand, and in the meantime, diversion is filling a gap.

## 2. METHODS

### 2.1. Eligibility and recruitment

Study participants were recruited from two cohort studies in Vancouver: the AIDS Care Cohort to Evaluate Exposure to Survival Services (ACCESS) and the Vancouver Injection Drug Users Study (VIDUS). These cohorts are comprised of over 2000 current and former adult PWUD and have been characterized elsewhere (Strathdee et al., 1997; Wood et al., 2003). We aimed to recruit participants who either accessed diverted POs or those who sold or exchanged them. We intended to interview 20 from each category, though many participants fit both categories, so we interviewed 31 participants in total (21 who sold/exchanged POs and 24 participants who accessed diverted POs). This analysis focuses exclusively on the experiences of those who reported diverting POs.

Eligibility criteria included selling or exchanging POs with someone else in the last six months. To recruit potential participants, via the cohort study staff, we were provided a list of participants who, during their most recent study follow-up visit, (i) reported selling POs, methadone, or suboxone in the last six months, and/or (ii) exchanged their POs for money, other drugs, or something else. Cohort participants provided prior consent to be contacted to participate in additional qualitative studies. The lead author and a research staff member contacted potential participants via telephone and e-mail. Additionally, during ongoing cohort interviews, interviewers informed potential participants of their eligibility when they reported diversion, and if they expressed interest, they were scheduled for a qualitative interview. To ensure demographic diversity (e.g., gender, race), we used a recruitment checklist. After the first 22 interviews, women were under-represented (based on an approximate men-to-women ratio of 3:2 in our study setting), so we limited the eligibility for the remaining interviews to women only.

### 2.2. Data collection

Between December 2019 and March 2020, the lead and senior authors conducted qualitative semi-structured interviews at two storefront research offices located in Vancouver's Downtown Eastside. Our study was guided by two overarching questions: What are the motivations for diverting POs? And how do contextual factors impact this practice? An interview guide was developed to facilitate comprehensive discussion of diversion practices and experiences, which was organized around the following topics: drug use patterns and perceptions, location of drug use, overdose risk, health and well-being, diverting POs, accessing diverted POs, relationships with physicians, and criminalization. Participants were given \$30 (CAD) cash honoraria and they provided written informed consent. Interviews were 20–50 min in length. Interviews were audio recorded, professionally transcribed, and checked for accuracy by the lead author.

### 2.3. Data analysis

The lead author reviewed a portion of the transcripts as well as notes taken during the interviews to develop a list of potential themes. The lead author reviewed these with the senior author to generate the thematic coding framework. We used a priori (e.g., health impacts, policing) as well as emerging themes (e.g., fentanyl preference, construction worker clientele) to develop the coding framework (Corbin and Strauss, 2015). NVivo 12 (i.e., qualitative data analysis software) was used to organize and code the interview transcripts. Analysis was further informed by situated rationality theory, which allowed us to examine larger socio-structural conditions that impacted the practice of diversion. This study received ethical approval from our university's Research Ethics Board.

### 2.4. Participants

Since some of our findings describe activities that could result in negative consequences (e.g., arrest, termination of prescriptions, loss of income), in order to protect participant anonymity, we chose not to include identifying information after each quotation. See to Table 1 for demographic details.

## 3. RESULTS

### 3.1. Accessing prescription opioids

The majority of participants (n = 19) diverted their own prescriptions, and the remaining two participants accessed POs to exchange via other means. A range of opioids (with varying strengths and quantities) were prescribed to participants, including oxycodone/acetaminophen, morphine, hydromorphone, fentanyl, methadone, and codeine/acetaminophen. Of those who were diverting their own prescriptions, some were provided with weekly or monthly take-away prescriptions (i.e., “carries”), while others had to strategize ways to manage their prescriptions so that they could divert them to others via “cheeking” (i.e., a practice whereby individuals put the medication in their mouth and store it in their cheek rather than swallowing it). Participants also accessed POs to redistribute through trades and purchasing in bulk.

Multiple participants were enrolled in OAT programs that provided daily drug dispensing at pharmacies or other clinical settings. The dispensing of POs often requires witnessed ingestion – either by a pharmacist, nurse, or other clinical staff. For participants who required more than one daily dose, they described getting carries. For example: “*They’d have to witness the one in the morning, and then I got to take the others ones for the day in a carry*” (P27), and “*I get five pills. The first one’s observed*” (P2). Participants described how they would divert their carries: “*They give me a carry every second day. So basically, I get rid of like 30, 40 bucks [worth] a day, every second day*” (P25).

Getting carries was seen as a privilege among participants, and not a reality for many of them given the strict stipulations under which they are prescribed. According to one participant:

*I could get [carries] but I would have to do something to stop having fentanyl or any opiates in my urine; that’s the only way you get your carries. So, my doctor*

*knows, I tell her I do fentanyl and jib [crystal methamphetamine], less, but I do fentanyl almost every day.*

(P6)

For participants who were unable to get carries, they discussed ways to sneak their prescriptions out of the pharmacy or clinic. “*Cheeking*” was described by multiple participants as a means to diverting their prescriptions. Participants discussed how pharmacists would “*sprinkle*” the medication in a cup to prevent cheeking (i.e., breaking open a capsule and emptying the medication so it is not intact when patients put it in their mouths) though not all pharmacists practiced this as evident in the following quote:

*It depends on the pharmacist. If he’s giving it to you in the straight capsule form without sprinkling it, you can always, like, put a couple in your cheek and maybe save them. And then if you get them out of your mouth real quick, you know, they’re not misshaped or anything like that from being liquefied, you can sell them for about five bucks a piece at 6:00 in the morning.*

(P8)

Through cheeking their prescriptions, there was the risk in damaging pills: “*I’ve made mistakes and I’ve destructed it*” (P30). Furthermore, this practice could also lead to other negative consequences, including prescriptions being terminated, if one gets caught, as illustrated by another participant: “*The pharmacy caught me ‘cause I didn’t swallow it. I just cheeked the medication and so they called the doctor and then the doctor had to cut me off*” (P24).

Participants would also acquire POs that were not prescribed to them through buying in bulk. Often referred to as “*wholesaling*,” participants described getting “*a good deal*” on POs if purchased in larger quantities rather than as individual pills, and how they could sell them individually to make a profit. For example: “*If I feel like I can get a bit of a profit then I’ll invest in it and buy them*” (P31). One participant described how he used part of his own prescription as a means to generate more money through a series of transactions. He said:

*It’d start out in the morning. I’d get my Methadose carry. And [take] half of it, and then I would sell half of it. And then I would sell some cigarettes to get money for an investment of morphine pills, because I get them cheaper than anybody else, because I buy wholesale. And then I would sell them on the street and double my money, and then I would purchase Valium and Tylenol, and I also buy them wholesale so I’d get them cheaper than anybody else, and then I’d double my money on those.*

(P1)

This quote not only illustrates how buying “wholesale” POs can be seen as a good investment, but also the intricate steps and considerable time investment that may be involved in acquiring them.

Lastly, participants also discussed trading other drugs, such as crack cocaine, crystal methamphetamine, and fentanyl, for POs. Trading drugs rather than using money was also described as advantageous, due to drug market dynamics. For example:



*I try to look for certain people who have pills that want to trade. If I'm selling drugs I will go out later at night, because that's when somebody's jonesing [craving] and they want to get more crack or whatever, and they're more likely to, "Like here's 30 T3s [Tylenol 3s] for a 10-rock."*

(P27)

Whether through trades, wholesaling, cheeking, or carries, participants utilized a variety of methods in acquiring POs to distribute to others.

### 3.2. Diversion benefits

Participants discussed a variety of reasons why they diverted POs. In the context of prohibitive policies intended to prevent diversion, participants had to navigate potential risks (e.g., damaging pills, getting cut off) in order to divert to others, which was rationalized as an appropriate means to help someone out, especially in the context of a toxic street supply – whether it was a random person, friend, known customer from the drug market, or family member. Participants identified POs as “safer” and “cleaner” alternatives to street drugs, and perceived POs as having minimal overdose risk. When asked about the benefits of diversion, one participant exclaimed: “well it's fucking necessary, because people need them, or else they're going to take fentanyl and die” (P12). Another participant, in describing his moral perspective on PO diversion versus selling street drugs, described selling fentanyl as “sleazier,” being more “careful about who I would sell [fentanyl] to,” and claiming that it is “a morality thing that I felt for my personal comfort. I didn't want to ruin somebody else's life” (P19). Another participant refused to sell illicitly-manufactured drugs and exclusively sold pills on similar moral grounds. She said:

I don't know if I'm selling you carfentanil and you're going to go home and you're going to be by yourself and you're going to pass away. I couldn't live with that with myself. And that's what I told my friends. That's why when I do sell anything, it's pills.

(P4)

Many participants described feeling a similar sense of social responsibility when diverting POs.

Providing others access to prescription drugs was discussed as a way to help people who are going through withdrawal or have other health needs (e.g., pain management) because their PO doses were inadequate and unable to hold them over until their next dose. For example, “The only time I really sell my pills now is if someone comes up to me extremely dope-sick and needs help to get through ‘til he can get better” (P2), and “they always have a good story why they need it” (P1). While POs such as methadone, are accessible via low-barrier clinics in our study setting (Amram et al., 2019), there are considerable contextual impediments to access, including financial costs, time spent attending clinics for dosing, and concerns among PWUD about witnessed consumption or compliance with program policies (McNeil et al., 2015). A couple of participants described specific people who access diverted methadone. According to one participant:

*The people who buy it, they are people that are working fulltime construction, electrician, whatever it is, so these people will come like either on the weekend or early, early in the morning, to try and buy juice so that they can go to work in a hurry, because you don't want to do construction work sick [i.e., in withdrawal]. I did it once and it's not working, you can barely carry something. Those are the people who are buying it ... I don't mind helping them because I know how it is, buying drugs, and getting out of the life and back to work fulltime, so I've got to respect them.*

(P6)

This quote illustrates how diverted methadone is of particular importance to people who require it to perform adequately at work while also avoiding accessing a methadone prescription, and how diverters see this practice as a needed service helping the community at large by providing them a flexible means (in contrast to strict prescribing policies that make it inaccessible) to manage their dependence and avoid withdrawal while still being able to carry out work duties.

Diversion also occurred against the backdrop of extreme poverty (macro context), and all participants were on social assistance programs, so unsurprisingly, income and money were also considerations that influenced diversion. For example, when one participant was asked why he diverted drugs, he said: *"Money, because I didn't have money. Yeah. Food. Debts that I had. I needed extra money"* (P9). Participants discussed not having jobs or being *"broke"* and the reality that *"everyone has to make a wage"* (P8). Diversion was not just discussed as a means to accessing money in general, but more so in terms of getting money to pay for other necessities: *"It buys me cigarettes and something to eat everyday"* (P2). Though participants did identify the competing needs for both money and their prescriptions. For example:

*It's getting me a few bucks in my pocket. And if I got no money for the rocks, I'll just sell it to get by. But I don't sell them all. I can't, I need them. I actually need those.*

(P18)

Aside from diverting prescriptions for money for day-to-day expenses, some participants described selling or trading their prescriptions for street drugs. Participants described needing to *"get the real dope"* to avoid withdrawal symptoms. For example, *"I'd sell three pills to get a point [0.1 g] of heroin ... in order to make it through the night"* (P4). One third of participants identified a preference for using illicit fentanyl compared to POs. Some participants discussed not liking their prescription medications and felt they do not adequately manage withdrawal, as illustrated in the following quote:

*Pills, I only do them if I have to because they don't do enough for me. Like I can do three Kadian 100s [extended release morphine], I can take three of them and still feel sick [withdrawal symptoms] ... until I actually get some fentanyl in me ...*

(P25)

This quote highlights how a high tolerance level coupled with an inadequate prescription of an extended release formulation that is not providing the desired effect led this participant to seek fentanyl. Other participants also described illicit fentanyl as being a stronger alternative to their medication:

*The fentanyl's a lot more potent. So, people stick to that because once they're wired [dependent] to that level, the pills ain't really working for them anymore. They got to take twice as much of the morphine or whatever.*

(P18)

While these particular participants had preferences for illicit fentanyl over their POs, one participant who had a transdermal fentanyl prescription that he would break apart to inject, described how his social circle preferred the effects of this over illicit fentanyl:

*"It's a cleaner high. You know, it's different. It's actually different".*

(P9)

### 3.3. Challenges and risks of diversion

While participants identified a variety of reasons for diverting or selling POs, diversion also posed challenges in the context of criminalization. Given that drug dealing is a criminal offence, some participants described experiences of being arrested or ongoing fears of arrest as shaping their diversion practices. For example:

*I've been arrested a couple times for prescription drugs, yeah. [I: Has that changed how you sell?] Yeah, I'm paranoid. I only sell to people that look like they're not so clean-cut. It might be a cop.*

(P1)

To avoid potential arrest, multiple participants discussed strategies to evade police encounters, including avoiding street dealing and only conducting exchanges within their homes. While criminalization affected some participants, others did not describe any concerns regarding arrest. Some participants discussed a lack of concern due to the fact that they were selling small quantities of POs or being "small fish" and identified people who sell illegal drugs as the priority for police: "it's the heroin and the coke [dealers] that they're after. They really don't bother people that are buying and selling prescriptions" (P20). This perspective was unsurprising given the more recent judicial response in British Columbia that has emphasized "enhanced deterrence" and lengthier prison sentences specifically for street-level fentanyl dealers (Hrymak, 2018).

Given that participants were prescribed opioids for a particular health reason (e.g., opioid dependence, pain), some participants also described how diversion impacted their health negatively. Participants described how a lack of consistent dosing affected them. For example: "It's not consistent the amount that I'm doing and that makes my health not consistent" (P15). Another participant described how diversion affected both his mental and physical health:

*[I: Do you think that selling your script impacts your health in any way?] Probably, my mental health and I guess my physical health because it's destabilizing because*

*if you're taking your methadone daily, it has a longer half-life and I guess it's free from the government compared to if you spend, I mean you're kind of back into the whole vicious cycle if you're getting rid of prescriptions and then have to sort of worry about maintaining your habit.*

(P19)

This quote illustrates the reality of opioid dependence for people living in poverty as they try to make money while also attempting to stabilize their drug use. Diversion, while providing multiple community benefits, also resulted in individual health challenges.

Participants also discussed challenges that came with running out of their drug supply. Participants described having to rely on other means for income generation, including collecting recycling materials or illegal activities such as theft: *"It sucks. I've got to go boosting [shoplifting] to make money"* (P29). A few participants described having positive relationships with either their doctor or pharmacist, which afforded abilities to negotiate and obtain additional medications in some instances. For example: *"I go see my favourite pharmacist and she'll usually refill it for me"* (P5). Others who did not have these positive relationships discussed resorting to using illegal drugs when their supply of POs was exhausted: *"that's when I purchase heroin and that's what frustrates me"* (P4). Participants also discussed how running out of supply, or having prescriptions terminated or reduced, impacted those who would access their drugs through diversion as illustrated in the following quote: *"When I was getting cut off for hot piss [illicit drug positive urinalysis], I mean it affected anybody I've given it to, right? Well, we're all going on a vacation"* (P2). Many participants described concerns with being cut off their POs by their prescriber and how this would affect them negatively: *"The doctor can just decide to say no, and that's it. You're done. You're cooked"* (P18).

#### 4. DISCUSSION

In summary, participants accessed POs to divert via a range of means (some involving more risk than others) including take-home prescriptions, "cheeking," wholesaling, and trading. In the context of an overdose crisis fueled by a toxic drug supply, participants identified a variety of benefits to diversion such as providing a safer drug supply to others to prevent overdose and other harms, helping people who are dope-sick, and getting money to pay for other expenses (e.g., food, other drugs). Participants also identified challenges and risks such as criminalization and fears of arrest, negative health impacts from not consistently taking their medications, and running out of their supply, which led some participants to rely on other means for income generation (including illegal activities), and for some, it meant a return to using illicit fentanyl. Taken together, these findings illuminate the complexities and situated rationalities involved in PO diversion, the complicated dynamics related to the practice, and how diversion is shaped by structural constraints (e.g., drug policies, poverty, laws).

Our findings importantly illustrate how participants' perceptions and choices as they relate to diversion are situationally-dependent based on their environments and relationships with others. Consistent with past research on OAT diversion (Duffy and Baldwin, 2012; Harris

and Rhodes, 2013; Havnes et al., 2013; Johnson & Richert, 2015a, 2015b), participants from our study were motivated by a desire to help others (i.e., overdose prevention, alleviate withdrawal), and similar to a study from Sweden where participants reported diverted OAT to be safer than street drugs and thus viewed diversion as morally right (Johnson and Richert, 2015b), our participants also perceived providing diverted POs as a safer alternative to street drugs, and these motivations were shaped by their relationships with other PWUD. Participants discussed a sense of social responsibility in providing POs to others. Despite the fears of arrest, as identified by some participants, most continued to divert their prescriptions, which demonstrates that concern of arrest is a lower priority. Since PWUD may not always regard their diversion practices as risky given that their social environments are accepting of these practices as habitual and part of their daily routines (Parkin, 2016), we augment Rhodes' (1997) "hierarchy of risk priorities" theoretical approach to include a hierarchy of priorities in general, which considers not just risks, but also opportunities or benefits. Prioritizing diversion to help someone in need is, in part, consistent with what Bourgois describes as the "moral economy of sharing" whereby social contracts within close networks of PWUD deem it unethical not to share drugs with peers who are experiencing withdrawal symptoms (Bourgois, 1998). However, diversion in our study was not just about alleviating others' withdrawal, but also preventing overdose. A recent study found that more frequent use of diverted buprenorphine, for example, was associated with lower overdose risk and recommends innovative methods to improve treatment availability (Carlson et al., 2020), demonstrating a benefit of diversion in other settings. Additionally, our findings illustrate how diverters are important social actors in a specific sector of the market, extending this sense of obligation beyond close networks of peers by providing informal low-barrier treatment to fill existing treatment gaps. Participants in our study also provided POs to random customers and complete strangers, including providing methadone to blue-collar workers so they are able to manage their dependence without a methadone prescription and adequately perform work tasks. Past research in our study setting revealed a negative association between methadone maintenance therapy and employment initiation, which may be due in part to the daily dispensing and witnessed ingestion requirements that would limit one's ability to engage in fulltime employment (Richardson et al., 2012). Thus, those who divert their methadone to this particular population are providing convenient and low-barrier access outside of the conventional treatment system and thereby allowing buyers to remain engaged in work.

Our findings demonstrate how, in the context of an overdose crisis where safer opioid supply programs are minimal and prohibitive drug policies exist, diversion is rationalized because it is perceived as a practice that provides a low-barrier means to accessing a regulated drug supply. By having a desire to help someone out via diversion, participants were enacting micro-social actions, which have been described elsewhere as a means by which PWUD collectively develop self-protection for themselves and their social networks and demonstrates their ability to exercise autonomy within their environments (Friedman et al., 2007). However, these micro-social actions also exist within the context of capitalism and poverty and thus participants' opportunities to divert POs to help others need to also be understood in relation to these larger contextual factors, which have been shown elsewhere to constrain employment opportunities thereby making drug dealing perceived as the only



study setting and these predominantly exist in clinical settings and are governed by health authorities (Ivins et al., 2020a). Some safer supply prescribing regulations have temporarily loosened since the emergence of the COVID-19 pandemic (Bonn et al., 2020), which occurred after data collection. While such safer supply strategies are needed, of value, and could have wide-reaching implications for overdose prevention if brought to an appropriate scale, if everyone had sufficient access to a safer supply of drugs and adequate doses to manage withdrawal symptoms, an unintended policy consequence may mean that some diverters would be left to find other means to generate income for food and other expenses. Other street-based income generation activities (e.g., theft, drug dealing, sex work) are often prohibited or criminalized and have been associated with exposure to violence in our study setting (Richardson et al., 2015). Thus, it is important to consider the potential unintended effects of more progressive drug policies to ensure that PWUD, including those who divert POs, have access to alternative employment opportunities (Bardwell et al., 2018; Greer et al., 2020). These would also allow PWUD to exercise more autonomy and self-determination outside of impoverished conditions. Additionally, rather than terminating prescriptions due to diversion or for illicit drug positive urinalyses, drug monitoring policies and prescribing practices should be informed by harm reduction approaches that consider contextual constraints. These might include prescribing POs that individuals prefer via safer supply programs. Lastly, de facto decriminalization of the possession of diverted buprenorphine has been implemented in two American cities due to a significantly lower overdose risk profile compared to fentanyl and is considered a law that could save lives (del Pozo, Krasner and George, 2020). This policy should be explored in our study setting, and include the decriminalization of PO diversion, particularly given the negative effects of criminalization as reported by our participants and how PO diversion was perceived as a protective measure.

While there are many perceived benefits to PO diversion, there likely would be some objections from physicians that challenge this alternative perspective. Doctors are responsible for ensuring proper use of medications and if they believe that they are facilitating diversion to unknown parties, there may be concerns regarding breaches of professional standards with respect to responsible prescribing, potential overdose risks for unknown parties, and creating new cases of opioid dependency. However, should there be an adequate safer supply of POs for everyone who needs them, there would not be a need for diversion. Diversion, as we have illustrated above, is filling a gap. This is similar to a recent study on buprenorphine diversion, which found diversion to be common due to treatment capacity and access issues (Carroll et al., 2018). This objection further emphasizes the need to implement and evaluate novel safer supply programs.

There are some limitations to this study. We attempted to recruit a range of participants; however, our findings may not be applicable to all PWUD in our study setting. Additionally, given the high fentanyl-related overdose mortality rates in our study setting is unique to North America, our findings may not generalize well to other international settings, and may raise particular concern in countries where diverted methadone and buprenorphine have accounted for a high proportion of overdose deaths (Andersson et al., 2020; Fugelstad et al., 2019). Further, all study participants were over the age of 34, and thus we did not encompass

the perspectives of youth who divert prescription drugs. Future research should consider other settings and the experiences of youth and how they relate to the practice of diversion.

In conclusion, our study findings illuminate the practice of PO diversion and how various situational contexts affected this practice. While diversion has largely been framed as a negative practice to be stopped, these findings demonstrate the important role that diverters play in providing a safer opioid supply and thereby reducing overdose and other drug-related harms among PWUD. In addition, our study identifies challenges associated with diversion that are shaped by criminalization, poverty, and prohibitive drug policies. Our findings emphasize the need for policy strategies that address the negative consequences that are affected by these larger social and structural contexts. These could include decriminalization measures, opportunities for income generation, and the provision of a safer supply of drugs. These would undoubtedly alleviate the negative effects that shape PO diversion and provide PWUD with greater autonomy and freedom.

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### HIGHLIGHTS

- The “problem” of prescription opioid diversion is examined.
- Diversion was rationalized as a protective measure for others.
- Social and structural contexts framed motivations for diversion.
- Strategies are needed to reduce harms and alleviate contextual constraints.
- Policies promoting decriminalization and a safer drug supply are needed.

**Table 1.**

## Sample characteristics (n = 21)

<b>Age</b>	
Range	35–63
Median	48
<b>Gender</b>	
Cis man	12
Cis woman	9
<b>Race</b>	
White	12
Indigenous	9
<b>Opioids Prescribed<sup>a</sup></b>	
Methadone	6
Hydromorphone	5
Acetaminophen/codeine	3
Morphine	3
Acetaminophen/oxycodone	2
Fentanyl (transdermal)	1
Buprenorphine/naloxone	1
<b>Drug preference<sup>b</sup></b>	
Heroin	8
Fentanyl	7
Prescription opioids	5
Crystal methamphetamine	3
Cocaine	3
Alcohol	2
Speedball	1
Cannabis	1
<b>Frequency of use</b>	
Daily	18
3–4 times per week	2
Once or less per week	1
<b>Income generation (last 30 days)</b>	
Social assistance	21
Drug selling	16
Recycling/vending	13
Part-time employment	10
Theft	8
Panhandling/busking	5
Sex work	1

<sup>a</sup>Some participants had more than one prescription.

<sup>b</sup>Participants were able to select more than once choice.

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