

## COMMENTARY

### Unsafe Supply: Why Making Controlled Prescription Drugs Available for Unsupervised Use Will Not Target the Syndemic of HIV, Hepatitis C, Overdose, and COVID-19— A Commentary on Bonn et al. (2020)

THE NORTH AMERICAN Opioid Epidemic was sparked by increased prescribing of pharmaceutical-grade opioids for minor and chronic pain conditions, in the absence of scientific evidence to support their expanded use. Of note, opioid prescribing in the United States quadrupled between 1999 and 2012. As a result of both legitimate and diverted prescription opioids, more people became addicted to opioids, developed physical dependence on opioids, and died from opioid use. Increased supply fueled demand as consumers turned toward cheaper and more readily available illicit sources such as heroin and illicit fentanyl.

A task force appointed by the Association of Schools and Programs of Public Health issued a report on November 1, 2019, concluding, “The tremendous expansion of the supply of powerful (high-potency as well as long-acting) prescription opioids led to scaled increases in prescription opioid dependence, and the transition of many to illicit opioids, including fentanyl and its analogs, which have subsequently driven exponential increases in overdose” (Association of Schools and Programs of Public Health, 2019, p. 8).

Bonn et al. (2020—this issue) have proposed a mitigating strategy for the “syndemic” of the opioid crisis and COVID-19: “a safe supply of pharmaceutical-grade drugs to PWUD [people who use drugs], such as hydromorphone, methylphenidate, diazepam, and diacetylmorphine” (p. 557). Moreover, they define *safe supply* as explicitly “not a form of treatment aimed at abstinence from substances,” and “not traditional OAT [opioid agonist therapy] (i.e., methadone, buprenorphine, or slow-release oral morphine)” (p. 557). In sum, Bonn et al. advocate for a vastly increased supply of addictive prescription drugs for “unsupervised” use to address the opioid epidemic and the global coronavirus pandemic.

Their safe supply proposal is ill-advised for a number of reasons.

If there’s one thing we should have learned from today’s opioid crisis, it’s that increased access to addictive prescription drugs leads to increased harms through misuse, overuse, addictive use, and diversion. We already tried this experiment by increasing the supply of prescription opioids to target pain. It failed miserably. Further, there is

limited evidence in North American populations for using hydromorphone (Dilaudid), methylphenidate (Ritalin), or diacetylmorphine (heroin) to target addiction, dependence, or problematic use—much less for making it available for unsupervised use among people who use drugs.

Contrary to the evidence, the authors claim that increased access to pharmaceutical-grade drugs “would ensure that they are appropriately dosed and not adulterated” (p. 557). Although it is true that a regulated prescription drug is of known quantity and potency (unlike illicit fentanyl-adulterated heroin), it is not true that simply knowing what you’re using ensures “appropriate use.” The current opioid crisis is rife with reports of misuse and adulteration of prescription opioids, from crushing OxyContin tablets, to smoking prescription fentanyl patches, to injecting Opana (the cause of the rapid spread of HIV in rural Indiana counties in 2015; Strathdee & Beyrer, 2015).

Bonn et al. argue that a safe supply would “facilitate physical isolation by preventing a need to seek funds to purchase unknown substances from unregulated drug markets” (p. 557). I agree that their plan would facilitate isolation, which might be helpful for reducing transmission of COVID-19, but it would potentially increase addictive use and overdose death. Isolation is a risk factor for addiction. People who use drugs alone are at higher risk of overdose. Disseminating lethal drugs with a low therapeutic index, such as opioids, to people using alone, is contrary to other consensus recommendations, such as providing naloxone to drug users so they can administer this life-saving intervention to each other, and supervised injection facilities where people who use drugs can be observed in case of overdose.

The authors contend that a safe supply could decrease HIV and HCV transmission by reducing “the likelihood of sharing drugs or drug-using equipment, including re-using filters and washes, potentially reducing risks of HIV and HCV transmission” (pp. 557–558). Providing drugs won’t reduce the risk of sharing contaminated drug paraphernalia, as demonstrated in Indiana (Strathdee & Beyrer, 2015). Rather, expanding and supporting existing clean needle exchange programs, for which there is already robust evidence (Wodak & Cooney, 2006), will accomplish that goal.

The disruption of the drug supply caused by the COVID-19 pandemic is a golden opportunity to get people struggling with addiction into treatment. According to the United Nations Office on Drugs and Crime (2020), countries all around the world are reporting increased admissions to drug addiction treatment facilities since quarantine. We need to scale up existing services to meet this increased demand, not create easier access to addictive drugs. Further, the drug supply shortage has led to a decrease in consumption of drugs consumed in recreational settings “such as bars and clubs” (United Nations Office on Drugs and Crime, 2020, p. 6), the consequence of which may be to reduce the harms among recreational, non-addicted users.

The expanded use of controlled prescription drugs should not occur in the absence of reliable evidence to support it, lest we find ourselves contending with a worse drug crisis than the one we’re already in. No supply of potent, addictive, lethal drugs is “safe” without guarding against misuse, diversion, addiction, and death.

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## Conflict-of-Interest Statement

I have been retained as a medical expert witness in federal, state, and county opioid litigation (plaintiff side) against opioid manufacturers, distributors, and pharmacies.

## References

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