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Accessible Care: The Human Rights Case for Take-Home Injectable Opioid Agonist Treatment

Soins accessibles : le cas des droits de la personne pour le traitement par agonistes opioïdes injectables à domicile

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Abstract

Substance use disorders comprise a significant portion of disability experiences in Canada and are often experienced alongside other disabilities. During the pandemic, there were declines in healthcare and substance use treatment utilization. In response, new risk mitigation guidelines aimed to increase substance use treatment accessibility, advancing the right to available, accessible, acceptable, and quality healthcare. Injectable opioid agonist treatment (iOAT), a highly regimented treatment with daily supervised doses, became available in take-home doses for a select group of clients. We conducted qualitative interviews with iOAT clients to understand intersections of disability and accessibility with traditional and take-home iOAT. Twenty-three clients accessing either traditional iOAT, take-home iOAT, or delivery through COVID-19 mitigation guidelines were interviewed (2021-2022). Data were analyzed through a critical realist lens, using an abductive coding approach. Clients described traditional iOAT as, at times, inaccessible. Clients encountered barriers in neighbourhoods (e.g., sidewalk obstructions) and within social housing units (e.g., broken elevators), as well as through physical symptoms (e.g., chronic pain) and mental health concerns. Clinic attendance was impeded by drug- and treatment-related stigma and fear of discrimination (e.g., by employers, in social relationships). Conversely, take-home iOAT increased accessibility, offering clients a sense of freedom, dignity, autonomy, and free time, and thus greater emotional and social fulfillment. Take-home iOAT is a more accessible treatment approach that addresses the fluctuating needs of clients, especially those with additional disabilities. Expanding access to take-home iOAT aligns with human rights-based healthcare and uplifts economic, social, and cultural rights of people who need this care.

Résumé

Les troubles liés à la consommation de substances représentent une part importante des expériences liées au handicap au Canada et sont souvent vécus parallèlement à d'autres handicaps. La pandémie a vu une diminution de l'utilisation des soins de santé et des traitements contre la toxicomanie. En réponse à ce constat, les nouvelles lignes directrices sur l'atténuation des risques visaient à accroitre l'accessibilité du traitement de la toxicomanie, faisant progresser le droit à des soins de santé disponibles, accessibles, acceptables et de qualité. Ainsi, le traitement par agonistes opioïdes injectables (TAOi), un traitement hautement règlementé utilisant des doses quotidiennes supervisées, est devenu disponible pour un groupe sélectionné de personnes en doses à emporter à domicile. Nous avons mené des entrevues qualitatives auprès de personnes bénéficiant du TAOi pour comprendre les intersections entre le handicap et l'accessibilité au TAOi traditionnel et au TAOi à domicile. Vingt-trois personnes ayant accès au TAOi traditionnel, au TAOi à domicile ou à la prestation par le biais de lignes directrices d'atténuation ont été interrogées (2021-2022). Les données ont été analysées à l'aide d'un cadre réaliste critique, en utilisant une approche de codage abductif. Les participantes et participants ont décrit le TAOi traditionnel comme étant parfois inaccessible. Les obstacles rencontrés se situaient au niveau des quartiers (p. ex., obstructions sur les trottoirs) et des logements sociaux (p. ex., ascenseurs en panne) ainsi que des symptômes physiques (p. ex., douleur chronique) et des problèmes de santé mentale (p. ex., anxiété). La fréquentation de la clinique était entravée par la stigmatisation liée aux médicaments et aux traitements ainsi que par la peur de la discrimination (p. ex., par les employeurs, dans les relations sociales). À l'inverse, le TAOi à domicile a augmenté l'accessibilité, offrant aux participantes et participants un sentiment de liberté, de dignité, d'autonomie ainsi que davantage de temps libre, et donc un plus grand épanouissement émotionnel et social. Le TAOi à domicile est une approche de traitement plus accessible qui répond aux besoins fluctuants des utilisatrices et utilisateurs, en particulier les personnes qui ont d'autres handicaps. L'élargissement de l'accès au TAOi à domicile repose sur des soins de santé fondés sur les droits de la personne et sur l'amélioration des droits économiques, sociaux et culturels des personnes qui en ont besoin.

Keywords: Injectable opioid agonist treatment; human rights; substance use; Canada.

Mots-clés :
Traitement par agoniste opioïde injectable; droits de la personne; consommation de substances; Canada.

Introduction

Twenty-seven percent of Canadians aged 15 or older live with one or more disabilities.[1a] According to both Statistics Canada data and the Global Burden of Disease Study, a significant proportion of disabilities include "substance use and mental health disorders,"[b] and the Canadian Human Rights Act defines disability as including, "…previous or existing dependance on alcohol or a drug."[1–3] While not everyone with problematic substance use may identify as disabled, characteristics of substance use disorders (SUDs) affect daily life through physical and mental health impacts (e.g., executive function, memory) and by shaping financial, social, and daily activities (e.g., through substance use and procurement).[4,5] SUDs may be characterized as chronic or episodic, with fluctuations in experience of symptoms.[6] SUDs are also associated with disabilities related to physical health such as cardiovascular and respiratory conditions, chronic pain, infectious disease (e.g., HIV, Hepatitis C), as well as co-occurring mental health experiences (e.g., PTSD, depression, anxiety).[7] Together, SUDs and experiences of disability can exacerbate existing barriers to healthcare and treatment, and in effect, worsen health conditions.[8] For instance, people with chronic pain are often unable to access effective pain treatments and instead, may access unregulated and potentially toxic opioids.[9] Further, stigma surrounding visible, invisible, mental, and physical disabilities are amplified by substance use-related stigma, especially in healthcare, resulting in reluctance to seek support from the healthcare system among people with substance use and its related problems.[8,10] These barriers to healthcare for people in need of treatment for SUD violate their "right to enjoyment of the highest attainable

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[a] Based on data derived from the Canadian Survey on Disability, which is limited to respondents over 15 years of age and excludes those living in institutions, collective dwellings (e.g., military bases), and First Nations reserves.

[b] While substance use occurs on a spectrum, ranging from beneficial use (e.g., health benefits, spiritual use, personal enjoyment) to harmful use, we are primarily focused on problematic use that creates negative impacts on a person's wellbeing and life. We employ the term "substance use disorder" when discussing government and medical definitions that shape people's access to disability benefits and to treatment but use varying terms, including "people who use criminalized substances," in reference to a group whose substance use is criminalized (i.e., not prescribed).

standard of health," as expressed in both the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).[11,12]

During the COVID-19 pandemic, these barriers persisted, alongside declines in healthcare and substance use treatment access and utilization.[13,14] Simultaneously, the overdose crisis intensified. As the drug supply became increasingly toxic, people who used criminalized substances faced isolation and harm reduction services became less accessible or shuttered entirely—negatively impacting those with problematic substance use and those with compounded disabilities.[15,16] In response, governments adopted risk mitigation measures to ensure continuity of substance use treatment and reduce COVID-19 risk for people who use criminalized substances, who are particularly vulnerable to adverse health outcomes.[17] While the dispensation of medications for opioid use disorder (MOUD; e.g., methadone, buprenorphine, slow-release oral morphine) is typically highly restricted, pandemic-era policies increased treatment accessibility. For instance, some providers were empowered to prescribe MOUD via telehealth, provide longer prescriptions, or dispense take-home doses.[17–19] In some jurisdictions, providers prescribed pharmaceutical-grade medications (i.e., prescription opioids, stimulants, benzodiazepines) so people using criminalized substances could access a "safer supply" alternative to the unregulated drug supply.[20] For this population, these pandemic-era measures may ease the burden of intensive treatment schedules, promote person-centered care, and increase dignity and autonomy.[21] From a human rights-based health perspective, the expansion of take-home MOUD aligns with the right to healthcare that is available (e.g., expanding clinic capacity), accessible (e.g., take-home doses without discrimination), acceptable (e.g., catering to specific treatment needs), and of sufficient quality (e.g., more efficient and timely),[22] but whether this treatment expansion persists remains to be seen.

During the pandemic, one particularly regimented treatment, injectable opioid agonist treatment (iOAT), was also made more accessible for some.[23] In Vancouver, Canada, iOAT is utilized as a safe and effective treatment for severe problematic opioid use, where specialized clinics provide injectable hydromorphone or diacetylmorphine.[24–26] Clients attend iOAT clinics up to three times daily, where medication is dispensed and taken under observation by healthcare providers. Most iOAT clients have been engaged in care for years, until the pandemic presented challenges. For instance, some immunocompromised clients, concerned about COVID-19 risks, shifted to treatments that were previously ineffective for them (e.g., oral medication doses) in order to attend clinic less often.[27] However, other clients were able to access take-home iOAT, also known as “carries,” through pilot or risk mitigation programs, where they attended clinic once daily and took home their remaining doses. Similar to other recent efforts to increase MOUD accessibility, this pilot program is a first step in improving person-centered care for people who are struggling with substance use and its related problems,[23] and ensuring the right to healthcare that is available, accessible, acceptable and of quality.[11,12,22]

However, it remains unclear how take-home doses shaped experiences of treatment accessibility for clients, including those with additional disabilities. To our knowledge, there are no studies addressing the intersection of iOAT delivery and disability experiences, especially through the lens of human rights. Nevertheless, beneficial outcomes have been reported. For example, a German study demonstrated remarkable health improvements during the iOAT trial,[28] and a Canadian study showed health and quality of life were the top outcome indicators for clients to deem a treatment effective.[29] As iOAT provides access to a Schedule I-controlled substance via injection, it is widely accepted that iOAT should be offered with a system-centered approach, while serving a population that requires low-threshold, accessible services. Challenges surrounding daily treatment access were a primary negative perception emerging from an analysis of 1688 open-ended negative comments in a Canadian study with 126 iOAT clients, and significantly associated with treatment satisfaction, an indirect measure of treatment retention.[30] Notably, 54% of this sample reported chronic health or disability experiences that interfered with activities of daily life.[30] As such, it is imperative to continue exploring the reach of accessibility (or lack of) in MOUD in general and iOAT in particular, for people using criminalized opioids that are in need of this care, including those with additional disabilities, and how the provision of this care can ensure the right to accessible and effective healthcare. Therefore, we conducted a qualitative study with clients accessing take-home, delivery, or traditional iOAT during the pandemic, to understand how disability experiences intersect with current iOAT treatment guidelines and to explore the expansion of more accessible, person-centered care.

Methods

Study Overview

This study is part of a larger multi-methods project, the Program of Outcomes Research on Treatment with Injectables for Addiction (PORTIA) study, which aims to understand and enhance clients' experiences with iOAT. For the current study, 23 clients were interviewed, with one to three interviews collected at different timepoints to capture changes in access. To represent a range of perspectives with take-home iOAT, interviews were collated from clients in different iOAT access programs: 1) clients in the take-home iOAT pilot program ("Pilot Group," n=10)[23]; 2) clients who had iOAT delivered while isolating for COVID-19 ("Delivery Group," n=3); 3) clients accessing take-home iOAT through other providers utilizing risk mitigation guidelines ("Risk Mitigation Group," n=6); and 4) iOAT clients interested in take-home doses but not yet accepted into the program ("Waiting Group," n=4). The study was approved by the University of British Columbia/Providence Health Care and Fraser Health research ethics boards.

Data Collection

Recruitment was conducted within PORTIA and by drawing upon longstanding relationships with iOAT partners. Conducted between July 2021 and November 2022, interviews explored clients' experiences accessing take-home or delivery iOAT or reasons for applying to the take-home iOAT program. For those accessing take-home or delivery iOAT, interviews focused on program benefits and drawbacks, changes in clients' lives, and characteristics of an accessible iOAT program. Among those waiting to access take-home iOAT, clients described experiences and barriers with traditional iOAT, potential benefits of take-home iOAT, and their ideal iOAT program. Interviews were conducted in-person and lasted 30-45 minutes. Sociodemographic information was collected, including whether clients identified as a person with a disability as defined in the Accessible Canada Act.[31] Race, ethnicity, and gender identity were self-identified by clients. Interviews were recorded, transcribed, and de-identified and data was protected in accordance with institutional policies. Participants received $30CAD/hour or fraction. All interviewees provided written consent to participate.

Analytical Approach

We approached the data from a critical realist perspective to explore underlying social structures and mechanisms that shape accessibility experiences for disabled people.[32,33] While some of the study authors have lived experience with disability and iOAT programs, we acknowledge the diversity and uniqueness of their experiences as individuals.[32] Following the Social Model, we recognize embodied disability experiences can be affected by characteristics of problematic substance use, but disability is also an identity and social construct shaped by contexts and power structures.[34] In particular, the cultural milieu and stigma surrounding drug use can perpetuate the oppression and social exclusion of people who use criminalized substances, often creating more barriers than substance use itself. Further, disabled people report stigmatization, trauma, and harm related to ableism embedded within a healthcare system that frequently devalues disabled lives.[35] By applying a critical realist perspective, we analyze how these broader influences shape iOAT clients' experiences with disability, stigma, and accessibility.

In analysis, we used a "flexible coding approach"[36] that relies on abductive reasoning, consistent with critical realism,[32,37] in which we move back-and-forth between the data and expertise held by the research team, related to iOAT and disability. We also note the current analysis is rooted in understandings derived from previous analyses of the pilot program,[23] where we first identified potential themes related to accessibility, prompting further pursuit of this line of inquiry. The flexible coding approach involved first indexing transcripts using NVivo software, in which index codes represent large sections of text that corresponded with the interview guide. Next, the team deliberated on relevant index codes and developed more focused, analytic codes that were applied to the text, related to disability and accessibility surrounding take-home iOAT. Themes were organized under accessibility barriers related to traditional iOAT and benefits of take-home iOAT to inform future implementation. While some clients were interviewed at multiple timepoints, we decided to analyze data cross-sectionally instead of longitudinally, due to group differences and inconsistencies in the number of follow-ups.

Results

In total, 23 iOAT clients participated, with 47 interviews. Client averaged 54.7 years of age and 7.5 years of treatment. There were 16 (69.6%) clients who self-identified as men and 7 (30.4%) who self-identified as women. Clients were asked to “select all” the racial and ethnic groups they belonged to, with 21 (91.3%) clients who identified as white and 3 (13.0%) as Indigenous. Most clients (n=20, 87.0%) identified as having a disability, as described in the methods section. Additional sociodemographic information is provided in Table 1.

Table 1. Self-Reported Participant Sociodemographics (N=23)

Characteristic	n (%)
Age (M ± SD)	54.7 (± 7.3)
Years on iOAT[c] **(**M ± SD)	7.5 (± 4.3)
Type of iOAT[1]	
Diacetylmorphine (DAM)	14 (60.9)
Hydromorphone (HDM)	4 (17.4)
Race and Ethnicity[2]	
White	21 (91.3)
Indigenous	3 (13.0)
Gender (self-identified)	
Female	7 (30.4)
Male	16 (69.6)
Education	
Up to Grade 11	6 (26.1)
High school completion	5 (21.7)
Some College/University	8 (34.8)
College/University Diploma	4 (17.4)
Disabled (self-identified)	20 (87.0)
Housed[4]	23 (100)
Partnered	4 (17.4)
Has children	9 (39.1)

Note: M, mean; SD, standard deviation

[1] Data available only for 18 participants.

[2] Participants encouraged to 'select all' racial and ethnic groups they belong to, with one individual identifying as both white and Indigenous.

[3] In Canada, this refers to people who identify as "First Nations, Métis or Inuk (Inuit); regardless of Status".

[4] Defined as having access to a stable place to sleep and store possessions.

Barriers to Accessing Traditional iOAT

In discussing traditional iOAT, client narratives illuminated the interplay between socioeconomic marginalization, housing, and the accessibility of treatment. Clients described how the elevators would break in social housing units and remain unusable for long periods, posing physical barriers to treatment for people using mobility devices. One client using a wheelchair describes feelings of confinement, vulnerability, and uncertainty in social housing:

> There's no ramps or anything, so the only way up and down off the fourth floor is in an elevator. And they only have one elevator and it's been breaking down on a consistent level for probably seven, eight months now…I would say it was almost every day for six months…The company would come out, reset it, by the end of the day it would break down again. If I'd go out, I would never know if I could get back to my room. If I'd be in my room, I could never know if I can go out. So I wasn't able to get wound care. I wasn't able to go to [iOAT clinic]. I wasn't able to go grocery shopping. –Risk Mitigation Group

While iOAT clinic staff could deliver this client's medication, this dedicated care may uniquely reflect the capacities of this clinic. For clients in social housing with mobility disabilities, broken elevators eliminated the means to leave their homes, much less access the clinic, rendering treatment entirely inaccessible and impacting their freedom of movement and right to participate in social and cultural life. For clients living further away, there was an added burden of commuting to one of the few clinics where iOAT is available. Clients could not drive while taking medication and not all clients had transit passes. Some clients had the financial resources to occasionally take taxicabs, but this was a significant expenditure. One client explained their situation during a programmatic pause in take-home iOAT:

> I've been paying for a lot of cabs because I just feel like I don't want to fucking spend two hours doing this. So it's been costing me a lot more to do this too…I end up spending $25 to get there and back. After doing that for a few days I'm like, "wouldn't it be cheaper for me to just buy dope and stay at home?" – Pilot Group

For iOAT clients, these limitations occur within a broader milieu of economic vulnerability, social marginalization, and stigmatization, which in turn, shapes accessibility and acceptability of iOAT.

Further, clients described physical obstacles to treatment access that reflected challenges related to community-level marginalization. While the built environment of the clinic did not produce barriers, clients expressed that it was located in a neighbourhood that was physically challenging to navigate daily:

> After so many years of doing it, it's tough at times, because it's every day, three times a day. And if I'm working on top of that, I get exhausted fast. And I'm disabled as well, so it's even harder…Walking, [is] probably one [of the challenges], and just going from A to B, you have to go through the gauntlet to get to the clinic. – Waiting Group

Similarly, a few clients described how neighbourhood sidewalks were often filled with crowds of people and belongings, creating navigation challenges for people using assistive mobility devices or with mobility-related pain. Clients also spoke about their episodic disability experiences with recurring pain symptoms, acute injuries, and infection:

> "I just had bad medical issue[s]—broken hip, my back. Just a bad year for medical and infection in my heart. That's how easy it is to get an infection. Just being around people, they can pass it on to you. It's getting dangerous down there." – Delivery Group

These persistent or episodic disability-related experiences could be compounded, affecting physical mobility, energy levels, and mental health, and consequently, the ability to get to the clinic. Clients with respiratory issues were especially concerned about COVID-19 and felt that attending clinic posed a risk, including one client with chronic obstructive pulmonary disease: "There's still COVID around…and I'm not always sure where my peers have been. [Attending iOAT clinic is] probably the weakest link between me and the virus" (Pilot Group). This also serves as an important reminder that significant risks for immune compromised clients remain after the pandemic has been declared over.

Others recounted how mental health issues, which frequently co-occur with problematic substance use, could be a barrier to attending clinic:

> I know from my own personal experience with my bipolar disorder, I'm falling into some serious depressions. And if it wasn't for the fact that I pushed it to the point where I was dope-sick and had to go to the clinic—I've had days in the past where I'll contemplate missing my dose because it's just like, "No, I just cannot go down. I can't deal with it" kind of day. – Pilot Group

While most clients consistently attended clinic, it is possible that such cyclical mental health episodes impacted their ability to attend. For others, attending the clinic was a mental health trigger. For instance, one iOAT client described the challenges of traveling to clinic and being around crowds in the neighbourhood: "I do have a disability, and I have extreme like—I'm really introverted. I have high anxiety around people…So it's very hard for me to be around people. Like I get very uncomfortable. The traveling is hard" (Waiting Group). Others described some of the anxiety they felt in traveling to the clinic at night: "I like seeing the staff there. So, I've just got issues walking in at night. I just don't like going there after dark, as soon as it's dark, yeah. My neighbour was robbed last week by somebody," (Delivery Group). For some, this anxiety about attending the clinic at night prompted them to stop their evening doses. By compelling in-person clinic visits and denying alternative options (e.g., telehealth, home visits) for mental health-related barriers, access becomes more restricted with consequences for treatment regimens and overall wellbeing.

Stigma and Discrimination

Mental health concerns around clinic attendance are exacerbated by the stigmatizing aspects of iOAT—a highly controlled and regimented treatment.

> I mean, strapped down to the clinic going three times a day for 15 years you have– no time to go anywhere. You have to go there specifically so you're not getting sick, right. If you want to go on vacation, you don't have your drugs, you're strapped down, you can't go out of town. You can't do nothing at work. – Pilot Group

For some, this daily routine felt like discrimination or punishment: "It seems like they're just like, 'well you're a drug addict, let's punish you, you've got to come', you know? The way we've been treating opiate dependency for the last 30 years. Like why can't we think a little bit more about the client and what they need and base their care plan on what their life looks like?" (Pilot Group). For others, the daily routine of a supervised dose could feel infantilizing: "We're grown men and women, you know, we're not children. Give us our carries. We've been responsible with it" (Pilot Group). Many iOAT clients felt they were responsible, as demonstrated by their long-term treatment adherence, and they should be treated accordingly, with take-home doses.

Beyond feelings of stigma related to treatment administration, clients remarked on the visibility of clinic attendance. For example, attending treatment up to three times per day meant marked, regular absence from work or social settings. One client described not being able to travel for the holidays due to their regimen and the fear of disclosure around their substance use and treatment:

> [At] Christmas time when [partner] goes to his family, I don't go. I stay home. We used to use the cats as an excuse. But now, we'll have to think of another reason why I can't go. Like his family, nobody knows about this stuff except for him… it's a big deal that nobody knows. – Waiting Group

In addition to these conspicuous absences, clients also noted on the stigmatizing aspects of being seen near the clinic. While clinic procedures seemed to be changing to allow more clients inside at a given time, clients remarked on their visibility while waiting outside the clinic: "To be honest, when people are all standing around smoking crack–it does kind of make me embarrassed to be standing out there" (Pilot Group). As these narratives highlight, feelings of shame and stigma associated with substance use were compounded by shame and stigma associated with features of traditional iOAT.

Experiences With Take-Home iOAT

Among take-home iOAT clients, a central interview component focused on how this treatment modality had positively affected their lives. After years of attending clinic multiple times per day, take-home doses felt like "freedom," as expressed by several clients, and clients described newfound independence or autonomy:

> I can make plans because I knew I didn't have to be at the clinic those extra two times during the day. Because whenever I would plan an activity, I'd have to say to somebody, "oh sorry I can't do it at this time of the day because I have to be at the clinic." And if I miss my shot then it's not good right?…When they gave us the carries, I think life really improved. I've got no ball and chain. It was just like having a prescription for antibiotics. – Pilot Group

Take-home iOAT clients also spoke about participating in community life and expanding their social networks beyond the radius of the neighbourhood:

> [Take-home doses give] me freedom to add to my social circle, to go out and do something differently. Meet people in different settings…As soon as I leave in the morning with my carry dose, I have the rest of the day at my disposal, which [was] not the case before. – Pilot Group

Other clients used this time to visit with or care for family. One iOAT client was caring for their disabled adult child with a terminal illness. Prior to receiving take-home doses, they commuted into Vancouver every morning and stayed to receive subsequent doses, leaving their daughter alone for significant periods of time:

> [Take-home doses allow] me to have a more normal feeling life. I had to spend three hours downtown just waiting for my second shot. It was horrible. Now I get

> to be home by noon or 11:00 and be with my daughter and not be thinking, "What if something goes wrong and I'm sitting down here wasting time?" – Pilot Group

Without the added wait, this client could enjoy more time with their daughter, as well as reduced stress from worrying. Take-home doses increased the accessibility of their treatment by supporting their needs as a caregiver and a person with a medical need and serves as a reminder that while disabled people are often perceived as the objects of care, they frequently provide care for others in their community. Altogether, take-home iOAT client narratives made clear that increased autonomy and ability to meet social needs had beneficial effects on mental health and relationships.

Mental health benefits were also derived from clients' ability to return to school or work and associated sense of accomplishment. One client described their ambitions after receiving take-home doses: "Just going back to school, I'll feel good. It's a good thing for me. I haven't been able to do all that because of going to the clinic all the time. You can't get work because your boss is going, 'where the hell are you going?'" (Pilot Group). Without the interruption of clinic attendance or concerns about potential employers' perceptions, take-home iOAT granted clients freedom to work. Other clients described feeling dependable and trustworthy: "I could tell somebody that I'm going to be on the job at a certain time and be able to work eight hours in a row. That's because of carries. I wouldn't be able to do that before" (Pilot Group). Clients waiting to receive take-home doses anticipated similar impacts: "[I] could volunteer, I could get a dog. I could finish my house…It's like a full-time job, just [to] come in here" (Waiting Group). For people using criminalized substances who are often denied work opportunities, access to take-home iOAT meant access to employment, self-efficacy, an ability to embrace relationships, and feelings of contribution to society.

Discussion

In this study, we explored iOAT clients' experiences with treatment delivery and reflections on take-home doses as more accessible, person-centered care. While iOAT has been shown to be safe and effective, our findings highlight how traditional iOAT can be inaccessible for some, including those with compounding disabilities, especially as disability experiences are interwoven with socioeconomic marginalization and stigmatization. Conversely, take-home iOAT has begun to make treatment more accessible and person-centered, by allowing iOAT clients and iOAT clients with other disabilities to individualize their treatment to meet their needs. Through the lens of human rights, we explore how the structure of traditional iOAT can impede access, while novel approaches to care, like take-home iOAT, can support the autonomy, dignity, and freedom of clients to manage their own care.

The Right to Healthcare

A human rights-based approach to healthcare reflects care that is available, accessible, acceptable, and of good quality.[22] While iOAT is an effective, lifesaving treatment for many, it is *available* to only a select few, with access to take-home doses even more restricted, despite many clients who desire access (e.g., clients in the "Waiting Group"). As client narratives show, there were concerns with *accessibility* in the neighbourhood and in local social housing units (e.g., broken elevators), that created obstacles to clinic commutes. Other clients noted clinic attendance was challenging amidst episodic and unpredictable disability experiences (e.g., chronic pain, mental health symptoms), as well as feelings of shame, stigma, and fear. Features of traditional iOAT may not always align with principles of *acceptability,* in which "health facilities, goods, services and programmes are people-centered and cater to the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent."[22] The strict schedule and visibility (e.g., marked absences, clinic line-ups) of traditional iOAT meant sacrificing autonomy and risking confidentiality, whereas take-home doses could be structured to meet the needs of clients, and made more discreet with fewer visits. Finally, take-home iOAT is a marked improvement on the *quality* of treatment, as it can be more effective (e.g., fewer missed doses), people-centered (e.g., tailored to individual needs), timely (e.g., reduced wait times), and efficient (e.g., avoiding unnecessary clinic visits to maximize healthcare and harm reduction resources).

Economic, Social, and Cultural Rights

Clients accessing traditional iOAT attend clinic for treatment three times a day, every day. While iOAT has saved lives amidst an ongoing overdose crisis, after years of treatment (averaging 7.5 years), clients described feeling trapped in the management of their chronic condition. From a human rights perspective, the rigid format of traditional iOAT impedes an individuals' ability to enjoy their social, economic, and cultural rights. For instance, the UN Human Rights Convention on the Rights of Persons with Disabilities (CRPD), the UN International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Accessible Canada Act all recognize people's right to work,[11,12,31] but as many clients expressed, the rigidity of iOAT can preclude employment. However, the flexibility of take-home iOAT expanded clients' employment options. They spoke about the positive effects on their work or the desire to work, where they could generate income but also gain a sense of purpose, value, and daily structure. A human rights-based approach also recognizes that people have the right to take part in “cultural life” (ICESCR) or the “right to belong” (CRPD) through effective participation and inclusion in society.[11,12] Traditional iOAT limits clients’ free time to the duration between doses, but those accessing take-home iOAT felt it allowed them time and distance from the clinic so they could socialize, volunteer, work, provide care, and attend school. Finally, ICESCR recognizes the right of “enjoyment of the highest attainable standard of physical and mental health.”[12] While traditional iOAT protects clients against overdose and other drug-related physical harms, it can also have detrimental effects on clients’ mental health. This highly regimented treatment can restrict clients’ autonomy and at times, feel infantilizing, as iOAT requires strict attendance and monitoring—feelings and experiences that reflect those of many disabled people accessing the healthcare system.[38] Conversely, among those receiving take-home iOAT, clients described a sense of freedom, autonomy, and experienced greater fulfillment from social connections, working, and caregiving, consistent with UN CRPD emphasis on respect for inherent dignity, autonomy, and liberty for disabled people.[11] In sum, expanding access to take-home iOAT aligns with principles of human rights-based healthcare, economic, social, and cultural rights, and with a society that supports the rights and needs of people who use drugs.

Limitations

This study has several limitations. First, clients may have primarily reported positive experiences with take-home iOAT, for fear of the clinic shutting down or being cut off from their treatment. The study interviewer made efforts to communicate that interviews would not be shared with study staff or affect their treatment. Second, our study sample was heterogenous in a few ways. While the majority of the sample identified as having a disability beyond substance use, they were not asked to expand on this concept, thus it was unclear how clients understood disability. Further research should explore conceptions of disability in this population. Clients also varied in their iOAT experiences, including those waiting to receive take-home iOAT. However, this choice was intentional to incorporate diverse perspectives and highlight that take-home iOAT remains limited to a select few, with significant progress needed before widespread implementation. Finally, clients in different groups were interviewed at varying timepoints and some were lost to follow-up, and thus we could not conduct longitudinal analyses. With expansion, future studies of take-home iOAT could assess experiences with treatment over time.

Conclusion

To uphold the rights and autonomy of people who rely on the criminalized opioid drug supply, it is critical to expand access to take-home iOAT. While take-home iOAT guidelines were developed in the pandemic, efforts to claw back accessibility measures must be resisted in healthcare, as well as in employment, services, and social arenas. Our findings surrounding take-home iOAT are consistent with researchers, activists, and policy recommendations for continuation of take-home programs for other MOUDs, such as methadone, developed during the pandemic.[19,39] Such take-home MOUD programs address the fluctuating needs of iOAT clients, including those with compounding disabilities, by providing the option, if medically to administer medication at home and spend their time in fulfilling ways. Still, significant work remains. Future research should continue to explore treatment approaches and accessibility through a human rights lens, and with leadership from communities and individuals with lived experience, in order to create truly accessible treatments and center clients as experts in their accessibility needs.

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