Performance Audit

Implementation and Oversight of Ontario's Opioid Strategy

// Independent Auditor's Report

Office of the Auditor General of Ontario

ANNUAL REPORT 2024

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1.0 Audit at a Glance

// Why We Did This Audit

Ontario's opioid crisis continues to escalate, even after the Ministry of Health (Ministry) implemented the Opioid Strategy in 2016, with both opioid-related deaths and emergency department visits increasing significantly over the last decade (2014–23), by almost 300%. In 2023, an average of seven Ontarians per day died from opioid-related causes.

Initially, Ontario's opioid crisis was driven by the unnecessary dispensing or over-prescribing of opioids; however, it has since intensified with an increase in the illegal supply of more potent opioids such as fentanyl. As such, having access to sufficient and appropriate treatment and harm-reduction services is essential to combat the opioid crisis. At the same time, monitoring opioid prescriptions continues to be critical as some people are first exposed to opioids through prescriptions before progressing to the deadlier illegal supply.

This audit covered four key types of opioid-related services:

1. **Consumption and Treatment Services (CTS) site:** A space for people to consume their own substances, including opioids, in a supervised setting that provides clean, sterilized tools and overdose-prevention support if needed.

2. **Opioid agonist therapy (OAT):** A medication-assisted treatment to help people reduce their cravings for opioids and prevent withdrawal symptoms.

3. **Rapid access addiction medicine (RAAM) clinic:** A walk-in clinic designed to be a low-barrier option for people to obtain quick access to addictions services, without the need for a referral or appointment.

4. **Naloxone:** A medication to temporarily reverse an opioid overdose.

// Our Conclusion

We concluded that the Ministry does not have effective processes in place to meet the challenging and changing nature of the opioid crisis in Ontario. Specifically, the Ministry did not:

- effectively implement Ontario's 2016 Opioid Strategy and initiatives that are responsive to the needs of Ontarians;
- effectively oversee and co-ordinate the delivery of evidence-based services for people who require opioid-related services in an equitable, integrated and timely manner, and in accordance with applicable legislation, policies and agreements;
- adequately and proactively monitor and enable appropriate opioid-prescribing and dispensing practices in accordance with applicable legislation, policies and standards;
- adequately measure and publicly report on the performance of publicly funded services for people who require opioid-related services; and
- provide a thorough, evidence-based business case analysis for the 2024 new model, Homelessness and Addiction Recovery Treatment (HART) Hubs, to ensure that they are responsive to the needs of Ontarians.

The Ministry has accepted all seven recommendations.

// What We Found

The 2016 Opioid Strategy Is Outdated and Does Not Address Increased Risks and Needs, Even with the New Hubs Model

- The Ministry implemented the Opioid Strategy in October 2016, with an investment of more than $222 million over three years to combat the opioid crisis, as presented at the time. The Ministry has not holistically updated the comprehensive Opioid Strategy to ensure ongoing commitment and sustained attention to address the continuous increase in opioid-related deaths.

- In addition, the outdated Strategy does not address ongoing issues, such as the disproportionate impact of the crisis on specific regions and population groups and emerging risks, including an increase in poly-substance use (that is, using multiple drugs at once, such as opioids with stimulants and/or benzodiazepines) and the availability of more potent opioids from illegal markets.

Opioid Strategy Lacks Clear Accountability Structure and Leadership

- Numerous Ministry branches and other parties have been responsible for managing different aspects of the opioid crisis. This includes providing advice to the government, setting policies and standards, overseeing service providers, monitoring opioid prescribing and dispensing, and collecting opioid-related data. There is no specific party that has been designated to lead, oversee and co-ordinate the work. No specific goals or targets have been set for different parties to work toward, and there is no ongoing monitoring or evaluation of performance and outcomes.

Poor Data Tracking Made It Challenging to Accurately Plan, Monitor and Improve Addictions Services

- Outcome-based performance measures for the Opioid Strategy were not consistently tracked and reported. The Ministry identified 24 performance indicators to monitor and evaluate the Strategy's outcomes and progress. Twenty of these indicators were identified five years ago during our 2019 audit on Addictions Treatment Programs. Of the 24 indicators, only 10 were consistently tracked. The remaining 14 indicators were never tracked or reported on consistently to show whether specific treatments or services were having an impact. Examples of these indicators include the number and rate of hospitalizations for opioid overdoses, the percentage of people who are prescribed opioids and subsequently develop an opioid addiction, the number and proportion of patients who are referred from RAAM clinics to primary care, and the number of CTS site client visits.

// What We Found

- The Ministry created the Mental Health and Addictions Centre of Excellence (MHA CoE) within Ontario Health in 2020 with a legislated mandate to put into operation the Roadmap to Wellness strategy, which is the Province's broader strategy to transform the mental health and addictions system.
- Included as part of the strategy was a multi-year data and digital initiative to standardize the collection of provincial mental health and addictions data and improve the accuracy, completeness and reliability of the data collected. While the strategy has been in place for four years, MHA CoE does not currently have reliable, validated and standardized data. The lack of data on the need for mental health and addictions services, as well as on the availability and quality of existing services, makes it difficult to identify service gaps and to accurately plan, provide, monitor and improve services for people with opioid addiction and co-occurring mental health issues.

» **Recommendation 1**

The Decision to Change Supervised Consumption Services Was Made Without Proper Planning, Impact Analysis or Public Consultations

- During our audit, on August 20, 2024, the Ministry publicly announced its intention to introduce new legislation in fall 2024 that, if passed, would prohibit the establishment and operation of supervised consumption services within 200 metres of schools or child-care centres (the "buffer zone") and lead to the closure of 10 sites that currently offer such services by March 31, 2025.
- The Ministry is planning to invest more in treatment and supportive housing by implementing a new model called Homelessness and Addiction Recovery Treatment (HART) Hubs. Unlike CTS sites, these Hubs will not provide some key harm-reduction services, such as supervised consumption or needle exchange, despite the fact that these services have been proven to prevent overdose deaths. For instance, in 2022/23 alone, the 10 sites that will be closed upon passing of the new legislation had successfully prevented fatalities from the over 1,500 overdoses that happened on-site.
- The Ministry's investment of $378 million for the HART Hubs was decided upon without a needs-based assessment.
- The Ministry did not develop a comprehensive plan to assess and quantify the impacts on public health and Ontario's health system (for example, a potential increase in overdoses and emergency department visits) prior to finalizing the decision to introduce the new legislation.
- The Ministry also did not conduct formal consultations with all affected external stakeholders, such as users of the sites being closed and high-risk populations, including Northern communities and Indigenous and younger populations.

// What We Found

Access to Supervised Consumption Services in Regions with High or Growing Needs Was Further Reduced Without Evidence-Based Analysis

- Prior to the Ministry's decision to introduce legislation to close down 10 supervised consumption services sites, several communities had submitted CTS applications, but the approval process was slow. With the intended change announced in August 2024, the Ministry confirmed that outstanding CTS applications will not be approved, including the ones from Timmins and Sudbury, even though the opioid-related death rates in those regions had increased significantly between 2018 and 2023 (by 227% in Timmins and 184% in Sudbury) and were among the highest of all regions in Ontario, ranking second and third, respectively, in 2023.
- With the ban on supervised consumption services within the buffer zone following the passage of the new legislation, the only remaining site in the North in Thunder Bay, which had the highest opioid-related death rate in 2023, will also cease operations by March 31, 2025. This will leave Northern Ontarians with no access to supervised consumption services going forward.

» **Recommendation 2**

Access to Comprehensive Care Through OAT Providers Was Limited

- Providing opioid users with access to comprehensive care (or wraparound services) is important, as many users who require OAT would also benefit from other services such as primary care, counselling and social support that would help to address their co-occurring mental health and other health-care needs. Only some OAT providers offer these services. For example, the two largest chains of OAT clinics (with 73 and 123 locations, respectively) primarily provide medication to their patients and none of the other services.
- While the Ministry was made aware of this concern eight years ago, it has not reviewed or evaluated whether changes need to be made to the current service delivery model to ensure people have access to all necessary services.

Initiation of OAT in Primary Care Settings and Emergency Departments Was Infrequent Despite Benefits

- Our review of data on addictions and mental health treatment service providers and programs noted that the availability of OAT in the primary care sector was limited. Across Ontario, only three (or 2%) of 187 family health teams, which are primary care organizations that provide health services to their community, were classified as providing addictions services such as OAT.

// What We Found

- Despite the continued increase of opioid-related emergency department visits, a number of hospitals still do not initiate OAT in their emergency departments, mainly due to the lack of addiction medicine specialists. Only one in 18 patients in Ontario who were consuming opioids received OAT in the emergency department or following hospital admission within seven days, which is the critical period with the highest mortality risk.
- The quality standard for opioid use disorder developed by Health Quality Ontario in 2018 states that patients should have access to OAT within a maximum of three days.

» Recommendation 3

Performance of RAAM Clinics Has Not Been Monitored Due to Lack of Accurate and Complete Data

- The process of collecting information from RAAM clinics is fragmented and inconsistent across the province. The level of detail collected varies from one RAAM clinic to another due to the absence of a provincial requirement and standards on data collection and reporting, as well as a lack of accurate and complete data on patient outcomes. Quality metrics were also not used to measure and compare performance across the clinics.

RAAM Clinics Were Not Available or Not Accessible in All Communities with the Highest Service Needs

- A majority of RAAM clinics do not operate daily and have limited hours of operation due to funding and staffing constraints. For example, over 15% offered access by appointment only, even though RAAM clinics were intended to be low-barrier with no referral or appointment required.
- Of the 60 RAAM clinics that offered drop-in access, over 60% of them operated three days or less per week, and about 50% of them operated 10 hours or less per week. Due to the lack of accurate and complete data, no province-wide assessment has been done to determine whether RAAM clinics are sufficiently meeting needs during those hours.
- Our review of the locations of RAAM clinics found that some communities did not have a RAAM clinic despite their need. For example, in Belleville, a state of emergency due to an opioid crisis was declared in February 2024, but the nearest RAAM clinic was one hour away in Kingston. Funding was approved to set up a RAAM clinic in Belleville, which opened in August 2024.

» Recommendation 4

// What We Found

Naloxone Claims from Pharmacies Were Not Monitored Adequately to Identify Inconsistent and Inappropriate Billing Practices

- Oversight of pharmacies is important, as the low-barrier design of the Ontario Naloxone Program for Pharmacies (ONPP) (no prescription required, limited collection of recipient information) could increase the risk of inappropriate claims.
- Of the 10 pharmacies we visited during the audit, we noted that two of them had occasionally submitted claims for payment when naloxone kits were ordered from suppliers, not when the kits were distributed as per program requirements. The Ministry could be reimbursing pharmacies for naloxone kits that have not been distributed. Our visits also noted that the level of documentation maintained to support naloxone claims varies between pharmacies.

Questionable or Unusual Distribution Practices by Pharmacies Were Not Addressed in a Timely Manner to Prevent Potential Abuse of ONPP

- Our review of the claims data from 2019/20 to 2023/24 noted that the top distributing pharmacy had accumulated almost $40 million in naloxone claims over the five-year period. The pharmacy was the subject of public complaints and the pharmacy's professional was investigated by the regulatory college for misconduct.
- We also noted that some of the pharmacies we visited had distributed naloxone in ways that may not conform with the program's intent. For example, some pharmacies used aggressive marketing (such as direct solicitation with local businesses) or through online channels without any follow-up inquiries.
- Some of these practices stopped after the Ministry issued a notification in February 2024 that clarified that the provision of naloxone kits must occur at the physical premises of the pharmacy. We found the notification to be overdue, as the Ministry was made aware of the unusual or questionable practices as early as 2017.

» **Recommendation 5**

// What We Found

Opioid-Prescribing and Dispensing Activities Were Not Monitored Adequately to Identify Concerning Trends

- Our analysis of dispensing data from 2019/20 to 2023/24 identified some concerning trends. For example, the number of dispenses of high-dose opioids (that is, a daily dose equal to or exceeding 200 morphine milligram equivalents) increased by 147% among all users and 31% among new users over the period. Also, for almost 20% of benzodiazepine dispenses (substances often used as sedatives and tranquilizers), an opioid was also dispensed to the same individual at least once within seven days. Taking benzodiazepines and opioids together can increase the risk of overdose.

Information on Opioid-Prescribing and Dispensing Activities Was Not Regularly Shared with Regulatory Colleges to Support Their Enforcement Work

- Despite the risk associated with inappropriate opioid use, the Ministry and regulatory colleges did not work together to actively detect abnormal trends to deter health-care professionals from inappropriately prescribing and/or dispensing opioids. Also, since 2018, the Ministry has not had a regular forum that engages regulatory colleges and other stakeholders to share ideas and explore ways to optimize the use of opioid-dispensing data.

Not All Prescribers and Dispensers Had Real-Time Access to Drug-Dispensing Data

- An individual's opioid-dispensing history is available through a provincial repository maintained by the Ministry. While the repository provides essential data that can inform opioid-prescribing or dispensing decisions, not all physicians and pharmacists have signed up, as access is not mandatory.
- Dentists can also prescribe opioids; however, they are not eligible to access the repository.

Oversight of Physician Billings for Addiction Medicine Services Continued to Be Lacking

- Addiction medicine experts have expressed concerns with physicians scheduling excessive consultations and urine tests with patients in order to maximize their billings under the fee-for-service model. This issue was also raised four years ago in our 2020 audit on Virtual Care: Use of Communication Technologies for Patient Care.

// What We Found

- Our review of physicians with the highest billings for addiction medicine services corroborates this, as we found cases where physicians were billing for an unreasonably large number of patients per day. For example, in 2023/24, one physician was reportedly seeing an average of 113 patients in-person and 74 virtually per day for addiction medicine services (that is, approximately 2.5 minutes per patient in an eight-hour work day), and billed almost $1.8 million for providing these services. The Ministry had conducted limited reviews or audits of these high billers.
- Physicians seeing a large number of patients per day also raises concerns about the quality and comprehensiveness of care provided, given the limited amount of time that a physician could spend with each patient.

» **Recommendation 6**

Emerging Practices Exist in Isolation and Require Evaluation

- Service providers in Ontario and other provinces have started offering other forms of treatment such as Safer Opioid Supply (SOS), which is a harm-reduction approach, and injectable opioid agonist therapy (iOAT), which offers an alternative to people who have not benefitted from other common forms of OAT that use oral medication (that is, methadone or suboxone). Despite this, the Ministry has not taken any action to evaluate the extent of adoption, effectiveness, outcomes and risks of these emerging practices and practices in other jurisdictions, such as the treatment approach in Alberta.

» **Recommendation 7**

2.0 Background

2.1 Use and Misuse of Opioids

Opioids are a class of drugs that are used to relieve pain. There are over 100 different types of opioids. Examples of opioids by level of strength or potency, from strongest to weakest, include fentanyl, buprenorphine, hydromorphone, heroin, methadone, oxycodone, morphine and codeine.

When prescribed and used as directed, opioids can be effective pain killers. When abused, opioids can lead to addictive feelings of euphoria like a "high." With prolonged use, misuse or abuse, opioids can lead to tolerance, dependence, addiction known as opioid use disorder, overdose and even death.

Opioids can be obtained through prescription by health-care professionals or through the illegal drug market, where they are often stronger and/or contaminated with other substances that can put people's health at even greater risk and can be fatal.

2.2 The Opioid Crisis

A lack of education on the risks associated with opioid use, improper prescribing and a proliferation of illegal opioids available for sale have resulted in an opioid crisis in many jurisdictions in Canada, including Ontario. An opioid crisis refers to the growing number of harms and deaths attributed to the overuse, misuse or abuse of opioids.

This crisis is not unique to Canada, and is a public health concern worldwide. According to the latest estimates from the World Health Organization, approximately 125,000 people worldwide died of an opioid overdose in 2019.

The impacts of the opioid crisis in Canada have been far-reaching, not only causing more deaths, but also creating an economic burden to society as a whole. While putting an economic value on people's lives does not reflect the impact of opioid addiction, in 2023, the Canadian Centre on Substance Use and Addiction published a report that presented the estimated costs of substance use in Canada by province from 2007 to 2020. The estimated opioid-attributable costs in Ontario were over $2.7 billion in 2020, which is more than a two-fold increase from $1.3 billion in 2007. Nearly 75% of these costs were related to lost productivity from people dying at a young age from opioid use. The remaining 25% was related to health care, criminal justice and other direct costs.

2.2.1 The Opioid Crisis in Ontario

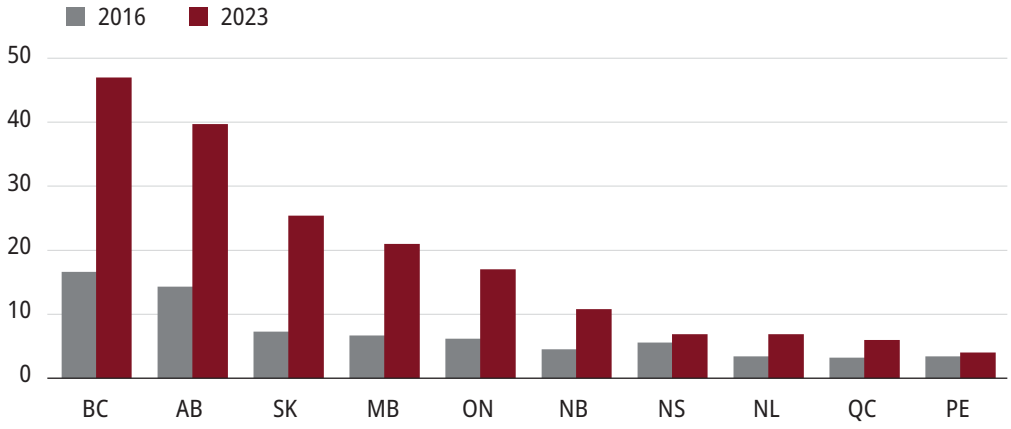
According to data published by the Public Health Agency of Canada, Ontario's opioid crisis has escalated in recent years, in line with the national trend. Between 2016 (when Ontario's Opioid Strategy was launched, as discussed in **Section 2.3**) and 2023, the number of opioid-related deaths in Ontario increased by about 205%, slightly higher than the national rate of 200%. In addition:

- About one-third (35%) of Canada's total number of opioid-related deaths between 2016 and 2023 happened in Ontario. In 2023, an average of seven Ontarians per day died from opioid-related causes (a total of 2,647 deaths).

- On a per capita basis, Ontario ranked fifth in Canada behind British Columbia, Alberta, Saskatchewan and Manitoba in 2023, with an opioid-related death rate of about 17 per 100,000 people, an increase from about six per 100,000 people in 2016 (see **Figure 1**).

Figure 1: Opioid-Related Death Rate by Province, 2016 and 2023 (per 100,000 people)

Source of data: Public Health Agency of Canada



Note: The figure does not include data for the territories (Northwest Territories, Nunavut and Yukon) because of the territories' small population size. Some data are based on ongoing investigations by coroners and medical examiners and are subject to change.

2.2.2 Trends and Changes

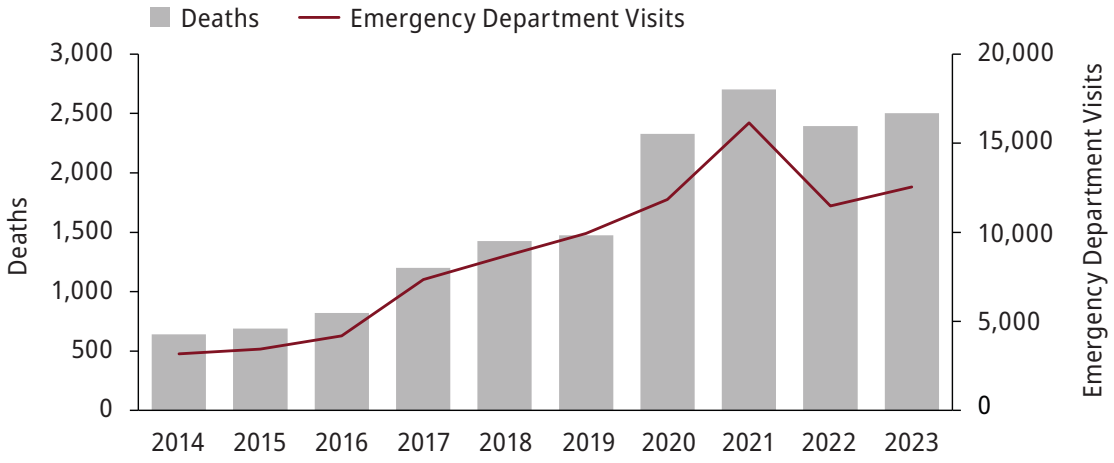
The opioid crisis in Ontario was initially driven by a surge in the number of opioid prescriptions. The crisis then worsened with the increased availability of potent opioids, such as fentanyl, in the illegal drug supply, as well as an increase in poly-substance use, where multiple drugs are taken together, whether through the illegal supply or by choice. According to our review of data from Public Health Ontario, both opioid-related deaths and emergency department visits increased significantly over the last decade, by 292% (from 676 deaths in 2014 to 2,647 deaths in 2023) and 296% (from 3,347 visits in 2014 to 13,267 visits in 2023), respectively (see **Figure 2**).

During the COVID-19 pandemic, opioid-related emergency department visits and deaths rose dramatically in 2020 and peaked in 2021 due to numerous factors. These included increased use of substances as a way to cope with stress, reduced access to health-care supports and services for people who use drugs, and the increased toxicity of the illegal drug supply. All of these factors played a role in exacerbating and escalating the crisis.

As shown in **Figure 2**, while the numbers dropped in 2022 as the effects of the pandemic subsided, they were still substantially higher than in 2019. The numbers started to increase again in 2023. The increased toxicity of the illegal drug supply and the increase in poly-substance use continued to contribute to this upward trend.

Figure 2: Opioid-Related Emergency Department Visits and Deaths in Ontario, 2014–2023

Source of data: Public Health Ontario



Note: Death data for 2022 and 2023 are preliminary and are subject to change.

2.2.3 Demographic and Geographic Variations

While the opioid crisis has impacted people from all walks of life, certain demographics and communities in Ontario have been more negatively affected by the opioid crisis. Specifically:

- Individuals aged 30–59 accounted for 73% of opioid-related deaths in 2023, significantly greater than the share of the population for this age group (about 40% of Ontario's population), while youth (aged 15–24) and young adults (aged 25–29) accounted for about 5% and 9% of opioid-related deaths, respectively.

- In recent years, a number of communities in Ontario (including Belleville, Hamilton, Kingston and Niagara) have declared states of emergency due to the opioid crisis and related challenges, such as untreated mental health concerns and homelessness. Northern, remote and rural communities have also been impacted by the opioid crisis, with the highest rates of opioid-related deaths in 2023 (see **Appendix 1**).

2.3 Ontario's Opioid Strategy

In October 2016, the Ministry released the *Strategy to Prevent Opioid Addiction and Overdose* (Opioid Strategy) to combat the opioid crisis. In August 2017, the Ministry announced an investment of more than $222 million over three years to implement the Strategy. In 2018/19, the total amount of funding for the Opioid Strategy was revised upward to over $260 million. The Opioid Strategy organizes the provincial response into four pillars: appropriate prescribing and pain management; treatment; harm reduction; and surveillance and reporting (see **Figure 3**).

Soon after the Opioid Strategy was released, the Province decided to pursue a broader transformation of the mental health and addictions system. A new provincial strategy, *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System* (Roadmap to Wellness), was released in March 2020.

The Ministry has continued to invest in addictions services through the Roadmap to Wellness with over $168 million in new base funding from 2019/20 to 2024/25, with additional investments through the Addictions Recovery Fund of $90 million from 2021/22 to 2023/24 and $124 million over three years starting in 2024/25. **Section 4.1** provides more details on the Opioid Strategy and the Roadmap to Wellness.

Opioid-related services can generally be grouped into two models: treatment and harm reduction. While the majority of jurisdictions offer a combination of treatment and harm-reduction services, their focus and allocation of resources between the two models vary.

Figure 3: Four Pillars of Ontario's 2016 Opioid Strategy

Source of data: Ministry of Health

Pillar	Goal	Target Population
1. Appropriate Prescribing and Pain Management	Improved provider competency related to prescribing and better care for people with acute and chronic pain	People using prescribed opioids for pain may require alternative pain management and appropriate prescribing or tapering
2. Treatment	Better access to comprehensive addictions care for people living with opioid use disorder	People dependent on opioids and seeking treatment may require access to comprehensive mental health and addictions services
3. Harm Reduction*	Improved health outcomes for people who use drugs and better access to harm-reduction services	People using illicit opioids may require supports to reduce harms associated with drug use and connections to health and social services
4. Surveillance and Reporting	Better access to the necessary data for health system partners to plan effective interventions to address and prevent opioid overdose	Health system partners require the necessary data to plan effective interventions to address and prevent opioid overdose

* Harm reduction is an evidence-based, client-centred approach to reducing the health and social harms associated with addiction and substance use, without necessarily requiring people who use substances to abstain or stop using.

As noted in **Figure 1**, British Columbia and Alberta have also been severely impacted by the opioid crisis. While both jurisdictions provide a range of treatment and harm reduction services such as OAT, supervised consumption, take-home naloxone and residential treatment, they put different emphasis on these services and support different models to combat the crisis. British Columbia initially embraced harm reduction services by experimenting with SOS, which is meant to prescribe certain types of opioids to people as a safer alternative to illegal opioids. In contrast, Alberta has emphasized treatment and recovery, such as expanding treatment facilities and rehabilitation beds, and has not adopted SOS. Alberta is also shifting away from supervised consumption, with one such site scheduled to be replaced with treatment services.

In Ontario, the Opioid Strategy was weighted more toward harm reduction, which included expanding proven harm-reduction services such as naloxone-distribution and CTS sites. **Figure 4** provides an overview of the four key types of opioid-related services covered in this audit.

During our audit, the Province has demonstrated its intent to shift resources from harm reduction to treatment and recovery, as evidenced by an announcement on August 20, 2024, where the Province proposed new legislation that would ban CTS sites that were within 200 metres of schools and child-care centres and instead invest $378 million over a four-year period (2024/25–2027/28) for up to 19 new HART Hubs (see **Section 4.2.1**).

Figure 4: Four Key Types of Opioid-Related Services Covered in This Audit

Prepared by the Office of the Auditor General of Ontario

Opioid-Related Service	Description	Approach		Section of Report
		Treatment	Harm Reduction	
CTS Site[1]	A space for people to consume their own substances, including opioids, in a supervised setting that provides clean, sterilized tools and overdose-prevention support if needed.		✓	4.2
OAT[2]	A medication-assisted treatment to help people reduce their cravings for opioids and prevent withdrawal symptoms.	✓	✓	4.3
RAAM Clinic	A walk-in clinic designed to be a low-barrier option for people to obtain quick access to addictions services, without the need for a referral or appointment.	✓		4.4
Naloxone	A medication to temporarily reverse an opioid overdose.		✓	4.5

1. Also called supervised or safe consumption sites.
2. OAT is both a treatment and a harm-reduction initiative, according to the *Guidance on Opioid Use Disorder Program* developed by the Government of Canada.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry) has effective processes and procedures in place to:

- implement Ontario's Opioid Strategy and initiatives that are responsive to the needs of Ontarians;
- oversee and co-ordinate the delivery of evidence-based services for people who require opioid-related services in an equitable, integrated and timely manner, and in accordance with applicable legislation, policies and agreements;
- monitor and enable appropriate opioid-prescribing and dispensing practices in accordance with applicable legislation, policies and standards; and
- measure and publicly report on the performance of publicly funded services for people who require opioid-related services.

Our audit scope focused on the provincial health sector's response to the opioid crisis, not on policing efforts to investigate and enforce laws related to illegal opioid-related activities. Specifically, our audit focused on the following two areas:

- the availability, accessibility and co-ordination of opioid-related services and other necessary services that are funded and overseen directly by the Ministry and delivered in the community; and
- the Ministry's oversight and monitoring of opioid-related services and physician billings, as well as opioid-prescribing and dispensing practices.

For more details, see our **Audit Criteria**, **Audit Approach** and **Audit Opinion**.

4.0 What We Found

4.1 Ontario's Opioid Strategy

4.1.1 The 2016 Opioid Strategy Is Outdated and Does Not Address Increased Risks and Needs, Even with the New Hubs Model

The Ministry has not updated its holistic 2016 Opioid Strategy to ensure continued commitment and sustained attention to address the ongoing issues and emerging risks of the opioid crisis.

As noted in **Section 2.3**, soon after releasing the Opioid Strategy, the Province decided to pursue a broader transformation of the mental health and addictions system. In March 2020, it launched a new provincial strategy, Roadmap to Wellness, with an investment of $3.8 billion over 10 years.

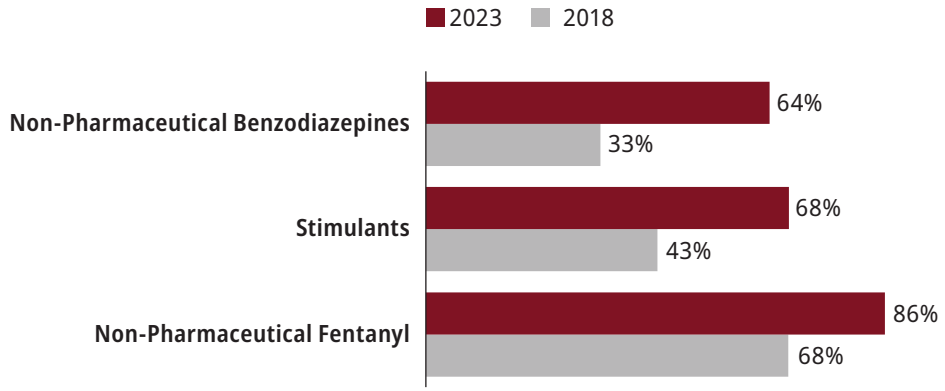
The Roadmap to Wellness was based on recommendations by the Select Committee on Mental Health and Addictions in its 2010 final report, which called for a comprehensive approach to the mental health and addictions system. This broader, system-wide approach did not include an updated opioid-specific strategy, which is critical to address the unique circumstances of the opioid crisis.

In March 2024, the Chief Medical Officer of Health of Ontario released their 2023 Annual Report, *Balancing Act: An All-of-Society Approach to Substance Use and Harms*. The report indicated the importance of having substance-specific strategies to reduce the current trends and health threats, which vary from substance to substance. This report cited Ontario's tobacco strategy as an example of a substance-specific strategy that has been successful in changing social norms and reducing the number of Ontarians who smoke.

Our review of opioid-related data, reports by experts and information from stakeholders identified the following concerns, which reflect a need to revisit and renew the Opioid Strategy. This is necessary to ensure that a cohesive and responsive long-term plan is in place to tackle this complex issue and reverse the rising trend in opioid-related deaths and emergency department visits, as noted in **Figure 2**.

Figure 5: Substances Involved in Opioid-Related Deaths in Ontario, 2018 and 2023

Source of data: Office of the Chief Coroner for Ontario



Increases in Poly-Substance Use and Illegal Opioid Use Remain the Key Emerging Risks, and Are Not Addressed in the 2016 Opioid Strategy or the 2024 Hubs Model

Prior to the release of the Opioid Strategy, the opioid crisis was primarily driven by the unnecessary dispensing and over-prescribing of opioids. The crisis then intensified with the illegal drug supply and the increase in potent opioids such as fentanyl. As shown in **Figure 5**, an increasing proportion of opioid-related deaths has involved non-pharmaceutical fentanyl (or its analogues), accounting for 86% of opioid-related deaths in 2023, an increase from 68% in 2018.

In recent years, the opioid crisis has also exhibited complex patterns of poly-substance use, with a majority of deaths involving combinations of opioids and other substances such as stimulants and/or benzodiazepines, intentionally or unintentionally due to drug contamination. **Figure 5** shows that the proportion of deaths involving multiple substances also increased between 2018 and 2023.

Specific Regions and Population Groups Continued to Be Disproportionately Impacted by the Opioid Crisis

Northern Communities

As noted in **Appendix 1**, the five public health units with the highest opioid-related death rates in 2023 were located in Northern communities (for example, Thunder Bay, Timmins and Sudbury). Their death rates, which ranged from about 37 to 55 per 100,000 people, were about two to three times higher than the average rate in Ontario, which was about 17 per 100,000 people.

The largest increases in opioid-related death rates also occurred among these Northern communities. For example, the rate increased by 227% in Timmins and 184% in Sudbury between 2018 and 2023.

The Ministry's actions to address the needs of these communities have been insufficient (see **Section 4.2**). A similar concern was raised by the Chief Medical Officer of Health of Ontario, who indicated in the aforementioned 2023 Annual Report that the Ministry needs to tailor services to the specific needs of these Northern, rural and remote regions, including working with Indigenous communities to increase access to culturally appropriate services.

Younger Populations

Although the Province has identified the importance of addictions services for youth, in part through the introduction of Youth Wellness Hubs in 2016 (an initiative to provide integrated services to youth aged 12 to 25), opioid-related deaths among this population continued to surge, with a substantial increase of 114% between 2016 (when the Opioid Strategy was introduced) and 2023.

A 2023 study by researchers from various universities in Ontario also noted that, even though there has been an acceleration in opioid-related deaths among youth aged 15–24 over the last decade, rates of accessing opioid treatment declined for this population. This indicates that barriers, such as stigma and lack of availability of youth-oriented services, continue to exist.

Along with indicating that young people aged 15–24 are more likely to experience substance-use disorders than any other age group, the Centre for Addiction and Mental Health also identified the use of opioids among students in grades 7 to 12 as a public health concern. Its Ontario Student Drug Use and Health Survey found that, in 2023, 21.8% of students reported the non-medical use of prescribed opioid pain relievers, a significant increase from 11.0% in 2019.

Issues Raised by Experts in 2016 Have Not Been Fully Addressed and Continue to Exist

Prior to releasing the Opioid Strategy, the Ministry established the Methadone Treatment and Services Advisory Committee, which released a report with 30 recommendations that cover a number of areas, including, for example, access, standards of practice, youth, Indigenous communities, harm reduction or overdose prevention, educational supports and research. While there has been some progress, we found that many key recommendations were not fully implemented, and some systemic issues raised by the committee eight years ago continue to exist. For example:

- Access to comprehensive care remains limited, even though many people with opioid addiction have co-occurring mental health and other health-care needs that require a more integrated range of services, including medical treatment, addiction counselling and mental health services, primary care and additional community supports (see **Section 4.3.1**).

- Access to OAT (an evidence-based and effective treatment for opioid addiction) remains limited, especially in Northern, remote, rural and Indigenous communities, as well as in emergency departments and primary care settings (see **Section 4.3.2**).

- Provincial investment in research on the opioid crisis and treatment options remains limited. Research on emerging practices, specific areas of study and other jurisdictions' experiences (for example, effective regulatory and education strategies to reduce opioid overdose, people's experiences with different treatment models, factors affecting treatment retention rates, and optimal treatment for youth) is important to inform clinicians and policy makers about the optimal approach to treating people and effective interventions to control the opioid crisis (see **Section 4.7.1**).

4.1.2 Opioid Strategy Lacks Clear Accountability Structure and Leadership

The Ministry's 2020 Roadmap to Wellness highlighted "fragmentation and poor co-ordination" as one of the key challenges facing the mental health and addictions system, where "poor co-ordination across the system results in inefficiencies and poor client and family experience, as people struggle to navigate between services." We found that the system continues to be fragmented, and multiple parties are working in silos with no well-defined accountability structure and leadership in place at the provincial level. A report issued by the Association of Municipalities of Ontario in July 2024, *The Opioid Crisis: A Municipal Perspective*, also noted that municipalities "urgently need provincial leadership and meaningful action."

Numerous Ministry divisions or branches and other parties in the health sector have been responsible for managing and overseeing different health-related aspects of the opioid crisis (see **Figure 6**). While they each have their own responsibilities, we found that accountability is lacking and remains unclear, with no specific party being designated as a lead to oversee and co-ordinate the work, no specific goals or targets being set for different parties to work toward, and no ongoing monitoring or evaluation of performance and outcomes (see **Section 4.1.3**). Unclear accountability was also evidenced in multiple instances during our audit when the various branches in the Ministry had difficulty co-ordinating and identifying the right parties to address our questions and requests.

4.1.3 Poor Data Tracking Made It Challenging to Accurately Plan, Monitor and Improve Addictions Services

No Consistent Tracking and Reporting of Outcome-Based Measures for the Opioid Strategy

While the Ministry has funded a number of initiatives and services as part of its Opioid Strategy, we found that there has been limited evaluation of the Strategy's impacts and outcomes because few of the performance measures were being tracked and reported.

As noted in our 2019 audit on Addictions Treatment Programs, for the first two years of the Opioid Strategy, the Ministry had used outcome measures, such as opioid-related deaths, emergency department visits and hospitalizations, to broadly assess the effectiveness of the Opioid Strategy. Moving forward, the plan was to develop a set of performance indicators to monitor and evaluate

Figure 6: Key Government Groups Involved in the Provincial Response to the Opioid Crisis

Prepared by the Office of the Auditor General of Ontario

	Key Responsibilities
Ministry of Health	
Mental Health and Addictions Division[1]	• Provide policy advice to government on mental health and addictions issues • Manage the provincial mental health and addictions service system • Identify ways to better co-ordinate addictions services • Work with system-level partners to translate provincial policy direction into services
Drug Programs Policy and Strategy Branch	• Develop strategic policy • Oversee public drug funding • Provide drug-related program policy support
Office of Chief Medical Officer of Health, Public Health	• Set standards for public health units related to health surveillance and promotion, harm reduction and other services relevant to the opioid crisis • Oversee policy and program work related to CTS sites • Provide advice on public health matters to the health sector, Ministry of Health, other ministries and the provincial government
Provincial Programs Branch	• Oversee the delivery and quality of harm-reduction services • Manage funding relationships with transfer payment recipients • Provide policy advice to government on harm-reduction issues • Manage the ONP
Other Parties	
MHA CoE	• Support the Province in building a comprehensive and connected mental health and addictions system through the 2020 Roadmap to Wellness strategy • Oversee the delivery and quality of mental health and addictions services
Public Health Ontario	• Manage the Interactive Opioid Tool that provides the public with opioid-related morbidity and mortality data
Office of the Chief Coroner for Ontario	• Conduct death investigations and inquests, including suspected drug-related deaths • Collect data and supplementary information about opioid toxicity deaths, such as the circumstances surrounding the death and treatment history
META:PHI[2]	• Support health-care providers working with people who use substances, through education, mentorship, advocacy and clinical tools • Oversee the RAAM clinics

Note: Key responsibilities are based on publicly available information from Government of Ontario websites (for example, ontario.ca and infogo.gov.on.ca) and other provincially funded organizations (for example, META:PHI, Public Health Ontario and Ontario Drug Policy Research Network).

1. The task of co-ordinating the opioid response has been assigned to different divisions over time. Currently, this responsibility lies with the Mental Health and Addictions Division.
2. META:PHI stands for Mentoring, Education, and Clinical Tools for Addiction: Partners in Health Integration, which is a provincial initiative funded through the Ministry with in-kind support from Women's College Hospital.

the overall outcomes of the Strategy, as well as the progress of specific initiatives within each of the Strategy's four pillars. In 2019, 20 performance indicators were identified.

During this audit, we followed up with the Ministry on the implementation status of the 20 indicators that it had planned to track five years ago. We found that the Ministry identified four new performance indicators, increasing the total number of indicators relevant to the Opioid Strategy from the original 20 to 24 (see **Appendix 2**). Only 10 of the 24 indicators were consistently tracked. The remaining 14 indicators were not tracked or reported on consistently to show whether specific treatments or services were having an impact. These indicators included the number and rate of hospitalizations for opioid overdoses, the percentage of people who are prescribed opioids and subsequently develop an opioid addiction, the number and proportion of patients who were referred from RAAM clinics to primary care, and the number of CTS site client visits.

We asked the Ministry why it had not consistently tracked the 24 indicators, particularly the 20 indicators it proposed five years ago. The Ministry indicated that, within a year of releasing the Opioid Strategy, it had begun planning the launch of the broader mental health and addictions system transformation strategy, Roadmap to Wellness (see **Section 2.3**).

Roadmap to Wellness was intended to support the data collection and performance measurement that was envisioned for the Opioid Strategy by establishing system-wide standards, as well as the required data and digital infrastructure. As discussed below, that foundational work is yet to be completed.

No Reliable and Complete Data Available to Assess Needs, Availability and Effectiveness of Addictions Services

We found that the lack of reliable and complete data has become a barrier to the Province's ability to plan, monitor and improve the quality and accessibility of the mental health and addictions services that are critical for people with opioid addiction and co-occurring mental health issues.

As part of its decision to pursue a broader transformation of the mental health and addictions system through the Roadmap to Wellness strategy (see **Section 4.1.1**), the Ministry created the MHA CoE within Ontario Health in 2020. MHA CoE's role was to help implement the strategy's key priorities, which include improving accessibility to and the quality of mental health and addictions services, expanding existing services and implementing innovative solutions.

MHA CoE identified four clinical areas of focus: depression and anxiety-related disorders; schizophrenia and psychosis; eating disorders; and substance use disorder. MHA CoE confirmed that its work related to the substance use disorder area of focus, including work specific to opioid addiction, is in the initial stages.

The Roadmap to Wellness strategy, which has been in place for four years, recognized the importance of improving the available provincial mental health and addictions data with the inclusion of a multi-year data and digital initiative through MHA CoE. However, MHA CoE confirmed

that it does not have reliable, validated and standardized data on mental health and addictions services. This limits MHA CoE's ability to perform meaningful analysis to identify service gaps.

The service providers and stakeholders we spoke with also indicated that the following reliable and complete data is not available for service planning and monitoring:

- the needs for addictions (including opioid-related) services versus the current availability of such services;
- the number of people at each level of need (that is, severe, moderate or low level of need) versus the needs of the general population; and
- the quality of services provided by different service providers.

The Roadmap to Wellness strategy was aimed at developing a new core services framework as a first step toward building a high-quality system, to identify and define the provincially funded mental health and addictions services that will be made available over time to Ontarians, regardless of where they live. This goal will be difficult to attain without a comprehensive understanding of service needs and availability, which can only be identified through data collection and analysis.

Recommendation 1

We recommend that the Ministry of Health:

- develop a new holistic strategy including all best practices targeted at addressing the current drivers of the opioid crisis, reducing opioid-related harms, and preventing opioid addiction and overdose;
- develop a clear governance, accountability and leadership structure to guide work on the provincial health sector's responses to the opioid crisis;
- identify and implement outcome-based performance measures to evaluate progress of work and initiatives under the Opioid Strategy, and report annually on the results; and
- work with the MHA CoE on improving the provincial mental health and addictions data in order to assess the needs, availability and effectiveness of services for people with opioid addiction and co-occurring mental health issues.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.2 CTS Sites

An evidence-based harm-reduction initiative, CTS sites (also known as supervised consumption services sites) are spaces for people to consume their own substances, including opioids, in a supervised setting. Applicants that received an exemption from Health Canada to establish a supervised consumption services site, and have met provincial CTS program criteria (for example, demonstrated need, community support and engagement, valid and reasonable costs) were considered by the Ministry for provincial CTS funding. Our review of the data and discussions with service providers identified a number of benefits to CTS sites:

- preventing many overdose deaths;
- providing clean, sterilized tools to prevent the transmission of diseases; and
- connecting CTS site users to addiction treatment options, such as OAT, and other services, such as mental health services, social supports and primary care.

Supervised consumption services at CTS sites are proven life-saving interventions. In 2022/23, none of the over 2,500 opioid-related deaths in Ontario happened at CTS sites and none of the over 3,600 overdoses reported by CTS sites resulted in death (Over 1,500 of these potentially fatal overdoses were prevented at the 10 to-be-closed supervised consumption services sites, as discussed in **Section 4.2.1.**)

Besides CTS sites, there are other sites in different parts of Ontario that also provide supervised consumption services. These sites have received the necessary exemption from Health Canada, but are not approved to operate under the provincial CTS program through the aforementioned application process. As such, they are not funded by the Ministry, except for one site in Toronto that received provincial funding based on an arrangement that pre-dated the CTS program.

4.2.1 The Decision to Change Supervised Consumption Services Was Made Without Proper Planning, Impact Analysis or Public Consultations

As noted in **Section 2.3**, during our audit, on August 20, 2024, the Ministry publicly announced its decision to introduce legislation that, if passed, will impose new restrictions on supervised consumption services, as well as its plan to implement a new model called HART Hubs. **Figure 7** provides a timeline for the implementation of the Hubs model. According to the announcement, the planned changes were aimed at protecting community safety and helping people get needed treatment.

Specifically, the Ministry announced the following planned changes:

- banning the operation of supervised consumption services sites within 200 metres of schools or child-care centres (the "buffer zone");

- closing the 10 sites (including nine provincially funded sites and one that is self-funded) currently operating within the buffer zone by March 31, 2025; and

- investing $378 million over four years (in addition to the 10-year investment of $3.8 billion through the 2020 Roadmap to Wellness, as noted in **Section 2.3**) to open up to 19 HART Hubs across the province, with direct pathways to supportive housing to help vulnerable individuals with complex service needs.

Figure 8 lists all supervised consumption services sites (including those recently closed or that will be closed if the new legislation is passed), regardless of their source of funding. Of the 10 sites subject to closure by March 31, 2025, under the proposed legislation, the nine that are provincially funded will be given the option to transition to HART Hubs.

The Ministry will also implement up to 10 additional HART Hubs selected through a call for proposal. Along with supportive housing, the Hubs will provide a mix of services that could include primary care, mental health and addictions services, social services and employment support, shelter and transition beds, as well as other supplies and services (such as naloxone, showers and food). The intention is to provide these services either on-site or at co-located facilities whenever possible. If that is not possible, it is expected that referrals will be made to other community service providers. The HART Hubs will not provide some key harm-reduction services such as supervised consumption services or needle exchange programs.

While investing $378 million in treatment, recovery and housing through the Hubs model is a very positive development, we found that the proposed changes to harm-reduction services were decided upon without proper planning, comprehensive impact or risk analysis, or public consultations.

Figure 7: Timeline for the Implementation of the HART Hubs Model

Source of data: Treasury Board/Management Board of Cabinet (TB/MBC)

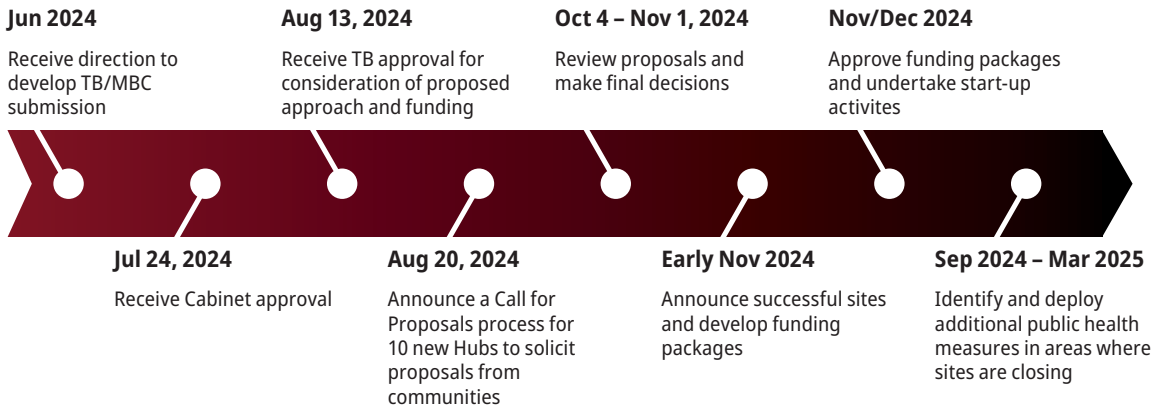


Figure 8: List of All Supervised Consumption Services Sites in Ontario, as of August 31, 2024

Source of data: Ministry of Health

Site	City	Provincially Funded[1]	2022/23 # of Visits[1]	2022/23 # of Fatal Overdoses Prevented[1]
10 sites to be closed as a result of the Ministry announcement on Aug 20, 2024				
Guelph Community Health Centre	Guelph	✓	7,257	40
Hamilton Urban Core Community Health Centre	Hamilton	✓	3,863	71
Kensington Market Overdose Prevention Service[2]	Toronto		n/a	n/a
Parkdale Queen West Community Health Centre (Bathurst)	Toronto	✓	4,092	151
PATH 525	Thunder Bay	✓	7,058	160
Regent Park Community Health Centre	Toronto	✓	6,939	74
Somerset West Community Health Centre	Ottawa	✓	10,037	261
South Riverdale Community Health Centre	Toronto	✓	13,187	132
Sanguen Health Centre	Kitchener	✓	14,356	179
The Works[3]	Toronto	✓	26,057	511
Total			**92,846**	**1,579**
13 remaining sites				
Carepoint	London	✓	12,475	144
Casey House Outpatient (Day Help) Supervised Consumption Service	Toronto		n/a	n/a
Casey House Inpatient Supervised Consumption Service	Toronto		n/a	n/a
Fred Victor Centre	Toronto	✓	32,851	386
Healthy Sexuality and Risk Reduction Unit	Ottawa		n/a	n/a
Integrated Care Hub	Kingston	✓	16,123	288
Moss Park Consumption and Treatment Service	Toronto	✓	14,181	323
Parkdale Queen West Community Health Centre (Dufferin)	Toronto	✓	3,771	133
Peterborough Consumption and Treatment Service	Peterborough	✓	8,536	67
Sandy Hill Community Health Centre	Ottawa	✓	20,128	404
Street Health	Toronto		n/a	n/a

Site	City	Provincially Funded[1]	2022/23 # of Visits[1]	2022/23 # of Fatal Overdoses Prevented[1]
StreetWorks	St. Catharines	✓	17,241	162
Trailer 2.0	Ottawa	✓	77,448	670
Total			**202,754**	**2,577**
3 sites closed prior to the Ministry announcement on Aug 20, 2024				
The Spot	Sudbury		n/a	n/a
Safe Health Site Timmins	Timmins		n/a	n/a
SafePoint	Windsor		n/a	n/a

Note: This figure includes all supervised consumption services sites, both provincially funded and self-funded.

1. n/a means data is not available for sites that are not provincially funded, as they are not subject to the Ministry's oversight.
2. The Kensington Market Overdose Prevention Service site is not considered to be a CTS site because it is not funded by the Ministry and subject to Ministry oversight.
3. The Works, operated by Toronto Public Health, is not considered to be a CTS site because it is not subject to the Ministry's oversight even though it has received funding from the Ministry. The number of lives saved was provided by The Works, as the Ministry did not have that data. This number included overdoses that took place at the site and overdoses that took place in the immediate vicinity of the site to which staff responded.

No Proper Planning and Comprehensive Impact or Risk Analysis for HART Hubs Decision

The new Hubs model expands on addiction treatment and recovery services, but also scales back on the harm-reduction services available in Ontario. The 10 supervised consumption services sites subject to closure by March 31, 2025, under the proposed legislation, had collectively served over 1,600 people in 2022/23. Those individuals had used the services of these sites over 92,000 times during that year. In addition, actions taken by staff at these sites had successfully prevented fatalities from the over 1,500 overdoses that happened on-site during that same time period (see **Figure 8**).

Our review of the government's internal documents noted that the Ministry recognized the potential impacts to the health system of closing the 10 supervised consumption services sites, including:

- an increased risk of deaths from overdoses and emergency department visits;
- increased instances of public drug use and the public discarding of drug supplies; and
- no access within a reasonable distance to supervised consumption services for Northern Ontarians going forward as a result of the closure of the only remaining site in Thunder Bay (see **Section 4.2.2**).

Despite these foreseeable impacts, we found that the Ministry has not performed comprehensive analysis to assess and quantify the impacts on and risks to public health and the health system prior to the finalization of its decision to introduce the new legislation. In addition:

- The Ministry has not developed plans to mitigate the risks prior to making the decision, which include the number of impacted individuals, the increased overdoses and risk of death, and the financial and operational burden on emergency departments.

- The Ministry has not specified detailed public health measures and the associated costs. Instead, it will work with system partners, such as Ontario Health, public health units and the supervised consumption services sites being converted to Hubs, to identify and deploy additional public health measures in the affected areas between September 2024 and March 2025, when the sites are closing (see **Figure 7**).

- The Ministry has yet to develop a performance measurement plan with measurable indicators, targets and a timeline to evaluate the effectiveness of the Hubs model, but had only outlined some of the expected outcomes, such as how the model would broaden services to a vulnerable population, increase the number of individuals seeking addiction treatments and increase the housing rates for these individuals.

No Consultations with Key External Stakeholders

Our review of the government's internal documents noted that the Ministry has only engaged internal stakeholders, including its own divisions, partner ministries (Ministry of Children, Community and Social Services, Ministry of Municipal Affairs and Housing, and Ministry of Labour, Immigration, Training and Skills Development) and Ontario Health to inform the development of the proposed Hubs model. No formal consultations with key external stakeholders affected by the proposed new model, as well as Public Health Ontario, were conducted prior to the announcement of the decision. Specifically:

- **Users of Existing Sites Being Closed:** As noted previously, over 1,600 people used the services of the soon-to-be closed supervised consumption services sites in 2022/23. The Ministry did not consult with the users, their families or the staff of these sites to understand how the well-being of users would be impacted. This is especially important in certain regions, such as Northern Ontario, where supervised consumption services will no longer be available (see **Section 4.2.2**).

- **High-Risk Populations:** As noted in **Section 4.1.1**, Northern communities (which tend to have a higher population of Indigenous people) and younger populations are among the groups being disproportionately impacted by the opioid crisis. Without formal consultations, the proposed Hubs may not adequately address the needs of these under-served populations.

- **Communities:** Since the proposed Hubs will not provide some key harm-reduction services, such as supervised consumption services, the Ministry indicated that there is an

increased risk of discarded drug supplies ending up in public spaces. This could create community safety concerns, especially for children and youth. As such, local businesses and community members may not continue to support the Hubs model over the long-term.

- **Other Groups:** The Ministry noted that further consultation is required with Francophones, newcomers and women, as well as with the 2SLGBTQQIA+, aging (above 55 years old) and rural populations.

4.2.2 Access to Supervised Consumption Services in Regions with High or Growing Needs Was Further Reduced Without Evidence-Based Analysis

Prior to the Ministry's decision to introduce legislation that will lead to the closure of 10 supervised consumption services sites, as announced in August 2024, the availability of supervised consumption services was already limited in regions with high or growing needs.

At the time of its inception in 2018, the Ministry's CTS program approved annual funding of $31.3 million to establish up to 21 CTS sites. Prior to the Ministry's announcement in August 2024, there were 17 CTS sites operating in 10 communities in Ontario.

Several communities had submitted CTS applications, but the approval process was slow, and it eventually was paused in October 2023 when the Ministry decided to review the CTS program. Finally, with the decision announced in August 2024, the Ministry confirmed that the application process is now closed and the Province has decided not to approve any outstanding CTS applications.

In reviewing the CTS applications that were outstanding prior to the Ministry's announcement (see **Figure 9**), we noted that:

- Some applicants had been waiting for Ministry approval for over two years. In addition, in June 2024, one applicant (Barrie) withdrew its application as it could no longer afford to pay for the location it rented in the hope of setting up a CTS site.

- While the opioid-related death rates in Timmins (the Porcupine Health Unit) and Sudbury had increased significantly between 2018 and 2023 (by 227% in Timmins and 184% in Sudbury) and were among the highest of all regions in Ontario (ranking second and third, respectively, in 2023, as shown in **Appendix 1**), the CTS applications from both cities were pending. While awaiting Ministry approval of their applications, they relied on temporary funding from a variety of sources at different points in time (for example, municipal governments, local hospitals, businesses and anonymous community donors) to set up supervised consumption services sites to meet local needs. The sites in Sudbury and Timmins were closed in March 2024 and June 2024, respectively, when the temporary funding ran out.

Figure 9: Applications for CTS Sites Outstanding as of August 2024 and Opioid-Related Deaths Within the Health Region

Source of data: Ministry of Health and Public Health Ontario

CTS Application			Opioid-Related Deaths (per 100,000 people)	
City	Date Submitted	Status (as of Aug 31, 2024)	Public Health Unit	2023*
Sudbury	Apr 2022	Not approved	Public Health Sudbury & Districts	46.0
Barrie	Mar 2022	Application withdrawn in Jun 2024	Simcoe Muskoka District Health Unit	23.0
Windsor	Apr 2023	Not approved	Windsor-Essex County Health Unit	29.0
Timmins	Aug 2023	Not approved	Porcupine Health Unit	50.0
Hamilton	Spring 2023	Not approved	City of Hamilton Public Health Services	24.3

* See **Appendix 1** for a ranking of the rate of opioid-related deaths (per 100,000 people) by public health unit.

With the Ministry's decision in August 2024, the open CTS applications from Sudbury and Timmins were declined. And if the legislation to ban the operation of supervised consumption services sites within the buffer zone is passed (see **Section 4.2.1**), the only remaining site in the North (in Thunder Bay, which had the highest opioid-related death rate in 2023, as shown in **Appendix 1**) will also cease operations by March 31, 2025, leaving Northern Ontarians with no access to supervised consumption services going forward.

Supervised consumption services sites in Northern Ontario serve a relatively large number of users, including those from the Indigenous population. According to a report by the Chiefs of Ontario and the Ontario Drug Policy Research Network in November 2023, First Nations populations had an opioid-related death rate (11.4 deaths per 10,000 people) that was seven times higher than non-First Nations people (1.6 deaths per 10,000 people) in 2021.

Recommendation 2

We recommend that the Ministry of Health complete all necessary planning work before transitioning to the new HART Hubs, including:

- working with providers to support CTS users being impacted by any closure of a CTS site and to perform impact, risk and financial analysis;
- engaging with all relevant stakeholders;
- developing a performance measurement plan; and
- deploying public health measures in areas where supervised consumption services sites are closing.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.3 OAT

OAT is a medication-assisted treatment for people with opioid addiction to reduce their cravings for opioids and prevent withdrawal symptoms. The quality standard for opioid use disorder issued in 2018 by Health Quality Ontario (now part of Ontario Health) indicated that people with opioid use disorder who are treated with OAT have better retention in addiction treatment, less use of addictive substances, improved health and social functioning, and lower rates of mortality than those who do not receive OAT as part of their treatment. The number of OAT users increased by only about 3% from 2019 to 2023, despite these noted benefits.

4.3.1 Access to Comprehensive Care Through OAT Providers Was Limited

Providing opioid users with access to comprehensive care (or wraparound services) is important, as many individuals who require OAT would also benefit from other services (for example, primary care, counselling and social support) to address co-occurring mental health and other health-care needs. Only some OAT providers offer these additional services, creating care gaps and resulting in care not being offered in accordance with best practices.

We found that OAT is primarily delivered by clinics that focus on offering medication, such as methadone, with no or limited other services, mainly because these clinics operate on a fee-for-service payment model. Under this model, physicians working in OAT clinics submit claims to the Ontario Health Insurance Plan (OHIP) for services rendered to each person seen and served, but the clinics are not compensated by OHIP for providing other services on-site. For example, the two largest chains of OAT clinics (with 73 and 123 separate locations, respectively) primarily provide medication to their patients and none of the other services.

Various reports and guidelines have identified that people with opioid addiction have a better chance of success with OAT when they have access to a wide range of services that go beyond medical treatment. For example:

- The 2016 report by the Methadone Treatment and Services Advisory Committee, which informed the Ministry's Opioid Strategy, recommended that, "In addition to medical treatment, clinics/services must include and provide access to a broad range of health care services and supports, including mental health and addictions counselling, and have plans, protocols, and timelines in place for transferring stable patients to appropriate care for ongoing management."

- The quality standard for opioid use disorder issued in 2018 by Health Quality Ontario indicated that care providers offering treatment with either methadone or suboxone in specialized clinic settings "should ensure that people receiving opioid agonist therapy also have their physical health, mental health, additional addiction treatment needs and social needs addressed concurrently either in the clinic or via other care providers. Care providers in specialized clinic settings should encourage and support a transition to primary care providers for those receiving ongoing treatment with suboxone to ensure they receive comprehensive primary care."

While the Ministry was made aware of this concern eight years ago through the 2016 report by the Methadone Treatment and Services Advisory Committee, it did not act. Specifically, the Ministry has not evaluated whether the fee-for-service model used by many OAT clinics, which primarily focuses on offering medication, has led to successful outcomes, or whether changes are needed to ensure people have access to all necessary services (see **Section 4.6.5**).

4.3.2 Initiation of OAT in Primary Care Settings and Emergency Departments Was Infrequent Despite Benefits

The availability of OAT in primary care settings and emergency departments has remained low, despite opioid overdoses often resulting in visits to these settings. Various reports and guidelines have identified the importance of initiating OAT in these settings. For example:

- According to the 2016 report by the Methadone Treatment and Services Advisory Committee, the Ministry should "mandate hospitals and interprofessional primary care clinics (including Family Health Teams, Community Health Centres, and Aboriginal Health Access Centres) to develop programs to support the initiation of opioid agonist therapy in patients presenting with opioid overdose or opioid use disorder, based on best practice treatment guidelines."

- In 2020, the Canadian Association of Emergency Physicians recommended that "emergency departments initiate first-line opioid agonist treatment in patients with opioid use disorder" and that "providers should treat opioid withdrawal early, aggressively, and compassionately to reduce the risk of fatal overdose."

Limited Access to OAT in Primary Care Settings

While we noted that ConnexOntario (a provincially funded organization that maintains a directory of community mental health and addictions services) does not track data from all family health teams, community health centres and physicians, our review of 2024 data reported by service providers to ConnexOntario noted limited availability of OAT in the primary care sector. For example, among those service providers who reported data to ConnexOntario, only three (or 2%) of 187 family health teams (primary care organizations that provide services to their community) and only five (or 7%) of 75 community health centres (not-for-profit organizations that provide primary care and other services to vulnerable populations) across Ontario were classified as providing addictions services such as OAT.

In addition, our review of prescription data found that of the approximately 67,000 people who received OAT in 2023/24, almost 70% did not have a family doctor or primary care provider, but would have had to access primary care through other channels (for example, walk-in clinics or community health centres), indicating that the majority of them lacked ongoing comprehensive care from primary care providers.

Limited Access to OAT in Emergency Departments

Along with infrequent initiation of OAT in primary care settings, we also found that a number of hospitals did not initiate OAT in their emergency departments for various reasons, including lack of training and resource constraints. For example:

- According to a study published in the *Canadian Medical Association Journal* in December 2023, in Ontario, only one in 18 patients who were consuming opioids received OAT within seven days of an emergency department visit or after a hospital admission even though these patients could have benefitted from OAT. This seven-day window is the critical period with the highest mortality risk for patients.

- This does not meet the quality standard for opioid use disorder developed by Health Quality Ontario in 2018, which states that patients should have access to OAT within a maximum of three days. The study noted that several other studies in the US between 2020 and 2022 had identified the lack of formal training, as well as limited knowledge of available resources, local protocols and outpatient follow-up options among clinicians, as potential barriers to OAT initiation in emergency departments.

- According to a 2020 proposal submitted to the Ministry by the Toronto Academic Health Sciences Network and Toronto Public Health, data based on trials and observational studies in Canada and the US showed that many people who presented to the emergency department due to opioid overdose, but who did not receive OAT before being discharged, eventually died due to overdose.

- Despite this proposal being made four years ago, some hospitals we met with still did not have the resources and expertise necessary to initiate OAT before discharging patients. For example, Quinte Health, which operates Belleville General Hospital, does not offer addiction medicine services. This means that patients are referred to community clinics for OAT.

We noted that some hospitals have developed strategies to improve the accessibility of OAT in emergency departments. These strategies have been successful in treating people with opioid addiction, reducing the number of overdoses and preventing repeated hospital visits, and can be shared with other hospitals for implementation. For example:

- In 2020, Timmins and District Hospital introduced an emergency department protocol that included offering OAT combined with timely admission to an inpatient withdrawal program at the hospital. Preliminary data involving 90 patients demonstrated a 22% reduction in the number of overdoses, 78% reduction in the number of emergency department visits and 77% reduction in the number of hospital admissions.

- In 2019, Kingston Health Sciences Centre developed a Substance Treatment and Recovery Team that not only assists patients in emergency departments and in-patient units, but also works with patients in the hospital's nearby detox centre to initiate OAT

before discharge. An evaluation found that some services provided by this team, such as OAT, harm reduction and pain management, resulted in reductions in the length of hospital stay, as well as reductions in the number of revisits and readmissions.

4.3.3 Accessibility of Different Medication Treatment Options for OAT Varies and Requires Evaluation

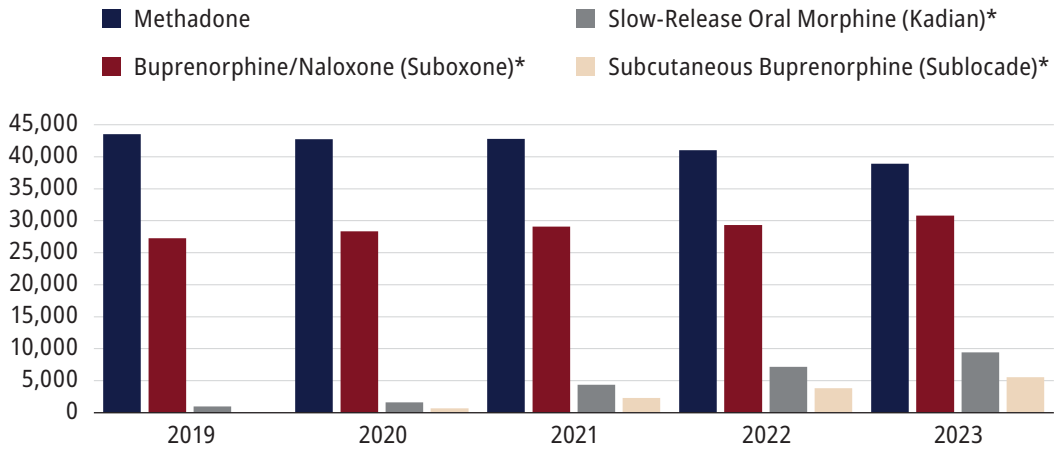
OAT can be offered using different medications, as shown in **Figure 10**, with significant variations in the extent of use of each medication. While variations are expected, because treatment decisions are dependent on a physician's assessment of the patient's condition or needs, as well as the patient's preference, it is important to ensure that variations are not also caused by a lack of choice or other barriers. We found that the Ministry has not evaluated the availability of different OAT medications across the province to determine whether patients are offered the options that best meet their needs.

Use of Methadone and Suboxone

Methadone and suboxone (a brand name of buprenorphine/naloxone) have been the most common medication options for OAT. In 2016, the Methadone Treatment and Services Advisory Committee recommended that OAT providers prescribe suboxone as the first-line medication, before methadone, given that it is safer and more accessible. This recommendation is consistent with the 2018 quality standard for opioid use disorder developed by Health Quality Ontario, as well as guidelines in other provinces.

Figure 10: Number of Recipients by Major Types of Medication Used in OAT

Source of data: Ontario Drug Policy Research Network



Note: Slow-release oral morphine and hydromorphone are alternative medication options for people who have not responded well to the more conventional options (methadone and suboxone). The figure does not include hydromorphone, as hydromorphone is used in a relatively new treatment called injectable opioid agonist therapy or iOAT (see **Section 4.7.1**) for which the number of recipients is unavailable.

* Brand name of medication in parentheses.

Our review of OAT data from 2019 to 2023 noted that, despite an increase in the number of recipients of suboxone treatment (13%) and a corresponding decrease in the number of recipients of methadone treatment (11%), the overall number of suboxone recipients remained below that of methadone as of 2023 (see **Figure 10**). A large provider of OAT with multiple locations also informed us that approximately 70% of people it treated were on methadone and about 25% were on suboxone. Another large OAT clinic also indicated that about 60–70% of their patients were on methadone and the remaining 30–40% were on suboxone.

Our discussion with experts and review of studies found that suboxone is not expected to replace methadone, as evidence suggests that methadone may be preferable for individuals who have been on methadone for a long time or who use high-potency opioids such as fentanyl. In addition, research studies have indicated that treatment retention rates for patients on methadone are higher than for those on suboxone. It is critical that all individuals seeking OAT treatment have access to suboxone given that it is a safer medication. We noted that the Ministry has not analyzed opioid-dispensing data to identify prescribers with unusually low use of this medication in comparison with peers, in order to determine if further actions (for example, reinforcement of standards, enhanced training and education) are warranted.

Use of New Medication

In 2018, Health Canada approved an injectable slow-release medication called sublocade as a new option for OAT. Since becoming available, we noted that use of sublocade in Ontario has gradually increased, with over 5,500 OAT recipients on that medication in 2023 (see **Figure 10**).

One of the primary advantages of sublocade is that it typically only requires a monthly visit to an OAT provider compared to multiple visits a week for methadone or suboxone. Although sublocade is relatively new compared to methadone and suboxone, some OAT providers indicated that its use showed success in terms of treatment retention and outcomes.

Even though sublocade has shown promising results, our discussion with experts identified multiple factors that may have prevented it from being used more widely. For example:

- Sublocade is a relatively new treatment option, so prescribers may not be familiar with it.
- Sublocade is an injectable option that has to be administered by a health-care provider in-person as administering a substance by injection is a controlled act regulated by the *Regulated Health Professions Act*, while methadone and suboxone are taken orally and can be either taken under observation at a clinic or pharmacy or self-administered at home.
- Sublocade is quite expensive ($550 a dose, lasting for about a month), so it could be cost prohibitive for someone not eligible for Ontario Drug Benefit program coverage or other drug benefit plans.

- Sublocade is classified as a "limited use" drug in Ontario, meaning that it will only be reimbursed under specific clinical criteria or conditions, which could make clinicians more reluctant to prescribe it. Other medications used in OAT, such as methadone and suboxone, are classified as "general benefit" and have no restriction. Unlike Ontario, some provinces (such as Alberta and British Columbia) classify sublocade as "general benefit."

Recommendation 3

We recommend that the Ministry of Health:

- work with OAT providers to improve access to comprehensive or wraparound services (for example, primary care, mental health and addictions counselling, and social support) by offering these services either directly or through partnerships with other community service providers;
- work with hospitals, medical practitioners and regulatory colleges to identify best practices and ways to increase the availability of OAT offered by primary care providers and emergency departments; and
- work with clinical research experts and medical practitioners to assess whether all OAT medication treatment options are accessible to ensure different needs are met.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.4 RAAM Clinics

The Ministry began funding RAAM clinics in 2015. RAAM clinics are walk-in clinics intended to be a low-barrier option for people with any form of substance use to obtain quick access to addictions services, including opioid-related treatment such as OAT (see **Section 4.3**), without the need for a referral or appointment.

RAAM clinics differ across the province in terms of days and hours of operation, types of services offered (for example, assessment, counselling, medication treatment, connection or referral to community treatment programs and group supports), and location or organizational structure (for example, within a hospital or a community health centre). The number of RAAM clinics across the province increased from the initial 11 in 2015 to 81 in 2024 at the time of our audit. META:PHI is a clinician-led community of practice that supports health-care providers to deliver evidence-based, consistent care across RAAM clinics and other health-care settings.

4.4.1 Performance of RAAM Clinics Has Not been Monitored Due to Lack of Accurate and Complete Data

Our review of data related to RAAM clinics found no performance monitoring of these clinics, mainly due to deficiencies in the information collected and the reporting process, as well as concerns with data quality. Quality metrics were not used to measure and compare performance across these clinics.

We found that the process for collecting and reporting information is fragmented and inconsistent across the province. The level of detail collected varied from one RAAM clinic to another because of the absence of a provincial requirement and standards on data collection and reporting, as well as a lack of accurate and complete data on patient outcomes. Apart from financial and administrative reporting requirements set out in the accountability agreements between RAAM clinics and Ontario Health, the Ministry has not requested or collected any data related to RAAM clinics' operations, performance or patient outcomes.

META:PHI administers the only province-wide survey of all RAAM clinics to collect information about their operations. The majority of RAAM clinics voluntarily responded to the survey. META:PHI indicated that it has not been able to collect reliable patient-level data through the survey, as the clinics cautioned that they could not confirm data accuracy and completeness because some sites still rely on paper to record data and some sites have no ability or resources to pull data from their electronic medical records.

We also found that the lack of accurate and complete data had impeded the implementation of quality metrics to assess the performance and effectiveness of RAAM clinics. While META:PHI developed some quality metrics, these were only shared with RAAM clinics for consideration for their own internal reporting. No party has used these metrics to evaluate or monitor the performance of all RAAM clinics as that data is unreliable. As such, no province-wide assessment has ever been done to determine whether RAAM clinics are meeting needs and delivering the

expected outcomes, and whether certain RAAM clinics' practices and models are more effective (for example, being located in a hospital versus a community health centre, or having longer hours of operation per week).

Our review of the quality metrics developed by META:PHI noted that some of the metrics could have provided value if they had been appropriately used to monitor and evaluate the performance of RAAM clinics. Examples of these metrics include:

- availability of specific services such as peer and psychosocial support;
- availability of in-person, telephone, virtual and mobile appointments;
- medications being offered by clinicians for opioid use disorders;
- user satisfaction across the care journey;
- outcome measurements of RAAM users; and
- connecting users without a primary care provider to primary care and addiction resources.

Our discussion with RAAM clinics and other health-care providers noted varying opinions, as illustrated below, on the effectiveness of RAAM clinics depending on the organizational structure and hours of operation. As such, regular monitoring and assessment of the performance of RAAM clinics is important to identify best practices and areas for improvement, and to assess patient outcomes.

- Some service providers think establishing a RAAM clinic within a community health centre is the best use of resources because these centres typically already offer comprehensive care (including primary care, dietician care and social support) to vulnerable populations and those with an addiction who require these services on top of what a RAAM clinic can offer.

- Other service providers support having a RAAM clinic within a hospital because an emergency department is often the first interaction with the health-care system for people with an addiction, so it is important for a hospital to initiate addiction treatments such as OAT (which is currently lacking, as discussed in **Section 4.3.2**). Some service providers consider having a RAAM clinic within a hospital as a barrier because vulnerable populations generally avoid hospitals and would be more likely to seek and receive treatment in the community.

4.4.2 RAAM Clinics Were Not Available or Not Accessible in All Communities with the Highest Service Needs

Our review found that many RAAM clinics have limited hours of operation, and some communities do not have RAAM clinics in close proximity. These limitations could become barriers for people seeking, or continuing, addiction treatment.

Our review of the latest information collected by META:PHI through a survey of RAAM clinics noted significant variations in terms of service availability. Of the 71 RAAM clinics that responded to the survey, we found that 11 of them (or over 15%) offered access by appointment only, with no drop-in options available. Of the remaining 60 RAAM clinics that offered drop-in service (in-person and/or virtual), the majority of them did not operate every day and had limited hours of operation throughout the week. For example, almost 40 RAAM clinics (or over 60%) operated three days or less per week (see **Figure 11**) and over 30 RAAM clinics (or about 50%) operated 10 hours or less per week (**Figure 12**). As mentioned in **Section 4.4.1**, no province-wide assessment has ever been done to determine whether RAAM clinics are sufficiently meeting needs.

Our discussion with RAAM clinic personnel and physicians noted that funding and staffing constraints limited their ability to offer more days and hours of service per week. They acknowledged that services should ideally be flexible and available throughout the week. They also indicated the importance of drop-in services at RAAM clinics, because a patient's desire to get help is often fleeting and time-sensitive. If patients do not get immediate help through drop-in services when motivated to do so, they may change their minds, forget to attend their appointments and/or revert back to drug use.

Our review of the locations of RAAM clinics also found that not all communities with high service needs had a RAAM clinic in close proximity. For example, Belleville, which declared a state of emergency due to an opioid crisis in February 2024, did not have a RAAM clinic. The closest RAAM clinic was located at the Kingston Community Health Centre, which is about an hour's drive from Belleville. Funding was approved to set up a RAAM clinic in Belleville, which opened in August 2024.

Figure 11: Number of RAAM Clinics by Days per Week of Operation and Type of Service Offered, 2022
Source of data: META:PHI

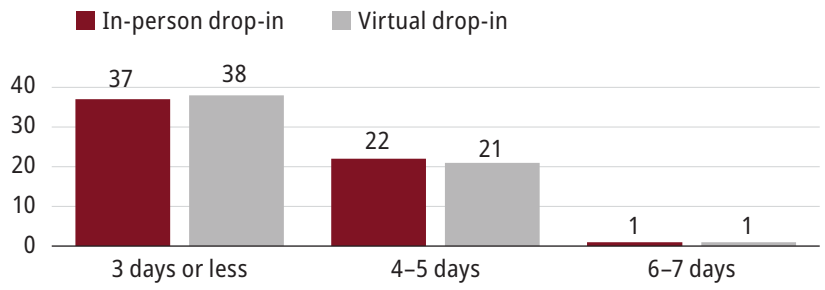
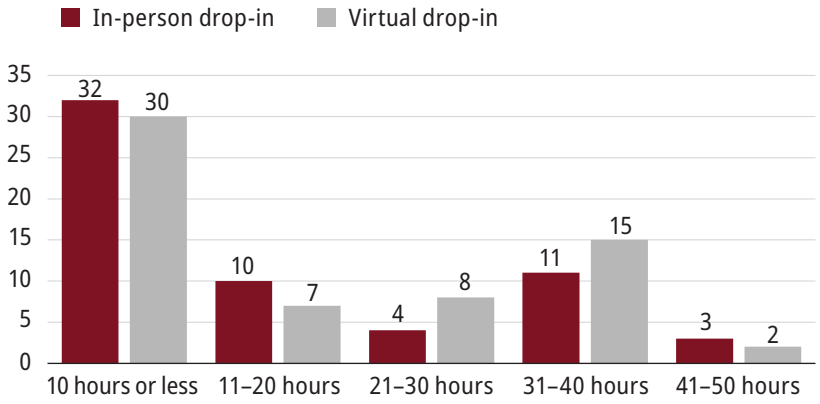


Figure 12: Number of RAAM Clinics by Hours per Week of Operation and Type of Service Offered, 2022

Source of data: META:PHI



Recommendation 4

We recommend that the Ministry of Health:

- conduct an evaluation on the availability, effectiveness and outcomes of RAAM clinics;
- use the evaluation results to identify areas of improvement and implement necessary changes to provide people with appropriate and timely access to services at RAAM clinics across the province; and
- develop and implement standard quality metrics to monitor the performance and outcomes of RAAM clinics on a regular basis.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.5 Naloxone Programs

Naloxone is a fast-acting drug that can temporarily reverse the effects of an opioid overdose. It helps save lives and is considered a key harm-reduction element in the opioid response. In Ontario, naloxone is available to eligible individuals for free, without prescription, through two core programs overseen by the Ministry: the ONP, launched in 2013, and the ONPP, launched in 2016. The programs' target populations include individuals at risk of opioid overdose, as well as their friends, family and/or people in a position to care for these at-risk individuals. **Figure 13** provides descriptions of the programs.

Over the years, the Ministry has expanded naloxone distribution by amending the ONP and ONPP, such as extending ONP eligibility to include more organization types, removing the ONPP requirement for recipients to present a health card, thereby lowering the barrier to naloxone access, and making naloxone available in both intranasal and injectable forms to cater to different preferences. As a result of these changes, we noted that:

- The total cost of these two programs increased by 190% (from $37 million in 2019/20 to $107 million in 2023/24). In 2023/24, ONPP accounted for the majority (about 73%) of the total cost.

- The total number of naloxone doses provided through these two programs increased from 430 in 2013 to about 2.1 million in 2023 (see **Figure 14**). Of the two programs, ONPP showed a more significant growth in recent years.

Figure 13: Naloxone Programs Administered by the Ministry of Health

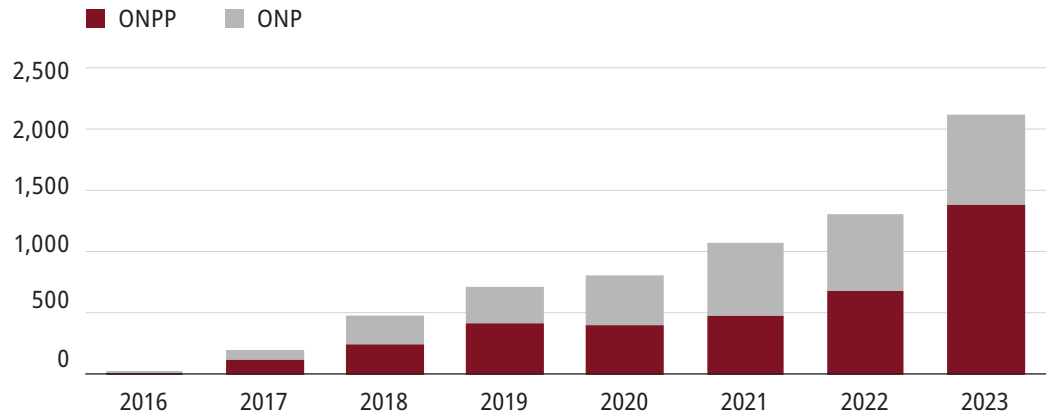
Source of data: Ministry of Health

	ONP	ONPP
Year of Implementation	2013	2016
Distribution Sites	896 participating community-based organizations[1]	4,263 participating pharmacies[2]
Procurement Process	The Ministry purchases and ships naloxone to sites that act as distribution hubs for other participating community-based organizations	The pharmacies purchase naloxone and submit claims to the Ministry for reimbursement after naloxone is distributed and training (if required) is provided
Cost in 2023/24	$29 million[3]	$78 million[4]

1. Eligible organizations and programs that choose to participate in ONP as of March 31, 2024, such as public health units, community health centres, outreach programs, shelters and emergency departments. In addition to the 896 sites, ONP also provides naloxone to 264 participating police services, fire services and St. John Ambulance branches for use during emergency responses.
2. Pharmacies that distributed at least one naloxone kit in 2023/24.
3. The cost of ONP covers procuring, warehousing and shipping naloxone.
4. The cost of ONPP covers the standard rates paid to pharmacies for purchasing and dispensing naloxone, as well as training individuals receiving an injectable naloxone kit for the first time.

Figure 14: Number of Naloxone Doses Provided Through Two Ontario Naloxone Programs, 2016–2023 (000s)

Source of data: Ontario Drug Policy Research Network



Note: Data for ONP and ONPP represent doses shipped to participating community-based organizations for distribution and doses that pharmacies submitted for reimbursement, respectively.

While the Ministry has succeeded in its goal to make naloxone more accessible, we found that it has not performed sufficient oversight or provided adequate and timely guidance to program participants to help ensure the appropriate and optimal use of funding.

4.5.1 Naloxone Claims from Pharmacies Were Not Monitored Adequately to Identify Inconsistent and Inappropriate Billing Practices

Unlike other provincial drug reimbursement programs, naloxone claims from pharmacies do not require prescriptions and do not have to include the recipient's health card information. Fewer requirements help to lower the barrier to naloxone access, but also increase the risk of inappropriate claims and lead to the need for an enhanced level of oversight.

As shown in **Figure 15**, the majority of the pharmacies we selected to visit had large naloxone claims and/or a significant increase in the number of claims over the five-year period

Figure 15: Naloxone Claims of Pharmacies Visited, 2019/20 and 2023/24

Source of data: Ministry of Health

Pharmacy	2019/20 ($)	2023/24 ($)	Increase ($)
A	420	2,090,540	2,090,120
B	179,675	904,205	724,530
C*	n/a*	676,185	n/a
D	4,439	156,705	152,266
E	3,055	128,590	125,535
F	56,705	111,585	54,880
G	42,635	95,170	52,535
H*	n/a*	87,405	n/a
I	18,180	31,500	13,320
J	350	6,590	6,240

Note: These pharmacies' 2023/24 naloxone claims ranked in the top three among pharmacies operating within the same city or public health unit, except Pharmacy J, which ranked outside the top 10 among pharmacies operating within the same city. However, fluctuations in claims were noted for Pharmacy J within the five years examined.

* Pharmacy was not in operation in that year.

from 2019/20 to 2023/24. Our review noted inconsistent billing practices among these pharmacies that were against the Ministry's policies or guidance. For example:

- **Claim submission process:** Instead of following program requirements to submit claims on the same day that naloxone kits and training were provided to recipients, two pharmacies indicated that they had occasionally submitted claims earlier (that is, when naloxone kits were received from their suppliers). This means the Ministry could be reimbursing pharmacies (including professional and applicable training fees) for naloxone kits that were not actually distributed.

- **Supporting documentation for claims:** The level of documentation maintained to support naloxone claims varied between pharmacies, with nine out of 10 pharmacies unable to provide sufficient documentation for all the claims we sampled. While ONPP is a low-barrier program, and identification information for naloxone recipients is not required to be collected, certain information (for example, details of the training provided) still needs to be retained as per program requirements. Although the Ministry had issued a notification to pharmacies on February 9, 2024, to clarify the documentation requirements (see **Section 4.5.2**), we noted exceptions in claims that were sampled from periods both before and after the notification date.

As discussed further in **Section 4.5.2**, the Ministry performs post-payment verification of pharmacy claims through its inspection program. Two out of the 10 pharmacies we visited were inspected by the Ministry over the past two years (2022 and 2023), with no naloxone-related recoveries resulting from those inspections.

4.5.2 Questionable or Unusual Distribution Practices by Pharmacies Were Not Addressed in a Timely Manner to Prevent Potential Abuse of ONPP

Instead of increasing efforts to provide naloxone kits to their existing customers with known opioid exposure, our visits to pharmacies and meetings with stakeholders noted that some pharmacies have distributed naloxone in atypical ways that may not conform with the ONPP's intent. In some occasions, they appeared to be taking advantage of the low-barrier nature of the ONPP to generate revenues. In a survey conducted by the Ontario College of Pharmacists in March 2024, about one-third of the responding pharmacy professionals expressed that they have faced "direction or pressure to dispense a set number/dollar amount of naloxone kits" at their workplaces.

Limited Ministry Oversight of Naloxone-Distribution Practices by Pharmacies

Our review of the ONPP claims data from 2019/20 to 2023/24 noted that the top distributing pharmacy had accumulated almost $40 million in naloxone claims, representing over 20% of the ONPP's total expenditure over the five-year period. Since as early as 2017, the Ministry had received complaints about a pharmacy professional at this pharmacy for providing free naloxone kits outside of the physical premises of the pharmacy and collecting the recipients' personal information to submit claims for payment to the Ministry.

The Ministry completed inspections of this pharmacy in December 2019 and January 2023, but the inspections only resulted in small recoveries (including about $33,500 in 2019 for discrepancies in naloxone claims) as naloxone-distribution practices were not within the scope of the inspection program. Findings noted in the December 2019 inspection were referred to the Ontario College of Pharmacists. The College investigated the conduct of the pharmacy professional involved and took certain disciplinary action against them for violating rules of the College.

In addition to this pharmacy, we also identified other questionable or unusual distribution methods among the 10 pharmacies we visited, as listed in **Figure 15**. For example, through observations, interviews and/or examination of records, we noted that:

- Some pharmacies we visited distributed the majority of naloxone kits through community outreach activities that took place outside the pharmacy. Some destinations for outreach included festivals, ski resorts, golf courses, shelters and conferences. We also noted aggressive outreach practices, such as distributing naloxone kits through direct solicitation with local businesses.

- Some pharmacies left naloxone kits in baskets for anyone to pick up, although naloxone is classified as a Schedule II drug that must be obtained directly from the pharmacist and kept away from public access (that is, not available for self-selection).

- One of the pharmacies we visited ran a website where people could order naloxone kits simply by providing a mailing address, without any follow-up inquiries.

While these activities and practices would have increased the distribution of naloxone, we question the appropriateness of the methods. Specifically:

- As confirmed with the Ministry, the intent of the ONPP has always been to distribute naloxone kits primarily within the physical locations of pharmacies.

- Outreach activities may not be reaching the right population and could overlap with the other provincial naloxone program that already uses shelters as a naloxone-distribution site, as discussed further in **Section 4.5.3.**

- For pharmacies using a website to take naloxone orders or offering free pick-up baskets, no real-time training would have been provided to recipients on how to use the kits and deal with opioid overdoses. Also, without any personal interactions, pharmacists would be unable to tell whether kit recipients actually understood the purpose of naloxone and had a need for it.

We found that the Ministry had not developed a mechanism to examine the effectiveness of the ONPP. It did not have a system in place to ensure that pharmacies do not abuse the program and that naloxone kits funded by the ONPP reach the intended population (that is, individuals at risk of opioid overdose and those who are in positions to care for that population) through proper distribution methods.

Delays in Clarifying Program's Intent and Requirements to Pharmacies

The Ministry issued a notification to pharmacies on February 9, 2024, followed by another one on July 24, 2024, to clarify the ONPP's intent and requirements in order to standardize distribution practices and address the unusual practices noted above. Both of these notifications were issued after the start of this audit. Key program updates included:

- The provision of naloxone kits must occur on-site at the physical premises of the pharmacy. The only exemption is when an individual who is already receiving care from the pharmacy is unable to physically attend the pharmacy to obtain the kit (for example, home-bound). In such a case, the pharmacy may deliver the naloxone kit to the individual at an address in Ontario.
- Training for individuals receiving naloxone kits must be provided on an individual basis, in real-time, either in-person or virtual, and not in group settings. Training consisting solely of instructional videos or websites is not permitted.
- Pharmacies must keep minimum records of the service provided, such as the type of naloxone kit provided, details of the training provided, the date of service, the name and address of the pharmacy, and the signature of the pharmacy staff who provided the kit (refer to the documentation issue identified in **Section 4.5.1**).

While the Ministry's notifications have clarified the ONPP's intent and requirements, we found the notification was overdue. The first notification was not issued until February 2024, almost seven years after the Ministry was made aware of unusual or questionable practices (similar to those identified above) through public complaints.

We also obtained email correspondence from 2019 in which Ministry staff informed a pharmacy that distributing naloxone outside of the pharmacy location "may be outside the scope of ONPP" and advised the pharmacy "to cease offering ONPP-funded kits through the online program until the ONPP review is finalized and policy decisions on any changes to the program are announced." This expectation was not communicated to all pharmacies at that time. Instead, the policy decisions were only clarified in the notifications issued to all pharmacies in 2024.

As a result of the notifications, some of the practices noted above, such as community outreach and use of free pick-up baskets, had stopped by the time we started visiting pharmacies in June 2024. One of the pharmacies we visited was distributing naloxone kits through a website. We found that this pharmacy was still taking naloxone orders online from anyone who would provide a mailing address by the time we completed our fieldwork in August 2024. This was against the Ministry's updated requirement, which only permits naloxone kits be distributed outside of a pharmacy's physical premises if the individual is already receiving care from the pharmacy and is unable to physically attend the pharmacy.

4.5.3 More Collaboration Between Naloxone Programs Needed to Enhance Distribution

The two Ministry-administered naloxone programs, ONP and ONPP, are complementary programs that use different distribution channels (community-based organizations and pharmacies, respectively) to maximize access to naloxone by individuals at risk of opioid overdose and their families and friends. Other individuals in positions to care for at-risk individuals may also be eligible under the ONPP. The questionable or unusual activities by pharmacies noted in **Section 4.5.2** showed that there are opportunities for these two programs to work more collaboratively to reach the target population in a more co-ordinated manner. For example:

- Instead of distributing naloxone to shelters through one-off outreach activities by pharmacies participating in ONPP, shelters should be encouraged to participate in ONP and become distribution sites to ensure that people in shelters, a known population at risk of opioid overdose, have continuous access to naloxone. Based on feedback from their respective participants, the two programs could also work together to identify communities and populations that may benefit the most from outreach activities, and co-ordinate such efforts to maximize naloxone accessibility and awareness among these groups.

- Rather than having pharmacies run their own naloxone-ordering websites to address the needs of those who are unable to physically obtain naloxone kits from pharmacies (for example, those who are home-bound), ONP and ONPP could better co-ordinate to address the needs of this population. For instance, some organizations participating in ONP are already offering mobile distribution services to deliver naloxone kits and related training to people in their communities, especially the homeless population, as part of their outreach programming. An expansion of this service to a larger population could be valuable to others who are currently relying on pharmacy-operated websites.

Recommendation 5

We recommend that the Ministry of Health:

- monitor naloxone claims (or any such pharmaceuticals in the future) from pharmacies regularly to identify red flags or risks of inappropriate billings that warrant further review and corrective action in order to prevent and deter recurrences;
- identify and address unreasonable or unusual naloxone-distribution practices by pharmacies regularly and follow up on a timely basis in order to ensure that they conform with the intent of the program; and
- strengthen the collaboration between the ONP and ONPP to maximize access to naloxone for people with needs in a more co-ordinated manner.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.6 Monitoring of Prescriptions and Physician Billing

4.6.1 Opioid Prescribing and Dispensing Were Not Monitored Adequately to Identify Concerning Trends

The Ministry established the Narcotics Monitoring System (NMS) in 2012 to collect dispensing data from community pharmacies on all monitored drugs, including opioids. Examples of data collected include prescriber and pharmacy identifications, as well as dispensed date, name, strength, quantity and estimated days' supply of the drugs dispensed. The Ministry intended to use NMS data to identify drug-utilization patterns, detect unusual activity, improve prescribing and dispensing practices, and intervene in potentially inappropriate practices. Despite these potential benefits, we found that NMS data has been underused.

While the Ministry provided more health-care professionals with access to NMS data (see **Section 4.6.3**) and used NMS data to produce practice reports for physicians (see **Section 4.6.4**), use of NMS data for monitoring and oversight was limited. Aside from reporting the system-level opioid-dispensing trends, the Ministry has not analyzed NMS data regularly to proactively identify concerning patterns at the prescriber or dispenser levels or other trends that warrant further review and action.

Our analyses of NMS data from 2019/20 to 2023/24, as well as our meetings with stakeholders, identified some opioid-prescribing or dispensing patterns and trends that warrant additional attention. Results of these analyses are summarized below.

Significant Increase in Number of High-Dose Opioids Dispensed

Although the number of opioid dispenses has remained steady over the last five years, we noted that the number of dispenses of high-dose opioids (that is, a daily dose equal to or exceeding 200 morphine milligram equivalents, or MMEs) increased by an estimated 147% between 2019/20 and 2023/24. We noted a similar trend among new opioid users, where the estimated number of dispenses of high-dose opioids also increased by 31% during the same period (see **Figure 16**). For reference, Health Quality Ontario's quality standards for prescribing opioids recommend that an initial opioid prescription for pain treatment should not exceed 50 MMEs per day. While this trend alone may not provide a complete picture of opioid prescribing practice, the Ministry has not performed analyses to understand the trend and determine its appropriateness.

Risk of Co-dispensing of Opioids and Benzodiazepines

Taking benzodiazepines (substances often used as sedatives and tranquilizers) and opioids together can cause serious breathing problems and increase the risk of overdose, and even death. The quality standard for opioid use disorder issued by Health Quality Ontario in 2018 highlighted the risk and indicated that the co-dispensing of these two medications should be avoided whenever possible.

Figure 16: Opioids Dispensed to All Users and New Users by Daily Dose and Percent Change, 2019/20–2023/24

Source of data: Ministry of Health

Daily Dose (MME)[1]	2019/20	2020/21	2021/22	2022/23	2023/24	% Change
Opioids Dispensed to All Users						
≤ 50	5,593,289	5,420,682	5,388,419	5,366,296	5,323,842	(5)
> 50 but < 200	1,631,607	1,535,571	1,511,012	1,464,219	1,419,627	(13)
≥ 200	**341,031**	**412,515**	**550,752**	**681,582**	**842,689**	**147**
Opioids Dispensed to New Users[2]						
≤ 50	739,224	688,142	728,657	765,905	775,593	5
> 50 but < 200	123,850	101,695	95,690	97,672	94,822	(23)
≥ 200	**1,153**	**1,224**	**972**	**1,168**	**1,506**	**31**

Note: The figure excludes opioids dispensed for OAT, as well as some forms of opioids (for example, injectables and suppositories) that do not have valid milligram morphine equivalent conversion factors. Opioids dispensed for OAT were identified using criteria that we developed based on research and input from a subject matter expert, but may be over/under identified due to data limitations.

1. MME stands for morphine milligram equivalent, which is a standardized measure of the total amount of opioid dispensed in a single prescription. According to quality standards, for chronic pain, opioid prescription should start at the lowest effective daily dose, preferably below 50 MMEs. For acute pain (for example, post-operative treatment), a maximum daily oral dose of 50 MMEs is recommended. In selected cases, the daily dose may be adjusted up to 90 MMEs per day if an individual is informed of the increased risk of harm.
2. We define new users of opioids as those who have not received an opioid in the previous 12 months.

This risk was also highlighted in a study released by the Ontario Drug Policy Research Network and Public Health Ontario in March 2024. Of the 783 benzodiazepine-related toxicity deaths between January 1, 2018, and June 30, 2022, the vast majority (98%) of these deaths involved other substances, most commonly opioids.

Based on our analysis of drug data, we estimated that in almost 20% of the instances when benzodiazepines were dispensed between 2019/20 and 2023/24, an opioid (with an indication for pain management) was also dispensed to the same individual at least once within seven days (before or after) of the benzodiazepine being dispensed. In some cases, we noted that more than five separate opioid prescriptions were dispensed within a two-week period.

Other Risk Factors Identified by Stakeholders

Aside from our analyses above, information we obtained from stakeholders also demonstrated a need for regular monitoring of opioid-prescribing and dispensing activities to identify and address at-risk patterns and trends. For example:

- While an increasing proportion of opioid-related deaths in recent years have involved non-pharmaceutical opioids (refer to **Figure 5** in **Section 4.1.1**), we learned from stakeholders that some people are first exposed to opioids through prescriptions, before progressing to the stronger and deadlier illegal supply. Therefore, it is important to monitor opioid prescriptions and address potentially abnormal trends in

a timely manner. An analysis from the Office of the Chief Coroner for Ontario on opioid-related deaths showed that almost half of the individuals who died of opioid-related toxicity in 2019 were found to have been dispensed legally prescribed opioids within two years prior to their death.

- Contrary to over-prescribing, some stakeholders also noted a "chilling effect" among some physicians who became hesitant to prescribe opioids, and even stopped prescribing them entirely or reduced the dosage without an appropriate tapering plan, to avoid scrutiny from authorities (for example, the Ministry and/or regulatory colleges). If not identified and addressed early and proactively, the "chilling effect" could lead to other issues over time.

4.6.2 Information on Opioid-Prescribing and Dispensing Activities Was Not Regularly Shared with Regulatory Colleges to Support Their Enforcement Work

Regulatory colleges are mandated to regulate their respective health-care professions (for example, physicians, dentists, pharmacists). As the data owner, the Ministry does not proactively provide the colleges with comprehensive information to support their efforts to guide professional conduct and uphold quality care from their professions. Currently, the Ministry only provides regulatory colleges with limited NMS data for investigation purposes upon request.

In the past, the Ministry did implement various initiatives to engage regulatory colleges in the area of prescription monitoring, but those initiatives have been discontinued. For example, in 2017 the Ministry formed a Prescription Monitoring Leadership Roundtable (PMLR), which included representatives from various regulatory colleges, to ensure that NMS data was used in an effective, consistent and evidence-based manner.

The PMLR proposed the implementation of a provincial prescription-monitoring system to respond to data analysis requests, establish common indicators and definitions, and provide reports for purposes ranging from quality improvement to quality assurance and enforcement. No PMLR meetings have been scheduled since the change in provincial government in 2018. As a result, there has been no regular forum for regulatory colleges and other stakeholders to share ideas and explore ways to optimize the use of NMS data.

Past investigations based on NMS data had potentially contributed to the "chilling effect" (see **Section 4.6.1**). However, given the risk associated with inappropriate opioid use, the Ministry and regulatory colleges need to work together to actively detect abnormal prescribing trends to deter health-care professionals from inappropriately prescribing and/or dispensing opioids.

We noted that governments in some other provinces, such as British Columbia and Saskatchewan, have funded prescription-monitoring programs that regularly analyze opioid-dispensing data. This analysis is used to either identify and follow-up on unusual activities at the practitioner-level or flag trends of concern at the system level to support regulatory colleges' quality assessment and investigative activities.

4.6.3 Not All Prescribers and Dispensers Had Real-Time Access to Drug-Dispensing Data

It is important for health-care professionals (for example, physicians, dentists, pharmacists) to have access to real-time NMS data at the point-of-care. This access can help them assess risks and make informed decisions when prescribing or dispensing opioids, which in turn can reduce the potential for duplicate prescriptions, harmful drug interactions and diversions (when an individual sells a prescribed opioid on the illegal market). Our analysis of NMS data from 2023/24 further illustrates the importance of access, as we estimated that almost 22% of individuals obtained opioids for pain treatment from more than one prescriber, with some having more than 20 prescribers within the year.

NMS data is available to users through the Digital Health Drug Repository (DHDR), which is funded by the Ministry and operated by Ontario Health. In general, access is granted to interested health-care professionals or organizations that fall within one of the eligible health information custodian groups (for example, hospitals, community health centres, physician practices and family health organizations).

While progress has been made in recent years to expand DHDR access to more users, we found that such access is still lagging among opioid prescribers and dispensers. This was an issue that was raised five years ago in our 2019 audit on Addictions Treatment Programs.

Opioid Prescribers

Opioids are primarily prescribed by physicians and dentists.

- **Physicians:** Although physicians are eligible for DHDR access, not all of them have obtained access as it is not mandatory. The Ministry is unable to determine the number of physicians who have (or do not have) access to the DHDR, as some could gain access through the eligible health-care organizations they work for and Ontario Health does not collect user-level information from these organizations.

- **Dentists:** While dentists can prescribe opioids for pain treatment, unlike physicians, they do not fall under one of the eligible health information custodian groups discussed above. Therefore, dentists do not have access to the DHDR, with the exception of dentists who work for an eligible organization (for example, a hospital). In contrast, other provinces, such as British Columbia and Saskatchewan, have made their provincial drug-dispensing repositories (which consist of records from community pharmacies) available for viewing by all professionals who can prescribe or dispense opioids.

Opioid Dispensers

In 2021, Ontario Health partnered with key stakeholders (for example, the Ontario Pharmacists Association, Ontario College of Pharmacists and large pharmacy chains) to launch a communications campaign among pharmacies to promote the adoption of "clinical viewer," a

web-based portal that provides users with access to digital clinical data repositories, including the DHDR. The campaign led to an increased uptake of DHDR access among pharmacies, but because access is not mandatory, we estimated that about 3,000 pharmacies (61%) were yet to be onboarded as of May 2024.

4.6.4 Not All Opioid Prescribers Had Fully Utilized or Had Access to Practice Reports to Improve Prescribing Practices

Ontario Health develops practice reports (using data from various sources, including NMS) for certain medical specialties to help drive quality improvement. These reports provide physician-level data and indicators that give an overview of a physician's practice activities, such as opioid prescribing, with comparable provincial and/or regional data to help physicians learn about and evaluate their practices in relation to their peers. It is not mandatory for physicians to sign up for these reports.

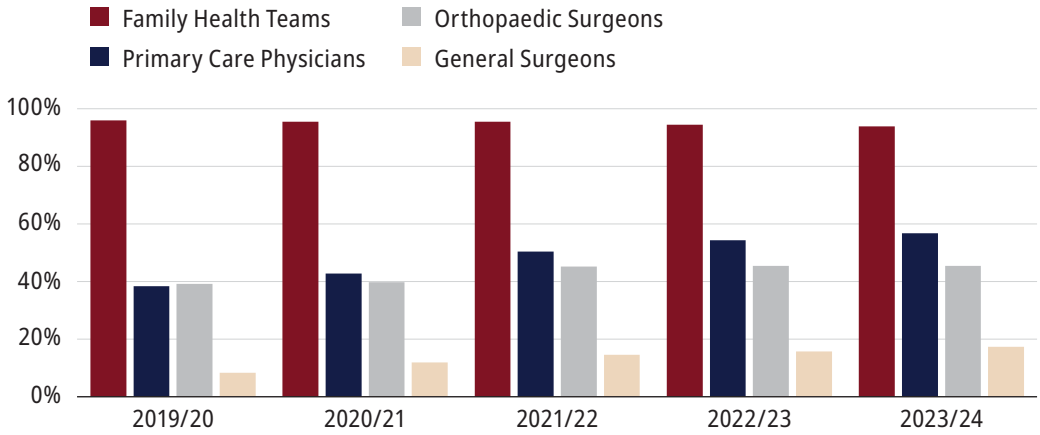
The first set of practice reports was developed for primary care physicians in 2013 by Health Quality Ontario (now part of Ontario Health). When the Ministry released the Opioid Strategy in 2016, it decided to leverage these practice reports to provide information that would help physicians understand and improve their opioid-prescribing practices. In 2017, the practice report for primary care physicians (including family health teams) was expanded to include opioid-related indicators on new opioid users, chronic opioid use, high doses dispensed and co-dispensing with benzodiazepines. Since then, practice reports have been developed for other medical specialty groups, including orthopaedic surgeons (2019) and general surgeons (2020), primarily focused on post-surgical opioid-prescribing patterns.

Despite providing valuable insight into one's opioid-prescribing practices, we found that the practice reports have not been utilized by all prescribers within the medical specialty groups that are eligible to receive the reports. Our analysis found that the uptake rates of practice reports have generally increased over the last five years, but vary significantly across the medical specialty groups (see **Figure 17**). As of March 31, 2024, the uptake rate was highest among family health teams (94%), followed by primary care physicians (57%), orthopaedic surgeons (45%) and, lastly, general surgeons (17%).

Practice reports are not available for all health-care professionals who have opioid-prescribing authority. For instance, no practice reports have been developed for dentists, who prescribed opioids to an estimated 17% of new opioid users (for pain treatment) in 2023/24. Ontario Health indicated that there is currently no plan to develop practice reports for the dentistry sector, as this is not a sector that Ontario Health typically supports and interacts with. Representatives from the Royal College of Dental Surgeons of Ontario that we spoke with indicated that practice reports, or other similar resources, could be helpful tools for dentists to understand and evaluate their opioid-prescribing behaviours and patterns.

Figure 17: Percentage of Physicians Receiving Practice Reports by Medical Specialty Group, 2019/20–2023/24

Source of data: Ontario Health



4.6.5 Oversight of Physician Billing for Addiction Medicine Services Continued to Be Lacking

As noted in **Section 4.3.1**, physicians who provide OAT are generally paid on a fee-for-service basis, where they bill OHIP directly for each person seen and served. People on OAT generally are required to see physicians either in-person or online for services, including an assessment, a prescription of medication (mainly methadone or suboxone) and/or a urine test to detect substance use. Physicians then submit their OHIP claims for services provided. As such, the fee-for-service model could incentivize physicians to see patients more frequently than necessary to make more money. Physicians seeing a large number of patients per day also raises concerns about the quality and comprehensiveness of care provided by OAT clinics, given the limited amount of time that physicians could spend with each patient.

Addiction medicine experts expressed concerns about physicians who require excessive numbers of patient visits and urine tests to increase their billings. A large private chain of OAT clinics also raised the same concern in its submission to the Ministry in 2020, indicating that there was evidence of "bad actors" who misused the fee-for-service model. The concerns have been growing, as virtual care is on the rise, with more physicians delivering addictions services via video and telephone to improve access and increase efficiency. The same issue was raised four years ago in our 2020 audit on Virtual Care: Use of Communication Technologies for Patient Care.

We identified the 150 physicians with the highest billings for addiction medicine services over the last five years, and reviewed these top billers' average and maximum numbers of patient visits in a single day to assess the reasonableness of these numbers relative to their billings. Of these 150 top billers for addiction medicine services, we identified that 50 of them billed $700,000 or higher in any year over the last five years, and only five out of the 50 (or 10%) were reviewed by the Ministry. In 2023/24, the top biller was reportedly seeing an average of 113 patients in-person and

Figure 18: Examples of Addictions Medicine Physicians with High Billings and Number of Daily Patient Visits, 2023/24

Prepared by the Office of the Auditor General of Ontario

Physician	Total Billings ($ 000)	Number of Patient Visits (per Day)*			
		Average		Maximum	
		In-Person	Virtual	In-Person	Virtual
A	**1,766**	113	74	304	191
B	**1,328**	112	29	253	116
C	**1,326**	63	51	181	152
D	**1,242**	96	27	171	88
E	**928**	63	59	152	148
F	**839**	64	45	143	131

Note: Total billings and patient visits are related to addiction medicine services provided by these physicians in 2023/24.

* The majority of in-person visits were for urine tests, while the majority of virtual visits were for assessment and/or prescription of medication. It is possible that a patient had both in-person and virtual visits on the same day (for example. the patient had a virtual visit and then went in person for a urine test).

74 virtually per day for addiction medicine services (that is, approximately 2.5 minutes per patient in an eight-hour work day), and billed almost $1.8 million for providing these services.

Figure 18 provides anonymized examples of physicians with significantly high billings and high reported numbers of patient visits for addiction medicine services in 2023/24. As these physicians also provided other non-addictions services, their total billings and number of patient visits were even higher than the numbers presented.

Among the examples of physicians included in **Figure 18**, we noted that the Ministry reviewed two of them, but the review was not timely or effective, as these physicians' billings and patient visits remained unreasonably high subsequent to the Ministry's review. For example:

- One physician (Physician F) was cautioned by the Inquiries, Complaints and Reports Committee (ICRC) of the College of Physicians and Surgeons of Ontario (CPSO) in February 2019 as a result of two patient complaints, which involved issues such as never seeing the physician and only interacting with the physician assistant to receive their prescription. The CPSO could not find any evidence that the physician had reviewed the work of the physician assistant. The Ministry reviewed this physician's billings in 2022, three years after the physician was cautioned by the CPSO, and also noted concerns such as billing for an excessive number of urine tests for patients who were in a stable condition and an inability to prove that the services billed were provided to patients personally. While the Ministry provided this physician with billing education, we noted that this physician's billings continued to remain high subsequent to the Ministry's

review in 2022. For example, in 2023/24, in addition to about $839,000 in addiction-related billings as noted in **Figure 18**, this physician also had non-addiction related billings of about $1.5 million.

- The Ministry reviewed another physician (Physician E) in 2020 and noted high billings and instances where this physician billed in excess of 160 virtual patient visits per day, but no further action was taken. We noted that this physician continued to bill for a high number of patient visits subsequent to the Ministry's review, seeing up to 152 patients in-person and 148 patients virtually a day in 2023/24, as noted in **Figure 18**.

In addition to the examples noted in **Figure 18**, we identified another physician who was required by CPSO's ICRC in 2017 to complete continuing education as a result of concerns arising from the physician's practice, including "quick visits" with patients.

A 2017 study by researchers and clinicians also found that a majority of patients in Ontario who were consuming opioids were receiving OAT services from a small number of physicians who carried high daily patient volumes, raising concerns about the quality of care provided by these physicians. The study suggested that future research be conducted to examine the quality of services provided to OAT patients in Ontario and how clinical outcomes were impacted.

Recommendation 6

We recommend that the Ministry of Health:

- perform regular analyses and follow-up on unusual cases or trends of opioid-prescribing and dispensing activities;
- share information on unusual cases or trends of opioid-prescribing and dispensing activities identified with the regulatory colleges as necessary on a regular basis to help facilitate their quality improvement and enforcement activities;
- actively promote health-care professionals' access to data in the NMS through the DHDR and evaluate whether such access should be mandatory among those who frequently prescribe or dispense opioids, including physicians, dentists and pharmacies;
- work with Ontario Health to expand the use of practice reports by raising awareness and encouraging adoption of these reports among eligible physicians, as well as developing practice reports for health-care professionals who are currently ineligible but who frequently prescribe opioids (for example, dentists); and
- conduct a comprehensive review of physician billings related to opioid care to identify outliers with unreasonable billings and patient volumes, and refer cases that warrant further investigation to the CPSO.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.7 Emerging Practices

4.7.1 Emerging Practices Exist in Isolation and Require Evaluation

While methadone, suboxone and sublocade are considered the primary forms of medication treatment for OAT in Ontario (see **Section 4.3**), we found that service providers in Ontario and other provinces have started offering other forms of treatment that have yet to be fully evaluated for effectiveness and outcomes.

Safer Opioid Supply

Safer Opioid Supply (SOS), a harm-reduction approach, is meant to prescribe certain types of opioids to people as a safer alternative to illegal opioids, so that people are less likely to seek opioids from illegal sources. Typically, SOS involves prescribing hydromorphone, which is a potent opioid that is generally prescribed as a painkiller for treating cancer-related pain or acute pain in specific clinical situations (for example, after surgery). Currently, some SOS programs exist in Ontario. They are funded by Health Canada, and the Ministry provides indirect funding through physician payments or organizations (for example, community health centres) where physicians or nurse practitioners provide SOS.

Safer Opioid Supply (SOS), a harm-reduction approach, is meant to prescribe certain types of opioids to people as a safer alternative to illegal opioids, so that people are less likely to seek opioids from illegal sources.

Through discussions with service providers and clinical experts, we found significant differences in opinions on the use of SOS in treating opioid addiction. Specifically:

- Some service providers strongly opposed the use of SOS because they believe that SOS does not provide the same treatment value as OAT. These service providers also raised concern about the risk of diversion, as many SOS providers allow people to take tablets home, and people may then sell the drugs on the illegal market. For example, London Police Service seized eight-milligram Dilaudid tablets (a brand name of hydromorphone), some of which were prescribed as part of SOS and subsequently diverted into the community. According to a November 2023 submission by a group of addiction clinicians in Ontario to Health Canada, which funds some SOS programs in Ontario, there was evidence that diversion of take-home hydromorphone tablets was common. Both this submission and one of its authors who we met with indicated that SOS has treatment value in certain cases, but cautioned that consumption should be supervised to avoid people selling the tablets.

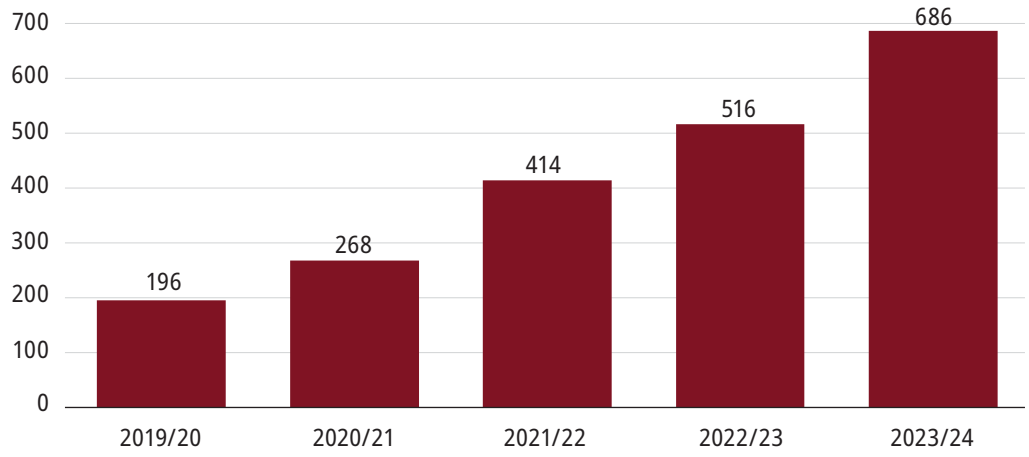
- Other service providers felt strongly that SOS has value because it prevents people from getting opioids from the illegal market. SOS also helps curb illegal drug use for people who are in situations where traditional treatments such as OAT alone are not working.

Based on our data analysis, we estimated that the dispensing of hydromorphone through SOS increased by 251% between 2019/20 and 2023/24 (see **Figure 19**). Despite the increasing prevalence of SOS in Ontario, the Ministry has not taken any action to evaluate the extent of SOS's adoption, as well as its effectiveness and outcomes, in order to determine the role of SOS in the Province's opioid response going forward. Also, because the existing SOS programs in Ontario are not provincially funded, the Ministry has not issued any policies or guidelines to address the risk of diversion.

Our jurisdictional review noted that in March 2024, the Auditor General of British Columbia released a report that indicated that British Columbia has implemented a prescribed safer supply program and collected data related to service utilization, program outputs and population-level impacts. British Columbia also initiated an evaluation of the program, although the results were not available at the time of our audit.

Figure 19: Estimated Number of Hydromorphone Doses Dispensed as SOS, 2019/20–2023/24 (000s)

Source of data: Ministry of Health



Note: The Ministry's NMS does not identify whether hydromorphone was dispensed as part of SOS or for pain management. Data presented in the figure includes the hydromorphone most likely tied to SOS (four-milligram or eight-milligram hydromorphone tablets) identified based on our research and input from a subject matter expert, but may be over/under identified due to this data limitation.

Injectable Opioid Agonist Therapy

Injectable opioid agonist therapy (iOAT) offers an alternative to people who have not benefitted from other common forms of OAT that use oral medication (that is, methadone or suboxone), as mentioned in **Section 4.3.** Similar to SOS, iOAT typically uses hydromorphone, but the key difference is that it is in an injectable form and must be administered under supervision. As with SOS, the Ministry does not fund iOAT, and iOAT providers rely on funding from Health Canada or other sources to run their programs. Health Canada told us that it currently only funds one iOAT site in Toronto. The Ministry was also informed by addictions medicine practitioners that there is another iOAT program in Ottawa.

The aforementioned November 2023 submission by a group of Ontario addiction clinicians recommended that iOAT be prioritized over SOS, primarily because the supervised nature of iOAT reduces the risk of diversion and injection-related infections. The submission also noted that Health Canada should consider expanding iOAT by partnering with provinces to cover the costs. We met with a provider of an iOAT program in Toronto. While the program has had positive results (for example, 60% of people on iOAT stopped using fentanyl from the illegal market), it will likely stop once the temporary federal funding comes to an end in 2024/25, as the Province has not indicated whether it will take over the funding.

Our jurisdictional review noted that iOAT has been used in other provinces (for example, British Columbia and Alberta) and European countries (for example, Switzerland, the Netherlands and the United Kingdom).

Recommendation 7

We recommend that the Ministry of Health work with clinical research experts to conduct comprehensive evaluations of emerging practices being implemented in other jurisdictions (for example, SOS and iOAT) to assess their effectiveness and make an evidence-informed decisions on whether these practices should be considered for implementation in Ontario.

For the auditee's response, see **Recommendations and Auditee Responses**.

Recommendations and Auditee Responses

Recommendation 1

We recommend that the Ministry of Health:

- develop a new holistic strategy including all best practices targeted at addressing the current drivers of the opioid crisis, reducing opioid-related harms, and preventing opioid addiction and overdose;
- develop a clear governance, accountability and leadership structure to guide work on the provincial health sector's responses to the opioid crisis;
- identify and implement outcome-based performance measures to evaluate progress of work and initiatives under the Opioid Strategy, and report annually on the results; and
- work with the MHA CoE on improving the provincial mental health and addictions data in order to assess the needs, availability and effectiveness of services for people with opioid addiction and co-occurring mental health issues.

Ministry of Health Response

The Ministry agrees with this recommendation.

The government's approach is to develop a comprehensive continuum of care for mental health and substance use disorders that includes opioid addictions through historic investments in the Roadmap to Wellness strategy and the Addictions Recovery Fund. The Ministry will evaluate this approach and build out a full continuum of care and develop new strategies to reduce opioid-related harms, prevent addiction and overdoses, and support people with addictions into recovery and treatment.

The Ministry will review its existing governance structures and processes, including its steering committee, and its co-ordination and oversight with public health units and with Ontario Health. The Ministry will also work with the MHA CoE in Ontario Health to better align their mental health and addictions system oversight model into future system design and oversight, including but not limited to their advisory committees focused on substance use disorders.

The Ministry recognizes the need for identifying and implementing outcome-based performance measures and will continue to work with the MHA CoE in Ontario Health, who is leading the development of the data strategy that will support evidence-based decision-making and assess progress on programming and initiatives related to substance use disorders and concurrent mental health issues.

Recommendation 2

We recommend that the Ministry of Health complete all necessary planning work before transitioning to the new HART Hubs, including:

- working with providers to support CTS users being impacted by any closure of a CTS site and to perform impact, risk and financial analysis;
- engaging with all relevant stakeholders;
- developing a performance measurement plan; and
- deploying public health measures in areas where supervised consumption services sites are closing.

Ministry of Health Response

The Ministry agrees with this recommendation.

As announced, the government has introduced legislation that, if passed, would result in the closure of CTS sites within the 200-metre buffer. Any CTS site that is closing has the opportunity to transition into a HART Hub.

The Ministry is committed to working with providers to support clients who may be impacted by the closure of any CTS sites. This includes:

- Working with potentially impacted CTS sites that fall within the 200-metre buffer to transition into a HART Hub. CTS sites converting to HART Hubs will be eligible for more funding and be able to offer a suite of addiction, mental health and other treatment services not previously available to them as a CTS.
- Outreach to public health units to update their harm reduction strategies to enhance programs and partnerships that would identify alternatives to the services previously provided by a closing CTS site.
- CTS sites that are planning to convert to a HART Hub by March 31, 2025, are also required to develop wind-down plans that outline impacts, risk and financial analysis, timelines, communication with existing clients, and referrals to other health services.
- For the CTS sites that will continue, increased data collection and monthly reporting will assist with impact assessments and transition from supervised consumption to HART Hub services.

As part of the HART Hub three-year Demonstration Project, there will be a third-party evaluation to determine outcomes, lessons learned and areas for improvement. Results of the evaluation will inform future decisions on mental health and addictions services, including HART Hubs in Ontario.

The Ministry will require HART Hubs and other health service providers to collect the necessary data to support the evaluation.

Recommendation 3

We recommend that the Ministry of Health:

- work with OAT providers to improve access to comprehensive or wraparound services (for example, primary care, mental health and addictions counselling, and social support) by offering these services either directly or through partnerships with other community service providers;
- work with hospitals, medical practitioners and regulatory colleges to identify best practices and ways to increase the availability of OAT offered by primary care providers and emergency departments; and
- work with clinical research experts and medical practitioners to assess whether all OAT medication treatment options are accessible to ensure different needs are met.

Ministry of Health Response

The Ministry agrees with this recommendation.

The Ministry recognizes the importance of integrated care models. It will build on the existing work currently under way, including RAAM Clinics, Youth Wellness Hubs, and HART Hubs, and leverage work in existing communities of practice for addictions medicine. The Ministry will review opportunities to increase access to wraparound care for clients who receive OAT, including in hospitals, primary care and other health-care settings.

The Ministry will work with partners in the health sector to support and implement an integrated and evidence-based care continuum for substance use disorder. This continuum includes but is not limited to primary care, OAT clinics, RAAM clinics and hospitals. The Ministry acknowledges that the list price for drug products is determined by pharmaceutical manufacturers and subject to oversight nationally by the Patented Medicines Prices Review Board.

Recommendation 4

We recommend that the Ministry of Health:

- conduct an evaluation on the availability, effectiveness and outcomes of RAAM clinics;
- use the evaluation results to identify areas of improvement and implement necessary changes to provide people with appropriate and timely access to services at RAAM clinics across the province; and

- develop and implement standard quality metrics to monitor the performance and outcomes of RAAM clinics on a regular basis.

Ministry of Health Response

The Ministry agrees with this recommendation.

The Ministry is working with the MHA CoE in Ontario Health to assess the availability and effectiveness of, and to standardize and monitor, community mental health and addictions services, including RAAM clinics. This work will be used to identify opportunities to improve timely access to clinic services and develop performance metrics.

The Ministry will also work with the MHA CoE on ensuring that their mental health and addictions system plan for implementation of the Roadmap to Wellness, which is under development, incorporates plans for an integrated and evidence-based care continuum for substance use disorder. This continuum includes but is not limited to primary care, OAT clinics, RAAM clinics and hospitals.

The MHA CoE is implementing a data strategy which includes a provincial dataset for the purposes of evidence-informed decision-making. This data will provide for improved planning, performance management and outcome monitoring.

Additionally, the Ministry is working with the MHA CoE and Canadian Institute for Health Information (CIHI) to expand the Ontario Healthcare Financial and Statistical System (OHFS) chart of accounts to include a RAAM-specific functional centre, which will enable more effective performance monitoring.

Recommendation 5

We recommend that the Ministry of Health:

- monitor naloxone claims (or any such pharmaceuticals in the future) from pharmacies regularly to identify red flags or risks of inappropriate billings that warrant further review and corrective action in order to prevent and deter recurrences;
- identify and address unreasonable or unusual naloxone-distribution practices by pharmacies regularly and follow up on a timely basis in order to ensure that they conform with the intent of the program; and
- strengthen the collaboration between the ONP and ONPP to maximize access to naloxone for people with needs in a more co-ordinated manner.

Ministry of Health Response

The Ministry agrees with this recommendation, which is aligned with actions that the Ministry has taken.

Red flags and inappropriate billings as well as unreasonable or unusual naloxone-distribution practices by pharmacies that warrant further action are addressed through the Ministry's inspection process and review of quarterly reports. If the Ministry observes unusual billings or practices during the course of an inspection or review of quarterly reports, referrals to appropriate regulatory bodies (e.g., Ontario College of Pharmacists, Ontario Provincial Police) may be made where warranted.

With respect to unreasonable or unusual naloxone-distribution practices by pharmacies, the Ministry provided clarifications on the requirements of the ONPP in Executive Officer communications materials issued on February 9, 2024, and July 24, 2024, and had since noted a decline in the naloxone claims under the ONPP.

Regarding the collaboration between the ONP and ONP, since 2016, these two programs have been working together to meet Ontarians' needs. Going forward, the Ministry will identify opportunities to strengthen the co-ordination of these two programs.

Recommendation 6

We recommend that the Ministry of Health:

- perform regular analyses and follow-up on unusual cases or trends of opioid-prescribing and dispensing activities;
- share information on unusual cases or trends of opioid-prescribing and dispensing activities identified with the regulatory colleges as necessary on a regular basis to help facilitate their quality improvement and enforcement activities;
- actively promote health-care professionals' access to data in the NMS through the DHDR and evaluate whether such access should be mandatory among those who frequently prescribe or dispense opioids, including physicians, dentists and pharmacies;
- work with Ontario Health to expand the use of practice reports by raising awareness and encouraging adoption of these reports among eligible physicians, as well as developing practice reports for health-care professionals who are currently ineligible but who frequently prescribe opioids (for example, dentists); and
- conduct a comprehensive review of physician billings related to opioid care to identify outliers with unreasonable billings and patient volumes, and refer cases that warrant further investigation to the CPSO.

Ministry of Health Response

The Ministry agrees with this recommendation.

There is an established process for sharing of NMS data and analytical requests from the regulatory colleges. The Ministry is committed to using the NMS to detect and analyze unusual prescribing and dispensing practices within the limitations of the NMS claims data. The Ministry

agrees to meet with regulatory colleges and discuss how to improve monitoring of dispensing and prescribing practices through the use of NMS data.

The Ministry will work on further expanding access to the data held within the DHDR. This includes direct integration for community-based health-care providers (using OntarioMD certified electronic medical records) and through the provincial clinical viewers. There are continued efforts to grow the number of health-care providers accessing DHDR, including ongoing adoption of the clinical viewers in pharmacies. The Ministry will also engage with stakeholders such as the CPSO to raise awareness of the availability of dispensing data through the DHDR.

The Ministry, together with Ontario Health, will work on further expanding the use of practice reports, which is aligned with actions taken. Ontario Health engaged with the CPSO to promote increased attention and participation in the MyPractice Report among physicians through various initiatives. For example, Ontario Health recently released the MyPractice Primary Care Plus report to consolidate and streamline access to multiple reports, and also developed a Continuing Medical Education accredited learning series to support uptake of the MyPractice Report and improve use of the data by family physicians. The next phase of the initiative will be focused on enhancing the new report (with new and/or updated indicators and methodology) and possible expansion of the report to health-care professionals who currently are ineligible to receive the reports (i.e., Nurse Practitioners).

The Ministry will regularly monitor for inappropriate billing, which would include reviews of physicians who may be inappropriately billing for opioid care. If a potential concern involving "opioid-related billing" was referred to the Ministry, the Ministry would open an audit as per the process posted on the Ministry's website. This includes actions that can be taken and when referrals are made to the regulatory colleges.

Recommendation 7

We recommend that the Ministry of Health work with clinical research experts to conduct comprehensive evaluations of emerging practices being implemented in other jurisdictions (for example, SOS and iOAT) to assess their effectiveness and make an evidence-informed decisions on whether these practices should be considered for implementation in Ontario.

Ministry of Health Response

The Ministry agrees with this recommendation.

The Ministry will assess opportunities to undertake targeted assessments of promising approaches to, and strategies for, mitigating the negative impacts of opioids that are being used in other jurisdictions.

The Ministry will also work with Ontario Health to identify promising practices, and will deploy research assets (both internal capacity and external partners' capacity) on an as-needed basis to evaluate their suitability for implementation in Ontario.

Audit Criteria

In planning our work, we identified the audit criteria we would use to address our audit objectives (outlined in **Section 3**). These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry of Health reviewed and agreed with the suitability of our objectives and associated criteria:

1. Effective governance structures with clear roles and accountabilities are in place to support the development, implementation and monitoring of opioid strategy and initiatives.

2. Access to evidence-based services for people who require opioid-related services is inclusive, equitable and timely across the province to meet the needs of Ontarians.

3. Co-ordination and integration between service providers is in place to connect people who require opioid-related services to other necessary services, to enhance the quality and continuity of care.

4. Monitoring processes and systems are in place to collect and maintain complete dispensing records of opioid prescriptions, and share information with service providers and regulatory colleges to support appropriate prescribing and dispensing and to take corrective actions against any issues identified.

5. Appropriate and relevant performance measures and targets are established for opioid strategy and initiatives, monitored regularly against actual results, and publicly reported on to ensure that intended outcomes are achieved and corrective actions are taken on a timely basis when issues are identified.

Audit Approach

We conducted our audit between January 2024 and October 2024. We obtained written representation from the Ministry of Health (Ministry) management that, effective November 27, 2024, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

As part of our audit work, we:

- interviewed key personnel at the Ministry and Ontario Health's MHA CoE;
- examined relevant legislation and regulations, as well as documentation related to the 2016 Opioid Strategy;
- reviewed data and reports from the Office of the Chief Coroner for Ontario and Public Health Ontario;
- performed data analyses on opioid-related deaths and emergency department visits, opioid prescription and dispensing activities, and physician billings;
- met or spoke with representatives and subject-matter experts, including emergency and addiction medicine physicians, from various entities below:
  - Addictions & Mental Health Ontario
  - Canadian Mental Health Association
  - Chiefs of Ontario
  - College of Physicians and Surgeons of Ontario
  - ConnexOntario
  - Essex-Windsor Emergency Medical Services
  - Families for Addiction Recovery
  - Hastings-Quinte Paramedic Services
  - Health Sciences North Research Institute
  - META:PHI
  - Ontario College of Pharmacists
  - Ontario Drug Policy Research Network
  - Royal College of Dental Surgeons of Ontario
  - Toronto Paramedic Services

Audit Approach (Continued)

- conducted site visits or met with providers of opioid-related services below:
  - Anishnawbe Health Toronto
  - Belleville General Hospital
  - Canadian Addiction Treatment Centres
  - Coderix Medical Clinic
  - Kingston Community Health Centre
  - London Intercommunity Health Centre
  - Ottawa Inner City Health
  - Parkdale Queen West Community Health Centre
  - Safe Health Site Timmins
  - Sandy Hill Community Health Centre
  - St. Michael's Hospital
  - The Works (Toronto Public Health)
  - Timmins and District Hospital
  - trueNorth Medical Centres
  - Unity Health Toronto
- conducted site visits and testing at a sample of pharmacies that participated in the naloxone programs; and
- performed benchmarking and jurisdictional comparisons where applicable.

Audit Opinion

To the Honourable Speaker of the Legislative Assembly:

We conducted our work for this audit and reported on the results of our examination in accordance with Canadian Standard on Assurance Engagements 3001—*Direct Engagements* issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies Canadian Standards on Quality Management and, as a result, maintains a comprehensive system of quality management that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our conclusions.

December 3, 2024

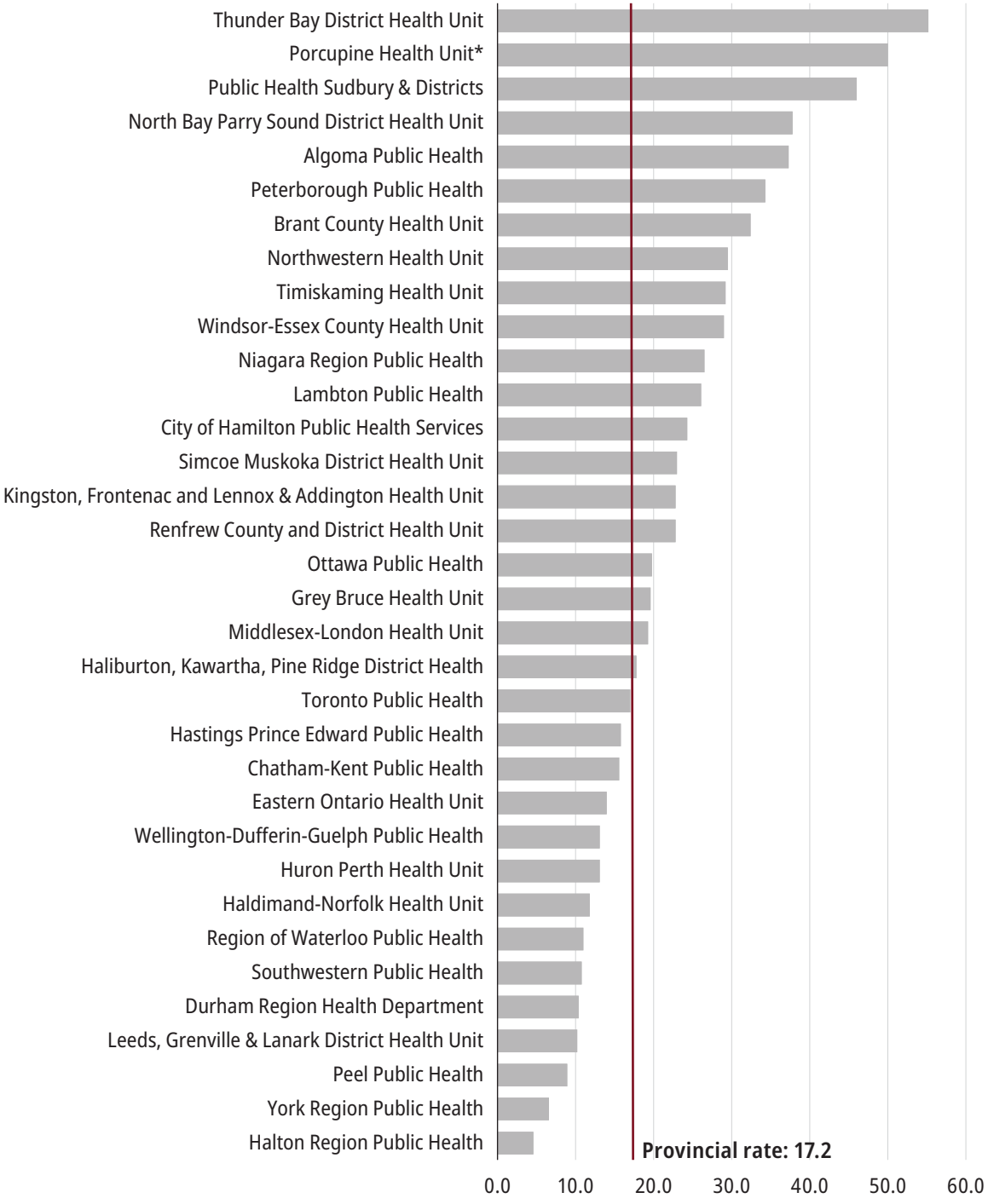
Shelley Spence, FCPA, FCA, LPA
Auditor General
Toronto, Ontario

Acronyms

Acronym	Definition
2SLGBTQQIA+	Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex and Asexual
CMOH	Chief Medical Officer of Health
CPSO	College of Physicians and Surgeons of Ontario
CTS	Consumption and Treatment Services
DHDR	Digital Health Drug Repository
iOAT	Injectable Opioid Agonist Therapy
HART	Homelessness and Addiction Recovery Treatment
ICRC	Inquiries, Complaints and Reports Committee
META:PHI	Mentoring, Education, and Clinical Tools for Addiction: Partners in Health Integration
MHA CoE	Mental Health and Addictions Centre of Excellence
MMEs	Morphine Milligram Equivalents
NMS	Narcotics Monitoring System
OAT	Opioid Agonist Therapy
ONP	Ontario Naloxone Program
ONPP	Ontario Naloxone Program for Pharmacies
PMLR	Prescription Monitoring Leadership Roundtable
RAAM	Rapid Access Addiction Medicine
SOS	Safer Opioid Supply

Appendix 1: Opioid-Related Death Rate by Public Health Unit, 2023 (per 100,000 people)

Source of data: Public Health Ontario



* Timmins falls under Porcupine Health Unit.

Appendix 2: Ministry of Health's Performance Indicators for the 2016 Opioid Strategy

Source of data: Ministry of Health

Performance Indicators		Consistently Tracked
Overall Outcomes[1]		
1.	Number and rate of emergency department visits for opioid overdose	✓
2.	Number and rate of hospitalizations for opioid overdose	
3.	Number and rate of opioid-related deaths	✓
Pillar 1: Appropriate Prescribing and Pain Management		
4.	Milligram morphine equivalents (MMEs) per population	
5.	Percentage of people who are prescribed opioids and subsequently develop an opioid addiction	
6.	Proportion of opioid-related deaths where the patient was dispensed an opioid in the previous seven days	
7.	Number and rate of patients newly started on opioids (within six months)	
8.	Number and rate of patients newly started on opioid dosages of over 50 and 90 MMEs daily	
Pillar 2: Treatment for Opioid Use Disorder		
9.	Number and proportion of patients who were referred from RAAM clinics to primary care	
10.	Wait time for access to RAAM clinics	✓
11.	Proportion of emergency department visits for opioid overdose where the patient was dispensed an OAT medication in the previous seven days	
12.	Proportion of opioid-related deaths where the patient was dispensed an OAT medication in the previous seven days	
13.	Wait times for RAAM patients to see an addictions specialist[2]	
Pillar 3: Harm Reduction		
14.	Number of naloxone kits and refills ordered per naloxone program site[3]	✓
15.	Number of CTS site client visits	
16.	Number of referrals to treatment, health and social services provided to clients at CTS sites	
17.	Number of (self) reports of naloxone administration	

	Performance Indicators	Consistently Tracked
18.	Number of overdoses reversed/treated with (a) oxygen/rescue breathing (b) naloxone at CTS sites	
19.	Number of public health units and public health unit regions with opioid response plans	✓
20.	Number of needles/syringes distributed[2]	✓
21.	Number of client contacts made by harm-reduction workers[2]	✓
Pillar 4: Surveillance		
22.	Number of public health units and public health unit regions with early warning systems	✓
23.	Number of warnings issued by public health units and public health unit region partners	✓
24.	Weekly emergency department opioid-overdose reporting[2]	✓

Note: This table reflects 24 performance indicators relevant to the 2016 Opioid Strategy. This includes 20 performance indicators originally provided by the Ministry during our 2019 audit of Addictions Treatment Programs and reported in **Appendix 9** of that audit report, as well as four new indicators that were subsequently implemented.

1. Cross-cutting indicators that apply to all pillars.
2. New indicator implemented by the Ministry after our 2019 audit.
3. This indicator was revised in 2021 from the number of naloxone kits and refills distributed to the number of naloxone kits and refills ordered.

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