CPSO's safer supply amendments: what does the evidence say?

How the CPSO's October 13, 2026 safer opioid supply (SOS) amendments compare with Ontario research.

WHAT CPSO DECIDED

- **No take-home doses:** every SOS dose observed by a health professional, indefinitely, for all ~5,300 Ontarians on SOS.[1,2]
- **OAT required** alongside any SOS prescription.[1]
- **Stated intent:** reduce hydromorphone diversion and move people to OAT; the Board noted diversion from SOS is unquantified.[1]

These amendments are expected to be fully enacted by November 16, 2026.

WHY SOS: MORE TOOLS FOR THE FENTANYL ERA

Fentanyl is potent and short-acting. OAT remains essential for the people it works for, but it was built for a pre-fentanyl supply. SOS is an adaptation that responds directly to the toxicity of the current drug supply and engages people whom OAT alone has not reached.

193 → 86 days
median time on methadone dropped from 2014-16 vs 2020-22, as fentanyl became more present in the drug supply[3]

87.4%
of people starting SOS had already received OAT in the prior year[4]

9 vs 3.5 months
average retention on SOS vs matched people starting methadone[4]

Fewer harms
after starting SOS in Ontario: fewer opioid toxicity events, ED visits, admissions and infections[4,5]

Evidence check 1 · Requiring OAT

Already common: ~80% of SOS recipients are on OAT.[6] But OAT doesn't work for everyone, and the CPSO amendments remove the option for prescribing SOS to those OAT hasn't helped.

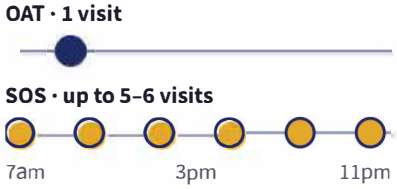
Evidence check 2 · How requiring witnessed doses conflicts with the evidence

1 · Conflicts with OAT evidence

Among 21,000+ Ontarians on OAT, starting take-home doses was linked to **lower** risk of opioid toxicity, treatment interruption and discontinuation.[7] Guidance requires daily witnessed dosing only at initiation or when clinically indicated.[8]

2 · SOS is not OAT: one visit becomes many

OAT is long-acting: one witnessed dose covers the day. Hydromorphone, like fentanyl, is short-acting, so witnessing every dose means a pharmacy trip every 2–3 hours.



3 · The burden falls on daily life, and on the system

People who work
About half of workers who died of opioid toxicity were employed.[9] Shift-work and remote job sites make repeat visits hard.[9,10]

Caregivers and students
Visits clash with childcare, family care and school; people on SOS call flexibility essential.[11,12]

Rural and remote areas
Distant pharmacies and limited transport make several daily trips unrealistic.[11,12]

Community pharmacies
Many observed doses per patient add workload and crowding, delay other customers.

What's at stake: destabilizing people who are doing well on SOS, and taking away an intervention that multiple studies link to lower overdose risk and improved health.[4,5,13,14] Many may have to choose between their job and their treatment, and those who leave SOS may return to a far more toxic unregulated supply.

A proportionate path forward

Adapt Ontario's OAT take-home framework[8] to address diversion without destabilizing care:

1 Daily dispensing by default. Picking up doses once daily, without a witnessed dosing requirement, at initiation and titration, and whenever clinically indicated.

2 Take-homes tied to stability. Additional take-home doses introduced gradually for patients who are clinically and socially stable, increased or reduced with ongoing assessment.

3 Stability set in partnership. Defined by the treating clinician together with the patient, preserving the clinical discretion CPSO policy recognizes.

4 Proportionate safeguards. CPSO-led initiatives to respond to complaints or concerns about individual prescribers, and clear guidance on the clinical response to suspected diversion.

CPSO: College of Physicians and Surgeons of Ontario · SOS: safer opioid supply · OAT: opioid agonist treatment

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ABOUT THIS BRIEF

Prepared by the Ontario Drug Policy Research Network to summarize evidence relevant to CPSO's October 2026 amendments to safer supply prescribing. It draws primarily on ODPRN population-based research using routinely collected Ontario health data, supplemented by other peer-reviewed and grey literature.

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