Ministry of Health

Addictions Treatment Programs

1.0 Summary

Addictions are complex conditions in which problematic patterns of substance use or behaviours can interfere with a person's life. Addictions can be broadly defined as conditions that lead to a compulsive engagement with a substance or behaviour, despite negative consequences.

According to the Canadian Mental Health Association, it is estimated that approximately 10% of the population in Ontario uses substances problematically. A 2018 study published by the Canadian Centre on Substance Use and Addiction estimated that the overall costs and harms of substance use in Ontario was over $14.6 billion in 2014. Overall, the rates of problematic substance use and gambling in Ontario are fairly close to the rest of Canada based on our review of various studies.

The Ministry of Health (Ministry) is the primary funder and overseer of addictions services in Ontario. In 2018/19, about $212 million was spent by about 200 addictions treatment service providers to treat over 76,700 clients largely through three main types of programs:

- non-residential treatment programs, where clients do not stay at a facility in the community overnight but generally receive weekly or twice weekly treatment services during the day;
- residential treatment programs, where clients stay at a facility in the community for treatment services; and
- withdrawal management or detox programs, where clients receive medical and non-medical support to deal with symptoms related to the withdrawal from one or more substances either in the community or in a residential setting.

Between 2014/15 and 2018/19, spending on addictions treatment programs grew almost 25% or $42 million, rising from $170 million to $212 million. Since August 2017, an additional $134 million was spent on the Ministry's Opioid Strategy. Despite this increased spending, we found that wait times for addictions treatment, repeat emergency department visits for substance-use conditions, as well as opioid-related emergency department visits, hospitalizations and deaths continue to increase.

We found that the Ministry does not allocate funding to addictions treatment programs based on need. We also noted that the Ministry requires service providers to follow just a single set of standards, relating to withdrawal management programs only, resulting in significant variability in the operations and services for other addictions treatment programs. The Ministry also does not measure the effectiveness of addictions treatment service providers, which results in funding being given to service providers without consideration of whether their programs are effective. Funding

decisions are historically based or driven by allocations in prior years rather than program effectiveness or outcomes. In addition, we found that the Ministry does not proactively and regularly share with health-care providers and regulatory colleges information on opioid prescriptions dispensed to ensure that opioids are prescribed and dispensed appropriately.

As Ontario has committed to investing $3.8 billion over 10 years (from 2017/18 to 2026/27) for mental health and addictions services, it is important that going forward, funding for addictions services is allocated appropriately to meet the needs of Ontarians.

The following are some of our significant observations.

- **Longer wait times for addictions treatment leads to people being hospitalized or dying before receiving treatment.** Between 2014/15 and 2018/19, wait times for all addictions treatment programs increased. For example, the average wait time for residential treatment programs increased from 43 days to 50 days, with about 58% of programs having wait times of 30 days or greater, and in one case, over a year. Service providers informed us that they were aware of their clients dropping off wait lists for treatment programs because they were hospitalized, incarcerated, attempted suicide or even died while waiting for treatment.
- **Insufficient community-based addictions services causes more people to seek treatment from emergency departments.** Between 2014/15 and 2018/19, all types of emergency department visits grew by 6%, but visits to emergency departments for substance-use conditions increased by almost 40% and repeat unscheduled visits to emergency departments within 30 days for substance-use conditions increased almost 50%. While it is appropriate for emergency departments to provide emergency medical care to people with urgent substance-use issues (such as alcohol poisoning), people should obtain treatment for their addictions from community-based service providers as opposed to visiting emergency departments repeatedly. We estimated that over $5 million was spent in 2018/19 on providing care to frequent visitors of emergency departments for substance-use conditions. This same money could have been spent on addictions treatment programs delivered by service providers; for example, this amount would have funded 19 days of non-residential treatment for each of the frequent visitors.
- **The Ministry allocates funding for addictions treatment services without determining the need for each type of service across the province.** While a model exists that enables the Ministry to identify the need for addictions treatment services, the Ministry has not set a timetable for its implementation. Between 2014/15 and 2018/19, funding for addictions treatment programs grew by about 25%, (from $191 million to $239 million). Over half of the new funding was allocated to new service providers or programs and was primarily reported as being spent on non-residential counselling services, even though the majority of people seeking treatment presented with increasingly complex issues and may have required more intensive services, such as case management, as opposed to counselling services alone. We also noted that funding for the majority of ongoing addictions treatment programs only increased by 3.6% or less, which was half the inflation rate, making it challenging for some service providers to maintain the current program's service level.
- **The Ministry funds addictions treatment service providers without evaluating the effectiveness of their programs.** The Ministry only requires that service providers submit information on their spending and service activity, but has not collected any information

on their operations and performance to assess the effectiveness of their programs. While some service providers identified ways to assess the effectiveness of their programs (such as interviewing clients or conducting client surveys before and after clients receive treatment to assess their outcomes), the Ministry has never asked for this information.

- **Lack of provincial standards results in inconsistent delivery for most addictions treatment programs.** Of the three main types of addictions treatment programs (non-residential, residential and withdrawal management), the Ministry requires service providers to follow a set of standards that applies only to withdrawal management programs. In the absence of standards for non-residential and residential programs, service providers determine on their own how to deliver their programs, resulting in significant differences among service providers for the same types of programs. For residential treatment programs, the expected length of the program ranged from 19 to 175 days, and the client-to-staff ratio ranged from two to 12 clients per staff. For non-residential treatment programs offered by the community-based service providers, about 30% did not offer any services during weeknights and 76% did not offer any weekend services.
- **Integration and co-ordination is lacking among ministries that provide addictions services.** Since more than half of individuals in correctional institutions in Ontario suffer from substance-use conditions, it is important to better integrate and co-ordinate addictions services for individuals within these institutions (currently the responsibility of the Ministry of the Solicitor General) and upon their discharge. In 2018, the Office of the Chief Coroner identified 31 deaths where individuals died from opioid overdoses within four weeks of discharge from a provincial correctional institution.
- **Emerging issues, including cannabis legalization and vaping, need further monitoring:** The impacts of recent changes in legislation and consumer habits need to be monitored to identify whether additional addictions prevention and treatment services are necessary. In September 2019, three incidences of vaping-related severe lung disease were under review in Ontario. In October 2019, the U.S. Centers for Disease Control and Prevention also reported over 30 deaths and more than 1,400 cases of lung injury associated with the use of e-cigarettes or vaping. Amid such growing concern, the US government announced a plan to remove unauthorized flavoured e-cigarettes (except "tobacco" flavour) from the market and several states have enacted legislation to ban the sale of e-cigarettes. In Canada, none of the provinces have banned the sale of vaping products. In September 2019, the Minister of Health in Ontario issued an order that requires public hospitals to provide the Chief Medical Officer of Health with information related to incidences of vaping-related severe lung disease.

Another set of significant findings relates to the Ministry's Opioid Strategy (Strategy), which was launched in August 2017 to address the opioid crisis as evidenced by the significant growth of opioid-related deaths from more than one death a day in 2007 to about two deaths a day in 2016. A 2018 study by the Institute for Clinical Evaluative Sciences found a significant rise in opioid-related deaths in Ontario among young adults and youths. One out of six deaths among Ontarians aged 25 to 34 was related to opioids in 2015. Meanwhile, one of nine deaths among those aged 15 to 24 was related to opioids, which is nearly double the rate of 2010 when one in 16 deaths in the age group was opioid-related.

- **Despite spending about $134 million on the Strategy between August 2017 and March 2019, opioid-related deaths,**

emergency department visits and hospitalizations continue to increase. Opioid-related deaths grew by about 70% (from 867 to 1,473), from over two deaths a day in 2016 to more than four deaths a day in 2018. Over the same period, opioid-related emergency department visits more than doubled (from 4,427 to 9,154); and opioid-related hospitalizations also grew over 10% (from 1,908 to 2,106).

- **Most of the Strategy's funding for treating opioid addictions is not allocated to the regions with highest need.** Of the over $58 million the Ministry allocated to Local Health Integration Networks (LHINs) for opioid addictions treatment as part of its Strategy, only one-third was allocated based on factors that reflect regional needs (such as population size, opioid-related deaths, emergency department visits and hospitalizations), with the remainder being equally distributed among the LHINs. For example, in comparison with the South East LHIN, the Central East LHIN's population was over three times larger, its opioid-related deaths were more than double, and it had more than triple the number of opioid-related emergency department visits. However, in 2017, funding for opioid-addiction treatment to the Central East LHIN was only about 1.6 times higher than the South East LHIN.
- **Opioids appear to be inappropriately dispensed as prescribers do not have access to the Ministry's system that identifies the history of opioid prescriptions dispensed to a patient**. Ontario does not provide all health-care providers who can prescribe opioids, including physicians and dentists, with access to a provincial system containing the history of opioid prescriptions dispensed to patients. Therefore, prescribers may have to rely on information self-disclosed by their patients, who may intentionally or mistakenly provide wrong or incomplete information. This can lead to inappropriate or excessive opioid prescriptions, because prescribers are unable to verify if their patients have already received opioids prescribed and dispensed by others. We identified cases where patients received multiple opioids prescribed by different health-care providers. For example, in 2018/19, there were almost 1,500 instances where an individual received at least an eight-day supply of opioids prescribed by a physician and within one week received additional opioids prescribed by a dentist.
- **Information on unusual or suspicious instances where opioids were dispensed, such as opioids prescribed by physicians and dentists with inactive licences, is not shared with regulatory colleges for investigation.** The Ministry does not proactively monitor and share information on opioid dispensing events that appear to be unusual or suspicious with regulatory colleges on a regular basis, even though such information can assist the regulatory colleges to identify inappropriate practices, perform investigations and take corrective actions on a timely basis. Based on our review of information reported by pharmacy staff on opioids dispensed between 2014/15 and 2018/19, we identified cases that would have been appropriate for the Ministry to proactively bring to the attention of regulatory colleges. For example:
  - **Instances where opioids were prescribed and dispensed in large dosages:** In 2018/19, a physician prescribed opioids to 58 patients where the average daily dosage dispensed was over 17 times higher than the average daily dose dispensed based on prescriptions by all physicians. Another physician prescribed an 840-day supply of opioids within one year that was dispensed to a patient.
  - **Instances where pharmacists dispensed opioids associated with physicians**

and dentists with inactive licences: From 2014/15 to 2018/19, there were about 88,000 instances where opioids were dispensed that were associated with approximately 3,500 prescribers (2,900 physicians and 600 dentists) with inactive licences. The licences, dating back to at least 2012, were inactive for various reasons: about 400 prescribers were deceased (including two physicians who died in 1989 and a dentist who died in 2002), 10 prescribers had had their licences revoked for disciplinary reasons (including one physician whose licence was revoked in 2000), and 3,100 prescribers were no longer maintaining an active licence (for reasons such as retirement). A number of pharmacists and pharmacies had multiple instances where dispensing events for opioids were associated with prescribers with inactive licences. In one case, at a pharmacy in Belleville, 18 pharmacists collectively dispensed opioids 230 times based on prescriptions that were associated with 15 different prescribers, all of whose licences were inactive. Subsequent to our audit field work, the Ministry investigated about 15% of the instances we identified and informed us that those cases were attributable to data entry errors.

- **The guideline for opioid agonist therapy is not followed consistently.** In 2018, Health Quality Ontario developed a guideline for treatment of opioid addiction. Despite the guideline identifying that opioid agonist therapy—using replacement drugs such as methadone or buprenorphine-naloxone to help individuals deal with the cravings and withdrawal symptoms, stabilize their lives and reduce the harms related to their opioid use—is a first-line treatment for opioid addiction and should be accepted by all addictions treatment service providers, we noted that about 40% of service providers do not admit individuals who are on methadone. While the guideline also recommends that individuals on opioid agonist therapy should have their additional addictions treatment needs met, service providers reported that only about 17% of the individuals on opioid agonist therapy received addictions treatment services, such as counselling services, from them in 2018/19.
- **No actions have been taken to achieve cost savings in the distribution of naloxone through pharmacies.** The distribution of naloxone (a medication that can temporarily reverse an opioid overdose to prevent death) by organizations such as public health units and pharmacies is the largest program within the Opioid Strategy and accounts for over $71 million, or about 27%, of the Strategy's cost. The Ministry buys injectable naloxone in bulk for public health units, but not for pharmacies. If the Ministry had done group buying for pharmacies (similar to British Columbia's practice and what is done by the Ministry for flu shots in the Greater Toronto Area) and had not reimbursed pharmacies for distributing naloxone and training people on how to use naloxone (similar to British Columbia), we estimated that the Ministry could have saved up to about $7 million between 2017/18 and 2018/19.
- **The Ministry has neither determined whether the number or capacity of Consumption Treatment Services sites is appropriate nor ensured each site operates consistently.** The sites provide a safe environment where their clients can consume substances they possess under supervision of health-care professionals, who help identify and respond to overdoses on site. The sites can also connect clients to other addictions, health and social services. The Ministry has not determined whether the capacity and locations of the existing sites align with regional needs. For example, in 2018,

although the number of opioid-related deaths in Hamilton was 50% higher than in Ottawa, the capacity of Ministry-funded sites in Hamilton is about eight times less than Ottawa (serving three people in Hamilton versus 25 in Ottawa). Additionally, while the Ministry has established some provincial standards for the sites, we identified differences in their operations, including the type of medical staff on site and procedures for contacting paramedic services or for taking people to the emergency department.

Overall Conclusion

Our audit concluded that the Ministry does not have effective processes and procedures in place to measure and report to the public about the results and cost-effectiveness of addictions services in meeting their intended objectives. We found that the Ministry has not collected enough information from addictions treatment service providers to assess the effectiveness of their services.

As well, the Ministry does not have effective processes and procedures in place to oversee and monitor addictions service providers, and its funding for them, to ensure that appropriate legislation, agreements and/or relevant policies are followed. We noted that the Ministry has not established sufficient relevant treatment and care standards to ensure consistent operations and service delivery by addictions treatment service providers.

In addition, the Ministry does not have fully effective processes and procedures in place to coordinate and deliver addictions services in a timely and cost-effective manner that meets the needs of Ontarians requiring these services because there are long wait times for addictions treatment and increasing repeat emergency department visits for substance-use conditions.

This report contains 13 recommendations, consisting of 37 actions, to address our audit findings.

OVERALL MINISTRY RESPONSE

The Ministry of Health (Ministry) appreciates the Auditor General's observations and agrees with the recommendations regarding Ontario's Addictions Treatment Programs. The recommendations included in the report will support improvements to strengthen accountability and investments that will expand access to quality supports and services for Ontarians.

To build a comprehensive and connected mental health and addictions service system, the government has committed to investing $3.8 billion over ten years for mental health, addictions (MHA) and housing supports, which is a combination of federal and provincial investments. This investment includes a plan to improve and expand access to addictions treatment programs as well as the broader continuum of services that support people with addiction and prevent addiction issues before they begin.

The Ministry is embarking on a significant change initiative to improve the overall healthcare delivery system through the creation of Ontario Health and Ontario Health Teams. At full maturity, it is expected that Ontario Health Teams will be responsible for delivering MHA services across the lifespan with Ontario Health monitoring and reporting on system performance, quality and accountability. The Ministry looks forward to leveraging this new opportunity in health system planning to deliver better supports and services across our health system. Within Ontario Health, the Ministry is proposing to create an MHA Centre of Excellence that would drive a provincial quality agenda for the MHA sector.

The Ministry recognizes that the challenges facing mental health and addictions services have an impact on all Ontarians, including clients and service providers in other public service sectors (e.g., schools, policing, first responders, social housing). This understanding

drives the Ministry's commitment to invest more in the sector to expand capacity, scale-up evidence-informed programs and work closely with our partners to deliver a whole-of-government approach to mental health and addictions.

2.0 Background

2.1 Overview of Addictions

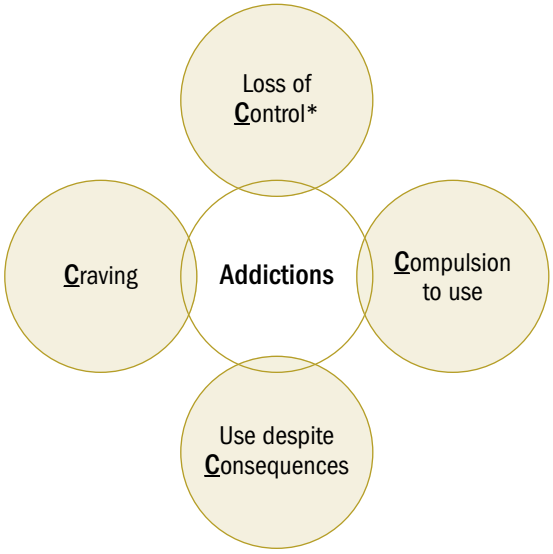
According to the Centre for Addiction and Mental Health, Canada's largest psychiatric hospital, a simple way of describing an addiction is the presence of the "four Cs" (see **Figure 1**). Addictions are caused by a combination of factors, including genetics and environment (see **Figure 2**). **Appendix 1** provides a glossary of terms used in this report.

An addiction is present only when use of a substance (such as alcohol, cannabis or nicotine) or engagement in a behaviour (such as gambling, Internet use or gaming) becomes habitual and compulsive, and results in negative health or social consequences. That is, experiencing enjoyment from the substance use or behaviour is not by itself an evidence of addiction:

- A 2017 survey conducted by the government of Canada identified that more than 75% of Ontarians consumed alcohol, but only about 21% of these individuals' alcohol use exceeded Canada's Low-Risk Alcohol Drinking Guidelines, developed by a national group of experts.

Figure 1: The Presence of the "Four Cs" in Addictions

Source of data: Centre for Addiction and Mental Health



* Specifically, loss of control of amount or frequency of use.

Figure 2: Causes of Addictions

Prepared by the Office of the Auditor General of Ontario

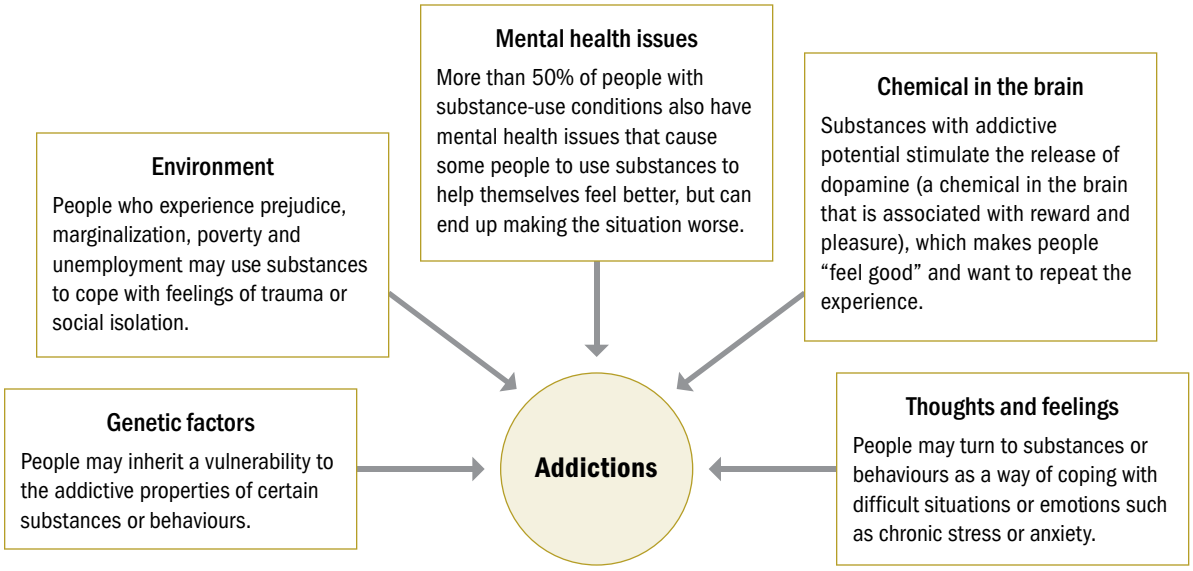
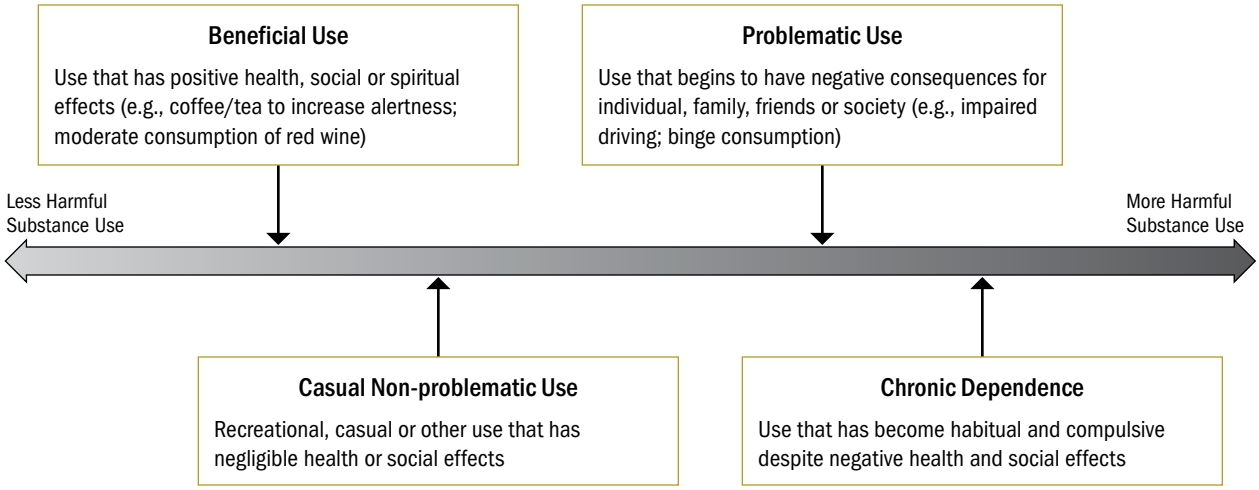


Figure 3: Spectrum of Substance Use

Source of data: Canadian Mental Health Association



- A report published by the Canadian Partnership for Responsible Gambling in 2016/17 noted that over 80% of Ontarians participated in gambling activity, but only about 1% of them were considered to be "problem gamblers."

Figure 3 shows the spectrum of substance use.

2.2 Addictions in Ontario

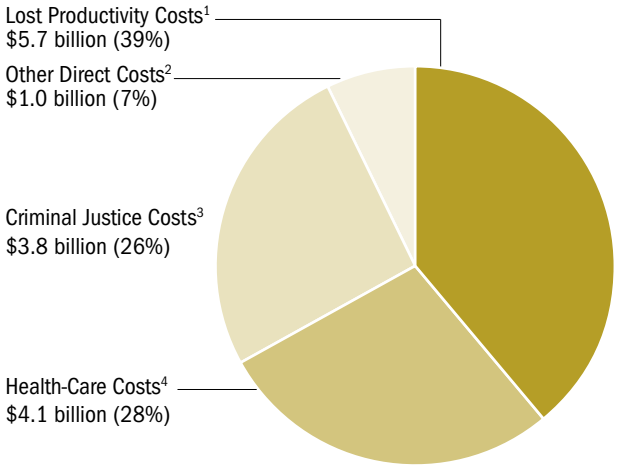
2.2.1 Prevalence and Cost of Addictions in Ontario

According to the Canadian Mental Health Association, it is estimated that approximately 10% of the population in Ontario uses substances problematically. Overall, based on our review of various studies, the rates of substance use and problem gambling in Ontario are fairly close to the rest of Canada.

A 2018 study published by the Canadian Centre on Substance Use and Addiction estimated that the overall costs and harms of substance use in Ontario was over $14.6 billion in 2014. **Figure 4** provides a category breakdown of this overall cost. Given the breakdown shown, government spending on addictions treatment to help reduce problematic substance use can achieve savings in areas ranging from health care to criminal justice and more.

Figure 4: Breakdown of the Overall Estimated Costs and Harms of Substance Use in Ontario, 2014

Source of data: Canadian Centre on Substance Use and Addiction



1. Examples of lost productivity costs include costs related to disability and premature death.
2. Examples of other direct costs include costs associated with damages to motor vehicles and other properties as a result of an individual's substance abuse.
3. Examples of criminal justice costs include costs related to police work, courts and correctional services.
4. Examples of health-care costs include costs associated with emergency department visits, hospitalizations and physician time.

2.2.2 Impact of Addictions on People and Society

Depending on its type and severity, addiction has adverse consequences not only for people with addictions, but also for their family members, friends and society. Specifically:

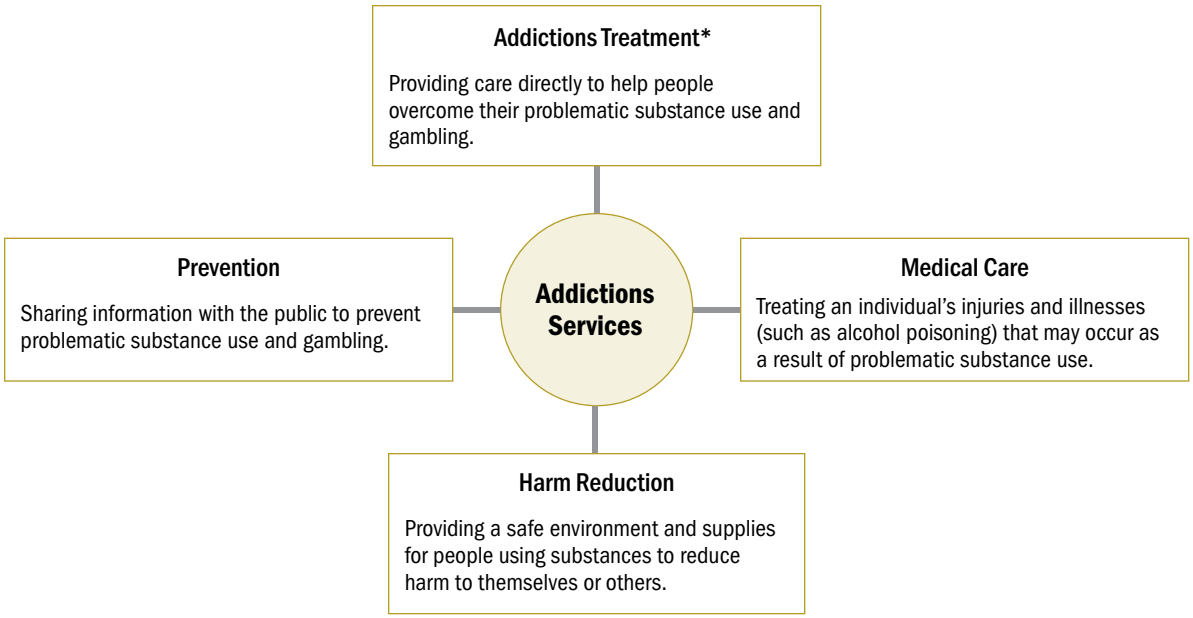
- In addition to harmful social consequences (such as losing a job or experiencing negative relationships with friends and family), problematic substance use can have health effects (such as decreased co-ordination or damage to organs) and even prematurely end a person's life. According to the death investigations performed by the Office of the Chief Coroner, between 2014 and 2018 the number of investigations that involved individuals with a history of problematic alcohol and/or drug use increased by 25% (from about 2,000 to about 2,500). Of these investigations, individuals who were confirmed to have died from alcohol and/or drug toxicity grew over 50% (from about almost 630 to about 970). **Appendix 2** provides examples of death investigations related to addictions conducted by the Office of the Chief Coroner.
- Behavioural addictions such as problem gambling can also harm individuals. Beyond financial concerns, research has shown that problem gamblers can have higher rates of depression, stress, anxiety, violence against intimate partners, divorce and thoughts of suicide. Between 2014 and 2018, over 20 individuals who had a known history of problem gambling, died as a result of suicide in Ontario.

2.3 Addictions Services in Ontario

2.3.1 Access to Addictions Services

Addictions services can be broadly grouped into four main categories: (1) addictions treatment; (2) prevention; (3) harm reduction; and (4) medical care (see **Figure 5**). Since most of these addictions services do not require a referral, individuals can refer themselves or can be referred by other

Figure 5: Four Main Categories of Addictions Services
Prepared by the Office of the Auditor General of Ontario

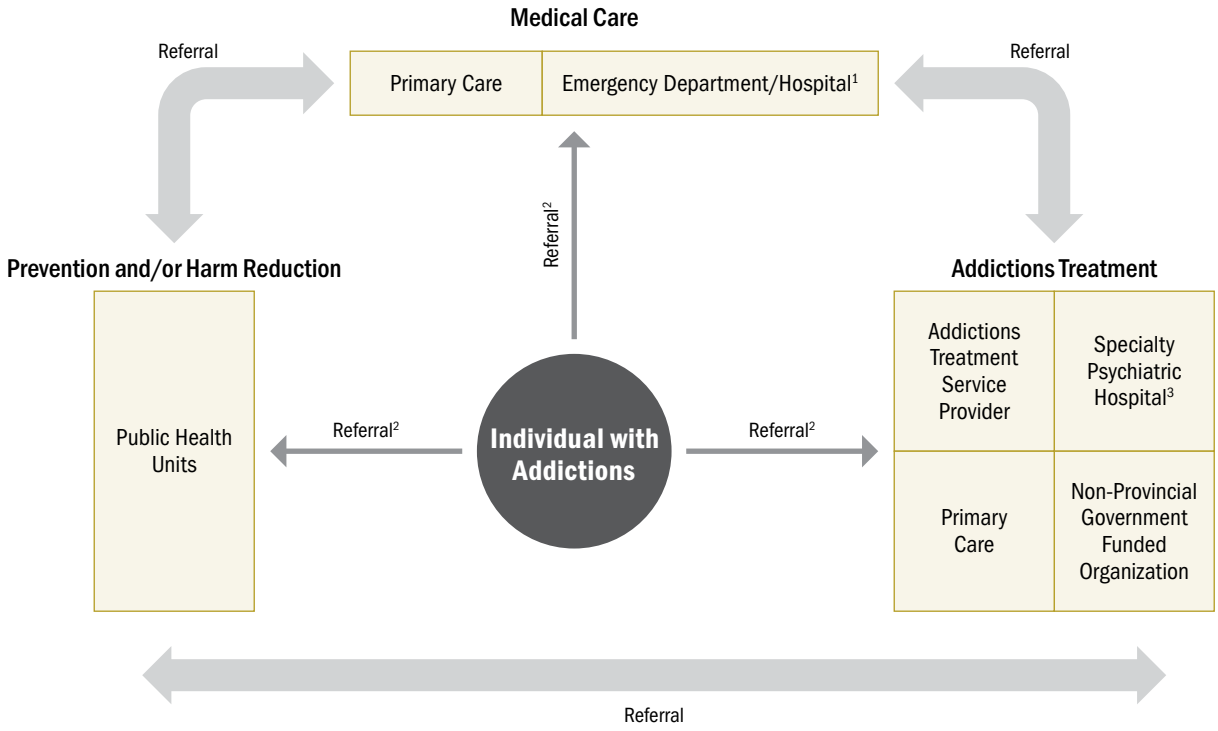


Note: One or more of these addictions services may be provided by the same provider.

* Subject of this audit.

Figure 6: Common Ways to Access Addictions Services

Prepared by the Office of the Auditor General of Ontario



1. Emergency departments provide immediate treatment for medical injuries and illnesses caused by addictions (such as intoxication).
2. Initial referral can be self-referral or by another party (such as the police or paramedic services).
3. Specialty psychiatric hospitals provide treatment to people with complex or severe addictions (including those who have other mental health conditions).

providers. **Figure 6** shows how people can connect to these addictions services.

Typically, an individual can access addictions services through various channels, which include addictions treatment service providers, public health units, primary care providers, emergency departments and specialty psychiatric hospitals. They can also contact ConnexOntario, which is an organization funded by the Ministry to provide information (through various methods, including by phone, by email and on a website) on publicly funded addictions and mental health resources available to Ontarians.

Addictions services are primarily community-based (located outside of hospitals) and focus on treating clients with mild to moderate addictions. Emergency departments and specialty psychiatric hospitals also provide addictions services: emergency departments focus on providing immediate treatment for medical injuries or illnesses caused by addictions (such as intoxication), while specialty psychiatric hospitals focus on providing treatment to clients with complex or severe addictions (including those with other mental health conditions).

2.3.2 Funding and Spending on Addictions Services

Parties providing addictions services include both those funded by the provincial government and those funded by other means. Unlike government funding for hospital services, including emergency departments and inpatient services, and physician services, which are mandated under the *Canada Health Act*, government funding for all other health services, including addictions services, are at the government's discretion.

Services Funded by Ministry of Health

In Ontario, the Ministry of Health (Ministry) oversees and funds health-care services, which include addictions services. In 2018/19, the Ministry allocated or spent over $490 million to be spent on community-based addictions services, generally to treat people with mild to moderate forms of addictions. These services were mainly delivered by the following types of service providers funded by the Ministry (see **Figure 7**):

- **Addictions treatment service providers:** There are about 200 of these providers. They are generally independently incorporated not-for-profit organizations that operate in the community (through over 450 locations) and receive their funding from the Ministry through 14 Local Health Integration Networks (LHINs). **Figure 8** shows the spending by these services providers between 2014/15 and 2018/19. **Appendix 3** lists all addictions treatment service providers funded by the Ministry and their programs.
- **Primary-care providers:** These include physicians who provide assessment, monitoring and medical management, such as prescription services, to people with substance-use issues. Physicians bill their services to the Ontario Health Insurance Plan (OHIP). Prescription drugs may be paid by the Ministry through the Ontario Drug Benefit Program.

Figure 7: Description of Key Providers of Addictions Services Funded by the Ministry of Health

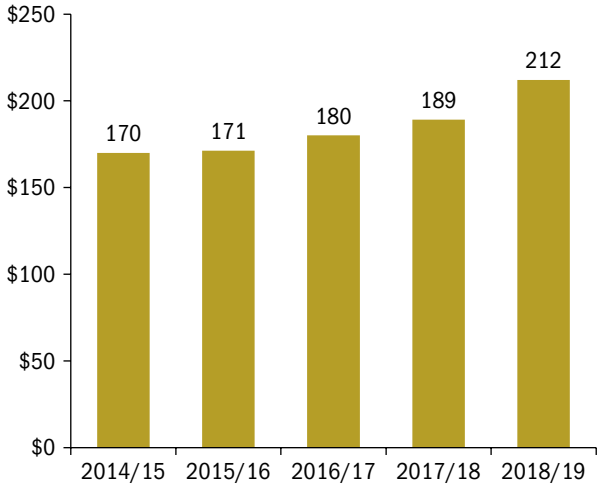
Prepared by the Office of the Auditor General of Ontario

Service Provider	Main Type of Service			Description of Services	Spending in 2018/19 ($ million)
	Addictions Treatment	Prevention and Harm Reduction	Medical Care		
Addictions treatment service providers	✓			• Provide treatment to people suffering primarily from mild to moderate addictions (over 76,700 people in 2018/19). See **Figure 10** for common treatment approaches and **Figure 11** for different types of treatment programs.	212
Primary care providers	✓		✓	• Treat medical injuries as a result of an individual's problematic substance use (such as minor injuries associated with a fall while intoxicated). • Perform an assessment to determine if an individual has an addiction. • Provide counselling services. • Prescribe medication (such as methadone) to help people manage the symptoms of opioid withdrawal. • Monitor patients who deal with withdrawal symptoms.	182[1]
Public health units and various organizations[2]		✓		• Share materials with the public to prevent problematic substance use.	44
Others[3]	✓	✓		• Offer services funded by the Ministry's Opioid Strategy (see **Section 2.4** and **Section 4.6**).	56
Total					**494**

1. $182 million includes about $100 million through OHIP billings (related to assessing individuals with addiction concerns and the monitoring of prescribed medications) and about $82 million through the Ontario Drug Benefit Program (related to prescriptions such as buprenorphine-naloxone and methadone). The OHIP billings amount is based on 2017/18 data (2018/19 data will not be available until at least six months after March 31, 2019, since physicians have a window of up to six months after rendering a service to submit billings).
2. The Ministry of Health provides funding to 35 public health units and various organizations, such as municipalities, universities and not-for-profit organizations, to provide services
3. Examples of other service providers include community health centres and pharmacists.

Figure 8: Spending by Addictions Treatment Service Providers, 2014/15–2018/19 ($ million)

Source of data: Ministry of Health



- **Public health units and various organizations:** The Ministry provides funding to 35 public health units (that have been established by municipalities to administer health promotion and disease-prevention programs) and other parties, including municipalities, universities and not-for-profit organizations, to share materials with the public to prevent problematic substance use.
- **Others:** These are community health centres and pharmacists. They provide services funded by the Ministry's Opioid Strategy (see **Section 2.4** and **Section 4.6**)

Services Funded by Other Ministries and Agencies

Other ministries and agencies apart from the Ministry of Health also fund and provide addictions services in Ontario. However, the Ministry does not have any details on the funding of addictions services provided by these other parties. We therefore contacted these other ministries and agencies ourselves. We noted that they spent a total of at least $42 million annually on mental health and addictions services, such as the Ministry of Education for development of educator training relating to addictions (see **Figure 9**).

Services Funded by For-Profit and Not-for-Profit Sectors

Service providers that do not receive provincial government funding also offer addictions treatment. Examples of these providers include not-for-profit organizations (such as Alcoholics Anonymous) that are funded by donations and/or fees from clients; and for-profit businesses that operate clinics and residential facilities that charge their clients fees for their services that are paid out of pocket by clients or through their insurance. Since the Ministry does not fund these service providers, it does not oversee their services and does not collect information from them.

2.3.3 Approaches and Types of Addictions Treatment

As discussed in **Section 2.1**, addictions are caused by a combination of factors. Therefore, two clients with the same addictions may require different treatment approaches. The two most common treatment approaches are: (1) counselling; and (2) medication. Depending on their needs, clients can be treated using just one of the methods or a combination of the two (see **Figure 10**).

Counselling is generally offered through three main types of programs: (1) non-residential treatment; (2) residential treatment; and (3) withdrawal management services or detox (see **Figure 11**). Medication is generally offered by physicians, such as those in solo or group practices, or by hospitals as emergency or inpatient services.

2.3.4 Initiatives for Addictions Services

Ontario has introduced initiatives in recent years to address problematic substance use and gambling. It has committed to investing $3.8 billion in total ($1.9 billion received from Health Canada and $1.9 billion of its own funds) "to develop and implement a comprehensive and connected mental health and addictions strategy" over 10 years (from 2017/18 to 2026/27). At the time of this audit, the

Figure 9: Summary of Mental Health and Addictions Services Funded by Other Ministries and Agencies

Sources of data: Ontario Lottery and Gaming Corporation, Ministry of the Solicitor General, Ministry of Children, Community and Social Services, Ministry of Education, and Ministry of Training, Colleges and Universities

Ministry/Agency	Description of Service	Spending in 2018/19 ($ million)
Ministry of the Solicitor General[1]	• Funds and provides health-care services, including for mental health and addictions, to individuals in provincial correctional facilities.	74[2]
Ontario Lottery and Gaming Corporation	• Funds and delivers responsible gaming program to prevent gambling problems from occurring and to minimize harm for those who experience problems, by referring to services such as counselling.	17
Ministry of Training, Colleges and Universities	• Funds campus-based mental health workers for 45 publicly assisted post-secondary institutions. • Funds development of campus-based services or programs (such as counselling, peer-to-peer support programs and awareness programs) for students with mental health and addictions issues.	16
Ministry of Education	• Funds and develops evidence-based training and practice guides related to mental health and addictions for educators and school-based mental health clinicians in all 72 district school boards. • Provides training to educators related to the legalization of recreational cannabis.	7
Ministry of Children, Community and Social Services	• Funds problematic substance use programs for certain youth in detention and those serving sentences in custody or in the community.	2
Total (excluding Ministry of the Solicitor General)[2]		**42**

1. Formerly known as Ministry of Community Safety and Correctional Services.
2. The Ministry of the Solicitor General does not separate its health-care spending by program area (such as for addictions services). $74 million is the amount spent on all health-care services for individuals within provincial correctional facilities. As a result, the total spending on addictions services of $42 million does not include $74 million of spending by the Ministry of the Solicitor General.

government had not determined exactly how the money would be allocated.

In May 2019, the Ministry announced new legislation, which, if passed, would establish a Mental Health and Addictions Centre of Excellence within Ontario Health (see **Section 3.0**) to oversee mental health and addictions services.

2.4 Opioid Crisis

Opioids are a class of drugs (including morphine, heroin, and codeine) that are commonly prescribed for pain relief, but which, for various reasons, can lead to physical dependence and addiction. The strength or potency varies from one type of opioid to another. For example, oxycodone (an opioid for moderate to severe pain) is 1.5 times stronger than morphine, while fentanyl (an opioid for long-term stable pain) is 50 to 100 times stronger than morphine. Depending on the quantity or strength of the opioids they take, an individual may experience drowsiness or respiratory depression, go into a coma or even die.

The studies and data we reviewed showed that the growth of opioid use and its harmful consequences have become a significant concern in Ontario. For example:

- A research study of opioid prescription trends in Ontario found that "from 1991 to 2007, annual prescriptions for opioids increased from 458 to 591 per 1000 individuals" and "prescriptions of oxycodone increased by 850%." This increase was in part due to the manufacturer marketing a form of oxycodone as having minimal risk of addictions.

Figure 10: The Two Most Common Addictions Treatment Approaches

Prepared by the Office of the Auditor General of Ontario

	Counselling	Medication
Purpose	• Helps individuals to understand why they have addictions and assists them in developing strategies to prevent or reduce their engagement with a substance or behaviour.	• Helps individuals deal with withdrawal symptoms and reduce drug cravings when they stop using a substance to which they are addicted.
Description	• This approach is provided by different professionals with diverse experiences and educational backgrounds through individual counselling (which is more comprehensive and personalized) or in a group setting (which provides a support network for learning and sharing of experience).	• This approach requires a prescription from a health-care practitioner, such as a physician or nurse practitioner.
Targeted at	• Addictions related to problematic substance use and behaviours (such as problem gambling).	• Addictions related to problematic substance use.
Example	• Counselling can be provided by a psychologist with a Ph.D, social worker with a Master's degree or addiction counsellor with a college diploma.	• Medication (such as methadone and buprenorphine-naloxone) can be prescribed to help people deal with their withdrawal symptoms when they stop their use of opioids.

Note: Studies have shown that providing an individual with both counselling and medication can be more effective than just providing counselling or medication alone.

Figure 11: The Three Main Types of Addictions Treatment Programs

Prepared by the Office of the Auditor General of Ontario

	Non-Residential[1]	Residential[1]	Withdrawal Management (or Detox)[2]
Description	Clients do not stay at a treatment facility overnight but only attend programs (such as individual or group counselling) during the day (ranging from one hour to all-day) and receive additional services (such as case management, whereby a case manager meets regularly with an individual to provide other health and social services).	Clients live at a treatment facility for a period of time (at least a couple of weeks) and attend daily structured programs such as individual or group counselling.	Clients stay at a treatment facility for a short-term period (generally less than five days) where they can receive medical care as well as individual or group counselling, and are monitored while dealing with their withdrawal symptoms from stopping their substance use. Clients can also access these services while staying at home.
Targeted at	Problematic substance use and behavioural addictions such as problem gambling.	Problematic substance use and behavioural addictions, such as problem gambling.	Problematic substance use.
Number of Service Providers[3]	170	73[4]	49
Spending in 2018/19 ($ million)	104	64	45

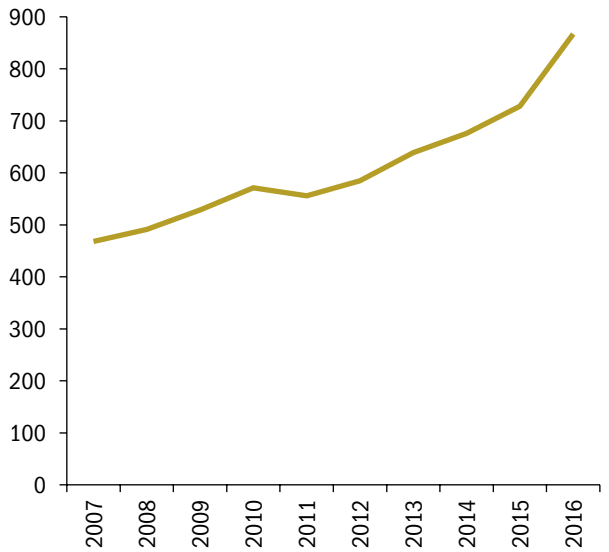
1. Whether a client obtains addictions services through a non-residential program or a residential program will depend on a number of factors. These factors include a client's preference (for example, a non-residential program may be more appropriate for a client who has work or family commitments) and the severity of the addictions, as residential treatment is generally more appropriate for people with more serious or complex addictions.
2. Generally, to effectively treat a client's addictions, withdrawal management should be followed by other non-residential or residential addictions treatment.
3. Some addictions treatment service providers offer more than one type of program.
4. Collectively, these service providers have 1,394 beds to provide clients residential addictions treatment.

- Between 2007 and 2016, opioid-related deaths, hospitalizations and emergency department visits increased significantly. In particular, opioid-related deaths grew from more than one per day in 2007 (468 deaths) to more than two per day in 2016 (867 deaths) as shown in **Figure 12**.
- A 2018 study by the Institute for Clinical Evaluative Sciences, a not-for-profit research institute that conducts research on Ontario's health data, found a significant rise in opioid-related deaths in Ontario among young adults and youths. One out of six deaths among Ontarians aged 25 to 34 was related to opioids in 2015. Meanwhile, one of nine deaths among those aged 15 to 24 was related to opioids, nearly double the rate of 2010 when one in 16 deaths in the age group was opioid-related.
- The Office of the Chief Coroner collects data on opioid-related deaths. Based on the most recent data available, about half of opioid-related deaths involved males aged 25 to 54, and fentanyl (or fentanyl analogues, which are similar but chemically different than fentanyl), was a direct cause in the majority of all opioid-related deaths (about 70%). While the Office of the Chief Coroner was unable at the time of our audit to determine in all cases how the individuals obtained the opioids that resulted in their deaths, reports show that fentanyl has become more widely circulated illegally across Canada.

In response to the growing concern and crisis related to opioids, in August 2017, the Ministry announced an investment of more than $222 million over three years to "enhance Ontario's Strategy to Prevent Opioid Addiction and Overdose." **Appendix 4** provides background and key events related to Ontario's opioid crisis. **Appendix 5** lists key initiatives of the Opioid Strategy. **Section 4.6** provides details on the issues related to the Opioid Strategy.

Our Office conducted a value-for-money audit on Ontario Drug Program Benefits in 2017 when

Figure 12: Opioid-Related Deaths, 2007–2016
Source of data: Public Health Ontario



the Ministry initiated the Opioid Strategy. As part of the 2017 audit, we recommended that the Ministry work with hospitals and the Office of the Chief Coroner for Ontario to link reported overdoses and deaths to the Ministry's system (containing data on controlled substances and other monitored drugs, including opioids) in order to identify whether the opioids were from legal or illicit sources. In 2019, our Office followed up on this recommendation and found that the Ministry was in the process of implementing this recommendation (see our *2019 Annual Report: Follow-Up Volume,* **Chapter 1 Section 1.09**).

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry) in partnership with other ministries, agencies and addictions treatment service providers, together have effective processes and procedures in place to:

- co-ordinate and deliver addictions treatment services in a timely and cost-effective manner that meets the needs of Ontarians requiring these services;

- oversee and monitor addictions treatment services, including Ministry funding, to ensure that appropriate legislation, agreements and/or relevant policies are followed; and
- measure and report publicly on the results and effectiveness of addictions treatment services in meeting their intended objectives.

In planning for our work, we identified the audit criteria (see **Appendix 6**) we would use to address our audit objective. 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 reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between December 2018 and June 2019. We obtained written representation from Ministry management that, effective November 8, 2019, the Ministry had provided us with all the information it was aware of that could significantly affect the findings or the conclusion of this report.

Our audit work was conducted primarily at the Ministry's Mental Health and Addictions Policy, Accountability and Provincial Partnership Branch, as well as at addictions treatment service providers' offices.

Our audit work at the Ministry included a review of relevant documentation and data related to its oversight of addictions treatment service providers, including data on funding to and spending by addictions treatment service providers, as well as data on emergency department visits related to substance-use conditions and opioid prescriptions between 2014/15 and 2018/19.

We visited or spoke with 29 addictions treatment service providers located in 11 of the 14 Local Health Integration Networks (LHINs). **Appendix 7** provides a listing of the addictions treatment service providers we contacted. We selected these service providers based on geography (to obtain representation across Ontario) and on demand for addictions treatment services (to reflect LHINs with a larger number of people seeking addictions treatment services and/or making visits to emergency departments for substance-use conditions). Our audit work with the addictions treatment service providers included the following:

- meeting with senior management and staff to understand their services and challenges; and
- reviewing program policies, procedures and other relevant documentation to understand their services and operations.

For addictions treatment service providers we did not meet or speak with, we conducted a survey to obtain information on their operations and challenges.

Appendix 8 contains information on additional work we performed and stakeholders we contacted as part of this audit.

Furthermore, we engaged an external advisor who had previous experience at a senior level of government with oversight over addictions services.

During the course of our audit, on April 18, 2019, Bill 74, the *People's Health Care Act, 2019*, received royal assent. It will come into force on a date to be proclaimed by the Lieutenant Governor. This legislation is designed to integrate multiple provincial agencies, including the LHINs, Cancer Care Ontario and Health Quality Ontario, into a single agency called Ontario Health.

4.0 Detailed Audit Observations

4.1 Increased Spending on Addictions Treatment Services Has Not Reduced Wait Times and Emergency Department Visits

As shown in **Figure 8**, between 2014/15 and 2018/19 spending on addictions treatment services increased almost 25%, rising from $170 million to $212 million. Despite increased spending, wait times for addictions treatment became longer.

Longer wait times not only result in more people seeking treatment at emergency departments (which are not designed to provide addictions treatment services) but can also cause people to forgo treatment altogether, and in some cases, this has led to hospitalization, incarceration, suicide attempts and even death.

4.1.1 Wait Times Increasing for People Seeking Treatment in Most Regions across the Province

Wait times for addictions treatment (from the time when an appropriate treatment option for a client has been determined through an eligibility assessment to the time when treatment starts) increased over the past five years.

Our review of wait time information reported by addictions treatment service providers and collected by ConnexOntario (an organization funded by the Ministry that maintains a centralized database of addictions and mental health treatment service providers and programs) noted that between 2014/15 and 2018/19, the average wait times reported for all addictions programs increased in 11 of the 14 Local Health Integration Networks (LHINs), as shown in **Figure 13**. During the same period, the average wait times for all three types of treatment programs increased (see **Figure 14**). Specifically:

- **Non-residential programs:** The average wait times grew from 18 days to 23 days, with about 14% of programs having wait times of 30 days or greater.
- **Residential programs:** The average wait times increased from 43 days to 50 days, with almost 58% of programs having wait times of 30 days or greater. We also noted instances where wait times were 143 days, 147 days, and even 235 days. While wait times for

Figure 13: Average Wait Times for Addictions Treatment Programs by Local Health Integration Network, 2014/15 and 2018/19 (Days)

Source of data: ConnexOntario

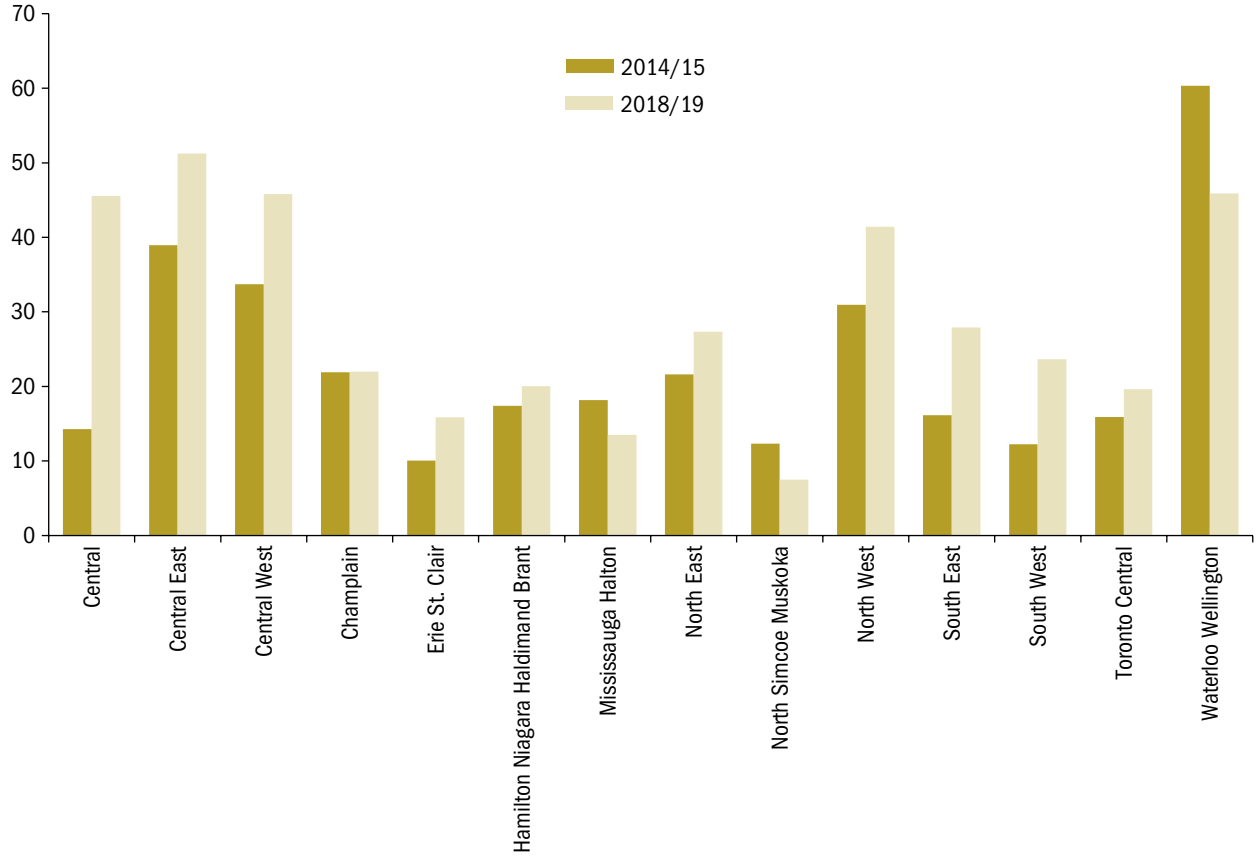
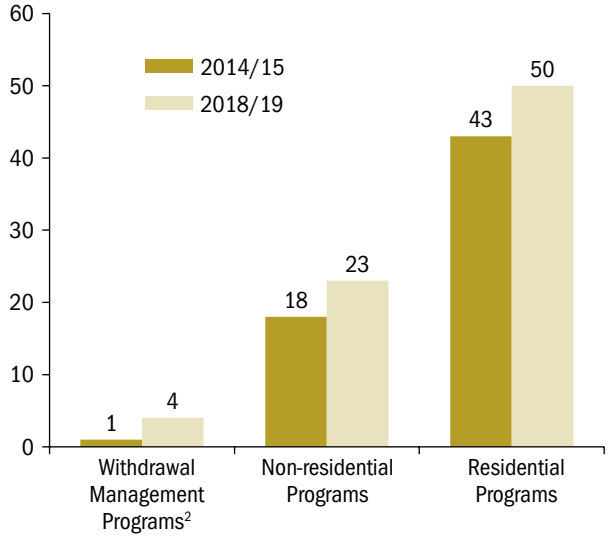


Figure 14: Average Wait Times for Addictions Treatment[1] by Type of Program, 2014/15 and 2018/19 (Days)

Source of data: ConnexOntario



1. These wait times do not include wait times for an eligibility assessment, which is performed by service providers to identify and place each of their clients into an appropriate treatment program. The average wait time for an eligibility assessment was almost nine days in 2018/19, up from 7.5 days in 2017/18, which was the first year that wait times for assessment were collected.
2. ConnexOntario collects information only on wait times for non-residential withdrawal management programs (where people can access services without staying overnight at a treatment facility). Service providers generally do not maintain a wait list for residential withdrawal management programs—residential withdrawal management services are expected to be available as soon as a client seeks them, without waits.

youth programs remained steady, they were on average longer than adult programs at about 65 days. One youth addictions program had a wait time of 413 days.

- **Withdrawal management programs:** The average wait times increased from about one day to four days.

Figure 15 shows timeline and average wait times by type of program in 2018/19. When clients are put on a wait list for addictions treatment, they will continue to struggle with their addictions, which can put themselves and/or others at risk. Our survey of 27 (or about 37%) of the 73 service providers of residential treatment programs found that they were aware of cases where their clients dropped off the wait lists before obtaining treatment. The majority of them indicated that they were aware of clients dropping off because they were waiting too long, were hospitalized or incarcerated and in some cases they attempted suicide or even died while waiting for treatment (see **Figure 16**).

4.1.2 Insufficient Access to Addictions Treatment Services Results in More Repeat Emergency Department Visits

Increased spending on addictions treatment programs has not effectively reduced the number of people with addictions seeking treatment from emergency departments repeatedly and frequently. More people visiting emergency departments for substance-use conditions indicated that community-based addictions services are not sufficiently available to meet people's needs.

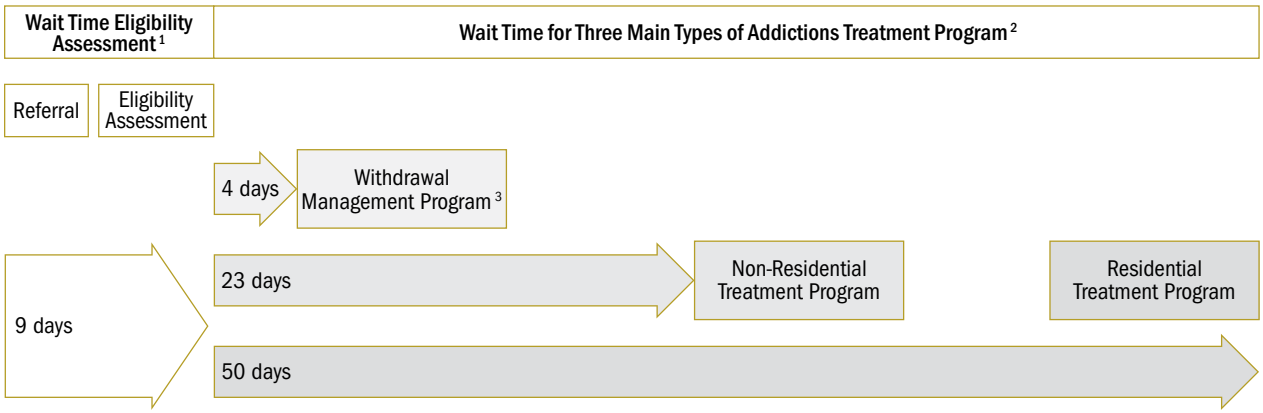
While an emergency department can provide immediate medical care for people with addictions (such as for alcohol poisoning), it does not provide ongoing treatment that helps people to overcome their addictions. For example, unlike withdrawal management programs offered by addictions treatment service providers, emergency departments are generally not staffed with addictions counsellors, who can make referrals and develop treatment plans for clients. Clients obtaining services from addictions treatment service providers on a regular basis are likely to make fewer repeat visits to emergency departments.

Based on our analysis of data on emergency department visits between 2014/15 and 2018/19, we noted that while all types of emergency department visits grew about 6% (from about 6.1 million visits to almost 6.5 million visits), visits relating to substance-use conditions (primarily alcohol and opioid use by males between the ages of 25 and 44) increased significantly. Specifically:

- Emergency department visits for substance-use conditions increased by almost 40% (from about 68,000 visits to 95,000 visits).
- Repeat unscheduled visits to emergency departments within 30 days for substance-use

Figure 15: Timeline and Average Wait Times by Type of Addictions Treatment Program, 2018/19 (Days)

Prepared by the Office of the Auditor General of Ontario



1. Wait time for eligibility assessment measures the time from when an individual contacts an addictions treatment service provider to when the service provider performs an eligibility assessment. Service providers perform eligibility assessments to identify appropriate treatment programs for their clients and place them into those programs.
2. Wait time for addictions treatment program measures the time from when the eligibility assessment is completed to when treatment starts.
3. An eligibility assessment is not always required for withdrawal management programs. ConnexOntario collects information only on wait times for non-residential withdrawal management programs.

conditions increased almost 50% (from about 20,000 visits to almost 29,800 visits).

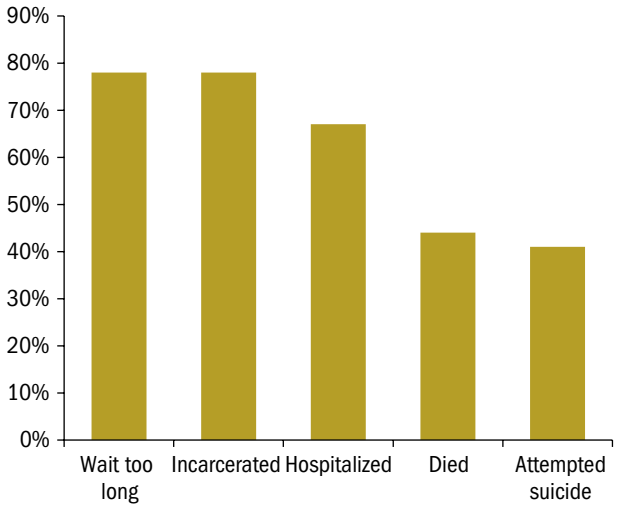
- Frequent visitors of emergency departments (six times or more within a fiscal year) for substance-use conditions increased by 60% (from about 1,250 visitors to about 2,000 visitors).

We also analyzed the cost associated with providing care to about 2,000 frequent visitors of emergency departments for substance-use conditions in 2018/19. We estimated that over $5 million was spent on these frequent visitors. This same money could have been spent on programs delivered by addictions treatment service providers; for example, this amount would fund 19 days of non-residential treatment for each of these frequent visitors.

More repeat and frequent emergency department visits for substance-use conditions indicates that people do not have access to effective and prompt community-based addictions treatment; for example, because of lack of awareness or wait times. However, the Ministry has not performed any analysis to determine what addictions services need to be expanded to reduce emergency department visits.

Figure 16: Reasons Clients Dropped off Wait Lists for Residential Addictions Treatment Programs

Prepared by the Office of the Auditor General of Ontario



Note: The percentage is calculated based on 27 (or about 37%) of the 73 residential addictions treatment service providers we contacted that are aware of instances of clients being dropped off wait lists and the reasons for those instances. As one provider may be aware of multiple reasons, the sum of all bars equals more than 100%.

RECOMMENDATION 1

To reduce wait times for addictions treatment and repeat emergency department visits for substance-use conditions, we recommend that the Ministry of Health:

- analyze wait times for addictions treatment to identify regions or programs with long wait times and work with those service providers to take corrective actions; and
- further analyze frequent and repeat emergency department visits for substance use across the province to determine what addictions services need to be expanded to reduce the number of these visits.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and recognizes that long wait times for addictions services can pose a setback to those seeking help. To address this recommendation, the government is committed to addressing capacity issues to these necessary services, across the whole spectrum of supports. In 2019/20, Ontario invested over $33 million in new funds for community addictions services with this aim.

To ensure new investments are optimal, the Ministry is exploring options to improve data quality and performance measurements. With better data quality and a performance measurement system in place, the Ministry will then analyze wait times to identify regions or programs with long wait times, which is one of multiple factors that may be used for capacity planning and resource allocation.

The Ministry also acknowledges that frequent and repeat emergency department visits are an indicator that services in the community are not reaching people in a timely fashion. The Ministry will continue to monitor this indicator to determine if additional addictions services in the community are needed. The Ministry is currently working on a co-ordinated access framework that would make it easier for people to access community services, which will help reduce frequent and repeat emergency department visits for substance use.

The Ministry will also work closely with Ontario Health, Ontario's new health agency, to ensure that the capacity for evidence-informed system planning continues to evolve.

4.2 Funding for Addictions Treatment Programs Not Tied to Clients' Needs and Programs' Effectiveness

Between 2014/15 and 2018/19, funding for addictions treatment programs increased about 25%, from about $191 million to $239 million. However, since the Ministry has not studied and determined the level of addictions treatment needed across the province and has not assessed the effectiveness of funded programs, it does not allocate funding based on clients' needs and on the effectiveness of these programs.

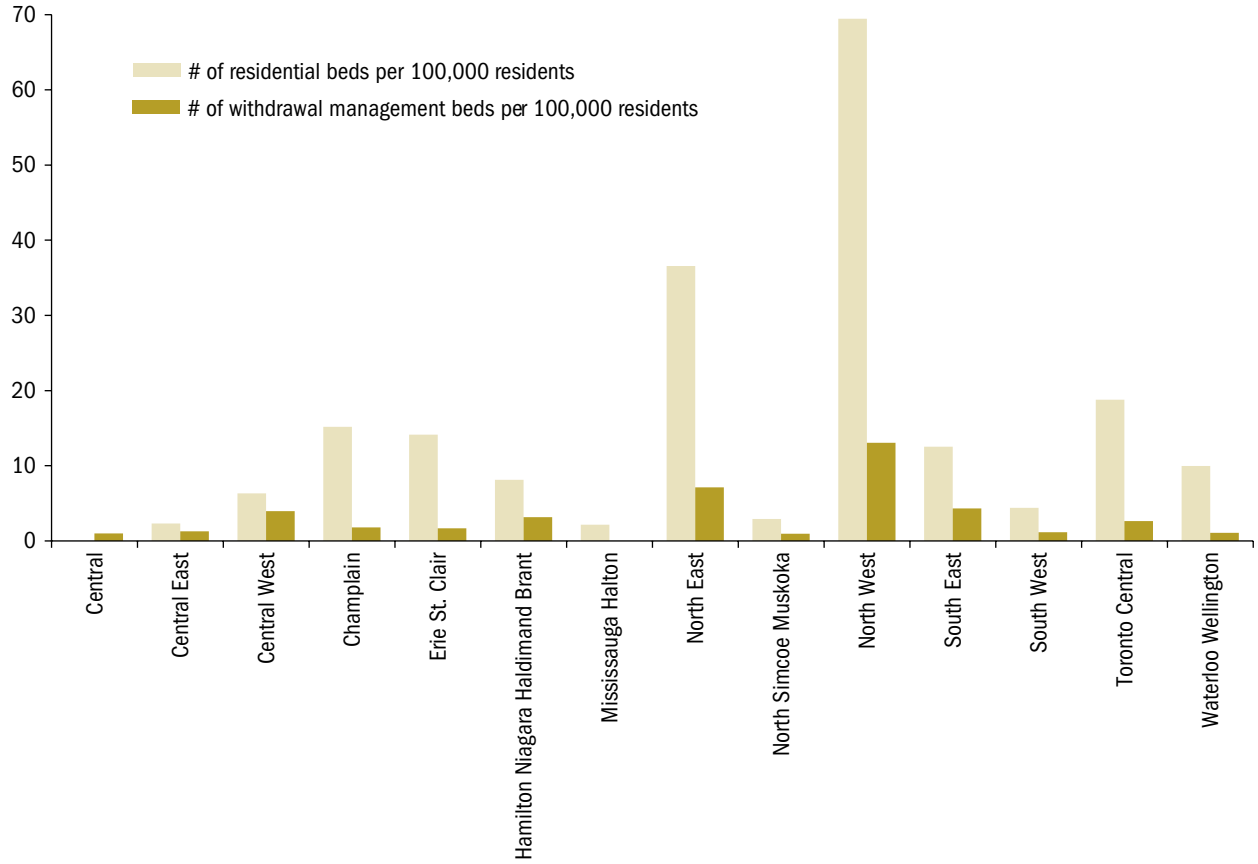
4.2.1 Method to Determine Needs for Addictions Treatment Programs Exists, But Not Used by Ministry

The Ministry does not know which specific addictions treatment programs and resources, such as withdrawal management or residential treatment beds, are needed across the province—even though there is a method that could be used to estimate this.

This method was identified by researchers in 1990 and updated based on 2012 information taken from the Canadian Community Health Survey conducted by Statistics Canada to estimate the severity of substance-use addictions and the type of addictions treatment programs, such as non-residential, residential and withdrawal management, that should be available to meet the province's needs. However, we found that the Ministry was still reviewing this model at the time of our audit and has not set a timetable for its implementation.

Figure 17: Number of Residential Treatment Beds and Withdrawal Management Beds per 100,000 Residents by Local Health Integration Network (LHIN)

Prepared by the Office of the Auditor General of Ontario



We also noted that no assessment of regional needs by the Ministry has contributed to differences in the availability of addictions treatment across the province. **Figure 17** identifies the number of withdrawal management beds and residential treatment beds for every 100,000 residents by LHIN. Specifically:

- The number of withdrawal management beds varies by LHIN, ranging from no such bed in the Mississauga Halton LHIN to 13 beds per 100,000 residents in the North West LHIN.
- The number of residential treatment beds differs by LHIN, ranging from no such bed in the Central LHIN to 69 beds per 100,000 residents in the North West LHIN.

4.2.2 Funding Not Allocated to Addictions Treatment Programs Based on Clients' Needs

Since the Ministry has not used a model to determine needs for addictions treatment services as discussed in **Section 4.2.1**, it did not allocate new funding to the service providers and programs based on where needs were highest.

Most of the new funding between 2014/15 and 2018/19 was allocated to ongoing programs (as opposed to one-time funding that is generally given to a service provider for a single fiscal year). The majority of the funding increase for ongoing programs was allocated to new service providers, and was primarily reported as being used to provide non-residential counselling services, which are generally less intensive and more appropriate for clients

with a mild form of addiction. Yet during the same period, the majority of clients obtaining addictions treatment presented with increasingly complex issues. For example, the percentage of clients obtaining addictions treatment who also had mental health conditions increased from 46% to 51%, and the percentage of clients obtaining addictions treatment due to problematic use of multiple substances remained high at 82%. These factors indicated that they may have required more intensive services, such as residential programs and case management, as opposed to counselling services alone.

As most of the new funding for ongoing programs went to new addictions treatment service providers, between 2014/15 and 2018/19, the majority of the ongoing programs delivered by the existing service providers received a funding increase of 3.6% or less, much lower than the inflation rate of about 7.2%. Service providers informed us that this has made it challenging to maintain the current programs' service levels. For example, a service provider indicated that it cut one staff member from its case management program, resulting in about an 8% reduction in the number of staff contacts made with clients enrolled in the program between 2017/18 and 2018/19.

4.2.3 Funding Allocated to Existing Addictions Treatment Programs without Evaluating Program Effectiveness

The Ministry has not collected any information from addictions treatment service providers about their operations to assess the effectiveness of their programs. Without this information, the Ministry continues to fund service providers without considering and determining whether their programs meet clients' needs effectively and contribute to a reduction in addictions.

The Ministry and the LHINs require service providers to submit information on spending and service activity (number of clients treated) by their programs. This enables them to compare this information to service activity targets set by the LHINs. However, the Ministry and the LHINs do not collect any information from the service providers to assess the effectiveness of the addictions treatment services. While what effectiveness means can differ depending on the specific goals of a client, it generally refers to improvements in a client's health, function and quality of life.

We noted that some service providers have identified ways to evaluate the effectiveness of their addictions treatment programs. For example:

- One service provider we visited evaluates its clients' outcomes through tracking a number of measures that include change in substance use and in the number of hospital visits and police interactions before and after treatment. Between 2010 and 2016, it noted that 75% of the 192 individuals who entered its program identified their substance use as consistent and problematic. Two years later, when contact was made with 18 clients who completed the program, only 17% identified their substance use as consistent and problematic.
- Another service provider offering residential addictions treatment has worked with a research institute since 2015 to survey its clients. Of those who completed the surveys, 61% reported not using any substances over a one-year follow-up period. Regarding alcohol use specifically, the percentage of clients who were abstaining from alcohol increased from 48% prior to admission to 87% one-year after treatment.

While these examples are based on survey results from only a sample of clients, they demonstrate that it is possible to assess the effectiveness of addictions treatment programs in various ways, which the Ministry and/or LHINs could have done by requiring program evaluation performed by the service providers or conducting their own work in this area.

4.2.4 Needs of Vulnerable Population Groups for Addictions Services Not Fully Met

While certain population groups, such as children and youth, as well as Indigenous people, have additional or special needs for addictions treatment services, the services available and the Ministry's funding does not appear to be sufficient to meet their needs.

Children and Youth

The average wait time for youth residential treatment programs between 2014/15 and 2018/19 has remained long at about 65 days. However the total number of residential beds designated for youth has been reduced from 116 to 113.

According to Statistics Canada, young people aged 15 to 24 are more likely to experience mental health conditions and/or substance-use disorders than any other age group in Canada. In 2018/19, Children's Mental Health Ontario, an association representing nearly 100 publicly funded child and youth mental health agencies, conducted a survey and found that 67% of respondents indicated that there are not enough addictions services available for children and youth in their regions.

Studies also showed that youth with untreated addictions can develop more serious addictions later in life that can result in other adverse consequences, including the aggravation or development of depression or anxiety, increased risk of being arrested, or involved in motor vehicle accidents and other violent events. Therefore, it is important that youth can obtain appropriate addictions treatment services in a timely manner.

In addition, we noted that one of the barriers to providing addictions treatment for children and youth is that consent is required from children and youth themselves for the majority of addictions services in Ontario, as well as across Canada. This differs from other regions, such as parts of the United States, where medical consent begins at age 18, meaning that a parent or guardian can consent to addictions treatment on behalf of a child. Stakeholders we met with also raised concerns that children and youth with addictions often lack the capacity to make decisions in their own best interests, but laws in Ontario give priority to the rights of children and youth to refuse treatment, which allows their addictions to progress and puts them at risk.

Indigenous Peoples

The needs of Indigenous peoples for addictions services are not fully met despite the Ministry's dedicated funding.

A 2016 report published by the province, *The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples*, showed that throughout Ontario, 82% of on-reserve First Nations (a subset of Indigenous peoples) adults and 76% of First Nations youth identified problematic alcohol and drug use as the main challenge facing their community. While Indigenous peoples can access addictions treatment from any addictions treatment service providers, some service providers focus their programs on culturally appropriate treatment services, such as the use of sweat lodge ceremonies and traditional healing for Indigenous peoples both on-reserve and off-reserve.

The Ministry dedicated over $100 million in new funding for mental health and addictions initiatives for Indigenous peoples to be allocated between 2018/19 and 2022/23. In 2017, the Ministry asked Indigenous communities, organizations and service providers to submit potential programs that could be considered for new funding. The Ministry received 114 proposals and ranked 60 as highly able to meet the needs of Indigenous peoples. However, the Ministry's dedicated funding was sufficient to fund only 44 of the 60 proposals.

4.2.5 Funding Provided for Addictions Services Late in Fiscal Year Not Spent

We noted that between 2014/15 and 2018/19 the amount of funding received by a number of addictions treatment service providers was more

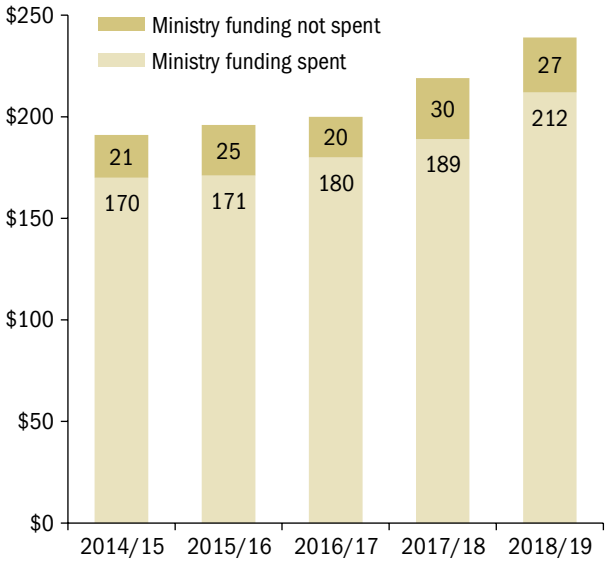
than the amount they spent on their addictions treatment programs. As shown in **Figure 18**, the difference between funding received and spent by service providers on their programs amounted to $123 million or almost $25 million on average annually, representing 12% of the total funding. While the Ministry informed us that the difference can be attributed to administration costs incurred by the service providers that they would not report as spending on addictions treatment programs, we found that this is also because service providers receive funding late in the fiscal year.

While the Ministry has increased funding for addictions treatment services since 2014/15, service providers have been unable to use all funding effectively within the designated fiscal year because they received new funding late in their fiscal year and did not have time to plan for its use. As such, they returned unspent annual funds to the Ministry.

There were instances where the Ministry did not allocate new funding to the LHINs until late in the fiscal year for distribution to the service providers. For example, in 2018/19, the Ministry had over $1.6 million in one-time funding available for one of the LHINs for community mental health and/or addictions programs. However, the Ministry did not inform the LHIN until January 11, 2019, about this funding, which had to be spent by March 31, 2019, and required the LHIN to submit a plan to the Ministry indicating how it intended to spend this money. While the LHIN was able to submit the plan to the Ministry on January 18, 2019, and allocate about $1.1 million to service providers, it was unable to allocate the remaining $500,000 due to the short time frame. In addition, the LHIN was unable to guarantee service providers as to the availability of this funding in future fiscal years due to its one-time nature, which made it difficult for the service providers to effectively plan how these funds could be used.

Figure 18: Funding Spent and Not Spent by Service Providers on Addictions Treatment Programs, 2014/15–2018/19 ($ million)

Source of data: Ministry of Health



RECOMMENDATION 2

To better meet clients' needs by providing them with timely access to appropriate and effective addictions treatment services, we recommend that the Ministry of Health:

- implement a needs-based funding model for existing and new programs;
- develop a standard approach to collect information (such as client outcomes) from service providers to assess the effectiveness of their treatment programs and take this into consideration when making future funding decisions;
- monitor the needs of children and youth as well as Indigenous peoples for addictions services to determine whether additional investment is necessary;
- work with stakeholders and peer deputy ministers of health from other provinces in Canada to discuss and identify ways of providing parents with a voice to positively guide addictions treatment for their children and youth; and
- develop a process to communicate one-time and ongoing funding decisions sooner to addictions treatment service providers to enable them to properly plan and use funding effectively for treatment services.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to provide people with timely access to appropriate and effective addictions treatment services by building a comprehensive and connected mental health and addictions system. The Ministry is exploring ways of assessing need and applying evidence of need to future funding decisions, including a core services framework. The Ministry is also working to identify opportunities to enhance quality throughout the mental health and addictions service system including robust data collection and analysis as well as quality assurance and improvement.

To further ensure that funding for addictions treatment services meets clients' needs, the government has committed to investing $3.8 billion over ten years for mental health, addictions and supportive housing. Of this investment, more than $25 million has flowed to build capacity and reduce wait times for community mental health programs, including services targeted to areas with the highest needs and priority populations, such as Indigenous people and communities.

Through these investments, the Ministry will improve access to front-line services and build a modern system focused on core services, and a robust data and digital strategy as well as a performance measurement framework to more effectively assess the effectiveness of addictions treatment service providers' programs.

The Ministry acknowledges the importance of addictions treatments for children and youth and will continue to identify ways to address the recommendation with respect to the consent to treatment for children and youth. Currently, there is no age specified in the *Health Care Consent Act* that governs an individual's ability to consent to treatment. A child may be capable of consenting to treatment, depending on the treatment proposed. Rather than age-based consent, the ability to consent is based on the person's capacity to understand the treatment being proposed and the reasonably foreseeable consequences of accepting, or not accepting, the treatment proposed.

The Ministry's current funding process exists within the broader government financial planning processes and is subject to the constraints of those processes. The Ministry will continue to communicate funding decisions as promptly as possible to all health service providers. Health service providers seeking assistance with their financial planning are encouraged to work directly with the health authority in their area (i.e., the Local Health Integration Network or Ontario Health).

4.3 Lack of Provincial Standards Can Contribute to Variability in Addictions Treatment Services across the Province

The Ministry has not established provincial standards for most types of addictions treatment programs to ensure consistency of the services these programs provide.

4.3.1 No Provincial Standards for Residential and Non-Residential Addictions Treatment Programs in Place in Ontario

While the Ministry has identified withdrawal management program standards that service providers are required to follow, it has not mandated standards for residential and non-residential addictions treatment programs. As a result, there are differences between addictions treatment service providers' operations and programs, because service providers are responsible for determining how to structure and deliver their programs (see **Sections 4.3.2, 4.3.3**, and **4.3.4**).

Currently, there is only a set of standards that the Ministry requires service providers to comply with, and it is for withdrawal management programs—no standards have been imposed on

service providers of residential and non-residential programs. Specifically:

- **Residential programs:** In 2017, Addictions and Mental Health Ontario released a standard for residential programs. This standard stipulates that staff in residential programs should use evidence-based treatment, such as cognitive behaviour therapy, peer mentoring or support for clients with addictions (or counselling services for family members of clients with addictions). However, at the time of our audit the Ministry informed us that it was not planning to require service providers to follow this standard.
- **Non-residential programs:** The Ministry informed us that it has not identified nor developed any standard for non-residential programs for addictions treatment service providers to follow.

4.3.2 Addictions Treatment Programs are Delivered Inconsistently across the Province

As discussed in **Section 4.3.1**, limited provincial standards are in place for addictions treatment programs to follow. Therefore, service providers are responsible for determining how to structure and deliver their programs, resulting in significant differences between service providers for the same type of program.

For residential treatment programs, our review of information from 28 service providers identified differences such as the expected length of program, duration of treatment and client-to-staff ratio. Specifically, we noted that:

- The expected length of programs ranged from 19 to 175 days.
- The duration of treatment ranged from three to four hours a day to eight or more hours a day.
- The client-to-staff ratio ranged from two clients per staff to 12 clients per staff.
- The staff who delivered group counselling sessions had credentials ranging from college diplomas (such as addictions service workers) to post-graduate degrees (such as psychologists).

For non-residential programs (primarily counselling and case management), our review of information from 38 service providers identified variability in their service availability during weeknights and weekends. Limited weeknight or weekend programs can make it challenging for some clients (such as those who go to school or work during the day) to access addictions treatment. Specifically, we noted that:

- Approximately 30% of programs did not offer any services during weeknights, with about 50% of programs offering services one to two weeknights a week and only 20% of programs offering services three or more nights a week; and
- 76% of programs did not offer any weekend services, with only 21% of programs offering services at least three weekends a month.

RECOMMENDATION 3

To provide people with consistent and evidence-based addictions treatment services, we recommend that the Ministry of Health:

- collect information on addictions treatment service provider programs (withdrawal management, non-residential and residential) to understand differences in their operations and service delivery (such as program length and duration, client-to-staff ratio and staff qualifications);
- review the hours of operation of non-residential service providers to determine whether services are being offered at times to meet the needs of those requiring addictions treatment counselling and case management services; and
- use the information collected and work with the service providers, stakeholders and clinical experts to implement standards for the programs.

MINISTRY RESPONSE

The Ministry agrees with the Auditor General that having better data on addiction programs is an important part of improving service quality and access. This means improving the collection, analysis, and reporting of data in the mental health and addictions sector for Ontarians of all ages.

To support the development, implementation and monitoring of evidence-based core service standards, the government has introduced legislation for the Centre of Excellence for Mental Health and Addictions, housed at Ontario Health, to take on these core responsibilities.

The Ministry has also been working to enhance its data collection capacity through the development of key performance measurement indicators and data collection alignment, and for addictions specifically, implementation of the Staged Screening and Assessment tools.

To support better quality of addictions services and access to those services, the Ministry has been working on the development of a set of evidence-based service standards, along with the implementation and monitoring of those standards. Standards could address hours of service to improve access to services, though greater access may be achieved by a variety of methods, particularly in rural and remote communities. Implementation of standards based on best practices would be a key component and could include developing communities of practice and providing on-the-ground support to individual programs.

As part of monitoring service provider performance, the Ministry will work on developing high-level performance indicators, outcome measures and program-specific assessment tools that assess key components of the standards.

4.3.3 Operation of Centralized Access Centres for Addictions Treatment Differs Across the Province

While some regions of the province have set up centralized access centres where individuals can obtain assessments and referrals to the appropriate service provider from one source, the services offered by these centralized access centres vary.

As discussed in **Section 2.3.1**, people with addictions can refer themselves by directly contacting an addictions treatment service provider to arrange for an eligibility assessment and work with the service provider to determine which program will best meet their needs. However, given that there are about 200 service providers operating at over 450 locations across Ontario that can offer different addictions services, it can be challenging for an individual to research them and figure out which service provider at which location would be the most helpful and appropriate for their needs.

The Ministry informed us that, apart from ConnexOntario (from which, as explained in **Section 2.3.1**, people can obtain information on the addictions services available in their local area), six of the 14 LHINs have established access centres to help people identify and be referred to addictions services available in the region. However, we noted significant differences in the operations of these six access centres (see **Figure 19**).

RECOMMENDATION 4

To allow people across the province to easily identify addictions treatment services that will meet their needs, we recommend that the Ministry of Health:

- develop and implement a centralized access centre model for addictions services that minimizes variations in accessibility across the province; and
- evaluate the costs and benefits of consolidating the existing addictions treatment service providers to identify potential efficiencies by integrating their operations and programs.

Figure 19: Differences in Operations between Access Centres of Six Local Health Integration Networks (LHINs)

Prepared by the Office of the Auditor General of Ontario

LHIN	Provides Services Related to Youth Less than 16 Years Old	Performs Eligibility Assessment for People[1]	Has One Common Referral Form for All Programs[2]	Can Schedule Appointments Directly with Service Providers	Hours of Operation
Mississauga Halton	×	×	✓	×[3]	Monday–Saturday, 8:30a.m.–8:00p.m.
Waterloo Wellington	✓	✓	×	✓[4]	24 hours a day, seven days a week
Champlain	×	✓	×	✓	Monday–Friday, 8:00a.m.–8:00p.m.
South West	✓	×	×	✓	24 hours a day, seven days a week
Toronto Central[5]	Varies	Varies	Varies	Varies	Varies
Central	×	✓	✓	×[3]	Monday–Friday, 8:30a.m.–4:30p.m.

Note: The Ministry informed us that while some form of centralized access for service providers exists in other LHINs, the models used there were generally less developed than the six more established centralized access centres identified above.

1. This ensures that an individual is being referred to the appropriate addictions treatment service provider and program.
2. This ensures a more efficient process by collecting the same information and giving it to each relevant addictions treatment service provider.
3. This functionality is being explored.
4. Only for four of the 11 addictions treatment service providers in the region.
5. Toronto Central has four centralized access centres (St. Michael's Coordinated Access to Addictions, Access CAMH, Central Access and the MHA Access Point) that provide different services in the region. The population served, ability to perform detailed assessments for people, ability to schedule appointments directly with service providers and hours of operation differ among these access centres. Each of these centralized access centres uses a common referral form for all programs it refers to.

MINISTRY RESPONSE

The Ministry supports this recommendation and recognizes the need to improve access to addictions services. The Ministry is currently exploring a model that would seek to streamline access to mental health and addictions (MHA) services by building a co-ordinated access and navigation system that would include a single phone number and website (with texting and chat capability).

This access system would provide online programs/supports, general MHA information, and screening and referral using common MHA screening tools to refer people to the appropriate type of service and level of care, enabling better navigation and increased consistency in access across the province.

In addition to a provincial access system, Ontario Health Teams, mandated to provide health care across the continuum including MHA, will drive MHA providers to be more integrated with each other and with the rest of the health services within their Ontario Health Teams, improving access to services.

4.3.4 Behavioural Addictions Not Treated or Reported Consistently by Addictions Treatment Service Providers

The Ministry has not established a consistent provincial approach for treating and reporting behavioural addictions. This results in differences between addictions treatment service providers, both in terms of how they treat clients with behavioural addictions and in the way they report such services to the Ministry.

Since service providers do not accurately and consistently report the types of behavioural addictions that they actually treat, the Ministry does not know the extent of provincial behavioural addictions (other than problem gambling) being treated. In addition, the Ministry does not have the information needed to determine whether the services available to treat behavioural addictions are sufficient and effective to meet people's needs.

Apart from problem gambling, which is a well-established diagnosable addiction, there are other types of behavioural addictions, such as Internet, gaming and sex. The standard published by the American Psychiatric Association in 2013 does not include a diagnosis for any behavioural addictions other than problem gambling; it identifies Internet gaming disorder as a "condition for further study." A more recent standard, produced by the World Health Organization in 2018, identifies gambling and gaming disorders as "disorders due to substance abuse or addictive behaviours" and compulsive sexual behaviour disorder under "impulse control disorders."

The Ministry funds addictions treatment service providers to treat either problematic substance use or gambling and asks them to report back on how many clients they treated for either one or the other addiction. In other words, problem gambling is the only type of behavioural addiction funded and tracked by the Ministry. We identified differences in how service providers treat behavioural addictions other than problem gambling.

We collected information from 41 service providers and noted that the majority of them (about 73%) did provide treatment for behavioural addictions other than problem gambling. (Gaming and Internet were the main addictions treated, but treatment was also provided for pornography, sex and shopping addictions.) However, they reported such treatment to the Ministry in various ways: about 54% of them reported it as problematic substance use, 23% reported it as problem gambling and the remaining 23% reported it as either problematic substance use or gambling. For example:

- One service provider treated 62 clients in 2018/19 with different types of behavioural addictions, but reported them all to the Ministry as treatment for problem gambling.
- Another service provider treated 89 clients in 2017/18 with different types of behavioural addictions, but reported some services as problematic substance use and others as problem gambling.

For the remaining (about 27%) service providers who did not treat behavioural addictions, most of them indicated that they would like to treat behavioural addictions. However, since their funding was for treating problematic substance use and gambling only, they could not provide treatment to individuals with any other types of behavioural addictions and could only direct these individuals to other addictions or mental health service providers for treatment.

RECOMMENDATION 5

To provide Ontarians with treatment for behaviour addictions in a consistent manner, we recommend that the Ministry of Health develop reporting standards for behavioural addictions and require addictions treatment service providers to report the types of behavioural addictions they actually treat separately from problematic substance use and gambling.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and will review avenues for incorporating behavioural addictions more formally in reporting standards and processes as research and understanding matures. The Ministry will also explore how behavioural addictions could fit within a core services model should this be included in the Ministry's policy agenda moving forward.

The Ministry generally does not fund community mental health and addictions services by diagnosis. The Ministry funds services through

three streams: mental health, addictions/substance use and addictions/problem gambling. Financial reporting is aligned to these three streams by functional centre. The Ministry is aware of people with problematic behaviours, such as Internet gaming addiction and problematic technology use, receiving treatment in our publicly funded system. We have found that currently funded programs are often helpful as they are, currently structured or with minor adjustments, and are responsive to a wide range of behavioural addiction.

4.4 Programs or Practices to Reduce the Number and Frequency of Emergency Department Visits for Addictions Services Are Not Widely Adopted

As discussed in **Section 4.1.2**, more people are visiting emergency departments to obtain services related to substance-use conditions, even though emergency departments are not designed to treat addictions. While a number of programs or practices offered by addictions treatment service providers can help to reduce emergency department visits and therefore result in more effective or, in some cases, less costly, addictions treatment, they are not widely adopted and not available consistently throughout the province.

Examples of these programs and practices include the following:

- **Rapid Access Addiction Medicine clinics (clinics)**, primarily located in hospitals, community health centres and physicians' offices, provide walk-in access where people can obtain addictions treatment (such as counselling, prescriptions for medications and referral to appropriate treatment programs). A 2015 evaluation of a clinic in one hospital identified that, when comparing client outcomes 90 days before and 90 days after using the clinic, emergency department visits dropped 60%, days admitted into hospital dropped 80%, and there was an approximately 80% (or $5,000) savings in health-care costs to treat the client. Despite the benefits of the clinic, we noted that the existing 54 clinics in Ontario funded by the Ministry are, on average, open only about four hours at a time, and more than half of them are open three or fewer days a week. Based on our discussion with the clinics, this was often due to a lack of funding for staffing and resources. The Ministry has not conducted any review of the overall cost-effectiveness of the clinics to identify if the operating hours and days of the existing ones should be expanded or if additional clinics should be opened to meet people's needs.
- **Case management** is a program where case managers meet regularly with clients to ensure that apart from addictions treatment, they also obtain the other health and social services they need. In other words, case management offers clients a single point of contact to replace a haphazard process of referrals. Since 2010, an addictions treatment service provider in Toronto has operated a case management program that focuses on supporting clients who frequently visit emergency departments. This program has been proven to successfully reduce emergency department visits. In 2018/19, emergency department visits by the 167 program participants was reduced by almost 80%, dropping from 2,886 visits before participating in the program to 607 visits after joining the program. Based on our 2018/19 analysis of data of frequent visitors to emergency departments, considered as 10 or more visits within a fiscal year, for substance-use conditions, we estimated that if this same case management program had been implemented by other service providers province-wide, it could have reduced almost 22,000 emergency department visits during the fiscal year.

- **Nursing care on-site for withdrawal management programs** can help to reduce the need for emergency department visits by people with addictions. However, we noted that withdrawal management programs are primarily delivered by non-medical staff, including addictions counsellors. Our review of information from 15 withdrawal management programs noted that over 40% did not have nursing staff in their programs, and only one had access to nursing staff 24 hours a day, seven days a week. Service providers with nursing on site could admit more people into their withdrawal management programs (as they did not need to turn away people who required basic medical care), and they did not need to send clients to emergency departments to obtain basic medical care (for example, to have wounds treated or be prescribed antibiotics). For example, one service provider informed us that after adding nursing to its withdrawal management program, the number of its clients increased by more than 80%. Another service provider informed us that after adding nursing staff to its withdrawal management program, the number of its clients going to the emergency department was reduced by more than 10%.
- **Protocols for transporting people from police and paramedics to addictions treatment service providers** can provide a number of benefits (such as saving the time spent by police and paramedics waiting in an emergency department, as well as avoiding the costs of treating people in an emergency department or incarcerating them overnight) and better addictions treatment (since the service provider has trained staff who can begin expert treatment right away). However, we noted that Thunder Bay is the only region with a protocol for police and paramedic services to bring people experiencing the effects of problematic substance use directly to a local withdrawal management program. This protocol has been in operation with local police for over 20 years and with local paramedic services since 2014.

RECOMMENDATION 6

To provide Ontarians with more effective addictions treatment, we recommend that the Ministry of Health:

- evaluate the effectiveness of the existing Rapid Access Addiction Medicine clinics (clinics) to determine the costs and benefits of expanding the clinic hours or establishing additional clinics;
- evaluate the costs and benefits of expanding the case management program to regions where emergency departments have a large number of frequent visitors;
- identify withdrawal management programs with no nursing staff and evaluate the costs and benefits of adding nursing staff to these programs; and
- work with addictions treatment service providers, police and paramedic services to develop protocols for taking individuals directly to service providers versus emergency departments in appropriate circumstances.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to ensuring effective delivery and ongoing assessment of mental health and addictions services in Ontario. As the Ministry works to build a comprehensive and connected mental health and addictions system, we, along with Ontario Health, will continue to evaluate the benefits of various programs, including Rapid Access Addiction Medicine (RAAM) clinics and case management services, and explore opportunities to expand effective evidence-based mental health and addictions services and supports across the province.

The Ministry is currently working with the Mentoring, Education, and Clinical Tools for

Addiction: Primary Care-Hospital Integration (META:PHI) team at Women's College Hospital, the organization that first designed and piloted RAAM sites in Ontario, to gather information on RAAMs across the province including opportunities to address emerging issues, identify service gaps, and implement a consistent model of care. The Ministry will continue to engage with stakeholders across the mental health and addictions sector to inform ongoing policy work and address emerging needs across the province.

The Ministry recognizes the need for increased capacity for the medical management of clients, such as by nursing staff, at residential withdrawal management centres and will explore opportunities to fill this gap.

The Ministry is also committed to working across the whole of government, including with police and correctional officers, to address the mental health and addictions needs of Ontarians. The Ministry will continue to work with the Ministry of the Attorney General and the Ministry of the Solicitor General to ensure Ontarians with mental health and addictions needs who have contact with justice or correctional services are better supported.

4.5 Integration and Co-ordination is Lacking Among Ministries that Provide Addictions Services

Apart from the Ministry of Health (Ministry), other ministries and agencies also fund and provide addictions and/or mental health (which is closely related to addictions) services in Ontario. As identified in **Section 2.3.2**, at least $42 million was spent annually by other ministries and agencies on mental health and addictions services. We identified instances where integration and co-ordination is lacking (both between different ministries and between different divisions and branches within the Ministry).

4.5.1 Despite Expert Recommendation, Addictions Treatment for Individuals in Correctional Institutions Remains Outside the Ministry of Health's Responsibility

The Ministry of the Solicitor General oversees health care, including mental health and addictions, for individuals in provincial correctional institutions. From March 2015 to March 2019, the number and overall percentage of individuals in provincial correctional institutions identified as currently or previously experiencing problematic substance use increased. The number went from about 3,680 to 4,370 (up about 18%) and the overall percentage rose from 46% to 54%.

In 2018, an expert advisory committee prepared a report for the Ministry of the Solicitor General and the Ministry of Health. The committee identified that when compared to the general population, Ontario's correctional population is two to three times more likely to have mental health conditions or experience problematic substance use. The committee also raised a number of concerns, including lack of integrated and consistent correctional health care across the province; poor linkages and co-ordination between correctional health and the broader health system; and gaps in continuity of care and funding of services. To address these concerns, the committee recommended transferring the responsibility of health care for those in correctional institutions from the Ministry of the Solicitor General to the Ministry of Health.

However, both the Ministry of Health and the Ministry of the Solicitor General informed us that they do not have plans to implement this recommendation at this time. Instead, the Ministry of the Solicitor General is working on a new health-care strategy in 2019/20 to standardize treatment for problematic substance use at correctional institutions.

A number of provinces (British Columbia, Alberta, Quebec and Nova Scotia) have already transferred health-care service responsibility in correctional institutions from their justice or correctional sector to their health-care sector. Newfoundland has also committed to such a transfer by 2021.

We also found that more work still needs to be done to better integrate and co-ordinate addictions services for individuals, not only within correctional institutions, but also upon their discharge from institutions. In 2018, the Office of the Chief Coroner identified 31 individuals who died from opioid overdoses within four weeks of discharge from a provincial correctional facility. This indicates that better integration and co-ordination between correctional health and the broader health system could have facilitated these individuals' access to addictions treatment services in the community upon discharge. (See our Adult Correctional Institutions value-for-money audit report for additional details.)

4.5.2 Children and Youth Could Benefit from Better Integrated Mental Health and Addictions Services

Since April 1, 2019, the Ministry of Health has been responsible for both mental health and addictions treatment services for children and youth. However, it has not co-ordinated the two services effectively, even though a significant portion of children and youth with addictions issues also have mental health conditions.

In 2017, the Mental Health and Addictions Leadership Advisory Council recommended that the Ministry "implement a single set of core services for mental health and addictions for children and youth 0–25, to be delivered in a concurrent-disorder capable way" and "increase capacity in youth addictions services." In response to this recommendation, as of April 1, 2019, the Ministry of Health took over full responsibility for the oversight of children and youth mental health agencies from the Ministry of Children, Community and Social Services.

In 2019, an addictions residential treatment program for youth in Ontario published a survey of parents of clients admitted into this program between 2010 and 2017. The survey showed that 69% of admitted youth had at least one mental health issue, in addition to the addictions for which they were seeking treatment.

However, the Ministry has identified that only seven (or 3%) of 247 children and youth mental health agencies provide addictions services. Due to the lack of service providers capable of treating youth with both mental health conditions and addictions, people seeking treatment are forced to spend more time on identifying service providers, going through separate assessments to determine what addictions and mental health service they need, and travelling to different sites to obtain services.

RECOMMENDATION 7

To better integrate and co-ordinate the addictions services provided by different ministries and agencies in an efficient and effective manner, we recommend that the Ministry of Health:

- work with the Ministry of the Solicitor General to develop procedures to improve access to addictions treatment services for individuals in correctional institutions and after being discharged;
- formally reassess the costs and benefits of transferring the responsibility of health care for those in correctional institutions from the Ministry of the Solicitor General to the Ministry of Health; and
- evaluate the need for additional co-ordination of mental health and addictions treatment services for youth, and assess whether the existing service providers have the capacity and skill set to meet their needs or whether new service providers are needed.

MINISTRY RESPONSE

The Ministry of Health supports the Ministry of the Solicitor General with their plan to enhance addictions support in institutions, and is exploring opportunities to invest in addictions workers, etc., and expand training on the Global Appraisal of Individual Need (GAIN) assessment tool to correctional workers and/or Release From Custody Workers, to improve access to addictions treatment for incarcerated and discharged individuals.

The Ministry of the Solicitor General created a Corporate Health Care and Wellness branch in November 2018 that provides strategic oversight and health-care expertise within correctional services and centralizes all health-related roles and responsibilities. The Ministry of Health continues to support the Ministry of the Solicitor General with its implementation of a correctional health-care strategy that is focused on improving the quality of care provided to inmates and offenders, in alignment with the broader health-care system.

In June 2018, the Ontario government announced that funding and accountability for child and youth mental health programs would transfer from the Ministry of Children, Community and Social Services to the Ministry of Health to support the vision of a mental health and addictions system that reaches Ontarians of all ages and is co-ordinated with other health services to better support Ontarians.

The Ministry of Health continues to evaluate and be responsive to identified gaps in Ontario's health system, including service gaps for children and youth in addictions treatment. In 2018/19, the Ministry invested $51 million in youth residential treatment, youth withdrawal management, and child and youth mental health services. The Ministry of Health is also piloting an integrated youth services model known as 'Youth Wellness Hubs Ontario' where young people aged 12 to 25 can receive walk-in, one-stop access to mental health and addictions services, as well as other health, social and employment supports under one roof.

4.6 Opioid Strategy Needs Improvements to Address Ontario's Opioid Crisis

As discussed in **Section 2.4**, in August 2017, the Ministry of Health announced an investment of over $222 million for an Opioid Strategy (Strategy). This was in response to what was being recognized as an opioid crisis, evidenced by the significant increase in opioid-related deaths from more than one per day in 2007 to more than two per day in 2016. While many of the initiatives of the Strategy (see **Appendix 5**) are supported by evidence that they can have a positive impact on people addicted to opioids, the opioid crisis in Ontario continues, indicating that more needs to be done to end the crisis.

4.6.1 Opioid-Related Emergency Department Visits, Hospitalizations and Deaths Increased Despite Spending about $134 Million between August 2017 and March 2019 on the Opioid Strategy

While the Ministry spent approximately $134 million on the Strategy between August 2017 and March 2019, opioid-related deaths continued to grow from more than two deaths per day to four deaths per day, and opioid-related emergency department visits and hospitalizations also increased.

Figure 20 shows the trend of opioid-related emergency department visits, hospitalizations and deaths in Ontario between 2009 and 2018. We noted that between 2016 and 2018 (during the period shortly before and after the Strategy was launched):

- Opioid-related deaths grew almost 70% (from 867 to 1,473).
- Opioid-related emergency department visits more than doubled (from 4,427 to 9,154).
- Opioid-related hospitalizations increased by more than 10% (from 1,908 to 2,106).

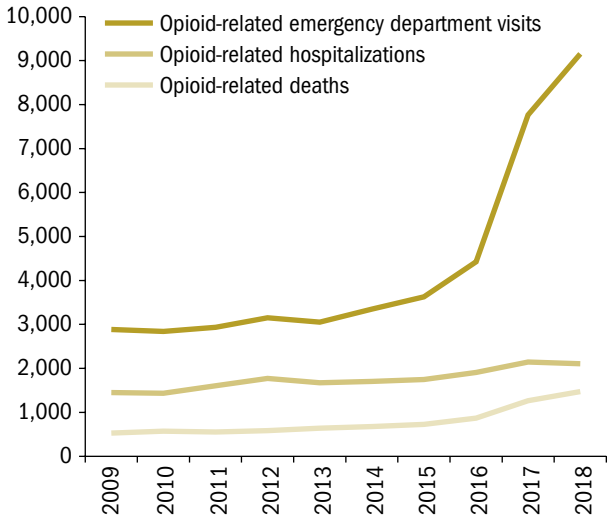
Figure 21 shows opioid-related deaths, by LHIN, in 2018.

These opioid-related trends and regional data indicate that the effectiveness of the Strategy has yet to be seen. We identified a number of areas where improvements are necessary to reduce the burden of the opioid crisis on the province as follows:

- No specific funding goals and specific performance targets were set for the Strategy (see **Section 4.6.2**).

Figure 20: Opioid-Related Deaths, Emergency Department Visits and Hospitalizations in Ontario, 2009–2018

Source of data: Public Health Ontario



Note: The significant increase between 2015 and 2017 was related to the use of fentanyl, which became more widely circulated and sold either as an opioid itself or mixed with other drugs (such as heroin or cocaine) to make them more potent. Fentanyl is much stronger than most other opioids—up to 100 times stronger than morphine. Beyond fentanyl, fentanyl analogues (compounds that are similar to fentanyl) have also started to be sold illegally or are being added to other illegal drugs sold by drug dealers. One example of this is carfentanil, which is 100 times stronger than fentanyl. Even a small amount of fentanyl or fentanyl analogues can cause an overdose, resulting in more emergency department visits, hospitalizations and even deaths.

- The Opioid Emergency Task Force is not used effectively by the Ministry to implement the Strategy (see **Section 4.6.3**).
- Funding for the Strategy is not targeted at treatment or highest need (see **Section 4.6.4**).
- Information on unusual or suspicious dispensing events related to opioids is not regularly shared with prescribers and regulatory colleges (see **Section 4.6.5**).
- Guidelines for opioid agonist therapy are not consistently followed by service providers (see **Section 4.6.6**).
- No actions have been taken to achieve cost savings and insufficient information has been collected to assess the effectiveness of naloxone distribution through pharmacies (see **Section 4.6.7**).
- Consumption and Treatment Services sites are not set up in all regions with a need and not operated consistently (see **Section 4.6.8**).

4.6.2 No Specific Goals and Targets Were Set for the Opioid Strategy

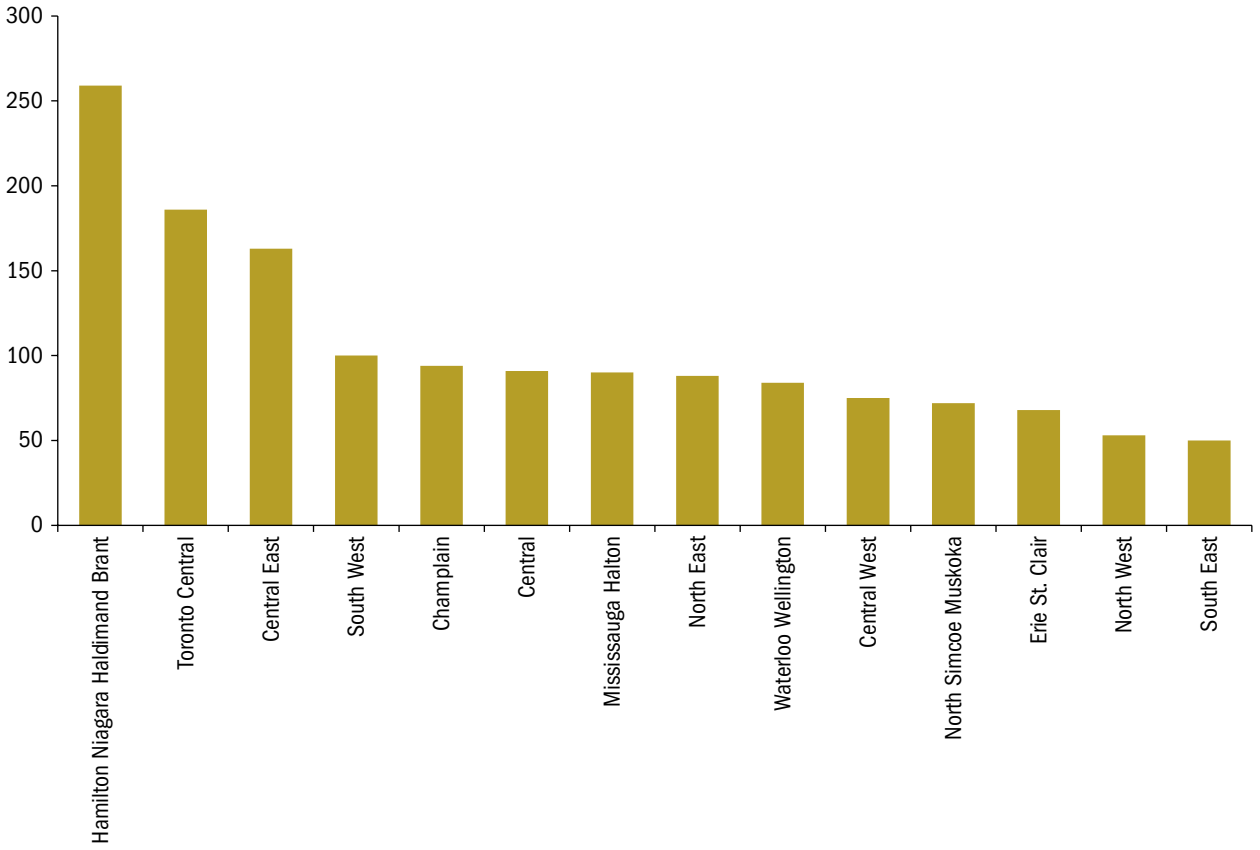
When the Opioid Strategy was developed in 2017, the Ministry did not establish any specific measurable goals and targets to determine if its funding for the Strategy was sufficient and allocated appropriately to various initiatives. The Ministry set broad and vague goals and desired outcomes, such as "enhance care for opioid use disorder" and "expand harm reduction services for all individuals using prescription or illicit drugs."

The Ministry informed us that for the first two years of the Strategy, it used initial outcome measures (including opioid-related deaths, emergency department visits and hospitalizations) to broadly assess the effectiveness of the Strategy and worked on developing more detailed performance indicators. **Appendix 9** provides a listing of the 20 indicators that the Ministry plans to measure. At the end of our fieldwork, the Ministry indicated that it had not finalized the performance report to measure performance and outcomes of the Strategy's initiatives. The Ministry has not determined when it will begin setting targets for the indicators or when regular reporting will commence.

4.6.3 Ministry Not Using Opioid Emergency Task Force Effectively to Implement the Strategy

In October 2017, the Ministry established the Opioid Emergency Task Force. The Task Force is composed of over 40 representatives from sectors that include emergency response, frontline community mental health and addictions, addictions medicine and people with lived experience. The Task Force's responsibilities included providing the Ministry with information on barriers to implementing the

Figure 21: Opioid-Related Deaths by Local Health Integration Network, 2018
Source of data: Office of the Chief Coroner



Strategy effectively, feedback on proposed measures to address the opioid crisis and potential solutions to deal with the opioid crisis.

The Ministry has not met with the Task Force since August 2018 and, at the time of our audit, had no plans to do so even though the Strategy is still under way and the opioid crisis continues, as shown by the increase of opioid-related emergency department visits, hospitalizations and deaths (see **Section 4.6.1**).

A December 2018 inquest verdict released by the Office of the Chief Coroner (regarding a Toronto man who died from an opioid overdose in 2015) recommended the Ministry reinstate the task force, stating that it "performed an important role."

4.6.4 Majority of Funding for the Strategy is Not Targeted at Treatment or Highest Need

We identified instances where the Ministry has not targeted its Strategy's funding at treatment or at areas with the highest need. Specifically:

- Over half of the funding for the Strategy is targeted at harm reduction, with only about 35% (or about $93.5 million) of the funding going toward actual treatment for opioid addictions (see **Appendix 5**). A 2019 study in British Columbia estimated that over 1,800 deaths were prevented in the province as a result of harm-reduction activities. While harm reduction is a set of strategies and ideas aimed at reducing the harmful consequences and preventing deaths associated with opioid use (such as providing an environment where people have access to sterile supplies, which can reduce

the risk of Human Immunodeficiency Virus and Hepatitis C Virus infection), it does not directly help stop people's problematic opioid use and treat their underlying addiction.

- The Ministry has allocated over $58 million to the LHINs for opioid addiction treatment in their regions. However, only one-third of the funding was allocated based on factors that reflect regional needs (such as population size, opioid-related deaths, emergency department visits and hospitalizations), with the remainder of the funding equally distributed amongst the LHINs with no consideration of local needs. For example, in comparison with the South East LHIN, the Central East LHIN's population was over three times larger, its opioid-related deaths were more than double, and its opioid-related emergency department visits were triple that of the South East LHIN. However, the Central East LHIN's funding in 2017 was only about 1.6 times higher than the South East LHIN's funding.

RECOMMENDATION 8

To implement the Opioid Strategy (Strategy) cost-effectively and address the opioid crisis in Ontario more effectively, we recommend that the Ministry of Health:

- establish targets for the Strategy's performance indicators to achieve, measure achieved results against the targets on a regular (such as quarterly) basis and take corrective action where targets are not met;
- direct the Opioid Emergency Task Force to meet and report regularly; and
- collect information on the need for opioid addiction treatment across the province and modify the funding and/or initiatives of the Strategy based on the needs information.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to monitoring the effectiveness of its opioids response and has developed an internal performance measurement report for opioids-related investments. The Ministry will continue to update the report periodically and to share with partners within the Ministry. The Ministry will further examine the feasibility of establishing targets to enhance performance monitoring.

The Ministry is also committed to listening to diverse voices and working together with stakeholders to address the opioid crisis. For example, a range of stakeholders, including members of the Opioid Emergency Task Force, were consulted as part of the 2018 review of Supervised Consumption Services and Overdose Prevention Sites. The Ministry has indicated that it will continue to communicate with the Opioid Emergency Task Force. The Ministry will take this recommendation under advisement.

In addition, the Ministry is committed to directing health-care funding to where it is needed most, and that strong accountability mechanisms are in place for all funding agreements. To help address the opioid crisis in Ontario, the Ministry is working to develop a core services framework that will identify a consistent set of core mental health and addictions services, including services for opioid addiction in Ontario, and provide an evidence-based approach to making targeted investments across the province.

As part of the health system transformation, the Ministry has created a new Crown agency, Ontario Health, as a central point of accountability and oversight for the health-care system. The Ministry will explore opportunities to work with Ontario Health to allocate funding in a way that is both accountable and reflective of local and regional needs for opioid addictions treatment.

4.6.5 Information on Opioid Prescriptions is Not Regularly Shared with Prescribers and Regulatory Colleges

Over the last five fiscal years (2014/15–2018/19), there was an average of about 9 million instances where opioids were dispensed to about 1.9 million patients each year. This amount does not include opioids dispensed in hospitals and correctional institutions or for opioid agonist therapy. These opioids were prescribed by over 48,000 health-care providers, who were primarily (about 90%) physicians and dentists.

While opioids can treat pain effectively, the Canadian Medical Association indicated that "opioid dispensing levels are strongly correlated with increased mortality, morbidity and treatment admissions for substance use." It is important to share information on dispensed opioids among prescribers and regulatory colleges to ensure that opioids are being prescribed and dispensed appropriately. However, regular information-sharing with these parties is lacking.

Prescribers Do Not Have Real-Time Access to the History of Opioids Dispensed to Patients

The Ministry has not provided all health-care providers who can prescribe opioids, including physicians and dentists, with access to information on the history of opioids dispensed to their patients, even though this information is readily available from an existing system. Therefore, prescribers may have to rely on information self-disclosed by their patients, who may intentionally or mistakenly provide wrong or incomplete information, leading to inappropriate or excessive prescriptions of opioids by health-care providers.

According to the College of Physicians and Surgeons of Ontario, while the majority of physicians are prescribing appropriately, "in order to support the safest and most effective care possible, it is essential that physicians have real-time access to information about the drugs their patients have been dispensed, particularly opioids and other controlled drugs." Since 2006 or earlier, other provinces such as Alberta and British Columbia have allowed physicians to access a provincial database that contains details on each patient's history of dispensed opioids. In contrast, Ontario still had not made patient information on opioids dispensed available to all physicians and other prescribers even though this information is already stored in an existing system (Narcotics Monitoring System) and is available for viewing through an existing computer application (Digital Health Drug Repository), as shown in **Figure 22**.

Access to the Digital Health Drug Repository is limited to some physicians and dentists. We noted that as of June 30, 2019:

- While about 360 primary care settings (such as family physicians and family health teams) have access to the repository, this is significantly lower than the number of family physician practices in Ontario (over 12,300).
- Dentists generally do not have access to the repository. (Some may if, for example, they work in one of the approximately 220 hospital sites with access to it.) Unlike Ontario, dentists in other provinces, such as Alberta and Nova Scotia, are given access to their provincial databases and are able to access details about their patients' history of opioids dispensed.

Without having access to a patient's history of opioids dispensed, prescribers are unable to verify if their patients have already received opioids dispensed by others. Based on our review of data of opioid dispensing events, we found that there were cases where patients received multiple opioids prescribed by different physicians and/or dentists, creating the risk of overdose. For example, in 2018/19:

- There were almost 1,500 instances where an individual received at least an eight-day supply of opioids prescribed by a physician and within one week subsequently received more opioids prescribed by a dentist. In one case, a patient received a 30-day supply of opioids prescribed by a dentist after receiving a 28-day supply of opioids prescribed by a physician.

Figure 22: Systems Containing Details on Opioids Prescribed and Dispensed

Prepared by the Office of the Auditor General of Ontario

	Narcotics Monitoring System	Digital Health Drug Repository
Developed in which year	2012	2016
Developed by whom	Ministry of Health	Ministry of Health, in collaboration with eHealth Ontario
Type of data available	• Data on all narcotics, controlled substances and other monitored drugs (including opioids) dispensed by pharmacists, irrespective of whether the prescription is paid for under a publicly funded drug program, through private insurance or by cash. • Examples of data include type of opioid prescribed, dispensed date, quantity, strength, prescriber's information (such as licence number), pharmacy information, and patient's information (such as health card number).	• Data from the Narcotics Monitoring System • Data on publicly funded drugs dispensed and pharmacy services (including service date and service description) under the Ontario Drug Benefit Program
Purpose of the system	• Gives notifications to pharmacists at the time of dispensing regarding situations that warrant further review or action, such as contacting the prescriber to confirm the accuracy of a prescription, before the prescription should be dispensed. For example, this could include an individual being dispensed opioids prescribed by three or more health-care providers within 28 days.	• Allows health-care providers to view data from the Narcotics Monitoring System, as well as data on publicly funded drugs dispensed and pharmacy services under the Ontario Drug Benefit Program

- There were nearly 1,000 instances where an individual received opioids prescribed by a dentist, but also received methadone or buprenorphine-naloxone (which are replacement drugs used in opioid agonist therapy) prescribed by a physician less than a week before receiving the opioids.
- More than 5,000 individuals received opioids within a week after receiving methadone or buprenorphine-naloxone. In each case, the physician who prescribed the opioid was not the one who prescribed the methadone or buprenorphine-naloxone.

While our review of data is based on information reported by pharmacy staff dispensing the opioids, the Narcotics Monitoring System does not contain patients' clinical information for why opioids were prescribed and dispensed. The Ministry informed us that to determine the appropriateness of prescriptions, a review would need to be performed of the patient clinical information at the practice level (such as the physician, dentist or pharmacist) in addition to reviewing the details of the individual prescriptions.

Regulatory Colleges Do Not Have Real-Time or Regular Access to Information on Opioids Dispensed to Identify and Investigate Inappropriate Practices by Their Members

While regulatory colleges are responsible for investigating inappropriate practices by their members and for taking corrective actions, they do not have real-time or regular access to information on the opioids prescribed and dispensed by their members on which to base their investigations.

Regulatory colleges generally have to rely on information reported by other parties, such as members of the public, to identify prescribers, dispensers and situations that may require further investigation. The Ministry provides regulatory colleges with information on the prescribing or dispensing activities of their members only if it

receives a request, but does not share such information proactively and regularly—even though the information may assist the regulatory colleges to identify inappropriate practices, perform investigations and take corrective actions on a timely basis. Specifically, we noted that:

- In 2015 and 2016, in response to a request from the College of Physicians and Surgeons of Ontario, the Ministry passed information about 125 physicians with potentially problematic opioid prescribing practices to the College of Physicians and Surgeons of Ontario for further investigation. It also passed information about 17 pharmacies with potentially problematic opioid dispensing practices to the Ontario College of Pharmacists. This has not happened since, as there have not been any further requests like this from the regulatory colleges.
- The College of Physicians and Surgeons of Ontario conducted investigations of physicians in 2017 based on information received from the Ministry in 2016. As a result of these investigations, we identified that two physicians were required to engage in continuing education and one of the physicians was required to have their prescriptions of opioids and other controlled substances monitored by another physician for six months. We noted that, subsequent to the investigation, both physicians reduced the average dosage of the opioids they prescribed per day. This indicated that the sharing of information with the regulatory colleges can be and was effective in correcting and deterring inappropriate practices by prescribers.

Figure 23 shows unusual or suspicious cases that we identified where opioids might have been prescribed or dispensed inappropriately. The Ministry could have proactively flagged these cases to the regulatory colleges for further investigation. The cases we identified can be classified into two categories:

- instances where large dosages of opioids were prescribed and dispensed; and
- instances where pharmacists dispensed opioids that were associated with physicians and dentists with inactive licences.

The Ministry indicated that the approach we used to identify these instances and reach our overall conclusion was valid and that it does not know for certain why they happened. Subsequent to our audit fieldwork, the Ministry investigated about 15% of these instances we identified and informed us that the instances were due to data entry errors, such as entering the wrong prescriber licence number or attributing a licence to the wrong regulatory college. The Ministry informed us that they will continue to investigate these incidents to identify appropriate next steps to take.

We spoke with several regulatory colleges whose members can prescribe or dispense opioids, including the College of Physicians and Surgeons of Ontario, the Ontario College of Pharmacists, and the Royal College of Dental Surgeons of Ontario. They informed us that it is important for the regulatory colleges to have real-time access to information on instances of opioids dispensed or at least to receive regular reports on opioids dispensed that appear unusual or suspicious, so they can be proactive in identifying irregular or inappropriate activity that warrants investigation.

RECOMMENDATION 9

To better prevent and deter inappropriate prescribing and dispensing of opioids, we recommend that the Ministry of Health:

- provide access to data on patients' history of dispensed opioids to all health-care providers who can prescribe opioids;
- implement additional controls in its health information system to validate the prescriber's licensing status before allowing pharmacists to dispense;
- review the unusual or suspicious cases we identified and share appropriate information

Figure 23: Examples of Unusual or Suspicious Instances Where Opioids Were Dispensed

Prepared by the Office of the Auditor General of Ontario

Opioids Dispensed in Large Quantity or Dosage[1]

- The average strength of a daily dosage of dispensed opioids is about 53 morphine milligram equivalents (MMEs) (this is based on all prescriptions from all physicians except prescriptions dispensed for opioid agonist therapy). However, one physician wrote prescriptions to 58 individuals that resulted in 283 opioid dispensing events; the average daily dosage was 924 MMEs, which is over 17 times higher than the average of 53 MMEs. Another physician wrote prescriptions to 11 individuals that resulted in 90 opioid dispensing events; the average daily dosage was 731 MMEs, almost 14 times higher than the average of 53 MMEs.
- A patient received an 840-day supply of opioids within one year, prescribed by one physician and intended for use over two years. Another patient received a 100-day supply of opioids and subsequently received another 100-day supply of opioids one month later at the same pharmacy (these were dispensed based on prescriptions made by the same physician).

Pharmacists Dispensed Opioids Associated with Physicians and Dentists with Inactive Licences[2]

- About 88,000 instances of opioids dispensed between 2014/15 and 2018/19 were prescribed by approximately 3,500 prescribers (2,900 physicians and 600 dentists) with inactive licences. The licences had been inactive since at least 2012, for different reasons (including because the prescribers were deceased, had their licences revoked or were retired):
  - About 9,000 instances of dispensed opioids were associated with about 400 prescribers who died in 2012 or earlier. For example, between 2014/15 and 2018/19, two physicians who died in 1989 were associated with 519 instances of dispensed opioids, and a dentist who died in 2002 was associated with 54 instances of dispensed opioids.
  - About 375 instances of dispensed opioids were associated with approximately 10 prescribers whose licences were revoked for disciplinary reasons in 2012 or earlier. For example, one physician whose licence was revoked in 2000 was associated with 195 instances of opioids dispensed from 2014/15 to 2018/19.
  - Almost 79,000 instances of dispensed opioids were associated with about 3,100 prescribers whose licences became inactive in 2012 or earlier for reasons such as retirement.
- A number of pharmacists and pharmacies had multiple (10 or more) instances where they dispensed opioids associated with prescribers with inactive licences. For example:
  - One pharmacist in Hamilton dispensed opioids 125 times associated with 22 different prescribers (14 physicians and eight dentists) whose licences became inactive in 2012 or earlier (including a dentist who died in 2006).
  - At one pharmacy in Belleville, 18 pharmacists dispensed opioids 230 times associated with 15 prescribers (14 physicians and one dentist) with inactive licences.

Note: Our review was based on information on dispensed opioids reported by pharmacy staff in the Narcotics Monitoring System (see **Figure 22**).

1. Examples are based on 2018/19 data.
2. We identified these cases by comparing licence numbers of physicians and dentists who prescribed opioids that were dispensed between 2014/15 and 2018/19 to active licence numbers provided by the College of Physicians and Surgeons of Ontario and the Royal College of Dental Surgeons of Ontario.

with the regulatory colleges as necessary; and

- work with the regulatory colleges to provide them with direct or real-time access to information contained in the Narcotics Monitoring System or regular reports on unusual and/or suspicious prescribers and dispensers.

MINISTRY RESPONSE

The Ministry supports this recommendation and recognizes the importance of improving provider access to information that is needed to support care. The Ministry will continue efforts to expand provider access to provincially held data, such as the drug and pharmacy services information in the Digital Health Drug Repository (Repository), by supporting the continued deployment and adoption of clinical viewers, particularly in Ontario Health Teams, and by supporting interoperability standards that will allow Repository information to be integrated with point-of-care systems.

The Ministry acknowledges the analysis and observations by the Auditor General regarding unusual cases and notes that the appropriateness of prescriptions cannot be

determined without review of the patient's clinical information at the practice level for all health-care providers involved (for example, physicians, dentists, pharmacists). Investigative work performed by the regulatory colleges in the past has demonstrated that the prescribing patterns observed by the Auditor General would have been clinically appropriate in most circumstances. In other cases, further review has revealed data entry errors, as opposed to inappropriate prescribing or dispensing.

The responsibility for practice-level assessment resides with the regulatory colleges. The Ministry worked with the regulatory colleges and Health Quality Ontario to collectively consider how the Narcotics Monitoring System data could be used in a consistent and evidence-based manner to support health-care providers, including potential responses to prescribing issues and identifying inappropriate dispensing practices. The Ministry will continue to work with the regulatory colleges to explore opportunities to ensure they are provided timely access to information contained in the Narcotics Monitoring System.

4.6.6 Guidelines for Opioid Agonist Therapy Are Not Consistently Followed by Service Providers

As part of the Strategy, the Ministry funded Health Quality Ontario to develop a guideline for caring for people (aged 16 and over) with opioid addiction. The guideline identified opioid agonist therapy as the first-line treatment for individuals addicted to opioids. Opioid agonist therapy uses replacement drugs (such as methadone or buprenorphine-naloxone) to help individuals deal with the cravings and withdrawal symptoms, to stabilize their lives and to reduce the harms related to their opioid use. Various studies have identified that people on opioid agonist therapy were less likely to engage in criminal activity compared with when they were not on opioid agonist therapy. From 2014/15 to 2018/19, the number of individuals on opioid agonist therapy increased by 26%, rising from about 54,000 to 68,000.

We identified that not all addictions treatment service providers and prescribers of opioid agonist therapy follow this guideline. For example:

- The guideline identifies that "if a person receiving opioid agonist therapy enters an inpatient facility (e.g., a hospital or residential addiction treatment program) or a correctional facility, their opioid agonist therapy should be continued without disruption." However, many addictions treatment service providers do not admit people who are taking methadone or buprenorphine-naloxone as part of opioid agonist therapy. We noted that about 40% of providers do not admit individuals who are on methadone. About 20% of providers do not admit individuals who are on buprenorphine-naloxone. Some service providers informed us that they do not follow this guideline because they have been following an abstinence-based approach whereby individuals are encouraged to stop taking all drugs, including methadone and buprenorphine-naloxone. Other service providers indicated that they do not have enough staff to monitor and take care of people who are on opioid agonist therapy.
- The guideline also recommends 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 specialized clinic or via other care providers." However, not all service providers ensure that people on opioid agonist therapy also receive other addictions treatment services. In 2018/19, about 68,000 individuals received opioid agonist therapy, but addictions treatment service providers reported that only about 11,600 (or about 17%) of these individuals received addiction treatment services (such as counselling services) from them in

2018/19. While it is possible that these clients may have received addictions treatment services from someone other than an addictions treatment service provider, such as by paying out of pocket or through insurance for private counselling, it appears that many people on opioid agonist therapy are not receiving other addiction treatment services. Some individuals receive opioid agonist therapy from clinics operated by physicians specializing in providing this therapy. The Ministry does not have information on the number of these clinics, but we identified, using ConnexOntario, over 120 of them (see **Section 2.3.2**). Our review of information from 69 of these clinics noted that about half do not offer counselling services to their clients, primarily because they are not funded to do so.

RECOMMENDATION 10

To provide appropriate and effective treatment based on guidelines for people addicted to opioids, we recommend that the Ministry of Health work with addictions treatment service providers to:

- develop a process that allows individuals on opioid agonist therapy to be admitted to treatment programs; and
- incorporate other addictions treatment services (such as counselling services) into the opioid agonist therapy.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to supporting people with opioid addiction to get the help that they need. The Ministry has been working to improve access to comprehensive addictions treatment, including opioid agonist therapy, in keeping with best practice guidelines. For example, the Ministry has supported initiatives to increase the capacity of primary-care physicians to treat opioid addiction. It has also funded Rapid Access to Addiction Medicine clinics that provide immediate access to short-term, comprehensive addictions care.

To help incorporate other addictions treatment services into the opioid agonist therapy, the Ministry is working to develop a core services framework that will identify a consistent set of core mental health and addictions services in Ontario and provide an evidence-based approach to making targeted investments across the province. Service standards for core services will be developed.

In May 2019, the government introduced legislation that would create a central driver of system quality, the Mental Health and Addictions Centre of Excellence within Ontario Health. If passed, this new partnership will also help address this recommendation by:

- supporting consistent, high-quality mental health and addictions services across the province;
- building a robust data system to inform ongoing performance measurement and monitoring of the system; and
- building a knowledge base that will support continuous improvement across the sector.

4.6.7 No Actions Have Been Taken to Achieve Cost Savings and Insufficient Information Collected to Assess Effectiveness of Naloxone Distribution Through Pharmacies

Naloxone distribution is the Strategy's largest funded program, accounting for over $71 million, or about 27%, of the Strategy's cost. However, the Ministry has not taken action to achieve potential cost savings for the naloxone program and has not assessed its effectiveness.

Naloxone is a drug that can be sprayed into the nose or injected into muscle to temporarily reverse an opioid overdose. It helps the individual to breathe and regain consciousness. The Ministry's naloxone program distributes naloxone kits to

individuals free of charge through three separate initiatives under the Strategy:

- an initiative that distributes naloxone kits through public health units and other eligible community-based service providers;
- an initiative that distributes naloxone kits through pharmacies; and
- an initiative operated by the Ministry of the Solicitor General to distribute naloxone kits to individuals in provincial correctional facilities at risk of an opioid overdose and those who would like to receive one when they are released from custody.

Ministry Has Not Achieved Potential Cost Savings from Distributing Naloxone Through Pharmacies

The Ministry could have achieved potential cost savings of up to about $7 million if it had administered its naloxone distribution initiative through pharmacies as British Columbia does. Specifically:

- Unlike British Columbia, the Ministry does not buy injectable naloxone kits for pharmacies in bulk. Instead, the Ministry pays pharmacies to purchase their own kits at $35 each. This is about $24 more per kit than the Ministry pays when bulk buying the kits for public health units and other eligible community-based service providers. While distribution costs would be incurred, up to about $2.8 million could have been saved with bulk buying given that pharmacies billed the Ministry for about 118,000 injectable naloxone kits purchased between 2017/18 and 2018/19. The Ministry also bulk buys flu shots for public health units, pharmacies, community health centres and hospitals in the Greater Toronto Area.
- Unlike British Columbia, the Ministry reimburses participating pharmacies for dispensing naloxone kits to individuals ($10 per naloxone kit dispensed) as well as for, training individuals, upon request, on how to use injectable naloxone kits ($25 per person trained). The Ministry spent about $4.3 million on these payments between 2017/18 and 2018/19.

Ministry Has Not Collected Sufficient Information to Assess Effectiveness of Naloxone Distribution Through Pharmacies

The Ministry has collected limited information to assess the effectiveness of the naloxone program, even though about 339,000 naloxone kits have been distributed since 2017/18 and the program cost about $35 million between August 2017 and March 31, 2019.

While the Ministry requires public health units to report details of their naloxone distribution, reporting these details is voluntary for participating pharmacies. The details public health units must report include the number of people they train to administer naloxone, the number of kits they distribute and the number of people that receive naloxone.

Although pharmacies have accounted for over 60% of the distributed naloxone kits since the launch of the program in 2017, only about 36% of the approximately 1,575 pharmacies participating in the program have voluntarily reported details of their distributions to the Ministry on a quarterly basis.

While the Ministry is aware of the number of naloxone kits distributed by pharmacies based on their billings, it is unable to fully assess the effectiveness of the naloxone distribution program without collecting complete information from the pharmacies. Such information, where possible, should include the number of people who receive naloxone injections and the number of times paramedic services are called when naloxone is administered.

RECOMMENDATION 11

To achieve savings and assess the effectiveness of its naloxone distribution through pharmacies as part of the Opioid Strategy, we recommend that the Ministry of Health:

- evaluate the costs and benefits of bulk buying injectable naloxone kits for pharmacies and implement bulk buying if it results in cost savings; and
- collect detailed information from all participating pharmacies about their naloxone distribution, such as how many people are trained to use naloxone kits to assess the effectiveness of this initiative in order to identify whether any changes are needed.

MINISTRY RESPONSE

The Ministry appreciates the Auditor General's suggestions regarding naloxone distribution in the province and will revisit the appropriateness of bulk buying naloxone kits for pharmacies. Although the Ministry currently pays pharmacies $35 for each injectable naloxone kit distributed through the Ontario Naloxone Program for Pharmacies (ONPP), this includes the cost of procuring the supplies and assembling the kits. Bulk buying of naloxone will need to consider the operating and distribution costs as well.

The Ministry will review and evaluate the possibility of a centralized distribution system for supplying naloxone kits to the province under all of the Ministry's publicly funded naloxone programs. The logistics of potentially supplying naloxone to approximately 4,500 pharmacies, in addition to the current public health units, were previously examined when the programs were launched but can be further explored at this time.

The Ministry is in the process of updating the Quarterly Report Back Form that pharmacies participating in the ONPP complete for the purpose of gathering outcome information and experiences on the ONPP. This automated and user-friendly form will decrease the administrative burden for pharmacies and will likely encourage higher response rates. More relevant and higher quality data to assist with evaluating the ONPP will be obtained.

4.6.8 Consumption and Treatment Services Sites Not Set Up in All Regions with a Need and Not Operated Consistently

As of April 1, 2019, a new program, Consumption and Treatment Services sites (sites), replaced the previous Supervised Consumption Services and Overdose Prevention Sites that had been in operation since August 2017 and February 2018, respectively. While the Ministry has developed some provincial standards, such as required staffing levels and the range of services to be offered, it has not developed other standards to ensure consistent operations of the sites. Additionally, the Ministry has not determined whether the existing sites are adequate and in appropriate locations.

The sites are considered a harm-reduction initiative, as they are not primarily operated to treat an individual's addictions. Rather, the sites can provide a safe environment where people can:

- consume substances they possess under supervision of health-care professionals (who identify and respond to overdoses);
- access sterile needles and other drug supplies (which reduces the risk of disease transmission from sharing supplies); and
- connect to addictions treatment and other health or social services on-site or off-site (such as primary care and rehabilitation, and mental health and social supports).

The Ministry requires each site to get support from its community, including its local municipal government and local businesses, as part of the application process to establish and run a site.

The sites are mainly located within public health units or community health centres. As of October 15, 2019, the Ministry was funding 16 sites and reviewing the applications from three others. From August 1, 2017 to March 31, 2019, about 157,000 visits had been made to these 16 sites. In this same period, opioid-related deaths had been prevented—none of the over 2,400 overdoses resulted in death, and over 34,200 referrals to other services were made (the equivalent of about one referral for every five visits).

Capacity and Locations of Consumption and Treatment Services Sites Do Not Fully Reflect Community Needs

Not all regions with a need for sites have them. The Ministry approves sites through an application process, but not all regions with a need have applied to establish sites. The Ministry continues to review and accept applications for the establishment of sites. As for the existing sites, the Ministry has not determined whether their capacity and location align with the needs of the region or should be changed.

In 2018, the Ministry assessed the regions showing the greatest need for sites, using information on opioid-related emergency department visits, hospitalizations and deaths between 2013 and 2017. The assessment identified that of the 10 regions with the highest need for a site, eight had sites in place. As of fall 2019, two regions still had no site set up, despite the need. While the Ministry informed us that one region was preparing its site application, the other region had no plans for a site at the time of our audit—even though in 2017, the opioid-related death rate in that region was over double the provincial average and the opioid-related hospitalization in that region was nearly triple the provincial average.

We also noted that the Ministry has not determined what capacity each site should have based on the region's need. For example, although the number of opioid-related deaths in Hamilton in 2018 was 50% higher than that of Ottawa (123 compared with 82), the capacity of Ministry-funded sites in Hamilton is about eight times less than Ottawa. (The Hamilton site currently has three consumption booths versus 25 in Ottawa's sites.)

Lack of Provincial Standards for Consumption and Treatment Services Sites Results in Inconsistent Operations

While the Ministry has established some provincial guidelines for sites, such as staffing levels and services the sites should offer, it has not established provincial standards for how services should be provided at the sites to ensure that they operate as effectively and efficiently as possible and in a consistent way.

The sites are required to fulfill a number of criteria as part of their application to the Ministry. For example, a health-care professional must be present during operating hours, and used supplies must be discarded using appropriate equipment, such as tamper-proof bins.

Our review of information from five of the 16 Ministry-funded sites identified that their operating policies and procedures differed with respect to the type of medical staff on site, the administration of naloxone, contacting paramedic services and taking people to emergency departments, and whether drugs could be checked for the presence of fentanyl (see **Figure 24**).

RECOMMENDATION 12

To provide people addicted to opioids with sufficient and consistent services at Consumption and Treatment Services sites (sites), we recommend that the Ministry of Health:

- analyze data from the existing sites and work with service providers (such as public health units and community health centres) to identify appropriate locations for the sites and what each site's capacity or size should be; and
- work with the existing sites to develop standard policies and procedures for operations (such as the type of health-care provider on site and when to contact paramedic services).

MINISTRY RESPONSE

The Ministry acknowledges that monitoring and evaluating program outcomes are important components of the Ministry's Consumption and Treatment Services (CTS) funding program. The Ministry agrees with the recommendation to analyze data from CTS sites and to work with service providers to monitor performance of the

Figure 24: Differences in Operations between a Sample of Consumption and Treatment Services Sites

Prepared by the Office of the Auditor General of Ontario

Site Location	Type of Medical Staff On-Site	Quantity of Naloxone Administered During an Overdose	Procedure for Contacting Paramedic Services/Taking Client to Emergency Department	Availability of Drug-Checking for Fentanyl[1]
Kingston	Paramedic	Decided by paramedic	Decided by paramedic	No
Guelph	Nurse	One dose or titration method[2]	As naloxone is administered	No
Ottawa	Nurse	One dose or titration method[2]	If two doses of naloxone are not effective	Yes
Middlesex-London	Nurse or paramedic	One dose	If client is not breathing/has no pulse or if other medical complications are present	Yes
Niagara	Paramedic	Titration method[2]	Decided by paramedic	Yes

1. The purpose of drug-checking for fentanyl, an opioid which is much stronger than most other opioids such as morphine, is to reduce the chance of overdose. Drug-checking services help people find out what is in their drug, including if the drug contains toxic substances like fentanyl. Drug-checking is done using fentanyl test strips. For sites to receive fentanyl test strips from the Ministry, they must obtain approval from Health Canada as part of their exempted services under the *Controlled Drugs and Substances Act*.
2. The titration method is a process that more slowly releases a dose of naloxone to an individual. This decreases the risk of providing excessive naloxone, which can result in an individual experiencing withdrawal symptoms from opioids and desiring to immediately use them again.

CTS funding program in order to assess whether any changes to CTS site capacity are required. A monitoring and reporting process is already in place and the Ministry will continue this process.

Based on monitoring and evaluation results, and taking into consideration the need for site-specific operational flexibility, the Ministry will work with existing sites to develop standard policies and procedures where appropriate.

The Ministry's CTS funding program is a new application-based program where communities determine whether to apply for a CTS. The Ministry has established funding criteria for CTS, which is publicly available. All approved CTS went through a rigorous application screening process, and sites that met the Ministry's CTS funding program requirements were approved. This includes local or neighbourhood data to support the location of the proposed CTS site, and how the proposed service delivery model is best suited to local conditions. CTS applications continue to be accepted.

4.7 Recent Changes and Emerging Trends Relating to Addictions Need To Be Monitored

Changes in government policy, regulations and consumer habits can impact the types and trends of addictions as well as Ontarians' need for addictions treatment. We identified a number of recent changes and emerging issues relating to addictions that warrant close monitoring by the Ministry (see **Appendix 10**). For example:

- The legalization of cannabis may increase cannabis use in Ontario.
- The use of electronic cigarettes (also known as e-cigarettes or vaping) has resulted in cases of severe lung illnesses.
- The provincial government's policy decisions will increase the availability of alcohol across Ontario, which research has shown can increase alcohol consumption as well as acute and chronic health harms.

RECOMMENDATION 13

To address emerging addictions issues related to recent government initiatives and consumer

habits, we recommend that the Ministry of Health:

- monitor the use of cannabis by Ontarians of different age groups to determine whether there is a need for additional prevention and addictions treatment services;
- monitor the use of electronic cigarettes (or vaping products) by Ontarians of different age groups to determine whether there is a need for additional prevention and addictions treatment services;
- study the long-term health effects associated with vaping and investigate cases of vaping-related illness to determine whether there is a need to strengthen the monitoring and applicable regulation on the manufacture, labelling, sale and promotion of vaping products; and
- perform an assessment on the impacts of increased alcohol availability to the health system (including impact on emergency department visits and need for addictions treatment services) and use this assessment as part of future addictions treatment funding decisions.

MINISTRY RESPONSE

The Ministry agrees with the Auditor General that protecting the health and well-being of all Ontarians, especially children, youth and young adults, is of the utmost importance. Therefore, the Ministry invests in programs that:

- protect the public, especially children and youth, from the harmful effects of tobacco use and vaping;
- raise awareness of the responsible consumption of cannabis (e.g., Lower-Risk Cannabis Use Guidelines);
- promote the safe consumption of alcohol (e.g., Low-Risk Alcohol Drinking Guidelines);
- prevent alcohol, cannabis and nicotine addiction; and
- provide addiction treatment services, including smoking/vaping cessation services, community and residential withdrawal management, community counselling services, residential treatment and support, and supports within housing.

The Ministry also collaborates with the federal government on issues within their legislative requirements (e.g., manufacturing, labelling).

The Ministry agrees that continued monitoring of the health impact of substance use—cannabis, e-cigarettes and vaping products, and alcohol—on Ontarians is a priority. The government is taking urgent action to address the issue of youth vaping. Starting January 1, 2020, the promotion of vapour products will only be permitted in specialty vape stores and cannabis retail stores (not in convenience stores, gas stations or grocery stores) to which entry is restricted to adults aged 19 and over.

Building on its existing monitoring and surveillance plans, the Ministry is committed to continue monitoring the use of cannabis, e-cigarettes and instances of vaping and vaping-related illness in order to assess the impact that consumption of these products has on addiction in Ontario, including specific age groups. In September 2019, a Minister's Order was issued under section 77.7.1 of the *Health Protection and Promotion Act*, which requires public hospitals in Ontario to provide the Chief Medical Officer of Health with statistical, non-identifying information related to incidences of vaping-related severe pulmonary disease.

The Ministry will also monitor and assess any health impacts that result from the increased alcohol sales (availability) in Ontario. The Ministry will do this once the regulatory changes pertaining to increased alcohol sales availability have been fully implemented and data becomes available.

Appendix 1: Glossary of Terms

Prepared by the Office of the Auditor General of Ontario

Addiction: A chronic, complex condition that is characterized by an individual having cravings, compulsive, uncontrollable use, and use despite harmful consequences. Addictions are classified as either substance (e.g., alcohol, tobacco) or behavioural addictions (e.g., gambling).

Addictions Treatment: Care that helps an individual overcome their addictions. Counselling is the most commonly used form of treatment. Medications are often an important part of treatment, especially when combined with counselling.

Addiction Severity (Mild/Moderate/Severe): Substance use disorders are classified as mild, moderate, or severe, depending on how many diagnostic criteria are met. The Diagnostic and Statistical Manual of Mental Disorders lists 11 Criteria: 1) Hazardous use; 2) Social or interpersonal problems related to use; 3) Neglected major roles to use; 4) Withdrawal; 5) Tolerance; 6) Used larger amounts/longer; 7) Repeated attempts to control use or quit; 8) Much time spent using; 9) Physical or psychological problems related to use; 10) Activities given up to use; and 11) Craving. To be diagnosed with a substance use disorder, individuals must meet two or more of these criteria within a 12 month period. Two or three is considered a mild addiction. Four to five is considered moderate. Six or more criteria is considered severe.

Behavioural addiction: Also known as process addictions, behavioural addictions are not a result of ingesting substances like drugs or alcohol. Behavioural addiction is the compulsion to continually engage in an activity or behavior despite it being a significant disruption to a person's life, relationships and mental and/or physical health and functioning. Problem gambling is the most widely accepted behavioural addiction that is commonly treated.

Case Management: A service where a case manager meets regularly with an individual to assist them in obtaining all health and social services they require.

Counselling: This involves helping people understand why they have an addiction and assisting them in developing strategies to prevent or reduce their engagement with a substance or behaviour. This can be done with a professional in an individual or group setting.

Harm Reduction: An evidence-based, client-centered approach that seeks to reduce health and social harms associated with problematic substance use, without necessarily requiring people who use substances from abstaining or stopping. Essential to a harm reduction approach is that it provides people who use substances a choice of how they will minimize harms through non-judgemental and non-coercive strategies. Interventions may include promoting physical safety, preventing overdose/infection or consequential health issues. Specific practices may include Consumption and Treatment Services sites and supplies as well as housing and shelters that permit substance use.

Non-Residential Treatment Program: Services are offered to individuals while they reside in their home or community. Services may range from an hour-long session to all-day programs and include counselling and case management.

Office of the Chief Coroner for Ontario: Office conducts death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. The findings are used to generate recommendations to help improve public safety and prevent deaths in similar circumstances.

Opioids: Opioids are drugs such as oxycodone, morphine or codeine that are used primarily to treat pain from conditions such as injuries, surgery, dental procedures or long-term chronic pain. Opioids can also induce euphoria (feeling high), which gives them the potential to be used improperly. Opioids are an effective medication when used properly. When being misused, opioids have serious side effects and risks such as the potential for developing an addiction, overdose and death.

Opioid Crisis: The Opioid Crisis is a complex public health issue and can be linked to the rapid rise in overdoses and deaths involving both legally prescribed opioids and illegally produced opioids such as fentanyl, a drug 50-100 times more potent than morphine.

Opioid Agonist Therapy: This is also called opioid substitution therapy, which is a treatment for addiction to opioids. The therapy involves prescribing replacement drugs (such as methadone or buprenorphine-naloxone) to help individuals deal with cravings and withdrawal symptoms, to stabilize their lives and to reduce the harms related to their opioid use.

Rapid Access Addiction Medicine Clinics: They are walk-in clinics where people can obtain addictions treatment (such as opioid agonist therapy, counselling and referral for longer-term addictions treatment programs). They are often located in hospitals, community-health centres and physicians' offices.

Residential Treatment Program: Individuals live at a treatment facility for a set period (often at least a couple of weeks) and receive daily structured programs such as individual or group counselling.

Withdrawal Management Program: Also known as detox programs, these programs provide medical and non-medical assistance to help individual to withdraw from substances. Individuals may attend a program in a residential setting (often for a period of five days or less) or non-residential setting.

Appendix 2: Examples of Death Investigations Related to Addictions Conducted by the Office of the Chief Coroner

Prepared by the Office of the Auditor General of Ontario

A 27-year-old female's accidental death due to fentanyl toxicity

The deceased had a history of opioid addiction (using both prescription and non-prescription opioids) related to a chronic pain disorder resulting from traumatic brain and thoracic spine injuries suffered from a motor vehicle collision. She had never been on an opioid agonist therapy, but was reportedly working with a physician to taper her opioid doses at the time of her death.

A 28-year-old female's accidental death due to toxicity from multiple substances

The deceased had a history of complex medical and psychosocial issues, including problematic substance use, resulting in more than 100 hospital visits dating back to 2005. She was last seen in hospital six weeks prior to her death due to problematic use of multiple substances (fentanyl and methadone), at which time she requested treatment.

A 31-year-old male's accidental death due to life-threatening allergic reaction after use of multiple substances

The deceased had a long history of asthma and problematic substance use (both opioids and non-opioids). He began using prescription drugs about 10 years ago and started using street drugs during the last five years. He made multiple attempts to treat his addictions by enrolling in programs offered by rehabilitation centres and by seeing psychiatrists. His last rehabilitation attendance was about one year prior to his death. He was also treated in hospital for several overdoses over the years. The last overdose treatment took place during the morning of the day he died in hospital.

Appendix 3: List of Addictions Treatment Service Providers by Local Health Integration Network (LHIN) and Type of Treatment Programs for Problematic Substance Use and Gambling, 2018/19

Source of data: Ministry of Health

LHIN	Addictions Treatment Service Provider		Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
Central	1.	Across Boundaries	✓			
	2.	Addiction Services of York Region	✓		✓	✓
	3.	Black Creek Community Health	✓			
	4.	Canadian Mental Health Association – York Region	✓			
	5.	Caritas School of Life	✓			
	6.	Humber River Hospital	✓		✓	
	7.	North York General Hospital	✓			
	8.	Vitanova Foundation	✓			
Central East	9.	Chinese Family Services of Ontario				✓
	10.	Four Counties Addiction Services Team Inc	✓		✓	✓
	11.	Lakeridge Health	✓	✓	✓	✓
	12.	Peterborough Regional Health Centre	✓			
	13.	Scarborough Health Network	✓			
	14.	Senior Persons Living Connected	✓			
Central West	15.	Canadian Mental Health Association – Peel Branch	✓		✓	
	16.	Family Transition Place	✓			
	17.	Governing Council of the Salvation Army in Canada	✓	✓		
	18.	Punjabi Community Health Services	✓			
	19.	Services and Housing in the Province	✓			
	20.	William Osler Health System	✓		✓	✓
Champlain	21.	Amethyst Women's Addiction Centre	✓			✓
	22.	Canadian Mental Health Association Ottawa-Carleton Branch	✓			
	23.	Centretown Community Health Centre	✓			✓
	24.	Cornwall Community Hospital	✓	✓	✓	✓
	25.	David Smith Youth Treatment Centre	✓	✓		
	26.	Empathy House of Recovery	✓	✓		
	27.	Governing Council of the Salvation Army in Canada		✓		
	28.	Hopital General de Hawkesbury & District General Hospital Inc	✓		✓	✓
	29.	Mackay Manor Inc	✓	✓	✓	
	30.	Maison Fraternite – Fraternity House	✓	✓		
	31.	Montfort Hospital	✓			
	32.	Montfort Renaissance Inc	✓	✓	✓	
	33.	Ottawa Inner City Health Inc	✓		✓	
	34.	Pathways Alcohol & Drug Treatment Services	✓			

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
	35.	Renfrew Victoria Hospital	✓			✓
	36.	Rideauwood Addiction & Family Services	✓			✓
	37.	Royal Ottawa Health Care Group	✓	✓	✓	
	38.	Sandy Hill Community Health Centre	✓			✓
	39.	Serenity House Inc	✓	✓		
	40.	Sobriety House		✓		
	41.	Vesta Recovery Program for Women Inc	✓	✓		
	42.	Wabano Centre for Aboriginal Health Inc	✓			
Erie St. Clair	43.	Bluewater Health	✓		✓	✓
	44.	Canadian Mental Health Association Lambton Kent Branch	✓		✓	
	45.	Charity House (Windsor)	✓	✓		
	46.	Chatham-Kent Community Health Centres	✓			
	47.	Chatham-Kent Health Alliance	✓		✓	✓
	48.	Hotel-Dieu Grace Healthcare[2]	✓		✓	✓
	49.	House of Sophrosyne	✓	✓		
	50.	Victorian Order of Nurses for Canada — Ontario Branch	✓			
	51.	Westover Treatment Centre	✓	✓	✓	
	52.	Windsor Essex Community Health Centre	✓			
Hamilton Niagara Haldimand Brant	53.	A Y Alternatives for Youth Hamilton	✓			
	54.	ARID Group Homes	✓	✓		
	55.	Centre de Sante Communautaire Hamilton-Niagara Inc	✓			
	56.	City of Hamilton	✓			✓
	57.	Community Addiction and Mental Health Services of Haldimand and Norfolk	✓			✓
	58.	Community Addiction Services of Niagara	✓			✓
	59.	Good Shepherd Centre Hamilton	✓			
	60.	Good Shepherd Non-Profit Homes Inc	✓			
	61.	Hamilton Health Sciences Corp	✓			
	62.	Hamilton Urban Core Community Health Centre	✓			
	63.	Joseph Brant Hospital	✓			
	64.	Mission Services of Hamilton Inc	✓			
	65.	Native Horizons Treatment Centre	✓	✓		
	66.	Niagara Health System	✓	✓	✓	
	67.	Norfolk General Hospital	✓	✓	✓	
	68.	Quest Community Health Centre	✓			
	69.	Six Nations of the Grand River	✓			
	70.	St Joseph's Healthcare Hamilton	✓	✓	✓	
	71.	St Leonard's Community Services Inc	✓	✓		✓

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
	72.	Wayside House of Hamilton	✓	✓		
	73.	Wayside House of St Catharines		✓		
	74.	Wesley Urban Ministries Inc	✓			
Mississauga Halton	75.	Halton Alcohol Drug and Gambling Assessment Prevention Treatment – ADAPT	✓		✓	✓
	76.	Hope Place Centres	✓	✓		
	77.	Peel Addiction Assessment and Referral Centre (PAARC)	✓		✓	✓
North East	78.	Algoma Family Services	✓			
	79.	Algoma Substance Abuse Rehabilitation Centre	✓	✓		
	80.	Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre	✓	✓		
	81.	Canadian Mental Health Association–Cochrane Timiskaming Branch	✓			✓
	82.	Centre de Reeducation Cor Jesu De Timmins Inc	✓	✓		
	83.	Community Counselling Centre of Nipissing	✓		✓	✓
	84.	Counselling Centre of East Algoma	✓			
	85.	District of Algoma Health Unit	✓			
	86.	Health Sciences North	✓		✓	✓
	87.	La Maison Arc-En-Ciel Inc		✓		
	88.	La Maison Renaissance Inc	✓	✓		
	89.	Maamwesying North Shore Community Health Services			✓	
	90.	Monarch Recovery Services	✓	✓		
	91.	Noojmowin Teg Health Centre	✓		✓	
	92.	North Bay Recovery Home	✓	✓		
	93.	North Bay Regional Health Centre	✓	✓	✓	
	94.	North Cochrane Addiction Services Inc	✓			✓
	95.	N'Swakamok Native Friendship Centre	✓			
	96.	Sagamok Anishnawbek	✓			
	97.	Sault Area Hospital	✓		✓	✓
	98.	Sault Ste Marie Alcohol Recovery Home Inc		✓		
	99.	Services de Sante de Chapleau Health Services	✓			
	100.	Shkagamik-Kwe Health Centre	✓			
	101.	Smooth Rock Falls Hospital		✓	✓	
	102.	South Cochrane Addiction Services Inc	✓		✓	✓
	103.	St Josephs General Hospital		✓	✓	
	104.	Weeneebayko Area Health Authority	✓			✓
	105.	West Nipissing General Hospital	✓			
	106.	Wikwemikong Unceded Indian Reserve (WUIR)	✓			

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
North Simcoe Muskoka	107.	Canadian Mental Health Association—Muskoka-Parry Sound Branch	✓			✓
	108.	Canadian Mental Health Association—Simcoe County Branch	✓		✓	✓
	109.	Royal Victoria Regional Health Centre	✓	✓	✓	
	110.	Seven South Street Treatment Centre		✓		
North West	111.	Alpha Court Non-Profit Housing Corp	✓			
	112.	Atikokan General Hospital	✓			✓
	113.	Canadian Mental Health Association—Fort Frances Branch	✓			
	114.	Changes Recovery Homes		✓		
	115.	Children's Centre Thunder Bay	✓			
	116.	Crossroads Centre Inc		✓		
	117.	Dilico Anishinabek Family Care	✓	✓	✓	
	118.	Dryden Regional Health Centre	✓	✓	✓	✓
	119.	Fort Frances Tribal Area Health Services Inc	✓	✓	✓	
	120.	Kenora Chiefs Advisory Inc	✓			
	121.	Lac Seul Band	✓			
	122.	Lake of the Woods District Hospital (LWDH)	✓	✓	✓	✓
	123.	Matawa Health Co-Operative Inc	✓			
	124.	Mishkeegogamang First Nation		✓		
	125.	North of Superior Community Mental Health Program Corp	✓			✓
	126.	North of Superior Healthcare Group	✓			✓
	127.	Northern Chiefs Council	✓			
	128.	Norwest Community Health Centre	✓			
	129.	Red Lake Margaret Cochenour Memorial Hospital Corp	✓			✓
	130.	Riverside Health Care Facilities Inc	✓			✓
	131.	Sioux Lookout First Nations Health Authority	✓			
	132.	Sioux Lookout Meno-Ya-Win Health Centre	✓		✓	✓
	133.	St Joseph's Care Group Corp[2]	✓	✓	✓	✓
	134.	The Reverend Tommy Beardy Memorial Wee Che He Wayo-Gamik Family Treatment Centre		✓		
	135.	Three C's Reintroduction Centre Inc		✓		
	136.	Thunder Bay Counselling Centre	✓			
	137.	Thunder Bay Seaway Non-Profit Apartments		✓		
	138.	Weechi-It-Te-Win Family Services Inc	✓			
South East	139.	Addiction and Mental Health Services—KFLA	✓			✓
	140.	Addictions and Mental Health Services—Hastings Prince Edward	✓	✓		✓

LHIN	Addictions Treatment Service Provider	Problematic Substance Use			
		Non-Residential	Residential	Withdrawal Management	Problem Gambling[1]
	141. Belleville and Quinte West Community Health Centre	✓			
	142. Brockville General Hospital	✓			
	143. Governing Council of the Salvation Army in Canada		✓		
	144. Kingston Community Health Centres (KCHC)	✓			
	145. Kingston Health Sciences Centre			✓	
	146. Lanark Leeds and Grenville Addictions and Mental Health	✓	✓		✓
	147. Peer Support South East Ontario	✓			
South West	148. Addiction Services of Thames Valley	✓		✓	✓
	149. Alexandra Hospital			✓	
	150. Canadian Mental Health Association Grey Bruce	✓	✓		✓
	151. Chippewas of the Thames First Nation	✓			
	152. Choices for Change Alcohol Drug and Gambling Counselling Centre	✓		✓	✓
	153. G&B House		✓		
	154. Grey Bruce Health Services	✓		✓	
	155. HopeGreyBruce Mental Health and Addictions Services	✓	✓		✓
	156. Mission Services of London		✓		
	157. Oneida Nation of the Thames	✓			
	158. Southwest Ontario Aboriginal Health Access Centre (SOAHAC)	✓			
	159. Turning Point Inc		✓		
Toronto Central	160. Alpha House		✓		
	161. Anishnawbe Health Toronto	✓			
	162. Breakaway	✓			
	163. Centre for Addiction & Mental Health (CAMH)	✓		✓	✓
	164. City of Toronto	✓			
	165. COSTI Immigrant Services				✓
	166. Fred Victor Centre	✓			
	167. Good Shepherd Non-Profit Homes Inc	✓			
	168. Good Shepherd Refuge Social Ministries		✓		
	169. Governing Council of the Salvation Army in Canada	✓	✓		
	170. Hospital for Sick Children (HSC)	✓			
	171. Jean Tweed Treatment Centre[2]	✓	✓		✓
	172. Lakeshore Area Multi-Services Project Inc (LAMP)	✓			
	173. Loft Community Services	✓	✓		
	174. Parkdale Queen West Community Health Centre	✓			
	175. Pine River Institute		✓		
	176. Reconnect Community Health Services	✓			

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
	177.	Regent Park Community Health Centre	✓			
	178.	Renascent Foundation Inc		✓		
	179.	South Riverdale Community Health Centre	✓			
	180.	St Michael's Homes	✓	✓		
	181.	St Stephen's Community House	✓			
	182.	St Vincent de Paul Ozanam		✓		
	183.	Street Haven at the Crossroads	✓	✓		
	184.	The Four Villages Community Health Centre	✓			
	185.	Toronto East Health Network	✓		✓	
	186.	Transition House		✓		
	187.	Unison Health & Community Services	✓			
	188.	Unity Health Toronto (O/A Providence St Josephs & St Michaels Healthcare)	✓		✓	
	189.	University Health Network	✓		✓	
	190.	YMCA of Greater Toronto	✓			
	191.	Young Women's Christian Association of Greater Toronto (YWCA)	✓			
Waterloo Wellington	192.	Grand River Hospital Corporation	✓		✓	
	193.	Guelph Community Health Centre	✓			
	194.	Homewood Health Centre Inc	✓	✓		✓
	195.	House of Friendship	✓	✓		✓
	196	Portage Program for Drug Dependencies Inc	✓	✓		
	197.	Ray of Hope Inc	✓	✓		
	198.	St Mary's General Hospital	✓			✓
	199.	Stonehenge Therapeutic Community	✓	✓		
Total			**170**	**73**	**49**	**52**

Note: This lists the names and locations of addictions treatment service providers the Ministry of Health funded in 2018/19. Information on the services provided generally came from the Ministry of Health and ConnexOntario's database. The locations and the actual services offered may differ from what is shown above. About 50 of these addictions treatment service providers are hospitals. Hospitals generally use funding to provide addictions services to hospital outpatients or residential services to individuals at dedicated sites (as opposed to their primary hospital location).

1. All problem gambling treatment programs are non-residential.
2. Provides residential problem gambling programs in addition to the non-residential problem gambling programs indicated.

Appendix 4: Background and Key Events related to Ontario's Opioid Crisis

Prepared by the Office of the Auditor General of Ontario

Year	Description
1996	Opioid prescriptions increased after a form of oxycodone (an opioid to treat pain) was approved in 1996 and the manufacturer marketed the opioid as having minimal risk of addictions.
2000	In 2000, the Ontario government added oxycodone to the public drug formulary, which allowed it to be obtained free of charge by people who qualified for the Ontario Drug Benefit Program.
2003–2012	Fentanyl is a very strong opioid that can be obtained through a prescription or illicitly and is profitable to sell (according to various sources, fentanyl powder can be ordered from overseas for as little as $12,500 to make 500,000 or more fentanyl pills, which can result in a profit of about $10 million or more). Opioid deaths related to fentanyl increased from 34 in 2003 (responsible for about 9% of all opioid-related deaths) to 151 in 2012 (responsible for over 25% of all opioid-related deaths).
2006	In 2006, the Ministry of Health (Ministry) established the Methadone Maintenance Treatment Practices Task Force, which published a report in 2007 with recommendations for improving patients' access to methadone, implementing best practices and training for health-care providers, and implementing appropriate payment models. As a result of this report, the Ministry reduced the amount that physicians could bill for urine drug screening through the Ontario Health Insurance Plan.
2012	In 2012, as the risks associated with opioid addiction and overdoses became better understood, the Ontario government removed the previously mentioned form of oxycodone from its public drug formulary. Since they could not obtain this form of oxycodone funded by the province, some individuals began to turn to illicit forms of opioids sold by drug dealers. The Ministry started to require community pharmacies to report data on all narcotics, controlled substances and other monitored drugs (including opioids) into the Ministry's Narcotics Monitoring System (see **Section 4.6.5** and **Figure 22**). As well, the Ministry established the Expert Working Group on Narcotic Addiction, which published a report with recommendations for reducing the impact of removing oxycodone from the formulary and improving the addictions treatment system in Ontario.
2016	In 2016, as the number of opioid-related emergency department visits, hospitalizations and deaths continued to rise (see **Figure 20**), a Methadone Treatment and Services Advisory Committee was established to prepare a report with recommendations on how to improve treatment for those addicted to opioids. The report was used as a basis for the Opioid Strategy announced by the Ministry of Health in August 2017.

Appendix 5: Key Initiatives of the Opioid Strategy in Ontario

Prepared by the Office of the Auditor General of Ontario

Program Area	Key Initiatives	Funding ($ million)*
Appropriate opioid prescribing and reporting	• Improving data collection and reporting in an existing system to make more information available to opioid prescribers at the point of care about medications that have been dispensed to patients in the past. • Providing education and professional development for health-care providers about opioid prescribing. • Launching a web-based tool on the Public Health Ontario website that publishes data on opioid-related deaths, hospitalizations and emergency department visits over the last 10 or more years.	15.8
Treatment	• Expanding the number of Rapid Access Addiction Medicine clinics. These walk-in clinics provide immediate and short-term addictions care to patients (such as medication, brief counselling, referral to other services and primary care for long-term follow-up). • Providing funding to addictions treatment service providers through Local Health Integration Networks for new and existing services, such as withdrawal management.	93.5
Harm reduction	• Adding Consumption and Treatment Services sites, which replaced the former Supervised Consumption Services and Overdose Prevention sites models by offering on-site or defined pathways off-site to addictions treatment services, primary care, mental health and other social supports. • Expanding the distribution of naloxone, a drug that can temporarily reverse an opioid overdose. • Expanding the distribution of harm-reduction supplies, such as sterile needles, to people who use drugs through the Ontario Harm Reduction Distribution Program.	150.8
Total		**260.1***

* Funding for the Opioid Strategy has been allocated from 2017/18 to 2019/20. Specifically, in August 2017, the Ministry of Health announced an investment of over $222 million. In 2018/19, the total amount of funding for the Opioid Strategy was revised upward to over $260 million as a result of a decision to increase the amount of naloxone that would be distributed through its naloxone distribution initiatives, as well as to make additional investments in treatment services.

Appendix 6: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Effective procedures and co-ordination among service providers are in place to ensure Ontarians have timely and equitable access to safe, evidence-based addictions services that meet their needs regardless of where they live.
2.	Funding is allocated in an outcome-based, timely and equitable manner to service providers, used for the purposes intended, and administered with due regard for economy and efficiency.
3.	Adequate co-ordination is in place to facilitate the provision of addictions services. The roles, responsibilities and expectations for the delivery of services are clearly defined, and best practices are shared.
4.	Appropriate accountability requirements, performance measures and targets are established and continuously monitored against actual results to help guide decision-making, and ensure that intended outcomes are achieved and corrective actions are taken on a timely basis when issues are identified.
5.	Relevant, accurate, and timely information on addictions services is regularly collected and publicly reported to assist Ontarians in finding the services they need.

Appendix 7: List of Addictions Treatment Service Providers Contacted for Our Audit

Prepared by the Office of the Auditor General of Ontario

Local Health Integration Network (LHIN)	Name	
Central	1.	Addiction Services of York Region
Central East	2.	Four Counties Addiction Services Team Inc.
Central East	3.	Lakeridge Health
Central West	4.	William Osler Health System
Champlain	5.	David Smith Youth Treatment Centre
Champlain	6.	Maison Fraternite – Fraternity House
Champlain	7.	Montfort Renaissance Inc.
Champlain	8.	Royal Ottawa Health Care Group
Champlain	9.	Sandy Hill Community Health Centre
Erie St. Clair	10.	Chatham-Kent Health Alliance
Erie St. Clair	11.	Westover Treatment Centre
Hamilton Niagara Haldimand Brant	12.	St. Joseph's Healthcare Hamilton
Hamilton Niagara Haldimand Brant	13.	St. Leonard's Community Services Inc.
Hamilton Niagara Haldimand Brant	14.	Wayside House Of Hamilton
Mississauga Halton	15.	Halton Alcohol Drug & Gambling Assessment Prevention Treatment (ADAPT)
Mississauga Halton	16.	Peel Addiction Assessment & Referral Centre (PAARC)
North West	17.	Children's Centre Thunder Bay
North West	18.	Dilico Anishinabek Family Care
North West	19.	Riverside Health Care Facilities Inc.
North West	20.	St. Joseph's Care Group Corp
South West	21.	Addiction Services of Thames Valley
Toronto Central	22.	Jean Tweed Treatment Centre
Toronto Central	23.	Pine River Institute
Toronto Central	24.	Renascent Foundation Inc.
Toronto Central	25.	St. Michael's Homes
Toronto Central	26.	St. Stephen's Community House
Toronto Central	27.	Unity Health Toronto
Toronto Central	28.	University Health Network
Waterloo Wellington	29.	Homewood Health Centre Inc.

Appendix 8: Additional Audit Work Performed

Prepared by the Office of the Auditor General of Ontario

During our audit, in addition to the activities described in Section 3.0, we obtained information from the following parties:

- ConnexOntario (an organization funded by the Ministry to provide information on addictions and mental health resources available to Ontarians) for information about addictions treatment service providers and wait times; and
- Centre for Addiction and Mental Health for information on the number of people treated by addictions treatment service providers between 2014/15 and 2018/19 as well as their socio-demographic information.

In addition, we met or spoke with various parties, including:

- staff from all 14 Local Health Integration Networks (LHINs) to understand how they distribute Ministry funding to addictions treatment service providers and their challenges of integrating and co-ordinating addictions treatment services in their regions;
- staff from 11 hospitals in eight LHINs to understand their challenges and how their emergency departments co-ordinate with addictions treatment service providers;
- staff from five Consumption and Treatment Services sites that provide a safe environment where people can consume substances they possess under the supervision of health-care professionals and receive referrals for other services to understand their policies, procedures and operations;
- representatives from regulatory colleges (including the College of Physicians and Surgeons of Ontario, Ontario College of Pharmacists and Royal College of Dental Surgeons of Ontario) to understand their roles and challenges regarding opioids prescribed and dispensed by their members;
- representatives from local police and paramedic services (including the Ontario Provincial Police, Ottawa Police Service, Thunder Bay Police Service and the Ontario Association of Paramedic Chiefs) to understand their roles and challenges when dealing with the opioid crisis and people with addictions;
- representatives from other ministries and agencies (including the Ontario Lottery and Gaming Corporation, the Ministry of the Solicitor General, the Ministry of Children, Community and Social Services, the Ministry of Education, and the Ministry of Training, Colleges and Universities) to understand the addictions services they perform and fund;
- staff from the Office of the Chief Coroner to obtain and review information on its investigations of people who died due to substance use;
- representatives from research and advisory groups (including Gambling Research Exchange Ontario, Homewood Research Institute, Ontario Drug Policy Research Network, Mentoring, Education, and Clinical Tools for Addiction: Primary Care–Hospital Integration, Public Health Ontario and Health Quality Ontario) to understand current research on addictions treatment;
- representatives from stakeholder groups (including Addictions and Mental Health Ontario, Canadian Mental Health Association, Children's Mental Health Ontario and Families for Addiction Recovery) to understand the needs and challenges of both addictions and mental health service providers and individuals seeking addictions treatment; and
- other jurisdictions (including Alberta Health Services, British Columbia's Ministry of Mental Health and Addictions and British Columbia's Ministry of Health) to understand their oversight and funding of addictions treatment services as well as their actions in response to the opioid crisis.

Appendix 9: Ministry of Health's Planned Indicators to Assess Its Opioid Strategy Initiatives

Prepared by the Office of the Auditor General of Ontario

Response-Wide Indicators	
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
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*
Treatment for Opioid-Use Disorder	
9.	Number and proportion of patients who were referred from Rapid Access to Addiction Medicine clinics to primary care
10.	Wait time for access to Rapid Access to Addiction Medicine clinics
11.	Proportion of emergency department visits for opioid overdose where the patient was dispensed an opioid agonist therapy medication in the previous seven days
12.	Proportion of opioid-related deaths where the patient was dispensed an opioid agonist therapy medication in the previous seven days
Harm Reduction	
13.	Number of naloxone kits and refills distributed per naloxone program site
14.	Number of Consumption and Treatment Services site client visits
15.	Number of referrals to treatment, health and social services provided to clients at Consumption and Treatment Services sites
16.	Number of (self) reports of naloxone administration
17.	Number of overdoses reversed/treated with (a) oxygen/rescue breathing (b) naloxone at Consumption and Treatment Services sites
18.	Number of public health units and public health unit regions with opioid response plans
Surveillance	
19.	Number of public health units and public health unit regions with early warning systems
20.	Number of warnings issued by public health units and public health unit region partners

* Patients beginning long-term opioid therapy for chronic non-cancer pain should not be prescribed more than 50 MMEs a day. This is according to the 2017 Canadian Guideline for Opioids for Non-Cancer Pain. If more than this is prescribed, there is a risk of overdose. The Guideline also recommends that, before a health-care provider prescribes a beginning dosage of greater than 90 MMEs a day (because, for example, the patient's pain is extreme), they get a second opinion from another health-care provider.

Appendix 10: Examples of Recent Changes and Emerging Issues Related to Addictions

Prepared by the Office of the Auditor General of Ontario

Recent Change and Emerging Issue	Description
Cannabis Legalization	• In April 2017, the federal government introduced the *Cannabis Act, 2017*, to legalize recreational cannabis. This Act came into force on October 17, 2018, allowing persons 18 or older to possess up to 30 grams of cannabis in public. The provincial governments are responsible for enacting further regulations related to sales, distribution and use of cannabis. On October 17, 2018, Ontario passed the (provincial) *Cannabis Act, 2017*, which increases the age to buy, use, possess and grow recreational cannabis to 19 to be on par with alcohol and tobacco. • While the Ministry of Health (Ministry) has not performed any studies after cannabis legalization in October 2018, studies from other jurisdictions that have legalized cannabis (such as Colorado and Washington State) have shown mixed results. In some cases, cannabis use among specific populations increased or cannabis use temporarily increased and returned back to pre-legalization levels; in other cases, there was no significant increase in cannabis use pre- or post-legalization. • Statistics Canada, through the use of a survey, has compared cannabis use across Canada each quarter. In the most recent survey, it noted that the prevalence of cannabis use in Ontario has remained stable (16.8% in the second quarter of 2019 compared to 17.8% in the second quarter of 2018); it is still higher than the quarter directly before cannabis legalization (15.1% in the third quarter of 2018).
Electronic Cigarette Usage	• While tobacco usage dropped in Ontario from around 23% of Ontarians over the age of 15 in 1999 to about 13% in 2017, the usage of electronic cigarettes (also known as e-cigarettes or vaping) has increased, especially among youth. In 2019, Health Canada released the results of the Canadian Student Tobacco, Alcohol and Drugs survey, which indicated a growth in Ontario's students (in Grade 7 to Grade 12) who used e-cigarettes between 2014/15 and 2016/17. The percentage of students who tried e-cigarettes increased from 16% to 18% and the percentage of those who used e-cigarettes within the past 30 days grew from 5% to 7%. • E-cigarettes generally contain fewer harmful chemicals than burned tobacco products, but they can still pose health risks. For example, they contain nicotine, which is highly addictive and can harm adolescent brain development. An Ontario study in 2018 assessing vaping products at retail outlets found that it was common for products to be mislabeled—27% of products labeled as "with nicotine" had concentrations above the amount indicated. • In September 2019, three incidences of vaping-related severe lung disease were under review in Ontario. In October 2019, the Centers for Disease Control and Prevention in the United States also reported over 30 deaths and more than 1,400 cases of lung injury associated with the use of e-cigarettes or vaping. In light of this, the US government announced a plan to remove unauthorized flavoured e-cigarettes from the market (i.e., only the "tobacco" flavor was to remain available). While waiting for a federal plan to be finalized, some US states (including Michigan, New York, Massachusetts and Rhode Island) have enacted legislation to ban the sale of vaping products and a number of other states (including Illinois, New Jersey and Delaware) are considering similar legislation. In Canada, none of the provinces have banned the sale of vaping products. In September 2019, the Ontario Minister of Health issued a Minister's Order requiring that public hospitals in Ontario provide the Chief Medical Officer of Health with information on incidences of vaping-related severe lung disease, so that the potential scope of this issue may be understood.

Recent Change and Emerging Issue	Description
Increased Availability of Alcohol	• As part of its 2019 budget, the Ontario government identified various plans to expand the availability of alcohol, such as by expanding the sale of alcohol to corner, grocery and big box stores as well as extending alcohol service at licensed establishments (such as bars and restaurants) to earlier in the day (9:00 a.m.). • In April 2019, the Centre for Addiction and Mental Health released a response to the proposed changes on alcohol policy in Ontario. It identified that as alcohol availability increases, alcohol consumption increases, as does both acute (such as emergency department visits) and chronic health harms related to alcohol use. It also referred to the World Health Organization's stance on alcohol availability, which was updated in September 2018 and identified actions governments could take to reduce the harmful use of alcohol and strengthen restrictions on alcohol availability. • The Ministry informed us that it has not performed any analysis to identify the impact of changes to increasing the availability of alcohol in Ontario, including the potential increased need for more addictions treatment services for alcohol.