Office of the
Auditor General
of British Columbia

March 2024

B.C.'s Toxic Drug Crisis: Implementation of Harm Reduction Programs

An independent audit report

Office of the
Auditor General
of British Columbia

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The Honourable Raj Chouhan
Speaker of the Legislative Assembly
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Dear Mr. Speaker:

I have the honour to transmit to the Speaker of the Legislative Assembly of British Columbia the report, *B.C.'s Toxic Drug Crisis: Implementation of Harm Reduction Programs*, which includes two independent audits.

We conducted the audits under the authority of Section 11(8) of the *Auditor General Act*. All work in the audits was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements, set out by the Chartered Professional Accountants of Canada (CPA Canada) in the *CPA Canada Handbook – Assurance*.

Michael A. Pickup, FCPA, FCA
Auditor General of British Columbia
Victoria, B.C.

March 2024

Contents

The Office of the Auditor General of British Columbia acknowledges with respect that we conduct our work on Coast Salish territories. Primarily, this is on the Lekwungen-speaking people's (Esquimalt and Songhees) traditional lands, now known as Victoria, and the W̱SÁNEĆ people's (Pauquachin, Tsartlip, Tsawout and Tseycum) traditional lands, now known as Saanich.

Audits at a glance

Why we did these audits

- At least 14,000 deaths as of January 2024 have been linked to drug-related toxicity since the province declared a public health emergency in 2016, making it B.C.'s leading cause of unnatural death.
- The Ministry of Mental Health and Addictions and the Ministry of Health lead B.C.'s response to the emergency. The response spans the continuum of care, from prevention and harm reduction, to treatment and recovery.
- Two key harm reduction approaches are overdose prevention and supervised consumption services, and increased access to prescribed safer supply.

About this report

- Our two audits looked at whether the ministries effectively implemented (1) overdose prevention and supervised consumption services, and (2) the initial phase of prescribed safer supply.
- Our report considers the two programs in separate chapters, each with its own conclusions.

Chapter 1: An audit of the implementation of overdose prevention and supervised consumption services

Objective

To determine whether the Ministry of Mental Health and Addictions and the Ministry of Health ensured effective province-wide implementation of overdose prevention and supervised consumption services by the health authorities.

Audit period

January 1, 2020 – June 30, 2023

Conclusion

We found that the ministries:

- monitored operational performance;
- monitored funding and adjusted when necessary; and
- reported publicly on the implementation of overdose prevention and supervised consumption services.

However, we found deficiencies in key areas:

- Operational guidance lacked minimum service standards and did not always reflect engagement with health authorities, people with lived and living experience, and Indigenous Peoples.
- Persistent challenges and barriers to province-wide implementation were not addressed.
- There were deficiencies in target setting and evaluation.

For these reasons we concluded that the Ministry of Mental Health and Addictions and the Ministry of Health did not ensure effective province-wide implementation of overdose prevention and supervised consumption services by the health authorities.

The ministries have accepted all five of our recommendations on service standards, target setting, evaluation and addressing barriers.

Audits at a glance *(continued)*

What we found

Provincial guidance for health authorities and service providers was inadequate

- Operational guidance for overdose prevention and supervised consumption services (OPS/SCS) didn't include minimum service standards to support consistent quality, access, and availability of services.
- The ministry consulted with Indigenous Peoples and health authorities, but their input was not consistently reflected in the guidance.
- The guidance was out of step with changes in the toxic drug supply.
- Some health authorities created their own guidance to address gaps, such as delivery of services in remote and rural Indigenous communities.

OPS/SCS recommendation 1

The ministries planned, monitored, evaluated, and reported on OPS/SCS, but a new provincial evaluation is needed

- The ministries set objectives and worked with health authorities to develop performance measures, but only two health authorities set explicit quantitative targets for OPS/SCS in their detailed implementation plans.
- The ministries monitored the operational performance of OPS/SCS.
- The ministries monitored funding and worked with health authorities to reallocate funds as needed.
- The ministries evaluated OPS/SCS programs but the toxic drug supply has changed considerably since the last evaluation in 2021.
- The ministries reported publicly on OPS/SCS.

OPS/SCS recommendations 2, 3

The ministries had not developed strategies to address persistent challenges and barriers to province-wide OPS/SCS implementation

- The ministries identified challenges and barriers through established lines of communication with health authorities and other key groups.
- Significant barriers included municipal resistance, the lack of infrastructure, and health-care staffing.
- The ministries didn't work effectively with health authorities, people with lived and living experience, or Indigenous Peoples to develop or implement strategies addressing persistent challenges and barriers to OPS/SCS implementation.

OPS/SCS recommendations 4, 5

Audits at a glance *(continued)*

Chapter 2: An audit of the initial implementation of prescribed safer supply

Objective

To determine whether the Ministry of Mental Health and Addictions and the Ministry of Health effectively monitored the initial province-wide implementation of prescribed safer supply.

Audit period

July 1, 2021 – June 30, 2023

Conclusion

We found that the ministries:

- developed a data collection framework;
- monitored and adjusted funding; and
- initiated an evaluation of prescribed safer supply.

However, we also found deficiencies in key areas. Specifically:

- the ministries didn't develop or implement strategies to address prominent barriers to implementation; and
- they didn't effectively report publicly on the performance of prescribed safer supply.

For these reasons we concluded that the Ministry of Mental Health and Addictions and the Ministry of Health did not effectively monitor the initial province-wide implementation of prescribed safer supply.

The ministries have accepted both of our recommendations on addressing barriers and public reporting.

What we found

The ministries implemented a data collection framework and initiated an evaluation of the prescribed safer supply program	▪ Data collected included service utilization, program outputs, clinical outcomes, and population-level impacts and outcomes. ▪ The ministries had contracted an external evaluation on prescribed safter supply, which was underway.
The ministries monitored and adjusted funding for prescribed safer supply	▪ The ministries monitored funding and worked with health authorities to reallocate funds as needed.

Audits at a glance *(continued)*

The ministries' strategies do not adequately address key barriers to prescribed safer supply implementation	▪ The ministries are aware of challenges and barriers, such as lack of prescribers, and types of drugs offered. ▪ Prescribed safer supply meetings with health authorities and health sector partners haven't resulted in sufficient collaborative strategies. ▪ Current strategies don't demonstrate how the ministries will address key issues. ▪ Prescribed safer supply delivery in rural and remote communities faces persistent challenges. **Prescribed safer supply recommendation 1**
The ministries' public reporting on prescribed safer supply was not sufficient	▪ Current public reporting doesn't compare prescribed safer supply program performance to its objectives. ▪ Internal data monitoring wasn't made public, despite plans for release. ▪ Current reporting is inadequate because it doesn't inform the public about work done to monitor and evaluate prescribed safer supply. **Prescribed safer supply recommendation 2**

After reading the report, you may want to ask the following questions of government:

1. What are the most important lessons learned from the development and implementation of OPS/SCS and prescribed safer supply programs?
2. How can government establish clear lines of accountability to support complex mental health and addiction program implementation?
3. How can government improve public information and education about complex health programs and issues in order to reduce stigma and build public confidence?

Background

In April 2016, the Provincial Health Officer declared a public health emergency due to a significant rise in unregulated drug-related toxicity and deaths.[1] Since then, at least 14,000 people in B.C. have died as of January 2024 from unregulated drug toxicity. According to the BC Coroners Service, unregulated drug toxicity is the leading cause of death in British Columbia for people between the ages of 10 and 59, accounting for more deaths than homicides, suicides, accidents, and natural disease combined. The toxic drug crisis has so severely impacted men that it has reduced their overall life expectancy in B.C.

The impact of the toxic drug crisis is not felt evenly across the province. In 2023, the health authorities with the highest rates of death were Northern Health (67 per 100,000) and Vancouver Coastal Health (56 per 100,000). The health authorities with the highest overall unregulated drug deaths were Vancouver Coastal and Fraser Health, which together had 56 per cent of unregulated drug deaths in 2023.

Certain populations – including people experiencing poverty, people who are or have been incarcerated, transgender and non-binary people, Indigenous Peoples, and survivors of violence and trauma – have been disproportionately impacted by the unregulated toxic drug crisis.

For example, from January 2021 to August 2023, 16.5% of all unregulated toxic drug deaths in B.C. were First Nations people, despite only making up 3.4% of the provincial population. First Nations women are also disproportionately impacted compared to non-First Nations women. In the first half of 2023, the rate of toxic drug deaths of First Nations women was 11.9 times higher than non-First Nations women. A key principle of the government's response to the unregulated toxic drug crisis is to include Indigenous Peoples and people with lived and living experience (PWLLE) of substance use in its policy design, planning, and service delivery.

Who are "people with lived and living experience"?

In this context, lived experience refers to people who have used one or more substances and who are currently in recovery. Living experience refers to people who are currently using one or more substances.

The toxic drug crisis was compounded by the COVID-19 public health emergency, which posed obstacles to the delivery of health services by governments. Restrictions and social distancing measures limited in-person services, disrupting the continuity of care. Various other factors contribute to the ongoing, complex toxic drug crisis, including stigma, poverty, and housing insecurity. During the same period, the toxicity of the unregulated drug supply increased.

1 Language describing the unregulated toxic drug crisis has changed since the crisis was declared in 2016. Throughout this report we refer to unregulated toxic drugs and the unregulated toxic drug crisis. The terms drugs and substances are used throughout the report and can include both legal (e.g., prescribed opioids) and illegal or illicit substances (e.g., non-prescribed opioids, amphetamines, etc.).

Responding to the toxic drug crisis: roles and responsibilities

The Ministry of Mental Health and Addictions (MMHA) and the Ministry of Health (HLTH) lead the province's response to the toxic drug crisis but it's a complex governing structure and numerous other ministries and organizations have roles (see "Appendix C: Abbreviations" on page 49)

MMHA was established in 2017, approximately one year after the toxic drug crisis emergency was declared. Policy development, program evaluation and research relating to mental health and addictions (including facilities designated under the Mental Health Act) were transferred to MMHA from HLTH. One assistant deputy minister is responsible for HLTH's Mental Health and Substance Use division and MMHA's Substance Use Policy division.

The current mandates of the ministries include working together – with HLTH in support – to lead and accelerate B.C.'s response to the toxic drug crisis and involves the full continuum of care: prevention, harm reduction, treatment, and recovery. The two harm reduction programs covered in this audit are part of this comprehensive response to the toxic drug crisis.

A 2018 memorandum of understanding between the ministries establishes their respective roles and responsibilities for mental health and addictions initiatives. Today these initiatives include – but aren't limited to – overdose prevention and supervised consumption services, and prescribed safer supply:

- MMHA is responsible for developing a response to the toxic drug crisis, including setting strategic direction, engaging in policy development, program evaluation and research, deciding on investments, and monitoring and adjusting the response over time.
- HLTH is also accountable for working with health authorities to provide funding and ensure implementation of policy direction. It also supports MMHA to respond to the toxic drug crisis.

The five regional health authorities govern, plan, and deliver health-care services, including harm reduction services, within their geographic areas. They are responsible for:

- identifying population health needs;
- planning appropriate programs and services;
- ensuring programs and services are properly funded and managed; and
- meeting performance objectives.

MMHA has relationships with Indigenous Peoples through a partnership with First Nations Health Authority (FNHA), which is formalized in a letter of understanding. FNHA plans, designs, manages, and funds the delivery of First Nations health programs and services in B.C. This work doesn't replace the role or services of HLTH, MMHA, and the regional health authorities. They collaborate, co-ordinate, and integrate their respective health programs and services.

The Provincial Health Services Authority oversees the co-ordination and delivery of provincial programs and highly specialized health-care services. One of these services is the BC Centre for Disease Control, which provides public health surveillance, detection, treatment, prevention and consultation services.

With help from HLTH, MMHA implemented essential health sector programs (delivered by regional health authorities and FNHA) to reduce drug toxicity death and drug-related harms, including expanding overdose prevention and supervised consumption services and introducing prescribed safer supply.

About harm reduction

Supervised consumption and overdose prevention services and prescribed safer supply are considered harm reduction initiatives. Harm reduction is a set of principles, practices and approaches to care that aim to minimize the negative health, social, and legal impacts associated with substance use. An integral component of the substance-use system of care, harm reduction is grounded in equity, justice, human rights, and respect for self-determination. This pragmatic and person-centred response focuses on keeping people safe and minimizing substance-related morbidity and mortality. Harm reduction-oriented services do not require a person to stop using substances as a precondition of care, support, and respect for human rights.

Source: The Ministry of Mental Health and Addictions

Our audits looked at whether the ministries effectively implemented overdose prevention and supervised consumption services, and the initial phase of prescribed safer supply, across the province.

The report considers these two programs in separate chapters and offers two conclusions about their implementation by the ministries:

Chapter 1: An audit of the implementation of overdose prevention and supervised consumption services

Chapter 2: An audit of the initial implementation of prescribed safer supply

Harm reduction supplies.

Source: Island Health

An independent audit report

Chapter 1: An audit of the implementation of overdose prevention and supervised consumption services

Abbotsford mobile OPS and inhalation tent.

Source: Fraser Health

Observed consumption spaces allow people to use their own substances in settings where trained staff are available to respond to drug poisoning events. In B.C., observed consumption is offered through supervised consumption services (SCS) and overdose prevention services (OPS). OPS and SCS are managed by health authorities under a variety of operational structures and often in cooperation with community partners.

Supervised consumption services are regulated by Health Canada. They require applicants to receive an exemption under section 56.1 of the *Controlled Drugs and Substances Act*. This process can be time consuming and cumbersome, especially in the context of a public health emergency. There are four SCS locations in B.C. (as of December 2023).

In response to increasing deaths from toxic drug events, the Minister of Health authorized overdose prevention services in December 2016, under the *Emergency Health Services Act* and the *Health Authorities Act* (Ministerial Order 488/2016). It mandates regional health authorities and BC Emergency Health Services to establish overdose prevention services "in any place there is a need for these services, as determined by the level of overdose related morbidity and mortality." There are 46 OPS locations in B.C. (as of December 2023).

OPS and SCS vary in design and operation, based on local context. For example, mobile OPS operates from vehicles moving between multiple locations. Fixed-site OPS remain in a permanent location.

Responding to COVID-19, the ministries introduced an episodic OPS protocol to allow clients of health and social services to use substances on-site under staff supervision (e.g., in a hospital or supportive housing site).

OPS and SCS provide safer environments for people to use drugs under the supervision of a health-care professional, harm reduction worker, and/or a trained peer (i.e., a person who formerly used or currently uses drugs) to monitor for signs of drug toxicity. This permits rapid response if a drug toxicity event occurs, reducing the risk of brain injury or death. OPS and SCS are meant to be low-barrier access points to health and social services for people who use drugs.

OPS/SCS sites provide different levels of service and may include:

- witnessed consumption for injection, inhalation, oral consumption, or insufflation (i.e., snorting) of drugs
- overdose prevention/harm reduction education
- Take Home Naloxone training and distribution
- distribution of harm reduction supplies (e.g., sterile needles)
- safe disposal options
- drug checking
- referrals to mental health and substance use services

Objective

The objective of the audit was to determine whether the Ministry of Mental Health and Addictions and the Ministry of Health ensured effective province-wide implementation of overdose prevention and supervised consumption services (OPS/SCS) by the health authorities.

Scope

We audited the Ministry of Mental Health and Addictions and the Ministry of Health to see whether they:

- effectively provided strategic guidance and monitored, evaluated, and reported on the implementation of OPS/SCS;
- monitored and adjusted funding as necessary;
- identified and addressed challenges and barriers to implementation; and
- sought and incorporated, across all aspects of service implementation, the perspectives of health authorities, Indigenous Peoples and people with lived and living experience.

We only looked at publicly accessible, adult-serving OPS/SCS that are funded by the ministries.

We did not audit the delivery of OPS/SCS by health authorities or by contracted service providers. However, the audit team did interview staff from all health authorities, including the First Nations Health Authority and the Provincial Health Services Authority, and reviewed relevant documents to understand their perspectives and experiences working with the ministries to implement OPS/SCS.

The audit period was from January 1, 2020, to June 30, 2023.

Learn more about the audit criteria on page 47.

Learn more about how we did this audit on page 42.

Conclusion

We found that the ministries:

- monitored operational performance;
- monitored funding and adjusted when necessary; and
- reported publicly on overdose prevention and supervised consumption services implementation.

However, we found deficiencies in key areas:

- Operational guidance lacked minimum service standards and did not always reflect engagement with health authorities, people with lived and living experience, and Indigenous Peoples.
- Persistent challenges and barriers to province-wide implementation were not addressed.
- There were deficiencies in target setting and evaluation.

For these reasons we concluded that the Ministry of Mental Health and Addictions and the Ministry of Health did not ensure effective province-wide implementation of overdose prevention and supervised consumption services by the health authorities.

Source: Island Health

Findings and recommendations

Province-wide standards and guidance

Province-wide standards and guidance help ensure accessibility and a consistent quality of care. Guidance must reflect the perspectives of Indigenous Peoples since they are disproportionately affected by the toxic drug crisis. The Ministry of Mental Health and Addictions and the Ministry of Health have committed to building a substance use continuum of care that is culturally safe for Indigenous Peoples and includes the perspectives of people with lived and living experience.

Provincial guidance was inadequate

What we looked for

We examined whether the ministries developed province-wide guidance for providing overdose prevention and supervised consumption services and whether the guidance had:

- minimum service level standards, including accessibility and availability;
- policies and guidelines, including physical space requirements; and
- reflected engagement with health authorities, Indigenous Peoples and people with lived and living experience (PWLLE).

Given the emergent nature of the toxic drug crisis, and the ministerial order to provide OPS where necessary, it may not have been feasible to determine minimum service standards during the early emergency period. However, given the crisis was in its seventh year at the time of the audit, we expected the ministries to have set minimum level service standards.

Learn more about the audit criteria on page 47.

What we found

The ministries developed high-level and operational OPS/SCS guidance, but the operational guidance wasn't current and it was out of step with changes in the toxic drug supply. We found that OPS/SCS guidance didn't include standards to ensure quality of care, availability, and accessibility. We also found that while the ministries consulted with health authorities, Indigenous Peoples, and PWLLE, their perspectives weren't always reflected in the guidance.

Operational guidance developed

The ministries delegated the development of OPS guidance to the BC Centre for Disease Control (BCCDC), which published the BC Overdose Prevention Services Guide in 2019. The ministries also adopted the existing Supervised Consumption Services Operational Guidance, which was originally developed by the British Columbia Centre on Substance Use in 2017.

The operational guidance includes, but isn't limited to:

- drug toxicity event prevention, recognition, and response;
- physical space requirements for ventilation and privacy;
- participant eligibility;
- equipment;
- data collection; and
- staff training.

No service standards in guidance

The operational guidance doesn't provide any service standards for providers to ensure quality of care, accessibility, and availability of OPS/SCS across the province. The need for service standards was also noted in the Select Standing Committee on Health's 2022 report *Closing Gaps, Reducing Barriers: Expanding the Response to the Toxic Drug and Overdose Crisis.*

Consultation not reflected in guidance

Health authorities, Indigenous Peoples, and PWLLE were consulted during the development of the BC Overdose Prevention Services Guide. Their perspectives weren't always reflected in the guidance. This was particularly evident for health authorities serving rural and remote communities where the guidance wasn't always relevant. For example, two regional health authorities stated that a lack of implementation guidance was a barrier to OPS/SCS implementation in their region. The guidance was also seen as urban-focused. Further, the First Nations Health Authority developed its own guidance because the OPS guidance didn't adequately reflect the needs of the rural and remote First Nations communities that the FNHA serves.

Guidance out of step with developments in toxic drug supply

The BC Overdose Prevention Services Guide describes itself as a living document that will be updated as circumstances change. We found that its detailed operational guidance was lacking and out of date. For example, the guide was published in early 2019 before the widespread introduction of benzodiazepines into the unregulated drug supply chain. Benzodiazepines made drug toxicity presentation and reversal more complex. There is a need for detailed guidance on approaches to respond to toxic drug events involving benzodiazepines. At the time of the audit, the BCCDC was working on guidance specific to indoor inhalation to address changing preferences in modes of consumption and changes in observed consumption service delivery.

Why this matters

Because the ministries haven't developed minimum service level standards for availability, services may not be available when and where they are needed, creating geographic inequity across the province. Additionally, because the ministries haven't developed service standards for accessibility, it's possible that even if an OPS/SCS is available, it may not be physically accessible or safe for particular groups of people, such as women or Indigenous Peoples (e.g., physical safety, cultural safety). Additionally, a lack of detailed, up-to-date guidance may put client safety at risk and increase legal risks – related to standard of care – for health authorities delivering the services in partnership with non-profits.

Because Indigenous Peoples are disproportionately affected by the toxic drug crisis, and because the ministries have committed to a culturally safe continuum of care, it's imperative that guidance reflect Indigenous perspectives, including the perspectives of rural and remote Indigenous communities.

Recommendation

1. We recommend that the ministries work collaboratively with health authorities, service providers, PWLLE, and Indigenous Peoples to:
   - develop appropriate minimum level standards for OPS/SCS province-wide, including availability, accessibility, and service quality; and
   - update guidance for OPS/SCS to ensure it meets the needs of all these groups.

See the response from the auditee on page 43.

Planning, monitoring, evaluating and reporting

Clear objectives, performance measures, and targets help the ministries adopt a focused approach to OPS/SCS implementation across the province. The ministries are also responsible for province-wide data collection, which they monitor to make informed decisions about priorities, resource allocation, and program evaluation. The ministries track, assess, and analyze data to evaluate implementation progress and risks, and guide the allocation of resources.

The ministries can use program evaluations to know whether OPS/SCS are effective, if they meet community needs, and meet the needs of the diverse populations who use OPS/SCS. Regular reporting between the health authorities and the ministries supports OPS/SCS implementation. Public reporting by the ministries on OPS/SCS implementation supports government transparency and promotes public trust.

Objectives and performance measures were set, but not all health authorities had quantitative targets

What we looked for

We examined whether the ministries worked with health authorities to develop objectives, performance measures, and targets.

Learn more about the audit criteria on page 47.

What we found

The ministries set high-level objectives related to OPS/SCS. They worked with health authorities to set and use performance measures to monitor the province-wide performance of OPS/SCS. However, challenges were noted with respect to the ministries' monitoring of performance measures set by health authorities. We also found that not all regional health authorities set quantitative targets in implementation planning.

The objectives were included in policy documents, service, and business plans, and in program implementation planning with the health authorities. For example, recent MMHA service plans had the objective of ensuring people at risk of overdose can access life-saving interventions. These included harm reduction services, with a related strategy to reduce harms by ensuring that people who use drugs can access OPS/SCS. The ministries also worked with health authorities to set performance measures within the detailed implementation plans that health authorities and the First Nations Health Authority are required to complete.

In a sample of accelerated overdose detailed implementation plans, the ministries provided general, high-level objectives and guidance to each of the five regional health authorities. They worked with health authorities to set program level objectives and performance measures. The ministries directed each health authority to set their own targets (within set parameters). Targets are output based, such as total number of sites, and total consumption visits. This collaborative process allowed the health authorities to maintain autonomy in their operations. Autonomy is important given the level of variation across the province in OPS/SCS, the low-barrier nature of the services, and the different needs of communities.

Only two health authorities set quantitative targets

The ministries requested health authorities submit targets when completing their detailed implementation plans. However, in the sample of plans we received (one from each regional health authority for accelerated overdose funding in 2021/22) only two health authorities of the five explicitly set quantitative targets for OPS/SCS. Examples of targets set by the health authorities include number of total OPS sites and inhalation OPS sites, and number of visits to OPS sites.

Lack of collaboration with some health authorities created planning challenges

Three health authorities noted a lack of collaboration with the ministries contributed to challenges in their implementation planning. This included difficulties for health authorities to ensure funding could be used to meet objectives and targets within a given timeframe, or in adapting high level goals to meet the needs of community specific contexts (e.g., rural and remote). Short timeframes also contributed to one health authority being challenged to develop appropriate plans and appropriately consult Indigenous Peoples and PWLLE.

Why this matters

Without clear objectives, performance measures, and targets agreed to by both ministries and health authorities during planning processes, the health authorities may lack clear direction and purpose, which can affect efforts to ensure a focused approach to OPS/SCS implementation across the province. Objectives, performance measures, and targets can help ministries establish clear oversight of OPS/SCS operations. They also help the ministries and health authorities situate OPS/SCS within a whole-of-government response to the toxic drug crisis and across the continuum of health and social care.

Recommendation

2. We recommend that the ministries work proactively with health authorities to develop targets that are achievable within given timeframes to help ensure effective province-wide implementation of OPS/SCS.

See the response from the auditee on page 44.

The ministries monitored the operational performance of OPS/SCS

What we looked for

We looked at whether the ministries monitored operational performance of OPS/SCS across the province.

Learn more about the audit criteria on page 47.

What we found

The ministries worked with health authorities and the BC Centre for Disease Control to monitor the province-wide operational performance of the OPS/SCS program. The ministries receive program monitoring reports three times per year from all health authorities. In these, health authorities provide data on agreed-upon OPS/SCS indicators and give qualitative updates on program status (relative to the detailed implementation plans). Ministries update the program monitoring templates as needed in response to changes in program context (e.g., to reflect accelerated overdose funding in the 2021 provincial budget).

In the sample of program monitoring reports we received (one per regional health authority from the same reporting period), all were submitted to the ministries as required. The ministries also monitor program performance through monthly regional response team meetings (attended by the MMHA, HLTH, regional health authorities and the FNHA), as well as through additional ad-hoc meetings as needed.

BCCDC receives OPS/SCS data from health authorities monthly and shares it with the ministries in a highlights document. BCCDC also publishes data on select indicators (visits to OPS/SCS, visits to inhalation OPS/SCS, overdoses attended at OPS/SCS) on the OPS/SCS tab of the publicly available Unregulated Drug Poisoning Emergency Dashboard that the ministries use.

We found duplication of some of the indicators health authorities reported to BCCDC and the ministries. Some health authorities noted that the program monitoring templates contribute to a high reporting burden and are resource-intensive and time consuming.

There had been discussion within MMHA around updating the program monitoring templates, but they face capacity issues to move the work forward. However, we didn't find that these issues prevented the ministries from monitoring overall province-wide OPS/SCS operational performance.

Why this matters

Efficient operational performance monitoring allows the ministries to determine if objectives for OPS/SCS are being met. It informs decisions on priorities, resource allocation and program evaluation. It also allows the ministries to compare implementation to larger policy priorities.

Recommendation

No recommendation.

The ministries monitored OPS/SCS funding and adjusted funding as necessary

What we looked for

We looked at whether the ministries monitored OPS/SCS funding and adjusted funding as necessary.

Learn more about the audit criteria on page 47.

What we found

The ministries monitored OPS/SCS funding and worked with the health authorities to adjust and reallocate funds as necessary. Monitoring was also done by the health authorities, and there are several processes the ministries use to gather and monitor financial data.

Finance departments in HLTH and in MMHA receive financial information from health authorities three times per year. Program areas within each ministry receive additional financial information, as needed, from health authorities. The ministries worked with the health authorities to make funding adjustments throughout the fiscal year.

During the audit period, we found OPS/SCS funding was usually overspent by health authorities. Some health authorities attributed overspending to the initial investments in new sites. The ministries worked with health authorities to cover the difference by reallocating funding from other mental health and substance use programs that were underspent.

Why this matters

Tracking and analyzing funding information allows the ministries to determine whether adjustments need to be made to support provincial OPS/SCS implementation. It allows the ministries to track spending against spending frameworks, and to determine if OPS/SCS are operating within allocated budgets. It also helps inform ministry decision making and resource allocation, including requesting additional funding from government when needed.

Recommendation

No recommendation.

The ministries evaluated OPS/SCS, but new evaluation needed

What we looked for

We looked at whether the ministries conducted evaluations of OPS/SCS to assess effectiveness, and whether the evaluations included engagement with health authorities, Indigenous Peoples, and people with lived and living experience.

Learn more about the audit criteria on page 47.

What we found

We found that the ministries evaluated the effectiveness of OPS/SCS and that they engaged with health authorities, Indigenous Peoples, and PWLLE. The most recent evaluation of the provincial response (including OPS/SCS) was completed in 2021. No further provincial evaluation has been conducted since then, and the landscape of the toxic drug crisis has changed considerably.

The ministries contracted with the Michael Smith Foundation for two performance evaluations (completed in 2019 and 2021) of the overall provincial response (including OPS/SCS) to the unregulated toxic drug crisis. These evaluations included engagement with health authorities, Indigenous Peoples, and PWLLE.

In addition, the ministries rely on a number of other methods of evaluation, including:

- external, peer-reviewed literature on OPS/SCS effectiveness;
- health authority-initiated evaluations;
- the BC Harm Reduction Client Survey; and
- BCCDC's quarterly reports on mathematical modelling of deaths averted by the key harm reduction programs (e.g., number of take-home Naloxone kits, visits to OPS/SCS, and access to opioid agonist therapy).

No new formal evaluation of the overall provincial response (including OPS/SCS) has been started since the Michael Smith Foundation evaluations were done in 2021. Those findings, based on data up to August 2020, are likely to be outdated given the increased preference for inhalation of drugs, the expansion of OPS/SCS, and the introduction of different, more toxic, drugs into the supply chain.

We recognize that COVID-19 and the unregulated toxic drug crisis created compounding challenges that would have made it difficult for the ministries to undertake an evaluation during the audit period. However, COVID-19 has stabilized. Given the severity of the toxic drug crisis and the rapidly changing circumstances – and since evaluation is a core mandate of MMHA – we expected the ministries to have initiated or planned a new province-wide evaluation of OPS/SCS.

Why this matters

The ministries need to evaluate the effectiveness of OPS/SCS to determine if they are meeting the needs of communities. Because the ministries didn't conduct timely evaluations, there's a risk of them not knowing if OPS/SCS respond as effectively as possible to the rapidly changing unregulated toxic drug crisis.

Engagement with health authorities, Indigenous Peoples, and PWLLE in the evaluation process allows for a diversity of perspectives and ensures that the ministries know if services are meeting the needs of people who use them.

Recommendation

3. We recommend that the ministries work with health authorities, Indigenous Peoples, and PWLLE to initiate a new, systematic evaluation of OPS/SCS in B.C.

See the response from the auditee on page 44.

The ministries reported on OPS/SCS implementation

What we looked for

We looked at whether the ministries reported on the province-wide implementation of OPS/SCS.

Learn more about the audit criteria on page 47.

What we found

The ministries reported to the public on OPS/SCS through several channels. BCCDC's Unregulated Drug Poisoning Emergency Dashboard is the main source of information on OPS/SCS implementation. It's online, updated monthly, and provides reports for each health authority and the province as a whole. It uses three OPS/SCS indicators:

- the number of visits to OPS/SCS;
- number of visits to inhalation OPS/SCS, and
- the number of overdoses attended at OPS/SCS.

The ministries also publish information on the toxic drug crisis response, including on OPS/SCS implementation. Fact sheets (generally coinciding with the release of BC Coroner's reports), reports, updates, and policy documents are on the ministries' websites.

Why this matters

Public reporting by the ministries educates health system partners and the public, provides transparency, and builds public trust in OPS/SCS.

Recommendation

No recommendation.

Identifying and addressing challenges and barriers

The ministerial order establishing overdose prevention services states they should be available wherever there is need, as determined by the level of drug toxicity-related morbidity and mortality.

MMHA's role is to resolve barriers to overdose prevention at local, regional, and provincial levels. HLTH works with MMHA to ensure policies are implemented.

OPS/SCS are largely concentrated in urban areas, and inhalation OPS sites are only available in three of the five regional health authorities (as of June 2023). In the absence of OPS/SCS, people who use drugs face increased risk of death and injury. This places an additional burden on people who use the services and their families, communities, and the health-care system.

The ministries identified but had not addressed persistent challenges and barriers impacting OPS/SCS implementation province-wide

What we looked for

We looked at whether the ministries worked with health authorities, PWLLE, and Indigenous Peoples to identify challenges and barriers to the effective province-wide implementation of OPS/SCS.

We also looked at whether the ministries worked with health authorities, PWLLE, and Indigenous Peoples to develop and implement strategies to address challenges and barriers to the effective implementation of OPS/SCS.

Learn more about the audit criteria on page 47.

What we found

The ministries worked with health authorities to identify challenges and barriers and provided funding to support OPS/SCS service expansion. However, they didn't work effectively with health authorities, PWLLE, or Indigenous Peoples to develop or use strategies to address persistent obstacles to effective province-wide implementation of OPS/SCS.

The ministries are aware of challenges and barriers

The ministries engaged with health authorities and other health sector partners across several forums, and worked with community-based organizations (e.g., Community Action Teams and the Provincial Peer Network). They used multiple reporting mechanisms to understand challenges and barriers to OPS/SCS implementation province-wide (see "OPS/SCS roadblocks to implementation" on page 24). MMHA developed and maintains a tracking tool to ensure awareness of bylaws in development, being proposed, or in force that may impact OPS/SCS implementation.

OPS/SCS roadblocks to implementation

The ministries, health authorities, and health sector partners face several hurdles to establishing and maintaining OPS/SCS sites, among them:

Municipal resistance This includes bylaws, zoning, and/or permits used by municipalities to prevent health authorities from implementing the services where they are needed.

Infrastructure/location Finding and securing appropriate sites for OPS/SCS, including renovations to support inhalation OPS/SCS. This can be linked to difficulties securing capital funding.

Human resources Challenges relate to hiring and retaining staff (including for service expansion) and high rates of burnout.

Service access and acceptability Services are concentrated in urban areas and there's a lack of services in rural and remote areas. There's a need for comfortable and safe spaces for a range of service users, including Indigenous Peoples and women. There can be access barriers related to privacy (e.g., concerns of privacy in smaller communities, stigma around drug use).

Service models Challenges relate to integration with external support services, and with providing and optimizing services in rural and remote areas. This also includes the overarching challenge of the services being set up quickly under ministerial order M488, and the shift to the services becoming more permanent programs.

Collaboration This includes a lack of effective collaboration between health authorities and the ministries during planning, siloing within the ministries, and the need for greater cross-ministry action and integration of services to support a government-wide response to the crisis.

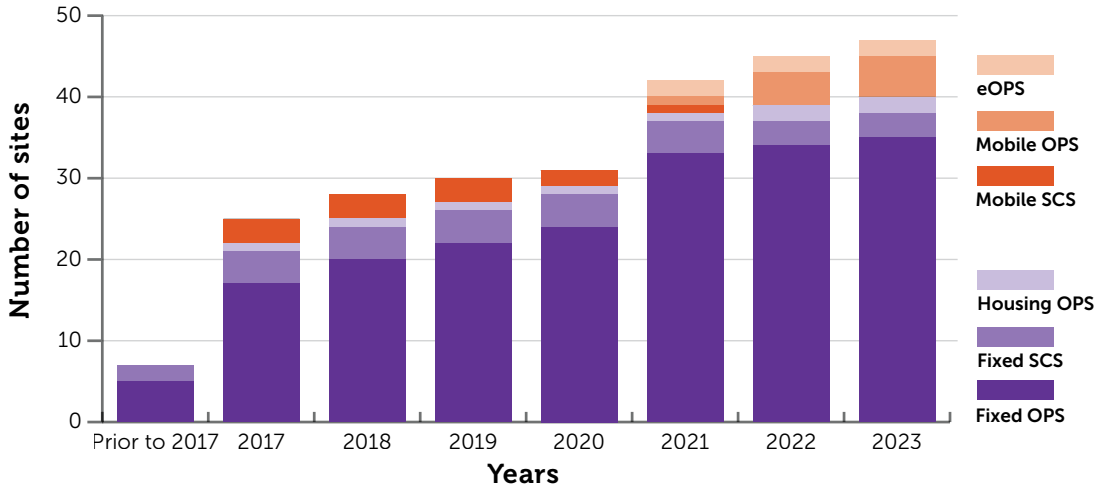
Lack of progress addressing persistent challenges and barriers

The ministries alone can't fully address everything that stands in the way of province-wide implementation of OPS/SCS. However, we expected the ministries to have developed strategies to begin addressing the persistent, known barriers, such as municipal resistance.

We found that the ministries funded and supported community organizations and community-based initiatives, including:

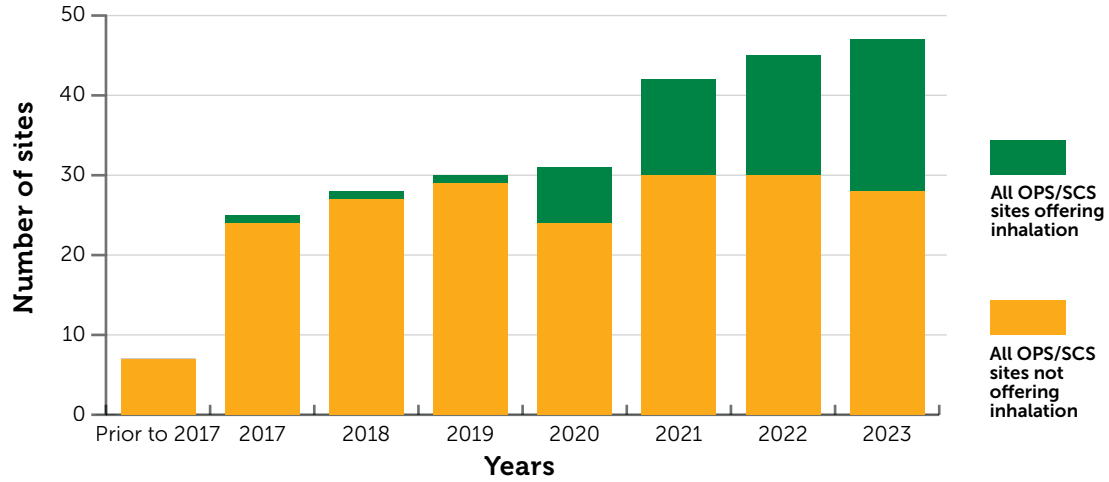
- research and projects addressing issues including stigma, inequities in drug toxicity response, and harm reduction in rural, remote, and Indigenous communities and at the regional level;
- peer coordinators, funded by MMHA with positions in all health authorities, work to enable the meaningful engagement of people with lived and living experience in harm reduction policy, program development, and implementation;
- Community Action Teams, which facilitate representatives from community organizations (e.g., local government, health authorities, NGOs) in the most at-risk communities to work together to respond to the toxic drug crisis. They often advocate for OPS implementation and extended OPS hours, engage communities, and support peer employment at OPS.
- Local Leadership United, a project to bring together local governments and harm reduction resource providers. It encourages engagement among key parties on related issues facing local governments and strategies for responding to them.

Number of differing types of overdose prevention and supervised consumption service sites over time



The different types of OPS/SCS shown may or may not offer inhalation. Please see the chart below for number of sites offering inhalation.

Number of overdose prevention and supervised consumption service sites (all types) offering inhalation



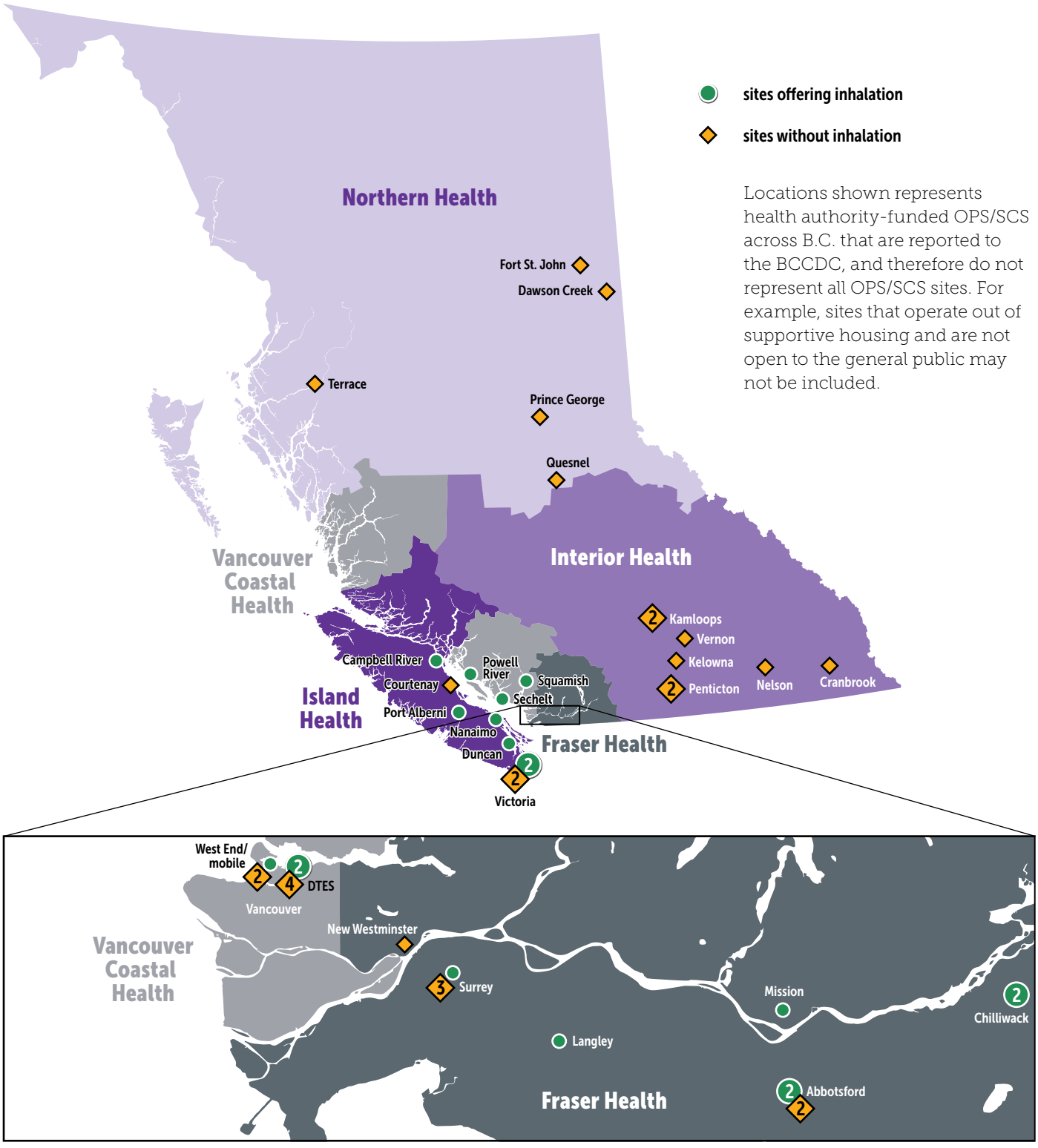
Data shown in these two charts only represents health authority-funded OPS/SCS across B.C. that are reported to the BCCDC, and therefore do not represent all OPS/SCS sites. For example, sites that operate out of supportive housing and are not open to the general public may not be included.

Source: The Ministry of Mental Health and Addictions and the BC Centre for Disease Control to June 2023

The ministries secured more funding for access to OPS/SCS services and new inhalation OPS to meet the shift in consumption preferences towards inhalation. In response to challenges posed by COVID-19, and to support expanded access to OPS services, MMHA and BCCDC created a protocol intended to increase access to episodic OPS, an on-demand overdose prevention service offered by trained health and social services staff outside established OPS/SCS locations.

As of June 2023, the ministries had worked with the health authorities to set up 47 OPS/SCS sites of which 19 are inhalation sites. Inhalation sites were only in three health authorities (Vancouver Coastal Health, Fraser Health, and Island Health) despite inhalation being the preferred method of drug use province-wide, according to the 2021 BC Harm Reduction Client Survey (see "Overdose prevention and supervised consumption service locations in B.C." on page 26).

Overdose prevention and supervised consumption service locations in B.C.



Source: Prepared by the Office of the Auditor General of British Columbia, with data provided from the Ministry of Mental Health and Addictions and the BC Centre for Disease Control as of June 2023

Lack of tools to support OPS/SCS implementation

Three health authorities and one key party reported a lack of support to address difficulties in OPS/SCS implementation, noting that there has been little leadership from the ministries in this area.

In one case, a health authority asked – verbally and in writing – for support to address a municipality's opposition to a proposed OPS site. The ministries didn't take substantive action in response.

Some health authorities and health sector partners raised concerns about how issues and challenges are escalated and acted upon within the ministries. For example, they noted they had lacked access to decision-making meetings, and that the meeting structures were ineffective.

We also found gaps in support tools – like current guidelines and toolkits – to help health authorities deal with municipal opposition. For example, one health authority noted the need for additional guidance on municipal engagement for implementing OPS/SCS.

The perspectives of PWLLE and Indigenous Peoples were not adequately sought or reflected

The ministries work with health authorities and other partners to incorporate the perspectives of Indigenous Peoples and PWLLE in strategy development and implementation. But, the health authorities and health system partners don't universally consider the relationships to be working well or as intended.

We found evidence that the ministries' work with Indigenous Peoples and PWLLE had challenges related to peers entering the mental health and substance use workforce. One health authority reported a need for the ministries to work with them to address barriers to peers entering and remaining employed in an OPS/SCS.

Some health authorities and a key party also noted the ministries' ineffective engagement with Indigenous Peoples and PWLLE. The FNHA observed an overreliance placed on them to speak for all First Nations Peoples and that they didn't feel heard at larger meetings with the ministries.

Why this matters

The ministries' development and use of strategies to address implementation challenges and barriers is key. It can provide a structured, organized approach to complex challenges facing OPS/SCS programs. Despite the ministries' awareness of the importance of OPS/SCS, persistent hurdles remain unresolved.

A comprehensive approach to overdose prevention involves collaboration and integration with other health and social services. It's integral to the effective implementation of OPS/SCS. Lack of guidance to support health authorities and communities resistant to these services contributes to barriers, making it more difficult for people who use these services to access them.

Multiple reports and organizations, including the Select Standing Committee on Health, have pointed out the risks of OPS/SCS not being available. The most serious risk is an increase in injury and death from drug toxicity among B.C.'s most vulnerable people.

Recommendations

4. We recommend that the ministries work with health authorities to develop province-wide strategies to address barriers to OPS/SCS implementation. The strategies should:
   - clearly articulate the ministries' and health authorities' responsibilities for implementation, oversight, and engagement; and
   - meaningfully reflect the needs of Indigenous Peoples and PWLLE.
5. We recommend that the ministries continue to work with health authorities to develop community-level guidance that supports health authorities and communities with OPS/SCS implementation.

See the response from the auditee on page 45.

Interior of the Cheam mobile OPS in Chilliwack.

Source: Fraser Health

An independent audit report

Chapter 2: An audit of the initial implementation of prescribed safer supply

Source: Getty Images

In the face of mounting drug toxicity deaths and the increasingly toxic drug supply, the Ministry of Mental Health and Addictions and the Ministry of Health released a prescribed safer supply policy in July 2021. The policy allows physicians or nurse practitioners to prescribe pharmaceutical grade alternatives for people at risk of harm or death from the toxic drug supply.

The program's goals are to reduce injury and death, increase well-being, and increase health and social supports for people who use drugs. MMHA provides stewardship and oversight of prescribed safer supply, in partnership with HLTH. The policy mandates regional health authorities to provide prescribed safer supply either directly or through contracted service providers. It lays the groundwork for individual prescribers to offer prescribed safer supply outside of health authority programs.

B.C. is the first province to introduce and invest in a provincial prescribed safer supply policy. Because of its novelty, the program was introduced in phases.

The first phase allowed certain opioids to be prescribed through health authorities or federally funded programs. The ministries are using the evidence from the programs to evaluate effectiveness. The BC Centre on Substance Use is using the evidence to develop provincial clinical protocols for specific drugs.

The clinical protocols and evidence from previous phases (e.g., risk mitigation guidance) will be used to expand the program to additional settings, with additional funding.

Risk mitigation guidance

- Risk Mitigation in the Context of Dual Public Health Emergencies (RMG) was introduced in 2020 as an emergency, interim, clinical guidance document for prescribing various pharmaceutical alternatives in the context of the COVID-19 pandemic.
- Like prescribing under the 2021 provincial prescribed safer supply policy direction, the goal of RMG is to reduce harm to those at risk of drug toxicity. It's also intended to assist in social distancing and isolation and prevention of withdrawal.
- Unlike the initial phase of prescribed safer supply under the 2021 provincial policy direction, RMG includes non-opioid drugs such as stimulants and benzodiazepines.
- RMG prescribing continues and is understood to be under the umbrella of prescribed safer supply even though it is a distinct clinical protocol.

Objective

The objective of the audit was to determine whether the Ministry of Mental Health and Addictions and the Ministry of Health effectively monitored the initial province-wide implementation of prescribed safer supply.

Scope

We audited the Ministry of Mental Health and Addictions and the Ministry of Health to see whether they effectively monitored the initial province-wide implementation of prescribed safer supply, including:

- whether the ministries implemented a data collection framework;
- initiated an evaluation;
- reported publicly on program performance;
- monitored and adjusted funding if necessary;
- identified, and worked to address, implementation challenges and barriers; and
- sought and incorporated, across all aspects of service implementation, the perspectives of health authorities, Indigenous Peoples and people with lived and living experience.

We did not look at the delivery of prescribed safer supply by health authorities, although the audit team interviewed representatives of all five regional health authorities, the First Nations Health Authority, and the Provincial Health Services Authority. The team reviewed their documents to understand their perspectives and experiences working with the ministries to implement prescribed safer supply.

The audit period was from July 1, 2021, to June 30, 2023.

Learn more about the audit criteria on page 47.

Learn more about how we did this audit on page 42.

Conclusion

We found that the ministries:

- developed a data collection framework;
- monitored and adjusted funding; and
- initiated an evaluation of prescribed safer supply.

However, we also found deficiencies in key areas. Specifically, the ministries:

- did not develop or implement strategies to address prominent barriers to implementation; and
- did not effectively report publicly on the performance of prescribed safer supply.

For these reasons we concluded that the Ministry of Mental Health and Addictions and the Ministry of Health did not effectively monitor the initial province-wide implementation of prescribed safer supply.

Source: Getty Images

Findings and recommendations

Data collection, evaluation, and financial monitoring

Prescribed safer supply is a novel practice and there's limited evidence to develop provincial clinical guidance, so consistent and high-quality data are crucial to the success of the program. A data collection framework is the foundation for evaluating the effectiveness of prescribed safer supply.

Performance evaluations play a vital role in ensuring accountability, improving program effectiveness, optimizing resource allocation, and promoting evidence-based decisions. The quality of the evaluation largely depends on the quality and consistency of the data used by researchers.

Tracking and analyzing funding information allows the ministries to determine whether adjustments need to be made to guide the allocation of resources supporting provincial prescribed safer supply implementation.

Prescribed safer supply data collection framework and program evaluation initiated

What we looked for

We looked at whether the ministries:

- implemented a data collection framework for prescribed safer supply, including service utilization, program outputs, clinical outcomes, and population-level impacts and outcomes;
- initiated a provincial evaluation of prescribed safer supply to assess effectiveness, including clinical outcomes and population-level impacts; and
- included PWLLE and Indigenous Peoples in the provincial evaluation to ensure prescribed safer supply is meeting their needs.

Learn more about the audit criteria on page 47.

What we found

We found that the ministries developed and implemented a data collection framework that includes monitoring service utilization and outputs and evaluating clinical outcomes and population-level impacts and outcomes.

We also found that the ministries initiated a provincial evaluation of prescribed safer supply to assess effectiveness, including clinical outcomes and population-level impacts. The evaluation included working with PWLLE and Indigenous Peoples to ensure prescribed safer supply is meeting their needs.

Data collection framework implemented

In June 2021, MMHA released its prescribed safer supply evaluation and monitoring framework, which serves as the basis for several subsequent monitoring and evaluation plans. The framework was developed to support consistent data collection by health authorities and third-party evaluation experts and researchers. The framework also enables monitoring and evaluation activities at the provincial and regional level.

The framework includes a table of outcomes of interest and potential data sources for measuring outcomes along four dimensions: service utilization, individual clinical and social outcomes, population-level impacts and outcomes, and implementation barriers/facilitators. The sources range from administrative data such as PharmaNet (a province-wide prescription database), to quantitative surveys and qualitative interviews.

BCCDC and the Health Sector Information Analysis Reporting branch of HLTH worked together to develop prescribed safer supply monitoring. Data is available to staff in the ministries and health authority epidemiologists through a browser dashboard maintained by BCCDC.

Prescribed safer supply evaluation underway

Evaluation focuses on an overall picture of the impacts of prescribed safer supply. It brings together monitoring and new primary data collection to better understand specific program implementation activities, individual clinical outcomes, and population-level outcomes. MMHA solicited expert evaluators through a request for proposals issued in December 2021. In June 2022, the external evaluation team developed the detailed evaluation plan envisioned in the MMHA evaluation and monitoring framework.

Source: Getty Images

The evaluation of prescribed safer supply was to:

- determine the impacts on non-fatal/fatal drug toxicity and all-cause mortality (primary outcomes), substance use, mental health, referrals, access and use of health and social services, and health-related quality of life (secondary outcomes);
- identify barriers and facilitators to implementation and service delivery from the perspectives of PWLLE, prescribers, service providers (including health authorities), Indigenous organizations and communities, and policymakers; and
- explore potential unintended consequences of prescribed safer supply implementation (e.g., availability/diversion), including harms and benefits to PWLLE and wider communities.

Early work by the evaluation team demonstrates participation of PWLLE and Indigenous Peoples in evaluation design and conducting. We found that the evaluation is on schedule. Additionally, an earlier evaluation of risk mitigation guidance (begun in 2020) had significant overlap and continuity with the prescribed safer supply evaluation in terms of evaluation team members and methodology. Results from the earlier evaluation are currently under peer-review.

The evaluation and monitoring framework originally included an examination of unintended consequences, including diversion (see textbox). However, considering persistent concerns from the public regarding the potential diversion of prescribed safer supply, MMHA has developed an enhanced plan to further monitor the impact of prescribed safer supply diversion, as part of the broader evaluation and monitoring framework.

Diversion

The ministries define diversion as "the channeling of regulated pharmaceuticals from a legal source to another party. This may include redirecting prescribed drugs into the illicit market, sharing prescribed drugs with others, and/or using these drugs in ways that were not intended by the prescriber."

Why this matters

Prescribed safer supply is intended to be an evidence generating program, and evidence gathered through evaluation is crucial to the program's continuation. The ministries' data monitoring framework means data is being collected to form an evidence base. Given clinician concerns about a lack of evidence for prescribed safer supply, and the politicization of the program, high-quality evaluation data is a requirement for assessing the success of prescribed safer supply. The ministries, having initiated the evaluation, will know how the program is performing compared to its intended outcomes. They will be aware of implementation barriers and unintended consequences.

By including PWLLE and Indigenous Peoples in the design and conducting of the evaluation, the ministries ensure that the evaluation is asking the right questions to determine if prescribed safer supply is meeting the needs of those groups.

Recommendation

No recommendation.

The ministries monitored prescribed safer supply funding and adjusted if necessary

What we looked for

We looked at whether the ministries monitored prescribed safer supply funding and adjusted it if necessary.

Learn more about the audit criteria on page 47.

What we found

The ministries monitored prescribed safer supply funding and had processes to adjust funding if necessary. Monitoring was carried out by both ministries and the health authorities. There are several processes in place for the ministries to gather financial data and obtain an accurate picture of how initiatives are performing compared to budget allocation, and to monitor program implementation.

Finance departments in HLTH and in MMHA receive financial information from health authorities three times per year, which they share with program specific areas in the ministries. Program areas receive additional financial information on an ad-hoc basis from health authorities. The ministries work with health authorities to make funding adjustments throughout the fiscal year.

During the audit we found health authorities consistently underspent prescribed safer supply funding due to program implementation challenges, such as filling staff vacancies. The ministries worked with health authorities to use the underspent funds to support other mental health and substance use programs.

Why this matters

Tracking and analyzing funding information allows the ministries to determine whether adjustments need to be made to support prescribed safer supply. Monitoring allows the ministries to compare spending with spending frameworks, determine if programs are operating within budget, and it can inform future decisions and resource allocations.

Recommendation

No recommendation.

Identifying and addressing challenges and barriers

The ministries' mandates include expanding prescribed safer supply programs so that more people have safer alternatives to the toxic drug supply. The ministries must work with regulatory colleges, professional associations, and other levels of government to ensure program success. Prescribed safer supply is delivered by health authorities, so the ministries need to work with them to identify and address challenges and barriers. Since prescribed safer supply is a novel program, it's important for the ministries to closely monitor it to identify barriers and act quickly to address them before they become entrenched.

The ministries' current and planned strategies do not adequately address key barriers to prescribed safer supply implementation

What we looked for

We looked at whether the ministries have worked with health authorities and other partners, including other ministries, agencies, service providers and clients/user groups, to identify and address obstacles to prescribed safer supply.

Learn more about the audit criteria on page 47.

What we found

The ministries have regular opportunities to collaborate with health authorities and other key parties to identity issues surrounding prescribed safer supply. While these efforts have yielded solutions to some issues, continued efforts are needed to devise a comprehensive workplan to tackle key barriers more effectively.

The ministries haven't made significant progress in addressing some of the most challenging barriers such as rural and remote access, a lack of prescribers and prescriber hesitancy, and appropriateness of drugs offered. The current strategy doesn't demonstrate how these barriers will be addressed.

The ministries are aware of challenges and barriers

The ministries have several ways to exchange information with health authorities and other partners about prescribed safer supply implementation challenges and barriers. They include the prescribed safer supply working group, prescribed safer supply steering committee, and regional response team meetings.

We recognize that COVID-19 compounded the challenges and barriers faced by the ministries. However, many of the issues were identified during the initial implementation of risk mitigation guidance in 2020, and through the 2021 Michael Smith Foundation evaluation of the provincial overdose emergency response.

Further, external committee reports, such as the BC Coroners Service Death Review Panel report (2022) and the Select Standing Committee on Health report on the toxic drug crisis (2022) noted similar challenges to prescribed safer supply implementation. The ministries also contracted external evaluations that identified important challenges and barriers.

Major obstacles to prescribed safer supply implementation

The ministries identified prescribed safer supply implementation issues:

1. **Drug type/strength/route of administration not available**
   - Drugs aren't often available in a smokeable form. The most prescribed drug, hydromorphone, isn't potent enough for many people who regularly use fentanyl.
2. **Lack of prescribers**
   - Health-care providers may be hesitant to prescribe safer supply to clients due to stigma and perceived risks, such as liability and unintended consequences, such as diversion.
   - Since the evidence for prescribed safer supply – especially for population-level outcomes – is new and evolving, health-care providers may be cautious and avoid prescribing under prescribed safer supply.
   - The lack of prescribers is also directly linked to broader shortage of staff across the health sector.
3. **Restrictive dispensing protocols**
   - Most prescriptions, to mitigate the risk of diversion, require the recipient to go to the pharmacy every day, sometimes at a specific time. This may conflict with a recipient's ability to keep a job, freedom of movement, and isn't feasible in communities where travel to a pharmacy is difficult and time consuming.
4. **Geographic inequity**
   - Many rural and remote communities lack health-care providers, prescribers, pharmacies, and support services required to safely and reliably access prescribed safer supply.
5. **Racism/trauma/stigma**
   - Racism, specifically anti-Indigenous racism, means that many people who would qualify for prescribed safer supply don't feel safe navigating the health-care system.
   - Stigma against people who use drugs prevents people from accessing prescribed safer supply and leads to a lack of prescribers.

Prescribed safer supply meetings have not resulted in effective collaboration

We interviewed all regional health authorities and the First Nations Health Authority regarding the initial implementation of prescribed safer supply. Four of the five regional health authorities, FNHA, as well as other health-system partners, reported that these channels haven't effectively supported the implementation of prescribed safer supply and they haven't resulted in collaborative solutions. Suggestions were made as early as December 2020 for engagement with PWLLE, clinicians, and key parties across B.C. for improved service delivery.

Current strategies do not show how key challenges and barriers will be addressed

The ministries haven't made significant progress on some of the most challenging barriers, such as access in rural and remote communities. To date, the ministries haven't shown how they'll be addressed.

The ministries have documented issues – including program, legal, and medical practice barriers – but they haven't assigned responsibility for the vast majority of specific steps to address them.

The ministries haven't developed strategies to address client-focused challenges (such as anti-Indigenous racism and sufficiency and appropriateness of drugs offered) which also affect the implementation of the prescribed safer supply program.

Health authorities and health-system partners also noted a lack of progress on strategies to address other issues. For example, health authorities noted the need for more engagement by the ministries with prescribers and the colleges. Prescribed safer supply relies on prescribers, and prescriber hesitancy has been a major barrier throughout the province. We found that health authorities want the ministries to be proactive and facilitate more coordinated planning to create province-wide support for implementation.

The ministries secured funding in 2023/24 to expand access to prescribed safer supply, and to expand the types of drugs available. With this funding, ministries indicated they are working on expanded and alternative service delivery options. We found no action plan or explanation of how the expanded/alternative service delivery options will resolve significant issues, especially those associated with prescribed safer supply implementation in rural and remote areas that lack health-care providers. Until these challenges are resolved, it's unlikely the services will be fully implemented.

While the program is novel and is in a relatively early stage of implementation, the barriers are known and significant. They should be addressed early on. We found substantive work hadn't started in this regard.

Why this matters

It's crucial for the ministries to engage with key parties, health-system partners, Indigenous Peoples and PWLLE to address prescribed safer supply implementation barriers. Up to 225,000 people in B.C. may be at risk of death from the toxic drug supply, yet less than 5,000 of them access prescribed safer supply (as of June 2023). As the drug supply has become more toxic, the need for low-barrier access to prescribed safer supply has become more pressing. People continue to die in increasing numbers across the province and at a high rate in rural and remote areas.

Recommendation

1. We recommend the ministries develop an action plan to address barriers to prescribed safer supply implementation that includes:
    - working with health authorities to clearly define ministerial and health authority responsibilities for implementation and oversight;
    - working with health authorities to ensure all key parties and partners, including Indigenous Peoples, PWLLE, and professional medical associations, are appropriately and adequately consulted and that their needs are meaningfully reflected in implementation strategies; and
    - targeted engagement with rural and remote communities to determine if implementation is feasible.

See the response from the auditee on page 46.

Public reporting

Regular public reporting provides transparency, allows the ministries to educate partners and the public, and builds public trust in the prescribed safer supply program. This is especially important for a novel program like prescribed safer supply since evidence of its impact is being gathered as the program emerges.

The ministries' public reporting on prescribed safer supply is insufficient

What we looked for

We looked at whether the ministries publicly reported on the performance of prescribed safer supply. Specifically, we looked for:

- the performance information the ministries have internally compared to what they reported publicly; and
- reporting metrics that inform the public whether the prescribed safer supply program is meeting objectives, such as decreasing the use of unregulated drugs, reducing illicit drug toxicity injuries and deaths, and mitigating potential harms of prescribed safer supply.

Learn more about the audit criteria on page 47.

What we found

We found that the ministries didn't adequately report publicly on the performance of prescribed safer supply. The ministries periodically publish the number of prescribed safer supply clients and they released some initial evaluation findings from early 2022. But the current level of public reporting is insufficient for the public to be informed about whether the prescribed safer supply program is meeting its intended outcomes.

Public factsheets do not inform public of performance

The ministries' periodic factsheets have updates on prescribed safer supply implementation and utilization. They include the number of monthly prescribed safer supply clients and they are updated monthly. However, archived factsheets are not available to the public, so there's no way to track trends or progress against objectives.

The factsheets also link to an infographic on initial risk mitigation guidance findings. At the time of the audit, the findings were approximately 18 months old.

The public information gives a snapshot of the number of prescribed safer supply clients but doesn't offer information about whether the program is meeting stated objectives.

Internal data not made public

There is an internal prescribed safer supply dashboard available to staff and partners of the ministries (e.g., regional health authority epidemiologists) with statistics for prescribed safer supply prescribers and prescribed safer supply clients. New clients per month, total clients per month, and total prescribers per month are listed in aggregate or by health authority, drug class, sex, and age group (if applicable).

The ministries had intended the dashboard to be public by September 2022, but this hadn't occurred during the audit period.

When and if the public dashboard is launched, analysis done by the ministries shows geographic reporting will be limited. This means that the public, including people seeking the service, will not see where prescribed safer supply is offered.

Lack of transparency

We found that health-system partners and some health authorities believe that communication by the ministries about prescribed safer supply, specifically about diversion, has been weak. MMHA has developed an enhanced monitoring plan on diversion, however they have not publicly reported that this work is underway. While the evaluation findings will report outcomes once they have been peer-reviewed (e.g., decreasing the use of unregulated drugs, reducing illicit drug toxicity injuries and deaths, and mitigating potential harms of prescribed safer supply), there's no communication plan for the ministries to publicly report the outcomes.

Why this matters

The ministries' current level of public reporting is insufficient for health system partners and the public to be informed about whether prescribed safer supply is meeting its intended outcomes effectively and efficiently.

Recommendation

2. We recommend the ministries report regularly to the public and health sector partners on whether the prescribed safer supply program is effectively meeting its objectives.

See the response from the auditee on page 46.

About the audits

We conducted these audits under the authority of Section 11(8) of the *Auditor General Act* and in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements, set out by the Chartered Professional Accountants of Canada (CPA Canada) in the *CPA Canada Handbook – Assurance*. These standards require that we comply with ethical requirements and conduct the audits to independently express a conclusion against the objective for each of the audits.

A direct audit involves understanding the subject matter to identify areas of significance and risk, and to identify relevant controls. This understanding is used as the basis for designing and performing audit procedures to obtain evidence on which to base the audit conclusion.

Due to the complex and technical nature of the subject matters for both audits, the audit team contracted three experts to act in an advisory capacity. The experts did not conduct audit work, but rather reviewed our work and provided feedback at all phases of the audits. The subject matter experts have a wide range of expertise, including clinical work, epidemiology, research, and provincial and federal policy work around harm reduction activities. The scope of their work on the audits included:

- reviewing the objectives and criteria and providing feedback to the audit team;
- reviewing and providing feedback to the audit team on the reasonableness of the findings and recommendations;
- reviewing and providing feedback to the audit team on the draft report, including use of correct terminology; and
- providing advice on any contentious issues that arose during the audits.

We carried out the following audit procedures for both audits: document review; sampling of administrative data; and interviews with ministries, health authorities and other health system partners.

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

Our office applies the Canadian Standard on Quality Management (CSQM 1), and we have complied with the independence and other requirements of the code of ethics issued by the Chartered Professional Accountants of British Columbia that are relevant to these audits.

Audit report date: March 6, 2024

Michael A. Pickup, FCPA, FCA
Auditor General of British Columbia
Victoria, B.C.

Appendix A: Recommendations and auditee response

An audit of the implementation of overdose prevention and supervised consumption services

Recommendation 1: We recommend that the ministries work collaboratively with health authorities, service providers, PWLLE, and Indigenous Peoples to:

- develop appropriate minimum level standards for OPS/SCS province-wide, including availability, accessibility, and service quality; and
- update guidance for OPS/SCS to ensure it meets the needs of all these groups.

Recommendation 1 response: The ministries agree with the recommendation. To improve availability, MMHA plans to develop a community needs assessment tool. To enhance service quality, safety, and accessibility, MMHA is working with partners to develop Minimum Service Standards (MSS) for OPS. Areas covered include (but are not limited to) governance, core services, facility requirements, staffing composition, and reporting requirements.

Regional health authorities, the First Nations Health Authority, and people with lived and living experience of substance use are among the partners that have or will been engaged in developing the MSS. MMHA staff will work with the BC Centre of Disease Control to ensure any updated OPS/SCS guidance is distinct from and aligned with the MSS.

Recommendation 2: We recommend that the ministries work proactively with health authorities to develop targets that are achievable within given timeframes to help ensure effective province-wide implementation of OPS/SCS.

Recommendation 2 response: The ministries agree with the recommendation. Given variations in OPS sites and local contexts, it will be necessary to work with individual health authorities to set appropriate targets for each site. The OPS Minimum Service Standards (MSS) will include enhanced data collection requirements to inform service planning. MMHA will establish OPS-specific standing meetings with each health authority to better understand local needs and how they relate to opportunities and barriers to province-wide OPS implementation.

In addition, there are currently no commonly accepted metrics for systematized OPS needs-assessment, though MMHA and system partners are working to develop them. Stakeholders and partners outside of the health system heavily influence the pace of OPS/SCS implementation through their interests and regulatory powers.

Recommendation 3: We recommend that the ministries work with health authorities, Indigenous Peoples, and PWLLE to initiate a new, systematic evaluation of OPS/SCS in B.C.

Recommendation 3 response: The ministries agree with the recommendation. MMHA, together with its partners, will initiate a new evaluation of OPS/SCS that includes health authorities, Indigenous Peoples, and people with lived and living experience of substance use. This evaluation may be contracted to an external research group. The evaluation will draw on metrics used in the OPS Minimum Service Standards as well as emerging metrics and tools developed to systematically assess the potential benefits of additional OPS in communities.

Recommendation 4: We recommend that the ministries work with health authorities to develop province-wide strategies to address barriers to OPS/SCS implementation. The strategies should:

- clearly articulate the ministries' and health authorities' responsibilities for implementation, oversight, and engagement; and
- meaningfully reflect the needs of Indigenous Peoples and PWLLE.

Recommendation 4 response: The ministries agree with the recommendation. The ministries have identified and begun to address persistent challenges and barriers impacting OPS/SCS implementation. More work is required to fully overcome these challenges and barriers.

The ministries will work with health authorities to clearly define, formalize, and where possible, standardize responsibilities for implementation and oversight. MMHA will establish OPS-specific standing meetings with each health authority to better understand barriers as they arise and inform internal strategies and direction to assist HAs w/ their defined role in OPS implementation. In addition, MMHA is working with health authorities and other interested parties on an updated Harm Reduction Community Guide with operational guidance and implementation strategies for OPS/SCS.

Recommendation 5: We recommend that the ministries continue to work with health authorities to develop community-level guidance that supports health authorities and communities with OPS/SCS implementation.

Recommendation 5 response: The ministries agree with the recommendation. MMHA is working with health authorities and other stakeholders on an updated Harm Reduction Community Guide, including implementation strategies for OPS/SCS. An open line of communication exists between health authorities and MMHA through standing monthly meetings.

An audit of the initial implementation of prescribed safer supply

Recommendation 1: We recommend the ministries develop an action plan to address barriers to prescribed safer supply implementation that includes:

- working with health authorities to clearly define ministerial and health authority responsibilities for implementation and oversight,
- working with health authorities to ensure all key parties and partners, including Indigenous Peoples, PWLLE, and professional medical associations, are appropriately and adequately consulted and that their needs are meaningfully reflected in implementation strategies; and
- targeted engagement with rural and remote communities to determine if implementation is feasible.

Recommendation 1 response: The ministries agree with the recommendation. Some of the most challenging barriers to implementing prescribed safer supply include access in rural and remote areas. The ministries have already been working to address these barriers. For example, MMHA and its partners have developed an enhanced evaluation and monitoring framework to address prescriber concerns and are exploring opportunities to support services to increase access in rural and remote communities.

MMHA will work with health authorities, rural and remote communities, and other relevant stakeholders and partners to better delineate ministerial and health authority responsibilities for prescribed safer supply implementation and oversight and to identify how to address barriers to implementation.

Recommendation 2: We recommend the ministries report regularly to the public and health sector partners on whether the prescribed safer supply program is effectively meeting its objectives.

Recommendation 2 response: The ministries agree with the recommendation. Work underway by the ministries include:

Supporting the BC Centre on Substance Use to develop a knowledge hub for prescribed safer supply resources for clinicians and the general public.

Appendix B: Audit criteria

An audit of the implementation of overdose prevention and supervised consumption services

Objective: To determine whether the Ministry of Mental Health and Addictions and the Ministry of Health (the ministries) ensured effective province-wide implementation of Overdose Prevention and Supervised Consumption Services by the health authorities.

Criterion 1.1 The ministries developed province-wide guidance for the provision of OPS/SCS.

- **1.1.1** Guidance included minimum level service standards, including availability and accessibility.
- **1.1.2** Guidance included province-wide policies and guidelines, including physical space requirements for ventilation and privacy.
- **1.1.3** Guidance development included engagement with health authorities, Indigenous Peoples and PWLLE.
- **1.1.4** Guidance reflects the results of engagement with health authorities, Indigenous Peoples and PWLLE.

Criterion 1.2 The ministries worked with health authorities to set objectives, performance measures, and targets for the provision of OPS/SCS across the province.

Criterion 2.1 The ministries monitored province-wide operational performance of OPS/SCS program.

Criterion 2.2 The ministries monitored province-wide OPS/SCS funding and adjusted if necessary.

Criterion 2.3 The ministries conducted evaluations of OPS/SCS to assess effectiveness that included engagement with health authorities, Indigenous Peoples and PWLLE.

Criterion 2.4 The ministries reported on the province-wide implementation of the OPS/SCS program.

Criterion 3.1 The ministries identified challenges and barriers impacting the effective implementation of OPS/SCS.

- **3.1.1** The ministries worked with health authorities to identify challenges and barriers.
- **3.1.2** The ministries sought input from health authorities on the perspectives of Indigenous Peoples and PWLLE.

Criterion 3.2 The ministries developed strategies to address challenges and barriers impacting the effective implementation of OPS/SCS.

- **3.2.1** The ministries worked with health authorities to develop strategies.
- **3.2.2** Strategies to address challenges and barriers included the needs of Indigenous Peoples and PWLLE.

Criterion 3.3 The ministries worked with health authorities to implement strategies to address challenges and barriers impacting the effective implementation of OPS/SCS.

An audit of the initial implementation of prescribed safer supply

Objective: To determine whether the Ministry of Mental Health and Addictions and the Ministry of Health (the ministries) effectively monitored the initial implementation of prescribed safer supply province-wide.

Criterion 1.1 The ministries implemented a data collection framework for prescribed safer supply, including service utilization, program outputs, clinical outcomes, and population-level impacts and outcomes.

Criterion 1.2 The ministries monitored prescribed safer supply funding and adjusted if necessary.

Criterion 1.3 The ministries worked with health authorities and stakeholders to identify and address prescribed safer supply implementation challenges and barriers.

Criterion 1.4 The ministries initiated a provincial evaluation of prescribed safer supply to assess effectiveness.

1.4.1 The evaluation included working with PWLLE to ensure prescribed safer supply meets their needs.

1.4.2 The evaluation ensured the prescribed safer supply is provided in a culturally safe manner that meets the needs of Indigenous Peoples.

Criterion 1.5 The ministries reported publicly on the performance of prescribed safer supply.

Appendix C: Abbreviations

BCCDC – British Columbia Centre for Disease Control

FNHA – First Nations Health Authority

MMHA – Ministry of Mental Health and Addictions

HLTH – Ministry of Health

OPS – Overdose prevention services

PWLLE – People with lived and living experience

RMG – Risk mitigation guidance

SCS – Supervised consumption services

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