Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

P-4

Standing Committee on Public Accounts

2024 Annual Report, Auditor General:

Ministry of Health

1st Session
44th Parliament

Monday 27 October 2025

Chair: Tom Rakocevic
Clerk: Thushitha Kobikrishna

Journal des débats (Hansard)

P-4

Comité permanent des comptes publics

Rapport annuel 2024, vérificatrice générale :

Ministère de la Santé

1re session
44e législature

Lundi 27 octobre 2025

Président : Tom Rakocevic
Greffière : Thushitha Kobikrishna

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Hansard Publications and Language Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400
Published by the Legislative Assembly of Ontario

Journal des débats et services linguistiques
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400
Publié par l'Assemblée législative de l'Ontario

ISSN 1180-4327

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Monday 27 October 2025

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Lundi 27 octobre 2025

The committee met at 1230 in room 151.

SUBCOMMITTEE REPORT

The Chair (Mr. Tom Rakocevic): Good afternoon, everyone. I would like to call the meeting of the Standing Committee on Public Accounts to order.

We will begin with the subcommittee report. Our first order of business on the agenda today is a report from the subcommittee on committee business. Can I please have one of the subcommittee members read the first report into the record? MPP Dixon.

Ms. Jess Dixon: Your subcommittee on committee business met on October 23, 2025, and recommends the following:

(1) That the following reports of the Office of the Auditor General be reviewed by the committee:

—Performance Audit: Skills Development Fund Training Stream (2025 special report);

—Performance Audit: Canada-wide Early Learning and Child Care Program (2025 special report); and

—Report on Progress to Reduce Greenhouse Gas Emissions (2025 special report); and

(2) That the Auditor General be invited to provide in-camera briefings on the four special reports tabled on October 1 on the following days:

—October 27, 2025, from 12:30 p.m. to 1:30 p.m.;

—November 3, 2025, from 12:30 p.m. to 1:30 p.m.;

—November 17, 2025, from 12:30 p.m. to 2:30 p.m.; and

(3) That the in-camera briefing from the Auditor General scheduled on October 27, 2025, on the 2024 Performance Audit: Implementation and Oversight of Ontario's Opioid Strategy be moved from 12:30 p.m. to 1:30 p.m.; and

(4) That the in-camera briefing from the Auditor General scheduled on November 3, 2025, on the 2024 Performance Audit: Ontario Place Redevelopment be moved from 12:30 p.m. to 1:30 p.m.; and

(5) That the start times of the public hearings scheduled on October 27, 2025, and November 3, 2025, be moved from 1:45 p.m. to 2:45 p.m.

I move that the report of the subcommittee be adopted.

The Chair (Mr. Tom Rakocevic): Any debate or comments? MPP Gélinas.

M^me^ France Gélinas: So for November 3, November 17 and October 27, we will still start at 12:30, and then what happens at 1:30?

The Chair (Mr. Tom Rakocevic): For those days, we will be hearing two briefings. So instead of just doing one briefing and then moving into hearings, we'll be hearing two on those days.

Any further debate or comments by members of the committee? Seeing no further debate by committee members, are members ready to vote? All those in favour? Any opposed? Carried.

Thank you, everyone. We will now pause briefly as we go into closed session.

The committee recessed at 1234 and resumed at 1445, following a closed session.

2024 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH

Consideration of the Performance Audit: Implementation and Oversight of Ontario's Opioid Strategy.

The Chair (Mr. Tom Rakocevic): I would like to call this meeting of the Standing Committee on Public Accounts to order. We are here to begin consideration of the 2025 Performance Audit: Implementation of Oversight of Ontario's Opioid Strategy.

Joining us today are officials from the Ministry of Health. You will have 20 minutes collectively for an opening presentation to the committee. We will then move into the question-and-answer portion of the meeting, where we will rotate back and forth between the official opposition, government and third party caucuses in 20-minute intervals. Before you begin, the Clerk will administer the oath of witness or affirmation.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Deborah Richardson, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but truth?

Ms. Deborah Richardson: Yes, I do.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Moving on to Alison Blair: Do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but truth?

Ms. Alison Blair: I do.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): And Kyle MacIntyre, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but truth?

Mr. Kyle MacIntyre: I do.

Has anyone ever not done it?

M^me^ France Gélinas: Not so far.

The Chair (Mr. Tom Rakocevic): You would have been the first.

Again, I would invite each of you to introduce yourselves for Hansard when you first begin speaking, and if at any point today you have to draw on staff who are seated behind you, we will be asking them to either affirm or swear an oath as well.

Please begin. You have 20 minutes.

Ms. Deborah Richardson: I'll begin by introducing myself in my Mi'kmaq language.

Remarks in Mi'kmaq.

My name is Deborah Richardson. I am from the Pabineau First Nation on the north shore of New Brunswick, and my spirit name is Eastern Star Woman. I'm the Deputy Minister of Health.

Good afternoon. Thank you so much, Chair and members of the committee, for an opportunity to speak to you today again—we got to spend some time together last week. As you know, we're here to speak today about the performance audit the Office of the Auditor General of Ontario released in late 2024 to evaluate the implementation and the oversight of Ontario's Opioid Strategy.

Through my daily work and the work of many, many staff at the Ministry of Health, Ontario Health and throughout the entire health care system, I can assure you that supporting mental health and well-being in Ontario is a key priority for all of us. To address this priority, the ministry is building a comprehensive and connected system that offers high quality, evidence-based services and supports for mental health and addictions where and when people need them.

I'm pleased to be here before you today to address questions this committee has about the audit. This committee plays a vital role in ensuring transparency, accountability and integrity in our public institutions. Your work is central to upholding the that trust people across Ontario place in the provincial government.

The Ministry of Health has accepted the findings of the Auditor General's report and acknowledges the need for a comprehensive continuum of care for mental health and substance abuse disorders that includes opioid addictions. The government's strategy also includes improving oversight and coordination with its partners at Ontario Health, local public health units and right across the health care system.

The ministry also agrees with the auditor that to meet the needs of people with mental health and addiction issues seeking treatment today, the ministry should focus on comprehensive care that includes both pharmacotherapy for opioid use disorder but also wraparound services and supports.

In 2016, the Ministry of Health issued the strategy to prevent opioid addiction and overdose, or the opioid strategy. This strategy was supported through an overall investment of $22 million. The 2016 opioid strategy was the focus of this Auditor General's report. The strategy was based on four pillars:

(1) appropriate pain management;

(2) treatment of opioid use disorder;

(3) harm reduction; and

(4) surveillance and reporting.

For context, there are a number of different types of opioids, and they are generally used to relieve pain. You may be familiar with opioids such as fentanyl, heroin or codeine, to name a few. When they are abused, it can lead to addiction, overuse and sometimes death.

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As the nature of opioid use has changed over time, so has the ministry's response. For example, in 2016, when the opioid strategy was released, opioid addiction was often the result of problematic prescribing and dispensing practices of pharmaceutical opioids. Today, much of the opioid addiction and overdoses are the result of something different. It is being driven through the proliferation and use of unregulated synthetic opioids, the most well-known among them being fentanyl. The illegal production of synthetic opioids results in substances that are more potent than prescription painkillers like oxycodone and more powerful than traditional street opioids like heroin.

Moreover, synthetic drugs are often mixtures of various psychoactive substances containing opioids, as well as stimulants, or substances that slow down brain activity or the nervous system or in many cases a mixture of both. The result is the rise of polysubstance use, where more than one psychoactive substance is consumed at a time. This often means that the illegal drug supply is tainted with powerful, addictive synthetic drugs. This has resulted in a shift from a non-medical opioid use problem to what a 2024 Lancet article describes as a polydrug use problem. The Lancet, for those of you who don't know, is a world-leading medical journal.

As the auditor acknowledges, the complexity of providing care and treatment for people with mental health and addiction issues has risen in recent years, and care needs to recognize the impacts of the proliferation of synthetic drugs, the rise of polysubstance use, homelessness and other factors. All of those factors contribute to the current-day need for provincial infrastructure for a mental health and addiction continuum of care that connects to better wraparound supports that meet the needs of people with mental health and addiction issues.

Further, the Auditor General's report advises that Ontario needs a new holistic and comprehensive response to opioid overdoses that recognizes the changes to drug supply and accounts for the social determinants of health exacerbating mortality rates. In 2020, the government released Roadmap to Wellness, the government's plan to build a world-class mental health and addiction system. It has been supported by a commitment to invest $3.8 billion over 10 years. Through Roadmap to Wellness, the Min-

istry of Health has committed to building a comprehensive and connected mental health and addiction treatment system to build local needs, filling gaps in the care continuum and creating the provincial infrastructure for a continuum of care that focuses on mental health and addiction and connects community, primary and acute care to better wraparound support for people with mental health and addiction issues.

To support our approach to helping people with an opioid or substance use disorder, the Ministry of Health is building a comprehensive and connected mental health and addiction treatment system that offers high quality evidence-based services and supports where and when people need them. This will help people recover from the cycle of addiction, help people repair their lives and help many of them enjoy a life with purpose and balance that many of us in this room take for granted.

The Roadmap to Wellness reflects the consensus among health service providers, experts and people with lived experience that Ontario needed to change how it organized and delivered mental health and addiction services to connect and integrate supports better, to establish better data on services and outcomes and to establish consistency in the care people can access right across this province.

The first indicator in the comprehensive nature of the Roadmap to Wellness is in its reference to a mental health and addiction system. Evidence shows that a significant number of people have a co-occurring or concurrent mental health and substance abuse diagnosis. In the case of opioid use disorder, a study published in 2020 showed that 87% of individuals enrolled in opioid agonist treatment in Ontario between 2011 and 2015 had also a mental disorder diagnosis.

Through Roadmap to Wellness, the government is building a comprehensive care continuum designed to address both mental health and substance use needs and indeed concurrent disorders. Since 2019-20, over $800 million in annual funding has flowed into mental health and addiction services for children, youth and adults. A significant portion of this funding, over $185 million in new base funding since 2019-20, has flowed to support community addictions health service providers.

Crucially, the community addictions sector in Ontario offers comprehensive substance-use treatment and support, and is growing in its capacity to deliver care for concurrent disorders. Community addictions programs funded by the Ministry of Health are well positioned to address the rise of polysubstance because they are needs-based services that admit clients who use any type of psychoactive substance. The focus of community addictions services is to provide evidence-based psychotherapy and psychosocial supports that address the common drivers of substance use.

It is important to stress that Ontario's Opioid Strategy's main treatment innovation, which was the rapid access addiction medicine clinics—otherwise known as RAAM clinics—is now a critical part of the community mental health and addiction care continuum, with 89 RAAM clinics in operation across Ontario providing low-barrier access to comprehensive assessment, peer support and care coordination.

RAAM clinics are of particular benefit to people who use opioids, because they are community services that provide rapid access to the first-line treatment for opioid use disorder, opioid agonist therapy—or OAT, as it's called within the sector. And the RAAM model includes supporting clients to move to the next stage of the service pathway to meet their needs whether that be primary care or community addictions treatment.

The Chair (Mr. Tom Rakocevic): Ten minutes remaining.

Ms. Deborah Richardson: Bed-based services also continue to be an important feature of the community addictions care continuum. Through Roadmap to Wellness and the Addictions Recovery Fund combined, Ontario is opening over 500 new addictions treatment beds. Of the 375 new beds created through the Addictions Recovery Fund, over half of those beds have been allocated to northern Ontario, the region that experiences the highest rate of overdoses for its population according to provincial data. Approximately 86 beds funded through the Addictions Recovery Fund have been allocated to Indigenous-led bed-based programs that offer Indigenous approaches to healing and recovery. As of today, there are over 2,000 government-funded addictions beds in total, providing withdrawal management, treatment and recovery services.

Ontario is also working to address developmentally appropriate substance-use treatment for children and youth. Sadly, we know for some, substance use starts in childhood, and statistics show that the risk of psychoactive substance use rises as a person moves through adolescence and into adulthood. Many of us think that youth substance use does not include opioids; however, a 2023 Ontario student drug use and health survey administered by the Centre for Addiction and Mental Health found that 22% of students reported non-medical use of prescription opioids in the previous 12 months.

The government is investing in developmentally appropriate youth addiction treatment through the Youth Wellness Hubs Ontario program. Youth wellness hubs are based on the internationally recognized Integrated Youth Services model, promoting the co-location and integration of primary care, mental health and substance use services in a youth-friendly setting that offers other services including recreational, skills-building, employment and housing services.

Clinical staff at each youth wellness hub receive training and supports to deliver developmentally appropriate substance-use and concurrent-disorders care for young people. Of the 32 youth wellness hubs, the government has committed to funding, 23 are now operational across Ontario, and three hubs are hosted by Indigenous-led organizations.

Most recently, in March of this year, the government announced that it is vesting over $550 million to create a total of 28 homelessness and addiction recovery treatment hubs across the province, nine more homelessness and

addiction recovery treatment hubs than initially planned. This includes two Indigenous-led hubs to ensure the delivery of culturally relevant care for community members.

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Similar to existing hub models in Ontario, homelessness and addiction recovery treatment hubs will reflect regional priorities by connecting people with complex needs to comprehensive and integrated care, including primary care, addiction treatment and supports, and supportive housing, as I mentioned.

A common need among clients of homelessness and addiction recovery treatment hubs is shelter. In particular, the Ministry of Health recognizes the importance of stable and long-term housing for people with serious mental health and/or addictions issues. It is critical to recovery, and it is a service proven to improve health and psychosocial outcomes. This is why every homelessness and addiction recovery treatment hub is required to offer supportive housing. In total, the government is funding the addition of close to 900 supportive housing units across Ontario, which is over 300 more than anticipated, helping people transition to stable and long-term housing.

It is important to say that the Roadmap to Wellness is not only about investments. It's about a strategy to build an infrastructure that supports responsive care and treatment. Under the Roadmap to Wellness, the government will create a central provincial administrator of the mental health and addiction system.

In 2020, the province proclaimed legislation to create the Mental Health and Addictions Centre of Excellence within Ontario Health, and actually, joining us here today—you may hear from him—is VP Graham Woodward.

The centre of excellence is responsible for implementing the provincial mental health and addictions strategy and has a legislated mandate to standardize care and align it with evidence through clinical, quality and program standards, and to collect data and develop performance metrics to support oversight of the system. Ontario is leveraging the centre of excellence to put in place the data and performance measurement structures that the Auditor General has recommended. For instance, the centre of excellence is implementing a provincial minimum data standard for mental health and addictions. That will support the collection of client-level standardized data elements from health service providers right across Ontario, providing consistent and comparable reporting of client statistics and service utilization across the province. In turn, this data will provide for improved planning, performance management and outcome monitoring.

The centre of excellence is also responsible for standardizing treatment and recovery services in line with evidence and is developing minimum program expectations to drive consistency of service delivery across the province.

While we strive to build a comprehensive and connected care continuum for mental health and addictions, we continue to be committed to addressing the changing nature of opioid use through the Roadmap to Wellness.

We also remain committed to maintaining systems that collect data on the prescribing and dispensing of prescription opioids, such as the narcotics monitoring system and the distribution of naloxone kits. This means working with Ontario Health and other partners to make practitioners aware of how they can access the narcotics monitoring system to inform their prescribing practices, and this means continuing to invest in pain management services that offer a range of supports for people that live with chronic pain every day.

The Ministry of Health is addressing the changing nature of opioid use in Ontario through the comprehensive and connected mental health and addictions system that we're building together, all of us: the Roadmap to Wellness.

Working with Ontario Health, the ministry is engaging in evidence-based policy-making and supporting a continuum of services that meet the needs of people across Ontario who have mental health and substance-use issues. To do this work, our colleagues with the ministry and Ontario Health obviously rely on a vast provincial network of partners, including people with lived and living experience, families and caregivers, front-line service providers, experts in public health and clinical care and regional health system planners.

We must also acknowledge that mental health and addictions transcend health care and affect every aspect of an individual's life. So, in addition to the people who work across the health system, we must acknowledge our partners in adjacent service sectors, including community and social services, housing, labour, education, corrections and policing, just to name a few.

The Chair (Mr. Tom Rakocevic): Two minutes remaining.

Ms. Deborah Richardson: Through Ontario's Roadmap to Wellness we can clarify, define and standardize the addiction services available in the province and, consequently, we will make it easier for colleagues in allied sectors to understand the services available. Cross-sector coordination of care will be easier and, of course, within the mental health and addictions care continuum a common set of provincial services, program expectations, data and performance metrics will drive consistency.

Thank you. Merci. Meegwetch. Marsi. Welalioq.

The Chair (Mr. Tom Rakocevic): Thank you very much, and again, welcome back.

This week we'll be beginning with the official opposition members, followed by the government members and the third party members. We will be following this rotation again for two rounds. You have 20 minutes beginning with the official opposition. I recognize MPP Lennox.

MPP Robin Lennox: Thank you very much for your presentation. I'd like to start by asking you about the decision to close the supervised consumption sites across Ontario. The Auditor General highlighted in her report that the decision to close the supervised consumption sites was made without proper planning, impact analysis or public consultations.

We're currently several years into a toxic drug crisis that is causing the death of seven Ontarians every day.

How can you justify closing a life-saving service without proper planning, impact analysis or public consultation?

Ms. Deborah Richardson: Thank you for the question. I'm also going to ask my executive lead Liz Walker to come here. I'm going to start to answer, and then I'll have her answer—so she will need to affirm.

Ms. Liz Walker: Thank you, Deputy.

I'm Liz Walker. I'm the executive lead at public health in the Ministry of Health.

The Chair (Mr. Tom Rakocevic): I'm pausing the time when these interactions occur, but you have to either swear an oath or affirm before you begin.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

Ms. Liz Walker: I do.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Thank you.

Ms. Deborah Richardson: So just maybe just to start directly to your question: The government remains committed to supporting individuals experiencing addiction and homelessness through a comprehensive and integrated system of care. And through initiatives such as the homelessness and addiction recovery treatment hubs, we are working to ensure that people are connected to the services they need when and where they need them.

A policy decision was made within government to focus in on giving people hope and recovery and treatment. That's a policy direction that the government did make, so that's why we created the HART hubs, so we call them, and we gave an option for existing consumption treatment centres to convert to HART hubs.

So, just to give an example, where some of the HART hubs might have been getting $700,000, maybe some were getting more, they were able to switch to enhance, to significant new services that are a level of $6.3 million. So, with that, there's a lot of more services that were available by just providing the consumption treatment services, but perhaps—

MPP Robin Lennox: That's okay. Thank you.

You mentioned the increased investment in money, but in fact, between March 31, when the supervised consumption sites closed, and April 1, none of the HART hubs were actually fully operational to the level of service that you described. So would you agree that between March 31 and April 1, there was a net loss of services for people who use substances across this province?

Ms. Deborah Richardson: We worked very closely with other service providers that were in that area to provide a continuum of care for the individuals all throughout that particular area. So, we worked with the emergency departments, we worked with other service providers.

And perhaps I can turn it over to Kyle MacIntyre, who can give the specifics of what we did to ensure that continuum of care.

Mr. Kyle MacIntyre: Thank you—Kyle MacIntyre, ADM with mental health and addictions division at the Ministry of Health.

As part of the closure of the CTS sites. As the deputy had mentioned, they were given an opportunity to submit a business transition plan to become a HART hub, which they submitted, and there was an approval of that plan.

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One of the things that we wanted to do was make sure that any transition that occurred from a former CTS site, or a consumption and treatment services site, into a HART hub was done looking at making sure that the transition worked well for the clients. As part of the approach to being able to do that, the Ministry of Health—Ontario Health, Public Health Ontario and others—worked with each of the consumption and treatment services sites to do a couple of things. One of them was to work with the partners to create a continuum of care plan for each of the clients in the hub, as well as work with each of the former CTS sites to identify minimum requirements for them to open as a HART hub. As part of each of those pieces, we were able to monitor and make sure that the transition of services for folks was done in a safe and appropriate way.

MPP Robin Lennox: Okay. Thank you.

In the Auditor General's report, according to internal ministry documents, the ministry was aware of the potential impacts of the closures, including the increased risk of death from opioid poisoning, the increased number of emergency department visits and the increased instances of public drug use and discarded public drug use equipment. I'm hoping you can help me reconcile this, because when Minister Jones announced the impending closures in August 2024, she said that people are not going to die, but her own ministry's documents showed that there was a known risk that more people would actually die of overdose. If the ministry knew this, why was the exact opposite communicated to the public?

Ms. Deborah Richardson: I could maybe start with that one. As anyone who's worked in this space—and I know you've worked in this space—Ontario has continued to experience opioid-related harms. While the rates have begun to stabilize since COVID-19, there's still a public health risk, obviously. We're watching trends. We set a baseline, obviously, before the closure of those centres from the year before—12 months before. We're monitoring closely. We're strengthening our surveillance systems and investing in programs that promote mental health and addiction treatment and recovery.

I think in terms of the data, Kyle can speak to that.

Mr. Kyle MacIntyre: Thank you for the question.

As I had mentioned in the previous answer, to support that transition into a HART hub, there were continuity of client care plans as well as transitional readiness requirements for that. As part of the work of the ministry, we set up a steering committee with partners at Ontario Health, Public Health Ontario and others to support that transition.

One of the first steps of the committee was to set up a surveillance approach for those transitioning CTS sites into those homelessness and addiction recovery treatment

hubs. What we did is we developed several indicators, including 911 calls, emergency department visits, hospitalizations and overdose-related deaths. As part of that, we monitored over a six-year period on a weekly basis.

As part of that surveillance, one of the things that we wanted to do was to make sure that we had a baseline that was identified to measure against any sort of substantive changes that we might have seen in the data. That baseline was using those indicators but for the previous 12 months as what we would measure against any kind of deviation. To date, the Ministry of Health hasn't seen any sustained trends in the data that would suggest that there was an increase in opioid deaths due to the closure of the CTS sites.

MPP Robin Lennox: Would it be practical to say that the coroner's data is often delayed by at least two quarters, so given those closures only occurred just over six months ago, you wouldn't actually see those trends yet because you don't have the data available?

Mr. Kyle MacIntyre: In terms of the 911 calls, the emergency department visits and the hospitalizations, I think those are happening in real time. There is a potential delay due to overdosing for what the coroners rely on, but I'd have to go back and check to see if that was the data that was used for the indicator.

MPP Robin Lennox: Thank you.

Mr. Kyle MacIntyre: But related—just to answer your question, what we have seen in the last quarter has been a reduction in the overdose deaths. It's just for the first quarter of this fiscal year—

MPP Robin Lennox: Which was when the supervised consumption sites were open?

Mr. Kyle MacIntyre: Yes, but it's quite a drop from year-over-year changes, and it's on par with what we're seeing in Q1 from 2018.

MPP Robin Lennox: Thank you.

My next question is: Similarly, the minister had publicly said that changes to the legislation were supposedly made to promote community safety, but ministry documents actually indicated that the ministry knew that the closures of the sites would most likely lead to increased incidence of public drug use and publicly discarded drug use supplies. This is in fact what we're hearing from our communities all across Ontario where these sites have closed.

So would you say that reducing indoor, safe, supervised spaces where people could consume drugs and instead pushing them outdoors into public spaces where they're more likely to use in an unmonitored setting, overdose in an unmonitored setting—would that be consistent with an approach promoting community safety?

Ms. Deborah Richardson: I can speak to that. Again, the policy decision is to focus in on recovery and treatment, to give people a sense of hope and to significantly increase investment in people that have addictions.

MPP Robin Lennox: Thank you.

I would say that having worked very closely with the community of people who use drugs, the decision to close the consumption and treatment sites did not actually engender any hope in the community. In fact, it made many people feel abandoned by this ministry and like their lives didn't have value.

But if we are going to focus on expanding treatment, why is it that of the HART hubs—27 were identified; nine were converted from CTS. Not even all nine of those nine are fully functional and operational right now; in fact, treatment is just as inaccessible now in Ontario as it was prior to these closures. So not only have we reduced hope in the community and reduced life-saving harm reduction services, but we haven't actually made treatment accessible for a single person in Ontario. So how would you say that plan is going?

Ms. Deborah Richardson: I can give you the specifics about the plan. There are actually more than nine that are up and running.

The Chair (Mr. Tom Rakocevic): Under 10 minutes remaining.

Ms. Deborah Richardson: There are 14 HART hubs that are up and operational. Some are offering some services, because it's taken a while to secure space to build the supportive housing, develop those partnerships.

Perhaps, Kyle, do you have any more specifics than that?

MPP Robin Lennox: That's okay for me. Thank you.

And I would agree; I completely agree that it takes time to build a really well-thought-out treatment program and to build secure and supportive housing. Why did you not give the sites that time to be able to do it, instead of assigning an arbitrary deadline of closing the sites March 31, and supposedly opening or transitioning to HART hubs April 1, when they did not have the time to be able to put in place those treatment programs, the supportive housing programs? As a result, if I'm not mistaken, not a single person has moved into HART hub supportive housing since the opening.

Ms. Deborah Richardson: Again, it takes time to get these programs up and running, and a policy objective of ours in our legislation was put in place by a certain date.

MPP Robin Lennox: Thank you.

Mr. Kyle MacIntyre: I just wanted to respond to your question around supportive housing. We've recently moved to biweekly reporting from the hubs, and as of the last biweekly report that we've had, 126 people have started to move into supportive housing.

MPP Robin Lennox: Thank you.

Last month, we learned from the Ottawa Public Health CTS on Clarence Street that they were closing because the ministry failed to provide endorsement for their federal exemption to be able to continue. And just this week, we learned that the Parkdale Queen West CTS has had to close because the ministry pulled their funding. Those sites were not identified for the initial closures, because they were not within the 200-metre radius of child care facilities. Can you confirm: Is it the intention of the Ministry of Health to systematically defund or block the exemptions of all the remaining CTS sites in Ontario, regardless of whether or not they are in close proximity to child care or schools?

Ms. Deborah Richardson: That hasn't been any direction that we've given at this point. We haven't given that direction.

MPP Robin Lennox: Thank you.

There's been a lot of discussion about the role of community safety in closing these sites, but there's actually an abundance of evidence that supervised consumption sites actually improve community safety by reducing overdoses in the 500 metres around the sites, by decreasing public drug use, by decreasing discarded drug use supplies, and having no effect on local crime rates. Supervised consumption sites have even been endorsed by the Ontario Association of Chiefs of Police for this reason.

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Knowing that community safety is a growing concern among people in Ontario, why would you remove one strategy that not only saves lives and promotes public health, but also improves community safety?

Ms. Deborah Richardson: So, again, if I could just speak to the policy objectives that we're trying to achieve, that really is focusing in on recovery and treatment, and that is the direction that we're going.

I don't know if, Liz, you wanted to add something on to that.

Ms. Liz Walker: Absolutely. I mean, we certainly recognize that opioid addiction is a complex and multifaceted public health issue that requires a coordinated response. Our health units are certainly utilizing comprehensive approaches, which include providing education and awareness, engaging youth and families, addressing stigma and connecting individuals who use drugs to local community resources and services.

They are also required to collaborate with local partners to develop and implement comprehensive community drug strategies and program enhancements, and in partnership with local community service providers, they implement measures to anticipate and prevent harms, which include developing and implementing local opioid response plans, informed by population health, situational assessments, community needs and local data. They act as naloxone distribution leads, and they establish systems to identify and track risks posed by illicit synthetic opioids, which include setting up real-time surveillance systems.

MPP Robin Lennox: Thank you very much.

My next question is, why did the ministry not consult with any external stakeholders, not consult with Public Health Ontario, or take the recommendations from its own commissioned reports regarding supervised consumption sites prior to the decision to close these sites?

Ms. Deborah Richardson: Governments are elected in a democracy that we're in, and they can make policy decisions, should they choose. The government chose to make a policy decision that is focused on recovery and treatment. You know, various people have different perspectives, various experts and practitioners have different perspectives, and that was the perspective that the government chose.

MPP Robin Lennox: Does anyone in the government who made that decision have any expertise or experience in addiction medicine treatment, which you say you would like to promote?

Ms. Deborah Richardson: Of course. We work at the Ministry of Health.

MPP Robin Lennox: What is your understanding of evidence-based treatment—and if so, why are you not offering every single Health Canada-approved evidence-based treatment for treatment-refractory severe opioid use disorder like injectable opioid agonist therapy?

Ms. Deborah Richardson: We definitely want to explore more OAT. Definitely, that's a path that we can go down. There's some really interesting ways of administering, either in the corrections system—in different places. There are different places to provide better access to folks. So I definitely think—I agree with you, that's an area that we should be pursuing more, and we want to.

MPP Robin Lennox: There was a group of physicians—I was one of them—who actually wrote to you back in 2021 requesting that you explore iOAT at that time, fund pilot programs and add it to the drug formulary. You've said that the intention of your government is to promote treatment. We're now four years out. How many years will it take before you actually implement Health Canada-approved treatments for opioid-use disorder?

Ms. Deborah Richardson: Kyle and Graham Woodward—I'm going to bring somebody else up as well. I don't know how much time there is left.

The Chair (Mr. Tom Rakocevic): You have two and a half minutes.

Ms. Deborah Richardson: Okay. So Kyle and Graham will come up quickly, but Graham will have to be sworn or affirmed.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Graham Woodward, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Graham Woodward: I do.

Ms. Deborah Richardson: Okay, great.

So, really, what we're talking about is more access to RAAM clinics or other ways to be able to access iOAT or OAT.

I'll turn it over to my colleagues.

Mr. Kyle MacIntyre: Thank you for the question. One of the recommendations, as you had mentioned, coming from the auditor's report was to look at the expansion of opioid agonist therapies, for example. I believe that even at the last scoping meeting last week, that was something that you had also mentioned in the youth wellness hub space as well.

The government is expanding services that do provide opioid agonist therapy through RAAM clinics. I think the Auditor General's report, for example, identified back in 2016 there were 11 rapid access addiction medicine clinics. There are now 89, with two just opening up in the north, in Kenora and Atikokan. That is one area we're looking at.

MPP Robin Lennox: Thank you.

Mr. Kyle MacIntyre: Sorry, I'll get there. It's just that I think the question was that we don't provide the full range, and I'm trying to—

MPP Robin Lennox: But RAAM clinics don't provide iOAT, so just to stay focused because I do recognize I have limited time, I'll ask you one question related to traditional OAT, which you were mentioning. Related to the Auditor General's recommendation 3.2, only one in 18 people are offered standard-of-care treatment for opioid use disorder after hospitalization for opioid poisoning, being OAT.

The risk of death following a non-fatal overdose is about 5% to 8% per year, similar to the risk of death after a non-fatal heart attack. The Auditor General recommended that the ministry increase access to OAT, and in your response you say that you're integrating this through the substance use disorder integrated care pathway and that EDs will be expected to offer care through this pathway with an implementation date of 2028.

My question for you is, would you find it acceptable if emergency departments didn't have a way of accessing or offering the standard of care for heart attack for another three years? And if so, why is that delay acceptable for people presenting with opioid poisoning?

Mr. Kyle MacIntyre: I think it could be turned it over to Graham to talk about the substance use disorder integrated care pathway program and the roll out of the approach.

Mr. Graham Woodward: Certainly. Thanks, ADM MacIntyre.

Graham Woodward, vice-president, Mental Health and Addictions Centre of Excellence.

Another strategic Ministry of Health investment to help persons at high risk of opioid morbidity and mortality who present at emergency departments is the substance use disorder integrated care pathway. Off the top, the hospital emergency department is—

The Chair (Mr. Tom Rakocevic): Sorry we're out of time.

We are now moving to the government side. You have 20 minutes. I recognize MPP Cooper.

Mrs. Michelle Cooper: Thank you for being here and presenting today. I'd like to ask about Ontario's Opioid Strategy. It was introduced in 2016, and a lot has changed since 2016: the types of drugs, the risks and the pressures on communities. Could you speak to how the ministry has been adapting the province's approach to reflect those changes?

Ms. Deborah Richardson: Thanks so much for the question. I am going to turn it over to the two gentlemen that are on my right and left, ADM Kyle McIntyre and Vice-President Graham Woodward, to respond.

Mr. Kyle MacIntyre: Thank you for the question. The opioid and substance use landscape has changed since the opioid strategy launch, as the deputy minister identified in her opening remarks. We've moved from a situation where addiction and fatalities were driven in large part by prescription opioid misuse to one where synthetic opioids are now the predominant form of opioids used by people today for non-medical purposes. The statistics show this evolution. In 2016, one third of opioid-related deaths in Ontario involved people using a prescription opioid for non-medical purposes. By 2023, only 10% of opioid-related deaths involved prescription opioids exclusively.

In contrast, between 2018 and 2022, almost 86% of opioid-related deaths in Ontario involved non-pharmaceutical opioids, particularly fentanyl from unregulated sources. Moreover, evidence is showing that an increasing number of opioid-related fatalities involve polysubstance use, defined as consuming more than one type of psychoactive substance at a time.

A 2023 article in The Lancet has shown that post-2020, approximately half or more opioid-related deaths in Canada have involved a psychostimulant such as cocaine or a methamphetamine substance, and that increasing proportions have also been featured for benzodiazepines or analogues.

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To respond to the changing nature of opioid-related harms, the Ministry of Health is taking a comprehensive, evidence-based and multi-pronged approach to supporting those with opioid or substance use disorders. Through the provincial mental health and addiction strategy, Roadmap to Wellness, the government is building a comprehensive and connected continuum of care for mental health and substance use issues across the lifespan.

The continuum of care we are building is enhancing people's access to addiction services, meaning the services that are transdiagnostic, meaning that the service is able to address all forms of substance use. For people with opioid use disorder, this is a significant change. While opioid agonist therapy is the gold standard in treatment for opioid use disorder, best practice is to provide an individual with evidence-based psychotherapy as well as wraparound services, as the Auditor General's report identified, to support those with more intensive case management and peer support needs.

The fact that polysubstance use is on the rise makes the approach of the road map even more critical. For example, the presence of cocaine in opioid-related fatalities in Ontario increased by 39.2%, and the presence of methamphetamine in opioid-related fatalities rose by 73.6% during this period.

What this means is that opioid agonist therapy needs to be offered alongside evidence-based psychotherapy, such as contingency management and cognitive behavioural therapy. Evidence-based psychotherapy is the first line of treatment for all substance use disorders except for opioid and alcohol use disorders—there is medication available for them.

The road map's emphasis on concurrent disorder-capable services is also critical. Substance use and mental illness often coexist, as the deputy had mentioned in her opening remarks. An Ontario study published in 2020 showed that 87% of individuals with opioid use disorder enrolled in treatment between 2011 and 2015 had a mental illness, meaning that they had a concurrent disorder. The study showed that people with opioid use disorder in addition to a mental health diagnosis visited emergency departments at a rate that was 2.25 times higher than people

in treatment who did not have a concurrent disorder. This suggests that there is a need for services to simultaneously treat mental illness and substance use issues broadly.

This is an important way that Roadmap to Wellness is shaping the mental health and addiction sector and the services delivered in Ontario; a system based on meeting clients' holistic needs rather than focusing on diagnosis—that focus on specific substances.

Roadmap to Wellness is also building a balanced care continuum that focuses not only on treatment and recovery, but also prevention and early intervention. And critically important, Roadmap to Wellness is a lifespan approach, recognizing that mental health and addiction issues, including opioid use disorder, can start at a young age. Implementing a lifespan strategy will bring together the child and youth mental health sector and adult sectors into a shared care continuum: a comprehensive care continuum for mental health and substance use that focuses on recovery services—services like case management, peer support and supportive housing.

Mental health and substance use are health conditions that have a pervasive impact on individuals' lives, impacting school, work and relationships, and these can be lifelong, especially without early interventions and timely access to supports. Since 2019-20, over $800 million in new annualized funding has flowed into community mental health and addiction services and supports in Ontario, including more than $185 million in new base funding for addiction treatment services and supports, bringing the total annual funding for addiction services to $370 million.

Ministry of Health investments are flowing to a range of substance use services, including:

—rapid access addiction medicine clinics, which offer quick, low-barrier access to medication-assisted treatment and connect clients to ongoing care in the community once they are stabilized;

—bed-based addiction services ranging from withdrawal management to intensive treatment and supportive recovery; and

—intensive addictions day/evening treatment programs that provide structured clinical care, similar to bed-based treatment, while enabling a person to live independently and continue their studies, maintain employment and meet other obligations in their lives.

Other services include peer support services, intensive case management and supportive housing for those with the most severe and chronic mental health and substance use disorders.

I'd like to take some time to highlight in more detail a few programs that the Ministry of Health is investing in. One of the innovative upstream programs that the Ministry of Health is investing in, which is tailored to youth, is the PreVenture program. It's a made-in-Canada, evidence-based substance use prevention program that's being delivered to students in grades 7 to 9 in 28 school boards across Ontario. The program imparts cognitive behavioural therapy skills to youth who participate in two 90-minute workshops. The program has been tested in 12 randomized control trials and has demonstrated an average of 50% reduction in early-onset substance use among youth. Since launching in 2022, over 4,000 young people have gone through the prevention program, and this number will continue to grow as it is expanded to more school boards.

By building a balanced continuum of care that offers services for all levels of need across all life stages, the government intends to reduce harm and suffering and promote early intervention so that people can get the help that they need when they need it. Paying to upstream services will have a positive impact across the entire system of care as people are matched to the level of care to meet their needs. Among other things, it will mean that the most specialized services are available for people who need them the most.

The Ministry of Health recognizes that for youth that are aging out of the child and youth mental health system—those between the ages of 18 to 25, or transitional-aged youth—there has historically been a gap in developmentally appropriate services.

The Chair (Mr. Tom Rakocevic): Ten minutes remaining.

Mr. Kyle MacIntyre: Adult services are not developmentally appropriate, so youth can receive inadequate support if those are not provided, which can lead to poor treatment retention and disengagement. To address this, the Ministry of Health is putting into place evidence-based lifespan approaches to mental health, substance use and addiction services.

One way we are doing this is by investing in Integrated Youth Services, a model that combines primary care, mental health and substance use treatment in one location, serving young people. Specifically, the Ministry of Health has made investments in two integrated youth service programs under Roadmap to Wellness, which are the Youth Wellness Hubs Ontario and Amani, a mental health and substance use programming for Black youth. These programs do not focus on a single diagnosis or problem or require a diagnosis to receive services. They are provided through evidence-based, developmentally appropriate and culturally safe services to young people between the ages of 12 to 25 with a mental health, substance use issue or concurrent disorder.

As youth wellness hubs are not diagnosis-specific, they can offer a wide range of services to address various levels of need. They offer counselling and group services for someone who may be an occasional substance user, and they are also capable of offering evidence-based care to youth who have more moderate to severe forms of substance use disorder and/or concurrent mental health and substance use disorders.

This includes lower-intensity services such as psychoeducation and solution-focused brief therapy to more moderate intensity services such as access to individual, group and/or family support and evidence-based psychotherapy such as cognitive behavioural therapy. It also includes high-intensity services such as access to psychiatry or addiction medicine or supported linkages to inpatient treatment or withdrawal management services.

The fact that both the Youth Wellness Hubs Ontario and Amani models offer primary care means that they can provide medication-assisted treatment to young people for opioid use disorder.

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Medication-assisted treatment is generally referred to as opioid agonist therapy. It consists of a range of medications that are prescribed to reduce the symptoms of withdrawal and ease cravings. Opioid agonist therapy is the first line of treatment for people with opioid use disorder, and only physicians and nurse practitioners are authorized to offer it. Both youth wellness hubs and Amani are offering those services.

Ontario has announced funding for 32 of the youth wellness hubs; 23 are now fully operational and the remaining nine sites are in development. Under Roadmap to Wellness, the province has invested in eight Amani mental health and substance use services for Black youth, and that's going to grow by another two sites over the coming months for a total of 10.

Amani started as a program at CAMH in downtown Toronto with an aim of connecting Black youth clients to Black mental health and addiction clinicians to improve help-seeking and the delivery of culturally safe services. With investments under the road map, as I've mentioned, this maturity will have 10 service sites across Ontario from Windsor to Ottawa and the greater Toronto area.

Both youth wellness hubs and Amani are programs supported by expert clinical and data teams at the Centre for Addictions and Mental Health. These provincial teams ensure that local services are aligned with evidence and that there is consistently high-quality care offered.

For example, both youth wellness hubs and Amani offer measurement-based care where clients are asked to respond to a set of questions that gauge their health at the outset of an appointment over the course of the treatment. This practice allows both the clinicians and the client to see the outcomes of their treatment, and data from measurement-based care can inform alterations to service plans or affirm the course that the youth is on. Young people have reported that they feel the measurement-based approach to care is empowering and provides the youth with assurance that they are involved in their care plans, improving their commitment to treatment.

This front-line delivery of measurement-based care is supported by a team of data and measurement experts who work as a provincial backbone for youth wellness hubs and Amani. They're trained clinicians in how to do measurement-based care and understand the results and how to use the data to improve those services.

Another investment I would like to highlight was created in response to the rise in opioid overdose rates during the pandemic. The government announced the Addictions Recovery Fund in February 2022. It's an investment of $90 million over three years that was recently renewed in 2024 for an additional $124 million over three years. Through the addiction recovery treatment investments, the Ministry of Health, working with partners at Ontario Health, have allocated opening 370 new addiction treatment beds across Ontario, and so far, these beds have served almost 17,000 clients.

The Addictions Recovery Fund also invested in youth substance use services. They helped to open the eight new youth wellness hubs that I had mentioned. The Addictions Recovery Fund also has funded initiatives for Indigenous land-based healing services, mobile treatment services, mobile crisis response teams, as well as other new services for addictions.

As we have mentioned previously, the government has announced it's investing almost $550 million to create 28 homelessness and addiction recovery treatment hubs across the province as well. Each HART hub will have a budget of $6.31 million, and of this, $1.3 million has been earmarked specifically for mental health and addictions supportive housing. HART hubs will add close to 900 supportive housing units across Ontario, which was 300 more than was anticipated, helping people transition to stable, long-term housing.

These investments are historic, but the road map is more than just about flowing funding to the system. It helps align how we provide our mental health, substance use and addiction services in Ontario.

The Ministry of Health, as I mentioned, has been working with the Mental Health and Addictions Centre of Excellence within Ontario Health to implement Roadmap to Wellness. And so what I will do now is turn it over to Graham Woodward to introduce himself and provide some information about the Mental Health and Addictions Centre of Excellence at Ontario Health and the work that they are undertaking.

The Chair (Mr. Tom Rakocevic): Two minutes remaining.

Mr. Graham Woodward: The Mental Health and Addictions Centre of Excellence draws on a wealth of made-in-Ontario experience, building on other modern parts of the health system such as cancer and renal care. While recognizing that mental health and addictions have their own distinctive attributes, there is a common set of structures and processes developed to improve cancer and renal care that can be applied in the building of a mental health and addictions continuum of care that is envisioned in the Roadmap to Wellness.

The Mental Health and Addictions Centre of Excellence is informed by a wide range of partners, including Ministry of Health colleagues, mental health and addiction service providers, people with lived and living experience, families and caregivers, regional health system planners, Indigenous partners and clinical experts. These diverse perspectives are brought to bear on the work the Mental Health and Addictions Centre of Excellence is doing to implement the Roadmap to Wellness.

Much of the Mental Health and Addictions Centre of Excellence work is to focus on the modernization of the community mental health and addiction sector. At the heart of the Ministry of Health strategy to modernize the community-based mental health and addiction sector is the concept of core services. This is not a term that is common in other parts of the health system. The need to define core

services for community mental health and addictions reflects the distinct nature of mental health and substance use health care.

Constituting of a blend of medical, psychotherapeutic and non-clinical services—all of which are required to meet the health care needs of people with mental health and substance use issues—mental health and addiction core services will provide standardized provincial definitions of the services provided across the province and will enable Ontario Health to drive consistency and quality improvements through data-driven and evidence-based planning, performance management and accountability agreements.

An example of this work is highly relevant to the audit recommendations—

The Chair (Mr. Tom Rakocevic): We're at time. Thank you very much.

We now move on to the third party. MPP Fairclough, you have the floor.

Ms. Lee Fairclough: Thank you all for being here today to talk to us about this important topic and the work that you're doing to try to build a mental health and addiction system in Ontario.

In our briefing today, the AG identified that there was not an evidence-based business case or analysis put forward for the HART model as a program. We've heard $378 million—it's now been increased, I think was in the reports, to $550 million to invest in this program. And so I really want to dig into that in my next few questions.

The first one is probably an easy, short answer. Prior to this change to the HART model in 2024, was there any direction from the government to update or establish an opioid strategy? We know that use and deaths increased by 203% in that time. So was there any direction prior to 2024 to do an update to the opioid strategy?

Ms. Deborah Richardson: I can speak to that. So 2016 is what this report is about. In 2020, Roadmap to Wellness was introduced. That's where we're building off of—everything from there.

HART hubs, what's interesting is—a number of service providers and municipalities were approaching us with proposals. Because a lot of times within the mental health and addictions space, and social services in general, it's a very fragmented area. I used to run a not-for-profit as an executive director; I know.

Basically, what happened was there was a number of proposals, and so we tried to think bigger and support municipalities and service providers, almost like the mother hen bringing the chicks into the yard, in a more coordinated way, and invest significant new resources into mental health and addictions.

So that's kind of how it came. But 2020 was the road map. Did I miss anything, Kyle?

Mr. Kyle MacIntyre: No, that's right for Roadmap to Wellness. There was also the Addictions Recovery Fund that was launched in 2022, as well, renewed for $124 million over three years. Did you want me to just pick up on something that the deputy said around the model itself?

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Ms. Lee Fairclough: It might come with my next question—how about I go to the next question.

So, then, really my question was, again, that it was suggested that there wasn't really an evidence-based business case for this particular part, around the HART hubs. I did want to ask about—did you proceed without getting that input, doing the needs assessment, doing the community consultation, or thinking about the public health impact analysis before the decision was made to proceed? And, I guess, what was the analysis that was done, including both the positive and negative effects of this particular model and losing the safe consumption in the same token?

Mr. Kyle MacIntyre: Maybe I can speak to the HART hub model specifically. The deputy minister had mentioned a couple of things: One, prior to the creation of the HART hub model, we'd been receiving a number of hub-like service models—different from one another, with different kinds of programming and services that would have been available in each. We also, prior to the announcement of the HART hubs, had funded other hub-like services, service delivery models as well, and had been receiving reports about how well they were going and the types of services that were there and some of the impacts in the local communities. We also undertook a literature review. We also had the opportunity to meet expert speakers who talked about this as well, who were brought in from other ministries. Through that, there was the approach of creating what would end up being the HART hub model.

I think the other thing that's important to note is that the HART hub model is a demonstration project as well. A key component of it is evaluating each of the hubs: what worked well, where there might be some opportunity for improvement. So this is very much also going out and learning from the different models that are being applied, because the HART hub model itself—while each hub gets up to $6.31 million, there are eligible services and also ineligible services in it. But they were very much locally driven. We get an opportunity to see different pieces of the service model in action across different communities in Ontario, and so, the evaluation will be a key component of that.

Ms. Lee Fairclough: Yes, I agree on that. I'm looking forward to coming back to some questions on it.

I guess I would just ask—like you said, this is a bit of a test case, in a way. But when you talk to people that were running the CTSs that you needed to close and are converting to HART models without them, or you talk to the scientific experts around what the continuum of services is that we need to effectively address substance use disorders, how many of them were suggesting that we move ahead with a model without this included in that pathway? Do you think many of them would agree that that's an evidence-based model?

Ms. Liz Walker: I think, as I mentioned before, there's a lot of complexity, as we all know, around addiction services and situations. In terms of some of the public

health and the measures that have been put in place around to support clients who were previously part of or accessing consumption treatment site services, that was absolutely part of the planning process and analysis that took place as the CTSs were converting into HART hubs for April 1. And as part of that, we worked very closely with Ontario Health with converting CTS sites, with local service partners, to put in place—and Kyle referenced earlier—the continuity of client care plans. That really looked at not just individual but community and neighbourhood supports and responses that supported transition and response components in all of those sites as they were transitioning over.

Those plans had four main components to them. One of them was individualized care plans that helped each client navigate local health services and access harm reduction education and supplies. A second part of the plans was emergency care: how sites were coordinating with local hospitals, shelters, first responders to manage any increased demand and readiness to respond to situations as they may have evolved locally. The third area was community support services. In that component of the plan, sites engaged with local partners to maintain access to culturally appropriate care, mental health supports and harm reduction tools. And then a fourth area of communication and safety protocols to ensure that comprehensive protocols were in place across each of those sites—

Ms. Lee Fairclough: I guess maybe I'll jump in: Do you feel they worked? And, from your perspective, were the HART hubs ready to deliver the full suite of services that were designed in those models for April 1 after we closed the CTSs at those sites?

Ms. Deborah Richardson: I can speak to that. As we shared earlier: No, all of the HART hubs were not ready. There are 14 of them that are up and running with a full suite of services. Now, there are some that have some services.

But that's why it was really important with the team from Ontario Health—I personally was meeting with the team from Ontario Health that was meeting with community service providers, hospitals, paramedics and police to make sure that there was a continuum of care for those individuals where that service was no longer provided.

I just wanted to add one more thing about CTSs: It is quite limited in scope. One of the critiques from the Auditor General was to have a more comprehensive plan. That's what HART hubs, basically, have done. We wanted to switch to more comprehensive options for people who have addiction issues and mental health issues and all the things that we've spoken about for this afternoon.

Alison Blair could add something too.

Ms. Lee Fairclough: Great.

The Chair (Mr. Tom Rakocevic): Ten minutes remaining.

Ms. Alison Blair: Alison Blair. I'm the associate deputy minister for health integration and partnerships.

As we were leading up to April 1, as the deputy said, fully operational, we had a set of minimum requirements that we worked with these hubs on, as the deputy spoke about, people from Ontario Health, people from the hubs. We had regular meetings. So they were able, on day one—all nine of them—to make sure that they were triaging people and referring them to service. Since that time, they've built out significantly the services that they've provided. But I just wanted to make sure, all 28—

Ms. Lee Fairclough: So I agree that having this full continuum of service is what is needed—desperately needed, actually. We've got the pathway that's being piloted as a great example. I think, for me, what I've been curious about is why we excluded this as part of that pathway, the CTS sites.

But I do want to ask about Parkdale. I understand that they have now also received news from the ministry that they will be losing their funding in the next 30 days. They weren't initially slated, I don't think, to be closed. Can you share any more about what the plan is for the remaining?

Ms. Deborah Richardson: There is no plan right now for the remaining.

For Parkdale, specifically: We did get notification of termination of funding. We'd be very open to enhancing the services, for example, within their HART hub.

I don't know if we have anything else to add on Parkdale. Anything else? Liz, do you want to go?

Ms. Liz Walker: I think there are a couple of things. Again, the continuity of client care plans that I was talking about that we worked with the CTSs and partners on in the spring: That is something we are going to be engaging with Parkdale on specifically to make sure that as they transition, as the funding agreement that they have currently is terminated, the supports that the clients require will still be part of those community care plans. That will be built out in partnership with them and local service providers.

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Then, as the deputy said, there will certainly be conversations with Parkdale to see what opportunities there may be to reallocate funding to treatment and recovery initiatives within the organization.

Ms. Lee Fairclough: Thank you. I'm going to keep going with questions. Thank you very much.

We did learn in the AG report that there was no measurable outcomes evaluation planned at the time of the launch of this program. That has me a little concerned. I'm excited about the level of investment, to be honest, in mental health and addiction services; we need it in this province. But I'm really concerned that we're not going to make sure that we're measuring how many more people are receiving the care they need, the kinds of outcomes we've been able to achieve with that additional amount of money.

I wanted to verify that. What are some of the measures that have been tied specifically to the first HART hubs that were opening on April 1, and are you confident that we'll be able to have those measurable results on a very real-time basis?

Ms. Deborah Richardson: I can maybe get started and then I'll ask Kyle to chime in. It's a great question, because why invest in things if they don't work?

A major commitment of Roadmap to Wellness is to build a data and digital infrastructure for the Ministry of Health-funded community mental health and addiction service sector. Data and performance metrics are crucial to everybody, obviously, as we have spoken about even this morning, for ensuring a high-quality, equitable and efficient health care system. They provide evidence to drive strategic decisions at all levels of care from informing individual client treatments to shaping provincial health policy and improving system performance.

You met VP Graham Woodward. He's leading a digital data initiative, which we did speak about last Monday—Kyle is going to speak about it a little bit more—to make it easier to deliver care, report on performance and track the value of investments.

Mr. Kyle MacIntyre: Thank you for the question.

There are a number of requirements that hubs are required to report to Ontario Health with, different data pieces around their performance, how they're operating and things of that nature. What we typically require is quarterly reporting from each of them, so we've had the first quarter reporting from the hubs that were open at that time. We're expecting the second quarter to be coming in within the next couple of weeks.

We have a set of metrics we've been asking them to report in on, which include things like the number of unique clients served, the total number of and types of services by client, the number of interactions by service type, referrals and the type of service that folks are being referred to, the number of addictions bed-based care by type that people are accessing and things of that nature.

I previously had mentioned that we're also establishing an evaluation framework for the hubs. We're working through what that would look like to bolster additional outcome-focused indicators that we would be asking each of the hubs to report on. We're getting close to finalizing that before speaking with the hubs about what that would look like, but they are much more focused on some of the other kinds of pieces that would support an eventual evaluation of it. It is top of mind for us.

One of the things that we're working through, for example, is that, as I had mentioned, each of the hubs is locally driven. Some of them might have different services, so we're trying to account for how one hub might offer services A, B, C and another might offer C, D, E—that kind of idea. We're thinking through that.

Ms. Lee Fairclough: Do they have targets for net new service provision and net new clients? Because some of these providers have provided some of these services before. You're confident it's going to be incrementally net new for people?

Mr. Kyle MacIntyre: These will be net new services. That's one thing. But I think one of the things that we want to do is get some stabilized sets of data first before you start putting in targets that might be not attainable. Graham Woodward's team at Ontario Health is leading a community of practice, where these types of conversations are also happening.

Ms. Lee Fairclough: How much more time have I got?

The Chair (Mr. Tom Rakocevic): You have two and a half minutes.

Ms. Lee Fairclough: Okay, great, so maybe I will ask this question.

When the AG was here, we did ask who the ministry received advice from to advance the HART model. In our briefing, we heard that the centre of excellence for mental health would typically provide advice in this area, but there was no documentation that the AG could actually find on whether they had been able to weigh in. Of course, they have a number of experts and leaders in mental health and addictions.

I just wanted to ask about that issue. Was the mental health centre of excellence consulted on finalizing the model for HART itself, prior to the government policy to move ahead in this direction?

Mr. Kyle MacIntyre: The answer is yes.

Ms. Lee Fairclough: There just was no documentation, then, that was provided to the Auditor General?

Mr. Kyle MacIntyre: There were presentations and conversations with them, but they didn't deliver a briefing note or anything like that.

Ms. Lee Fairclough: Okay. And that would have included their mental health and addictions clinical experts and leaders as well?

Mr. Kyle MacIntyre: There was some engagement with some of their clinical advisers at the table, yes.

Ms. Lee Fairclough: Okay. How much time do I have? I should probably wait until my next round.

The Chair (Mr. Tom Rakocevic): You have just about a minute.

Ms. Lee Fairclough: Maybe I'll just come back up for one second here.

Oh yes, I did have one question. The other question on consultation: When you went out to those that were responding to the HART hub, did any of them give you advice, particularly those that had CTS sites that they would have preferred not to close as part of the new model?

Ms. Deborah Richardson: Yes.

Ms. Lee Fairclough: Thank you.

The Chair (Mr. Tom Rakocevic): We're now back to the top of the order today, with the official opposition up to bat. Who will that be? MPP Lennox, one more time.

MPP Robin Lennox: You mentioned a move towards a comprehensive evidence-based and standardized continuum of services as being the aim of where you're headed. I think anyone working in this space would say that harm reduction and treatment exist on the same continuum of care. Often, we actually apply them concurrently. Many people accessing treatment also need to access harm reduction services at some point.

My question is, when you talk about an evidence-based continuum of care, this is a small sampling of the evidence for supervised consumption sites in terms of overdose death reduction, reduction of HIV, hep C, a reduction in a number of negative outcomes. The evidence for HART hubs is, as you say, a demonstration project. We don't have any evidence to support that model at all. Why, if

we're trying to establish a comprehensive continuum of services, would we eliminate an entire evidence-based arm of services in order to launch an as yet unproven model that you call a demonstration project?

Ms. Deborah Richardson: Again, government is able to make policy decisions, and a policy decision was to focus in on recovery and treatment, and that's where the emphasis is: focusing on more detox, more treatment beds, more services that are available—shelter, supportive housing. So that's a decision that was made.

MPP Robin Lennox: I completely agree with you. Government is able to make policy decisions. They're able to make bad policy decisions, but we wouldn't necessarily call those decisions evidence-based, right?

For example, let's talk about another evidence-based intervention. Even the Ontario Substance Use Prevention and Harm Reduction Guideline, which is used by the Ministry of Health and Long-Term Care and released in 2018, said, "The distribution of needles/syringes and other drug use supplies has proven to be an effective method in reducing blood-borne infections associated with injection drug use, such as HIV and hepatitis C." I've practised long enough to see a number of HIV outbreaks occur among people who inject drugs. So why isn't the ministry following its own guidelines and allowing HART hubs to distribute these evidence-based harm reduction supplies?

1610

Ms. Alison Blair: Within the HART hubs themselves, the HART hubs have worked with us, and the government has set terms and conditions for that. They apply at the HART hubs, and the ministry and the government continue to fund needle exchange services. At the HART hubs, there's the provision of the collection of needles. There are needle sweeps and those kinds of things, but there are other alternatives for the needle exchange programs.

MPP Robin Lennox: So HART hubs are not allowed to distribute evidence-based harm reduction supplies like needle and syringe programs?

Ms. Alison Blair: HART hubs do not provide clean needles.

Mr. Kyle MacIntyre: They do offer pathways to those providers that do.

MPP Robin Lennox: Great. Okay.

I want to just circle back, if we can, to the issue of Parkdale Queen West because this was sort of a new revelation this week. I understand that the ministry has pulled its funding for Parkdale Queen West's consumption and treatment services, but Parkdale Queen West still has its federal exemption to be able to operate supervised consumption services, should it wish.

Is the ministry supportive of Parkdale Queen West continuing to operate supervised consumption services if it were to find, for example, a private donor or alternative sources of funding, or would they be at risk of losing funding for other programming if they were to continue their supervised consumption services under their federal exemption?

Ms. Alison Blair: Between public health, the chief medical officer of health's office and the area related to mental health and addictions, we're in discussion with the Parkdale Queen West Community Health Centre about the reallocation of those dollars.

The intent would be to have that focus on recovery and treatment.

MPP Robin Lennox: That's fantastic. If they were able to reallocate those ministry dollars to focus on recovery and treatment and then find alternative funding to continue their supervised consumption services with their federal exemption that they have, would they still have access to that addiction treatment and recovery funding that you offered?

Ms. Alison Blair: I think maybe we'll have Elizabeth Walker come up and clarify. But under the act, there is a requirement for municipalities, if they are operating, to be requesting permission from the Minister of Health and that would be considered in due course.

MPP Robin Lennox: They already have their federal exemption, right? They wouldn't require that permission until their federal exemption was due for renewal? Okay.

I'll ask another question. The Minister of Health is on record saying that—if I could find the exact quote—she does not consider watching people inject drugs to be health care.

Would the minister consider resuscitating someone who stopped breathing because of an overdose to be health care?

Ms. Deborah Richardson: I can't speak for the minister.

MPP Robin Lennox: Okay. Fair enough.

You spoke about 14 HART hubs offering the full suite of services. What would you define as the full suite of services that they are currently offering?

Ms. Deborah Richardson: Kyle, could we expand on the HART hub services that are provided?

Mr. Kyle MacIntyre: Yes. So, as of today, there are actually 15 HART hubs providing service. They're not all at full-service operations; they're ramping up. They are operating different related ones as each of the local HART hubs themselves have different models. For example, some are working through the renovations to be able to add additional services. So it's things like that that are impacting whether or not they're able to get to a full suite. And then, for example, some, like the London hub, just opened today.

MPP Robin Lennox: So how many are currently offering the full suite of services, including initiation of substance use treatment, supportive housing, residential treatment. How many are currently offering that full suite of services?

Mr. Kyle MacIntyre: None are offering all.

MPP Robin Lennox: Okay. Thank you.

We've spoken a lot and the Auditor General identified that transparency was lacking and accountability was lacking in the province's opioid strategy. On the topic of transparency, why are the remaining HART hubs currently under embargo still and unable to speak about their pro-

gress in providing this treatment service that so many people in Ontario are relying on?

Mr. Kyle MacIntyre: There is a communication embargo to support, really, communication planning more than anything else.

MPP Robin Lennox: Okay. Thank you.

We've spoken a lot about the need to monitor for potential unintentional impacts of these closures and the public health measures, including rising rates of EMS response, emergency department visits, hospitalizations and opioid-related deaths.

You've said at this point you haven't reached any thresholds that you would necessarily be looking for. Do you have defined thresholds at which you would actually consider a change in policy and practice and consider reopening supervised consumption sites?

Ms. Deborah Richardson: We do have a baseline. We spoke earlier that we haven't seen an increase in any of the elements that we're monitoring from year-to-year. I know it was pointed out that coroners' data could be delayed, so that obviously could be one of the delays. But with all the rest of the data, the ER, the emergency department and all of that, there has been no increase.

Again, the government introduced legislation that has a policy in place around CTSs. So unless there was a change in policy direction, I don't envision those to reopen.

MPP Robin Lennox: Just to be clear, there is no threshold at which we might see an alarming increase in rates of death, alarming burden on the health care system, burden on community responders—there's no threshold at which we are likely to see this government reverse course on their political decision to close the supervised consumption sites?

Ms. Deborah Richardson: I think any government of the day will look at data and look at evidence and make decisions accordingly.

To date, we have not seen any increase. Yes, there are deaths with opioids. Yes, there are people who go to the emergency department. Yes, service providers are dealing with people each and every day that suffer from opioid addiction.

At this point, we have not seen an increase in the threshold, whatever the threshold is, but I am certain that any government would look at evidence and make decisions based on evidence.

The Chair (Mr. Tom Rakocevic): Ten minutes remaining.

MPP Robin Lennox: I would certainly hope that a government would look at evidence, but I think you had stated earlier that the decision to close the supervised consumption sites was not based on evidence. It was the government's prerogative to make a policy choice based on their political preference.

In terms of looking at objective measures, I'm thinking, just this past week in Hamilton, I was asked how emergency vehicles, ambulance calls for opioid poisoning increased from 37, in the months that the supervised consumption site was offering services, to a record of 142 consecutively for the past two months on record. How do we reconcile that with the statement that you made that you haven't seen an increase from baseline?

Ms. Deborah Richardson: We actually do have evidence, and I—Alison, do you have that? There actually is evidence, and the data does not show that.

Ms. Alison Blair: As I think a few of us have said, we've been monitoring that on a weekly basis. What we've been doing is calls from 500 metres around the site and about two kilometres. That's something we continue to monitor. We haven't seen that change compared to baseline—

Mr. Kyle MacIntyre: Consistently.

Ms. Alison Blair: —consistently.

MPP Robin Lennox: I think I'll just have one final question for you, and then I'm going to give the remaining time to my colleague.

The Auditor General identified that the ministry does not have a strategy to address the disproportionate impacts of the toxic drug crisis on northern and Indigenous communities specifically, who continue to face the highest per capita rates of opioid-related death. Instead, we've seen a reduction in harm reduction services in the north, and we've also seen extremely limited access to substance use treatment, including opioid agonist therapy, bed-based treatment and primary care.

Do you have any specific strategy in place right now that would offer that full continuum of care to northern and Indigenous communities, who have the highest per capita rates of opioid-related death currently?

Ms. Deborah Richardson: I will be inviting another ADM up who spearheads many of our health equity initiatives. It's ADM Sean Twyford. He will have to be sworn in, so we have to stop the clock.

1620

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Sean Twyford, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Sean Twyford: I do.

I believe the question was about Indigenous communities in the north. I will say—and I'll maybe go back to Kyle a little bit later—but we do have sort of a multi-front fight against addictions and improving mental wellness with our Indigenous communities. A centrepiece of that is our Indigenous Healing and Wellness Strategy, which is about a $70-million investment in a continuum of 17 Indigenous-designed and -delivered programs.

Just this morning, we were meeting with the NAN communities and are participating in their health provider meeting this weekend. A big part of the work that we do is ensuring that these are Indigenous-led and Indigenous-delivered.

Amongst those investments are things like community wellness workers, crisis responses, the Indigenous Healthy Babies Healthy Children Program as well as 12 Indigenous-led treatment and healing centres, and these are sort of all net-new investments over time.

In addition to that work, we're also working on something called First Nations health transformation, which would see the enhanced control and responsibility for a number of our services, including mental health, provided to Indigenous communities. That is work with Nishnawbe Aski Nation, the Anishinabek Nation, Grand Council Treaty 3, the Association of Iroquois and Allied Indians, the Six Nations of the Grand Rivers, and in addition we have a number of bilateral processes with urban Indigenous tables.

We've also done some work under the Roadmap to Wellness. Kyle, I can start but maybe turn to you, including—

MPP Robin Lennox: Thank you. I do appreciate that.

I do want to ensure my colleague has some time, so I'll yield to my colleague's time.

Mr. Sean Twyford: Great. Thank you very much.

The Chair (Mr. Tom Rakocevic): MPP Gélinas.

M^me^ France Gélinas: The number one recommendation of the Auditor General: The ministry should develop a new holistic strategy including all best practices targeted at addressing the current drivers of the opioid crisis, reducing opioid-related harms and preventing opioid addictions and overdose. Your answer says that we've done it because we, the Ministry of Health and Ontario Health, have launched a joint ministry/OH planning work to implement the next phase of the Roadmap to Wellness.

Are you telling me that the Roadmap to Wellness is a new holistic strategy for the opioid crisis? And if any of you don't know the difference between a strategy and a road map, I'm worried.

Ms. Alison Blair: I think the point that we're making is that this will not be an opioid strategy off to the side. It will be integrated within the components of the Roadmap to Wellness, and the investment of $3.8 billion over 10 years and the work that we're doing includes the addiction recovery work, includes the HART hubs that we've established. So that is what we're saying, that the oversight of how we address opioids is not just about people who use opioids, it's about substance use and addiction.

M^me^ France Gélinas: So a new holistic strategy specifically for the opioid crisis is not coming? We are dealing with the Roadmap to Wellness, and that's where it ends.

Ms. Alison Blair: That's our approach, through the Roadmap to Wellness.

M^me^ France Gélinas: Okay.

Many of you have answered the question by saying that you conduct surveillance of the key indicators—death, emergency department visits, hospitalization, 911 calls—around HART hubs. Can you share this information with the committee please? You've referred to those data multiple times. Share them with the committee.

My third question has to do with—in Sudbury we submitted a request for funding for a supervised consumption site. It was so needed that the city funded it, then donors funded it, then the mining communities funded it, and then you shut it down on March 31. During those two years, was there ever any analysis as to whether Sudbury needed a supervised consumption site?

Ms. Deborah Richardson: Liz?

Ms. Liz Walker: Yes, we do understand that Sudbury had submitted a proposal for a consumption treatment services site in the region. It wasn't shut down by us. It was not funded by the ministry.

M^me^ France Gélinas: My question is—you had two years to look at this demand for funding. Who looked at it during those two years? Did anybody look at it at all?

Ms. Liz Walker: There has been a process in place within the ministry for any proposals that have been received with respect to funding requests for consumption and treatment services.

M^me^ France Gélinas: And who looks at it?

Ms. Liz Walker: There's a process in the ministry where the ministry receives it, reviews it, has further discussions. Sometimes those proposals aren't complete, so there are further questions that come out. There is a full analysis that is done of the proposal.

M^me^ France Gélinas: Okay. Share that full analysis with the committee, please, so that we can better understand why it is that it took two years and that it never got funded. It saved hundreds of lives, yet it's not existing anymore. If you could please share that analysis with the committee as a whole so we can have a look.

My next question has to do with recommendation number 3 of the Auditor General that deals with pharmacies. The recommendation is that the Ministry of Health should "work with clinical research experts and medical practitioners to assess whether … OAT medication treatment options are accessible to ensure different needs are met."

In your answer, you said that, in the fall of 2025, the Ministry of Health would engage with the Ontario College of Pharmacists on pharmacist administration of partial opioid agonists by injection. Has this started?

The Chair (Mr. Tom Rakocevic): Just over a minute and a half.

M^me^ France Gélinas: We're in the fall of 2025.

Ms. Deborah Richardson: Can you stop the clock? I do want to invite up Dr. Karima Velji and, potentially, Patrick Dicerni. They work with the pharmacists on the scope of practice, and Patrick works on the drug side.

M^me^ France Gélinas: While you get sworn in and everything, the question will be, aside from Shoppers Drug Mart, do any other pharmacies participate in this?

Dr. Karima Velji: Karima Velji, assistant deputy minister and chief of nursing and professional practice.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): I'm just going to very quickly swear you in. Karima Velji, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Dr. Karima Velji: Yes, I do.

The consultation for pharmacists administering opioid agonists is under way now. We are currently consulting on it. We hope to bring the findings of the consultation early in the new year to cabinet, and upon approval, it will be implemented. It applies to all pharmacists in the province.

Mme France Gélinas: My next question has to do with narcotic monitoring. Why is it that dentists do not have access to the monitoring system although they do prescribe narcotics? In northern Ontario, many people get addicted through prescriptions by dentists.

Ms. Deborah Richardson: We have one more person to swear in, ADM Patrick Dicerni.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Patrick Dicerni, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Patrick Dicerni: I do.

Mme France Gélinas: Hi, Patrick.

Mr. Patrick Dicerni: Hi, MPP Gélinas.

The Chair (Mr. Tom Rakocevic): Thirty seconds.

Mr. Patrick Dicerni: I would like to ask our colleague Michael Hillmer to come up and speak to the applicability of the NMS for dentists. But, while Michael is making his way up, I will let you know that right now, the penetration of the narcotics monitoring database is for pharmacists. We are aware that dentists are actively prescribing in terms of dental procedures, but in terms of their access and applicability to it, Michael could—

Mme France Gélinas: It's okay. You'll have one second left.

The Chair (Mr. Tom Rakocevic): Yes, we're at time.

Next up are government members. You have 20 minutes, beginning with MPP Rosenberg.

MPP Bill Rosenberg: Thank you, Chair. Thank you, Deputy Minister Richardson.

Earlier today, the Auditor General mentioned the importance of monitoring how opioids are prescribed and dispensed. I'd be interested to hear about what the ministry is doing to support prescribers and ensure those practices remain safe and appropriate.

1630

Ms. Deborah Richardson: Thanks so much for your question, MPP Rosenberg. I will turn it over to my colleague Patrick Dicerni. Actually, ADM Velji will comment as well.

Mr. Patrick Dicerni: Thank you very much for your question. I look forward to speaking about some of the steps the ministry is taking to address issues related to over-prescribing and the dispensing of opioids.

The Auditor General's report noted that abuse and misuse of prescription medication, narcotics and other controlled-substance medications is a serious public health and safety problem in Ontario. We know there's a growing number of people who are addicted to these drugs, using them outside of their intended medical purposes, including unlawful activities and, in some cases, dying as a result of that improper use. When the ministry can take action to address over-prescribing and dispensing, steps are being taken. I look forward to explaining a few of those steps to you today.

One such step is Ontario's Opioid Strategy. The Ministry of Health is working to identify and follow up on unusual cases or trends in opioid prescribing and dispensing activities. The ministry relies first and foremost on a database that we just heard a little bit about, which is the narcotics monitoring system. The NMS system is a system that was implemented back in 2012 that collects prescribing and dispensing data from community pharmacies all across Ontario for monitoring drugs like opioids that are listed on the monitored drug list. This would be drugs such as oxycodone, fentanyl and others.

The data that is captured is for all prescriptions, whether those prescriptions are paid through the Ontario Public Drug Programs, private insurers or out-of-pocket cash payers. The NMS includes records of the recipient, the prescriber, the pharmacist who dispensed the drug, the location of that dispense and the drug dose that was dispensed.

In addition, the narcotics monitoring system does provide real-time utilization review capabilities which generates warnings and alerts to pharmacists. When a patient visits a pharmacy to fill a prescription for any narcotic, the pharmacy submits a dispensing record to the narcotics monitoring system and that system automatically conducts a check. The NMS can validate information submitted by the pharmacy against ministry data to ensure accuracy and completeness.

Perhaps most importantly, the system will alert pharmacists of potential issues such as double-doctoring, meaning a patient may have received multiple prescriptions from multiple physicians, and/or refills that are being refilled or sought too soon set against the prescription. These warnings help alert pharmacists to potential inappropriate use of monitored drugs, including opioids. It is the pharmacist's responsibility to exercise some degree of professional judgment in those situations and work collaboratively with the patient, often reaching back to the prescriber to determine what the most appropriate course of action would be.

Data from the NMS system is reviewed and can be reviewed and analyzed by the ministry for a variety of purposes including educational purposes, public health purposes, reporting possible professional misconduct to various regulatory professional colleges and reporting possible criminal conduct to law enforcement agencies.

Further, the ministry responds to requests for narcotics monitoring system data to support investigations and other work done by other regulatory colleges. If the Ministry of Health observes unusual billing practices during the review, referrals to the appropriate regulatory bodies may be warranted. This may include collaboration with the College of Pharmacists, the College of Physicians and Surgeons, the Ontario Provincial Police or the Royal Canadian Mounted Police.

The ministry is exploring options on how to address unusual billing practices that have been observed. If unusual dispensing patterns are identified, which may lead the ministry to believe that claims have been paid, claims submitted by pharmacies may be invalid, such as in the case of prescription forgeries. Those claims may be inspected for further compliance.

At this point, I'll hand it over to my colleague Dr. Karima Velji.

Dr. Karima Velji: Thank you, ADM Dicerni.

The health regulatory colleges, such as the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists, are responsible for regulating their respective professions in the public interest. Their mandate is to ensure that their members provide health care services in a professional, safe and ethical manner. This includes establishing regulations, policies and standards of practice for the professions. Health regulatory colleges update their policies on a regular basis and ensure relevance to the current practice environment, including changing population needs, advances in technology and clinical evidence.

The College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists have existing policies that outline the colleges' expectations for medical and pharmacy professionals regarding opioids, and, in fact, all regulatory colleges would have such mechanisms in place. These policies are in place to provide guidance to physicians, pharmacists and other health care professionals to ensure they are providing care based on their knowledge, skills and professional judgment to act in the best interests of their patients.

The ministry relies on the health regulatory colleges such as the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists to investigate complaints and to take disciplinary action where appropriate. Colleges investigate complaints related to unprofessional conduct, failure to meet standards of practice, inadequate care and billing issues, among others. The ministry continues to engage with internal and external partners to improve the monitoring of dispensing and prescribing practices. Together, we look to use the narcotics monitoring system data to reduce inappropriate opioid use and to improve the safety of Ontarians.

While we acknowledge that more work needs to be done to address the Auditor General's recommendation, the narcotics monitoring system has been found to significantly reduce inappropriate prescribing and dispensing activities in Ontario. For example, in 2014, a study published in the Canadian Medical Association Journal, CMAJ, found that the enactment of the Narcotics Safety and Awareness Act in 2011 and the implementation of the narcotics monitoring system in 2012 resulted in a 40% to 60% drop in potentially inappropriate prescriptions for opioids, benzodiazepines and other stimulant medications.

All narcotics monitoring system data are available in the provincial repository called the Digital Health Drug Repository. This repository is available to authorized health care professionals such as physicians, nurses and pharmacists and sponsored individuals working with the enrolled organization. The ministry and the Ontario College of Pharmacists regularly encourage pharmacies to gain access to the Digital Health Drug Repository to support clinical care information for their patients. To enable pharmacy access to these repositories, the ministry works collaboratively with Ontario Health to support the onboarding of pharmacy access to the database. As of January 2025, almost 50% of all active Ontario pharmacies have access to the Digital Health Drug Repository.

Additionally, the ministry has partnered with Health Quality Ontario to create personalized reports for physicians and administrators across the province. These practice reports are available for health care professionals in primary care, long-term-care specialists and hospital sectors and allow prescribers to compare their own prescribing patterns in relation to their peers using regional and provincial data.

The Chair (Mr. Tom Rakocevic): Under 10 minutes remaining.

Dr. Karima Velji: As of February 2025, approximately 62%, or 6,778, of the approximately 11,000 eligible physicians and organizations are now registered. Ontario Health is currently working with clinical stakeholders to review and update the clinical content. For example, this tool has recently been refined to provide seamless access to reports through an integrated online platform known as MyPractice Primary Care Plus. The report includes data on opioid prescribing and provides suggestions and resources so health care professionals can spend less time looking for solutions that may already exist and more time helping patients.

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In the fall of 2025, the Ontario College of Pharmacists and the Ministry of Health engaged in consultations on potential expansion to the scope of pharmacy practice. When the college proposes changes such as allowing pharmacists to prescribe additional medication, the ministry works in close collaboration with the college. This ensures that any proposed regulatory amendments are consistent with government policy and are designed to promote patient safety and improve access to care.

Just out of interest for the committee, I just want to say that we currently have pharmacies aligned with 19 prescription abilities for 19 minor elements. In Ontario, we are currently consulting on adding 14 additional minor elements to their scope of practice. In that consultation, Madame Gélinas, your question about their involvement in administering medication such as opioid agonist therapies are included in that consultation. We hope to gather the information from all stakeholders and then we'll report out the findings of the consultation to government.

The Chair (Mr. Tom Rakocevic): MPP Dixon.

Ms. Jess Dixon: What's our time, Chair?

The Chair (Mr. Tom Rakocevic): Seven minutes and 30 seconds.

Ms. Jess Dixon: Thank you.

You were just talking a little bit about the MyPractice reports. We also heard about the narcotics monitoring system. Can you talk a little bit more about how you actually encourage health care providers to use those tools? And how do they play a role in actually strengthening oversight of opioid prescribing practices?

Ms. Deborah Richardson: Thank you very much, MPP Dixon, for that question. I will ask Dr. Velji if you could maybe move back and get Graham Woodward to

come up and speak, and then we've got ADM Dicerni to speak as well.

Mr. Patrick Dicerni: Thank you for your question regarding the important role that digital tools play. You mentioned that I spoke a little earlier about the narcotics monitoring system; I'll touch on MyPractice reports, and my colleague Graham Woodward will augment some details around how those tools are appropriately spread and adopted.

We see that those digital tools are essential in our effort to monitor and manage prescriptions, particularly opioid prescriptions, and the ministry recognizes that there is a ways to go by way of some improvements.

The NMS system, which I spoke about a little earlier, does provide real-time alerts to pharmacists about potential inappropriate prescribing or dispensing. It's a really powerful tool, but its effectiveness largely depends on the uptake and the integration into clinical workflows. We appreciate the challenges that are created when these types of information systems exist outside of clinical workflows for physicians, nurses and pharmacists.

The Ministry of Health is working closely with our colleagues at Ontario Health to onboard more health care professionals to the digital drug repository, which allows providers access to a much more comprehensive medication history for publicly funded drugs and monitored drugs that are in the NMS. This prevents some degree of duplication, identifies immediate risks and supports safer prescribing.

Ontario Health is updating, I understand, their MyPractice reports to reflect what current trends are and provide actionable insights to those prescribers. These reports offer peer comparisons, prescribing patterns and recommendations for improvement related to those MyPractice reports that some do receive.

To increase the uptake, the ministry is investing in provider education first and foremost, user-friendly interfaces and integrating with electronic medical records. That speaks to the importance of fitting into clinical workflows that I mentioned a little earlier. We're also engaging with regulatory colleges and professional associations to promote and adopt deeper accountability and adoption of these tools.

Oversight of prescription opioids is very much a shared responsibility. The ministry is committed to providing the tools, training and support that's needed to ensure safe and appropriate use, and we're going to continue to rely on those systems to maximize the reach and effort.

Graham, I'm not sure if you wanted to add anything further.

Mr. Graham Woodward: Nothing to add. Thanks.

Ms. Jess Dixon: Sorry—time again?

The Chair (Mr. Tom Rakocevic): Time is three minutes, 30 seconds. MPP Firin.

MPP Mohamed Firin: I'd like to ask about the Mental Health and Addictions Centre of Excellence. Can you share about its role and how it's helping improve care for people living with opioid use disorder across Ontario?

Ms. Deborah Richardson: Thank you so much for your question, MPP Firin. I will now turn it over to Graham, who is a VP at Ontario Health.

Mr. Graham Woodward: Hi. Thanks so much for your question. I welcome the opportunity to provide you with information on the Mental Health and Addictions Centre of Excellence, the crucial work we've undertaken to connect and strengthen our mental health and addiction system overall and the specific initiatives we're implementing to address the needs of Ontarians with opioid use disorder with the ultimate aim of improving their lives by ensuring that system infrastructure programs and people are in place and are optimized for its success.

As you've heard, the Mental Health and Addictions Centre of Excellence was passed through an act in February 2020, and shortly thereafter the Ministry of Health announced their Roadmap to Wellness, which sets out our collective vision and priorities for building a high-performing mental health and addiction system in Ontario. As articulated in the Roadmap to Wellness, the Mental Health and Addictions Centre of Excellence within Ontario Health serves as a foundation on which the Roadmap to Wellness is built. The centre of excellence is responsible for system management, coordination of services and driving meaningful quality improvements to ensure more consistent patient experiences across the province.

The Mental Health and Addictions Centre of Excellence benefits greatly from being part of Ontario Health and the programs and portfolios that Ontario Health provides. What I mean by that is, at Ontario Health we work as one team, and the Mental Health and Addictions Centre of Excellence can access resources within digital health, primary care, hospital and emergency services, our regional partners and enterprise resources, such as communications, human resources, legal and privacy.

The establishment of a cross-sector representative advisory and oversight table has enabled the Mental Health and Addictions Centre of Excellence to gather clinical, operational and lived insights about mental health and addiction services while building trusted partnerships to drive improvement across the province. Composed of mental health and addiction sector partners, providers, clinical and administrative leadership and people with lived experience, these tables serve to provide critical guidance and advice on provincial program design and implementation. These tables also ensure that key government directions and decisions are informed by the collective wisdom of leadership throughout the sector, along with evidence and data.

Soon after our creation, this oversight structure identified several early priority areas of focus to support how we would implement the key priorities of the Roadmap to Wellness. First was the establishment of a provincial data and digital strategy, including the building of our first-ever provincial dataset for mental health and addictions that serves as a foundation for all of our work, enabling consistent evidence-building, planning, funding, performance measurement and management across the province.

Second was the establishment of four provincial clinical priority program areas, the first being substance use disorder, depression and anxiety—

The Chair (Mr. Tom Rakocevic): Sorry, we are at time. Thank you very much.

1650

We move to the third party with the final round of questions. MPP Fairclough, you have the floor.

Ms. Lee Fairclough: Thanks very much, and thanks again for all of this. I'm going to switch gears on my second session here to focus on some of the other aspects of the report around prescribing, RAAM, the naloxone distribution and some of the billing practices.

My first question is really on the prescribing. It was great to hear a bit of an update on where some of the MyPractice report work has gotten to, because I was surprised, actually, to read that there's been an increase again around the high-dose prescribing. One of my questions was—really, I'm curious what's at the root of that and what's being done. Are there more or less resources being put into trying to reduce the prescribing of high-dose opioids among practitioners?

Ms. Deborah Richardson: I'm going to bring up Dr. Karima Velji.

Ms. Lee Fairclough: Okay. That's great. Thank you.

Mr. Patrick Dicerni: Perhaps while we're waiting for our colleague to join, MPP Fairclough, I'm happy to talk to you a little bit about how we interact with the narcotics monitoring database. I touched on a little bit of this earlier.

I'd say it's both push and pull. I mentioned that we do frequently get requests, whether from law enforcement or the regulated health colleges, to share information that we see or that they have been made aware of through a complaint or an investigation. We share that information freely, obviously.

There would also be instances where we are observing challenging core outliers by way of prescribing patterns. Just recently, we've initiated some work with the Chief Coroner's office as well as the Ministry of the Solicitor General to bring a greater focus and a greater number of resources and eyes to bear on what information the narcotics monitoring system can tell us and what we can do to push that out.

One example of that would be, approximately a year ago, there was a spike in the dispensing and use of hydromorphone, or Dilaudid, in the London area. That's what brought some of our work more closely with Dr. Dirk Huyer's office and some of our colleagues at the Solicitor General. So it is both that we are on receive for requests and looking at what our own data tells us.

Ms. Lee Fairclough: Thank you. It's like you foresaw my next question, which was exactly that: What's the interaction with the colleges etc.? It sounds like it's managed very actively.

Mr. Patrick Dicerni: If I could respond to that question—

Ms. Lee Fairclough: Yes.

Mr. Patrick Dicerni: My experience in this area goes back to 2016 when we first, from a policy department perspective, saw the emergence of challenging opioid-prescribing data. That was at a time when records were shared.

One of the challenges that we had is that the condition—or, what that prescribing is being done for—is not present within the NMS. So understanding whether that's completely legitimate practice, behaviour and pattern, set against the type of practice you are in, or whether that would be something of concern—that's part of the work that we have done in the past with colleges and continue to do.

Ms. Lee Fairclough: Great. Thank you.

Dr. Karima Velji: The only thing I would add to this is that the mechanisms Patrick has described deal with patterns of issues that we see. But at an individual practitioner level, if there are professional misconduct issues, we rely on our regulatory colleges to deal with those.

Ms. Lee Fairclough: Okay. Thank you.

I just wanted to come back to RAAMs—again, another model that we've seen spread over time. I think the main observation for the AG was some of the variable hours that we've seen. I can confirm: As I got out across the province this summer, I saw very regular hours in a place like London—with huge volumes, actually—to other locations where now they've scaled right back to a two-hour slot in an afternoon in not the most accessible spot. I think I've been hearing today that there is quite a strong commitment to RAAM as part of the ongoing strategy.

The second thing I just wanted to ask about: I was surprised that there wasn't more data available because originally, I think there were some expectations around collecting data. Do we actually fund those sites to make sure that we're getting the data that we need, as well as part of what we're expecting from them?

Ms. Deborah Richardson: If I could ask ADM MacIntyre and perhaps Graham Woodward to come back up to speak to this.

But you're right: You spoke to the fact that there is the 89 clinics that are funded. It is a core part of the policy. We do need to standardize services because people should be able to access service where they live and when they need it. That will happen also through the development of the core services framework that the team spoke about a little bit earlier. And then the new data and reporting requirements for rapid access addiction medicine clinics will be introduced by April 2026 to support accountability and continuous improvement.

But I will turn it over to Assistant Deputy Minister Kyle McIntyre to provide more information on those clinics, specifically to get to some of your questions.

Ms. Lee Fairclough: Thank you.

Mr. Kyle MacIntyre: Thank you for the question. That's right: The observations of the Auditor General said there was varied hours in the services that are providing RAAMs across Ontario. Part of the work that's under way—which I'll turn over to Graham to talk to a little bit in a moment—is around the data digital initiative, which will help support getting at some of the recommendations that the Auditor General's report identified.

A key component of that is the creation of a core services framework. So, the core services framework, as we're being able to finalize our advice to government, is a key linking of the mental health and addiction system which will essentially identify and define what are the services that should be available to Ontarians. It essentially defines the what. Sitting behind those core services will be a series of standards and minimum expectations that each provider would be responsible for meeting, and then tied to that is the overall performance management of that. So there's the data side of it, there's the minimum expectations about it through the indicators associated with it and then there's the performance management of those 89 different rapid access addiction medicine clinics. Work is under way with the centre of excellence both to finalize, as I said, advice around the core services, of which a RAAM clinic would be one of the key components, but also the work around collecting that data that you're talking about.

I'll turn it over to Graham to give a little bit of an overview of some of the work that's under way around the data digital initiative and where we're sitting with it.

Mr. Graham Woodward: Thanks, ADM MacIntyre. So, to be clear: I'll go over the data digital component associated with RAAM? Yes, correct? All right.

Data and performance metrics are crucial to ensuring a high-quality, equitable and efficient health care system. They provide evidence to drive strategic directions at all levels of care and inform individual client treatments and shaping provincial health policy and improving system performance.

The ministry is working with us, the Mental Health and Addictions Centre of Excellence within Ontario Health, to lead a data digital initiative that will make it easier to deliver better care, report on performance and track the value of investments, including those within RAAM.

The centre of excellence will play a critical role in delivering the quality and mental health and addiction services and supports, including system management.

I'm going to get you to the data part: The Mental Health and Addictions Centre of Excellence has created a standard provincial data set to be submitted by all of the over 300 publicly funded mental health and addiction service providers by December 2026. That includes RAAM clinics. These data include service delivery and client information that will enable analytics and reporting to drive quality and performance improvements.

Version 2 of this data set is under development and will include the children and youth sector to capture data across the lifespan in one repository. To accomplish this, the Mental Health and Addictions Centre of Excellence has implemented digital infrastructure to receive automated data submissions from community mental health and addiction client management systems as well as from three hospital information systems, eliminating manual data collection for provincial reporting purposes for much of the sector. These data are captured in a central repository where it is linked to other provincial administrative data, such as hospital and physician activity, allowing for a complete picture of how mental health and addiction clients use the entire health care system.

1700

The Chair (Mr. Tom Rakocevic): Ten minutes.

Ms. Lee Fairclough: So just a quick question then: You feel the RAAM clinics themselves will be able to provide the level of detail around RAAM specifically as part of that process to ensure that we're keeping fidelity to what the model was to begin with etc.?

Mr. Graham Woodward: Yes.

Ms. Lee Fairclough: Are you confident in that?

Mr. Graham Woodward: Yes.

Ms. Lee Fairclough: Okay. Great. Thank you.

I'm going to move on to naloxone distribution. I just want to make sure we cover some of the key things in this. The report did highlight some serious issues with the distribution of naloxone kits, the reimbursements and the practices with the pharmacies. Can you just highlight what steps are being taken to address it, and if you do identify red flags or a risk of inappropriate billings in that program now, what happens?

Ms. Deborah Richardson: The ministry monitors naloxone claims under the Ontario Naloxone Program for pharmacies quarterly to identify unusual billing or distribution practices, and clarifications to program policy were issued in 2024 and 2025 to address inappropriate practices.

When irregularities are detected, referrals are made to the regulatory bodies, as Patrick spoke about earlier, such as the Ontario College of Pharmacists, or law enforcement even. Collaboration between the Ontario Naloxone Program and the Ontario naloxone program for pharmacies has been strengthened to maximize access and reduce duplication. These measures ensure naloxone remains widely available while maintaining program integrity.

I will turn it over to ADM Patrick Dicerni to talk more about some of the collaborative efforts that are under way in this space.

Mr. Patrick Dicerni: Thank you, Deputy.

This program—we can take it in a couple of different directions, but you sound quite familiar with the naloxone program in general, so I'll spare some of the topline information about what the program is.

MPP Fairclough, your question is related to how we monitor the program. About 4,000 pharmacies in the province participate in the Ontario Naloxone Program for pharmacists, a critical means by way of how naloxone is made available to people across the province. The deputy touched on some of the clarifications that the ministry has issued and we've implemented several steps to reduce the number of inappropriate billings from pharmacies that we had seen over the lifespan of the program.

What we have seen is a noted decline in the inappropriate claims under the program, and we would point to the clarifications in May 2025, July 2024 and February 2024 to address some of the unusual dispensing practices.

To give a little bit more texture to those clarifications, stressing that the program parameters are designed in a

pharmacy to establish a one-to-one relationship between an individual seeking a naloxone kit, which is comprised of two doses—and you can access up to two kits a day. That is meant to be a one-to-one therapeutic relationship between the pharmacist and the individual who may be a family member, a friend, loved one or somebody using drugs or at risk of overdose, and we clarified that it is meant to be that one-to-one relationship.

Another one of the clarifications that we brought to the program was this is a program that is meant to be delivered within the walls of the pharmacy, reason being—and the auditor detailed some of this in the report—the idea of making naloxone kits available en masse at public gatherings, the CNE, gatherings like that. I'm not suggesting there is no value, but that is not the policy parameters or intent of the ONPP. We clarified some of those and we have seen the decrease in some of the inappropriate billing practices that stem from that.

With respect to what we do about this when we do come across this, we do initiate a process of recovery for overpayments that are made to pharmacies for claims that are deemed to be not in compliance with the existing agreements and our policies of the program.

Professional practice issues are primarily the responsibility, as we've heard a couple of times and as you would know, of the College of Pharmacists. They have been addressing some of the issues that we've taken to them through their disciplinary means and actions as necessary.

If the ministry observes overbilling in practice, we do refer to the appropriate body and we do have an on-site inspection team that does travel the province and does initiate audits and inspections for a host of reasons, and this would be one of them.

Ms. Lee Fairclough: Just give me a sense: Have you done many of those in the last year, for example?

Mr. Patrick Dicerni: We have a well-developed audit and inspection plan across all the pharmacies for the entirety of the Ontario Public Drug Programs, so this is, I'd say, one of the information inputs and as we look across the expenditures within the program, it is one of the flags that we rely on and adapt inspection and audit plans against that and some other things.

Ms. Lee Fairclough: That's great.

My other question was actually around billing practices, like physician billing practices. There was a specific example in there around one physician who had billed 187 patients in a day. It was a $1.8-million bill. What's your plan around some of those practices as well? I just feel like it's appropriate for me to ask.

Mr. Patrick Dicerni: Absolutely. I'll ask my colleague Nicole behind me who—my division, the health programs and delivery division, and Nicole's provider and professional practice division does collaborate in terms of what we see writ large through the OHIP billing system. But with respect to specific claims for that, I'll pass it to my colleague.

Ms. Lee Fairclough: Great.

Ms. Deborah Richardson: She will need to swear in—or affirm.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Nicole Williams, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Ms. Nicole Williams: I do, thank you.

I'm following up: I'm the assistant deputy minister for physician and provider services at the Ministry of Health.

Similar to the work that my colleague Patrick does on the pharmacists in reviewing claims and billing, to support physicians in this space, the ministry engaged in several monitoring partnership practices. But specifically, we perform post-payment auditing on our fee-for-service billings—and that's part of our regular business for the OHIP system—to inform whether or not a physician's payments and billings were appropriate.

Fee-for-service billing audits do not include the review of the appropriateness of the care itself. Similar, again, to Patrick's and Karima's work that we have been referring to, we rely on the colleges to perform that function for us.

With that, if we do observe anything unusual in the billing practices, what we'll do is refer to the College of Physicians and Surgeons of Ontario. This includes concerns about patient safety and prescribing practices.

So when we do fee-for-service billing audits, what we do is, if we encounter inappropriate or unusual professional practices, we will refer to the College of Physicians and Surgeons of Ontario. This includes patient safety and patient care types of concerns. As you know, they regulate the physician services, the practice of medicine in the province. Those post-payment fee-for-service billing audits are prioritized by my team based on financial risk and observed behaviours and patterns. So the Ministry of Health reviews those claim submission activities to identify potential instances of unusual or inconsistent distribution practices, and then we work with the college to regulate and to look into individuals as required.

As you know, their mandate is to ensure that physicians provide health care services in a professional and safe manner and an ethical manner, which looks at the regulations, policies, standards of practice that are accountable for patient care.

The Chair (Mr. Tom Rakocevic): Under two minutes remaining.

Ms. Lee Fairclough: Thanks very much. That's great.

My last question is—you mentioned a number, over the next 10 years, that you're planning to invest in mental health and addictions, and I'm assuming a portion of that is funding—the $550 million—for the HART hubs. Can you talk about the sources of funding for that 10-year strategy? Is it federal transfer money? Is it primarily from within? Is it reallocation? Can you give me a general sense of how we've been able to put the $550-million investment into the HART hubs?

Ms. Deborah Richardson: So we're allocated from Treasury Board and from finance an allocation every year. There is a combination—some of the funding does come the federal government; I think it's about $21

billion that comes from the federal government. Some of that is allocated to mental health and addictions, but we receive it in a full envelope. So, of our $88 billion that's in public accounts, $21 billion is from the federal government.

Ms. Lee Fairclough: Is there any mental health indicator tied to that?

Ms. Deborah Richardson: There is. There's actually a program that's expiring March 31, 2026. Kyle, remind me what it's called—the federal program.

Mr. Kyle MacIntyre: I think you're referring to the $3.8-billion Roadmap to Wellness 10-year investment. So $1.9 billion of that comes from the federal government. As the deputy said, it's up for renewal on the date that she mentioned. The other $1.9 billion is from the provincial government. The HART hub funding, the $550 million, sits outside of that.

Ms. Lee Fairclough: Thanks very much.

The Chair (Mr. Tom Rakocevic): Thank you. We're out of time.

That concludes the questions for today's hearing. I want to thank the ministry again for appearing two weeks in a row. Thank you so much. You're dismissed. Thank you for being here today and for answering the questions.

We are now pausing to go into closed session to begin report writing.

The committee recessed at 1711 and later continued in closed session.

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