Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

P-3

Standing Committee on Public Accounts

Special Report,
Auditor General:

Performance Audit:
Community-Based Child and Youth Mental Health Program

1st Session
44th Parliament

Monday 20 October 2025

Chair: Tom Rakocevic
Clerk: Thushitha Kobikrishna

Journal des débats (Hansard)

P-3

Comité permanent des comptes publics

Rapport spécial,
vérificatrice générale:

Audit du rendement:
Programmes communautaires de santé mentale pour les enfants et les jeunes

1re session
44e législature

Lundi 20 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

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Monday 20 October 2025

Lundi 20 octobre 2025

The committee met at 1345 in room 151, following a closed session.

2025 SPECIAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH

Consideration of the Performance Audit: Community-Based Child and Youth Mental Health Program.

The Chair (Mr. Tom Rakocevic): Good afternoon, everyone. 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: Community-Based Child and Youth Mental Health Program. 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 government, official opposition and the third party caucuses in 20-minute intervals.

Before we begin, the Clerk will administer the oath of witness or affirmation.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): I'll begin with Ms. Richardson. 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 the truth?

Ms. Deborah Richardson: Yes, I do.

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

Kyle MacIntyre, do you 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. Kyle MacIntyre: Yes, I do.

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

The Chair (Mr. Tom Rakocevic): Thank you very much and welcome. I would invite each of you to introduce yourselves for the first time that you speak for the purposes of Hansard. So again, welcome, thank you very much and please begin.

Ms. Deborah Richardson: I'm going to introduce myself in my Mi'kmaq language first.

Remarks in Mi'kmaq.

Good afternoon. My name is Deborah Richardson and I'm the Deputy Minister of Health.

Mr. Kyle MacIntyre: Good afternoon. My name is Kyle MacIntyre. I'm the assistant deputy minister of the mental health and addictions division of the Ministry of Health.

Ms. Deborah Richardson: Good afternoon, everybody. It's really nice to be here. It started out being a little rainy, but it was beautiful on the walk over here.

Chair and honourable members of the committee, joining me here is Kyle MacIntyre, who introduced himself. He's the assistant deputy minister of the mental health and addictions division.

Thank you so much for the opportunity to speak with you about the Office of the Auditor General of Ontario's 2025 children and youth mental health program performance audit. The Ministry of Health appreciates the work that the Auditor General's office has done in developing this report, which speaks to ensuring children and youth throughout Ontario have access to timely, equitable and effective mental health care.

The findings of the Auditor General's report identified where progress has been made supporting children and youth getting the care they need. It also identified gaps and systemic challenges that impact the quality and consistency of mental health services for young people in Ontario. These are challenges that our ministry has been actively working to address, and the report reinforces that we need to continue to focus on those efforts. The recommendations provide a clear path forward for the ministry to improve the children and youth mental health system in this province.

I'd like to provide the committee, firstly, with some background information on some key mental health initiatives that have been under way at the Ministry of Health. In 2020, the government established Roadmap to Wellness, a plan to build a comprehensive, connected and world-class mental health and addiction services system, supported by a commitment to invest $3.8 billion over 10 years. Roadmap to Wellness is based on four pillars: improving quality, expanding existing services, implementing innovative solutions and improving access.

Roadmap to Wellness is adding capacity to meet demand and fulfill gaps in the care continuum. It's creating a provincial infrastructure for a mental health and addictions continuum of care, which connects community, primary

and acute care so that these services better support the needs of people with mental health and addiction issues.

A key achievement under the Roadmap to Wellness has been the creation of the Mental Health and Addictions Centre of Excellence within Ontario Health. The Mental Health and Addictions Centre of Excellence within Ontario Health was created with the passing of the Mental Health and Addictions Centre of Excellence Act, 2019. Working with the Ministry of Health, the Mental Health and Addictions Centre of Excellence is a centre point of accountability and oversight for mental health and addictions care: responsible for standardizing and monitoring the quality and delivery of evidence-based services and clinical care across the province, to provide a better and more consistent patient experience; responsible for creating common performance indicators and the infrastructure to collect and disseminate evidence and set service expectations; and, of course responsible for implementing Roadmap to Wellness.

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Historically, mental health and addiction care in Ontario has lacked a centralized body to oversee quality access and delivery. Now, the Mental Health and Addictions Centre of Excellence helps to embed mental health and addictions as a core component of Ontario's broader health care system. Since 2019-20, almost $800 million in new base funding has flowed into services and supports through the Roadmap to Wellness, including more than $200 million specifically for the child and youth mental health sector. This funding is focused on improving access to specialized mental health treatment, reducing wait-lists and wait times, expanding existing programs and creating new programs to help manage patient stress, depression and anxiety.

I'd like to provide an overview of the important work of the children and youth mental health program. Children and youth mental health services are delivered by over 200 community-based, not-for-profit providers that offer a range of mental health services for children and youth up to the age of 18 and for their families. Services are primarily based on a set of provincially defined children and youth mental health core services. The program services more than 120,000 young people each year.

Community-based children and youth mental health services are directly funded and overseen by the Ministry of Health and are governed under the authority of the Child, Youth and Family Services Act, 2017. The Ministry of Health provides more than $525 million in annual base funding each year for children and youth mental health initiatives. Children and youth mental health lead agencies, designated under the Child, Youth and Family Services Act, 2017, are responsible for planning the delivery of core services and coordinating services and supports for clients across various sectors, including health, education and child welfare, within their respective service areas.

Most agencies delivering these supports are multi-service agencies that are funded by the Ministry of Health for children and youth mental health services and other ministries; for example, for services and supports such as child welfare, youth justice and special needs, such as autism. Some children and youth mental health agencies also provide services for all ages: There are also some Indigenous-owned and operated organizations as well. As mentioned, services in this program are primarily based on a set of provincially defined children and youth mental health core services, ranging from prevention services to counselling and therapy to intensive and specialized services.

In 2024-25, the Ministry of Health convened a technical working group to assist in the development of a draft core services framework for community-based mental health and addiction services and supports, using an across-the-lifespan approach. The framework will identify the types of mental health and addiction services for the community-based mental health and addiction sector required for someone's lifespan, from children and youth to adulthood. Work that has been done to date in this space includes:

—research and jurisdictional scans on Canadian and international approaches to mental health and addiction systems planning and developing core service frameworks;

—engagement with mental health and addiction stakeholders and partners across the province, seeking advice on how to approach a core services framework in Ontario, and;

—meetings of the 22-person technical working group that provided advice to the ministry on how to adapt the Health Canada-funded national needs-based planning project core services framework, and incorporating the existing child and youth mental health core services in program requirements and guidelines.

The implementation of the core services framework will include elements such as the development of minimum program expectations or program standards that will provide guidance and standardize expectations for the delivery of core services across the lifespan. Implementation of the core services will also address many of the Auditor General's recommendations.

Before I speak more directly about the Auditor General's recommendations, I'd like to describe some of the work that is under way at the ministry, which is expanding services and will be important in addressing many of the Auditor General's findings.

The Auditor General's report included some recommendations on intensive service for children and youth, and I'm pleased to share that work is under way to establish a new, community-based service model called the Ontario intensive treatment pathway. It is being designed to facilitate improved access to new and existing services for children and youth with complex mental health needs.

This Ontario intensive treatment pathway will do a few things. I'd like to share those with you:

—create regional treatment networks that will be responsible for delivering and managing access to a coordinated system of intensive treatment for children and youth within their geographical service area;

—establish quality guidelines and standards for live-in treatment programming so that children and youth with complex mental health needs have consistent, high-quality services no matter where they are in the province; and

—address long-standing treatment gaps in the community by increasing the availability of evidence-based and specialized clinical treatment to improve equity of access and of service outcomes, optimize existing investments and support innovative local approaches.

The ministry is also working with system partners to help fill gaps in service and reduce wait times across the province. I just want to speak to some of those steps that we're taking.

Expanding One Stop Talk/Parlons maintenant: This is an innovative provincial virtual walk-in mental health counselling service that enables more children, youth and their families to access the care that they need. As of the end of the first quarter of 2025, almost 4,500 clinical sessions have been delivered to children, youth and their families.

Expanding the Complex Transition Fund: This provides short-term flexible funding to support children and youth with complex mental health needs as they transition into or out of community-based live-in treatment programs.

Creating four new Step-up Step-down live-in treatment programs across the province of Ontario: This program is for children and youth with complex mental health needs who require short-term supports to step down from hospital care to less intensive community-based services or to step up from less intensive supports to provide stabilization through more intensive interventions outside of the hospital setting.

The ministry is also investing to increase the capacity of the children and youth mental health workforce. Up to 2,200 clinicians who treat children and youth with complex service needs are being provided evidence-based training to build the skills they need to address the growing acuity of the need within the children and youth mental health system.

This year, the provincial budget included an investment of more than $303 million over the next three years to stabilize the community-based mental health and addiction services sector. This funding will provide a 4% increase in the sector's base funding to support community-led and deliver mental health programs, including services that children, youth and their families rely on.

The Auditor General's report also describes the need to support youth transitioning into adult programming. As a mom who had a child who experienced that, I can totally relate to this. That's why this is so important.

The ministry has been investing in youth wellness hubs, which consist of a network of 23 hubs operating across Ontario, with an additional nine youth wellness hubs in development. Youth wellness hubs are Ontario's model of integrated youth services, which is an evidence-based, developmentally appropriate addictions service for youth aged 12 to 25.

In addition to offering addictions treatment, youth wellness hubs offer mental health treatment and primary care. If any of you have ever been to one—or if you haven't, please go to one. They're incredible.

These are just some examples of the work that is under way to support children, youth and their families.

The Auditor General's report provides 22 recommendations. The government has committed to addressing all 22 of those recommendations, which will require a coordinated, phased approach to enhance mental health services for children and youth right across Ontario.

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The Ministry of Health is already undertaking several initiatives with partners across government as well as Ontario Health and its Mental Health and Addictions Centre of Excellence to prioritize actions that respond to the recommendations from now through to 2027, and you'll hear we've already started to implement many of them. The ministry is focused on actions that will have direct, timely impact on the services provided to children and youth, and build on initiatives already under way.

This includes—and I spoke to this—the Ontario intensive treatment pathway, which is focused on improving service for children and youth with intensive mental health needs, starting with live-in treatment services. This Ontario intensive treatment pathway has formalized a governance structure, including advisory subgroups and research. Reports have been completed that provide an overview of existing intensive services, focusing on live-in treatment and on a clinical population report that identifies profiles of children and youth who are most likely to benefit from live-in treatment. Work has begun to develop quality standard for live-in treatment services as well.

Parallel to the Ontario intensive treatment pathway, the ministry established an Indigenous steering committee, to work with the ministry to design and implement an intensive services model that is culturally grounded and structured to better meet the needs of Indigenous children, youth and their families.

We are collaborating also with the Ministry of Children, Community and Social Services and the Ministry of Education to develop a cross-sector protocol to support earlier collaboration and coordinated service delivery across various sectors that support children and youth and define roles in planning and providing comprehensive multidisciplinary support for youth with complex special needs. That protocol is expected to be in place by 2027-28.

We're continuing to improve data collection, which is so important, and the quality of data already collected at the ministry and also through the work of the Mental Health and Addictions Centre of Excellence's data and digital initiative. You'll hear more about that as well. The focus of the data and digital initiative includes, at a high level, creating a standard provincial data set to provide health system insights across the lifespan, building a central repository of mental health and addiction data and providing the mental health and addiction sector with recording and analytics to drive quality improvement.

Over the next two years, we're focusing on the following:

—filling service gaps, including those related to intensive treatment services;

—supporting better coordination and creating more consistency across sectors and across the province;

—improving the quality of data we gathered to inform programs and services and to improve outcomes for children and youth; and

—strengthening how we manage and oversee the system in place to deliver mental health services to children and youth.

I will note that implementing some of the Auditor General's recommendations will take more than two years. These actions are dependent on a broader system change which can take time to implement effectively and we want to ensure that the actions we take are effective and improve mental health outcomes for children and youth as they progress into adulthood.

For example, the ministry agrees with the Auditor General's recommendation to "establish performance indicators and timelines to measure progress in improving access to, and facilitate cross-sector coordination among ... service sectors such as autism and child welfare...." However, to advance this recommendation meaningfully, our first step would be to work with partners to develop a cross-sector protocol. This protocol will serve as a foundational framework for the indicators, providing shared definitions, standards and outcomes. These elements are essential prerequisites for the development of robust and meaningful performance indicators. We intend to build on system change initiatives already being undertaken to implement Roadmap to Wellness, Ontario's mental health and addictions strategy.

There's also more work to be done to better coordinate work across health, education, child welfare and community health agencies to come together in building a more responsive and inclusive child and youth mental health system—and, I would argue, primary care, of course, as well, and public health.

The Chair (Mr. Tom Rakocevic): Two-minute warning.

Ms. Deborah Richardson: The ministry will also continue to collaborate, of course, with the Mental Health and Addictions Centre of Excellence at Ontario Health to better support families.

Across the mental health sector, there's lots of really good examples. We all know those community organizations that just do tremendous work for our families. Some of the examples: Woodview Mental Health and Autism Services, celebrating 65 years of serving families in Brantford. In the northwest, the Indigenous-led Kenora Youth Wellness Hub, opened in November 2019. There's just so many positive examples—I know have two minutes.

We know that early identification and support to address mental health challenges leads to better outcomes for children and youth. We accept the Auditor General's recommendations and are fully committed to acting on them.

Thank you so much, Auditor General Spence and the team, for the work that you've done and the collaboration. We really appreciate it. It helps us deliver better services to the citizens of Ontario, no matter where they live.

Thank you so much for your time today, and we welcome the questions.

The Chair (Mr. Tom Rakocevic): Great. Thank you very much.

This week, we'll be proceeding in the following rotation, which is 20 minutes to the government, 20 minutes to the third-party members and 20 minutes to the official opposition. We will follow this rotation for two rounds, beginning with the government. MPP Smith.

Mr. David Smith: Thank you, and good afternoon. I am very pleased for that well-illustrated talk that you brought forward to us to give us sort of a road map as to where your industry is taking us, from the auditor's report.

Today, some of the questions that I have—when you talk about nine hubs, do you feel that is an adequate number to meet the needs of individuals here in Ontario, and where are they located?

Ms. Deborah Richardson: Just for clarification: There's already 23 hubs that are located right across the province. There's nine additional hubs that are in the works. We definitely can tell you where they are. We're just calling it up. We can tell you the locations.

Mr. Kyle MacIntyre: As the deputy has said, right now, we've got 23 across the province that are operational across all of the regions of Ontario. We've got a number in Toronto, we've got some in Kenora, Guelph-Wellington, Windsor-Essex, London, Sudbury, North Simcoe etc., and we've got another five hubs that are in full development right now, across Brampton, Oxford county, Port Hope, Thunder Bay and Vaughan–Woodbridge. These are the ones that are being more or less planned to be opening up this year, and then we've got another set of four that will be opening up next year.

Mr. David Smith: Thank you. I'm glad to hear that these are additional hubs that you're opening.

In terms of timelines, I'm glad to hear that you're taking seriously what the Auditor General has suggested, and I'm hearing, Deputy Minister, that you made mention that two years might not even be sufficient time to implement all of this. But my concern is, what do you see as the endgame to meeting this urgent need that is before us?

Ms. Deborah Richardson: Like I said, as a parent of somebody who—one of our five kids had some pretty serious mental health issues, and this was a number of years ago. It's amazing now that, through the centre of excellence, there's an actual body that takes the research and coordinates things in a way, so having to navigate—I'm in a position of privilege. I'm an executive in the government and know how to manoeuvre. Many people are not in that position, and I'm just so happy that we're centralizing things so that people will have more access to services and eliminate barriers. I think being able to provide virtual care—a lot of kids now, this is how they like to communicate, right? And so the fact that we're also providing tools that kids can access in different forms—

whether it's intensive and they need intensive treatment, whether they need a youth wellness hub with some mentoring or whether they need somebody to actually talk to and then get a referral if they're in trouble, I think that would be a system where everybody knows where and how to access services. I think that's pretty critical.

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Mr. Kyle MacIntyre: Can I answer that as well?

Ms. Deborah Richardson: Yes, please do.

Mr. Kyle MacIntyre: Thank you for your question.

The government's approach and plan starts with Roadmap to Wellness which is the strategy for building a comprehensive and connected mental health and addiction system across the province. It starts with a $3.8-billion investment over 10 years. Since 2019, that investment continues to grow. The government has added over $800 million in new base funding for mental health and addictions writ large, including over $200 million for children and youth mental health itself. That is going towards mental health treatment, wait-lists and expanding existing programs across the care continuum.

That includes the investment that the deputy was mentioning earlier, called the Ontario intensive treatment pathway, which is a $22-million investment focusing on community-based intensive services, which was one of the key areas that the Auditor General spoke about in terms of looking at things like enhancing the number of beds and the services across the province.

The deputy mentioned in her remarks that we're creating regional networks using a hub-and-spoke model for the delivery to better coordinate access for intensive services and then establishing quality guidelines, as well as identifying where there may be gaps in services for these really needed, intensive live-in treatment services which we're starting to focus on.

While that is being built and under way, the government has also invested across a number of other services to address both wait-lists, treatment options and opportunities for children and youth. For example, I'm not sure if folks have heard about One Stop Talk, if you've got a small child or children at school. This is really an innovative program that we invest about $4 million each year in. You can think about it as a virtual walk-in clinic where people can access free mental health services. It's low barrier—pretty easy to access. I think it's made available in over 200 languages, including sign language.

What happens is you can call up a number or access it through a website, and you're immediately talking to a therapist. There are zero wait times for this. It actually is really helpful because it supports folks who might have difficulty getting access to care of the province. Sometimes we know in more rural areas or in northern, remote communities, it might be more difficult to access services. What One Stop Talk allows people to do is, say you're in a remote community, if you have access to the Internet, you might be speaking to a clinician in Windsor. It makes people's access available across the province, as I said, without any wait times.

Mr. David Smith: Thank you. I think your answers suffice.

Chair, I would like to yield the rest of my time to my colleagues.

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

Ms. Jess Dixon: Thank you so much, both of you, for coming. I have sort of a two-part question, which I'll give you all at once.

The first part: The minister has talked a lot about how we can't improve what we don't measure, so I am curious about what types of key performance indicators or outcome measures the ministry is either using or developing to evaluate your progress, and also how that data will be published.

And then, second to that: Is there any plan as far as collecting or linking that data in a way that could ultimately show return on investment? For example: reduced emergency visits, less justice involvement, fewer hospitalizations for youth that get mental health support.

That was my two-part question.

Ms. Deborah Richardson: I think that's a great question. I think in the short term, we need to get this right. So it's kind of linked to your question and your question, because we have the short-term, the medium-term and then the longer-term, more systemic things.

In the short term: By March 2027, we want to be able to have a performance-monitoring framework for oversight of agencies and lead agencies, and then improve, obviously, wait-time definitions and data consistency, because right now how wait times are being tracked is all different. We need to have the standards so that we can know what we're measuring and do that collectively. That's the work we're doing through the centre of excellence.

Obviously, enhanced transition policies—this is all connected, right? You need to have the data, you need to have everyone measuring the same and the transition policies for youth and then expanding access to coordinated services through initiatives like the one that Kyle just spoke to. And then agency-level data attestation and reporting tools will be important. I think that's really key.

I don't know if you have specifics, Kyle, about some of the indicators.

Mr. Kyle MacIntyre: Yes. As the deputy is saying, there is the infrastructure side, to make sure that there's the capability for organizations to submit data. Then there is the approach of requiring standardization of that data so you can compare across different organizations. Then there is what you do with the data and how you performance manage with that data.

Right now in the children and youth mental health space we've got two systems that we're using to collect data from the children and youth mental health providers. One is called the business intelligence solution, which pulls in data from our providers and asks a number of different types of questions. So we get data from them related to wait times, for example, across the seven different core services that the children and youth mental health sector provide.

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

Mr. Kyle MacIntyre: We also collect data about what other services they're providing. We get data around the perception of care and whether or not positive outcomes are happening. We get a range of those types of stuff coming in through the business intelligence solution.

We also have something that is more focused on the financials. We have something called the Transfer Payment Ontario system. Organizations are required to submit data more on the financial side of things, so we collect data on that front as well.

Then there is the future that we're looking at, that the deputy had mentioned, which is the work being led by the Mental Health and Addictions Centre of Excellence and Ontario Health. As part of the work, one of the key elements of system transformation under way is improving the type of data we get. In the mental health and addiction system sometimes we get too much data in terms of folks submitting, but it might not be the right kind of data. In some cases we need to be collecting more data from providers and we certainly need to be standardizing it.

Through the work of the data digital initiative at the centre of excellence a number of things are happening. One, what we're doing is we're rolling out a provincial data standard so that every organization that receives funding for mental health and addictions in the community space is required to provide data that is to one standard. That will evolve over time. We're starting the process of having the second version of that being rolled out.

The second piece of that is, you want to make it as easy possible for the providers to be able to submit data, and so we're funding opportunities to move to compliant data systems and information systems so that the different pockets of technology can speak to one another. We want to make it as easy as possible. The technology allows us to pull that data on a nightly basis, so it's not manual. They don't need to submit it. That is a key component of being able to measure change over time, measure performance of organizations in a standardized way, collecting a similar type of data and then being able to use it on the performance side.

The deputy talked a little bit about two things on the performance side, which I think gets at your question about how we know we're getting results for the funding that we're doing. We do get some data, as I said, on the performance side, particularly on the financial side, through Transfer Payment Ontario and the business intelligence solutions. Eventually, once we onboard the children and youth mental health space into this data digital initiative, we'll be able to collect a whole range of indicators, not just financial, and assess quality outcomes.

A key element of being able to do that is the establishment of something called the core services framework. If you've seen the Roadmap to Wellness, one of the commitments there is to develop a core services framework that's across the lifespan.

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Right now we have seven core indicators for children and youth mental health. We're going to be expanding that and building in more core services for the adult and addiction community mental health space. Once those are established as part of the legislative authorities that are identified for the centre of excellence for mental health and addictions, they'll be developing what are called minimum program expectations and quality standards for each of those core services. When those are established, it allows the ability to compare apples to apples, performance to performance, against a set of expectations that each provider is meant to provide, and through the broader accountability framework and performance measurement, that's how you start to understand better if are you foreseeing more quality outcomes for the investments that you're making.

Ms. Jess Dixon: Just to follow up on that: Given that we're in public accounts, I'm still curious about the about the concept of what types of financial or performance measures are going to help you demonstrate that the investments are delivering value.

I'm also curious; you talked about partnering with MCCSS and education, but one of the things that is challenging in this area is the measure of the non-event, the fact that a child that receives an early intervention that has a preventative impact does not end up in an emergency room and often does not end up in the justice system specifically, with police involvement. I wonder if there's any discussion from the ministry as far as tapping into those other areas, because from an academia perspective, that is one of the most challenging things to demonstrate and also one of the most challenging things to demonstrate for the service providers, is to show that ROI that extends beyond just their own sector.

Mr. Kyle MacIntyre: Yes. A key component of that is that data digital initiative that I was saying about. One of the initiatives that is rolling out as part of that is using OHIP-level data collection, and so that you can start to see a person's card through the system. So we would be able to see, if they access a children and youth mental health program, did they turn up in the emergency department at a future date, for example. As a way of mapping across the different sectors, whether that's primary care, acute care or in the community, that's in the early stages. It's first being rolled out in the adult community and mental health sector, so we're going to be working with Ontario Health about how do we maximize that investment so that it also goes to the children and youth mental health providers so that we can start to track them across the system.

Ms. Jess Dixon: Thank you.

How much time do we have left, Chair?

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

MPP Firin.

MPP Mohamed Firin: It's very important to me that young people in my community, whether they be accessing youth services or transitioning into adult services after turning 18, have seamless access to mental health and addiction support. Deputy Minister, can you outline the steps that the province is taking to ensure this?

Ms. Deborah Richardson: So I spoke a little bit about this in my opening remarks. The information on the

significant steps that we're taking to meet the needs of transitional-aged youth and youth experiencing addiction issues, in alignment with several of the Auditor General's recommendations: In 2020, the government released—we spoke about Roadmap to Wellness, our plan to build a world-class mental health and addiction system supported by a commitment to invest $3.8 billion over 10 years. The road map is adding capacity to meet demand, filling gaps in the care continuum and creating a provincial infrastructure for a mental health and addictions continuum of care that creates community, primary and acute care to better wrap around the needs of children with mental health and addictions.

So, ADM MacIntyre, I know we just have a few minutes left, but maybe you could just give some of the details.

Mr. Kyle MacIntyre: Sure. As the deputy mentioned, there has been significant investments, both base funding for the mental health and addiction system writ large but also for children and youth.

The Auditor General's report did specifically talk about the need for developing coordinated pathways for children and youth who are of transition age. There are different ways to define that age, for sure. They also made mention of a quality standard that's in place.

One of the things just to remark on—currently, right now our children and youth mental health providers are required to make sure that they are engaging in transition planning across a number of different transition points already. We do have guidance towards those children and youth providers that they should be preparing for those transitions to support children and youth as they come into adulthood. That can be across a number of different providers, whether that is related to school, discharging out of a children and youth provider or into a community mental health space that is more targeted for adults. This is outlined in the program guidelines and requirements that the ministry has issued to support child and youth mental health programming. It's a partnership-based approach.

One of the things that we've heard loud and clear from the Auditor General's report is the need to do better and work with the centre of excellence of mental health and addictions to be able to do that.

The Chair (Mr. Tom Rakocevic): We're at time.

We're now going to move to questions from the third party. You have 20 minutes.

Ms. Lee Fairclough: Thank you very much for the description you've given today. I do want to start off by commending one thing that we heard about today, which was that in the last budget there was an over $300-million investment into the community mental health sector, which I think was needed, particularly around some of the issues on wages. I do want to commend that that has occurred, and I hope that it will make a difference in this sector. They hadn't had an increase in some time.

I will say, though, I do hear a lot from families still trying desperately to access service for youth and young people. When I read this report, it highlighted that we really need to bolster intensive services. It was the first recommendation in the report. You've talked a little bit about the creation of networks and the pathway, the $22 million, but we see big geographic differences in access to service today. I just wondered if you could speak a little more around how quickly we will see that money translating to services for young people, because I think it's pretty desperate out there.

Mr. Kyle MacIntyre: Thank you for the question. You're right. There's an orientation that we've sort of talked about, the Ontario intensive treatment pathway, which is the $22-million investment. Just, again, for folks to understand, it's focusing on live-in treatment, part of the intensive services care continuum.

We are establishing, first, the regional networks. We hope by the end of this fiscal year, we will have issued the call for proposals to identify who are those providers that are going to be the main hub and centre for delivering a good chunk of that care. It also requires us to establish quality standards for the programming as well as doing some work to assess where those gaps are.

While that work is under way, the Ministry of Health has continued to invest in this space in preparation for the creation of that pathway to go live. For instance, there have been investments that are supporting our ability to understand the landscape and the clinical profile for the children and youth who would go in there. We know that not all children and youth would benefit from this related type of access to treatment, so we want to be thoughtful about who can enter that service there.

As of last year, for example, we invested almost $14 million in that intensive services space to support stabilization, the reduction of wait-lists and building sector capacity. That happened with supporting clinicians with advanced tools. We built the capacity through supporting providers so that they could do some hiring as well. There was an element of training involved for the support services.

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What we're finding is that the range of complexity for children and youth mental health is increasing, so we want to make sure that clinicians and others are being able to be prepared to handle that change for the population.

There was also a number of investments that were related to capital renovations to support the therapeutic value of physical spaces.

There are other sorts of investments that have been happening as well so that we're continuing to address the care continuum through a number of different kinds of investments. We spent almost up to $3 million in expanding Indigenous-led intensive services in the north, for example. I did talk about the almost $4-million investments around One Stop Talk, which allows children and youth to access care right away. We spend up to $2 million annually on a basis and a multi-year $1 million to support the Complex Transition Fund as well, which provides short-term, flexible funding for children and youth with complex needs.

The Ministry of Health has also invested up to $8.5 million in new annualized base funding to create four new

Step-Up Step-Down programming, which helps folks in live-in treatment programs across Ontario. They may need short-term supports to step down from a hospital to get into the community for a less intensive service space, or maybe they need more intensive services to step up and receive care. That expansion occurred in the last couple of years and builds on existing programming for that as well. Those new programs are in Kenora, Sudbury, Hamilton and Waterloo.

There's also been an increase of funding of almost $6 million and one-time funding that we've been doing over multiple and multiple years, supported through the Children's Mental Health Ontario association, again, focused on that clinical training for complex needs. Over 2,000 clinicians who treat children and youth in that complex mental health space have accessed that kind of training.

We also have some money that—we've been doing some pilots as well of different types of treatment in this space to see what works.

Ms. Lee Fairclough: I guess my next question will be, then, given that: Are you pretty confident you're going to see a big jump in volumes between, say, last year to the end of this year in who's been able to access those intensive services? Right now, when we say that we've got 13 of 33 service areas that don't have live-in treatment, are you going to see more of those service areas actually receiving treatment in this year?

I think the work of the network—I've come from working in health care. I know what it takes to create these things. Again, I just really hope we've got a way to measure whether we actually cared for more people this year and are confident on that. It's not just money, right? It's actually—did it reach people? I worry a little because the service, the framework that you've described has been in development since 2018, right?

Mr. Kyle MacIntyre: The last two years.

Ms. Lee Fairclough: And so, how are we going to be sure people are going to get the care they need?

Mr. Kyle MacIntyre: We do track a couple of things. One is the volume of service within a core service space. We would be able to see whether volumes are increasing. We also do track wait times associated with those services, so that helps with that. Then, of course, we engage with the providers as well to see what they're seeing.

For that Ontario intensive treatment pathway, what we will see is not just an increase in service, but really the children getting the right kind of service. Because, right now, you could have 12 people access the service—I'm just making a number up; it could be 1,000, whatever the number is—but not all of those children should be in that service. They should be in something else that's more suitable to the treatment they require. So that following year, it might go down, but it is the right people getting the right access to the right service in that space.

Ms. Lee Fairclough: There will be a quality measure for that, presumably.

Mr. Kyle MacIntyre: That's right.

Ms. Lee Fairclough: That's great.

How am I doing for time?

The Chair (Mr. Tom Rakocevic): You have 11.5 minutes remaining.

Ms. Lee Fairclough: That's wonderful.

So then I guess my other question is really around the data. I just wanted to pick up on the theme of the data and making sure that we are developing out the systems that we need. I think sometimes this is a challenge for agencies when they're not funded, to be able to support those data systems and data collection systems and support the standards themselves. Does part of this plan include funding some of that infrastructure for these agencies?

Mr. Kyle MacIntyre: Yes, that's right. So a couple of different themes: We've invested over $4 million over the last two years to support more of the children and youth mental health providers to come on to the business intelligence unit. That funding also goes towards things like replacing—so that they're on a compliant system for them to send us data and for us to receive the data. That also comes with an investment of quality, so giving them some support to improve the quality of the data that they're sending as well. So that will continue.

I think the biggest, more transformative space for this is around that data digital initiative from the Mental Health and Addictions Centre of Excellence that I was talking about around the standardization of the data set itself and then funding that goes towards them being able to get compliant systems and on to that process. It is, as you understand, quite a transformative process and something that will take time to be able to do that.

I think the last stats that we had from the centre of excellence, the number of organizations that have onboarded or are plan to be onboarded, it's about 90% of the funding space that they're on. So a lot of progress is being made on that.

The children and youth sector is going to start a little bit after the adult sector, in part for two reasons: (1) we already have a data system that we are able to collect information and data from the children and youth space; and (2) we wanted to make sure that the adult space and the addictions space were starting to get onboarded—that's also where the majority of the money is relative to the different programming—and to be able to learn from that approach that's happening.

Working with this Mental Health and Addictions Centre of Excellence, we're on track to start onboarding children and youth mental health providers onto that data digital initiative, meaning they'll come on a compliant system, that they'll be submitting data toward a provincial data standard, starting next fiscal year. There has been some trial work already under way. We're working with four pretty large providers just seeing if there's any additional issues that we need to manage because they're transitioning on and they're coming from a different space.

One of the most important things that we're making sure that happens is that, as we're building up the children and youth mental health centre onto the data digital initiative, we're not losing the data that we're collecting from the business intelligence unit solution or the Transfer Payment Ontario solution. We want to be careful that

we're not creating too much burden for the providers themselves and that we're not losing the data that we actually have, so we want to do that in a thoughtful way.

Ms. Deborah Richardson: Maybe just to add: We do spend $2.1 million just for the BI right now, and as ADM MacIntyre said, we will be transitioning it to the broader system. So we are investing money right now to help service providers.

Ms. Lee Fairclough: And that will fix the issues around different definitions on wait times and all of these other—

Ms. Deborah Richardson: You got it.

Ms. Lee Fairclough: —a few of the other things that came out in the report.

Mr. Kyle MacIntyre: That's right. That provincial data standard should be defining not only the data you're doing, but how you describe that data, which would require the providers to work in a way that meets that definition. So that will be across the lifespan, across all the children and youth mental health providers, but also all the adult and addictions providers as well.

Ms. Lee Fairclough: How much time do I have now?

The Chair (Mr. Tom Rakocevic): You have just under seven minutes.

1440

Ms. Lee Fairclough: Okay, great.

There has been a lot of discussion today about the centre of excellence, and then in the report there's a lot of discussion about the oversight, the role of the Ministry of Health—and also the benefits around that transitional-age youth into the adult system. Are you looking for the child and youth mental health system to be led in more of a similar way out of the centre of excellence, for the adult system? Sorry, I'm tripping on my words here.

It feels like, from the report, I'm sensing there's still confusion on where the direction is coming from and where the accountabilities lie. Is the idea here that we'll transition that accountability in more of a model to the centre of excellence and the relationship that health care providers have with OH?

Ms. Deborah Richardson: Those are the options that we're looking at, but as you know, there are two pieces of legislation, so we need to make sure that there's legislative authority to do those things. I think that as OH has really developed the centre of excellence—it's awesome—but we're still kind of working with agencies on placing children and doing different things, right? And that's a legislative responsibility that we have, so we have to figure out how to give policy options to how you can do that and streamline it and move it over to one. But I think it does make sense at one point. We're slowly getting there and we're building as we bring forth those changes.

I don't know if it would be helpful to talk about CIHI when we're talking about data, so I don't know, Kyle, if you want to—

Ms. Lee Fairclough: Some of the discrepancies.

Mr. Kyle MacIntyre: Yes, I'll just answer part of it and then get into CIHI.

As the deputy said, there's two different constituting legislations that manage both the authorities and the role in the children and youth mental health space: the Child, Youth and Family Services Act and then there's the Connecting Care Act for Ontario Health and the centre of excellence, definitely moving towards making sure that there is a lifespan approach about collecting data, monitoring a person going through the system to help manage transition-age and the like, for sure. Again, we've sort of outlined the approach and what's happening on that front.

But there are special and particular things that we want to make sure happen in the children and youth space that is different than adult. They're much more vulnerable people, different age group. There are requirements under different acts that treat children and youth up to the age of 18 differently than they would be as an adult, so we want to be thoughtful about making sure that we're capturing them.

But we work with both the centre of excellence and the lead agency consortium as well and are thinking through what kind of additional governance mechanisms we can do to make sure that we're looking at things across the lifespan, including the establishment of a core services framework, for example.

With respect to that CIHI-related data that was identified in the report, I think the Auditor General made a recommendation. I won't say it exactly, but it was around two different things. One is maybe move towards a paying Canadian indicator for wait times, in this case particularly around counselling, and then there was an observation around making sure that, as part of that indicator, you're looking at being consistent in how you measure a wait time. There's a CIHI indicator right now that only four provinces are actually reporting fully into; the remainder of the provinces, like Ontario, are partial or incomplete. That's one observation.

The data that we pull and the indicators that we report on internally to ourselves around wait times is the average wait time for a person waiting for a core service like counselling or something like that. What the Auditor General's report said is, take a look at when someone is counted as coming into the system and take a look at when they're counted as leaving the system. And so, in the business intelligence solution, it looks at when someone enters—

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

Mr. Kyle MacIntyre: —the wait time part of the spectrum and then when it leaves the wait time. What the Auditor General's report said is maybe look at the referral piece and then when they start to service, which is sort of what the CIHI indicator said. When they identified that in the report it looked like if you used the process for the CIHI side it might add a little bit more time in terms of the wait time. But if we were to use the CIHI process and their actual indicator, they use the median wait time data. So if we were to look at the wait time data on the median scale for the CIHI it would be 25 days, as opposed to I think what was in the report, 120 days. So if anything we're

over-reporting if we use the median CIHI data. So that's something that we're looking at. We are able to take our data, use the process that CIHI uses for that indicator and submit to CIHI in that way.

Eventually what we want to do, to your question, is move towards a consistent lifespan approach, perhaps using the referral and then leaving service as a way of measuring that. But that work, we want to make sure that that's happening with DDI—that digital initiative—led out of the Mental Health and Addictions Centre of Excellence as well.

Ms. Lee Fairclough: Thank you. I do have more questions around concurrent disorders and access to those, but I'll leave those for the next session.

The Chair (Mr. Tom Rakocevic): We're at 30 seconds left, so—

Ms. Lee Fairclough: Oh, I still have 30 seconds? Okay. So maybe I will quickly ask, and maybe we can come back to it. I do think that we talked a lot about a pretty significant gap in concurrent disorders and being able to support people that have got mental illness and some kind of substance use challenge. Maybe I'll just seed that now, knowing that I'll come back to that in my next session.

The Chair (Mr. Tom Rakocevic): We're at time.

We're now moving to the official opposition, beginning with MPP Lennox.

MPP Robin Lennox: In the report the vast majority of child and youth mental health agencies reported difficulties with recruiting and retaining staff, and 87% reported that this was largely due to wage disparities between the amount that community child and youth mental health workers are paid when compared to those in the hospital or education sectors. Is the ministry committed to addressing these significant wage disparities in order to address this shortage of clinical staff? If so, how much new funding was dedicated to addressing these wage disparities in this year's budget?

Mr. Kyle MacIntyre: Thank you for the question. Just maybe a couple of points: One, the investments that have happened since 2019 have increased. It's $800 million in new base funding. That doesn't include one-time funding generally. If you add that up, it's certainly well over one billion new dollars into the community mental health space since 2019.

In 2019 the government had a 5% across the board for the children and youth space. In 2023 it also had an another 5% across the board, and in this budget this past year there was a reference to an additional $303 million over four years, which amounts to a 4% increase to the sector as a whole as well. So since 2019 there's been over 14% in the number across the boards in investing in the children and youth mental health sector programming on top of additional funding just generally around programming as well.

MPP Robin Lennox: If I may clarify, the $800 million was for both the child and adult mental health sectors? Only $200 million actually went to child and youth mental health?

Mr. Kyle MacIntyre: An additional $200 million.

MPP Robin Lennox: Yes, since 2019?

Mr. Kyle MacIntyre: That's right.

MPP Robin Lennox: Those increases that you mentioned, 5% per annum or 4% per annum, are just barely above inflation. These wage discrepancies that are being described are in the range of 20% to 50% below those in the acute sector, in the education sector. How do you expect child and youth mental health agencies to try to match when we're only giving them a fraction of the disparity that they're facing in terms of wages currently?

Mr. Kyle MacIntyre: I think a key component of that, in response, is one of the recommendations that the Auditor General identified, which is the need for a health human resources plan for it. The ministry has accepted that recommendation, and the Ministry of Health has over the last while developed a health human resource plan that looks at education expansion and clinical supports, scope of practice, looking to see if others can also support providing care, different pathways to international practitioners and looking at different ways for retention and distribution. There's a need to bring the mental health and addiction sector more into that, and so we're starting to look at opportunities to be able to do that, mindful of the compensation issues that you've raised.

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MPP Robin Lennox: Thank you so much.

In their 2020 report, Children's Mental Health Ontario called for an additional $150 million per year to be able to hire the amount of staff they would need to reduce the wait time to counselling within 30 days. The amount of investment that you're describing falls quite short of an additional $150 million per year.

How does the ministry reconcile that shortcoming? And what is the ministry's intended wait time for first point of counselling and how are you going to get there?

Ms. Deborah Richardson: I can maybe start on the HHR one. We have been developing a health human resource strategy just globally and we want to do it more specifically for the area of mental health and addictions. We haven't done it specifically, so that's kind of our next order of business that we're going to be working on.

We work closely with the Treasury Board to conduct a workforce data survey, in partnership. Some of the things you pointed out—those are what the sector is telling us as well. We need the be able to assess compensation gaps—all of those things as we develop our HHR strategy, health human resources strategy. We need to explore workload guidelines and retention, some of the things that you spoke to.

We have done some things, like building the capacity that we spoke to around the training for the 2,200 existing technicians, just to start to give them some additional tools in the space. There's a lot of work to be done and we definitely want it as a part of our broader HHR strategy. We need to have it specifically for mental health and addictions.

MPP Robin Lennox: Great, thank you.

In the report, the Auditor General identified an agency in northern Ontario which, over two years, advocated for the development of a secure treatment program to better meet the needs of children and youth in northern communities; to support children staying engaged with their communities and their families while meeting that secure, intensive treatment. The AG identified that there was no action taken on this proposal from the ministry and there's still no access to these programs in the north.

When you spoke about your new Ontario intensive treatment program, you spoke about that $22 million going towards live-in treatment but not secured treatment programs. When can communities in the north expect an investment to fill that gap of secure treatment programs that they've been asking for for several years?

Mr. Kyle MacIntyre: As part of that $22-million investment, part of it will allow us to understand where there are gaps in the system. In the north, we know that there have been some providers who have identified the need for potential secure treatment. One of our Indigenous providers, Dilico, has raised this as a potential issue in the past. While it wouldn't technically meet the need of what we describe to be a secure treatment program, the OITP will allow us to be able to identify those opportunities for more secure treatment programming, for sure.

We have been working with the existing providers right now to develop a framework so that they're providing consistent approaches to accessing care. That's one thing. And there has been investment for government to expand the number of secure treatment placements in the provider out in eastern Ontario and Ottawa. So there is some expansion that is under way, but we know that there are opportunities to assess for more need, for sure.

MPP Robin Lennox: Thank you.

Speaking more on the issue of concurrent disorders in terms of concurrent mental health and substance use disorders, 70% of the agencies surveyed reported that their services do not meet the needs of youth with concurrent mental health and substance use disorders. At the same time, we've seen that rates of opioid-related deaths among Ontario teens and youth have tripled between 2014 and 2021, and rates of treatment initiation in that same group have actually only gone down markedly.

What is the ministry doing to address that gap and prevent opioid-related deaths and other substance-related harms among youth with concurrent disorders in Ontario?

Mr. Kyle MacIntyre: I think that I might take parts of your question the next go round.

I would say that the children and youth mental health program is focused on seven core services; addiction isn't one of them. Most of the addiction programming comes from Ontario Health, so we have a different funding line that's associated with supporting children and youth addiction-related programming. So there are different investments that are under way.

The gentlemen over here raised youth wellness hubs as an opportunity, and the deputy spoke a little bit about that. Part of that is the expansion to 32 youth wellness hubs. We have 23 that are operating right now.

We also invest in programming—things like PreVenture, which is an evidence-based prevention program that targets children and youth who might have known risk factors for substance use. It is rolled out in schools through community organizations and also youth wellness hubs. I think we're at 28 school boards right now, focusing on grades 7 to 9, and I think it's expanding more. That's more on the prevention side of things.

And then there's other programming that we have that is also maybe considered transitional-age youth as well. Amani, which focuses on Black youth, also has a substance use focus for that specific population, so there's additional funding and programming that goes towards that as well for folks with concurrent disorders.

MPP Robin Lennox: I did recall that you mentioned youth wellness hubs initially as providing evidence-based addiction treatment, but I wonder what you consider evidence-based addiction treatment that is currently delivered at youth wellness hubs?

Mr. Kyle MacIntyre: The program itself is part of an integrated youth services model that is actually happening across Canada. It's actually a big programming focus of our federal, provincial and territorial organizations, and also a big focus of the federal government in terms of funding—what have you.

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

Mr. Kyle MacIntyre: The program is based off of that integrated youth model and is supported by a number of data. It is run through a backbone organization called Youth Wellness Hubs Ontario, which sits out of CAMH and is being led by Dr. Jo Henderson—very well-known in the children and youth mental health space.

They use a number of clinical assessment tools, and it is very data-oriented. It engages each of the youth along the way with surveys, including surveys when they leave the service. They use the best clinical knowledge to support children and youth with substance use disorders and in a measurement framework as well.

Ms. Deborah Richardson: If I could just add, there are a couple of other programs that I think are important that touch on what you were trying to get at. We've got the Ontario Structured Psychotherapy Program, which offers cognitive behavioural therapy for youth aged 15-plus with depression and anxiety, often reoccurring with substance abuse. A lot of times, people will use to ease the symptoms of what they have in terms of their anxiety and depression—so they've got cognitive behavioural therapy skills.

Kyle spoke about the Amani program for Black youth, which has been a really good program. It's a culturally responsive program for Black youth aged 12 to 29, which includes integrated mental health and substance abuse services.

I spoke about the Step-Up Step-Down programs earlier as well—that would kind of touch on that demographic as well, to support youth with complex needs that require stabilization either before or after hospital care.

Then we did speak about the cross-sector protocol development, because you can't operate in a silo. What's

happening on the child welfare side, what's happening in the school—we need to have that protocol, which is what we're working on as well.

Those are other kinds of tools that we're pulling all together.

Mr. Kyle MacIntyre: Just maybe some extra data points on the youth wellness hubs themselves: There have been studies published in the American Medical Association journal that show that these youth wellness hubs are diverting children and youth away from the emergency department into the community. They're seeing the same levels of improvements in the community mental health space as they would in an outpatient hospital program as well.

We're seeing something like 39% of the youth that have access to youth wellness hubs in Ontario right now say that, without that service, they wouldn't know where to go. We've got a 99% youth satisfaction rate of the services they have received from the hub themselves. They find 98% of them are saying that it's the right way of helping that they need, and 90% of youth are satisfied with the length of time that it takes to get the service that they're in there, so a lot of really positive metrics in terms of both the outcomes and how they are receiving the service in youth wellness hubs. I think we've had almost 365,000 visits up to March 31, 2025, so I am sure more have happened there.

1500

MPP Robin Lennox: Thank you, and I agree. I think youth wellness hubs provide a fantastic service, but they historically have not actually provided the full flight of evidence-based treatment for youth with substance-use disorders. Most often, we're seeing those youth being referred from youth wellness hubs to adult-focused services to access opioid-agonist therapy, for example, and other medication-based services.

Is there any effort within the ministry to adapt to the ongoing substance and toxic drug crisis that we're seeing in Ontario and actually expand the offerings of the youth wellness hub to match the needs that we're seeing among our youth, who are increasingly using substances that create more harms and increase the risk of death?

Ms. Deborah Richardson: There are definitely referral pathways for OAT from the hubs. With the youth wellness hubs, the whole goal is almost like one-stop shopping because you can get somebody in, and then you can refer them or bring them in. I think that is what's happening within. They're creating a whole network. All of the hubs also have primary care. They have access to primary care, so they are able to have physicians who can prescribe. That's why primary care connecting into that was so important.

Mr. Kyle MacIntyre: To develop your point, it also isn't a place to get all care. If you need withdrawal management services, you're not going to go to a youth wellness hub; you'll go to a different provider. We have a number of providers that do provide live-in treatment for children and youth, so there is opportunity for pathways into that for sure.

MPP Robin Lennox: Great. Thank you.

We know that the child and youth mental health sector has been drastically underfunded in recent years. Actually, over the past 20 years, the funding has been sort of based on historical allocations, as the auditor identified, which has meant that some regions are receiving far too little and can't offer the programs the communities need. What action has the ministry taken to address this? Are we able to move to a needs-based funding model, and on what timeline are you anticipating that might happen?

Ms. Deborah Richardson: There's been an increase of close to 30% since 2019-20, so there's been a pretty significant increase in terms of the budget.

MPP Robin Lennox: Is that accounting for inflation or not?

Mr. Kyle MacIntyre: It would be just the envelope-to-envelope increase, yes.

Ms. Deborah Richardson: Yes.

Mr. Kyle MacIntyre: So there has been that increase. There's also, then, additional programming. We talked about Step-Up Step-Down, for example, and adding new programming there. We've also added programming that, irrespective of where you are in the province, you can access without any wait times. One Stop Talk is a really good example of that brief service access to that.

We've also invested in different programming like Telemental Health, which allows access, no matter where you are, to a psychiatrist in order to get an assessment and referrals. And we've heard a little bit about the Ontario intensive treatment pathway; we've set up a network for intensive services for that.

A key component of what we're working towards is the establishment of a core services framework for across the lifespan. Right now, we have a core service framework that's for children and youth. We've engaged with a technical table with a number of clinicians and providers across the care continuity, whether that's children and youth mental health or on the adult and addictions space, to be able to get advice about what the core services are from a lifespan perspective that we should be establishing.

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

Mr. Kyle MacIntyre: We're working through the technical advice that we've heard from the table to be able to identify for that care continuum, irrespective of if you're a child or youth or into adulthood, what should be the expected type of services that you may be able to have access to. When you take that information and you map it onto some of the work that we're doing in the data digital space—which is able to, say, map different assets across the province of what providers are providing what service in what way—a step is to make sure that we understand those services, make sure that we're speaking apples-to-apples about those services. You might say counselling is one thing, another person might say counselling is a different kind of thing—so being able to understand that.

Through the establishment of that core services framework and that work that we talked about from the data digital collection, we will be able to better understand, across the lifespan, the different services that might be

required—for children and youth is what we're talking about today, but just in general, for mental health and addictions.

Ms. Deborah Richardson: If I can maybe just give you the specifics on the numbers as well: It's way more than inflation, obviously, at 29%. In 2019-20, the initial printed estimates were $406 million. Then in 2025-26, it was $526 million, which was the initial printed estimates, which is a 29.6% increase.

Mr. Kyle MacIntyre: And that wouldn't include, more recently—

Ms. Deborah Richardson: It doesn't include the 4%.

Mr. Kyle MacIntyre: —the $303 million over the years, as well.

MPP Robin Lennox: Great. Just returning to that question about the needs-based formula: Is there movement towards a needs-based formula rather than looking at the more historical allocations?

Mr. Kyle MacIntyre: The use of the historical allocations—yes, there was a sense of base funding for particular organizations some years, but that has changed over time. At the time of the report, there were 220 or thereabouts providers. Now, there's slightly less than that, so we see reallocations happening all the time. We work with the lead agencies on reallocations, as their new pro-rate comes up, in understanding who might be better to deliver that service—

The Chair (Mr. Tom Rakocevic): We're at time.

Mr. Kyle MacIntyre: So there is reallocation and looking at services pretty constantly.

The Chair (Mr. Tom Rakocevic): We move to the final round of questions, beginning with the government side. We're beginning with MPP Cooper. Please begin. You have 20 minutes in total.

Mrs. Michelle Cooper: From fast-tracking cancer drugs to opening HART hubs, the government has been implementing a number of innovative solutions to bolster our health care system. Can you outline some of the innovative steps the province is and has taken to support the mental health and well-being of children and youth in Ontario?

Ms. Deborah Richardson: Thanks so much for your question. This is a really good conversation, actually. I'm really enjoying—I wouldn't say I thought I would enjoy SCOPA, but I do, because it's important. It's important for those of us that have young people in our lives. We're really aware that the experiences of children and youth today are vastly different than it was 10 years ago. Two of my kids graduated from high school during COVID. It has really changed things, and we need innovative solutions to effectively serve children and youth and families today.

The Roadmap to Wellness is Ontario's plan to build a comprehensive and connected mental health and addiction system that delivers high-quality, evidence-based services across the care continuum and across the lifespan. Roadmap to Wellness was developed from consultations with hundreds of mental health and addictions organizations, front-line staff, hospitals, advocates, experts and people with lived experience. The plan will help improve mental health services for communities across Ontario and support patients and families living with mental health and addiction challenges.

Built on the four pillars that we spoke about, the road map lays out a path towards meaningful improvements to the care Ontarians receive, enabled by the $3.8 billion over 10 years that the province is investing to expand mental health and addiction services. The plan's four pillars support the delivery of the services people need, where and when they need them. These pillars are improving quality, expanding existing services, implementing innovative solutions and improving access. To help achieve the goals of the road map, more than $800 million in new base funding has been invested since 2019-20 to maintain and expand mental health and addiction services across the province. A significant portion of this new funding has been invested to support the third pillar of the Roadmap to Wellness, which is implementing innovative solutions.

The Ministry of Health has been investing in new, innovative, evidence-based programming. I spoke about this a little bit earlier—it was the Ontario Structured Psychotherapy Program, to provide access to evidence-based cognitive behavioural therapy for people living with depression and anxiety.

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Cognitive behavioural therapy is recognized as an effective intervention for depression and anxiety, the most common mental health issues to impact Ontarians. It builds resilience by equipping people with the lifelong skills they need to manage their mental health and overall well-being. It can lower the number of emergency department visits and admissions in Ontario, contributing to the broader provincial objective of ending hallway health care.

The Ontario Structured Psychotherapy Program is the first of its kind in Canada in terms of its scope, scale, focus on quality and public reporting on outcomes. There are no out-of-pocket costs for clients who participate in the program. The program is offered in various forms that best meet a client's needs, including telephone coaching and clinical counselling, psychoeducational groups, Internet-based cognitive behavioural therapy and face-to-face group and individual counselling. Youth as young as the age of 15 can access this programming to support them in dealing with anxiety and/or depression. Since launching in 2017, over 100,000 patients have benefited from the program.

Demand for mental health services across the care continuum has continued to grow, placing a strain on the service system and impacting access for clients. To address and build off the success of implementing programming like the Ontario Structured Psychotherapy Program, the Ministry of Health has implemented several innovative programs aimed at enabling timely intervention by providing low-barrier access to mental health and addiction services.

One such program—and ADM MacIntyre spoke about this—is One Stop Talk/Parlons maintenant, which launched provincially in September 2023. This program was developed by the provincial lead agency consortium in

2019 and under the leadership of Strides Toronto support services, the lead agency for the Toronto service area. With the continued support of the consortium and other sector partners, it has become a key provincial resource for children, youth and families. One Stop Talk/Parlons maintenant successfully leveraged provincial technology investments made during the pandemic to offer virtual access to immediate, in-the-moment, evidence-based, single-session therapy for children, youth and their families.

The service is available to any child or youth, no matter where they live in the province, and it's available in more than 200 languages and dialects, including—Kyle spoke about this—American Sign Language. It's a free, confidential service that lets children and youth get immediate mental health support with a registered therapist. And there is no wait time for this service, which is amazing, because when you're feeling like you want to talk to someone, you want to talk to somebody.

The One Stop Talk model was informed by research as well as the voices of those with lived and living experience. Unlike traditional therapeutic models that may span weeks, months or even years, One Stop Talk offers an immediate opportunity for clients to derive meaningful benefits from just one meeting with a clinician, similar to a walk-in-service model of primary care. This One Stop Talk/Parlons maintenant model enables equity of access for individuals right across the province and leverages capacity among child and mental health service providers across the province as well.

Clinicians providing services through One Stop Talk/Parlons maintenant are rostered from agencies across the province and are available to any child or youth in the province, no matter where they live. Kyle gave the example of Windsor being able to service somewhere in the north. This means a 16-year-old in Sault Ste. Marie can access evidence-based counselling from a clinician in Toronto without having to leave their community and their home.

One Stop Talk is a team of therapists who are registered health professionals, who can provide psychotherapy services. They are experts in giving focused help in a single session. They regularly undergo reviews and meet with supervisors to make sure they're offering the best care. The program also has a continued focus on improvement and skill development of the team.

Here's how it works. Children and youth and their parents can access the service by phoning the dedicated line at 1-855-416-TALK—8255—or they can access services online at onestoptalk.ca. It starts with a greeter and welcoming, and questions are asked to better understand the child or youth's needs. Then the child and/or parent is connected to a registered therapist, in under five minutes, for a session. Sessions are always free and usually last up to one hour.

During the session, the therapist will talk about what the child or youth is going through and feeling. Then, together, a plan will be developed to help the child or youth move forward and feel better. If additional or ongoing services are needed, the therapist will offer to connect the child or youth and/or parent with a One Stop Talk navigator that will connect them with services within their local area or other appropriate services that they may need. Before the session ends, a referral will be made to connect that child with what they need.

There is no limit on the number of times a young person can access the service, and it can be accessed anywhere in the province. For children and youth and their families, this means that access to service can be just one phone call, text or a web click away.

Numerous studies have evaluated the efficacy of single-session therapy, particularly in comparison to longer-term therapeutic interventions. While single-session therapy is not a replacement for ongoing therapy in complex cases, evidence indicates that it can be highly effective and all that's required for certain client populations and presenting issues.

In the face of growing demand, pressures on the mental health care system, One Stop Talk/Parlons maintenant is also an effective wait-list management tool, as it takes people off the wait-list whose needs are less intensive or complex and can effectively be met through a single-session counselling model. Again, there are no wait times for this service. For those who require additional services, it does get them to the right service without having to call around to different providers, navigate the system themselves and potentially be put on a wait-list for the wrong service that they don't need.

Since its launch, the service has seen a steady increase in usage numbers. Within two years of the provincial launch, there have been more than 47,000 connections with One Stop Talk/Parlons maintenant. These are people reaching out to learn more about the service, either for themselves or, frequently, for their children. It also represents children or youth who might have a mental health related question but are not yet ready to participate in counselling. Since the launch, there have also been almost 4,500 completed clinical sessions.

The Ministry of Health also supports the child and youth mental health sector to adopt innovative models of care, leverage research to design services and build awareness of emerging evidence to inform high-quality care by funding the Knowledge Institute on Child and Youth Mental Health and Addictions at the Children's Hospital of Eastern Ontario.

The Knowledge Institute is a key provincial expert partner that mobilizes the most current evidence and knowledge and provides system supports to the children and youth mental health and addiction sector. They work closely with lead child and mental health agencies and the broader community-based child and youth mental health sector to make services more responsive to the unique needs of children and youth, easier to navigate and better integrated with services and supports in other sectors. The Knowledge Institute also works with service providers to build sector capacity to deliver high-quality services. This includes working with the sector to implement evidence-based practices, to meet and respond to the changing needs

of children and youth and families, and to implement data collection solutions to measure activities and outcomes.

The Knowledge Institute is leading the development of quality standards for the children and youth mental health sector, with a current focus on live-in, intensive services. These standards will provide evidence-based guidance to providers across the province and support them in keeping up with innovative solutions.

In recognition of research that has consistently demonstrated that the early years of a child's life—especially from zero to six—are extremely important in terms of brain development, the Knowledge Institute has also begun to focus its efforts on opportunities to enhance supports for early and infant mental health, including an integrated care pathways project.

The Ministry of Health is also using technology to empower children and youth to access information about mental health, addictions and related services through the funding of Resources Around Me. Resources Around Me is operated by Kids Help Phone, an organization that is well known and trusted by children and youth across Ontario and Canada.

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Resources Around Me is a powerful, searchable directory of over 40,000 free, trusted virtual and in-person mental health, addictions and related services. It empowers children and youth to seek services to meet their needs, and it helps them navigate the mental health, addictions and complementary human service systems.

Finding the right support can be a barrier for youth. Resources Around Me helps them find what they need, whether it's an in-person youth wellness hub, a sexual health clinic or support for a specific issue like housing or substance abuse.

Kids Help Phone ensures the resources listed have a high level of clinical oversight, so that children and youth know that they are accessing safe and well-researched options. It's available 24/7 through their website. This tool provides an instant connection to support options and it has become one of the most popular pages on the Kids Help Phone site.

The ministry also has committed to funding to St. Clair Child and Youth Services to support an innovative mental health program for children and youth in Lambton county, an intensive outreach treatment program. This is a three-year pilot aiming at providing flexible and accessible mental health services to meet specific local need.

Over the past year, St. Clair has been collaborating with local agencies and other stakeholders and partners to better understand the local needs and identify a model to address young people with more complex mental health needs, because the community saw a 25% increase in children and youth with complex mental health needs over the past four years.

An intensive outreach treatment program will deliver individual therapy, family therapy, social skills training and parent-caregiver coaching in clients' homes, making services more accessible and personalized. This holistic approach will integrate services across health, education and child welfare sectors, providing a seamless and coordinated care experience. The program aims to treat children and youth with complex mental health issues, offering intensive services to prevent the worsening of their conditions. Intensive case management will ensure smooth transitions and continuous support, helping families navigate the mental health system effectively.

The integration of support through partnerships with multiple service providers is a key component of this model. This will include the launch of a newly developed, enhanced mental health respite program, delivered by Sarnia-Lambton Rebound, along with specialized education supports offered in partnership with the Lambton Kent District School Board.

The intensive outreach treatment program also provides an evidence-based assertive community treatment approach, like the adult program operated by Bluewater Health, providing intensive services in home and community settings to reduce the severity of issues.

This program is aligned with the Roadmap to Wellness and the strategic goals of the Sarnia–Lambton Ontario Health Team, aiming to reimagine community-based care and create healthier communities through an integrated and innovative approach. By reducing the need for high-cost institutional programs and decreasing reliance on emergency hospital services, this program is expected to significantly enhance the mental health landscape for youth in Lambton county. This intensive outreach team program is a significant step forward in ensuring that children and youth receive the support they need.

I just want to share another similar innovative, collaborative initiative that the ministry is supporting. It's a multidisciplinary intensive services team pilot led by the Youth Services Bureau of Ottawa, in partnership with the Children's Aid Society of Ottawa. This initiative is also being piloted in the adjacent services of Stormont, Dundas and Glengarry through a collaboration with Cornwall Community Hospital in Prescott and Russell, in collaboration with Valoris pour enfants et adultes de Prescott-Russell.

A number—13—child and youth mental health agencies are being engaged to support this pilot initiative, alongside other community partners, including children's aid societies, school boards, hospitals, primary care and police. This initiative is designed to offer an innovative approach to deliver intensive mental health treatment to children and youth served by the society with complex needs, including dual diagnoses and those who face barriers to timely and appropriate intensive mental health treatment.

The initiative includes a dedicated pathway for Children's Aid Society of Ottawa clients—

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

Ms. Deborah Richardson: —through a one call, one click, centralized access mechanism for children and youth services in the Ottawa area. This facilitates screening, intake and initial assessment for the service.

The initiative also includes care coordinators who work closely with clients and caregivers to create an integrated care plan that aligns with the client's needs, connects them to the services needed and provides immediate, on-the-spot clinical support as well as all of the other service connection points.

The initiative offers a range of specialized services, including in-home services, delivered by a multidisciplinary team—or "pod," as they refer to it. These services can be accessed depending on each client's needs. In addition to the care coordinator, the pod includes psychotherapists, psychologists for assessment and treatment, behavioural specialists for assessment and treatment, addictions consultants, occupational therapists, caregiver capacity-building, mobile crises response, trauma and attachment therapy, children and youth mental health therapy groups and mental health and addictions nurses.

Positive outcomes are already being reported through the children who have been going through this pilot. This pilot reduces service silos, increases partnerships and collaboration among service providers, which means that usage of publicly funded resources are being optimized. More cost-effective community resources are being used, where appropriate, where more specialized services are accessed. The initiative has improved client mental health and well-being through seamless and wraparound care and improving stabilization of living environments, including preventing child welfare placement disruptions.

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

We now move to the third party. MPP Fairclough, you have 20 minutes.

Ms. Lee Fairclough: I'll say I have four questions that I want to ask so maybe we can just judge the response times accordingly with that.

I want to start by saying I think that—you highlighted the Ontario Structured Psychotherapy Program in your response, and to me this is a great program. This is a program that should be what we're aiming to do to address the recommendations throughout this report. We know it's accessible to people; we know that we're measuring whether the program actually improves their outcomes; we know that there's transparency among all the providers around how we're doing from a performance perspective in that program. As I said, I think really, really importantly, people are able to self-refer, be assessed quickly and get connected to the right services. I do just want to say it's a good example of what we should be targeting in all of our mental health programs. I don't think that we've developed things to the same degree in other areas.

I do just want to come back, first of all, around the concurrent disorders and addictions. If I heard you correctly, you said that that's sort of funded out of a separate line of funding. But I am interested because in the report itself, 70% of agencies said that they don't feel that the services today currently meet the needs for concurrent mental health and addiction disorders for youth. I just wondered, again: What's going to be the plan to really close that gap, as part of this? One in five kids are trying an opioid before the end of high school. I'm a mom of teenagers too. I think that we know where our kids are at these days, and unfortunately, I'm quite concerned this is going to be an even more pressing need.

Mr. Kyle MacIntyre: Yes, thank you for the question. The previous question that touched on this topic focused on at least three different programs that we're focusing on: There's the youth wellness hubs side of things, there's—

Ms. Lee Fairclough: Yes, but there's limited concurrent, right, in it? That's what I heard from your comment. Am I correct in that?

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Mr. Kyle MacIntyre: Well, there are going to be 32 hubs.

Ms. Lee Fairclough: Yes.

Mr. Kyle MacIntyre: The youth wellness hubs themselves don't provide the full care continuum related to addiction services.

Ms. Lee Fairclough: No.

Mr. Kyle MacIntyre: So for instance, as I described, you're not going to go to withdrawal management if you're at any youth wellness hub, and that's not the intent. The—

Ms. Lee Fairclough: I think the big gap, if I understand from this—sorry to interrupt you—is actually around quite intensive concurrent treatment for people with mental illness who also have substance use.

I can say this, too that I think this has been supported by data: I've had four families in my office in the last six weeks telling me their stories about not being able to get this care for their teenagers, 15- or 16-year-olds. So I think it's great that we've got something starting, but I really was a little concerned with the response, which is that addictions is kind of funded over here, so it won't be part of this plan. I feel like the agencies are telling us they don't think it's there either. The families are saying it's not there.

Mr. Kyle MacIntyre: Maybe I can just spell it out and speak to it in a way that's more clear. The government invests different funding for different kinds of programming across a number of different kinds of programs. All I was saying is that the children and youth program doesn't include addictions funding specifically. That doesn't mean that there isn't addictions programming or funding for children and youth mental health. It was just that it was outside of the audit, was my point that I was trying to make.

Ms. Lee Fairclough: Oh, okay.

Mr. Kyle MacIntyre: Included for children and youth mental health addiction related programming that is out there, we did talk about youth wellness hubs. Amani is another one. I did talk about PreVenture. There is a number of programming that happens at schools as well, more on the preventative side of things.

Youth wellness hubs do, though, offer referral pathways into different programming. I think we have four or five live-in addiction treatment programming for children and youth up to the age of 18—so live-in, bed-based services for folks. Some of the HART hubs, which you

might have heard of—the homelessness and addiction recovery treatment hubs—there are going to be 28 across the province. Some of them do actually focus on that population of children and youth. Guelph has a focus on that, supporting folks in addictions and treatment itself.

I think more broadly, the systemic approach that's being undertaken was identified as part of the report in terms of when they reference the core service framework and make sure that you have a children and youth addiction core service. As part of that work that we've talked about is that we've met with a technical advisory group, including addictions specialists, children and youth providers, adult providers, and we're taking a care continuum approach to that. So because we're focused on the community side of things we're really—this is sort of a technical answer—focusing on the level 2, the level 3 and the level 4 severity for children and youth, so the acute sector sort of sits outside of that, more connected on full pathways on that way.

As part of the development of the core services framework, some of the technical advice that we've received from those providers is to look across the early prevention side to the more intensive services side and build out more service in that space for children and youth addictions. That will include, as I mentioned before, the build-out of minimum standard requirements for that service. That work is under way to finalize some advice to government around the core services, but that will be a key component of being able to take the addictions care for children and youth as a care continuum approach.

Some of the things that we've heard today already are also around making sure that we have the right transitions in place when you're under 18 to 18-plus. The reason why I'm mentioning that is because the core services do take that lifespan approach, where we haven't done it in that way. So I'm really excited to being able to finalize that and work with the centre of excellence, the Knowledge Institute and the providers to eventually roll that out.

Ms. Lee Fairclough: Thank you.

My next question is related to the standards and the accreditation that was referenced in the report. Again, unfortunately, we've seen a few of these examples of organizations that aren't necessarily even operating to some of the basic HR standards that we need. We've seen situations, right? So I wanted to just ask about that more generally. There's a large number of these agencies in the province. What do you see developing in terms of just general organizational standards?

Mr. Kyle MacIntyre: I think the report did identify a substantial portion of the organizations do get accredited. It's not a requirement in terms of related to the funding. Don't quote me on that, but I think it was in the 80-plus per cent range, but someone could tell me that I've got that wrong. It's just not a requirement. So it is something that we will be looking at in terms of whether or not that is something to be able to do. But the space that you're talking about in the quality standards area is what we're tying to the core services work.

One area, for example, is the Ontario intensive treatment pathway. We will have standards in place for that that will go into the transfer payment agreements that we have—so the formal contractual agreements that we have—that we can monitor and put into place. As those core services get implemented, working with the centre of excellence, those minimum programs will be put in there and will be a key component not only to drive the quality aspect of it but the performance side of it as well and the accountability.

Ms. Lee Fairclough: Thank you.

Ms. Deborah Richardson: If I could just speak to that as well: There are transfer payment agreements, and agencies need to comply with the transfer payment agreements. There are guidelines and requirements for existing—so I don't want there to be a perception that agencies aren't professional or doing standards. Most of our agencies offer top-notch service and they do comply with our standards. Like Kyle said, we're going to build off of that, particularly the live-in standards. I think that will be really important.

But we definitely have confidence that most of the agencies are doing really, really great work. Many of us know them. They're in our communities. They don't make a lot of money and they're delivering incredible work.

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

Ms. Lee Fairclough: I do agree. I know many, many agencies that are providing really good work.

Ms. Deborah Richardson: And we have taken action. If transfer payment agreements aren't complied with, we unfortunately have had to do interventions.

Ms. Lee Fairclough: Yes, and again, I'm speaking just from the experience of parents reaching out that have had—it will be one agency or a small number that unfortunately cloud the rest of the field. But it's good to hear of the work that's happening.

My next question was really around just the coordinated access and the integrated care. There are some comments in here on how that could be digitally enabled, what some of those connections to the broader system could be. I just wondered if you had any comments on that. There was discussion on the use of the OHIP card as one of the foundations to help that. I just wondered if you had any comments about that.

Mr. Kyle MacIntyre: I think the report identified that there are a number of coordinated access programs that are already across the province. A review was undertaken a couple of years ago and I think we've identified over 100 already, not just in the children and youth space but in the adult sector as well. What there is a need for is to standardize that.

We do have some work that's under way around how someone accesses the system, get in somewhat of an assessment and then navigate to the next service if they need the next service. We talked a little bit about One Stop Talk, which does that work. So if someone accesses through the website or does a phone call, there are a few questions that are asked, then an assessment is done. At the end of that session—which is often at least an hour

long—if that child or youth requires another type of service, there's a warm hand-off and referral that happens in the moment to a provider who can do that service with all the information that's been collected through the conversation such that they know who to go to next and when. So there is a warm hand-off.

I think from a provincial perspective, one of the key components of work that's under way—that really is also tied to the data digital initiative—is the creation of a provincial coordinated access system that's happening out of the Mental Health and Addictions Centre of Excellence. So they're developing this, focusing on being able to systematize an approach such that no matter where you are there's a regional network access point and a provincial one to be able to do that. That is starting to roll out; there have been investments over the last couple of years to try to build that up and understand that.

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It's going to take a lifespan approach. It will include the children and youth mental health sector as well, so when people access that point there will be an assessment and a referral to a provider. What's great about that as well is they'll be able to help us with some of the other pieces of the conversation that we've had about collecting data into the Auditor General's report around being able to understand demand better. When someone comes in, that's a data point; when they get referred and we know that they're getting service, that's a data point. So the provincial data standard and the provincial coordinated access system will be able to help across the lifespan approach using the core services when they're rolled out to be able to measure all of that.

Ms. Lee Fairclough: Great. Thank you. I think my colleague may have other questions on that.

My last question is really in the spirit of true public accounts. I think that the report identified an outstanding transfer payment reconciliation that was needed for the 2023-24 fiscal year and a plan to recover those unspent funds. Did you want to just comment a little bit on what the plan is to do that?

Ms. Deborah Richardson: Sure, I'll dive into that one. So the ministry obviously is taking steps and making progress in completing outstanding reconciliations for the transfer payment agreements it oversees, focused on prioritizing reviews by fiscal year and programs with the highest volumes of outstanding reviews.

A transfer payment reconciliation is a process where the ministry works with partners that receive government funding to reconcile the funds we see with the actual expenditures incurred during the fiscal year. The reconciliation ensures that funds were used according to the terms of the transfer payment agreement and any unspent or surplus funding is identified and recovered. The results of the reviews also help the ministry assess performance and program effectiveness and provide information to support future decisions.

This process requires many steps, including the collection of information and ongoing communication between the ministry and its partners, to complete the reconciliation review. Oftentimes the number that is there isn't the actual number that comes back because there's a lot of reconciliation—literally. That's why it's called reconciliation; that needs to happen.

After the end of each fiscal year, transfer recipients are responsible for submitting detailed reports to support the completion of the reconciliation. These reports include both financial data, including final third-party audited financial statements and data outlining performance against service targets. Child and youth mental health agencies provide this information to the Ministry of Health through the Transfer Payment Ontario system—TPON, we call it—which is the centralized online portal used to manage transfer payment funding and agreements.

In these reports, agencies may report estimated unspent or surplus funding amounts. This information supports a detailed review by the Ministry of Health in dialogue with the agency to determine whether funds have been expended in alignment with the eligible expenditures and other requirements, as outlined in the transfer payment agreement. It's only when this review has been completed that the Ministry of Health can confirm the funds have been spent in accordance with the transfer payment agreement and determine whether a final settlement is required to recover any unspent funds. While a recipient may identify an amount potentially to be recovered in the submitted financial statements, recovery amounts may vary and can only be finalized after a review is finally completed.

The Ministry of Health has implemented a plan for completing outstanding reconciliations which has included adding additional dedicated resources. We needed to bring on some extra bodies to actually be able to do this work because it's quite intensive, and to be able to go through outstanding reviews from previous fiscal years across all programs. In addition, the Ministry of Health is implementing changes to its processes to be more efficient and deliver sustainable reconciliation business practices to limit the accumulation of volume over time and avoid future delays.

Supporting this work, there has been a lot of progress over the last year to onboard additional programs to the TPON system. So we're actually moving on to TPON—I think when I first came into the ministry, we weren't on TPON, so we've got a significant number of programs that are actually on TPON now. That supports a more efficient and timely transmission of documentation from recipients and other reporting tools. We're really committed to completing all outstanding reconciliations by the end of this fiscal year. As outstanding reconciliations are completed for those reviews which result in an identified amount owed to the ministry—

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

Ms. Deborah Richardson: —there will be steps that we'll take to recover the funds from the recipient, either through reductions of future payments, where possible, or other direct payment arrangements.

Basically, we have completed over 236 settlements and recovered a total of $9.2 million. We're still working on 318, but those will be done by the end of this fiscal.

Ms. Lee Fairclough: Just a quick follow-up: Is there a mechanism with this sector that, if it looks like they're tracking to underspend and you know that there might be demand for services in other areas and those funds could be used, do you actively manage that closely with the sector to really limit the need to even recover funds at all in that final year? Do you do that with this sector?

Mr. Kyle MacIntyre: Yes, we do, and just generally at the Ministry of Health, we get quarterly reports and monthly forecasts as well. We use that to understand where there may be underspending that's happening and if there is a need somewhere else, there often is an approach to be able to reallocate that.

Ms. Lee Fairclough: Okay, that's great. Thanks very much. I appreciate all the questions.

The Chair (Mr. Tom Rakocevic): Okay, we are now moving to the final rounds of questions, for the official opposition. MPP Gélinas.

M^me^ France Gélinas: I will start by bringing you way back, when Christine Elliott put the motion in front of the House. At the time, she was in opposition. We had a majority Liberal government and she got the Select Committee on Mental Health and Addictions to be put together. Sylvia Jones, the present Minister of Health, was on that committee; so was I. We made 23 recommendations at the time.

I am speaking about this committee because the need at the time to improve children's mental health was huge. It motivated people on all sides of the House. She was in opposition, she was a brand new MPP and she brought this forward, and the majority Liberal government accepted to put this select committee together because we all recognized that things needed to change.

I will always remember: We stood in the media studio, all three parties—Liberal, NDP, Conservative—and we all agreed that this needed to be moved forward. It is the only time that all three parties have stood in the media studio and said things need to change.

We made 23 recommendations. I'm sad to say that we only moved on two of them. We moved on the recommendation that says that children's mental health should be moved under the Ministry of Health, which happened, and to create a centre of excellence, which has happened. The other 21 recommendations are still there and are very, very similar to the 22 recommendations that the Auditor General has put in the report 16 years later. What we heard in 2009, 16 years ago, is that children's mental health agencies cannot recruit and retain a stable workforce because they are too underfunded compared to other parts. They were hoping that moving them from community and support services into health would help, but it has not.

Just like the MPP was saying, not a month goes by that I don't have a family come to my office. I go to Costco to buy Kleenex, because this is how much crying happens in my office. It's a child with complex mental health that is on a wait-list that by the time anything happens, the family will have fallen apart. Dad thinks that we should do this and mom thinks that we should do that, but none of them are mental health workers. They do their best, but the stress on the family—they'll end up split up. Often, children's aid has to come in. In my neck of the woods, I represent 33 small, rural northern communities. The child will be taken away from its community and shipped somewhere else.

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Why is it so hard to properly fund children's mental health so that they can recruit and retain a stable workforce? Why do we have, in recommendation number 12—you say all the right things, but why does it never get done?

To tell me that in 2019 you had a 5% increase across the board and in 2023 we had a 5% increase and in 2025 we had a 4% increase across the board will never change the fact that if you work in children's mental health, you make 50% less than if you do the exact same job in another—go to the hospital, go to public health, go to the education sector, open up your own business and you will make more money than if you choose to help children with complex mental health issues.

So my question to you is, can you give me hope that we will fund children's mental health agencies in a way that will allow them to recruit and retain a stable workforce?

Ms. Deborah Richardson: There were a few things that you were asking—the first was the select committee. There have been more than two things that have been implemented—

M^me^ France Gélinas: I'm interested in recruiting and retaining a stable workforce in children's mental health agencies.

Ms. Deborah Richardson: That's what we spoke about a little bit earlier—the importance of having that health human resource strategy that's specific to mental health and addiction. So we are working with the Treasury Board on—they're doing that labour market analysis. We need to be able to tell that story and build that case to be able to make those decisions. We're developing a specific HHR strategy in children's mental health.

M^me^ France Gélinas: In your response, you said that cycle 4 of the TBS survey is expected to be launched in the sector in November 2025. The results are expected in the spring of 2026—I'm reading your response here—and implementation of this will come in 2027. Really? This is my hope—that in 2027 we will have a plan?

When will we act upon the recommendations of the Auditor General that say there is a wage disparity? We knew in 2010 that there was a wage disparity. We did a study that showed this, which was supported by all parties. The Minister of Health was there, sitting beside me during those audits. We know that there's a wage disparity. Why is it so complicated to address that?

Mr. Kyle MacIntyre: It goes back to an earlier question that was raised around this. There has been, you did mention, the 5%, 5%, 4%, which is a significant investment in the sector as an across-the-board—but there has been an increase of over $200 million to the sector itself since 2019, which is a significant investment.

When we talk about the health human resource aspects that you're talking about, it isn't just looking at wage either. An approach that we need to develop will be looking at the supply of health workers as well, which goes towards something that you've been saying before, that requires us looking at the types of training that would be required. We have started to roll out training programs to support the providers in this space—

M^me^ France Gélinas: I live in northeastern Ontario, a rural area. We have providers willing to take those jobs. They just don't want to work for $30,000 a year when they can make $70,000 doing the same job in a hospital. We do have them, even in northern Ontario, but we don't pay them.

Ms. Deborah Richardson: Just to reiterate, we are working on a specific health human resource strategy. And I hear you in terms of the timelines. We can take that back and look at what the timelines are as we're gathering all of that data. The increases that we have made, I think, are making a significant difference. We've heard from the sector—the 5%, then the 4%—those are starting to be able to address some of the wage issues that these agencies experience.

M^me^ France Gélinas: But the 5%—they had computer systems that were so, so old that they took some of the 5% to upgrade the old computer system. Most of it didn't work anymore. Most of them are still with Windows 10, which you can't upgrade anymore, because they haven't got the money to buy new ones. That means the staff doesn't see a 5% increase. The staff doesn't see that they're finally going to have a pension fund. The staff doesn't see that they're finally going to have—none of this, like a benefits package that buys you glasses and allows you to go to the dentist. They haven't got the money to provide any of this, when anywhere else, they will have a pension plan, they will have a benefit plan, they will have—none of that exists in children's mental health. Why? Why not? Why aren't they important?

Mr. Kyle MacIntyre: I would say that some providers do have pensions and benefits. I think that's fair to say. Also, our understanding when we've engaged with the associations and sectors where the 5% is—90% is gone to wages is what we're told, to wages and salaries. So, when that funding does get made, it is going towards more on the salary side and compensation side.

There have been other one-time investments that the government has taken to improve the capacity of the sector—that happened during COVID and after COVID—for things like computers, renovations to spaces. We've invested in making sure that if there's a need to address an issue with a roof, there's funding available—

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

Mr. Kyle MacIntyre: —that gets to providers to be able to do that. There has been a range of different funding opportunities that are outside of the across-the-board that you're talking about to go towards improving the capacity and the office space and otherwise for those organizations.

M^me^ France Gélinas: We all know that before the 5% in 2019, there were 12 years without a base budget increase, and then 5% came in 2019—hallelujah. But why is it that we treat children's mental health with such low priority when we—I am not a mental health provider or anything like this, but I hear it enough that, "If my child had had access to the services they needed, they would not have started to use drugs. They would not have overdosed. They would still be there with us." I hear this all the time. Two members of my community die of overdose every single week. Most of them are kids, are young, and we're stuck with a study that will take us until 2027 to deliver a new—anyway, I have to move on. I only have 10 minutes.

Health card numbers: I think we could do a lot if we had stronger data to show that if you support children when they need it, it will have a huge impact, including not needing to be admitted into a hospital etc. Your answers were making available a card reader program to support onboarding of CYMH agencies and updating material developed for the adult sector to support onboarding. The implementation date of that is in 2030. Why does it take five years to make an OHIP card reader available?

Mr. Kyle MacIntyre: It's the full implementation of it and the access to the data digital infrastructure side of things. It's not just getting a card reader: It is moving the children and youth mental health providers onto the provincial data standard that we talked about and making sure that we've got all the compliance systems in place for it as well. And then there is—sort of what you're talking about—a component of that is the access to a card reader as well.

Ms. Deborah Richardson: But if I could just reiterate that many agencies are already collecting OHIP data as well, so that helps. As we've got the BI—I picture this filing cabinet is over here and then we transfer to the main data infrastructure, then we'll take that data and we'll move that over there. As you probably know if you've implemented data initiatives, it takes quite some time to do it, and we're talking about people's health information and all of that, so things have to be done in a proper way.

M^me^ France Gélinas: Okay. Recommendation number 1 that the Auditor General made was "additional spaces for intensive core services and secure treatment" in all service areas, including northern Ontario. Your answer was that you created regional intensive treatment networks that will be responsible for delivering and managing access to a coordinated system of intensive treatment for children and youth. Is that in all 33 areas that you have done that?

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Mr. Kyle MacIntyre: Yes. It will be establishing provincial coverage for the Ontario intensive treatment programs.

M^me^ France Gélinas: Okay, but you have this under "completed," so is it completed in all 33 areas? Remember that you gave us the "completed" and the "coming." Under "completed," you have "created regional intensive treatment networks"—just curious to see if that includes

all 33 areas. I'm not the only one from northern Ontario; we're all interested in that.

Mr. Kyle MacIntyre: I think the first part of what you were referencing was context setting, so you had an understanding of what the initiative was, so you could see and sort of lead into the first three bullets. It says, "The initiative will." So that was giving you some context about what the initiative is, just so you could read that a little more clearly. Then it talks about of the following: What were the elements that have been completed? So the formalization of the governance structure and advisory committees. We've started the work around the development of a quality standard for it. We've done a landscape report to be able to do a cross-province understanding of the services—

M^me^ France Gélinas: Okay, so although it is under "completed," you've completed the idea of doing that work, but you haven't done the work?

Mr. Kyle MacIntyre: We've established a model of care. We've got a governance committee that's in place that's developing the standards. We've done a landscape assessment of who is being provided there. We've developed an understanding of who should be receiving these types of services, so the clinical profile of it—

M^me^ France Gélinas: Okay, you said that before. I got you. I want to use my time wisely.

Under "outstanding undertakings," you say the ministry will also work with the secure treatment provider to improve access to these services. Are you committed that the new treatment facility will be not-for-profit, or are you considering for-profit and not-for-profit in the future?

Mr. Kyle MacIntyre: The children and youth mental health programming and the secure treatment programming funding is publicly funded.

M^me^ France Gélinas: Yes, but right now, also delivered by not-for-profit—the 220 agencies that you fund are all not-for-profit.

Mr. Kyle MacIntyre: That's correct.

M^me^ France Gélinas: If we are to open up new secure treatment providers—you say also work with new secure treatment providers—are we committed that those providers will be not-for-profit, or it makes no difference and it could be for-profit?

Ms. Deborah Richardson: That hasn't been considered. To date, we fund not-for-profit organizations, so we haven't explored private at this point.

M^me^ France Gélinas: Then you go on to say you will hold a symposium on intensive treatment services for CYMH providers and system partners to continue to contribute to this design of Ontario's new live-in treatment models in the fall of 2025. Has this been done, or when is it scheduled to be done?

Mr. Kyle MacIntyre: I think it's in November.

M^me^ France Gélinas: In November, this year?

Ms. Deborah Richardson: Yes.

M^me^ France Gélinas: Do you know when in November?

Mr. Kyle MacIntyre: The 17th and 18th.

M^me^ France Gélinas: Very good. Okay.

The next one is—again, you're answering the number 1 recommendation of the auditor, and you say the protocol is expected to be in place by 2027-28. When you say the protocol will be in place, does that include the services will be in place, or just how the services will be provided? Is it the how or the actual delivery that we're talking about?

Mr. Kyle MacIntyre: We expect services for the live-in treatment, the Ontario intensive treatment, to be starting in 2027-28 in the full capacity, but starting some in 2026-27.

M^me^ France Gélinas: Okay, and the goal is to have them in all 33 geographical areas?

Mr. Kyle MacIntyre: The goal of the Ontario intensive treatment pathway is provincial coverage. So we'll be moving to a hub-and-spoke model. We'll have, I think, six regions, six hubs, that will work as a hub and then linking up through other providers to provide that coverage. The protocol itself is about how the sectors work with one another.

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

M^me^ France Gélinas: Could you just name me the six hubs?

Mr. Kyle MacIntyre: I think I had mentioned earlier: We're going to be doing a call for proposals for folks to be able to apply to be a hub.

M^me^ France Gélinas: Oh, okay.

Mr. Kyle MacIntyre: Yes. So that requires an engagement with the sector for them to see what the criteria will be, to see if they are going to able to be the type of provider that could provide that service.

M^me^ France Gélinas: Recommendation number 5 from the Auditor General talks about "define the roles and responsibilities of the two organizations in the current mental health" that is for children. You're under the ministry; the rest of them are under Ontario Health. What is your plan for this? Are we going to see children's mental health fully integrated with the rest of the mental health system or continue to have two organizations?

Ms. Deborah Richardson: This is where I sort of spoke to the fact that we need to be able to look at some policy options because of the legislative responsibilities of supporting children on the Ministry of Health side. We would have to make legislative changes to have Ontario Health be able to do that type of work, so that's the work that we need to do.

We've been really focused in on responding to this report directly, getting this up and running—all the things that we spoke about today. I think that those will be options that we'll have to be able to present to government at some point, sooner than later, but as we're starting to move all of that over to Ontario Health.

M^me^ France Gélinas: Recommendation number 6: "children and youth with complex needs." You're talking about protocol expected to be in place by 2027-28. I was just wondering if you had considered integrated services for northern children as a way to deliver services to chil-

dren and youth with complex needs, which are used in other parts of the health care system but are not used for children's mental health.

Mr. Kyle MacIntyre: Sorry, I missed the first part—

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

M^me^ France Gélinas: And we're out of time.

The Chair (Mr. Tom Rakocevic): That concludes the time for questions this afternoon. Thank you very much for your attendance today and for answering the questions. You are dismissed.

We are now moving into recess.

The committee recessed at 1607 and later continued in closed session.

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