Performance Audit

Community-Based Child and Youth Mental Health Program

// Independent Auditor's Report

Office of the Auditor General of Ontario

SPECIAL REPORT 2025

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1.0 Audit at a Glance

// Why We Did This Audit

- According to the Canadian Mental Health Association, one in five children and youth in Ontario will experience mental health challenges. Timely and effective supports for young people living with mental health concerns can provide lifelong benefits such as improved relationships with others and increased productivity. They may also reduce lifelong costs, including a decreased need for community-based mental health, primary care and acute-care services.
- In 2023/24, the Ministry of Health (MOH) provided over $530 million in transfer payments through its Child and Youth Mental Health (CYMH) program to over 220 organizations. These include agencies that deliver mental health services such as counselling, therapy, intensive treatment and family support to children and youth from birth to 18 years of age, and their families.
- Since our last audit of the CYMH program in 2016, major events have occurred that have impacted this program, such as the COVID-19 pandemic and the transferring of program accountability and oversight from the Ministry of Children, Community and Social Services (MCCSS) to MOH.

// Our Conclusion

The CYMH and adult mental health and addictions sectors are still separately overseen by two entities: MOH and Ontario Health, respectively. We found that MOH did not have fully effective processes in place to allocate funds and plan and oversee mental health services delivered by CYMH service providers for children, youth and their families in the community, in accordance with legislation, agreements and policies. These services were not always provided in an evidence-based, timely, equitable and co-ordinated manner. Allocated funding for these services did not fully reflect the current needs of people in different parts of Ontario or programs in areas with the highest needs.

We also found that MOH did not routinely measure or report publicly on the results and effectiveness of these services in meeting their intended objectives.

MOH has accepted all 22 recommendations.

// What We Found

Some Areas of the Province Do Not Offer a Full Suite of Intensive Services to Help Young People with More Severe Mental Health Issues

- Of the 33 service areas in Ontario, 13 do not have access to live-in treatment services. In 2023/24, the average wait time for intensive treatment across the province was 105 days.
- Access to a secure treatment program is also limited to only three agencies in the province, all located in the Greater Toronto Area and eastern Ontario. Children and youth in other regions would need to be significantly distanced from their families to receive these services.

105 days
Average wait time for intensive treatment

» **Recommendation 1**

Current Measures of Wait Times Do Not Accurately Capture Access to CYMH Services

- Wait-time information is not comparable between agencies given differences in agency processes, such as how agencies conduct client intake.
- MOH's internal definitions of wait times do not conform with the pan-Canadian wait-time definition established by the Canadian Institute for Health Information (CIHI), nor with the adult sector. Wait times measured using MOH definitions appeared to understate a client's wait by as many as 10 additional days in 2023/24.

Wait times understated by up to **10 days**

» **Recommendation 2**

Ministry Has Limited Information to Confirm Agencies Are Providing Client-Centred Care to Clients from Marginalized Communities

- MOH does not have complete identity-based data on clients to help it better understand how different population groups access and use the mental health system. MOH did not require agencies to submit client information such as race and ethnicity until late 2023 and, since then, the data submitted has been incomplete.
- MOH requires agencies to provide services in a manner that respects the diversity of communities, but it does not confirm that proper supports exist for clients from marginalized communities.

» **Recommendations 3 and 4**

CYMH Sector and MOH Co-ordination with Other Partners Is Not Always in Place

- The CYMH and adult mental health and addictions sectors are still separately overseen by two entities: MOH and Ontario Health, respectively. This is more than a decade after the Select Committee on Mental Health and Addictions recommended that a single body be responsible for designing, managing and co-ordinating the mental health and addictions system.
- About 70% of agencies responding to our survey noted that available mental health services are not sufficient to meet the needs of children and youth with concurrent mental health and addictions disorders.
- In 2017, MOH introduced the new Youth Wellness Hubs (YWHs) initiative, which offers services such as counselling to transition-aged youth. In our survey, 66% of the CYMH agencies that responded did not think sufficient mental health services exist for transition-aged youth in their service areas.
- Co-ordinated access systems, which help young clients and their families navigate mental health services through single regional access points, are not available in some parts of Ontario.

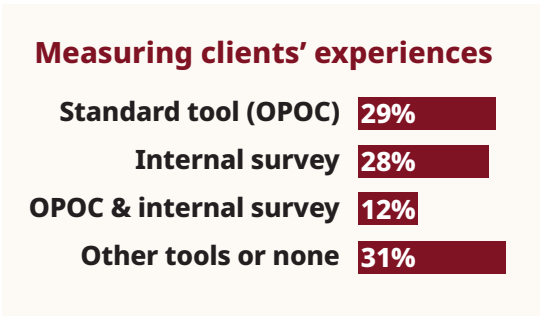
» **Recommendations 5, 6, 7 and 8**

70%
of CYMH agencies said services do not meet needs of youth with concurrent mental health and addictions disorders

66%
of CYMH agencies said there are not enough services for youth transitioning to adulthood

Tools Are Used Inconsistently in Delivery of Services, and Standards Are Not Widely Adopted

- Guidelines and requirements for the delivery of services by agencies were developed almost 10 years ago and no significant changes have been made.
- Different assessment tools are being used to measure client needs and clients' perception of care across agencies in Ontario, and MOH does not recommend or track which tools agencies use. Using different tools could affect how smoothly clients transition if they need to move from one service provider to another, or when they need to move to the adult sector.



- MOH does not require CYMH agencies to adopt available quality standards to ensure they provide quality care to clients. Through our survey, we found that agencies do not consistently use these standards, and some do not know they exist.

  » **Recommendations 9, 10 and 11**

Constraints in Health Human Resources Not Yet Addressed

- Significant pay disparities for clinical positions in CYMH agencies, compared to other sectors, create challenges for most agencies in recruiting and retaining clinical staff.
- MOH has no plan to address staff shortages in the CYMH sector.

  » **Recommendations 12 and 13**

No Agency Performance Oversight Framework to Guide Monitoring

- MOH relies on a team consisting primarily of nine program supervisors to oversee more than 200 agencies to ensure they are meeting legislative and contractual requirements. The MOH team members use different oversight methods, and most have had difficulty in getting some agencies to comply with these requirements.
- Lead agencies are responsible for working with other core service agencies and community partners to oversee and co-ordinate the delivery of core CYMH services in their service area. In 2018, MOH finalized designating lead agencies in all 33 service areas. Since then, MOH has not conducted any reviews of the lead agencies' performance or the impact of their work on their respective service areas.

  » **Recommendations 14 and 15**

Ministry Lacks Quality and Connected Data on CYMH, Undermining System- and Service-Planning

- All CYMH agencies are required to report information for accountability purposes through one system to MOH. Some must also report service performance data through another system to MOH. Agencies also use their own in-house client information systems. We noted discrepancies between all three systems in indicators like client counts, resulting in uncertainty of how MOH uses this information for system- and service-planning.

- Over a decade ago, the Ministry of Children and Youth Services (MCYS) identified a need to monitor the longer-term outcomes of children and youth who receive community-based mental health services. MOH still cannot connect community data to existing databases across the health sector, such as primary care or emergency departments, limiting its ability to determine complete health costs and track longer-term outcomes.

» **Recommendations 17 and 19**

Funding Provided to Agencies Has Not Been Adjusted to Fully Reflect Current Agency Needs

- Annual base funding to agencies was determined decades ago. While MOH has made updates to the annual funding, this still does not fully reflect the changing needs of clients in different service areas. Indicators of mental health needs by area are available and can help MOH direct funding to the areas with the highest needs.
- MOH, as of July 2024, had yet to complete funding reconciliations where it could recover an estimated $64 million in funding that CYMH agencies reported as unspent from 2020/21 to 2022/23.

$64 million
of unspent funding not yet recovered from CYMH agencies

» **Recommendations 20 and 21**

2.0 Background

2.1 State of Mental Health in Ontario's Children and Youth

According to the Canadian Mental Health Association, it is estimated that approximately one in five children and youth in Ontario will experience mental health challenges. These may include symptoms and behaviours consistent with mood and anxiety disorders and other mental health conditions.

The 2023 Ontario Student Drug Use and Health Survey (OSDUHS), published by the Centre for Addiction and Mental Health, found that of the 10,145 respondents, 27% reported that the COVID-19 pandemic negatively affected their mental health significantly, and 19% reported purposely harming themselves in the past year.

In Canada, suicide is among the top three leading causes of death among young people aged 10 to 19. The survey also noted that increased social media use and distress related to climate change are associated with worsened mental health in children and youth.

According to Statistics Canada, in 2018, 69.5% of young Ontarians aged 12 to 17 reported that they perceived their mental health to be "very good or excellent." By 2022, this percentage dropped to 54.8%.

Percentage of young Ontarians reporting their mental health as:

↓ **"very good or excellent"**

2018: **69.5%**
2022: **54.8%**

According to the Mental Health Commission of Canada, untreated and undertreated mental illness is associated with significant long-term impacts, including reduced quality of life, worsened overall health, unemployment and involvement with the criminal justice system. A recent report from Children's Mental Health Ontario (CMHO) found that 28,000 children and youth under the age of 18 were waiting for mental health services.

As well, the OSDUHS found that, in the past year, 33% of respondents reported that they felt they needed mental health support from a professional, but did not seek it. According to School Mental Health Ontario, "early intervention for children and youth can improve mental health outcomes and reduce the need for more intensive services later on."

2.2 How Community-Based Mental Health Services Are Delivered in Ontario

2.2.1 MOH

Since April 2019, MOH has provided funding for and overseen the delivery of community-based mental health services to children and youth aged 0 to 18 who are experiencing or at risk of experiencing mental health problems, illnesses or disorders, as well as their families. Previously, CYMH services were the responsibility of MCYS, which subsequently became MCCSS.

2.2.2 Community-Based Agencies

In 2023/24, MOH funded 222 organizations, primarily community-based service providers (hereafter referred to as agencies), to provide CYMH services to children, youth and their families in communities. Some agencies also provide other child and youth services funded by MCCSS and/or other levels of government. The 222 agencies are governed by their own boards of directors.

When MCYS oversaw the CYMH program, it divided the province into five regions (Central, East, North, Toronto, West) with 33 service areas (see **Appendix 1**). When the program was transferred to MOH, these service areas remained unchanged. The service areas are led by 31 designated lead agencies (one agency is the lead for three service areas). Each lead agency is responsible for overseeing and co-ordinating the delivery of core CYMH services and programs in their service area, and working with other agencies and community partners, such as hospitals and school boards, to establish clear service pathways for clients.

2.2.3 Ontario Health

Ontario Health is a Crown agency that is responsible for overseeing health-care planning and delivery across the province, which includes programs such as YWHs that provide Ontarians aged 12 to 25 with walk-in services for mental health and substance use, primary care, education, employment, housing and other social services under one roof. Under the *Mental Health and Addictions Centre of Excellence Act, 2019* and *Connecting Care Act, 2019*, Ontario Health, through its Mental Health and Addictions Centre of Excellence (MHA CoE), is responsible for putting into operation the Province's 2020 mental health and addictions strategy. The current strategy is known as the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System* (Roadmap to Wellness). This plan aims to provide Ontarians with better access to high-quality, evidence-based services across the entire lifespan, from young children, to adolescents, adults and seniors.

2.3 Services Provided by CYMH Agencies

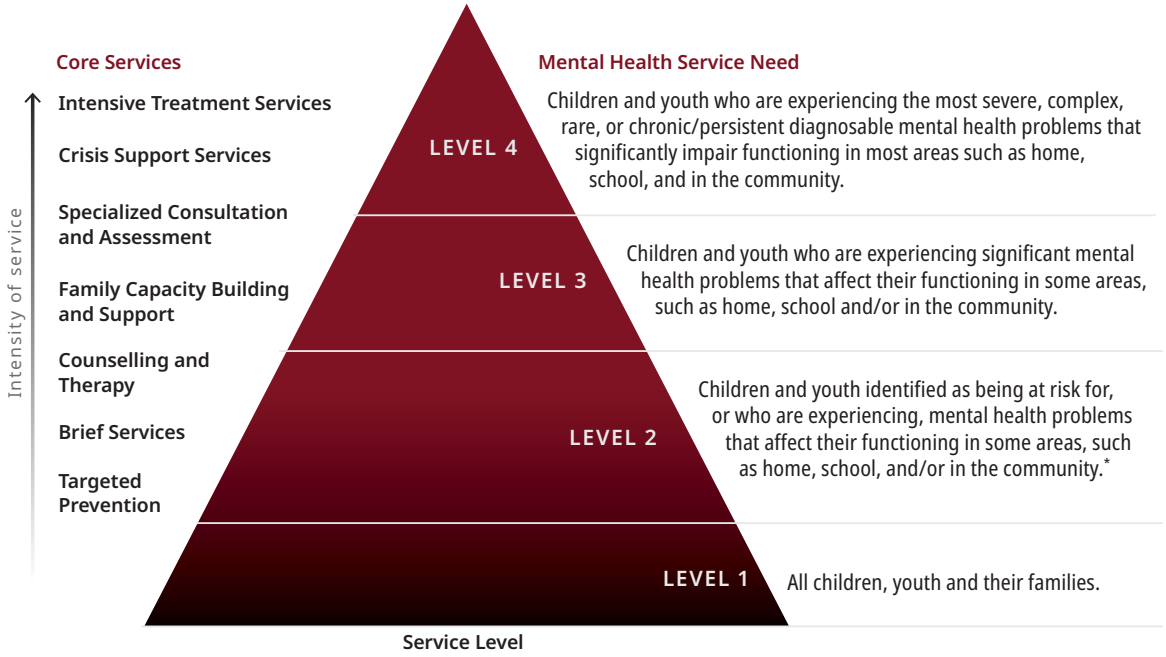
In 2023/24, 149 or two-thirds of the MOH-funded agencies provided one or more of the seven core mental health services originally developed by MCYS. These have not significantly changed since the CYMH program was transferred to MOH.

The seven core services consist of the following, listed in increasing order of severity of needs as shown in **Figure 1**:

- **Targeted prevention:** therapeutic activities that intervene in or avert the development or occurrence of a mental health problem;
- **Brief services:** quick access to therapeutic encounters that address immediate needs;
- **Counselling and therapy:** a series of planned interventions that focus on reducing the severity of and/or remedying emotional, social, behavioural and self-regulation challenges;
- **Family capacity building and support:** services that promote the resilience of families, the integral role families have to play, and families' capacity to support children and youth with mental health problems;
- **Specialized consultation and assessment:** specialized advice in the assessment, diagnosis, prognosis and/or treatment of a child or youth with identified mental health needs;
- **Crisis support services:** immediate, time-limited services delivered in response to an imminent mental health crisis or an urgent situation that places the child or youth or others at serious risk of harm; and
- **Intensive treatment services:** a range of services provided in or out of home that support children and youth with mental health problems that impair their functioning.

Figure 1: Continuum of CYMH Needs-Based Services and Supports

Source of data: Ministry of Children and Youth Services (now known as Ministry of Children, Community and Social Services)



* Includes members of a group that share a significant risk factor for a mental health problem(s).

MOH expects the agencies providing core services to have processes for supporting a client from their first contact with an agency through to discharge after completing mental health services. These processes include case management, service co-ordination, and monitoring and evaluating clients' response to service. MOH's expectations are outlined in the service description schedule, which is part of the transfer payment agreement (TPA) MOH holds with each core service agency, as well as its Program Guidelines and Requirements #01: Core Services and Key Processes (CYMH program guidelines and requirements).

MOH also funds agencies to provide more specialized services, such as the secure treatment program, which represents the highest level of intervention in the community-based CYMH system, and tele-mental health services.

MOH also funds the Knowledge Institute on Child and Youth Mental Health (Knowledge Institute) as a centre of excellence to help mobilize evidence, strengthen knowledge and skills, and accelerate system changes in the CYMH sector as a whole. The Knowledge Institute operates out of the Children's Hospital of Eastern Ontario.

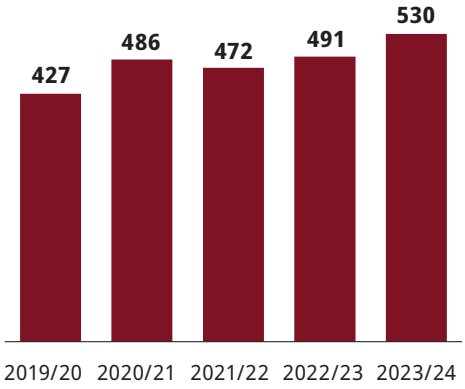
2.4 Funding

MOH funds the CYMH program under the authority of the *Child, Youth and Family Services Act, 2017*. The program is not mandatory, and services are provided to the level of available resources.

Figure 2 shows the funding trend from 2019/20 to 2023/24. MOH stated that the increased funding in 2023/24 was mainly due to a 5% across-the-board base increase to service providers and other related investments. That year, MOH spent $530 million on community-based CYMH services, up 24% from $427 million in 2019/20. About 73% of the 2023/24 funding was for the seven core services.

Figure 2: MOH's Transfer Payment Expenses for the CYMH Program, 2019/20–2023/24 ($ million)

Source of data: Treasury Board Secretariat and Ministry of Health



2.5 Oversight and Accountability

All CYMH agencies report information on each service through the Transfer Payment Ontario (TPON) system, as part of the TPA requirements. This information includes:

- staffing information, including each position and number of full-time equivalent (FTE) staff, FTE hours per year, salaries and benefits;
- financial information, such as budgeted amounts, annualized or one-time actual amounts and variances for the funding received, expenditures, administration costs and overheads; and
- performance-related information on the targets, actuals and variances, and comments for each type of output (for example, number of individuals served or wait times).

3.0 Audit Objective and Scope

Our audit objective was to assess whether MOH, in partnership with Ontario Health and community-based CYMH agencies, have effective processes in place to:

- fund, plan and oversee that evidence-based mental health services are provided to children, youth and their families in the community in a timely, equitable and co-ordinated manner, and in accordance with legislation, agreements and policies; and
- measure and report publicly on the results and effectiveness of these services in meeting their intended objectives.

Our audit scope focused on MOH's planning and oversight of CYMH services delivered by community-based agencies, consisting primarily of prevention, therapy and treatment programs. It also focused on the co-ordination of these services with other sectors, such as addictions services and adult mental health services. For the purposes of the audit, children and youth are defined as individuals under the age of 18.

We did not audit:

- the delivery of addictions or substance abuse services, eating disorder programs, mental health services provided by school staff, or hospital-based mental health services, as these are overseen by Ontario Health or the Ministry of Education (MEDU);
- the operational effectiveness of individual mental health agencies; or
- YWHs Ontario, since not all hubs were fully operational when we completed the audit. As well, they provide mental health services to youth over the age of 18, but also substance use support, education, employment, housing and other social services, which are beyond the scope of the CYMH program.

For more details, see our **Audit Criteria**, **Audit Approach** and **Audit Opinion.**

4.0 What We Found

4.1 Access to Services

4.1.1 Some Areas of the Province Do Not Offer a Full Suite of Intensive Services to Help Young People with More Severe Mental Health Issues

Some service areas throughout Ontario do not offer a full suite of intensive services to help young people who need higher levels of mental health treatment, such as:

- intensive treatment services provided in or out of home to people with impaired functioning due to their mental health problems, which may include community-based day treatment; and
- secure treatment, in which continuous restrictions are imposed due to the risk of self-harm or harm to others.

In 2023/24, MOH gave over **$163 million** to 81 agencies to provide intensive treatment services, and **$19.5 million** to three agencies to operate three secure treatment facilities.

In 2023/24, MOH gave over $163 million to 81 agencies to provide intensive treatment services, and $19.5 million to three agencies to operate three secure treatment facilities.

Intensive Treatment Not Available in All Service Areas

All 33 service areas in Ontario offer lower-intensity core services such as brief services, counselling and therapy, and family capacity building (as discussed in **Section 2.3**). As of February 2025, for intensive treatment services, 13 service areas do not have live-in treatment services, one does not offer in-home intensive treatments to families, and three do not offer day treatment.

We found that MOH does not provide direct subsidies to help young people with severe mental health needs travel to the locations that provide more intensive services. Agencies may have internal resources to support families with transportation needs, which would come out of their regular budget. Agencies we visited confirmed they sometimes cover clients' travel costs. For example, one agency told us it had to send a client to another province to obtain the services they needed.

Based on agency-reported information, in 2023/24, clients who needed intensive treatment waited 105 days on average to receive services, up from about 94 days in 2022/23. MOH has not completed a comprehensive analysis to determine whether establishing additional spaces for these services would be beneficial for some service areas.

At the time of our audit, MOH was collaborating with the Lead Agency Consortium (LAC), a group of senior leaders from the 31 lead agencies overseeing the delivery of CYMH core services, and the Knowledge Institute to develop the Ontario Intensive Treatment Pathway. The Pathway is a new community-based intensive service model that aims to facilitate improved access to services for children and youth who are experiencing the most severe, rare or chronic diagnosable mental health issues that significantly impair their functioning.

The Pathway was created in response to a draft proposal by CMHO. It also aligns with the LAC provincial priorities report published in March 2021, which noted a fragmented approach to live-in treatment services with no provincial or regional planning for capacity or quality for these services. This initiative was still at a very preliminary stage when we completed our audit.

Secure Treatment Programs Located Only in Southern and Eastern Ontario

The secure treatment program is not part of MOH's CYMH core services. It can only be accessed through a court order or emergency admission. In Ontario, only three agencies provide this program; all are located in the Greater Toronto Area and eastern Ontario. This means children and youth in parts of the province, including the West and particularly in the North, would need to be significantly distanced from their family to receive this service. This runs contrary to the *Child, Youth and Family Services Act, 2017*, which states that "services to children and young persons should be provided in a manner that respects a child's or young person's need for continuity of care and for stable relationships within a family and cultural environment."

The secure treatment program is not part of MOH's CYMH core services. It can only be accessed through a court order or emergency admission.

For example, an agency in Northern Ontario, along with other partner agencies, submitted a proposal to MCCSS in 2018 to create a secure treatment program to better meet the needs in that region. Over more than a two-year period, three letters were sent to MCCSS expressing the need for a regional option that keeps children in the North and allows for the provision of holistic care and engagement with family and community, but no action was taken.

MCCSS's initial response to the agency in late 2018 indicated that a review and analysis of existing service systems for children and youth across the province would need to be completed before confirming any significant service system changes. However, at the time of our audit, no progress on such a review had been made.

As well, the agency in eastern Ontario that operates a secure treatment program noted that in 2021/22, about half of its live-in clients originated from the same area as the agency, but the rest were from other parts of the province, including western and Northern Ontario.

A 2020 report from CMHO estimated that "almost 100,000 youth are seeking help in hospital emergency departments that could be prevented," and that this costs the health-care system an avoidable $260 million a year. Having intensive services more accessible to young people can help reduce pressures and financial strain on more costly hospital services, reduce the distance they may need to be apart from their family while receiving treatment, and improve the health and safety of vulnerable youth.

Client Story 1

"When you don't have services that are available close to home and those that are available have long wait times, you have to leave your home to find services that are very far away. It's easier to deal with it on your own, which many of my friends had to do, even in times of crisis. It's lonely, and sometimes it can get very serious and lead to hospitalization, but it feels like we don't have any other choice." – *Youth, 19, Kapuskasing*

Source: The New Mentality Youth Action Committee at CMHO

Recommendation 1

We recommend that MOH:

- assess whether additional spaces for intensive core services and secure treatment are warranted in service areas that do not have these resources; and
- based on the results of these assessments, establish plans with timelines to improve the accessibility of intensive CYMH services across Ontario.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.1.2 Current Measures of Wait Times Do Not Accurately Capture Access to CYMH Services

Service data is collected through two systems: TPON (see **Section 2.5**) and the Business Intelligence (BI) Solution.

MCYS launched the BI Solution system in 2018 to address the sector's lack of service data and help inform service delivery, system-planning, performance measurement and monitoring. Although its use is not mandated, as of June 2024, over 90 (about 60%) core service agencies that provide CYMH services have submitted data into the BI Solution, with more anticipated to join. The data is intended to answer four key questions measured in the CYMH program performance indicators (see **Appendix 2**).

MOH collects service data, such as wait times, from all transfer payment recipients through TPON, but it has not reviewed that data since 2021/22 (discussed in **Section 4.5.3**).

Inconsistent Agency Processes Result in Differences in Measures of Wait Times

We found that the wait-time information MOH collects on various core services is not comparable from one agency to another, as agencies follow different processes with their clients. This limits MOH's ability to accurately monitor and improve wait times for services.

When MCYS launched the BI Solution, it assumed agencies would follow similar business processes in serving clients, as outlined in **Figure 3**. However, this is not how all agencies carry out their processes, causing inconsistencies in measures.

The BI Solution report on CYMH data measures "average time on service wait lists" using a strict "wait list in" and "wait list out" method (see **Figure 3**). The "wait list in" date is defined as when a client is placed on a wait list for a specific service. The "wait list out" date is when a client is removed from the wait list.

Figure 3: Client Status at Different Stages in the BI Solution

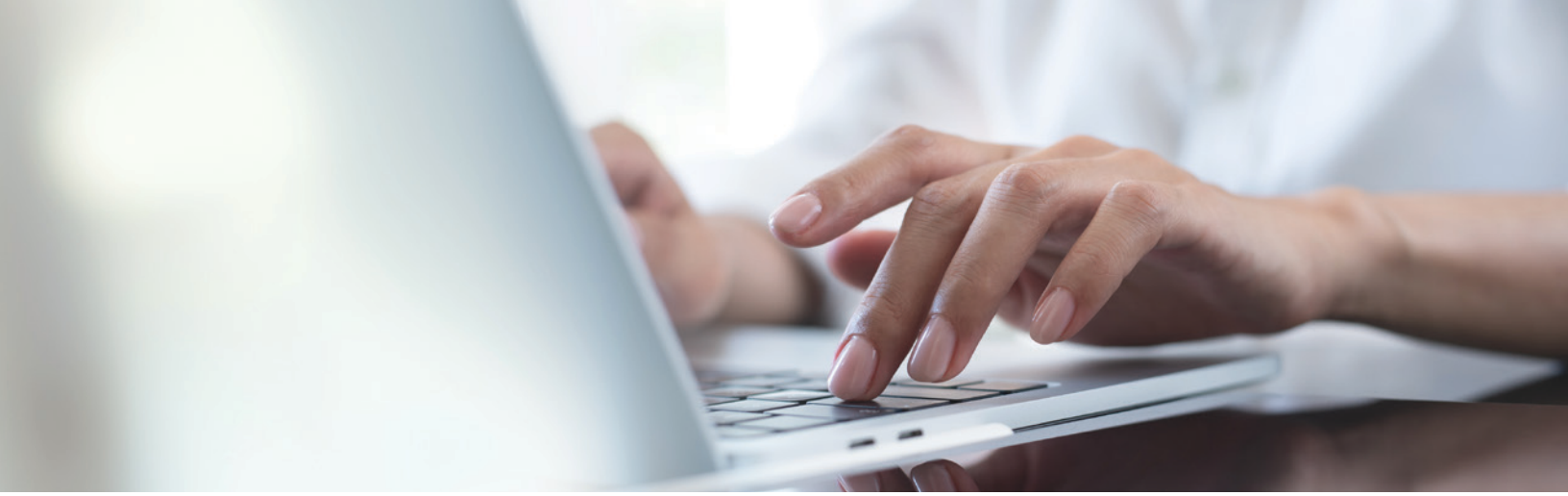
Source of data: Ministry of Health

Client Status	Stages
Referred	Initial contact
	Eligibility assessment
	Consent*
Screened	Needs assessment start
	Needs assessment end
	Service plan
	Referral to service
	Wait list in*
Waiting	Wait list out
	Service start*
Active	Service delivery
	Service end*
Waiting	Consent outcome
	Discharge*
Discharged	Follow-up*
Closed	

* Stage can overlap between different client statuses. For example, a client can be placed on a wait list while being screened and will also be considered waiting.

Our analysis of BI Solution wait-time data from 2022/23 and 2023/24 showed that, depending on the service, up to 45 agencies had clients whose service start date differed from their wait list out date. This difference added up to, on average, four additional days of wait clients experienced that would not be captured in 2023/24 wait times. MOH stated this is typically due to differences in business processes where, for example, some agencies would prematurely remove the client from the wait list when they schedule an appointment, even though the client has not yet started to receive their service. This can under-report the number of clients awaiting services.

Because the "average time on service wait lists" measure is only based on the wait list in and wait list out elements, it does not consider other processes that may impact a client's true wait. For instance, differences in agencies' intake processes can affect wait times. We calculated the average days it took an agency to add a client to a wait list from intake and identified one agency (Agency A) as having an average intake wait time of 19.7 days, while its wait time calculated in the BI Solution for brief services was 31.8 days. Another agency (Agency B) had a longer average intake wait time of 31.2 days, but its BI Solution wait time for brief services was only 2.9 days. Using only the average time on wait lists for specific services as a measure can create the impression that Agency A clients waited a much longer time to start services than Agency B clients.



Ministry Definitions of Wait Times Do Not Conform with CIHI's Definition

We found that the definitions of wait times in both TPON and the BI Solution do not align with CIHI's definition.

In 2022, CIHI established pan-Canadian indicators, including "wait times for community mental health counselling." Such indicators allow for a standard way to measure and compare a problem or area of focus and help staff understand the performance of health systems across Canada, regions, organizations and programs.

CIHI measures wait times as the duration from the date a client is referred to a service to their first scheduled appointment, and neither of Ontario's methods of calculating wait times (TPON or BI Solution) matched this. MOH informed us that it prepares a separate report that follows CIHI's definition for submission. As shown in **Figure 4:**

- TPON defines wait times as starting with a client's initial contact with an agency to the start of specific services (for more information on TPON, see **Section 4.5.3**).
- The BI Solution defines wait times as starting when a client is placed on a wait list to when they are removed from the list and begin specific services. This measure disregards the time a client waits between making initial contact with an agency and receiving a referral and being placed on a wait list.

Figure 4: Included Elements in Wait Time Definitions by Data Source

Prepared by the Office of the Auditor General of Ontario

Data Source	Initial Contact Date	Client Service Referral Date	Wait List In Date	Wait List Out Date	Service Start Date
TPON	✓	✓	✓	✓	✓
BI Solution			✓	✓	
PDS		✓	✓	✓	✓
CIHI		✓	✓	✓	✓

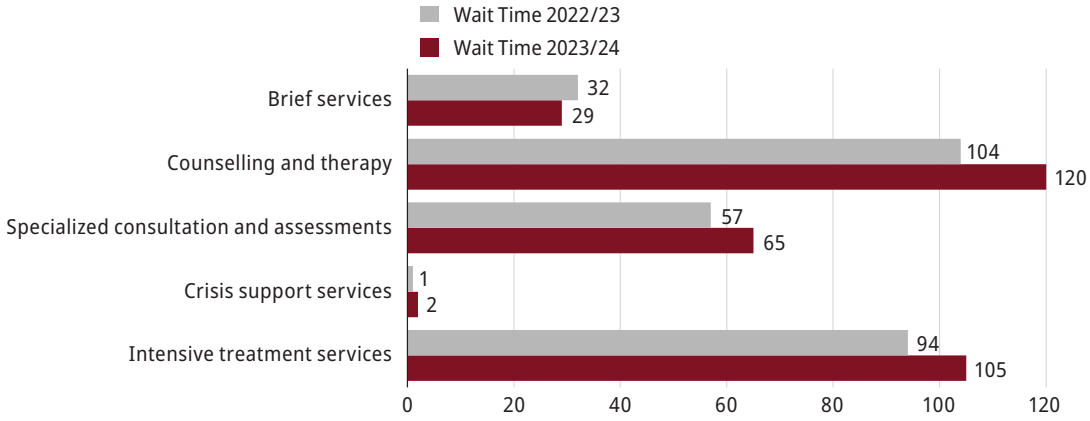
- Ontario Health's Mental Health and Addictions Provincial Data Set (PDS) collects key dates throughout a client's journey to analyze wait times, aligning with CIHI's definition of the number of days from referral to start of service. The PDS is currently used in the adult sector, but Ontario Health expects to include elements to enable a lifespan approach that incorporates CYMH sector by March 2026.

Wait times generally increased from 2022/23 to 2023/24 as measured in the BI Solution (see **Figure 5**). MOH uses BI Solution wait time data as its official measure as it has not verified TPON wait time data. For example, in 2023/24, clients waited on average:

- 105 days for intensive treatment services, up from 94 days in 2022/23; and
- 120 days for counselling and therapy, up from 104 days in 2022/23.

Figure 5: Wait Times as Defined in the MOH's BI Solution (in Days), 2022/23*–2023/24

Source of data: Ministry of Health



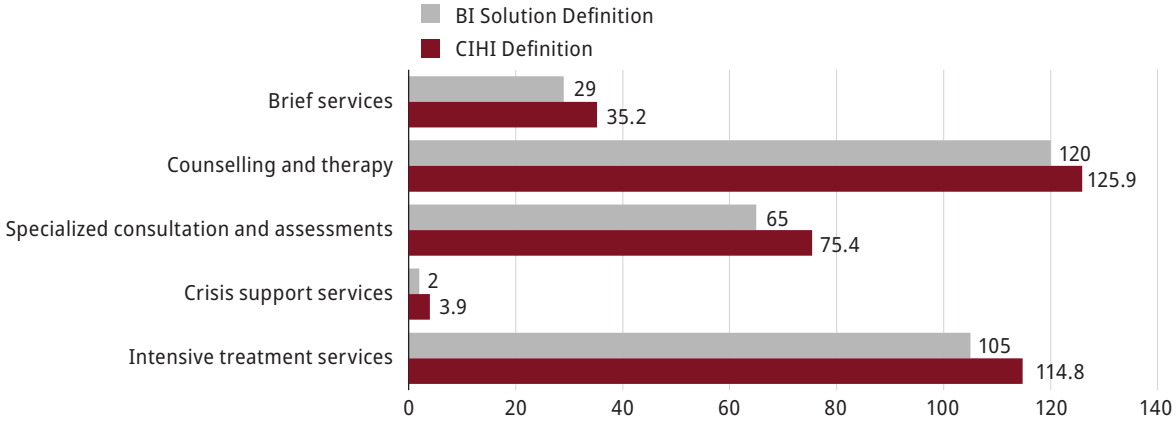
* MOH indicated there was an error in the way wait times were calculated and reported prior to 2022/23, and as a result we did not report those numbers.

We performed an analysis and found that agency wait times were underreported in the BI Solution for all five core services for which wait times are measured, when compared to how they would be measured using the CIHI definition (see **Figure 6**). This difference resulted in as many as 10 days of additional wait that a client faced in 2023/24 that was not captured in the BI Solution definition.

Different interpretations of wait times can affect the accuracy of wait-time data in the BI Solution. The results of our survey of MOH-funded CYMH agencies (see **Audit Approach**) showed 66% of responding agencies strongly disagree or disagree that indicators assessing effectiveness, such as wait times, are clearly defined and interpreted across all agencies in Ontario. Some agencies suggested a need for consistent definitions across the province and support for agencies to help improve their reporting.

Figure 6: Wait Times as Defined in MOH's BI Solution vs. Pan-Canadian Measure Developed by CIHI (in Days), 2023/24

Source of data: Ministry of Health



Having a wait-time measure that is consistent with the adult sector and CIHI could help MOH better measure clients' access to mental health services across their lifespan and compare ease of access to services across Canada.

Recommendation 2

We recommend that MOH work with the CYMH sector to:

- establish and monitor common wait-time indicators that are comparable with data collected across Canada, and data collected in the adult sector;
- create consistent definitions and target wait times, taking into account all stages of the client pathway that agencies use for data reporting purposes (see also **Recommendation 17**); and
- monitor that agencies consistently apply wait time definitions in data reports.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.1.3 Ministry Has Limited Information to Confirm Agencies Are Providing Client-Centred Care to Clients from Marginalized Communities

MOH outlines minimum expectations for core CYMH services in its service description schedule (as explained in **Section 2.3**), which states that agencies must provide core services and key processes in a manner "that respects the diversity of communities. There are many conditions that may constitute barriers to accessing services, or may reinforce existing barriers, including stigma, discrimination, and lack of cultural competency."

Certain population groups experience a higher burden of mental health issues than others. For example:

- Data from the Canadian Mental Health Association in 2018 found that Indigenous youth aged 15 to 24 experience a suicide rate five to six times higher than that of the general Canadian population, and higher rates of mental health problems, that are exacerbated by limited access to care. The Office of the Chief Coroner of Ontario found that between 2011 and 2021, over 70% of unnatural deaths among children aged 10 to 19 in the Sioux Lookout area First Nations communities were a result of asphyxia-related hanging.

- A 2022 report by the Black Health Alliance noted that Black children and youth encounter systemic barriers to mental health care, including longer wait times and difficulty accessing mental health services, in comparison to white children and youth. This can often result in disproportionate rates of accessing mental health care through the justice system and emergency care, which may mean that Black children and youth often do not receive care until they interact with the justice system or require more intensive treatment.

- Data from Statistics Canada's Canadian Community Health Survey from 2019 to 2021 found that, among Canadians aged 15 to 24 that identified as being part of the 2SLGBTQQIA+ community, approximately 30% reported having fair or poor mental health, instead of good, very good or excellent mental health, compared to less than 10% for non-2SLGBTQQIA+ youth of the same age group. Transgender or non-binary individuals were more than five times as likely as cisgender individuals to rate their mental health as fair or poor. Multiple studies and reports from Canada and the US also show that youth belonging to the 2SLGBTQQIA+ community experience greater barriers to access to services that meet their needs when compared with their cisgender and heterosexual peers.

Accessing appropriate mental health care is disproportionately more difficult for these communities due to the systemic issues they commonly face, such as racism and discrimination. In some cases, members from these communities have experienced, or continue to experience, trauma based on their communities' collective experiences (for example, surviving war, forced migration, intergenerational issues from residential schools, and enslavement), and may find it challenging to find services that adequately address the impacts of these histories of harm.

Client Story 2

"When you access services, people will make assumptions about your race and even your gender; address you with the incorrect pronouns. And sometimes if you do not fit the racial stereotype, they will assume that race is no longer a part of youth identity. Race affects other parts of my identity and it is a part of my identity. It should be acknowledged appropriately."
– Youth, 17, Scarborough

Source: The New Mentality Youth Action Committee at CMHO

Ministry Does Not Have Complete Identity-Based Data on Clients, Limiting Its Ability to Plan Effective Client-Centred Programs

MOH collects age, gender, Indigenous identity and race information on clients to help it understand "who are we serving?" We found that it does not collect other identity-based data outlined in a 2015 cross-government framework that standardized the collection of such data. We also found that the race data it collected is not complete. This limits MOH's ability to understand how different population groups access and use the mental health system.

MOH's service description schedule states that to reduce barriers, core service agencies should understand the demographics of populations within their service area. This includes, but is not limited to, newcomers and diversified populations that have their own linguistic and cultural needs.

In 2015, when the program was still under MCYS, that ministry received direction to develop a standardized cross-government framework to support the consistent collection of identity-based client data. The framework was included in the BI Solution data dictionary in the CYMH sector to help capture sociodemographic information and support alignment with other existing datasets.

However, when the BI Solution was first launched, it did not include identity-based client data indicators that the framework recommended, such as languages, sexual orientation, religion and race (see **Appendix 3**). As such, MOH does not collect or report on this information.

The only data MOH has been collecting since the BI Solution was implemented is age and gender. According to the most recent BI Solution dashboard, between January and March 2024:

- the average age at intake was **11 years old;**
- **49%** of clients were male;
- **47%** of clients were female; and
- **4%** were either "another gender identity" or did not report their gender identity.

We found that MOH's reporting of gender is not presented in a comprehensive way, as "another gender identity" includes many different gender identities, including transgendered, two-spirited and others.

MOH recently started requesting agencies to report data on race. In December 2023, after requests from agencies to report on race and ethnicity data, MOH informed agencies reporting into the BI Solution that it would begin to add these data elements to new reports. We conducted an analysis on BI Solution data from January and March 2024, and found that this data was incomplete; specifically, 86% of the active client records submitted by agencies did not include race-based data.

Of the agencies that included this information, we found they did not further specify the ethnicity of 39% of the clients. For example, of the 109 records that were reported as South Asian, 41% of those records did not specify, from the options available, whether clients were East Indian, Pakistani or Sri Lankan.

86% of the active client records submitted by agencies did not include race-based data.

Incomplete race data could be partially due to the BI Solution being limited to 12 race categories. One agency had almost 600 records flagged as errors by MOH in one-quarter's worth of data partly because the agency's internal data system captures over 30 race categories, which could not be easily mapped to the BI Solution's categories.

In contrast, the PDS used in the adult sector—which captures race-based data as well as language, sexual orientation and citizenship status—has over 220 categories for ethnicity, which were developed using data from the 2016 Census by Statistics Canada and have been aligned with provincial equity data collection efforts. This information is collected to help identify and evaluate any underlying systemic racial barriers.

Another opportunity to collect sociodemographic data is upon registration with the Ontario Health Insurance Program (OHIP) to obtain a health card. We found that the OHIP registration form also does not include sociodemographic information such as race and language. If Ontarians had the option to voluntarily provide this information in the health card application and renewal process, MOH would have access to more identity-based data across the health sector, and Ontarians would not be asked to self-report this information every time they seek treatment.

In October 2022, Nova Scotia began collecting voluntary race and language-based data from people applying for, or renewing, their health card. This was part of Nova Scotia's health equity framework, which aims to uncover inequities and identify which communities need greater support and why.

Collecting race-based and Indigenous identity data comes with responsibilities including, for example, providing anti-racism training to those who collect the data and ensuring that information is not used in any way to reinforce racism and discrimination.

Having sociodemographic data on clients who access the CYMH program can help MOH better understand the profile of those clients, identify groups that require more targeted approaches and gain insights into factors contributing to mental health outcomes, which in turn can better inform its system-planning. Aligning population groups with Statistics Canada would also ensure consistency across national data sources.

Recommendation 3

We recommend that MOH, in consultation with the Information and Privacy Commissioner of Ontario and Ontario Health:

- conduct a full review of identity-based client profile information and assist agencies in collecting the information in a culturally safe way;
- review other similar data systems' race categories, update race categories in all CYMH data systems and support CYMH agencies in their reporting of this information;
- develop tools to collect and analyze sociodemographic data annually and incorporate this knowledge into program and system-planning decision-making processes; and
- review the health card application requirements to identify opportunities to collect sociodemographic information at the application and renewal stage moving forward, and implement if feasible (see also **Recommendation 19**).

For the auditee's responses, see **Recommendations and Auditee Responses**.

Ministry Does Not Monitor Whether Client-Centred Supports Are Provided to Marginalized Groups Across the Province

MOH does not have a comprehensive mechanism to monitor whether CYMH agencies are adequately providing services to children and youth in an inclusive, affirming and culturally safe way.

As noted in **Section 4.1.3**, MOH does not collect key sociodemographic data on clients served at these agencies, and so cannot confirm if agencies are fully supporting specific populations as required. Each lead agency produces a service area plan every three years, which includes some sociodemographic statistics based on Census data and which outlines the programming offered in its service area. Also, each core service agency must submit a service description schedule to MOH, which would include services to marginalized communities, if offered. We reviewed the service description schedules of the seven agencies we visited, and found that only three specifically mentioned community supports for marginalized population groups.

To appropriately meet their clients' diverse needs, CYMH agencies may tailor programming or redirect clients to community partners that offer programming that better meets their needs. For example, one agency has a drop-in centre offering a space for self-expression, community

building and activities, with staff also providing one-on-one support to 2SLGBTQQIA+ clients. Another agency provides culturally specific practices and activities for its Indigenous clients, such as smudging, a traditional practice that uses the smoke of burning sacred tobacco and herbs to promote spiritual healing.

We surveyed all core service agencies and found that some have adapted existing programs and others have developed new programs to be more relevant for a specific population group, as shown in **Figure 7**. One agency noted that staff members are individually responsible to adapt treatment plans to address specific populations as needed. As well, agencies indicated they have consulted with organizations such as MOH, other CYMH agencies, community partners and organizations in other jurisdictions to help inform their modifications to or development of culturally responsive programming.

Figure 7: Summary of Survey Responses from CYMH Agencies with Programming for Children and Youth of Various Marginalized Communities, August 2024

Prepared by the Office of the Auditor General of Ontario

Population Group	% of Agencies That Adapted Existing Programming	% of Agencies That Developed New Programming
Indigenous	47	37
2SLGBTQQIA+	54	44
Black	36	21
Other Racialized Groups	35	19
Newcomers	28	15
Other*	29	24

Note: Percentages do not add up to 100 as agencies may serve more than one marginalized group.

* Other population groups include, for example, Francophones, German-speaking Mennonites, Persians, Muslims and South Asian populations.

Ministry Has Limited Information on Best Practices Developed in Partnership with Marginalized Communities

MOH has limited information on best practices for providing mental health services to marginalized communities, which could be shared through pathways such as communities of practice or centres of excellence. As a result, agencies cannot easily share or obtain best practices that have proven successful elsewhere.

The Knowledge Institute administers the Innovation Initiatives Program, which supports initiatives that address system-wide challenges such as wait times; geographical, cultural and language

barriers; lack of health literacy; and stigma. Successful applicants receive up to $75,000 to implement new evidence-based or promising practices that demonstrate the potential for driving change more broadly in the provincial CYMH system. The Knowledge Institute also informed us that it provides tailored coaching supports to implement and evaluate these initiatives, and that this program is one of very few grants that community-based agencies can access to test innovative ideas that address system-wide barriers.

To address systemic barriers, the Knowledge Institute funded nine initiatives from 2018 to 2024 to implement programming to better meet the needs of children and youth within marginalized groups: four were focused on Indigenous groups and five were focused on racialized groups. This approach reflected "nothing about us without us," which is asserted by many marginalized groups to indicate that no policy should be decided without the participation of members of the groups affected by that policy.

During our audit, multiple Indigenous stakeholders indicated that a lack of support for cultural programming makes it challenging to address the needs of Indigenous children and youth. One Indigenous-led agency that we visited had a cultural services team that provides programming for Indigenous children and youth, and also responds to crisis situations.

The Knowledge Institute informed us that, to date, it has not received any applications related to other communities, such as the 2SLGBTQQIA+ community and those living with disabilities. Funded projects that have transformative potential, as defined by the Knowledge Institute's evaluation, have not been shared and scaled provincially at this time, presenting a missed opportunity.

In addition, we found this program was not well-known among the CYMH sector; 47% of agencies that responded to our survey were not aware of this program.

Recommendation 4

We recommend that MOH:

- require CYMH agencies to explicitly detail how they are providing services to meet the needs of marginalized population groups, and identify and act upon any gaps in that service provision;
- promote the Innovation Initiatives Program to the CYMH sector;
- work with community stakeholders and partners to identify how CYMH agencies can better serve the needs of marginalized communities; and
- support core service agencies to establish communities of practice or centres of excellence with the goal to identify and disseminate locally developed best practices and programming for marginalized groups that are scalable.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.2 Co-ordination with Other Partners

4.2.1 Strategy Emphasizes a Connected System for All Ontarians Across Lifespan, but System Is Still Siloed

Responsibilities for CYMH Program Are Not Yet Consolidated, Over a Decade After Select Committee Recommendation

On February 24, 2009, the Select Committee on Mental Health and Addictions was appointed to consider and report its observations and recommendations concerning the development of a comprehensive mental health and addictions strategy for Ontario. The Committee reported that Ontarians waited too long for treatment; people with concurrent disorders were told to deal with their addictions first; and youth were caught in the gap between programs for children and adults, repeating their case histories to a series of unconnected service providers.

To address these issues, a key recommendation of the Committee in its 2010 report was to consolidate all mental health and addictions programs and services for all regions and ages into one ministry, and to make a single body responsible for designing, managing and co-ordinating the mental health and addictions system. More than a decade after the Committee's recommendation, the CYMH and the adult mental health and addictions sectors are still not consolidated under a single body, and Ontarians continue to face issues as highlighted in this report.

More than a decade after the Committee's recommendation, the CYMH and the adult mental health and addictions sectors are still not consolidated under a single body, and Ontarians continue to face issues as highlighted in this report.

Neither the *Mental Health and Addictions Centre of Excellence Act, 2019* nor the *Connecting Care Act, 2019* explicitly exclude CYMH services from MHA CoE's mandate. According to the MOH–Ontario Health accountability agreement, effective from October 2021 to March 2024, Ontario Health's current mandate does not include the children and youth sector, and MOH has accountability

and funding responsibility for CYMH services. The accountability agreement further notes that MOH would develop a plan to assign such accountabilities and funding to Ontario Health as appropriate.

As well, we found that MOH did not develop timelines, performance indicators or targets to implement the Roadmap to Wellness plan. This has limited MOH's ability to effectively monitor and assess its progress toward achieving the plan's implied objective to develop and implement a comprehensive and connected mental health and addictions system across a person's entire lifespan.

Consolidating all mental health and addictions services in a single entity is an important first step to address the system challenges that were identified in consultations while developing the 2020 Roadmap to Wellness plan.

MOH stated that CYMH lead agencies work with MHA CoE regularly to ensure that system-planning work is done in alignment with, and with consideration of, the needs of the CYMH sector. For example, CYMH lead agencies are represented on an advisory committee for the Provincial Co-ordinated Access model (discussed in **Section 4.2.3**), and are expected to advise MHA CoE on a data and digital initiative in the coming year.

Consolidating all mental health and addictions services in a single entity is an important first step to address the system challenges that were identified in consultations while developing the 2020 Roadmap to Wellness plan. Also, including specific indicators, targets and timelines throughout the Roadmap to Wellness plan can help MOH evaluate the progress made toward achieving the plan's objectives.

Recommendation 5

We recommend that MOH take the lead and work with Ontario Health to:

- review and update accountability agreements to better define the roles and responsibilities of the two organizations in the current mental health service delivery model;
- evaluate options to align adult and CYMH programs, and develop a plan with timelines and establish indicators to measure progress in improving client outcomes; and
- establish clear timelines, indicators and targets to ensure the Roadmap to Wellness plan's relevant areas for CYMH are implemented within specific timelines and achieve the intended goals.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.2.2 Ministry Collaborates with Other Partner Ministries to Better Meet Young People's Needs, but More Work Is Still Needed

Fragmented Services for Children and Youth Living with Complex Needs and Concurrent Disorders

We found that services in Ontario are not always integrated for children and youth with multiple challenges. This means some young people with complex needs are not always able to obtain services in a seamless way.

Children and youth with multiple and/or complex needs may experience challenges related to physical, communication, intellectual, emotional, social and/or behavioural development. These young people usually require services from multiple sectors and/or professionals and core mental health services, such as specialized consultation and assessment, crisis support services and intensive treatment services.

MOH could not provide us with complete and accurate data regarding the proportion of its children and youth clients that have complex mental health needs. This information is collected through MOH's BI Solution, but not all core service agencies report into this system, and MOH noted it had to correct data reported by agencies. Having such information would help MOH better plan for services in a seamless way for clients with complex needs.

In Ontario, MOH funds CYMH services, and MCCSS funds child welfare, autism and other developmental support services. Some community-based agencies receive funding from both ministries to provide multiple services to young people and their families. However, many CYMH agencies solely serve clients with mental illness; clients with multiple needs have to obtain needed services from multiple social service agencies.

Under a regulation of the *Child, Youth and Family Services Act, 2017*, each CYMH lead agency is required to prepare a service area plan outlining the needs and perspectives of children, youth, families and diverse populations within their geographic area, as well as service gaps and priorities and how those gaps will be addressed.

In our review of a sample of five service area plans covering five regions of the province, we found that all spoke to the challenges related to serving clients with complex needs and the increase in complex needs among younger children. One lead agency noted a need to review CYMH pathways and partnerships with MCCSS-funded sectors to determine where improvements can be made. According to the Knowledge Institute, a care pathway "helps guide children, young people and families to, through and out of care" and helps families "get the right service at the right time and in the right way."

Themes covered in the five service area plans we reviewed include:

- children, youth, families and service providers lack knowledge and an understanding of services and pathways to care due to system fragmentation and a lack of co-ordination across sectors;
- children and youth with complex needs do not always receive intensive treatments that meet their needs;
- the high level of services required by complex needs clients, with current capacity limitations, impacts wait times; and
- services and referral pathways, including clear roles across service providers such as those in the CYMH and child welfare sectors, are not always updated.

In March 2022, the Complex Mental Health Needs Collaboration Table, a provincial cross-sectoral table convened by MOH and MCCSS, issued a report that also highlighted similar challenges.

As noted in **Section 4.1.1**, at the time we were completing our audit, MOH was working toward a provincial initiative called the Ontario Intensive Treatment Pathway to improve access to live-in treatment for children and youth with significant or severe mental health needs. Other pathways, such as those for autism services, child welfare and developmental services, existed only in some local areas. We surveyed all core service agencies, and 48% of respondents had integrated care pathways with autism service providers, 69% had such pathways with child welfare providers and 53% had such pathways with developmental service providers.

One agency we visited could effectively co-ordinate services for complex needs—such as those related to mental health, respite, child welfare and youth justice—through cross-sector programs internal to the agency because it is funded by both MOH and MCCSS to provide these services, reducing the burden of developing external pathways and protocols to services. However, this is not always the case. In our survey, 14% of responding agencies either strongly agreed or agreed that they have had to discharge clients prematurely in the last year without referring them to other organizations because the intensity of services they required was too high.

Lack of Co-ordination with Addictions Services for Children and Youth

We found that children and youth with concurrent disorders cannot readily access addictions services in a co-ordinated manner. Addictions can be related to substance use or when a person engages compulsively and excessively in certain behaviours, such as gambling, video gaming and internet use. MOH recognizes there are gaps in substance use care for children and youth, and has made efforts to enhance mental health and addictions services for youth through establishing YWHs.

The Centre for Addiction and Mental Health's OSDUHS 2023 report noted that around 11% of students reported using cannabis during the past month and about 2% reported using cannabis daily. Also, 22% of students reported using a prescription opioid pain reliever without a prescription in the past year, up from 13% two years ago.

Around 70% of the agencies that responded to our survey noted that available mental health services are not sufficient to meet the needs of children and youth with concurrent mental health and addictions disorders. Also, 43% of responding agencies indicated their clinical staff were not sufficiently trained to provide support to this group of young people, and 45% indicated they did not have integrated care pathways with addictions or substance abuse service providers.

Around 70% of CYMH agencies said services do not meet needs of children and youth with concurrent mental health and addictions disorders.

Similarly, our review of service area plans in a sample of five service areas showed that demand for addictions services exceeded the available services in all areas. In one service area, children as young as nine years old presented with a need for both addictions and mental health services. The plans noted there is little movement toward creating a clear partnership between the siloed addictions services sector and the CYMH sector, resulting in a lack of co-ordinated services.

As well, the gaps in youth addictions services remain as there is no CYMH core service for addictions. MOH has started the work to develop a new core service framework, which will take a lifespan approach, and the technical working group will provide the government with recommendations on how to define substance use and addictions services for children and youth.

CYMH agencies are generally not funded to deliver addictions services. As of December 2024, only 10 out of the total 149 agencies were receiving MOH funding for addictions services. In addition, Ontario Health funded four agencies that operated a total of 102 targeted youth addictions beds, as well as a range of other community-based addictions services, including YWHs. According to MOH, as part of the Roadmap to Wellness plan, and discussed in **Section 2.2.3**, the government is now funding YWHs that deliver addictions and substance use services; it also supports the delivery of an evidence-based indicated prevention program that offers interventions, such as cognitive behavioural therapy and motivational interviewing, to delay the onset of substance use by children and youth in grades seven to nine across 14 school boards, YWHs and in community agencies.

Providing services for children and youth with multiple complex needs, and improving the accessibility and integration of mental health, neurodivergent disorders and addictions services can help these young people get the support they need to prevent their conditions from worsening.

Recommendation 6

We recommend that MOH take the lead to consult with MCCSS, LAC and Ontario Health, as appropriate, and:

- work with lead agencies in the CYMH sector to establish performance indicators and timelines to measure progress in improving access to, and facilitate cross-sector co-ordination among, other service sectors such as autism and child welfare for children and youth with complex needs;
- determine the most effective and efficient models to deliver addictions services to children and youth, and develop a plan to implement them; and
- include addictions services for children and youth in the new core services framework.

For the auditee's responses, see **Recommendations and Auditee Responses**.

Young People Not Sufficiently Transitioned to Receive Adult Mental Health Services on a Timely Basis

In its 2020 Roadmap to Wellness plan, the government acknowledged the gap in programming for transition-aged youth, defined as youth aged 16 to 25. Our review of a sample of service area plans indicated that clients approaching 18 years of age lack continuity of care and face challenges with access and navigation when aging out of the CYMH system into the adult mental health system. They also lack knowledge on what type of adult services are available. Of the agencies that responded to our survey, 56% noted they had integrated care pathways with adult mental health agencies.

Client Story 3

Jane* recently graduated from high school and was experiencing anxiety about going to university, getting her driver's licence and starting a new job.

Her mother reached out to a local CYMH agency for help. Jane received brief services that she "got so much out of," but was only able to attend two sessions before she turned 18. When Jane's mother asked for adult-related resources, the agency told her that very limited subsidized or free resources were available to adults in the area.

* Name has been changed to protect privacy.

Source: An Ontario mental health service agency

Client Story 4

Margaret,* a mother of two boys, said her family began their journey in the children's mental health system nearly 10 years ago. They found that the services offered were not always what they needed. The COVID-19 pandemic took a greater toll on her son's mental health when he had to transition to online schooling and receive virtual mental health services.

She said: "The pandemic has been really hard for my family, but especially my son. We've had multiple visits to the emergency department, resulting in multiple admissions. Each time has been increasingly challenging."

As her son approaches 18 years old, Margaret is concerned about his transition from the youth to adult mental health system, and if he will receive the services he needs. She said that having one door to access all mental health services is important.

* Name has been changed to protect privacy.

Source: Parents for Children's Mental Health at CMHO

According to MOH, community-based mental health services for people 18 and older do not have a defined core services framework, as further discussed in **Section 4.3.3.** Also, the system has evolved over the last few decades primarily to meet the needs of people with serious mental illness, making more basic services such as early intervention counselling difficult to access by those with mild or moderate levels of need that could become more serious. In contrast, the CYMH sector offers counselling and therapy as core services to all children and youth based on their level of need. As a result, transition-aged youth with lower levels of need may not always have their needs met in the adult system.

The adult mental health system has evolved over the last few decades primarily to meet the needs of people with serious mental illness, making more basic services such as early intervention counselling difficult to access by those with mild or moderate levels of need that could become more serious.

Ontario Health and MOH jointly fund and oversee adult mental health services in Ontario. Ontario Health informed us that, based on research and reports from the sector, transition-aged youth experience barriers to effective transitions into adult mental health services, and provincial data does not currently exist to assess this. Research indicates that evidence-based assessments, intervention services and supports are needed across this continuum of care. Our survey results show that 66% of the respondents did not think sufficient mental health services exist for transition-aged youth in their service areas.

MOH requires CYMH core service providers to engage in transition planning across various transition points, including preparing children, youth and families for transitions from CYMH services to other community supports, to adult mental health services, back to school, or for discharge from services.

As noted in **Section 2.2.1**, CYMH agencies are not funded to provide mental health services to clients once they turn 18. To respond to these clients' needs, a few CYMH agencies we visited developed internal programs (not part of official provincial programs) to provide counselling services to this age group. As these programs are being run with the agencies' limited, self-raised funds, individuals aged 18 and over may face long wait times; for one agency's adult services, clients have waited an average of 24 months.

As discussed in **Section 2.2.3**, MOH now has YWHs that offer services comprising a continuum of care for youth, with varying levels of intensity, to address differences in youth needs and goals in their communities. These services include, for example, counselling, family support, psychiatric response services and access to crisis supports.

Client Story 5

"My transition from the youth system into the adult system felt very lonely. The only supports I was aware of were for youth, so once I aged out I had nowhere to go and no one to turn to that could help me even find services for adults. My lack of a transitional plan resulted in me giving up on finding services in general. I knew that I wasn't able to afford therapy on my own and with nowhere else to turn and no knowledge of anywhere other than the ER [emergency room] at the hospital, I truly believed I was on my own in my mental health journey." – *Anonymous Transition-Aged Youth*

Source: The New Mentality Youth Action Committee at CMHO

The quality standard issued by Health Quality Ontario (HQO), now part of Ontario Health, outlines the transition process for young adults moving from child and youth-oriented services to adult-oriented services. It states that the original service provider is responsible for identifying those who need to transition as early as possible, creating a transition plan, and co-ordinating care and providing support throughout the transition until it is complete. Smoothly transitioning young people to adult mental health services can help reduce stress as they interact with other agencies and decrease the amount of time without services during the transition between agencies.

Recommendation 7

We recommend that MOH:

- work with Ontario Health to develop co-ordinated pathways that support transition-aged youth navigating between children and adult mental health sectors; and
- work with CYMH agencies to develop and implement requirements to establish internal policies to support the transition of youth from these agencies to appropriate services in the adult mental health sector, and to base these policies on recognized quality standards, such as Ontario Health's Transitions from Youth to Adult Health Care Services.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.2.3 Streamlined Access to Multiple Services Is Not Consistently Available Across the Province

We found that co-ordinated access systems (CASs) to help young clients and their families navigate multiple services are not available in some parts of Ontario.

MOH expects each CYMH agency to provide co-ordinated access and services to children, youth and families between and across core service agencies and community partners from related sectors. The CYMH sector has existing CASs with different scopes and regional coverages. These CASs often involve one phone number and website that serve as a central point of contact from which clients can access services offered by multiple providers in a specific service area, so clients do not have to approach multiple agencies on their own.

In 2021, MOH conducted a current state assessment of co-ordinated access models for mental health and addictions services across Ontario. The assessment identified 20 CASs serving children, youth and their families, which varied in their scope and function. It also found that the service areas in northeast Ontario and some parts of central Ontario do not have CASs.

MOH does not mandate agencies to develop CASs with a centralized intake and wait list, nor does it track which agencies participate in CASs. Based on our request, MOH identified 16 active CYMH CASs when we completed our audit. We noted that, of the agencies that responded to our survey, 21% do not participate in a CAS. The key reasons highlighted for not participating were a lack of guidance either from MOH or lead agencies and resource constraints.

The key reasons that agencies highlighted to us for not participating in co-ordinated access systems were a lack of guidance either from MOH or lead agencies and resource constraints.

In 2020, LAC developed One Stop Talk with funding from MOH, which is a phone number that children and youth under 18 years of age across Ontario can call to access a therapist for a single session. Clients requiring more than a single session can request help navigating local services that meet their needs.

In 2020, LAC developed One Stop Talk with funding from MOH, which is a phone number that children and youth up to age 17 across Ontario can call to access a therapist for a single session.

The government committed in the Roadmap to Wellness plan to improve access to mental health and addictions services. Specifically, MOH is funding Ontario Health's MHA CoE to develop a Provincial Co-ordinated Access (PCA) model, which will allow Ontarians of all ages to access regional mental health and addictions services through one phone number or website. The PCA model will also include centralized wait lists for intensive mental health and addictions core services in each region, standardized intake processes and tools to determine clients' most appropriate level of care, and a prioritization protocol to facilitate clients' access to services based on their level of urgency.

To ensure the PCA model will serve all age groups, Ontario Health's MHA CoE envisions the CYMH sector's CASs will be connected to the PCA model through appropriate pathways or protocols established by each region, in alignment with provincial standards. These standards had not yet been developed at the time of our audit.

MOH does not mandate CYMH agencies to participate in CASs, and Ontario Health does not oversee the development, scope or geographic coverage of the CASs within the CYMH sector. This means there is no assurance that CYMH clients from across Ontario will be able to access multiple services through a single point of contact, get on central regional wait lists or experience standardized intake processes.

Recommendation 8

We recommend that MOH take the lead and work with lead agencies and Ontario Health's MHA CoE to establish co-ordinated access to CYMH services that includes all service areas and is aligned with the PCA approach being developed for mental health and addictions services for all eligible Ontarians.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.3 Service Delivery Tools and Quality Standards

4.3.1 Agencies Use Different Tools to Assess Client Needs and Service Outcomes

Agencies Use a Variety of Tools to Assess Client Needs Before and During Treatment

MOH expects agencies to use evidence-informed tools to assess each client's strengths, needs and risks in order to develop a plan of care that includes specific services they would receive and expected outcomes. However, MOH does not mandate CYMH agencies to use a common set of tools to perform these assessments for clients.

MOH also does not track which tools agencies use. We asked, via a survey, what assessment tools core service agencies use. Of the agencies that responded, 48% use one or more of the following tools: InterRAI, CANS, CAFAS and CALOCUS, while around 7% do not currently use a standardized assessment tool.

The use of different tools hinders the comparability of data across agencies, such as clients' needs categories, level of severity and outcome, which in turn could affect how smoothly clients transition if there is a need to move from one service provider to another.

The absence of a common set of needs assessment tools also affects two performance indicators in MOH's BI Solution:

- One indicator measures program outcomes as the proportion of children/youth with positive outcomes as identified by a standardized assessment tool. This indicator was never implemented.
- The other indicator measures the profile of children/youth by need category and level of severity at their initial assessment. The reporting from agencies has improved on this as agencies are in the process of mapping their detailed assessment tools' categories with the BI Solution's needs categories. For example, the percentage of blank values reported for need category and severity level has decreased from 78% to 48% and from 79% to 44%, respectively, between the first quarter of 2020/21 and the fourth quarter of 2023/24.

LAC's 2019 and 2021 provincial priorities reports noted that it was a priority to implement a common assessment tool to help improve wait times, increase consistent quality across agencies and regions, facilitate co-ordination and enhance data collection.

LAC's 2024–2027 strategic plan and objectives continue to focus on strengthening the use of consistent tools through working with lead and core service agencies to increase their use of InterRAI (the tool recommended by LAC).

Clients' Perception of Care at Completion of Treatment Not Always Measured Using Standardized Tools

MOH expects that agencies use evidence-informed tools and practices to support positive outcomes for children and youth. To know whether such outcomes were achieved, agencies measure and record each client's perception of care and outcome of the services they received. However, MOH does not mandate CYMH agencies to use standardized tools to measure clients' perception of care.

MOH explained that agencies use different methods to monitor and evaluate a child or youth's response to service, perception of care and service experience, as well as the clinical outcomes of service. These include interviews, observations and repeated administration of standardized, evidence-informed tools. Agencies use both quantitative and qualitative information to monitor service impacts and make appropriate adjustments.

However, MOH does not monitor or track what tools agencies use to measure clients' perception of care. According to LAC's 2021 provincial priorities report, most core service agencies do not use a standardized tool to assess perception of care. They either rely on an internally developed tool or do not have one at all.

According to LAC's 2021 provincial priorities report, most core service agencies do not use a standardized tool to assess clients' perception of care.

Of the agencies that responded to our survey, 29% use a tool called Ontario Perception of Care for Mental Health and Addictions (OPOC-MHA); 28% use their own internally developed survey; 12% use both OPOC-MHA and their own survey; 14% use other tools; and 17% do not use a standardized tool to assess clients' perception of care.

LAC's 2024–2027 strategic plan and objectives included expanding the use of OPOC-MHA to measure clients' perception of care across agencies.

Having agencies use standardized tools to assess client needs and perception of care can help MOH better assess whether agencies are providing consistent quality services to clients, make system-planning decisions to improve core services and help clients transition from one agency to another more smoothly.

Recommendation 9

We recommend that MOH:

- work with relevant stakeholders such as the Knowledge Institute and LAC to evaluate the need and potential impact of implementing an assessment framework including standardized tools to measure clients' perception of care, and establish a plan with timelines to support CYMH agencies to effectively use these tools; and
- ensure the tools implemented for the CYMH sector also allow for transitioning young clients to adult services.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.3.2 Ministry Does Not Oversee Whether Agencies Adopt CYMH Quality Standards

We found that MOH does not mandate CYMH agencies to implement existing quality standards to promote delivery of quality services to people with mental health and addictions concerns. Quality standards define what quality care should look like for both clinicians and clients.

In 2021, the Knowledge Institute developed and issued two quality standards focused on family and youth engagement. The Knowledge Institute also has a list of other quality standards that are applicable to the CYMH sector, including those developed by HQO, as shown in **Figure 8**. MOH has not required the Knowledge Institute to establish a workplan to develop or adapt these standards

Figure 8: Quality Standards Related to Mental Health and Substance Use Established by HQO
Prepared by the Office of the Auditor General of Ontario

Quality Standard	Age Group
Anxiety Disorders	Children, youth and adults (across the lifespan)
Eating Disorders*	Children, youth and adults (across the lifespan)
Major Depression	13 years and older
Obsessive-Compulsive Disorder	Children, youth and adults (across the lifespan)
Opioid Use Disorder (Opioid Addiction)*	16 years and older
Problematic Alcohol Use and Alcohol Use Disorder*	15 years and older
Transitions Between Hospital and Home*	Children, youth and adults (across the lifespan)
Transitions From Youth to Adult Health Care Services	Transition-aged youth 15–24

* Applicable to children and/or youth but are not within CYMH agencies' scope of services.

for agencies in Ontario. The Knowledge Institute noted that it leverages existing standards to inform the development of their standards.

The Knowledge Institute also plans to release two more quality standards in the near future: one on levels of care, and the other on live-in treatment services.

We asked all core service agencies via a survey whether they have adopted these three quality standards into their practices: youth engagement, family engagement and transitioning from youth to adult health-care services. Of the agencies that responded, 31%, 23% and 21%, respectively, have adopted these standards. The Knowledge Institute informed us that it has supported 40 (about 27%) of the CYMH core service agencies in adopting its youth engagement and family engagement quality standards.

According to our survey results, agencies do not adopt these quality standards mainly because the standards are not applicable to their services or they were not aware of the standards.

Agencies do not adopt these quality standards mainly because the standards are not applicable to their services or they were not aware of the standards.

We also found that the MOH team's oversight process does not include a requirement to ensure that agencies are aware of applicable quality standards or that they have incorporated existing quality standards into their practice. The MOH team told us it assesses whether agencies provide quality services by reviewing documents such as licensing review reports by MCCSS, serious occurrence reports, third-party reviews of agencies and client complaints. In our survey, the majority of the team members indicated that they either disagreed that they have access to data to assess the quality of services provided by agencies, or were uncertain.

Without mandating CYMH agencies to use quality standards, and implementing a process to monitor their use, there is no assurance that children and youth are receiving quality care from MOH-funded mental health agencies.

Recommendation 10

We recommend that MOH:

- require CYMH agencies to annually declare if their practices comply with Ontario Health's quality standards and monitor agencies' progress to achieve compliance;
- work with the Knowledge Institute to establish a workplan to develop or adapt the needed quality standards that are relevant to CYMH; and
- establish a process to oversee if agencies are aware of and are incorporating the available quality standards.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.3.3 Program Guidelines Developed in 2015 Are Open to Interpretation; Ministry Is Working on a New Services Framework

The CYMH program's current guidelines and requirements were issued in 2015, when the program was with MCYS. MOH has not made any significant updates since the program was transferred in 2019. We found that the guidelines and requirements lack specificity in some cases, resulting in agencies interpreting minimum requirements differently and services being delivered inconsistently across the province.

Of the agencies that responded to our survey, 78% either strongly agree or agree that agencies have different interpretations and definitions for each of the core services. We reviewed a sample of the agency-completed section of the service description schedule, and noted that each agency can deliver services differently and MOH does not track program variations by region to determine whether they are reasonable. Such differences could affect the intensity of, and wait times for, the same type of service clients receive from one agency to another. Our review showed the following:

Each agency can deliver services differently and MOH does not track program variations by region to determine whether they are reasonable.

- One agency we visited defined brief services as a single session of therapy followed by three therapy sessions if needed, while two other agencies defined them as up to six sessions, and another agency as three to eight sessions.
- One agency provided clients up to three sessions of intensive clinical support, including safety planning, for an urgent mental health crisis. Another agency defined crisis support services as beginning upon referral and ending once the crisis has stabilized and a safety plan is in place, without limiting the number of sessions.

The CYMH program guidelines and requirements refer to two other documents with further details on how agencies should plan for core services and plan across the full continuum as shown in **Figure 1**. MOH stated these two documents were never finalized and were put on hold following the transfer of the program to MOH.

In April 2024, MOH procured consulting services from a management consulting firm with staff experienced in the mental health and addictions sector. A month later, MOH convened a technical working group to support the design and development of an across-the-lifespan core services framework. This new framework would include definitions and related guiding principles and replace the existing CYMH core service framework. MOH was still working on this framework at the time of our audit.

Having a complete framework integrating CYMH services with services in the adult sector, and which defines MOH's minimum expectations and its guidelines for agencies, could help drive consistency among CYMH agencies and reduce disparities in the services provided to children and youth.

Recommendation 11

We recommend that MOH develop and finalize a provincial core services framework that defines minimum expectations for core services, that aligns CYMH services with adult mental health services, and that includes definitions and guidelines to support consistent implementation of core services across agencies.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.4 Health Human Resources

4.4.1 Ministry Does Not Have a Health Human Resources Strategy for the CYMH Sector

MOH is aware that mental health and addictions agencies have been experiencing significant health human resources (HHR) shortages. According to an internal Ministry document, inadequate staffing at agencies will lead to increases in hospitalizations and emergency room visits, and longer wait times.

However, MOH does not have a workforce strategy for this sector that considers challenges such as geographical barriers, health-care workforce shortages, and the unique challenges facing children and youth, especially in Indigenous communities. Internal Ministry documents show that Indigenous peoples have higher suicide risks than non-Indigenous people, and suicide incidents have been exacerbated by the COVID-19 pandemic and lack of available mental health resources in these communities.

Our survey results showed that 81% of the agencies that responded had up to four vacancies for social workers, while about 78% had four vacancies for psychotherapists. About 87% of the agencies had up to two vacancies for psychologists.

MOH has been working on an HHR strategy for the entire health-care sector since 2022, but there is no strategy for the mental health and addictions sector. According to internal Ministry documents, in spring 2024, MOH started identifying potential solutions to address HHR challenges in the CYMH sector, for example, by addressing compensation differences and hiring more social workers and other CYMH professionals at universities or colleges. It has not yet developed any detailed plans to implement these solutions.

The Ontario government has several initiatives, such as Learn and Stay, to attract and retain health-care professionals, and has been increasing access to internationally trained health-care providers for the entire health-care sector. These initiatives do not include a specific focus on the community-based CYMH sector.

MOH also does not proactively plan for clinical staff shortages in the community-based CYMH sector, and its forecasts on demand and supply of health-care staff do not specifically focus on this sector. High staff turnover at CYMH agencies has made it challenging for some children with complex mental health issues to receive timely services and build good relationships with the clinicians. In some cases, clients had to take the clinicians assigned even if they were not a good fit.

Client Story 6

Liz's* 13-year-old daughter began showing signs of a complex mental health illness when she was seven years old. Liz wrote to CMHO that their experience with the mental health system has been "soul crushing." Although she found the mental health professionals they worked with were "mostly kind and caring," they "maybe didn't have the right experience to be able to help effectively."

"What has been most soul crushing is feeling like we have to justify every decision we've ever made as her parent from the time we got pregnant to the time we've sought services. It's exhausting to have to explain over and over again our story because every time our clinician changes, we have to refill in the same forms, we have to go through the same questions."

Liz also mentioned that there were not enough services in their area and a shortage of staff. After losing the psychiatrist they had, they had to rely on other services, such as Telehealth, but found the format was not ideal. They did find another psychiatrist they would like to keep, but were only able to see him once every three to four months.

* Name has been changed to protect privacy.

Source: Parents for Children's Mental Health at CMHO

Having an HHR strategy that recognizes the unique challenges in the community-based CYMH sector would help address recruitment and retention of clinical staff, which in turn could help children and youth get more timely access to the services they need at these agencies.

Recommendation 12

We recommend that MOH develop and implement an HHR strategy for the community-based CYMH sector, including an action plan with clear timelines, to address workforce needs and wage disparities with other sectors such as education and acute care.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.4.2 There Are Significant Pay Disparities for Clinical Positions Compared to Other Sectors, Contributing to Staffing Challenges

We found that MOH is aware of the staffing shortages and wage gaps in the mental health and addictions sector, but that it does not collect independent data on the difference in pay between professionals working in community-based CYMH services compared to those in acute-care and education sectors.

In our survey of core service agencies, 84% of respondents faced challenges in recruiting and retaining qualified clinical staff to ensure service quality, with 87% attributing this primarily to pay disparity. Some agencies reported losing staff to hospitals and schools that provided higher compensation. Agencies estimated that the average wage gap for their clinical staff compared to education and acute-care sectors in their community ranged from less than 10% to above 50%. Also, 60% of survey respondents noted they had the highest turnover rate for social workers since January 2022. According to internal Ministry documents, the repeal of Bill 124 (*Protecting a Sustainable Public Sector for Future Generations Act, 2019*) in February 2024 has made this more difficult.

A 2023 compensation review by community-based stakeholder groups showed that this sector had wage gaps of 20% to 50% compared with the education and acute-care sectors. For experienced staff, wage gaps increased to about 56%. The review also showed that over the past six years, social worker salaries increased only 8% in the community mental health and addictions sector, which was "considerably low" given the increase in the cost of living in the same period.

A 2023 compensation review by community-based stakeholder groups showed that this sector had wage gaps of 20% to 50% compared with the education and acute-care sectors.

Our survey of core service agencies showed that annual salaries ranged from $70,200 to $166,400 for psychologists, $53,300 to $137,500 for psychotherapists and $52,400 to $137,500 for social workers. Salaries vary based on factors such as level of education, years of experience, employment location and collective agreements. This information is not analyzed by MOH.

At the time of our audit, MOH was collaborating with the Treasury Board Secretariat on a workforce data survey, which will enable analysis of workforce data across broader public sector employers. Depending on the response rate and data inputs collected, MOH expects the survey to identify compensation gaps among various sectors, including the community mental health and addictions, education and hospital sectors. This survey will be sent to organizations identified through discussions with relevant ministries, including MOH, or through existing Ministry data reporting processes. The Treasury Board Secretariat completed this survey at the end of 2024 and was working on validating the responses at the time we completed our audit.

In April 2024, MOH set up a team to look into staffing shortages and related wage gaps in the mental health and addictions sector. At the time of our audit, it was in the "early information

discovery phase" and no formal working group or terms of reference had been developed to address these issues.

Recruitment and retention of staff has also been difficult due to staff burnout with higher workloads at some agencies. Our 2016 audit report on Child and Youth Mental Health included a recommendation for MCYS to periodically review agency caseloads per worker, assess their reasonableness and identify instances that require follow-up and/or corrective action. Eight years have passed and this recommendation is still not implemented. At the CYMH agencies we visited, workload of clinical staff varies. For example, one agency told us its staff typically carries 15–20 cases each, while the workload at another agency is typically 18–21 cases. Factors such as demands of case management, number and intensity of files, and additional assignments contribute to these different workloads.

Having a sustainable workforce is critical to ensuring children and youth receive timely and appropriate support to address their mental health challenges. Unaddressed wage gaps and higher workloads for some staff can increase staff turnover rates, placing more stress on existing staff and resulting in longer wait times for children and youth needing support.

Recommendation 13

We recommend that MOH:

- review results of the workforce data survey, and if needed, supplement the data by conducting an independent compensation study to quantify the wage gaps between the community-based CYMH sector and other sectors, and implement a plan to update this information every two years;
- identify potential solutions, as part of MOH's work on HHR, to support core service agencies' efforts to recruit and retain their staff;
- work with CYMH core service agencies and relevant stakeholders, such as the Knowledge Institute and CMHO, to develop staff workload guidelines, allowing for variations depending on the type of mental health services offered; and
- develop a plan to collect and monitor the relevant information, and monitor progress against workload guidelines on a regular basis.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.5 Program Monitoring and Funding

4.5.1 There Is No Agency Performance Oversight Framework to Guide MOH's Monitoring of Agencies

MOH Team Uses Different Methods to Oversee Agencies and Most Have Difficulty with Compliance

MOH does not have a framework, standard operating procedures or guidelines to help its team monitor the performance of CYMH agencies using consistent methods.

While the lead agencies are responsible for overseeing service-planning in their respective service areas, MOH has a team consisting primarily of nine program supervisors responsible for overseeing more than 200 agencies that are expected to follow the *Child, Youth and Family Services Act, 2017* and TPA requirements. They are the agencies' main contacts for MOH funding, information reporting and support.

MOH has a team primarily consisting of nine program supervisors responsible for overseeing more than 200 agencies.

Each program supervisor oversees between 15 and 37 agencies. We surveyed and received responses from the nine program supervisors. Our survey found that over three-quarters of the program supervisors agreed or strongly agreed that the number of agencies they oversee exceeds the number they are able to reasonably handle while providing each agency the level of attention required.

Over half of the program supervisors disagreed that they have sufficient support guidelines and tools to help them carry out their role and understand their duties, and eight agreed or strongly

agreed that they have had difficulty in getting some agencies to comply with TPAs and reporting deadlines. The lack of an agency performance oversight framework has resulted in gaps and inconsistencies in the program supervisors' oversight efforts. For example:

- **Third-party reviews:** In our survey, over half of the program supervisors agreed or strongly agreed that third-party reviews helped inform their work. For example, a third-party review of an agency that was non-compliant with its contractual obligations for over four years resulted in MOH ceasing its funding to the agency in July 2024 and terminating its agreement in October 2024. According to MOH, external parties, including the Ontario Internal Audit Division, a hospital and consultants, had conducted six reviews of CYMH agencies in the last four years. Four were completed by the end of our audit. The reviews resulted in recommendations that covered topics such as clinical practices and financial management. For example, one agency needed to ensure staff receive proper training in trauma-informed care; another agency needed to ensure individuals with appropriate authority approve invoices prior to payment.

- **Accreditation:** Accreditation is an internationally recognized evaluation process against established standards that promote quality of care for clients. It is commonly used in the health sector to ensure providers are meeting those standards for the programs they offer, and adds a level of accountability, over and above the TPAs set out by MOH. We found that MOH does not require CYMH agencies to be accredited, nor does it track which agencies are accredited or in the process of obtaining accreditation. We surveyed all core service agencies about their accreditation status; 86% of respondents indicated they were accredited, or were in the process of obtaining accreditation at the time of our audit. British Columbia requires accreditation from CYMH agencies that receive over $500,000, and Saskatchewan requires it from all agencies.

We found that MOH does not require CYMH agencies to be accredited, nor does it track which agencies are accredited or in the process of obtaining accreditation.

According to the TPAs, agencies must spend funds only in accordance with the budget. They must also carry out each service according to the agreement, service description schedules, policies, guidelines and requirements of MOH, and the best practices for service delivery. Schedules within TPAs, such as budget schedules and service description schedules, are renewed at least once each fiscal year.

MOH relies on standard TPA templates to contain the required clauses. It reviews TPAs—including all legal text, terms and conditions—as a whole every three years, but it does not review them with the intention to strengthen clauses to support its oversight of agencies.

MOH follows the Transfer Payment Accountability Directive (TPAD), which establishes the principles, requirements and responsibilities for ministries and provincial agencies when overseeing transfer payment activities. MOH completed its latest review for the 2023/24 fiscal year. At the time of our audit, it was planning to update the TPAs again by March 2025 to incorporate new TPAD requirements.

By developing a program monitoring framework, MOH will be able to better respond to agency non-compliances in a more timely and consistent manner, and ensure that agencies are providing services in accordance with the TPAs, ultimately benefitting the children and youth, and their families, receiving services.

Recommendation 14

We recommend that MOH:

- develop a performance monitoring framework that defines situations of non-compliance with program requirements by agencies that require timely follow-up by MOH oversight staff, and the intervention mechanisms that program staff need to execute at defined time intervals; and
- update the TPAs to include provisions outlining consequences for serious non-compliances that remain unresolved over a defined period.

For the auditee's responses, see **Recommendations and Auditee Responses**.

Lead Agencies Have Responsibility to Lead, Plan and Align Services, but the Ministry Does Not Sufficiently Monitor Their Performance

About two-thirds of the program supervisors we surveyed stated that they do not receive sufficient guidelines and tools to support their review of lead agency performance.

In 2012, MCYS introduced the lead agency model whereby lead agencies, in addition to delivering core mental health services to children and youth, have additional responsibilities to plan services in their service areas and work with other organizations (for example, schools, other community-based health organizations, hospitals) to support their clients' mental health needs.

MCYS began identifying these agencies in 2014/15 and, by 2018, almost all of these agencies assumed their responsibilities. The model, as well as the lead agencies, have remained unchanged since the CYMH program transitioned to MOH.

System-Planning Reports Submitted by Lead Agencies to Ministry Lack Indicators to Measure Progress

We found that MOH does not require lead agencies to establish indicators to measure their progress in meeting local needs.

We reviewed three service area plans for 2024 from the lead agencies we visited. The plans described how core services and community mental health priorities would be linked to action plans with objectives and deliverables. However, these priorities were not linked to specific indicators and targets, making it difficult to clearly demonstrate their impact and ensure accountability in implementing priorities and resolving gaps.

For example, a priority in one service area plan we reviewed was to reduce wait times for mental health services for children and youth, while the objectives included collecting, analyzing and sharing data to improve overall wait times. However, no clear indicators and targets were defined to assess the impact of this priority. Our survey showed that only 55% of program supervisors agreed the plans provide clear information on the lead agencies' performance in their respective regions.

Our survey showed that only 55% of program supervisors agreed the plans provide clear information on the lead agencies' performance in their respective regions.

Lead agencies also submit system management reports to MOH twice a year, which highlight in-progress and completed activities against each lead agency function and the funding assigned to each function. These reports also cover topics related to French language services and services for Indigenous communities. Our survey results showed that only 22% of program supervisors

agreed that the system management reports provide clear information on the lead agencies' performance in their respective regions.

Lead agencies may also work on initiatives initiated by the CYMH sector. For example, in 2022 the CYMH sector and the education sector published a report titled *Right Time, Right Care: Strengthening Ontario's Mental Health and Addictions System of Care for Children and Young People* (RTRC). The report highlighted service gaps between the two sectors and proposed a plan to address those gaps.

The Knowledge Institute's operational plan states it is expected to support the implementation of RTRC to improve mental health service co-ordination between CYMH agencies and school boards across the province. MOH did not mandate the implementation of RTRC, and agencies are not obligated to work with the Knowledge Institute. As a result, MOH did not set any targets on how many of the lead agencies across the province would be expected to work with school boards to set the basis for a broader co-ordinated system of mental health services.

Ministry Does Not Have a Process to Consolidate System-Planning Challenges Identified by Lead Agencies

We found that MOH does not have a process to consolidate the results of program supervisors' individual reviews of documents submitted by lead agencies to identify systemic gaps and priorities across the province that warrant ministry-level support.

Up to 2021, LAC would summarize these reviews and present them in its provincial priorities report, but it has since moved to developing a strategic plan that does not include this information.

The MOH team, consisting primarily of program supervisors, informed us that they each review reports and service area plans submitted by lead agencies, as well as MCCSS's licensing reviews for live-in treatment facilities, serious occurrence reports and third-party reviews. These reviews are done by service area, and each MOH team member has their own review process.

MOH has not conducted any reviews of the lead agencies' performance, or the impact of their work on their respective service areas, since conferring more responsibilities to them. We compared the three-year service area plans of three lead agencies for 2021/22–2023/24 and 2024/25–2026/27, and noted that even though some agencies reported some progress, several gaps have continued to appear in each agency's plans.

MOH has not conducted any reviews of the lead agencies' performance, or the impact of their work on their respective service areas, since conferring more responsibilities to them.

For example, one service area continued to report the need for clearer pathways, a lack of a co-ordinated access model and a limited capacity that was affecting accessibility. Another service area still showed long wait times for brief services and a lack of substance use services. The third service area continued to report almost the same gaps,

including inadequate addictions services, growing wait lists, children and youth whose complex needs are not always met, the absence of a system co-ordination navigation approach and a lack of seamless continuum of care across school boards and with local CYMH centres.

MOH expects lead agencies to perform important functions, such as helping CYMH clients receive more cohesive services and leading local service-planning. Having stronger processes and tools can help MOH more consistently monitor whether lead agencies effectively collaborate with other agencies and partners and address local challenges.

Recommendation 15

We recommend that MOH:

- update the existing templates for service area plans and the system management reports to include specific measurable indicators and targets for each priority and objective to allow for an assessment of progress and impact;
- update the existing template for system management reports to include linkages with objectives outlined in service area plans;
- establish a process to consolidate significant and systemic issues identified from individual reviews of lead agency–submitted reports and information and to review these issues on at least an annual basis to determine ministry-level intervention where needed; and
- set indicators and targets to monitor lead agencies' performance and the impact of their work on their respective service areas, including the work on any sector initiatives, such as RTRC.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.5.2 Reporting of and Accountability for Serious Occurrences Are Fragmented, Limiting Ministry's Ability to Track Trends

Serious occurrences are any incidents that may require intervention and/or investigation by a CYMH agency or other applicable parties. Examples include death, serious injury or illness, use of restraints, abuse or mistreatment, and errors or omissions in administering medication.

Over 50 Agencies Required to Report Serious Occurrences Through Two Ministries, Creating Administrative Burden

We found that some agencies are funded by MOH to provide CYMH services, and are also licensed by MCCSS to provide live-in services. They are therefore required to report serious occurrences to both ministries using different methods. This duplication of efforts creates an administrative burden on these agencies.

When the CYMH program was transferred from MCCSS to MOH in 2019, jurisdiction over serious occurrence reporting for licensed agencies with live-in treatment facilities, and the actual licensing of live-in treatment facilities, remained with MCCSS under the *Child, Youth and Family Services Act, 2017*. MOH-funded agencies that do not have any live-in treatment facilities, and thereby do not require licensing, are required to submit serious occurrence reports directly to MOH. As of July 31, 2024, 53 MOH-funded agencies were licensed by MCCSS because they provided live-in treatment services to clients.

MCCSS launched the Serious Occurrence Reporting–Residential Licensing (SOR-RL) online portal in 2019. It also developed the Serious Occurrence Reporting Guidelines (SOR Guidelines) to support agencies reporting through the portal, and updated these guidelines in 2023. MOH and its non-licensed CYMH agencies are not part of the SOR-RL online portal. Instead, MOH asks agencies to report serious occurrences manually using a form, which it developed using the SOR Guidelines and which has similar fields to MCCSS's online portal. The forms are sent to a MOH email address

that is monitored by MOH staff. Significant issues are flagged for the appropriate program supervisors.

We surveyed all CYMH agencies about their experiences reporting serious occurrences. Of the agencies that responded to our survey, 29% submit SORs both manually to MOH and through the SOR-RL online portal to MCCSS, and of these, 94% indicated they would prefer reporting through one method only.

According to MCCSS, the portal has the technical capacity to be enhanced to support the reporting and management of serious occurrences from agencies currently submitting SORs manually to MOH. A similar enhancement was implemented to the online portal in 2023 for MEDU to accommodate reporting and managing serious occurrences that may occur in Provincial and Demonstration School lodging settings.

Lack of Centralized Tracking of All Serious Occurrence Reports Results in Inability to Note Trends

MOH does not centrally track or analyze all SORs submitted by CYMH agencies; as a result, it is unable to identify trends to inform its decision-making.

Agencies we visited over the course of our audit indicated that MOH does not provide them with any trend analysis based on the SORs they have submitted. Several of the agencies we visited indicated that they track their own trends for SORs submitted to both MOH and MCCSS. Having agencies report serious occurrences through one channel would help reduce the administrative burden and time it takes to report these occurrences. By centrally tracking serious occurrences, MOH would be able to analyze trends to better understand province-wide common themes, such as increased use of restraints, and suggest best practices to assist agencies in mitigating any serious emerging trends.

Recommendation 16

We recommend that MOH take the lead and collaborate with MCCSS to:

- streamline the reporting method and requirements for serious occurrences at CYMH agencies; and
- monitor the type of serious occurrences reported on an annual basis to detect trends and themes, and share the results with CYMH agencies.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.5.3 Ministry Does Not Have Complete and Accurate Data to Measure Program Performance

Discrepancies in Data Reported Through Different Systems Undermine Its Usefulness in System- and Service-Planning

We found discrepancies in service data reported in three separate systems for indicators that should be measuring the same thing. In some cases, such as for wait times (as discussed in **Section 4.1.2**), these discrepancies can be caused by differences in how an indicator is defined. These discrepancies undermine the integrity of data collected and cast uncertainty on which dataset MOH and the agencies should use for system- and service-planning.

Service data is currently stored in the following systems:

- **TPON:** Per TPA requirements, CYMH agencies report service data such as spending, staffing information and performance data in TPON twice a year to allow MOH to assess how agencies meet service targets.
- **BI Solution:** The BI Solution uses client-level service data submitted from an agency's client information system to calculate indicators on a quarterly basis to better understand the performance of the sector and aid system-planning. These indicators are calculated based on definitions MOH has set in its BI Solution data dictionary.
- **The agency's own client information system:** Agencies use their own systems and most use EMHWare.

According to the most recent data in TPON, in 2021/22, approximately 122,000 clients were served by core and some of the Indigenous CYMH service agencies. We noted that this data may not be accurate because we found different data being reported in the BI Solution.

Specifically, we compared the number of clients served by a sample of 20 agencies, reported in both TPON and the BI Solution, from 2020/21 to 2021/22 and found that these numbers differed in every case. In most cases, the reported number was higher in TPON than in the BI Solution, ranging from a difference of 1 to over 2,400. We brought these differences to MOH's attention. MOH noted it would need to investigate to understand why these differences occurred.

MOH is aware of discrepancies between the two datasets. In comparing TPON and BI Solution data for three agencies, MOH found a similar trend in client counts. For one agency that was reporting into both systems, 720 more clients were recorded in TPON than in the BI Solution. MOH also found discrepancies in the number of clients receiving specific services and in wait times, which were sometimes overstated or understated by more than 100 days in the BI Solution.

MOH reviews TPON data for errors, but this manual process is lengthy, resulting in the last verified data dating from 2021/22. Despite these reviews, MOH relies on the agencies to submit accurate information without auditing their sources.

The BI Solution data is more easily retrieved and verified, but only about 60% of the CYMH agencies report into it, which means TPON's service data is also required for planning.

Our survey showed 87% of agencies strongly agree or agree that reporting data into two separate systems is administratively cumbersome.

Our survey showed **87%** of agencies strongly agree or agree that reporting data into two separate systems is administratively cumbersome.

Discrepancies go beyond TPON and the BI Solution. Agencies informed us of significant differences between their internal reports and MOH's reports on the BI Solution data. One agency noted that its average wait times were overstated in the BI Solution by 36–136 days for various

core services in the fourth quarter of 2023/24. Also, the average number of clients by age group at intake was understated by up to 212 clients in the BI Solution reports.

We found that 41% of agencies that responded to our survey faced a similar issue with discrepancies between the BI Solution data and their own internal data reports, and 46% of respondents did not currently use the BI Solution data.

41% of agencies that responded to our survey faced a similar issue with discrepancies between the BI Solution data and their own internal data reports.

These discrepancies and the uncertainty of how MOH is using data to inform decision-making have raised questions among the agencies. Thirty-two percent of agencies that responded to our survey indicated they strongly disagree or disagree that they know how MOH or their lead agency uses BI Solution data, while 61% reported not receiving reports from MOH or their lead agency showing their performance.

Recommendation 17

We recommend that MOH direct LAC to:

- conduct a full review of data that is submitted through both TPON and the BI Solution to identify causes for data discrepancies, duplication of efforts and opportunities to streamline reporting by agencies;
- implement a process in which agencies must attest that the data they submit to MOH is accurate and that it reflects the data in the agencies' own information systems;
- develop a distribution process for agencies to receive output reports related to the data they provide to allow them to gauge their performance; and
- conduct regular reviews with lead agencies for feedback on data reported to discuss its usefulness in service-planning and identify opportunities for improvement.

For the auditee's responses, see **Recommendations and Auditee Responses**.

MOH Has Limited Outcome Indicators to Measure the Effectiveness of the CYMH Program

MOH has limited outcome indicators to measure whether its CYMH program is effective and if services delivered by CYMH agencies are meeting the needs of children and youth. We also found that although MOH requires agencies to report on four outcome indicators, not all agencies report on them.

As shown in **Figure 9**, MOH currently requires core service agencies to report on three outcome indicators in TPON and one outcome indicator in the BI Solution. MOH has three additional indicators in the BI Solution but did not implement them and does not require agencies to report on them.

Figure 9: Outcome Indicators and Results Available in TPON and BI Solution, 2021/22 and 2023/24

Source of data: Ministry of Health

Indicator	Frequency of Reporting	Implemented by MOH	Results (%)*
TPON			
Proportion of children/youth with positive outcomes	Semi-annually	✓	53.3
Proportion of caregivers/youth reporting positive outcomes: the number of survey responses	Semi-annually	✓	52.5
Proportion of caregivers/youth reporting positive experience with the service system	Semi-annually	✓	55.0

Indicator	Frequency of Reporting	Implemented by MOH	Results (%)*
BI Solution			
Proportion of clients with positive outcomes	Quarterly	✓	93–96
Proportion of survey responses with positive perception of the outcome	Quarterly		n/a
Proportion of survey responses with positive perception of the service system	Quarterly		n/a
Proportion of children/youth with positive outcomes as identified by standardized assessment tool	Quarterly		n/a

* Based on most recent information available from TPON (2021/22) and BI Solution (2023/24).

The indicator on clients with positive outcomes reported in the BI Solution measures how well clients were served and their responsiveness to services they received. It reflects only the clients assessed at discharge during the reporting period who had a positive outcome, based on clinical judgment. Overall the trend and rate reported are positive, in that a higher proportion of clients were assessed as having a positive outcome in the fourth quarter of 2023/24 (94%) than the same period in 2019/20 (73%).

However, we found this indicator does not fully reflect the effectiveness of agency services because:

- only about 41% of the core service agencies submitted the required data for this indicator in 2023/24; and
- this indicator only includes clients that had an assessment done at the time of discharge.

Since our last audit in 2016, MOH has not set the agencies any targets for these indicators. Furthermore, before 2023/24, MOH focused only on reviewing the high-level data at the provincial level and did not analyze the detailed performance across agencies.

Even though MOH has set up three additional indicators in the BI Solution, these can only be implemented if agencies use a common set of standardized needs-assessment tools and a standardized tool to assess clients' perception of care, which collects data at the client level. MOH did not have any plans to update these three performance indicators.

The BI Solution includes a fifth indicator called "value for investment," which shows the effectiveness of the system and how well it is performing. MOH did not implement this indicator or determine how it would be measured.

Agencies also report on indicators through TPON, with the same objective of measuring the positive outcomes of services using either clinical judgment or the perception of the child, youth or caregiver. However, we found that the methods or data used to measure these indicators differ from those used in the BI Solution, as shown in **Appendix 4**.

Multiple groups within MOH and the Treasury Board Secretariat have responsibility to check for data completeness, review submitted reports, identify errors and request agencies to adjust data, but their roles or expected turnaround time are not fully outlined in MOH's internal process documents. MOH is two years behind on issuing the provincial TPON performance indicator reports. The most recent available report is for 2021/22, because the data for subsequent fiscal years is still being collected or reviewed.

Meaningful outcome measures can help both the agencies and MOH determine whether they are making a difference in the mental health of children and youth. Reducing redundancies in data reporting would reduce the administrative burden of agencies. Finally, analyzing performance results in a timely manner can help MOH know how effective the CYMH program is in meeting the mental health needs of children and youth so that it can intervene at the earliest opportunity.

Meaningful outcome measures can help both the agencies and MOH determine whether they are making a difference in the mental health of children and youth.

Recommendation 18

We recommend that MOH:

- review the current set of outcome indicators in TPON and the BI Solution, including those that are not being collected, and streamline the outcome indicators that CYMH agencies need to report;
- identify the barriers facing agencies that do not report data and assist them in establishing a plan to start reporting data to MOH;
- establish targets, monitor agency performance on outcome indicators, and follow up with agencies that show declining performance year over year; and
- establish internal turnaround time targets for reviewing agency-submitted data on outcomes.

For the auditee's responses, see **Recommendations and Auditee Responses**.

MOH Is Unable to Determine the Complete Health-Care Costs of Supporting Young People with Mental Health Needs and Their Longer-Term Health Outcomes

More than a decade ago, MCYS identified a need to monitor longer-term outcomes of children and youth who receive mental health services. MOH took over the program in 2019. MOH is still unable to connect data from community-based mental health agencies to databases across the health-care sector, such as primary care or emergency departments. Such data could help to identify whether clients need additional support, and the type of support they need throughout their lifetime.

More than a decade ago, MCYS identified a need to monitor longer-term outcomes of children and youth who receive mental health services.

In 2013, MCYS identified the importance of collecting a unique identifier, such as a health card number, for children and youth to avoid duplicating data, follow clients' progress across programs and over time, and monitor their longer-term outcomes, including their transition into adulthood. When the CYMH program was transferred from MCYS (which became MCCSS) to MOH, collection of personal health information became permissible because CYMH agencies are now considered health information custodians under the *Personal Health Information Protection Act, 2004*, which states that a custodian includes a "centre, program or service for community health or mental health whose primary purpose is the provision of health care."

MOH explained that there is no requirement for community-based mental health agencies to collect health card numbers from CYMH clients because CYMH services are funded through the CYMH program and not OHIP, and that mandating the collection would be a significant policy and practice shift. However, this would align with the Province's Roadmap to Wellness plan. A threat risk assessment and privacy impact assessment may be needed as it was last done in 2018 under MCYS.

The adult mental health sector is already collecting health card numbers, including expired health cards, as part of the PDS to enable the linking of clients across their datasets.

Also, at the time of our audit, MOH was planning a pilot project with the Institute for Clinical Evaluative Sciences (ICES)—a stakeholder in the health sector that specializes in data work—that would, if feasible, collect health card numbers of past and current CYMH clients in MOH-funded secure treatment facilities, to link with existing ICES data sources.

We found that 89% of agencies that responded to our survey would be capable of collecting health card numbers, including some agencies that already collect this information for medication purposes. As well, 88% of survey respondents strongly agreed or agreed that there is value in establishing a process to connect client data in community-based CYMH agencies and the broader health-care system to identify needed improvements in early intervention services.

We found that 89% of agencies that responded to our survey would be capable of collecting health card numbers, including some agencies that already collect this information for medication purposes.

Connecting data between the community-based CYMH sector and acute care can show a client's full journey through the care continuum, such as identifying clients who are on a wait list for CYMH services and end up in an emergency room. It can reduce the need for clients to repeat their story to multiple health-care points of contact, and help MOH quantify the value of addressing mental health at an early age.

Recommendation 19

We recommend that MOH take the lead and collaborate with LAC and Ontario Health to:

- support agencies to collect health card numbers from clients in a manner consistent with the *Personal Health Information Protection Act, 2004*; and
- establish a process to link the health-care visits of clients and patients across multiple health-care sectors, starting with CYMH, adult mental health and hospitals.

For the auditee's responses, see **Recommendations and Auditee Responses**.

4.5.4 Program Funding Largely Based on Historical Trends, and Ministry Analysis of Agency Spending Not Sufficient

Base Funding Determined Decades Ago Does Not Fully Reflect Current Needs or Agency Performance

Base annual funding for core service agencies was determined decades ago and generally continues year over year without fully reflecting the current needs of clients in different service areas and/or regions and agencies. As a result, agencies that have higher demand for their services may not be able to offer them due to insufficient funding, and agencies that have a lower demand may receive excess funds that other agencies could benefit from.

MOH staff stated that it reallocates existing funding and makes decisions related to new available funding primarily based on the recommendations that lead agencies make, for example, to reallocate resources for core service agencies in their service area, through their submitted service area plans (discussed in **Section 4.5.1**). Our review of the 2024/25 plans for all service areas showed that 73% of these plans did not include any recommendations or they indicated that no funding reallocation was required. Also, these plans did not include any recommendations related to Indigenous core service agencies as they are not under the purview of lead agencies.

Using the most recent agency data received and reviewed by MOH from 2021/22, we performed an analysis on the seven core services and their related measures for the number of individuals served and number of participants in sessions/workshops. We found that agency performance is not tied to funding level as:

CYMH agency performance is not tied to funding level.

- 14 agencies received the same amount of base funding for the following year despite not having reached one or more of their service targets; and

- 27 agencies exceeded one or more of their service targets, yet their funding stayed the same or decreased for the following year.

MOH provides each lead agency with yearly base funding of $210,000 plus additional funds based on the population in its service area. This is to oversee and co-ordinate delivery of core services in their service area and engage cross-sectoral partners in order to meet community needs. Most lead agencies oversee one to seven other core service agencies in their service areas. As of April 1, 2024, five of these lead agencies did not have any other agency in their area to oversee, yet they still received full lead agency funding.

Our 2016 audit recommended a needs-based funding model, but this recommendation was not implemented. MOH staff stated there were still several system components to be addressed in order to implement this recommendation. In its Roadmap to Wellness plan, MOH agreed the funding is based on historical arrangements. It stated that although it intended to update its decision-making on funding by spring 2021, this has still not been completed.

A more detailed, needs-based funding model could allow money to be directed according to the unique needs of each service area.

Recommendation 20

We recommend that MOH:

- analyze indicators of demand for community-based mental health services, such as emergency department visits by children and youth relating to mental health by service region and agency performance against service targets, build lead agencies' capacities in making requests to reallocate program funding through service area plans, and reallocate program funding to those areas that have higher needs; and
- evaluate the current number and coverage of core service agencies and lead agencies and take actions to reduce inequities in lead agency funding.

For the auditee's responses, see **Recommendations and Auditee Responses**.

Unreconciled Transfer Payment Funding Has Resulted in an Estimated $64 Million Yet to Be Recovered From Agencies

We found that MOH has not been timely in reconciling transfer payments made to CYMH agencies against what they spent between 2020/21 and 2022/23. Our 2024 report on the Public Accounts of Ontario also highlighted this as an issue. We asked MOH staff to calculate what CYMH agencies received and did not spend over this three-year period, and found that it was about $66 million. As of July 10, 2024, MOH had recovered only about $1.6 million, leaving just over $64 million to still be reconciled and recovered. The 2023/24 data was not yet finalized and recovery efforts were still under way when we completed the audit.

We found that MOH has not been timely in reconciling transfer payments to CYMH agencies and recovering any unspent funds.

MOH's Transfer Payment Policy stipulates that any unused funds from agencies are required to be recovered and collected by MOH within two years. However, MOH has failed to collect these funds from agencies ever since it took over the program from MCCSS in 2019/20. MOH staff informed us that MCCSS was responsible for reconciling payments to CYMH agencies in 2019/20 and prior years.

Better oversight of funding provided to each of the CYMH agencies can help identify any surplus funds that need to be recovered from them.

Recommendation 21

We recommend that MOH:

- perform an analysis as to why the transfer payment reconciliations were not being completed;
- provide the necessary resources to complete the outstanding transfer payment reconciliations along with the reconciliations relating to the 2023/24 fiscal year by June 30, 2025; and
- develop a plan to recover the identified unspent funding amounts from CYMH agencies by March 31, 2026.

For the auditee's responses, see **Recommendations and Auditee Responses**.

Ministry Does Not Analyze or Follow Up on Varying Agency Costs

Each year, MOH receives program-related expenditures and service data from its funded CYMH agencies, but it does not use this information to assess whether cost variations at agencies in the same region are warranted.

The most recent financial and service data submitted by agencies and reviewed by MOH is from 2021/22. We analyzed this data and found significant regional variances in the average cost per individual served for five core services. For example, as shown in **Figures 10** and **11**, our analysis showed that the overall provincial cost per person:

- for counselling and therapy was about $2,600, but average regional costs varied from about $1,500 in the West region to about $4,200 in the Toronto region;

Figure 10: Average Agency Cost per Individual Served by Region for Select Core Services ($ 000), 2021/22

Source of data: Ministry of Health

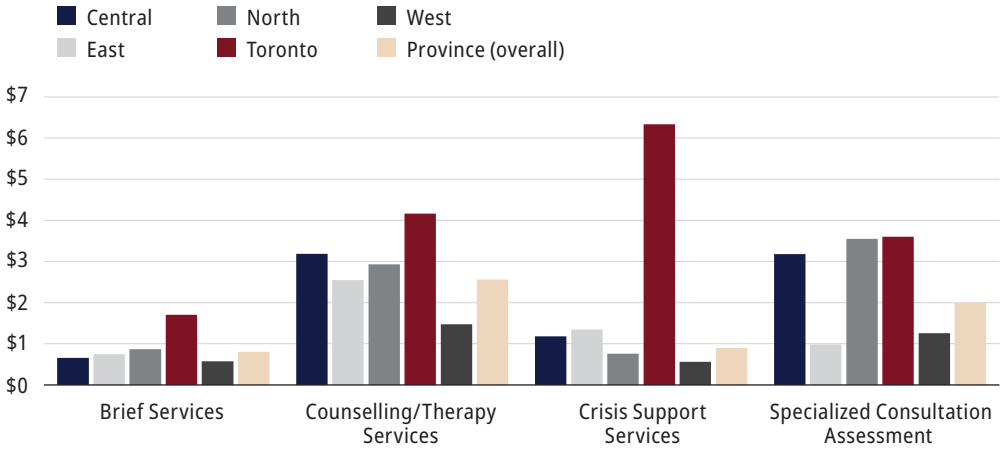
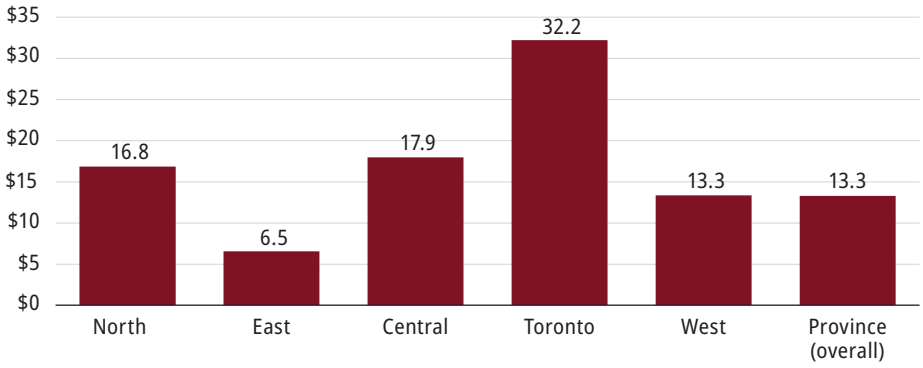


Figure 11: Average Agency Cost per Individual Served by Region for Intensive Treatment Services ($ 000), 2021/22

Source of data: Ministry of Health



- for crisis support was $900, but regional costs varied from about $600 in the West region to $6,300 in the Toronto region; and
- for intensive treatment services was $13,300, but regional costs varied from about $6,500 in the East region to $32,200 in the Toronto region.

This issue was also reported in our 2016 audit report on Child and Youth Mental Health, where we recommended that MCYS calculate and assess the agency costs per individual served and take corrective actions as needed. During this audit, MOH informed us that it would be challenging to calculate an accurate cost per client given the complexities and unique ways in which services and funding are allocated in each agency and within each service delivery area.

Without analyzing agency costs such as the cost to serve an individual for the core services, MOH would be unable to properly identify and assess the reasonableness of variations in these costs across the core service agencies, areas and regions in Ontario. The cost-per-individual analysis could also help agencies proactively identify service gaps and request additional funding before they are forced to interrupt services due to capacity constraints. This analysis can also help agencies pivot to a more suitable direction, such as mergers with other agencies.

Recommendation 22

We recommend that MOH:

- develop and implement a process to analyze costs of CYMH agencies using measures such as the cost per individual served for each core service at an agency on an annual basis, and assess if these costs are reasonable across different agencies, service areas and/or regions;
- identify any significant discrepancies within agencies in the same service area and/or region; and
- follow up with these agencies and take necessary corrective actions on a timely basis.

For the auditee's responses, see **Recommendations and Auditee Responses**.

Recommendations and Auditee Responses

Recommendation 1

We recommend that MOH:

- assess whether additional spaces for intensive core services and secure treatment are warranted in service areas that do not have these resources; and
- based on the results of these assessments, establish plans with timelines to improve the accessibility of intensive CYMH services across Ontario.

MOH Response

MOH agrees with this recommendation.

MOH will work with LAC, in partnership with other key stakeholders, and in alignment with work being undertaken by Ontario Health's MHA CoE, to assess ongoing needs and identify opportunities to build on the work under way to create an intensive services model. MOH will also work with the secure treatment providers to improve access to these services.

Recommendation 2

We recommend that MOH work with the CYMH sector to:

- establish and monitor common wait-time indicators that are comparable with data collected across Canada, and data collected in the adult sector;
- create consistent definitions and target wait times, taking into account all stages of the client pathway that agencies use for data reporting purposes (see also **Recommendation 17**); and
- monitor that agencies consistently apply wait time definitions in data reports.

MOH Response

MOH agrees with this recommendation.

MOH will work with Ontario Health's MHA CoE to continue the data and digital initiative. At maturity, this initiative will support full integration of CYMH data within the data and digital initiative, using consistent data definitions to enable standardized reporting on indicators, including wait times.

In the interim, MOH will continue to collect data through the BI Solution and will work with lead agencies and other key partners to assess reporting challenges and explore options to improve data quality and completeness.

Recommendation 3

We recommend that MOH, in consultation with the Information and Privacy Commissioner of Ontario and Ontario Health:

- conduct a full review of identity-based client profile information and assist agencies in collecting the information in a culturally safe way;
- review other similar data systems' race categories, update race categories in all CYMH data systems, and support CYMH agencies in their reporting of this information;
- develop tools to collect and analyze sociodemographic data annually and incorporate this knowledge into program and system-planning decision-making processes; and
- review the health card application requirements to identify opportunities to collect sociodemographic information at the application and renewal stage moving forward, and implement if feasible (see also **Recommendation 19**).

MOH Response

MOH agrees with this recommendation.

MOH will support full integration of CYMH data within the ongoing MHA CoE data and digital initiative, which will enhance the data collection of identity-based and data systems' race categories. MOH will also develop options to collect sociodemographic data and assess how it could be analyzed and used to inform policy design and program planning.

Recommendation 4

We recommend that MOH:

- require CYMH agencies to explicitly detail how they are providing services to meet the needs of marginalized population groups, and identify and act upon any gaps in that service provision;
- promote the Innovation Initiatives Program to the CYMH sector;
- work with community stakeholders and partners to identify how CYMH agencies can better serve the needs of marginalized communities; and

- support core service agencies to establish communities of practice or centres of excellence with the goal to identify and disseminate locally developed best practices and programming for marginalized groups that are scalable.

MOH Response

MOH agrees with this recommendation.

Currently, all CYMH core service providers are required to have a comprehensive understanding of the population they serve, so that CYMH issues are identified, understood, treated and supported in a manner that is responsive to that population. To build further capacity of the sector to address the needs of their marginalized populations, MOH will work with LAC and the Knowledge Institute to develop options to enhance the capacity of CYMH lead agencies and core service providers to effectively understand and meet the needs of their diverse communities, including promoting the Innovation Initiatives Program, and establishing communities of practice or centres of excellence.

Recommendation 5

We recommend that MOH take the lead and work with Ontario Health to:

- review and update accountability agreements to better define the roles and responsibilities of the two organizations in the current mental health service delivery model;
- evaluate options to align adult and CYMH programs, and develop a plan with timelines and establish indicators to measure progress in improving client outcomes; and
- establish clear timelines, indicators and targets to ensure the Roadmap to Wellness plan's relevant areas for CYMH are implemented within specific timelines and achieve the intended goals.

MOH Response

MOH agrees with this recommendation.

MOH and Ontario Health review their accountability agreement on a regular basis and will identify appropriate changes to further define roles and responsibilities.

Recommendation 6

We recommend that MOH take the lead to consult with MCCSS, LAC and Ontario Health, as appropriate, and:

- work with lead agencies in the CYMH sector to establish performance indicators and timelines to measure progress in improving access to, and facilitate cross-sector co-ordination among, other service sectors such as autism and child welfare for children and youth with complex needs;
- determine the most effective and efficient models to deliver addictions services to children and youth, and develop a plan to implement them; and
- include addictions services for children and youth in the new core services framework.

MOH Response

MOH agrees with this recommendation.

MOH is committed to working with LAC, MCCSS and MEDU to improve access to CYMH services for children and youth with multiple service needs, and support more seamless service delivery across child-serving sectors.

MCCSS, MOH and MEDU will explore opportunities to develop a cross-sector framework that enables earlier collaboration and co-ordinated service delivery across sectors for children and youth with complex special needs.

MOH is also committed to work with Ontario Health to build an evidence-based continuum of addictions care for children and youth, including embedding these within a comprehensive core services framework that will, along with the development of minimum program expectations or program standards, provide guidance and standardized expectations for the delivery of core services across the lifespan.

Recommendation 7

We recommend that MOH:

- work with Ontario Health to develop co-ordinated pathways that support transition-aged youth navigating between children and adult mental health sectors; and
- work with CYMH agencies to develop and implement requirements to establish internal policies to support the transition of youth from these agencies to appropriate services in the adult mental health sector, and to base these policies on recognized quality standards, such as Ontario Health's Transitions from Youth to Adult Health Care Services.

MOH Response

MOH agrees with this recommendation.

MOH will work with Ontario Health, LAC and other partners to identify opportunities to build and enhance co-ordinated pathways for transition-aged youth, including requiring core service providers to establish transition policies.

Recommendation 8

We recommend that MOH take the lead and work with lead agencies and Ontario Health's MHA CoE to establish co-ordinated access to CYMH services that includes all service areas and is aligned with the PCA approach being developed for mental health and addictions services for all eligible Ontarians.

MOH Response

MOH agrees with this recommendation.

MOH will collaborate with MHA CoE and LAC to develop options to design an integrated PCA system to facilitate equitable and timely access to the right mental health and addictions services and supports across the lifespan, and will explore options to integrate existing CYMH programs that are operational or in development that are supporting co-ordinated access.

Recommendation 9

We recommend that MOH:

- work with relevant stakeholders such as the Knowledge Institute and LAC to evaluate the need and potential impact of implementing an assessment framework including standardized tools to measure clients' perception of care, and establish a plan with timelines to support CYMH agencies to effectively use these tools; and
- ensure the tools implemented for the CYMH sector also allow for transitioning young clients to adult services.

MOH Response

MOH agrees with this recommendation.

Building on existing processes to help the CYMH sector effectively meet client needs, MOH will work with LAC, the Knowledge Institute and other key partners and stakeholders to develop options to improve data collection and assessment processes. This will include looking at whether a suite of evidence-based tools can better support the provision of client-centred care.

Recommendation 10

We recommend that MOH:

- require CYMH agencies to annually declare if their practices comply with Ontario Health's quality standards and monitor agencies' progress to achieve compliance;
- work with the Knowledge Institute to establish a workplan to develop or adapt the needed quality standards that are relevant to CYMH; and
- establish a process to oversee if agencies are aware of and are incorporating the available quality standards.

MOH Response

MOH agrees with this recommendation.

MOH will work with LAC, MHA CoE and the Knowledge Institute to assess the feasibility and appropriateness of, and analyze the cost/benefit of, implementing existing quality standards and any future quality/other standard expectations of care that are developed. Based on this review, MOH will also work with LAC and Ontario Health, with input from the Knowledge Institute, to develop options for monitoring service quality.

Recommendation 11

We recommend that MOH develop and finalize a provincial core services framework that defines minimum expectations for core services, that aligns CYMH services with adult mental health services, and that includes definitions and guidelines to support consistent implementation of core services across agencies.

MOH Response

MOH agrees with this recommendation.

MOH is currently developing a core services framework. The implementation of the core services framework will include the development of minimum program expectations or program standards that will provide guidance and standardized expectations for the delivery of core services across the lifespan.

Recommendation 12

We recommend that MOH develop and implement an HHR strategy for the community-based CYMH sector, including an action plan with clear timelines, to address workforce needs and wage disparities with other sectors such as education and acute care.

MOH Response

MOH agrees with this recommendation.

MOH's current HHR strategy is a multi-faceted approach focusing on education expansion and clinical supports, scope of practice and team-based care, expedited pathways for interjurisdictional and international practitioners, and retention and distribution.

MOH will refine and build on the current strategy, working across government to address urgent workforce challenges and stabilize the health-care system (including for CYMH and the broader mental health and addictions system). This work will be informed by a data collection exercise (relating to compensation), which is being undertaken in partnership with the Treasury Board Secretariat.

Recommendation 13

We recommend that MOH:

- review results of the workforce data survey, and if needed, supplement the data by conducting an independent compensation study to quantify the wage gaps between the community-based CYMH sector and other sectors, and implement a plan to update this information every two years;
- identify potential solutions, as part of MOH's work on HHR, to support core service agencies' efforts to recruit and retain their staff;
- work with CYMH core service agencies and relevant stakeholders, such as the Knowledge Institute and CMHO, to develop staff workload guidelines, allowing for variations depending on the type of mental health services offered; and
- develop a plan to collect and monitor the relevant information, and monitor progress against workload guidelines on a regular basis.

MOH Response

MOH agrees with this recommendation.

MOH will work with the Treasury Board Secretariat on the collection and analysis of workforce data for the mental health and addictions sector and consider next steps based on the data analysis.

MOH will also work closely with the CYMH sector, through LAC and with key partners, to consider initiatives that could support the recruitment and retention of qualified staff.

MOH will also explore the feasibility and appropriateness of implementing workload guidelines and/or other quality/effectiveness guidance, taking into consideration work that is under way, including the development of quality standards.

Recommendation 14

We recommend that MOH:

- develop a performance monitoring framework that defines situations of non-compliance with program requirements by agencies that require timely follow-up by MOH oversight staff, and the intervention mechanisms that program staff need to execute at defined time intervals; and
- update the TPAs to include provisions outlining consequences for serious non-compliances that remain unresolved over a defined period.

MOH Response

MOH agrees with this recommendation.

To strengthen stewardship and oversight and ensure consistency of application across the CYMH service system, MOH will develop options for creating a performance-monitoring framework and other tools to enhance monitoring of non-compliance.

Recommendation 15

We recommend that MOH:

- update the existing templates for service area plans and the system management reports to include specific measurable indicators and targets for each priority and objective to allow for an assessment of progress and impact;
- update the existing template for system management reports to include linkages with objectives outlined in service area plans;
- establish a process to consolidate significant and systemic issues identified from individual reviews of lead agency–submitted reports and information and to review these issues on at least an annual basis to determine ministry-level intervention where needed; and
- set indicators and targets to monitor lead agencies' performance and the impact of their work on their respective service areas, including the work on any sector initiatives, such as RTRC.

MOH Response

MOH agrees with this recommendation.

MOH will review and update service plan templates and will continue to work with LAC to consolidate significant/systemic issues and take appropriate action.

To ensure that the lead agency model continues to be optimized, MOH will develop options to build on current oversight mechanisms to make programs, policy and operational updates to support the effective oversight of CYMH lead agencies.

Recommendation 16

We recommend that MOH take the lead and collaborate with MCCSS to:

- streamline the reporting method and requirements for serious occurrences at CYMH agencies; and
- monitor the type of serious occurrences reported on an annual basis to detect trends and themes, and share the results with CYMH agencies.

MOH Response

MOH agrees with this recommendation.

MOH and MCCSS will continue to collaborate on the CYMH program, including identifying ways to reduce the administrative burden on agencies and improve monitoring of trends and themes of serious occurrences reported on a regular basis.

MOH will work with MCCSS and agencies to identify opportunities to enhance reporting practices of serious occurrences. This will include a review of current requirements to consider which updates should be proposed to support these enhancements.

Recommendation 17

We recommend that MOH direct LAC to:

- conduct a full review of data that is submitted through both TPON and the BI Solution to identify causes for data discrepancies, duplication of efforts and opportunities to streamline reporting by agencies;
- implement a process in which agencies must attest that the data they submit to MOH is accurate and that it reflects the data in the agencies' own information systems;
- develop a distribution process for agencies to receive output reports related to the data they provide to allow them to gauge their performance; and
- conduct regular reviews with lead agencies for feedback on data reported to discuss its usefulness in service-planning and identify opportunities for improvement.

MOH Response

MOH agrees with this recommendation.

MOH will perform a data review to compare TPON and BI Solution data at the agency level for all CYMH agencies that submit to these systems, and assess opportunities to improve the accuracy of

data submitted and streamline reporting, where appropriate. MOH will review whether to require agencies to attest to the accuracy of the information submitted.

Currently, CYMH agencies can directly access BI Solution reports by requesting access to their reports on the BI Solution system. MOH can send notices to agencies via lead agencies and/or Ministry staff to remind agencies of the process for requesting access to BI Solution.

MOH will also develop options to formalize a regular data table with LAC to review CYMH agency data reported each fiscal year to support service-planning and decision-making.

Recommendation 18

We recommend that MOH:

- review the current set of outcome indicators in TPON and the BI Solution, including those that are not being collected, and streamline the outcome indicators that CYMH agencies need to report;
- identify the barriers facing agencies that do not report data and assist them in establishing a plan to start reporting data to MOH;
- establish targets, monitor agency performance on outcome indicators and follow up with agencies that show declining performance year over year; and
- establish internal turnaround time targets for reviewing agency-submitted data on outcomes.

MOH Response

MOH agrees with this recommendation.

MOH will monitor and explore opportunities to improve the collection and reporting of indicators and targets in alignment with the data and digital initiative work under way. MOH will work with agencies to improve their data completeness and quality and will also develop options to formalize a regular data table with LAC.

Recommendation 19

We recommend that MOH take the lead and collaborate with LAC and Ontario Health to:

- support agencies to collect health card numbers from clients in a manner consistent with the *Personal Health Information Protection Act, 2004*; and

- establish a process to link the health-care visits of clients and patients across multiple health-care sectors, starting with CYMH, adult mental health and hospitals.

MOH Response

MOH agrees with this recommendation.

MOH will develop options to consider how to support agencies to collect health card numbers and collaborate with partners on options to share health-care visit data for patients across multiple health-care sectors, where feasible.

Recommendation 20

We recommend that MOH:

- analyze indicators of demand for community-based mental health services, such as emergency department visits by children and youth relating to mental health by service region and agency performance against service targets, build lead agencies' capacities in making requests to reallocate program funding through service area plans, and reallocate program funding to those areas that have higher needs; and
- evaluate the current number and coverage of core service agencies and lead agencies and take actions to reduce inequities in lead agency funding.

MOH Response

MOH agrees with this recommendation.

MOH will work with lead agencies in establishing and assessing additional indicators, data and other considerations that can support funding-reallocation decisions.

Further, MOH will identify opportunities to better understand service demand, in collaboration with ICES, MHA CoE, the Knowledge Institute and LAC, and in alignment with the work under way to support funding decisions.

Recommendation 21

We recommend that MOH:

- perform an analysis as to why the transfer payment reconciliations were not being completed;
- provide the necessary resources to complete the outstanding transfer payment reconciliations along with the reconciliations relating to the 2023/24 fiscal year by June 30, 2025; and

- develop a plan to recover the identified unspent funding amounts from CYMH agencies by March 31, 2026.

MOH Response

MOH agrees with this recommendation.

MOH acknowledges the importance of completing outstanding transfer payment reconciliations in a timely manner and is performing actions to address this, including dedicating targeted resources to complete outstanding transfer payment reconciliations, and implementing continuous monitoring of completion rates.

MOH will further consider how to maximize the completion of outstanding transfer payment reconciliations by June 30, 2025, through an ongoing assessment of expected completion timelines and adjustments and/or improvements to process as required.

MOH will also aim to recover unspent funding from CYMH agencies following the completion of outstanding transfer payment reconciliations.

Recommendation 22

We recommend that MOH:

- develop and implement a process to analyze costs of CYMH agencies using measures such as the cost per individual served for each core service at an agency on an annual basis, and assess if these costs are reasonable across different agencies, service areas and/or regions;
- identify any significant discrepancies within agencies in the same service area and/or region; and
- follow up with these agencies and take necessary corrective actions on a timely basis.

MOH Response

MOH agrees with this recommendation.

Currently, MOH reviews core service budgets to identify any significant discrepancies within agencies in the same service area and/or region, and support any necessary reallocations or adjustments with lead agency input. MOH will develop options on further approaches to assessing reasonableness of costs, identifying significant discrepancies and taking necessary actions to follow up with agencies.

Audit Criteria

In planning our work, we identified the audit criteria we would use to address our audit objectives (outlined in **Section 3.0**). These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at MOH reviewed and agreed with the suitability of our objectives and associated criteria:

1. Services are planned and co-ordinated between CYMH service providers and other providers and system partners including other mental health providers, other children and youth community and social services providers and education partners.

2. The Ministry plans and co-ordinates with other relevant ministries and agencies to help ensure gaps and duplications are minimized.

3. Clients receive timely and equitable access to evidence-based care that meets their needs.

4. The Ministry allocates and regularly evaluates program funding based on the relative needs of clients, and reconciles financial information submitted by service providers on a timely basis.

5. The Ministry monitors service providers to ensure that they comply with contractual requirements, legislation and regulations, program policies and standards, and takes corrective actions regularly when issues are identified.

6. The Ministry establishes and regularly monitors appropriate and reasonable performance measures to ensure quality services are provided and intended outcomes are achieved, and makes necessary program improvements.

Audit Approach

We conducted our audit between January 2024 and September 2024. We obtained written representation from MOH management that, effective March 7, 2025, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

As part of our audit work, we:

- interviewed relevant staff from MOH, primarily from the Mental Health and Addictions Division, the Capacity and Health Workforce Planning Branch, and the Financial Management Branch, as well as those from the I&IT Cluster of the Treasury Board Secretariat;
- conducted a survey of all MOH program supervisors responsible for overseeing CYMH agencies to obtain their perspectives on opportunities and challenges with their roles;
- interviewed relevant staff from Ontario Health, primarily from the following groups: MHA CoE; System Strategy, Planning, Design and Implementation; and Performance, Accountability and Funding Allocation;
- analyzed various program data including financial, wait time, serious occurrences and staffing;
- reviewed relevant legislation and regulations, program policies and guidelines, quality standards, TPAs, a sample of service area plans and service description schedules, and internal documents related to the CYMH program;
- spoke with and/or obtained information from external stakeholders and subject-matter experts to better understand the opportunities and challenges of delivering high-quality and timely CYMH services, including CMHO, Addictions & Mental Health Ontario, the Canadian Mental Health Association—Ontario, School Mental Health Ontario, the Office of the Chief Coroner and Ontario Forensic Pathology Service, Autism Ontario, Families for Addiction Recovery, and Patient Ombudsman;
- interviewed senior leaders of the CYMH LAC, the Knowledge Institute, YWHs Ontario and ICES to better understand the work they do to support service delivery to children and youth with mental illness;
- reviewed publicly available information of CYMH programs from jurisdictions including Alberta, British Columbia, Manitoba and Nova Scotia;

- interviewed senior staff from Associated Youth Services of Peel, the Black Health Education Collaborative, the Centre for Addiction and Mental Health, LGBT Youthline, the Ontario Native Women's Association, the Sioux Lookout First Nations Health Authority, Six Nations of the Grand River, Tungasuvvingat Inuit, and Wanasah to better understand the mental health service needs of children and youth from marginalized population groups;
- interviewed representatives from the Ontario Association of Mental Health Professionals to seek perspectives on opportunities and challenges on the mental health workforce;
- interviewed representatives from CMHA Waterloo Wellington, Starling Community Services, Strides Toronto and Valoris pour enfants et adultes de Prescott-Russell to better understand their role as co-ordinating lead agencies for the BI Solution for Ontario's CYMH agencies;
- conducted site visits and interviewed representatives from nine MOH-funded agencies. At seven of these agencies, we also examined documents and data relevant to our work. The nine agencies are located in Belleville, Burlington, Ottawa, Owen Sound, Thunder Bay, Timmins, Toronto, Windsor and Woodstock, spanning all five service regions. Collectively, they received about $72 million in MOH funding in 2023/24; individually, they received about $5 million to $16 million. Some of these agencies are MOH-designated lead agencies that have additional responsibilities to plan services for their service areas, working with any other agencies within the service areas, and some offer programming to Indigenous communities and/or French-speaking clients; and
- surveyed all MOH-funded CYMH agencies that provide core services to obtain their perspectives on areas we examined in this audit. Of the 149 agencies that MOH funded in 2023/24, 144 were still funded by MOH as of August 8, 2024. We surveyed them and 95 (or 66%) of them responded.

Audit Opinion

To the Honourable Speaker of the Legislative Assembly:

We conducted our work for this audit and reported on the results of our examination in accordance with the Canadian Standards on Assurance Engagements 3001—*Direct Engagements* issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies Canadian Standards on Quality Management and, as a result, maintains a comprehensive system of quality management that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

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

March 31, 2025

Shelley Spence, FCPA, FCA, LPA
Auditor General
Toronto, Ontario

Acronyms

Acronym	Definition
BI Solution	Business Intelligence Solution
CAS	Co-ordinated Access System
CIHI	Canadian Institute for Health Information
CMHO	Children's Mental Health Ontario
CYMH	Child and Youth Mental Health
HHR	Health Human Resources
HQO	Health Quality Ontario
ICES	Institute for Clinical Evaluative Sciences
LAC	Lead Agency Consortium
MEDU	Ministry of Education
MHA CoE	Mental Health and Addictions Centre of Excellence
MCCSS	Ministry of Children, Community and Social Services
MCYS	Ministry of Children and Youth Services
MOH	Ministry of Health
OHIP	Ontario Health Insurance Program
OPOC-MHA	Ontario Perception of Care for Mental Health and Addictions
OSDUHS	Ontario Student Drug Use and Health Survey
PCA	Provincial Co-ordinated Access
PDS	Ontario Health's Mental Health and Addictions Provincial Data Set
RTRC	*Right Time, Right Care: Strengthening Ontario's Mental Health and Addictions System of Care for Children and Young People*
SOR	Serious Occurrence Report
SOR-RL	Serious Occurrence Reporting – Residential Licensing
TPON	Transfer Payment Ontario
TPA	Transfer Payment Agreement
YWH	Youth Wellness Hub

Appendix 1: List of Regions and Service Areas in the CYMH Program

Source: Ministry of Health

Region	Service Area
Central	Dufferin/Wellington
	Halton
	Peel
	Simcoe
	Waterloo
	York*
East	Durham*
	Frontenac/Lennox and Addington
	Haliburton/Kawartha Lakes/Peterborough*
	Hastings/Prince Edward/Northumberland
	Lanark/Leeds/Grenville
	Ottawa
	Prescott and Russell
	Renfrew
	Stormont/Dundas/Glengarry
North	Algoma
	Cochrane/Timiskaming
	Kenora/Rainy River
	Nipissing/Parry Sound/Muskoka
	Sudbury/Manitoulin
	Thunder Bay
Toronto	Toronto
West	Brant
	Chatham/Kent
	Elgin/Oxford
	Essex
	Grey/Bruce
	Haldimand/Norfolk
	Hamilton
	Huron/Perth
	Lambton
	Middlesex
	Niagara

* These three service areas are led by one agency.

Appendix 2: CYMH Key Performance Indicators

Source of data: Ministry of Health

Question	Domain	Indicator
Who are we serving?	Client Profile	• Proportion of children/youth served • Profile of children/youth served by gender and age • Average age of children/youth served at initial assessment • Profile of children/youth with complex mental health needs
What are we providing?	Efficiency	• Service utilization (per core service) • Service duration (per core service) • Proportion of children/youth receiving brief treatment requiring no other services
How well are we serving children, youth and families?	Responsiveness Safety Access	• Proportion of children/youth with positive outcomes as identified by children and youth worker (also measures if caregiver agrees) • Proportion of children/youth (or caregiver) survey respondents with positive perception of the outcome • Number of children/youth with serious occurrence reports and/or complaints • Average children/youth time on service wait lists
How well is the system performing?	Effectiveness	• Proportion of children/youth survey respondents with positive perception of the service system • Value of investment

Appendix 3: Identity-Based Client Data Categories

Source of data: Ministry of Children and Youth Services (now known as Ministry of Children, Community and Social Services)

Identity-Based Client Data Categories	Data Collected from CYMH Agencies	Results Reported in CYMH BI Solution Data Dashboard
Age	✓	✓
Citizenship status		
Family status		
First language		
Gender identity	✓	✓
Identify as a person with one or more disabilities		
Languages spoken		
Marital status		
Place of birth		
Postal code		
Race	✓	
Religion		
Self-identify as an Aboriginal person	✓	
Sex at birth		
Sexual orientation		

Appendix 4: Comparison of Outcome Indicators in TPON and BI Solution

Prepared by the Office of the Auditor General of Ontario

Topic Measured	System Where Indicator is Defined	Indicator Name and Description	Difference Between Systems
Positive Outcomes Based on Clinical Judgment	TPON	Proportion of children/youth with positive outcomes: Based on all clients that ended services at the agency	The denominator is different.
	BI Solution	Proportion of clients with positive outcomes: Based on only clients that had an assessment at discharge. The positive outcome is based on clinical judgment.	
Positive Outcomes Identified by Assessment Tool	TPON	Indicator is not in TPON	n/a
	BI Solution*	Proportion of children/youth with positive outcomes as identified by standardized assessment tool: Proportion of children/youth with whom a validated tool was used at start of service and discharge, and use of the tool indicated a positive outcome at discharge	
Positive Outcomes Based on Survey Responses	TPON	Proportion of caregivers/youth reporting positive outcomes—the number of survey responses: Anonymous survey responses reported by caregivers and/or youth at discharge who indicated their experience of service resulted in positive outcome	TPON uses aggregated survey data. Survey responses are anonymous and cannot be tied to a client, so it is not implemented nor used by the BI Solution.
	BI Solution*	Proportion of survey responses with positive perception of the outcome: Proportion of survey responses with positive perception of the child/youth outcome, based on children/youth (or caregiver) perception	
Positive Experience with Service System	TPON	Proportion of caregivers/youth reporting positive experience with the service system: Proportion of caregivers and/or youth that have ended service and who report positive experience with the service system at end of service	
	BI Solution*	Proportion of survey responses with positive perception of the service system: Proportion of survey responses who reported positive experience with the service system at end of service	

* MCYS (now known as MCCSS) developed this indicator but did not implement it.

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of Ontario

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