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Standing Committee on Finance and Economic Affairs

Comité permanent des finances et des affaires économiques

Pre-budget consultations

Consultations prébudgétaires

1st Session
43rd Parliament
Tuesday 12 December 2023

1re session
43e législature
Mardi 12 décembre 2023

Chair: Ernie Hardeman
Clerk: Vanessa Kattar

Président : Ernie Hardeman
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Tuesday 12 December 2023

Mardi 12 décembre 2023

The committee met at 1000 in the Tosca Banquet and Conference Centre, Oshawa.

PRE-BUDGET CONSULTATIONS

The Chair (Mr. Ernie Hardeman): Good morning, everyone, and welcome to Oshawa. I call this meeting of the Standing Committee on Finance and Economic Affairs to order. We are meeting today to begin public hearings on pre-budget consultations 2024.

Please wait until I recognize you before starting to speak. As always, all comments should go through the Chair. The Clerk of the Committee has distributed committee documents including written submissions via SharePoint.

As a reminder, each presenter will have seven minutes for their presentation, and after we've heard from the three presenters, the remaining 39 minutes of the time slot will be for questions from the members of the committee. This time for questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members and two rounds of four and a half minutes for the independent members as a group.

SCARBOROUGH COMMUNITY RENEWAL ORGANIZATION

ONTARIO SHORES CENTRE FOR MENTAL HEALTH SCIENCES

The Chair (Mr. Ernie Hardeman): With that, I think our first panel—unless it has happened in the last couple of seconds, we have the first presenter of the panel, Scarborough Community Renewal Organization, here with us. The other two in the panel are not yet present, but we will start with the presentation, and then if we finish it and the others have not yet arrived, we will carry on with the questions and answers.

With that, let me say hi to the presenter, Larry Whatmore. Welcome, and thank you very much for being here. As you do your seven minutes of presentation—

Interjection.

The Chair (Mr. Ernie Hardeman): I believe we have someone else who has just arrived at the table. Yes, go ahead; sit down, and we'll get to that. You can both hear the directions at the same time. You have seven minutes to make your presentation. At six minutes, I will just say, "One minute." Don't stop, because that's the one minute for your punchline, and if you don't use it properly, I'll cut it off at the end anyway.

With that, we'll start with the presentation from the Scarborough Community Renewal Organization.

Mr. Larry Whatmore: Thank you very much, Mr. Chair, and good morning, committee members. My name is Larry Whatmore, and I am the president of the Scarborough Community Renewal Organization, an all-volunteer organization that strives to bring thoughtful advocacy to Scarborough civic affairs to create a more livable, dynamic and prosperous Scarborough that 650,000 Ontarians have chosen to call home.

Thank you for the opportunity to provide our ideas to inform your 2024 budget. My comments focus on the need for bold investments in public transit in Scarborough. We're all looking forward to the completion of the Eglinton Crosstown project to Kennedy subway station soon and the completion of the Scarborough subway extension, but there's much more to be done. Even after the completion of these projects, hundreds of thousands of residents in eastern and northern Scarborough will continue to endure punishing commute times on congested buses or congested roads to travel to jobs downtown or in other parts of Scarborough, or to study at the University of Toronto Scarborough campus.

And it's going to get worse. Toronto's population is expected to grow by 700,000 people between now and 2051. At least 175,000 of those new residents will come to Scarborough. How will we all get around? Gridlock is already a serious problem. We're not building any more roads, and buses in the suburbs are already jammed. The only solution is a large investment in public transit, and given the long lead times to plan, design and construct projects of this scale, we need to create a collective sense of urgency now, so we can address the issues we already face and prepare for the population surge that is coming.

Fortunately, there are three projects in play at this time where the Ontario government's financial participation can make a significant difference. The first is the proposed extension of the Eglinton East light rail transit project from Kennedy subway station to University of Toronto Scarborough and then to Malvern. This project is in the design phase, including a transit project assessment process, which the city of Toronto is expecting to complete in the spring of 2024.

The city of Toronto has committed $1.2 billion to this project, not a small sum by city of Toronto standards. But it illustrates the importance that the city of Toronto places on this project. However, the total price tag is likely to be in the neighbourhood of $4.6 billion. That's where you come in, but you don't have to do it alone. As you know, the federal government has a public transit infrastructure fund. This project should qualify for federal funding once the transit project assessment process has been completed. We are in regular contact with our Scarborough members of Parliament who are enthusiastic champions for this project, and I have spoken personally with the Prime Minister, who has expressed enthusiasm for this project as well.

So, let's work together to make this project happen and bring relief to Scarborough's long-suffering commuters. The Scarborough Community Renewal Organization is happy to support you to bring the federal government to the table to make this happen. That's the first project.

The second project is the proposed Scarborough busway. The Scarborough rapid transit line is now permanently closed. The Scarborough subway extension won't be completed until at least 2030. That means several more years of punishing commute times for our residents living in northern and eastern Scarborough. Toronto city council and the Toronto Transit Commission have quickly and wisely concluded that the best way to address this issue is through the construction of a busway, providing an express bus connection along the decommissioned line of the former Scarborough RT. The TTC is expecting to complete the design work by June 2024, so construction can take place in 2024 and 2025.

The estimated cost of this project is $72 million. I know the city is now having discussions with the Ontario government regarding funding for this project, which I would ask you to seriously consider as provincial funding for the busway would be a quick win for us all. That's the second project.

The third project is the proposed Sheppard Avenue transit extension. This project seeks to connect the Sheppard subway, which presently ends at Don Mills, east along Sheppard Avenue to McCowan Road where it would connect with the Scarborough subway extension. This is a great idea. Sheppard Avenue is going to experience significant intensification over the next 20 years as condo buildings sprout along the Sheppard corridor. We need to prepare now for the looming increase—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Larry Whatmore: —in the transit-dependant local population that will take place as this renewal happens. Furthermore, connecting Sheppard Avenue to the northern terminus of the Scarborough subway will allow the two lines to support each other.

This project is in the community consultation phase and there is significant support for this initiative by the local MPPs. Let's keep the consultation process going and proceed with the design work.

Thank you for your time, and I will be happy to take questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for that presentation.

Our next presentation will be from the Ontario Shores Centre for Mental Health Sciences: Phil Klassen.

And I forgot to mention it before: Make sure when we start the presentation to introduce oneself to make sure that Hansard has the proper name attributed to your comments.

Dr. Phil Klassen: Thanks to all of you for listening today. My name is Phil Klassen. I'm a psychiatrist and I'm vice-president of medical affairs at Ontario Shores Centre for Mental Health Sciences. I come to you today—just to put the lens on it, although I expect you folks all know about the lens—to ask, really, for a planning grant in relation to our proposal for an emergency department at Ontario Shores. I also want to acknowledge the work of MPP Coe in engaging with us around this project.

1010

Just by means of a bit of an introduction—although you probably know most, if not all, of this: Ontario Shores is one of four stand-alone mental health facilities in the province of Ontario. It's a 340-bed facility that employs about 1,300 staff and serves a wide range of different kinds of in-patients and outpatients. It's an academically affiliated teaching hospital. We have affiliations with the University of Toronto and Queen's and other universities as well. We think that we're well positioned to do something novel for Ontarians with respect to emergency mental health care.

In terms of the burning platform, if you will, or the problem, the challenge that we face, particularly in this region, is a mounting demand for mental health and addictions emergency services. I suspect that many of you are already aware of that, but the information that we've received from various sources indicates that, beginning pre-pandemic, mental health and addictions visits to Lakeridge Health emergency department increased about 25% in approximately the five years preceding. And mental health apprehensions by Durham Regional Police increased about 40% over that same period of time.

Conventional emergency departments, as I think you're probably well aware, struggle to deal with and integrate mental health and addictions problems within their usual workflow. Those kinds of emergency departments are really designed to take on heart attacks, strokes, trauma victims and those kinds of things. They're busy, they can be at times chaotic and, as you know, it's not uncommon for those kinds of emergency departments to have numerous mental health patients in gurneys, at times strapped to those gurneys, looked after by security guards, waiting for many hours for admission or simply to be discharged.

The other piece of the emergency department puzzle—and I've experienced this myself as somebody who worked in psychiatric emergency departments elsewhere, is that, conventionally, emergency departments are inherently somewhat unsatisfying experiences because the only decision that's made there is to admit or discharge. The issue of treatment or attempting to begin to remedy the person's difficulties is normally not on the table in most emergency departments.

In our search for something better and for something novel for Ontarians and Canadians, we landed on a model that some of you may be familiar with called the EmPATH model. We visited a number of these facilities in the United States, where there are now more than 20 such facilities. They're quite unique in a number of ways, and myself and some colleagues have walked through these departments to see them in action. They present a very, very different kind of model of care. We've incorporated what we think are some of the key features of the ones that we've toured and from the consultations we have received from the person who really developed this model, Dr. Scott Zeller, from California. We think there are a number of features here that could be really transformative of mental health emergency care.

The promises that we would make if we were to have this kind of an EmPATH model would be as follows: We should be able to reduce admission by at least 50%. In the United States and in Canada, typically about a third of patients seen in an ED for mental health reasons are admitted; in high-functioning EmPATH models, that number is about 20%. That's in part because of the unique structure of EmPATH, which is, it's an up to 23-hour, 59-minute length of stay in a milieu setting. That milieu setting has people in reclining chairs as opposed to in rooms, so it can expand or contract depending on need. In addition to being an emergency service in and of itself, it can also take overflow there from other places. The psychiatrist and other team members see the patient immediately. The other promise that we would make is that police and emergency services on average would be gone within 20 minutes.

These emergency services also tend to be very good in handling behaviourally disturbed individuals, and our focus would be on the most severely mentally ill—CTAS, or the triage scale: CTAS 1 and 2. The expected restraint rate would be less than 1%, and the expected patient satisfaction should be over 80%.

A lot of this comes from the culture you develop and the training you get when you're serving this kind of a group of people in this kind of emergency service, and part of it also comes from the very unique milieu. The milieu is unlike, really, any other kind of traditionally developed emergency service. There are interview rooms to interview family, to interview patients privately, but the main space has all the patients in one space in a community.

We know that with the surge in mental health and addictions activity that's taking place at Lakeridge and elsewhere in this region, there needs to be something to help absorb that growth. And that growth in mental health and addictions emergency services is independent of population growth, so we still also have to deal with population growth in addition to the need for mental health and addictions services. We should be able to absorb that.

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Phil Klassen: The current model is for 32 recliners, although that obviously can be adjusted somewhat, if necessary. There are obviously potential savings of this kind of a model: savings in terms of police and ambulance time, savings in terms of admission. Although, I also recognize, to be completely transparent, that we're also talking about absorbing some of the growth from other facilities. In part, it's a redistribution of funds, if I can put it that way.

We've gotten good support in the community. We have letters of support from Lakeridge Health, from Peterborough, from Durham police, from the Durham EMS. We think that we're also uniquely situated to staff this. There are health human resources challenges all over the system. We have had, I think, good success in that way. We're essentially fully staffed in terms of psychiatry. We're virtually fully staffed in terms of nursing. We have about 400 students a year, and so we think we can do it—

The Chair (Mr. Ernie Hardeman): That does conclude the time. I hope you can get that finished during the rounds of questioning.

I don't believe our third delegate has arrived, so we will now go with the questions. We'll start the questions with MPP French.

Ms. Jennifer K. French: Good morning. Welcome. It's nice to see you both here. I know that the committee appreciates being able to come to our neck of the woods here in Durham region.

I will start first with Mr. Whatmore. Certainly, this government and all of us as legislators have been hearing about the desperate need for transit, so I appreciate the way you laid out those three specific projects.

The one, though, that you talked about the province working with the feds: What would that have to look like as a next step, specifically?

Mr. Larry Whatmore: The federal government has a public transit infrastructure fund. It's been in place for, I believe, two or three years, if I'm not mistaken. I have been in regular contact with our members of Parliament in Scarborough, who are, as I mentioned, enthusiastic supporters of this project. They have been saying that this project should qualify easily for this funding, but we need to complete what they call the transit project assessment process—TPAP, for short—before it will qualify.

Once that is done, probably in the second quarter of 2024, then we've got a strong case to take to the federal government, saying, "We tick all the boxes; you need to come to the table." That will be easier to do, because I know that for projects of this scale, they almost always involve multiple levels of governments, each contributing. The city of Toronto has already made a very substantial contribution, by its standards, of $1.2 billion. If that remaining $3.4 billion could be cost-shared between the provincial government and the federal government in a way that allows this project to proceed, that would be transformational in terms of Scarborough public transit.

Just as SCRO is talking to you about this, we are also a dog with a bone in talking to our federal members of Parliament to make sure that this stays on the front burner at the right time so that we can bring both levels of government together in a way that allows this project to get done.

Ms. Jennifer K. French: Further, along the busway, that's on the decommissioned RT. Is that what you were saying?

Mr. Larry Whatmore: Yes.

Ms. Jennifer K. French: Okay. On that proposed Scarborough busway, you said that the city is already working with the province and that funding would be a quick win. How quick? In terms of timelines—I know that with transportation and infrastructure, quick is relative. I guess I'm wondering what the next immediate step would be and what the province's role should be in order for that to be, as you said, a quick win.

Mr. Larry Whatmore: Hence why I'm bringing it here, because if this is going to happen—and it ideally should happen as part of the 2024 budget. We know from the work that has been done so far by the city that we are looking at roughly a $72-million spend in order to get this done.

1020

We also know that it is urgent by public transit standards. At the moment, we have the very unappealing situation where, in the aftermath of the closure of the Scarborough rapid transit line, we have enormous congestion on all of our north-south routes—I'm sure Mr. Smith could speak to this—in order to pick up the load that had been carried by the Scarborough RT. We have express bus routes, but they're jammed, and they don't go a whole lot faster than what the traffic can. So it's a real, urgent problem, hence why this has been prioritized by the city of Toronto and by the TTC to get going.

To go from what was essentially a standing start to the completion of the design work in the spring of 2024, that is fast by public transit standards, although it is also a relatively small project by public transit standards, which makes it a little bit easier. So it would be important for—by the time the TTC's design work is complete, the business case is there, the TTC and the city of Toronto can bring something a little more fulsome to the provincial government for funding approval. But right now, I know from my conversations with city staff and politicians that they are warming up the provincial government in terms of, "This is the scope, this is the financial scale of what we are looking at. At a high level, this is the nature of the project. Stay tuned for the completion of the design work."

Ms. Jennifer K. French: I appreciate the need to warm up the government. Thank you for coming before the committee. That's an important piece of this.

If I may, I'll move to Mr. Klassen. Welcome. It's nice to see you here. I am really appreciative of the work that has been ongoing. Certainly, Ontario Shores in the broader community does unbelievable and unimaginable work, but I know the EmPATH project is awesome. As someone who has had the meetings and has the understanding beyond what you've had the opportunity to explain, I know that it is desperately needed in the community, but also something that we should want to have. The model, as you said, is quite innovative, quite different, but I would also say that it is about dignity in the care and how the folks who come there in crisis are treated and how they are able to be part, as you said, of that community.

I am dying to know what you have heard from the government, because I know that with the planning grant, there was a disappointment that we haven't seen that in writing. I know the member from Whitby clarified that in the Legislature, about the actual process with planning grants and whatnot. I'm in the opposition benches; I don't know what happens behind the scenes. But I would love to know: What are you anticipating in terms of timelines?

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Jennifer K. French: Have you been given signals from this government?

Dr. Phil Klassen: To the best of my knowledge, and I hope I'm not mistaken, we haven't heard anything back at this point. We've gone back and forth with IO, but we haven't heard anything about the planning grant—nothing fresh about the planning grant question.

Ms. Jennifer K. French: Okay. I'm hoping that doesn't mean it's not happening, because certainly I would like to add my voice to the record that says that we need to have this in Durham region and the province needs to have it as a model. So hopefully, in the next rounds, we can uncover whether it's in the pipeline, so to speak. But thank you both for coming and we'll look forward to our second round.

The Chair (Mr. Ernie Hardeman): We'll now go to the independent. MPP Bowman.

Ms. Stephanie Bowman: It's great to be here in Oshawa this morning. Thank you both for coming out here.

I'll start with Dr. Klassen. Dr. Klassen, I think you presented to this committee last year.

Dr. Phil Klassen: Either last year or—

Ms. Stephanie Bowman: Yes. I was newly elected last year, 2022, and I recall a very similar presentation. So I want to thank you for your perseverance, I guess.

I just wanted to confirm again the status. As my colleague Ms. French was just saying, you submitted the request for the planning grant. Just remind me of the amount of that?

Dr. Phil Klassen: One million dollars.

Ms. Stephanie Bowman: And you did not get that $1 million last year.

Dr. Phil Klassen: We have not heard anything positive about that.

Ms. Stephanie Bowman: Okay. So months have gone by, perhaps closer to a year now—I forget when you presented specifically—and nothing has happened for a $1 million—

Dr. Phil Klassen: Well, there has been some back and forth to clarify our submission, those kinds of things, but we've not received a planning grant at this point in time.

Ms. Stephanie Bowman: Right, okay. That's really disappointing, because again, I think you've laid out here—the evidence is fairly compelling that this model is working in the US in multiple sites and locations. It's a relatively small-dollar ask in terms of getting something off the ground or doing more of the work around planning, etc. Could you talk about what some of the reservations

might be that you've heard, either from the government or from the community or from other stakeholders? What would hold back this advance?

Dr. Phil Klassen: I suppose one potential reservation could be, "How does this align with the Lakeridge Health emergency department, and how would people know whether to go to Lakeridge or whether to go to Ontario Shores?" or those kinds of things. I think that's a communication issue. I think our focus, because we're a tertiary centre, is that we really want the most unwell people. We accept anybody; it's a walk-in model. But the goal would really be to take the high CTAS people—that's the Canadian Triage and Acuity Scale that the EDs use—particularly the police and EMS people, the most unwell people, because those are the people that we think we're best suited to deal with.

I think integrating the emergency and urgent care services at Lakeridge Health and at Ontario Shores should not be a complicated process to undertake. We know that Lakeridge has a huge surge. We know they cannot bed people in their ED even remotely close to that. They're always way over census. We're not asking for extra beds because we think the model itself will take care of the issue of needing additional beds by virtue of the model's advantages. The key thing is, you treat people, right? You treat people for up to 23 hours and 59 minutes. So we think that that model will not require additional beds at Ontario Shores.

Of course, everybody is understandably concerned about budgets and money and those kinds of things, and I fully appreciate that. I do think, though, that there is some important ice that needs to be broken when it comes to psychiatric emergency services for this region and, I think, for the province and for the country. Nobody in the country has put this model into play.

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Phil Klassen: So I think it would be great to demonstrate that, and I think that we're well positioned to do it.

Ms. Stephanie Bowman: Thank you. Again, it's a $1-million ask for the planning grant. Once you get that money, how long do you anticipate it could be till you're actually offering treatment to the people who need it?

Dr. Phil Klassen: Well, again, forgive me if I misspeak; I'm a psychiatrist, so some of these matters might be a little beyond me. The planning grant is to help establish what exactly those costs and time frames would be. The costs, as you know, are a bit of a moving target with inflationary pressures on construction. But we have our plans in place. We're basically ready to go.

Ms. Stephanie Bowman: Okay, that's great. Again, I just want to urge the government members that this is something that can make a real difference in people's lives and it's something that absolutely should be considered for this budget. I certainly would hope that you will get your grant this year.

The Chair (Mr. Ernie Hardeman): That concludes the time for that.

We'll now go to MPP Smith.

Mr. David Smith: It's a really great opportunity to address those issues that are on the front burner. I am from Scarborough, and I want to first start speaking to Mr. Whatmore because those are issues that are of great interest to me because it impacts Scarborough.

Transportation is a major concern. I, myself, face it every day to get to Queen's Park, and I can well imagine that that will continue. That is why our government is working diligently through infrastructure and transportation to make sure that we're investing the dollars that allow this to happen in terms of improving the transit operations. I know it's not happening as quickly as possible, but I can tell you, last Thursday evening, I was at the subway link along Sheppard, because it is a needed part that we need to look at in a very serious way. Because if we're talking about 700,000 persons coming into the GTA area, and many of those will find themselves either out in Mississauga or in Scarborough, we want to make certain that we have the roads and infrastructure in place to take on that. And we're talking about dollars of which I certainly would be happy to see get into that 2024 budget.

1030

However, there are many layers to those plans. I agree with the project—the decommissioned line of the LRT. Because in Ottawa, we have rapid transit. It's $72 million to get that up and going. Certainly, it's a conversation that we'll have more discussions about because it's a quick fix; it's easier than rail, and as a result of that, I'm very much in support of the things that you are bringing forward here today, of which we will be discussing further on.

I just have a quick question for you. What do you envision as the impact of these investments that we are putting into Scarborough through our transit? We are working on the Crosstown line. I know I personally like that. I like the fact that we are building along McCowan, getting across to Kennedy. I know that you support all of this, but you would like to see much more. We are working on a plan that will bring all of those things together. So what do you envision, and do you support what we have done thus far?

Mr. Larry Whatmore: As I mentioned at the beginning, Mr. Smith, the objective of the Scarborough Community Renewal Organization is to create a dynamic, livable, prosperous Scarborough. We're struggling with that now, thanks to the fact that we have a large public-transit-dependent population in Scarborough, and at the moment, we have two subway stations. Count them: two. Soon to be more—thank you—which is great.

But looking ahead, the provincial government has instructed the city of Toronto to prepare its next version of its official plan on the assumption that the city of Toronto—not the GTA, the city of Toronto—will absorb 700,000 more people in the next 30 years. That's an enormous growth in population. Given that many of them are going to come to the suburbs, Scarborough included, we need to be far-sighted enough to put in place the kind of infrastructure that's going to be necessary to enable those of us who live in Scarborough now, and the addi-

tional, say, 175,000 people, to be able to get around in Scarborough and commute to jobs downtown as well.

Without that transit spine and loop connecting various parts of Scarborough through the extension of the Scarborough subway, which is happening now, with the extension of the Sheppard line that's now under discussion, without those kinds of investments, it will be difficult for residents of Scarborough to be able to make a proper contribution to the economy of Toronto because they won't be able to get anywhere. This is the kind of concern that we need to prepare for, knowing we have this looming population spike coming over the next 20 to 30 years, as the city of Toronto is grappling with in its official plan now.

Mr. David Smith: I can tell you, sir, that the investment that we are putting into transportation and transit is to the tune of $70 billion. I can tell you that when things are neglected for a while, it creates some of these things. We are rapidly moving along the lane to make certain that we put the dollars in. But yet more work is still in progress to continue. So we're looking to work very much closely with you and your organization in partnership to make certain that we are meeting some of those headwinds.

Thank you very much. I'm going to pass the rest of my time over.

The Chair (Mr. Ernie Hardeman): MPP Kanapathi.

Mr. Logan Kanapathi: Thank you for your presentation, and thank you for being here. Thank you for your voice for Scarborough. I could talk about transit. I'll tell you—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Logan Kanapathi: —from my perspective, the Yonge North subway expansion. I was a former councillor of the city of Markham. We have been talking about it for two decades. It's never happened, then finally, the Yonge North subway extension is happening. Connectivity: You talked about connectivity. It's connecting York region and Markham people to Scarborough and connecting Scarborough people to Markham, vice versa. It's happening under our watch.

I know Scarborough is my heart of the city, because my whole family is living in Scarborough—my brothers, sisters—for 30 years.

My question to you, sir: Have you been supportive of the new investments we have made in Scarborough transit, including the three-stop Scarborough subway extension?

Mr. Larry Whatmore: Very much so. That's an important piece of the network that we're striving to establish, and we really are very grateful for the provincial support—

The Chair (Mr. Ernie Hardeman): A very important piece, but it will have to wait until the next round. The time is up.

We'll now go to MPP Kernaghan.

Mr. Terence Kernaghan: Thank you very much, gentlemen, for coming to committee to present today. Dr. Klassen, it's good to see you once again. I first wanted to congratulate you on your GTA top employer in regard to your micro-credential partnership with Ontario Tech Talent—very well done.

It is upsetting to learn that, despite having had you present last year at committee, your request has still gone unanswered. But I did specifically want to also commend the model of care that you offer, and I think it's something that is very intriguing. It's something that the province should be providing support for and engaging with to learn and to grow as we learn how to treat mental health and addictions. Specifically, I wondered if you could answer, what is the cost for the chair versus a bed in the hospital? Have you done any financial analysis of what that would look like?

Dr. Phil Klassen: The cost of the chair is going to be a little higher than the cost of a standard emergency department—I know that wasn't exactly your question—because, of course, people are typically getting more active treatment. They're being actively staffed and receiving active treatment. The cost of the chair itself is probably relatively comparable to that of a hospital bed, considering all the infrastructure and the things that surround it. It's the time spent in the organization where the cost savings are going to accrue and the prevention of other ED visits or re-hospitalization.

As you probably know, repeat ED visits and re-hospitalization are, unfortunately, a big part of the mental health and addictions story pretty much everywhere you go. Any kind of intervention that can reduce re-hospitalization is almost always a cost-effective intervention. It's a well-staffed situation because it's an active treatment situation. It's a little bit more expensive on the front end, but, ultimately, the savings come from preventing hospital days.

Mr. Terence Kernaghan: Understood. When you speak about the off-load delays and how your model actually does alleviate those, it also leads to quite significant savings and making sure that people are able to access care in other regards.

I wondered if you had any specifics in regard to what is the average treatment time. I know it's very difficult with mental health. Average treatment time: How long would patients spend in the chair? I know it's sort of a difficult question to answer given the diversity and the difference among the different situations you might see, but I wonder if there's a number you can share with the committee.

Dr. Phil Klassen: Sure. I think the average—this is from conversations that we've had with people who run these EmPATH units in the United States, and actually, we've developed some very happy friendships with some of the medical directors and other staff at some of the EmPATH units in the United States. I think what you typically anticipate, obviously with some spread, is about 16 hours. You can easily spend 16 hours for mental health and addictions problems in a standard ED. The problem is, you're spending 16 hours waiting, as opposed to getting 16 hours of treatment.

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Some of these EmPATH units in places with very severe drug problems have gone beyond 23 hours and 59 minutes, because sometimes they just need that substance to clear and then treat. So there is this secondary model that goes a little bit beyond 23 hours and 59 minutes,

particularly in places with severe crystal methamphetamine problems. But our target in our region would be to stick with the 23 hours and 59 minutes, and that's on the advice of Dr. Zeller, who's the person who put this all together. We expect that the average would be about 16 hours.

I will say that, of course, there are going to be some people who are going to need to go straight into a bed. I mean, there are going to be some people where you bypass, you get assessed and you go straight into an in-patient bed. Of course, there are people who are so in extremis in terms of mental health problems that that happens. But that's our working number.

Mr. Terence Kernaghan: Excellent. Well, then, Doctor, you anticipated my next question, which was what would happen if people were to exceed the 23 hours and 59 minutes.

Dr. Phil Klassen: The point, I think, is that like a lot of things, you need to go in at the front end with a time frame and a plan. You're seen immediately; the psychiatrist's and allied health's offices are right beside the door to the emergency department in these units. You're seen immediately, and the plan is made for the next up to 23 hours and 59 minutes. Then, obviously, you reassess.

Okay, some people do need to get admitted; about 20% of people will get admitted. But the plan is made immediately—that's really the key piece of this—so that those 16 hours are well spent.

Mr. Terence Kernaghan: Absolutely. I think that is one of the major concerns. We want to make sure we get people assistance when and where they need it, and time is of the essence when it comes to mental health and concerns in regard to that.

I know, in speaking with various organizations including the Police Association of Ontario as well as London Police Service, that when it comes time for first responders to access mental health supports, they feel as though attending a standard emergency room would be quite problematic for them, because oftentimes they're running into people they see in the field. There is this certain amount of stigma, and so often it has resulted in officers not seeking help.

Do you have any thoughts about what Ontario Shores could offer in terms of first responder accommodation?

Dr. Phil Klassen: First of all, I think it's probably safe to say that none of us really want people's first contact with mental health services to be in an emergency department. That's nobody's goal, and that's why we've expanded—

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Phil Klassen: —ambulatory services greatly. But the issue of emergency services for mental health and addictions problems is never going to go away completely, and so we need, I think, to provide the best possible service.

We have run, as you probably know, a first responder service for trauma. We remain connected with Wounded Warriors, and we're certainly available to support first responders' mental health needs on an ongoing basis.

Mr. Terence Kernaghan: Perfect.

Mr. Whatmore, thank you very much for your presentation. I don't have much time, but I wanted to ask, is there an intersection—pun intended—between transit and provincially significant employment zones, the employment lands that the government is currently considering opening up?

Mr. Larry Whatmore: I'm not sure I can answer your question directly, but let me try and answer it generically, which is to say that one of the strong objectives that we have as an organization, in alignment with trying to bring more prosperity to Scarborough—

The Chair (Mr. Ernie Hardeman): Thank you very much. That's the end of the time. Maybe we can finish in the next question.

MPP Hazell.

MPP Andrea Hazell: Good morning, everyone. I'm really excited to be here today. Thank you both, gentlemen, for your presentation. It was very well detailed. I am from Scarborough, and my questions are going to be to Mr. Larry Whatmore, president of SCRO—I'm using the acronym—Scarborough Community Renewal Organization.

I want to start off by saying I couldn't get on the bus today because I'm coming from Scarborough, and I took the wrong route and I got stuck. So I had to come back, take my car and get out here. It's a perfect example of the crisis we're facing in Scarborough for transportation.

I want to ask the president of SCRO to, again, validate to us—what are you hearing from the ground as you go about advocating for the people of Scarborough on transportation challenges?

Mr. Larry Whatmore: Well, it's certainly a real challenge at the moment because Scarborough was developed as a bedroom community back in the day and you got around through your car. That was fine up to a certain point, but Scarborough has grown way beyond the point at which that method of transportation is enough. Those of us who live in Scarborough—Mr. Smith alluded to it—gridlock is a real problem everywhere in Scarborough, not just on the 401 but on most of our arterial roads as well.

We're at a point where we're not building any more roads, so we need another solution in order to provide the capacity for our 650,000 residents, soon to be closer to 850,000 over the next 30 years, to be able to get around to make Scarborough livable. Scarborough is not going to be livable if you can live here but you have punishing commute times to get to work, whether it's downtown, whether it's other parts of Scarborough, whether it's York region. That's not a great quality of life for anyone.

We're trying to be far-sighted to anticipate a problem that we know is coming so that Scarborough can continue to be livable, desirable, prosperous and have the capacity that higher-order public transit will enable to bring more jobs to Scarborough and a broader range of jobs to Scarborough. We have some now; we'd like more. After all, if we had more jobs closer to home, that would actually take a little bit of pressure off public transportation and allow

people to spend more time with their families and less time commuting, whether it's on the road or on public transit.

That's thematically the kind of thing when we look at what public transit can bring to Scarborough. It's so much more than just a rail line. It's so much more than just a subway. It's what it enables in terms of an improved quality of life for our residents. That's really what we're striving for.

MPP Andrea Hazell: I have two more questions, and I'm doing rapid questions right now. I want to zero in on the busway, because I've been hearing from a lot of Scarborough businesses and also commuters, students that have to go down to the University of Toronto, seniors that have to go to their doctor appointments that they are really feeling it without that busway. How important is it for the government to invest in the busway for Scarborough?

Mr. Larry Whatmore: We've got just a horrible situation at the moment because of the closure of the Scarborough RT line and just gridlock on so many roads resulting from that, which is creating enormous frustration for our many residents in northern Scarborough, who relied for years on the Scarborough RT to make their commutes manageable. That's no longer possible and it's posing a lot of problems for Scarborough residents and Scarborough businesses that relied on that connection.

MPP Andrea Hazell: I am considering that we support the busway for Scarborough. I think my time is up.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll now go to MPP Coe.

Mr. Lorne Coe: Thank you, gentlemen, for your presentations.

Dr. Klassen, thank you so much for being with us today and thank you for your leadership with respect to the EmPATH initiative. You talked about partnerships, and they're so important here in the region of Durham. You and others associated with the project have done a great job in nurturing those types of relationships. Can you talk a little bit about the relationship that Ontario Shores has with Durham health? As you appreciate, there are 58 Ontario health teams in the province and Durham health is one of the pre-eminent teams in the province. Can you talk about the relationship with Durham health relative to the EmPATH project, please?

Dr. Phil Klassen: Sure. Yes, we do have a number of partnerships. We have it with the Scarborough Health Network now. We have a bundled care partnership around schizophrenia care that involves a couple of CMHAs. The way that I understand the centre of excellence is to sort of define the role of the four stand-alone or tertiary hospitals, to be the hub or the backbone and provide guidance as regard excellence in mental health care. I think that that's one of the roles that we could play in relation to an EmPATH unit.

We certainly are very connected with Lakeridge Health, which is obviously the home to that OHT. We've toured their emergency department. We've been in conversations with their medical director of mental health services, with their vice-president of clinical services to explore exactly how the two organizations could contribute, so to speak, to an overall emergency service for the region.

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We also recognize that we need to continue to have that partnership with Lakeridge and with first responders and with CMHAs to add an EmPATH to the mix, because once those patients leave at 16 hours or 23 hours and 59 minutes, they have to have a place to go. That place to go involves recruiting those community resources. So we've had those communications with the CMHA.

You may know that the medical director at Lakeridge is also a medical director at our hospital. That's Dr. Kevin Chopra. That was done purposefully and mindfully. We wanted that to happen so that that kind of connection within the OHT really makes sense. I don't want to put words in anybody's mouth; I think if you ask Lakeridge, I think they would say, "It's a deluge, and we're not in a position to do an EmPATH at this point in time, but we know we need to do something better and differently at Lakeridge." So I think that those conversations are really coming to the same place, which is how to best handle the search and need for emergency mental health and addiction services.

Mr. Lorne Coe: Thank you for that response, Doctor. I want to transition in terms of the conversations that you've had with Durham health.

I want to now lead into conversations that you've also had with senior civil servants at the Ministry of Health with respect to the EmPATH program. It's my understanding that some of these senior staff have been on campus, and they've had continued conversations with you about EmPATH, which I think is a good development, because you've led several briefings for ministers: the Minister of Health, the Minister of Long-Term Care, the Minister of Mental Health and Addictions, including other MPPs.

Can you speak specifically to the conversations with senior staff from the Ministries of Health and Long-Term Care and the outcomes of that to advance the EmPATH project, please?

Dr. Phil Klassen: Yes, certainly. We have had various staff from capital branch and from the ministry out to the hospital. They have learned about the model. They've seen our facility. They've seen the plans. We've had those conversations with them, and we visited some of those stakeholders, as well, in Toronto.

I would say, over the last little while, it has been mostly just refining the back-and-forth that kind of happens when you have a project of this scope and of this nature, asking for information from us about various things. I would say, recently, it's been more—we've had a lot of those in-person visits sort of in earlier days. I would say latterly it has been more back and forth in refinement about specifics of communication strategies, catchment area, relationship with Lakeridge Health—the kinds of things that you're just raising for us now.

Mr. Lorne Coe: So you're encouraged by those conversations then?

Dr. Phil Klassen: I mean, I think everybody is—I appreciate there's lots of pressures on the government, on

the system. I think everybody is excited about the project. I think everybody appreciates that it's a project that could have far-reaching ramifications for the region and potentially for Ontario. We're just hopeful that we get a chance obviously to demonstrate this.

Mr. Lorne Coe: As you indicated earlier the planning grant would provide you with approximately $3 million. What would be the effect of that grant? It doesn't mean that the EmPATH unit would be started right away; however, there would be work to be done. If you can just summarize quickly what would happen if that grant was granted.

Dr. Phil Klassen: No, you're quite right. A planning grant obviously is not tantamount to receiving the funding or the approvals necessary to actually be in the construction. The planning grant obviously is to refine and perfect the process and, particularly, I think now, given that a little bit of time as passed since our last pre-capital submission, some of those things need to be revisited. As you also know, MPP Coe, our more recent submission has scaled down the ask somewhat to really the core issue of the EmPATH unit as opposed to some of the other ancillary asks. So I think we want to use the planning grant to refine really what the core things are that we want to ask for and that we want to build into the region.

Of course, you know, we're obviously hopeful that it carries on from there, but we understand that the planning grant is what it is, but every step, I think, along the path would be something that we would welcome, and I think it's something that people in Durham would love.

Mr. Lorne Coe: To my colleagues, Chair, through you.

The Chair (Mr. Ernie Hardeman): One minute. MPP Byers?

Interjections.

Mr. Rick Byers: Okay, quick question—I'll go. Thanks, Mr. Chair.

Dr. Klassen, just some quick follow up—two really quick ones from me. First, the EmPATH model, how long it has been developing in the United States; and secondly, is it a separate facility that would be funded or is it within the existing facility? Really quick on both points.

Dr. Phil Klassen: So the current plan—I'll try to be as quick as I can—yes, it is a small additional building. Nothing gets torn down at Ontario Shores. It's an additional building for this unique space. But it's a relatively small building. The EmPATH model has been in the United States for, oh, my gosh—I can see the journal article announcing it in front of me and I can't pick the date out—but it's something in the range of 20 years.

Mr. Rick Byers: Okay. Perfect.

Dr. Phil Klassen: But it started in one place in Alameda, and then it sort of has grown in concentric circles.

The Chair (Mr. Ernie Hardeman): Thank you very much. That completes the time for that presentation, and it also completes the time for this panel. We want to thank the panel very much for being here today to help us with the start-off, the kick-off, to our pre-budget consultation of 2024. Thank you very much for being here.

PETERBOROUGH REGIONAL HEALTH CENTRE

ABILITIES CENTRE

VICTIM SERVICES OF DURHAM REGION

The Chair (Mr. Ernie Hardeman): As the first one is leaving, the next panel is Peterborough Regional Health Centre, Abilities Centre and Victim Services of Durham Region, if they will come forward. [*Inaudible*] in, we will have the presentations based on the same order as I announced them. You will have seven minutes to make a presentation. At six minutes, I will let you know that there is one minute left. It doesn't mean you need to stop; you just hear it and get your punchline in to make sure that the reason for your being here is not missed. With that, if each one could start with your name to make sure that we have the right name in Hansard for the presenter going forward.

We start with the Peterborough Regional Health Centre.

Ms. Laura Driscoll: Thank you. Laura Driscoll.

The Chair (Mr. Ernie Hardeman): The floor is yours.

Ms. Laura Driscoll: Okay. Thank you for having me today. My name is Laura Driscoll, and I'm the director of capital planning at Peterborough Regional Health Centre. I'm here to speak to you about the opportunity we have at Peterborough Regional Health Centre to alleviate capacity constraints at our hospital and others in the province, to invest in programs like mental health and cancer care, and to make it easier for people to connect to the care that they need, all closer to home.

I recognize many of your faces, and I'm sure you will recognize my request. PRHC is looking for an investment from the province into the regional program expansion project, or as we call it, the RPEP. Our president and CEO, Dr. Lynn Mikula, has given compelling cases to you for the past two years for why this project is important to our hospital, to the sector and to the community, and that need has not changed. If anything, the need has become more urgent.

PRHC has a busy emergency department, with over 80,000 visits annually, and regional centres of excellence in cardiac, vascular and cancer care. These regional programs serve a catchment of more than 600,000. We reach as far north as Haliburton, south to Northumberland and west to Durham. Driving distance for our patients can be more than an hour, and without these regional programs at PRHC, travel times are more like three. These lengthy travel times impose barriers to care for working parents who need to make a medical appointment for their child, or for people who cannot physically travel for extended periods of time.

PRHC is still advocating for the approval of our regional program expansion project to bring:

—a purpose-built mental health crisis unit to improve care and alleviate overcrowding in our busy emergency department for our most acute mental health patients;

—an expanded cancer care program for both adults and children to meet the overwhelming growth that we are experiencing and reduce wait times in this critical area;

—a new hybrid operating room that allows for us to complete minimally invasive surgery and reduce the need for open surgery, thus creating bed capacity and improving surgical wait times for some of our most complex surgical cases;

—a new electrophysiology program that will prevent patients from needing to travel out of town to Toronto and to Kingston for life-saving cardiac care; and finally

—a command centre that uses data and technology to optimize patient flow, reduce wait times and reduce the need for hallway medicine.

Collectively, these programs will have a broad impact across the region and bring care closer to home for thousands of patients, with more than 50% of our in-patients coming from outside of the city of Peterborough and the county of Peterborough. So, these programs have been a priority for PRHC for quite some time and I cannot understate our readiness to move forward with this project.

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Our foundation, in partnership with visionary donors, have led the funding for our local share. Our clinical leaders are collaborating with partner hospitals to begin the training process for new physicians to take on this new work in cardiovascular. Our four community hospital partners have been steadfast in their support for these programs and see this project as complementing their programs and supporting our patients across the region.

But what makes this project compelling to you, as members of the finance committee, is that we have the space sitting vacant. The shovels have already been in the ground. This is not about new construction; it's not about adding a new wing to the hospital or allotting a new capital allocation. It's unlocking provincial funds that we need to maximize the investment already made. So you will find few hospitals with space that is sitting, built, vacant, waiting to be fit out.

PRHC built a 17,000-square-foot tower in a courtyard within our existing site, adjacent to key programs that are already existing, such as our operating theatres. This means that you can invest in the regional program expansion project and say yes to mental health, say yes to cancer care, say yes to surgery, for a much smaller investment than if we were building new space or redeveloping entire programs.

We funded this construction project and went through the Ministry of Health's capital planning approval process. We followed the ministry's direction and completed a full master plan to show the rigour and our full site review, long-term. The construction of the building is complete. It was designed with the intent for these programs to expand and, as I said earlier, our clinical vision is unchanged. Investing in the regional program expansion project will help us reduce hallway health care, reduce wait-lists and improve patient outcomes right away—again, for those across our region.

So, the RPEP has been reviewed and is sitting, waiting for approval by the capital branch with the Ministry of Health. It awaits a government decision on an award for a planning grant to map out the nuts and bolts to the fit-out of the shelled-in space, and our costs are modest.

What I'm asking for today is a planning grant for $1 million, which would be a commitment to a total investment of the construction of this project for $51 million from the province. Our ask is for your support—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Laura Driscoll: —moving the regional program expansion project to the next stage of planning with the Ministry of Health and to unlock the funds we need to say yes to patients across the region, keep care closer to home and remove barriers to care. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much.

The next presenter will be the Abilities Centre.

Mr. Ross Ste-Croix: Thank you, Chairman Hardeman and members of the committee, for this opportunity to comment on the preparation of the province's 2024-25 budget, and thank you for the province's ongoing support of Abilities Centre.

Abilities Centre provides programs and services to individuals with disabilities who face barriers to accessing employment, recreational and rehabilitation opportunities in their communities. In addition, through our training and education services, we provide education to municipalities, school boards and public service organizations on disability inclusion and accessibility.

Through these initiatives that have proven concept in Durham region, Abilities Centre is poised to scale and assist the province with two of its most significant challenges: placing more Ontarians in jobs and reducing the strain on our overtaxed health care system. But we need your help.

November 2022, the province showed its commitment to reducing barriers to employment for individuals with disabilities in the changes it made to the Ontario Disability Support Program.

Our employment programs introduce Ontarians who face barriers to accessing employment opportunities to the skills needed to find and retain meaningful work. In addition, we engage with prospective employers in the community to educate them on disability inclusion in the workplace and the financial benefits of inclusion. In 2023, we provided training and coaching services to 138 prospective employees with disabilities and consulted with 78 prospective employers.

Securing employment alone doesn't represent the holistic approach that is needed to ensure that Ontarians with disabilities are included in society. We all need to lead well-rounded lives to build confidence, make social connections, and maintain and improve our health and wellness. Our adult day programs work with individuals who have aged out of the school system and need community outlets to engage in activities that support their health and well-being through programming focused on social engagement, creative expression, life skills, and sports and movement. These programs provide a strong foundational support for individuals to gain skills and achieve the goals that are most important to them. In 2023, we worked with

86 individuals to help them develop new skills, learn about activities to pursue in the community, increase their ability to plan and navigate outings, and build confidence and a stronger sense of autonomy.

Our therapeutic recreation programs work with individuals with disabilities and those who experience barriers while they are still in the school system, with the goal of ensuring they can more effectively transition to employment and recreation opportunities that match their interests and goals after they leave school. In 2023, we engaged more than 170 students and over 60 educators in our therapeutic recreation in schools program.

In addition, through our training and education services, we provide accessibility audits to public organizations across nine areas of their business, from their built environment to their hiring processes, and help them build accessibility improvement plans to ensure they can better serve and employ Ontarians of all abilities. To date, we have completed accessibility audits with over 40 organizations, including 12 municipalities, two school boards and one regional police service. This work has extended outside of Durham region, as far as the city of Vaughan and the Niagara region.

Our training and education services are easily scalable and vastly expand our capacity to make the communities of Ontario more accessible by changing the way our public service institutions approach accessibility and inclusion. By providing education on accessibility and inclusion to the organizations that shape our communities, and by providing individuals with disabilities and who face barriers access to the programs and training that will give them the skills, confidence and support they need, we provide a holistic solution to put more Ontarians in jobs across the province.

The ongoing strain on our health care system requires more supports to keep Ontarians healthy and out of hospitals. Two significant gaps that we see right now are proper education and prioritization in our education system on physical literacy, and a lack of available post-rehabilitation programs. Physical literacy is not effectively taught to our future educators. Physical education is taught in an ableist curriculum that does not prepare our future educators to be able to adapt to the needs of their students with disabilities. The result is the exclusion of students with disabilities and an early negative association with physical activity. Those negative experiences lead to inactive lives and earlier and more frequent health complications and hospital visits for individuals with disabilities.

Our physical literacy workshops train educators on how to approach the teaching of motor and sports skills in a way that adapts to the needs and abilities of each individual student in an inclusive environment. Educators attend a workshop with one of our facilitators, and then co-facilitate a class with their students with the aid of the facilitator to ensure the learnings can be more easily transferred into practice. In 2023, we delivered our workshops to 542 participants. Teaching inclusive physical literacy addresses pre-habilitation and ensures Ontarians grow up healthier and more active, and thus in need of less support from the health care system.

The other side of the equation is post-rehabilitation. Ontarians who experience a heart attack or stroke, or who live with a chronic lung or neurological condition, have access to time-limited rehabilitation programs, but are mostly left to their own devices once those programs conclude. If you know anyone who has had to recover from a traumatic event or who lives with a chronic progressive condition, you will know that those individuals are rarely ready to reengage with their previous activities when their rehab programs come to an end. As someone who lives with a progressive neurological condition myself, I can personally attest to the need for more post-rehabilitation programs across the province.

Abilities Centre works with health care partners, such as Lung Health Foundation and University Health Network, to ensure that our post-rehabilitation programs help Ontarians rehabilitate after a stay in the hospital and reduce future hospital visits and health care costs. In 2023, we reached over 250 Ontarians with these programs. By providing inclusive physical literacy education to educators to shape a more inclusive physical education curriculum and providing post-rehabilitation programming for those individuals that have experienced traumatic health episodes or who live with chronic health conditions, we provide a holistic solution to keep more Ontarians out of hospitals across the province.

All the programs I have spoken about—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Ross Ste-Croix: —are having a tremendous impact on the communities in Durham region and beyond, but the rising costs of inputs means that funds received are spread thinner, and more funding is needed to maintain and grow the number of Ontarians we can reach with our programs and services.

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In the 2024-25 budget, we ask you to consider additional funding to support Abilities Centre to allow us to maintain our operations and expand to new areas of the province to provide the programs and services that will put more Ontarians with disabilities in jobs and reduce the strain on the health care system.

The Chair (Mr. Ernie Hardeman): Thank you very much. We will now go to Victim Services of Durham Region.

Ms. Krista MacNeil: Good morning. Thank you so much for having me today and for your ongoing support. My name is Krista MacNeil, and I'm the executive director of Victim Services of Durham Region.

Victim Services of Durham Region, or VSDR, provides immediate crisis intervention for victims of crime or sudden tragedy through funding provided by the Ministry of Children, Community and Social Services, or MCCSS. Victim services agencies under MCCSS deliver the Victim Crisis Assistance Ontario program, or VCAO, as part of our core functions.

The first part of my request today I will repeat annually while the crisis in the VCAO programming continues. To

provide life-saving prevention and intervention services, our agency relies on grant funding to support 50% to 60% of our annual operating costs. Referrals have risen by over 160% since 2019 while our core ministry funding, minus a small amount for pandemic relief, has increased by just 5%.

Women and children are disproportionately impacted by victimization, comprising over 80% of our referrals. The average salary of a crisis intervention worker in Ontario is $37,000, a mere $10,000 above the poverty line. Yet without our support, more women and children will die.

Grant funding comes with lengthy applications, onerous targets and extensive reporting requirements. Our over-reliance on grants is unsustainable and it will not continue, because the lives and well-being of our staff are also now in crisis. The responsibility of saving lives of women and girls should not be our burden to carry alone. Our need for a core funding increase is dire, and without it, lives will be lost.

I would also like to request consideration for the formation of an inter-ministry task force to enhance cross-sectoral collaboration and communication, assess funding requests that have cross-sectoral benefits and analyze severe discrepancies that exist across intersecting and interdependent programs funded by separate ministries.

I'd like to provide a few examples. Supporting victims of crime is one of the five pillars of policing, yet police and victim services are funded by different ministries. Police rely on victim services to provide essential, practical and emotional support to victims, and we rely on police to connect us with victims. Without us, recidivism rises and people continue to live at risk. There is a direct correlation between crime and victimization, often with a single crime resulting in multiple victims. When crime rates rise, police budgets rise, yet funding to support victim services does not.

The Durham region HALT model, seniors' support unit and mental health support unit are all examples of models with demonstrated success. These models all pair social services professionals with police and are strongly supported by evidence-based research.

The HALT model in Durham region relies on embedding victim services staff in the human trafficking police unit to increase engagement with survivors. It has been incredibly successful, resulting in the police unit more than doubling in size since 2018 when the model started. The model's success is entirely dependent on the presence of victim services. Yet we still receive only $24,000 of sustainable funding to support our entire human trafficking response.

In October 2023, we positioned one of our staff at the hospital. In the first week alone, the number of referrals quadrupled all of the referrals we received in 2022. We've been able to expedite discharges by securing hotel accommodation for victims when shelters were full. We've connected with multiple victims whose only opportunity to get help was during their visit to the ER. We are able to secure residential addictions treatment for survivors within a day, further expediting discharges from hospital and keeping survivors safe. We are able to connect with vulnerable seniors at risk of elder abuse and continue to support them even after their return to the community. We also have no funding to sustain this pilot.

Using donations, we are piloting embedding a staff into the missing persons unit to work with missing youth upon their return to prevent and reduce risk of exploitation. We intentionally hired an Indigenous person for this role to meet the missing and murdered Indigenous women and girls inquiry calls to action. This role is proving critical in ensuring the right support for youth and their families and significantly reducing the workload of police. We also have no funding to sustain this program.

VSDR has on many occasions been able to identify gaps in supporting victims that, when addressed, also fill gaps in other sectors. Yet, we continue to face significant challenges obtaining funding for projects that are multi-sectoral. Social problems are complex and require an intersectional lens and multi-sector solutions. Balancing acute needs with the need for sustainability is a shared challenge. I believe that dedicated funding for inter-ministry programs could address gaps that would result in strategic partnerships, significant cost savings and provide mutual benefits across sectors. The creation of an inter-ministry task force responsible for cross-sectoral collaboration and communication may help to address severe—severe—discrepancies with intersecting programs and to assess requests for funding that address multi-systems challenges.

Thank you for the invitation to attend today and for hearing my recommendations.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the presentations.

We'll start the first round of questions with the independents. MPP Bowman.

Ms. Stephanie Bowman: Thank you to all the presenters for taking time to come today. I will start with the Peterborough Regional Health Centre. Laura, thank you for your presentation. For the benefit of those of us who are somewhat new still, could you just kind of give us a timeline? I understand you've got a building that is sitting vacant. How long has the building been sitting vacant, and how long has the request been with the Minister of Health to advance the operations of the building?

Ms. Laura Driscoll: Sure. Thank you for the question. So, we began the tail end of the planning and approval process in 2018. Construction started in 2019. Throughout the pandemic, we built the structure. It does house two MRIs that were delivered in January 2022. At that point we got occupancy for the space, and it has been sitting since January 2022 waiting for fit-out.

Ms. Stephanie Bowman: So, the documentation has been sitting on the Minister of Health's desk since January 2022?

Ms. Laura Driscoll: It's not on the minister's desk. It's in with the capital branch and it's awaiting government decision.

Ms. Stephanie Bowman: Since January 2022?

Ms. Laura Driscoll: That's correct.

Ms. Stephanie Bowman: Okay. You've talked a bit about the impact in terms of longer wait times, people having to travel further. Could you share a few stories, maybe, about what you're hearing from your community about this? I mean, there's a building sitting there waiting to treat people. We talk about this regularly in the Legislature, that building buildings and building infrastructure is, of course, important, but if we don't have the people and the staff and the money to operate them, then they're not really much use. We've seen this over and over again from this government. We're talking about building daycares, building hospitals, and yet they're not serving the people. Could you talk a little bit more about the impact that that's having in terms of the lack of service to your community?

Ms. Laura Driscoll: The construction of this tower is actually built in the centre of our building. It's fitting out part of a courtyard. Lots of people don't realize that it's sitting there vacant because it's so integrated into our hospital and, again, that was intentional so that it's adjacent to some really expensive programs to build, like surgery, so we could build a single OR rather than redeveloping an entire surgical program.

I will say, bringing new services to the region, like electrophysiology—it's entirely new programming than what we offer. We send a lot of patients to Toronto and Kingston General for this type of cardiac treatment. It means patients can stay in Peterborough, not have to either wait in a bed in PHRC. Oftentimes, Toronto and Kingston are backlogged, and so they will wait in a bed in our cardiac unit for two, three days, get the transfer, receive the procedure there, get transferred back to Peterborough and then go home. So, keeping it closer to home eliminates the burden on the individual for travel, of course, the resources with the travel and keeps the family involved throughout the care journey. So when I say it's about alleviating pressures both at our hospital and others, it's really about expediting that service and keeping them out of in-patient beds as well.

Ms. Stephanie Bowman: Thank you. I will move to Krista next. Krista, thank you again for your presentation and for the work that you are doing, because clearly you were trying to have a major impact, and are having a major impact, with very limited funds. I applaud your innovation in terms of trying pilots. I think pilots are something we should do more of.

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Mr. Ernie Hardeman: One minute.

Ms. Stephanie Bowman: Could you talk about what the police services staff, on the ground, say to you about the value of your services? It's kind of shocking that, again, we know we need to fund police, absolutely, but we also need to fund, as you said, victim services. Could you talk a little bit more about what the police are saying that the value of your services are?

Ms. Krista MacNeil: Yes, absolutely. So we now have expanded. We are embedded in multiple units and we've received the same response from police from every unit: They don't know how they did the work without us before. They're asking for more and more of us, and we don't have people to give them.

Our numbers for human trafficking alone in Durham have risen by seven times what they were four years ago. So we've been reliant on grant funding to hire more and more staff to respond, and police are using every body that we hire.

The impact to police is astronomical. Not only are we dealing with the social aspects of human trafficking, but victims are more likely to talk to us. So it's resulted in higher conviction rates, higher charge rates—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We'll now go to MPP Dowie.

Mr. Andrew Dowie: I want to thank all the presenters for being here today. Actually, I've learned a lot in just hearing your spectrum of presentations: mental health, victim services, Abilities Centre—really, some of the challenges you've described are certainly common through our communities throughout Ontario.

I wanted to focus my first question on Krista. Thank you for your presentation and for the letter you distributed to the committee as well. I was actually taken by—you highlighted one of the challenges I know many face, which is the inter-ministry participation. I just wanted to see if you were aware of the announcement last week of Ontario's stance, which was based on the National Action Plan to End Gender-Based Violence. It did highlight cross-government collaboration so much that actually it astounded me.

Marci Ien, the federal minister, was actually part of the news release from the province, but it was a commitment to that inter-ministerial "strategy to increase funding to service providers to increase their ability to provide supports, expanding initiatives that help stop gender-based violence before it occurs, making it more seamless for women and children to transition between supports, and expand programs that provide training and employment opportunities for women so they can gain financial independence."

I hear you, and I think the government hears you in making this announcement last week on December 6. It's just a point very well-taken. I know that there are many approaches we need to take that are similar to what you have raised.

I also wanted to dive into, though—well, actually, I'd like to get your thoughts. This starts, really, on women's issues, but I know it would go beyond. I'm wondering if you could relay to us some of the challenges you are experiencing, a bit more detail about how it's complicated and how it takes away from the work that you are trying to do.

Ms. Krista MacNeil: For sure. I am aware of the announcement. My understanding is, that's a four-year commitment, which again does not provide sustainability to us. Generally, that tends to come in grant funding. I know that the detail of where that funding will be allocated hasn't yet

been released, at least not to us. So my concern is sustainability.

Then, also, with the inter-ministry communication, I will say that that does not translate to the front line. We, as a front-line agency, do not have a particular body to go to to present our case for funding, to talk about these pilots. A lot of the data that we sometimes rely on for these pilots, we need police to capture, we need the health care sector to capture, and they tell us that they don't have the funding to capture those statistics that will support our programming. We continue to face those challenges with pretty much every project that we have that crosses sectors. So it's the translation to the front line that I'm concerned about, and again the sustainability.

Mr. Andrew Dowie: Thank you. In that, right now, your funding is, generally speaking, on the—call it a shorter-term horizon. Has it always been this way? Or has there been an evolution in the way the program has been funded historically?

Ms. Krista MacNeil: Our core funding through the Ministry of Children, Community and Social Services is sustainable funding, but it is about $600,000 a year. We currently have 21 staff, and that supports about seven staff. We supported 8,000 clients last year directly as direct victims, and another 40,000 through our prevention programming. And so, without the grant funding to offset about 60% of those costs, we would not have that reach. But we just can't continue to rely on the grants because it's now become completely unsustainable.

Mr. Andrew Dowie: I will share the rest of the time with MPP Coe.

The Chair (Mr. Ernie Hardeman): MPP Coe.

Mr. Lorne Coe: Thank you all for your presentations.

Mr. Ste-Croix from the Abilities Centre, thank you so much. You will know that earlier this year the government provided $3.5 million to the Abilities Centre. I'd like you to talk a little bit more specifically about how that money has been used since the announcement was made by Minister Parsa in May of this year. Particularly, I'd like you to talk about the Abilities Centre's enterprises, skill development and employment aspect of what you do and, added to that, the physical literacy and inclusion, and then I'll have a supplementary question when you respond.

Mr. Ross Ste-Croix: Thank you, MPP Coe. I'm glad you brought attention to the announcement about the $3.5 million over three years. Historically and in recent years, we received just shy of $3 million from the province of Ontario across a number of our programs that I detailed. We were very excited in March to hear about the announcement of the $3.5 million.

However, what has subsequently happened is MCCSS has communicated that those funds are not flowing. So, we have not received a penny of that announcement that was made during the budget announcement in March or that was reiterated in the fall economic statement. We have not received any additional funding and the word from MCCSS is that that funding is not coming.

Mr. Lorne Coe: Well, we'll move to another area. The programming that you have for post-stroke recovery: Can you talk specifically to some of the features of that program—how many participants you have and what some of the outcomes have been since you launched that program—and how you measure that program?

Mr. Ross Ste-Croix: Absolutely. The program that you are referring to is the TIME program—so that's Together in Movement and Exercise. What we do with all of our post-rehab programs, TIME included—and TIME is our original post-rehab program—is we partner with a hospital that has developed the programming. What we are able to do is get staff trained in the programming and be able to offer that post-rehabilitation program in the community as an outlet to individuals so that they don't have to travel as far to their hospital to get that programming.

We have TIME running; it runs daily at the centre from Monday through Friday for—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Ross Ste-Croix: —stroke recovery patients and we have approximately 12 individuals in each class, so different individuals come each day and they participate. Many of them will move back into traditional exercise programs and that is, in some ways, how we measure success. Others are going to have to remain in the program on an ongoing basis and the measurement is more about maintaining skills and abilities they are able to still have.

Mr. Lorne Coe: Right.

Thank you, Chair.

The Chair (Mr. Ernie Hardeman): We'll now go to the official opposition: MPP French.

Ms. Jennifer K. French: I'm really glad to have all of you here at committee, bringing voices from across Durham region—and Peterborough, we're glad to have you, too.

Actually, I will start with you, Ms. Driscoll. As someone with a senior grandmother—I'm her caregiver and we had spent a lot of time—four months, actually—at the hospital in Peterborough a while back. While we were very impressed and grateful with the care there, I take your point about what you are saying that there is a growing need, and certainly, to have space sitting vacant and to be almost there, I can only imagine the frustration.

When you say that the decision is sitting with capital branch awaiting government decision, from where you sit, what do you imagine that actually entails? What does "government decision" mean? Is it that the minister hasn't picked up the phone? Do you have any idea what is required by government to make that decision? Have you received any feedback in terms of those specifics?

Ms. Laura Driscoll: I'll start off by saying, given that these are regional programs, our MPP, Dave Smith, and the two other regional MPPs have been very supportive in advocating for this, and very specifically what we're asking for is for a planning grant. It's to move to functional programming. It's the next stage of design planning.

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Our understanding from the capital branch at the Ministry of Health is that our project is being presented at briefings, and it's about awaiting a decision. There's no action for the hospital. There are no further questions from

the Ministry of Health at this point. It is a funding decision. So the hope is that, given the support that we've been receiving from our MPPs and partners across the region, we're able to get to yes for that planning grant.

Ms. Jennifer K. French: Well, that's interesting, and I hope that the government takes that back to figure out where the sticking point is, because in that chair at the last panel was Ontario Shores, also looking for that planning grant and that next step that would essentially unlock that funding—as you said, the $51 million that would be the next part of that. So I have no idea why that is stuck in the process. Obviously, the needs of Ontarians, and specific to your area, are not going away.

Have you also noticed a change with the Minden emergency room having been closed? I know a lot of people from the counties are having to make choices about where they go for health care. Are you seeing an uptick in your numbers because of that emergency room closure?

Ms. Laura Driscoll: Not directly as a result of Minden, as far as I understand it. We do have a number of hospitals throughout the region that do have emergency departments, and we are all very supportive of each other, but ongoing staff shortages are the challenge. We've been very fortunate to not have an impact to our emergency department hours. It has been able to stay open.

Ms. Jennifer K. French: I'm glad to hear that.

Ross, welcome, and thank you for your presentation. I would like to have a better understanding of what the post-rehab programming not just looks like, but tell me why the investment, the additional investment is so necessary, because I'm not super familiar with the specifics. These are not numbers; these are individuals with opportunities, so can you walk us through that a bit more, please?

Mr. Ross Ste-Croix: Of course. Our post-rehabilitation programs work with individuals that either had a traumatic episode, such as heart attack or a stroke, or who are dealing with progressive conditions such as COPD, MS or something of the like. Our programs have been able to really assist those in Durham region. As has been mentioned by some of my colleagues up here, the availability of programs in particular areas of the province is just not there. So while Durham region has really benefited from individuals being able to come to regular, weekly, continued rehabilitation for issues that are not going away for them, there are many areas of the province that would benefit from our post-rehabilitation programs.

We've seen a little bit of that audience through some of the programs we offer virtually. One of our programs for individuals with COPD and other chronic lung conditions is called virtual Fitness for Breath. We partner with Lung Health Foundation on that program, and we offer it virtually across the province, particularly into northern communities. There are some sessions where we have upwards of 100 people attending the session virtually, which is an indicator that they don't have an outlet in their community to attend.

Understanding that this is a huge province with lots of remote areas and certainly a lack of infrastructure to support in the health care sector, additional funding would allow us to scale and be able to have this program available in other areas. We look at the programs we offer at the centre—it's not needing another Abilities Centre in other communities; we need other community partners that we can go in and use existing facilities to deliver programs. That would be our aim, to expand into other areas of the province to give the benefit that the residents of Durham region have been able to have through those programs.

Ms. Jennifer K. French: Thank you.

How am I for time?

The Chair (Mr. Ernie Hardeman): Just a little over a minute.

Ms. Jennifer K. French: Okay.

Krista, I'm going to save you for a second round.

But Ross, continuing on, in our office, we have actually been surprised as we have met with folks interacting with social assistance, specifically recently someone on OW who has identified that they're losing benefits, like the cellphone benefit and things like that. That's because of this new privatization, third-party service delivery and the transition. They're going to have to go to other doors to knock on to find benefits. We're struggling in our office to keep up with the changes, and we're seeing further limitations put on those reliant upon social assistance.

As an advocacy agency, as well as a massive centre, what are some challenges that folks you serve are facing that you'd like the committee to be aware of?

Mr. Ross Ste-Croix: I think the number one challenge for families with someone with a disability is that initial awareness and knowing where to go. They have to depend on their own networks and word of mouth for the most part in terms of understanding what their new reality is like. Some sort of element where they can reach out and have access to services and be connected—a referral network, if you will—would be huge asset for families. There are some supports, and there are certainly organizations like ours out there, but families have to do a lot of digging and a lot of asking around to get there.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time.

We'll now go to MPP Hazell.

MPP Andrea Hazell: Thank you so much for coming here and presenting. This is a big part of my heart and the health and well-being of our nation, of our community. You've all spoken so descriptively on your reason for funding, and I get it.

We're going through—I wouldn't want to call the word "horrific"—an awful health crisis whereby we are seeing emergency closures. We're seeing a huge wage gap. We're looking at staff shortages. It's all over, wherever you have health care and taking care of the community.

I know you're here for funding, for grants. You talk about your program. I hear, "sustainability, sustainability." If you did not get funding, what would your organization look like in 12 months from now? Starting with—

Ms. Krista MacNeil: That's for me?

MPP Andrea Hazell: Yes.

Ms. Krista MacNeil: Our team, right now, is 21 staff. We would go down to seven, which means we would have

four front-line staff responding to crimes in Durham region. Last year, we served 8,000 clients, so you can do the math and see. Each one of those clients had very high complex needs. We also know that, for every victim, there's also a family behind them that's also requiring support.

So, first of all, we would have a wait-list for services. For somebody who is at the scene of a crime, needing immediate support to exit an abusive situation, to save their life, we wouldn't be able to get there to help them. There would be a wait-list for that. In fact, many of the victim services agencies in our province right now have implemented wait-lists. Those are the agencies that have not relied 60% on grant funding.

We're in a position now where our staff turnover rate is so high because nobody wants to work on a contract, our salaries are so low that we can't keep people, and our staff are burning out because the numbers continue to skyrocket. We're at a point of crisis where we just cannot rely on grants anymore, even if it means we have to reduce our team, and we have a wait-list to support people for life-saving services.

MPP Andrea Hazell: Thank you for sharing that.

Mr. Ross Ste-Croix: For our part, I think it means the difference between scaling our services to support other areas of the province, which our programs are more than ready to do, and having to just stay as a Durham-region-specific organization. So without further funding, our ability to expand outside of Durham region is severely limited.

We do experience some of the challenges that my colleague just alluded to, which is that the rising cost for families to just live in the province and across the country is tremendous, and we're losing staff to other opportunities month over month. So I would say our ability to maintain our expertise and our ability to expand outside the borders of Durham region would be essentially cut off without further funding.

MPP Andrea Hazell: Thank you.

Ms. Laura Driscoll: It would vary across programs. As I discussed, essentially it means longer wait times and care outside of region but, very specifically, if we think about cancer care—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Laura Driscoll: —having wait times is completely intolerable. If you think about surgery, the opportunity of doing minimally invasive surgery means home same day or next day, versus doing an open surgery with an in-patient stay and travelling out of region, continuing to drive up wait times at Kingston and Toronto. Depending on the program, the impact is substantial.

MPP Andrea Hazell: So if either of you did not get funding, it will devastatingly cripple your program and hurt your community. Is that a factor?

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Ms. Krista MacNeil: Yes, absolutely. Our prevention programming alone reached 40,000 this past year. This year, we do have a little bit of funding. We're expanding to offer it to the entire province. We're going to reach every youth in the province who needs that education on violence prevention and human trafficking. This will be our last year running that program. We can't sustain it on grants, and we don't have sustainable funding, so that service will no longer be available.

MPP Andrea Hazell: So what's the last thing you want to—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We'll now go to MPP Byers.

Mr. Rick Byers: Thank you all for coming this morning. More importantly, thank you for the work you're doing in the community—

Interruption.

Mr. Rick Byers: That wasn't me. It's nice to have music this time of year, isn't it? It's lovely.

A question first to Laura, if I could: I want to make sure I understand the projects, because you had mentioned previously the existing facility that has space was completed in 2022, but you're now looking for a planning grant for—is this a separate project? Is it related? I want to just make sure I understand both of those, if you could.

Ms. Laura Driscoll: Sure. The original project was to build the tower itself. It's a 17,000-square-foot tower that filled in a courtyard. That project was what the hospital funded and it was completed in January 2022. What we're asking for is funding to actually fit out the space. You can imagine, it's concrete walls, and we're asking for government support to be able to fit it out to run a hybrid OR and to expand our oncology unit, among other programs.

Mr. Rick Byers: So it's complementary to the existing facility, as you said, and you're looking for the structure, and then operational funding to support that as a further request, essentially. Is that correct?

Ms. Laura Driscoll: That's correct, yes.

Mr. Rick Byers: Okay. But you're happy that at least you're feeling you're getting—it sounds like it's moving through the capital process. Is that a fair statement, if I understand that? I know you're waiting for a decision—I don't want to pre-judge—but are you satisfied at least you're getting conversations?

Ms. Laura Driscoll: Yes. When we first submitted it, it moved quite quickly through the question-and-answer period. There was resounding support for it from the capital branch. Like I said, we've received really strong support from our local MPPs and from our community partners as well. Where we're at right now is a stall, and that's my ask for today, is for support to get it pushed through to approval for that next stage.

Mr. Rick Byers: Good. Thank you. Message received.

Ms. Laura Driscoll: Thank you.

Mr. Rick Byers: Ross, to you, if I could make sure: I just talked a little bit earlier about the funding. I think in your opening remarks you were talking about how—is it fair to say you work co-operatively with various municipalities in the services you provide? Maybe if you could just expand a little on that, if you would be so kind.

Mr. Ross Ste-Croix: Yes, absolutely. Through our training and education pillar, we have a program called

LEAD, which is Leading Equitable and Accessible Delivery. It's a program that has been funded by the Ministry of Seniors and Accessibility. Through that program, we consult with organizations, mainly public sector organizations such as municipalities and school boards; we've worked with a police service.

We walk them through, essentially, an entire accessibility audit of their practices, so not just the traditional built environment, but also their HR practices and their culture within their environment, looking at their policies, looking at how their finances are structured and how they're advertising themselves to the community and whether or not they're, purposefully or otherwise, being welcoming to groups that include those with disabilities. We've gone through that.

The funding was specific to work with municipalities and school boards initially, so we've worked with almost all the municipalities within Durham region and then have also worked with a couple of others, including the city of Vaughan and, most recently, Niagara region as well, to walk them through that. We've also worked with both major school boards in Durham region and are looking now to expand those services outside of Durham.

Mr. Rick Byers: Great. And sounds like you've got a good working relationship, and it sounds like they certainly appreciate the services you provide.

Mr. Ross Ste-Croix: A very good relationship, yes. And it's trying to make a connection with our employment services, to try to place some individuals in those municipalities, as well.

Mr. Rick Byers: Great. And we've noted your point earlier about the funding, so we'll follow up on that.

Mr. Ross Ste-Croix: I appreciate it.

Mr. Rick Byers: Mr. Chair, I'll pass it over to MPP Kanapathi.

The Chair (Mr. Ernie Hardeman): MPP Kanapathi.

Mr. Logan Kanapathi: Thank you for coming out, for your presentations, and thank you for your hard work. I have to personally thank you, each and every one, for the great work you do for the people in Ontario.

I'll first start with Ross Ste-Croix. I met you at the event. You remember, Shanjay got the award.

Mr. Ross Ste-Croix: Yes.

Mr. Logan Kanapathi: Thank you for the great work you do, working with individuals with disabilities. You mentioned about the therapeutic recreation program. Would you elaborate on that? That's working very well in not only York; Durham people are coming from outside of York and Durham. They're getting benefits from your centre.

Mr. Ross Ste-Croix: Our therapeutic recreation program is a program that aims to engage individuals. Primarily, we're working with schools and in schools to engage individuals, before they sort of fall off the cliff that we speak about if you work in the disability sector, which is once individuals age out of the school system. Typically, there becomes a bit of a void in terms of services for them, so the aim of the therapeutic recreation program is to work with them early and identify where their interests lie, where their goals lie, so that we're able to establish their confidence and build the skills that are going to help them, both in terms of accessing both employment and recreational opportunities in the community.

Where we've seen a tremendous amount of success in that program is partnering with schools in our two local school boards here in Durham, but as well with some schools in the Toronto District School Board. Essentially, our therapeutic recreation specialists will go into the school and work with individuals that have been identified by the school as candidates who need that extra support as they go through the system, to be able to succeed in their lives as they age out of the school system.

It is a program that has a tremendous scalability potential to work around the province, as I mentioned before, not needing a physical infrastructure, just needing partnerships with school boards and other partners to go into communities and start delivering those services.

Mr. Logan Kanapathi: Thank you.

How much time do we have?

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Logan Kanapathi: One minute?

One more question to you: What action taken by the government has had the highest impact for these communities and which area needs more support for your organization?

Mr. Ross Ste-Croix: I think the areas that really need the most support are, as I mentioned, around anything that affects health care and unemployment services outside of our core. Typically, the GTA and surrounding areas and Durham region, to some degree, get a lot of attention and are having more resources, but we need to be mindful of the rest of the province. So what we're trying to do is to provide a solution that we can scale to those underserved areas of the province. I would say your areas out of Toronto—Niagara, Ottawa—are the areas that need our love and attention.

The Chair (Mr. Ernie Hardeman): Twenty-three seconds. Are you done?

Mr. Logan Kanapathi: Thank you, Mr. Chair.

The Chair (Mr. Ernie Hardeman): Okay.

I will now go to the official opposition: MPP Kernaghan.

Mr. Terence Kernaghan: Thank you, Chair, and thank you to all our presenters here today. I think we can spend many more rounds actually asking questions because of the wonderful work that you all do.

My first question is for Ms. Driscoll. Looking at recent media stories, in-hospital, in-patient medicine beds are at 105% occupancy and respiratory illness is up 40%, which is deeply concerning. But specifically, I wanted to ask: In terms of the capital expenditures that the hospital has already made in the creation of this unused facility right now, how much has been spent, would you say?

Ms. Laura Driscoll: The hospital spent around $20 million to build the tower and that was own funds. We do have a very strong foundation and visionary donors that are supportive of the local share for the remaining fit out, and that's around $16 million, is what we anticipate for

10% of construction costs and then the furniture and equipment expenses.

Mr. Terence Kernaghan: Understood. It seems to be wasteful for the government to not follow up with funding to actually make that space useful, so thank you very much.

Mr. Ste-Croix, I just wanted to say thank you. Your centre is very well-respected and tremendously well-known. I just want to thank you for addressing that gap between the school system and adulthood, something that the province really needs to address.

But, Ms. MacNeil, it's upsetting and disturbing to hear the government say that it hears you, but then chooses not to act. My question, though, is, would you like the province to admit there's a problem and declare intimate partner violence an epidemic?

Ms. Krista MacNeil: Absolutely. I think the numbers speak for itself. One year ago, we were using the stat that once every six days, a woman is killed by her intimate partner in Canada; the stat this year is once every 48 hours, and Ontario has one of the highest rates. I think the number speaks for itself. It's clear. Our numbers in Durham region alone for gender-based violence have grown seven times in the last four years, and it is continuing to grow.

I know there is an issue with the specific terminology that's used, so then let's use "a human rights crisis" or something similar. I think it's just recognizing the issue for what it is, and that's absolutely an epidemic, a human rights crisis, the violation of human rights of women, however you want to say it.

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Mr. Terence Kernaghan: Most definitely something the province should act on.

Chair, I'd like to pass it over to MPP French.

The Chair (Mr. Ernie Hardeman): MPP French?

Ms. Jennifer K. French: Ms. MacNeil, I will continue. First of all, I know that the work that victim services does across the community is in every nook and cranny, that there are some initiatives that people are aware of, your mentioning of the violence prevention program for youth, I think, being that one folks are aware of. I'm sorry to hear that that program will not be continuing without funding.

Certainly, it's important for the government members to understand that there is so much sharing of resources and information, whether it's police and victim services or other partner agencies. There is amazing innovation and really important work being done. So to find out that you don't have funding to sustain the pilot that you were referring to or that there is no funding to sustain the model that you had referenced—the government has to invest. There are lives at stake.

I wanted, though, to ask you about the important frontline workers. You had said the salaries are so low. I've been listening to that for years, that you are not able to retain your staff because, as much as they love and are invested in the work that they are doing, when folks can't pay the bills they are forced to make choices. Can you please talk about the salaries or what you are losing some of your dedicated staff to in the community, which means a loss for all of us as community members?

Ms. Krista MacNeil: The salaries are equally low across the non-profit sector. The challenge for us is that the work is particularly demanding. Again, it's demanding across the entire sector. We are first responders. We're not deemed first responders, we don't receive the pandemic pay or that sort of thing, but we are on the front lines at the crime scene. When a homicide happens, we are at the crime scene. When a child dies suddenly in a pool, we are there. We see the body. We are supporting the family in their worst moments.

If we are not there, women cannot exit their abusive situations, because shelters are full. Without us they can't access a hotel room or anywhere else to go. They're left in the abusive situation.

Human trafficking survivors will not talk to police. They will not. They will talk to us, which is why the model has been so effective. It's the vicarious trauma that the staff are exposed to in our particular role as first responders; we are not recognized for that, we're not paid for that. So why stay in a job that pays so low doing that kind of work when you can just go to another job that pays low and you're not exposed to that type of trauma?

Ms. Jennifer K. French: I appreciate the work that they do. Certainly, through the years we've had conversations around victims of crime. On the victim experience side, I'm grateful that they have victim services, but there has been government funding that has ended in terms of what the actual victims take away. You're here today asking for investment in victim services, but could you speak briefly about some of the government funding to victims of crime that no longer exists?

Ms. Krista MacNeil: Years ago, there was a compensation fund where it would provide up to $20,000 per victim and there was flexibility in how that was utilized. Now, through the Victim Quick Response Program, each need that a victim has is sort of piecemealed. We can apply for funding for food; we can apply for funding for shelter. It's all applied for separately. The amounts are completely unreasonable: $150 for a hotel room for a night doesn't even come close. We're talking about the worst of the worst hotels, where these girls are trafficked: They are $300 a night. It's just completely inadequate.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Krista MacNeil: We have asked that the standards for VQRP be looked at. We are hopeful that the government may increase those amounts. I understand it's being reviewed currently. My other ask, though, is that the staff delivering that program also need to be sustainable. If we don't have staff to respond to victims to even apply for VQRP, then victims can't access the support. Even if it's increased we still need our staff to be available so that victims can access that support.

Ms. Jennifer K. French: Anything else that you would like to get on the record with a few more seconds?

Ms. Krista MacNeil: Oh, gosh. A few more seconds—many things. Child and youth advocacy centres: Across North America, there are evidence-based models that are significant cost savings. We are trying to bring one to Durham region. It's a multidisciplinary team of health care,

victim services, police, child protection—again, no sustainable funding. So, we are ready to open one in Durham region, but grant funding will not sustain it, and I can't run two agencies on grants.

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time for this question and also for this panel. We want to thank all of the panellists for taking the time to prepare and to come here and share it with us.

With that, we will recess until 1 o'clock.

The committee recessed from 1155 to 1300.

The Chair (Mr. Ernie Hardeman): Welcome back. We'll resume consideration on public hearings of pre-budget consultations, 2024.

As a reminder, each presenter will have seven minutes for their presentation. After we've heard from all three presenters, the remaining 39-minute time slot will be questions from members of the committee. This time for questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members and two rounds of four and a half minutes for the independent members as a group.

We will also remind the presenters that you will have the seven minutes for presentation. At the point of six minutes, I will just—I was going to say "quietly say," but if it was really quiet, you wouldn't hear it, so I will announce that there's one minute left. Don't stop. But at the seven minute mark, you will be stopped.

COUNCIL OF ONTARIO DIRECTORS OF EDUCATION

FEDERATION OF ONTARIO PUBLIC LIBRARIES, ONTARIO LIBRARY ASSOCIATION AND AJAX PUBLIC LIBRARY

THE CHARLES H. BEST DIABETES CENTRE

The Chair (Mr. Ernie Hardeman): With that, the first panel we have is the Charles H. Best Diabetes Centre, the Council of Ontario Directors of Education and the Federation of Ontario Public Libraries, Ontario Library Association and the Ajax Public Library.

The first one is the Charles H. Best Diabetes Centre. With that, make sure we give Hansard your name at the start of your presentation so all those great comments will be attributed to the right person. With that, the floor is yours.

Interjection.

The Chair (Mr. Ernie Hardeman): Are they not here yet?

Interjection.

The Chair (Mr. Ernie Hardeman): Oh, my apologies. I should have seen that. It says "on the screen," so it's virtual.

With that, again, you've heard my comments. Now, the floor is yours.

Interjection.

The Chair (Mr. Ernie Hardeman): Oh, there's no sound yet. Okay, try it again.

Interjection.

The Chair (Mr. Ernie Hardeman): Okay. If we could just hold it for a minute, we'll go to one other presenter first so we can figure out where the sound is not going—or where the sound is going, because it's not getting here.

With that, the next one would be the Council of Ontario Directors of Education, Ms. Elliott.

Ms. Laura Elliott: So you can hear me okay?

The Chair (Mr. Ernie Hardeman): Oh, we can hear you just wonderful.

Ms. Laura Elliott: All right. Thank you very much for the opportunity to present some of the key issues from the Council of Ontario Directors of Education. My name is Laura Elliott, and I'm the executive director for CODE, as it's called. I'm joined—I think, hopefully—virtually by my colleague Camille Williams-Taylor, who is the director of education for the Durham District School Board.

In brief, the Council of Ontario Directors of Education is the professional association representing all 73 directors of education from Ontario's publicly funded school system, from public, Catholic and French-language. Together, we work with our Ministry of Education to create the best possible learning conditions for students and working conditions for staff to reach the highest levels of achievement and personal well-being for students. Just as an aside, CODE also manages projects on behalf of the Ministry of Education through transfer payment agreements in excess of $45 million.

I'm going to speak about three specific issues today: The first would be sick leave and other benefits; the second would be some of the transportation cost pressures; and the third would be the compensation for executives.

The first one, under sick leave and other benefits: Prior to the onset of the pandemic in March 2020, there had been a consistent upward trend in short-term supply staff costs. This was supported by the findings contained in the Auditor General's 2017 annual report, where supply staff costs were identified as a pressure across the province.

Just by way of background, the Grants for Student Needs—we call them GSNs. Our boards are provided with an amount for teacher and educational assistant supply costs. In 2022-23, the funding that was provided to school boards was approximately $344 million. The actual cost incurred by school boards was very close to $600 million, which is almost a $256-million variance.

Short-term sick leave plans are centrally negotiated between the province, the trustee associations and the respective unions; and as a party to the negotiations, the sole funding agent for public education in Ontario is the Ministry of Education. The ministry has a responsibility to fund the provisions of the central agreements negotiated through collective bargaining.

Sick leave benefits for employees in education is very generous: up to 131 days of short-term sick leave in a school year. Eleven days are funded at 100% and 120 at 90%. No funding is provided for short-term supply costs

for principals and vice-principals, while, in some cases, especially with some small schools, there needs to be a supervisor on site and that person is often—there is another supply principal that would come in to supervise if the principal is on a sick leave, and this would be at the cost to the school board.

So a significant issue regarding sick leave plan for teachers is also the lack of supply teachers in the province. CODE is a part of the discussions with OTF and Ministry of Education on the teacher supply and demand action table.

One of the other cost pressures around benefits would be that all organizations, including school boards, have encountered CPP and EI increases, and these have not been correspondingly provided in grants to school boards. This is an additional cost pressure to school boards. For last year, it is estimated to be $100 million that boards would have to absorb through their own budgets. So in this particular issue, we understand and appreciate that the Minister of Education made changes to the sick leave plan a number of years ago that eliminated the retirement gratuity liability, but this has created additional challenges for boards, which are not being fully funded or addressed through central negotiations or the Grants for Student Needs. The draw of funds takes away from students and the classrooms. Therefore, supporting employee wellness and incentivizing staff for the use of sick leave only when needed might prove to be more cost-effective and affordable in the long term.

The second issue that I wanted to address is the transportation issue. The Ministry of Education released a new transportation funding model in the 2023-24 fiscal year. The formula includes many cost elements. Based on a preliminary analysis, the grants that are provided to school boards are insufficient to cover the actual cost that school boards will be absorbing. It is estimated that 70% of school boards will face a significant deficit in this budget area as well.

While the ministry announced an increase in the total transportation funding of over $111 million, it does not account for the following cost increases: One would be that there is a transportation funding transition fund, which includes $89 million, which will phase out after the four-year transition period. It does not include funding for special-purpose vehicles, such as vans and minibuses. This creates a very inefficient system for some of those school boards that require those smaller vehicles to transport students. It does not account for annual inflation or contractual increases. In some cases, drivers are not being fully or adequately compensated for their time.

Other issues: Of course, I think everyone has heard around the driver shortages and route cancellations and—time?

The Chair (Mr. Ernie Hardeman): No, you've got three, two, one—and my apologies, I should have said "one minute" sooner. Your time is up now and hopefully we'll get the rest through in the question period.

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Ms. Laura Elliott: Okay, thank you.

The Chair (Mr. Ernie Hardeman): Okay. Do we have the other one now?

Interjection.

The Chair (Mr. Ernie Hardeman): Okay, we will now hear from the Charles H. Best Diabetes Centre—virtual. There we are again, and the same instructions from previously.

The floor is yours.

Interjections.

Ms. Jennifer K. French: We can't hear her.

The Chair (Mr. Ernie Hardeman): No, I can't hear it either, but they're trying to fix it, and they can't fix it if she quits talking.

Just go ahead.

Ms. Jennifer K. French: She doesn't know.

Interjections.

The Chair (Mr. Ernie Hardeman): Thank you again. We still can't hear. We'll go to the federation of public libraries and hopefully we'll have it fixed by the time we go through the next seven minutes.

The Federation of Ontario Public Libraries, Ontario Library Association and the Ajax Public Library, the floor is yours.

Ms. Sarah Vaisler: Good afternoon. My name is Sarah Vaisler and I am the CEO of Ajax Public Library, but I'm here today representing Ajax as well as the Federation of Ontario Public Libraries and the Ontario Library Association. Again, thank you for having me.

Our organizations have three priorities. Millions of Ontarians rely on local public libraries to connect to their communities, to work, to learn, to find or train for a job, and to connect to their community and government services. I want to thank the provincial government because two years ago, we were provided a $4.8-million grant to provide high-speed Internet to over 100 rural communities. In some cases, this is the only Internet in a community, making public libraries the destination for people to get online.

Building on that foundation, it is time to empower Ontarians with online resources they need to succeed, no matter where they live. Alberta and Saskatchewan already have a model that works well and the Ontario public libraries are proposing something similar: the creation of an Ontario digital public library. The Ontario digital public library would provide equitable access to a common set of online resources. These would include in-depth job and career skills training, language learning, live tutoring and homework help, and health and information resources to support vulnerable communities.

We know that these resources work well and are in demand because you can already find them at many large libraries across Ontario. In Ajax, we provide access to LinkedIn learning, curriculum-based resources, language learning, TumbleBooks and children's materials in multiple languages, as well as high-quality online research databases. This costs our library approximately $41,000 each year. Our neighbours to the north—for example, in Brock—are not able to provide the academic research information because it is too cost-prohibitive. This is espe-

cially true in small or rural libraries where they have fewer online resources. People don't have access to the same information simply based on where they live.

By leveraging volume purchasing and through annual provincial investment, as well as existing public library infrastructure, the Ontario digital public library could provide a core set of high-impact digital resources to every public library and every Ontarian at an overall cost savings of up to 40% when compared to the current library-by-library subscription model. This means that every library in Ontario would benefit. Larger libraries can reinvest this money into job-help programs or improving the safety and security in our branches. And small libraries can deliver access to these programs, perhaps for the first time. This is such a great solution because we already have the infrastructure and support systems in place to provide access and help people navigate these resources.

This is a proven model and we are requesting a funding level of $15 million, which would provide all Ontarians access to curriculum-based content, live tutoring, résumé and job coaching, health and small business reference information, and language learning.

Our second priority is the First Nations salary supplement. Of the 133 First Nations communities in Ontario, only 39 have public libraries. Public libraries are destinations for these communities—sometimes the last gathering place where their languages, stories, culture and artifacts are stored.

As you know, public libraries rely on municipal grant funding to fund their operations, and these are not available to First Nations public libraries. Often, they have to rely on one-time grants to fund their operations, and this is not sustainable. Librarians running these institutions have to make choices between the books and resources they provide or their salary, and their salary is far below a living wage. Ultimately, they make a choice between staying in their community below a living wage or leaving to support themselves and their families, which forces First Nations public libraries to close.

With an annual $2-million investment, we can ensure First Nations communities across Ontario can continue to collect their stories, culture, and have a community gathering place.

Our third priority is to increase the provincial funding for public libraries. Public libraries are grateful for the continued support through the public library grant, which has been happening for over 25 years. Unfortunately, over that 25 years, there has been no increase from the province to our funding level—in over 25 years.

Ontario public libraries are a key community gathering place that support job creation, job skills, education and our vulnerable communities. With so many competing priorities, libraries are asking for an increase to the Public Library Operating Grant so we can continue to support all Ontarians.

Thank you.

The Chair (Mr. Ernie Hardeman): That concludes that one. With that, I guess we're not going to be able to go online and get it—

Interjections.

Ms. Lorrie Hagen: Can you hear me now?

The Chair (Mr. Ernie Hardeman): Very good. The floor is yours now.

Ms. Lorrie Hagen: Can you confirm that you can indeed hear me, please?

The Chair (Mr. Ernie Hardeman): We can hear you very well.

Ms. Lorrie Hagen: Wonderful. Good afternoon. My name is Lorrie Hagen. I'm the executive director of the Charles H. Best Diabetes Centre. I am joined by Emily Malcolm, a parent, and Serge Babin, a parent volunteer and chair of the board.

We are a proud registered charity since 1989, located in Durham region. The Best centre's mission and objectives align perfectly with this government's goals. We have a pivotal role in protecting people's health and in the delivery of essential health care services across the provincial health care system.

Today, we are asking for $3.5 million to support our capital expansion. Our team specializes in type 1 diabetes for patients of all ages. We teach patients and caregivers how to self-manage, with frequent therapeutic sessions and mental health support. This incurable and potentially fatal disease is the rarest form of all diabetes types. Insulin injections are required for survival.

The Best centre has saved thousands of lives over its 34-year existence. Patient demand for our care has increased 15% year over year in the past decade, and this figure is sure to grow. Being that your members are from across the province, you will appreciate knowing that we see many patients from outside of Durham region as well.

Since opening our doors in 1989, we have filled a gap in specialized type 1 care. Hospitals and primary care providers refer to us because they do not have the medical expertise to ensure patients' self-management and proper use of medical technology. Our care keeps patients out of the hospital, full stop. There is no other centre that does what we do for the people of this province. Unique to the centre is our urgent care program, available 24/7, 365 days a year. We teach patients how to remain safe, medically healthy at home, reducing visits to the emergency room and preventing ICU admissions.

Without adequate funding for growth, timely access to this care would become impossible, meaning the acute care system that currently sends type 1 patients to us would be forced to take on this care in a very expensive and inefficient way. In fact, the cost of patient care in hospital is up to $1,800 a day, as compared to our interdisciplinary community-based preventive care that provides exceptional value at $3.50 a day. Additionally, an investment today will help reduce complications of this chronic disease in the future, as poorly managed type 1 can lead to several complications, like cardiovascular disease, renal failure and amputations.

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To meet the increased demand, we must double our capacity. To sustain the centre for the future, we need to raise over $8 million. The campaign team has already

raised $3.1 million to date. We are thankful for Ministry of Health base funding, but it does not address our capital expansion needs. We are asking the province to allocate $3.5 million to ensure that our expansion to our site and diabetes care program are successful. As a matter of fact, I'm thrilled to share that we have a private foundation committed to an astounding $3-million gift, but it is contingent on provincial backing.

On behalf of the people we serve and for the health of your constituents, we are asking for your support. Make this $3.5-million investment in the Best centre's expansion and show the people living with type 1 that you do indeed care. Thank you.

I'm handing it over to Emily Malcolm.

Ms. Emily Malcolm: Hello. On October 14, 2021, too tired to finish out the day at school, my 12-year-old daughter Claire called me and asked to come home. She was lethargic, thirsty and her vision was blurry. Later that day at the doctor's office was shocking. When they told us to go straight to the emergency room, that we would be admitted to the hospital, I was completely overwhelmed.

So many thoughts ran through my mind while I tried to grasp what they just told me, that for the rest of her life she will need to inject needles into her body every time she eats: "I know nothing about type 1 diabetes. I am embarrassed. In a year, she would be eligible for an insulin pump, but this first year meant manual injections at every meal, and without them, she would die. How do we go home? How does she eat? Who does the needles? I can't do the needles. How do we know how much insulin to give her? What's a carb ratio? What has happened to my daughter? I don't know what I'm doing. How do we leave this hospital? How do we sleep? How, how, how?" The Charles Best centre is how.

As we prepared to leave the hospital the next day, the staff there had already notified the Best centre of our arrival. When we arrived, a nurse and a dietitian welcomed us. They spent hours upon hours with us over the next few days, weeks and months to show us our new normal. They showed us how to do it, all of it: the finger pokes, monitoring blood glucose levels, what to do if she ever became unconscious from a low, basal insulin, carb counting. They held an information meeting to educate Claire's teachers so that she could go back to school and be safe.

My daughter had an entire team in one spot: her pediatrician; her dietitian who monitors the levels and adjusts the settings, sometimes weekly as Claire grows. They even had an on-site social worker to help with the mental health aspect that goes into living with such a complex disease to manage. My daughter is supported.

In that first year, between finger pokes and injections, Claire had over 3,000 needles. We are two years in. She has an insulin pump now, which is an incredible help but by no means a cure, and it too came with a learning curve. Would you like the one with the cord or the one with no cord? What's the difference? There were so many options to consider, all guided and supported by the centre.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Emily Malcolm: Today, Claire is thriving. She's a warrior. I wanted to share our story to support the Best centre and their campaign to expand. The centre is so important to our community and to families like mine. I am forever grateful for what this team has given to me. Filling in as a pancreas all day while trying to live a fulfilled life is a lot of work, but we know how too do it now, because we are educated.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation.

We will now start with the government with the questions. MPP Barnes.

Ms. Patrice Barnes: Thank you very much. My first question is for Laura. Nice to see you again. We talked a bit about the transportation funding formula and the shortfall that is currently starting. When the formula was developed, the Minister of Education worked with stakeholders and partners in regard to coming together and putting together a formula and we came up with a formula that we thought worked. We had done increases in driver wages. We've done increases in benefits. There are a lot of things that have gone into making transportation better for school boards. Could you just point out some of the things that were not working within that formula that you brought up?

Ms. Laura Elliott: Thank you very much for the question. Rightfully so, I think, when you bring a new model in there are some tweaks that need to be made along the way. The Ministry of Education engaged in stakeholder consultation. Of course CODE was part of that and a number of other board staff as well. I think the feedback that we have received so far is showing that, while the increases have been made overall to transportation, the flow-through—because we have the transportation consortia that would exist as a separate corporation, primarily made with the composition of the Catholic and public and/or French-language boards as well. In terms of some of the shortfalls in funding that school board superintendents are seeing is a lack of inflationary costs that have been provided for this school year. There had been inflationary costs tagged in previous years.

In other cases the transition funding of $89 million, while it is welcome now, will be phased out over the four-year period and the funding formula doesn't provide the funding for the special-purpose vehicles, which many boards will rely on—in some cases, a more cost-effective way of transporting students. Those are some of the areas, and of course annual inflation and contractual increases.

I believe, in terms of the driver shortages and some of the routes that are available, obviously it is a very fragile labour market as well and some of the drivers are not adequately or being fully compensated. In terms of some of the flow-through, typically it had gone to the consortia. It is coming through the boards and then to the consortia as well and there are some of those shortfalls that exist.

I do know that the ministry is still engaging school board officials with discussions around the formula and they do recognize that it is not perfect right now, but hopefully over the next few months changes can be made.

Otherwise boards are predicting that they are going to be in a deficit situation.

Ms. Patrice Barnes: Thank you. Just a clarification: With the consortium, each board has a different contract with their provider of transportation, right? I think that was probably some of the challenges with the formula is what we are saying, and it's in regard to what that contract with the school board looked like with the consortium. The contracts are not similar. They are all funded differently, they are sort of independent, and that has caused, what you are saying, some of the problems that we are seeing with the funding.

Ms. Laura Elliott: Just to clarify: With the transportation consortia, I was with the Thames Valley District School Board and we had a number of different bus operators that were part of the consortia. Because it is a huge geographic region, the labour costs that the bus operators—the cost or the salaries to a school board operator is not the same cost that the government is giving school boards to pay and to flow through for the operators. So there is that mismatch.

In some cases it would be 1 to 1, but in other cases the operators are paying more than is received by the school board and, of course, by the ministry to the school board. That's some of the issues right now that we're seeing.

Ms. Patrice Barnes: Thank you so much. The other question I have is, you mentioned executive compensation but didn't go into a lot of detail on that. Could you just expand on that a little bit more for us as well?

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Ms. Laura Elliott: Executive compensation?

Ms. Patrice Barnes: Yes, the executive compensation.

Ms. Laura Elliott: Okay. I won't go into the long story of executive compensation, but for those who are not familiar, the Broader Public Sector Accountability Act was introduced by the government in 2010. This act controlled compensation, expenses and perquisites for executives within the broader public sector, and that would be primarily for the director of education, superintendents of education and other individuals deemed as executives. Between the period of 2010 and 2018, there were a number of different changes to the legislation. Over that time, from the period of 2010 to the current time—in 2018, there was one opportunity for those who were deemed as executives to have an increase. So, essentially, the salaries for executives—and it's not just school board officials; it's for those in colleges, universities and hospitals—all of the executive salaries have been frozen since 2010, with that one potential increase in 2018.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Patrice Barnes: Okay, thank you so much.

One minute left?

The Chair (Mr. Ernie Hardeman): You've got a minute.

Ms. Patrice Barnes: Well, I'll just do a quick one to the library board. There was a brief—the funding for broadband—and thank you for being here. Thank you to all the presenters—I didn't even say that—for your presentation and what you do. Ajax has been doing amazing work around availability of libraries to our constituents.

The piece around the centralized resource: Can you expand on that a little bit more? Because right now, you're saying that Ajax has it, but you're looking at a more Ontario-wide availability—in 30 seconds, probably.

Ms. Sarah Vaisler: Through the Chair: Many libraries have different sets of online resources, so we pay third-party vendors, the problem being that there are small library systems across Ontario who cannot afford them. So if we could pool our money collectively, we could make the most of the money.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time—too long a question, too long an answer.

We'll go now to the opposition. MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to all our presenters today. I've got to tell you, I was very excited for 1 o'clock to arrive because we have three organizations that are very near and dear to my heart, London being the home of Sir Frederick Banting, as well as knowing my former director, Laura Elliott, and also, as a former teacher-librarian, it's just wonderful to see the Ontario Library Association and the council of Ontario.

So, my questions: I wanted to first ask Ms. Hagen from the Charles H. Best Diabetes Centre, do you have any thoughts about the province's current availability through ADP of continuous glucose monitors? I wonder if you might expand upon that for the committee.

Ms. Lorrie Hagen: Sure. So just so I understand your question, you're asking about availability and coverage for CGMs across the province?

Mr. Terence Kernaghan: That's correct, yes.

Ms. Lorrie Hagen: Okay. Although we've made some good strides in that arena, we are still working towards a more global coverage. There are some restrictions for folks living with type 1 whereby they need to meet certain criteria that, quite frankly, doesn't make a lot of sense from a clinical standpoint. But most certainly, the ADP, or Assistive Devices Program, that is supporting patients with type 1, at this point I would say it certainly improved in the past year or so.

Mr. Terence Kernaghan: Thank you very much. It's interesting to see other provinces and their coverage, Alberta being an example. Thank you very much for that.

My next question is for Laura. I want to thank you for pointing out some very important things that the committee needs to understand about the current funding for education. Now, specifically, you had mentioned CPP and EI increases, and that has been brought to the attention of the government. I wanted to dive into that for a moment. You said that those increases are not provided in grants to school boards. Would you be able to confirm for the committee, are boards legally required to provide those increases to their employees?

Ms. Laura Elliott: Through the Chair: Yes, they are, as would all other organizations. So, boards would have to do the same.

Mr. Terence Kernaghan: So, in other words, the government, by not providing funding for that, they are expecting school boards to absorb that legally required increase?

Ms. Laura Elliott: That's correct.

Mr. Terence Kernaghan: That's very concerning.

Recently, the Financial Accountability Officer had a report, and they indicated that low-enrolment school boards actually receive higher per-student funding than the higher-enrolment boards. It's a very curious situation. However, they also found that there are lower EQAO pass rates in those smaller and rural schools. But I think it speaks to your point about schools that lack an administrator, schools that lack access to a special education teacher and schools that lack access to a teacher-librarian. It becomes a very large disparity. Is that something that you think the government needs to address: the lack of educational access for rural schools?

Ms. Laura Elliott: Through the Chair: Very interesting question, because in my former board with Thames Valley District School Board, we had a large rural and urban piece as well. I know some small, mainly northern, school boards would qualify for specific grants that Thames Valley District School Board would not have received.

So you're looking at efficiencies within larger schools and larger units, but in some cases, because education is very much formula-driven—and there is some flexibility with the use of funding as it is received by the board, but obviously if you're in a smaller rural school, that may have fewer students or fewer access to resources and perhaps activities for students as well.

Mr. Terence Kernaghan: Absolutely. That could be a huge concern. Access to education is a fundamental democratic principle. Thank you very much.

My next question will be for Sarah. Sarah, you mentioned—can you please just restate for the committee, how many years has it been since libraries have received a base budget increase?

Ms. Sarah Vaisler: Over 25 years.

Mr. Terence Kernaghan: Twenty-five years—

Ms. Sarah Vaisler: Over.

Mr. Terence Kernaghan: Over 25 years. That's deeply concerning.

You had spoken about the value of spending money wisely. I think that's something that should really attract the attention of this committee. You mentioned the Ontario public library digital resource, an avenue whereby all libraries can share—it's making sure money is spent to its best effect.

I know this is a very difficult question perhaps to answer, but is there an estimate about what kind of cost savings this would realize by putting all of the money together into that single resource? How much would that save across Ontario?

Ms. Sara Vaisler: I can tell you in a percentage that it's about a 40% cost savings if we buy it for Ontario-wide versus what is happening now where every library has individual subscriptions with particular vendors.

Mr. Terence Kernaghan: Wow, that is a significant savings. It just makes good sense. If you're spending money, you should try to get the most benefit out of every single dollar that you spend.

I did notice that, in particular, in terms of the Ajax Public Library, library use is up 30% since 2019. But also you've seen a dramatic increase in substance abuse, medical emergencies and violence, because libraries really are that vital community resource, but you're also very much on the front lines. Do staff feel adequately supported by the province in terms of responding to these issues? Have there been provincial resources provided?

Ms. Sarah Vaisler: In the context of Ajax, there has been no provincial support—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Sarah Vaisler: —to the Ajax Public Library in that area.

Mr. Terence Kernaghan: That's a shame, because libraries are a vital community resource. As we've said, they are at the front lines where people are applying for jobs, are accessing information, and they are really the measure of a progressive society.

So I just want to thank you all for your presentations today.

The Chair (Mr. Ernie Hardeman): Thank you very much.

We'll now go to the independent. MPP Bowman.

Ms. Stephanie Bowman: Thank you to Lorrie, Emily, Laura and Sarah for being here today.

Sarah, I will start with you. I feel a bit like I'm in Groundhog Day, because I think we heard a lot of this tale last year in terms of the need for the support for digital libraries. I was hoping that we might get that in the fall economic statement; that did not appear there either.

As a big fan of libraries, as a user and someone who believes they offer significant value to residents, I want you to just talk a little bit about how you are being innovative. Because I think libraries have been on the front lines, as was just mentioned, of providing services and having to provide more services with less. So could you just talk a little bit about the kinds of impacts that this is having to your programming, in terms of how you're having to innovate to accommodate for this lack of sufficient funding?

1340

Ms. Sarah Vaisler: Thank you for the question. In terms of how we're innovating, I think libraries have a long history of stretching every dollar that we have to make, right? And often, when we are not able to use our municipal tax dollars to cover everything that needs to be covered, ultimately it's our collections that suffer. By collections, I mean the books, the online resources and the things that we actually share and give value back to our community. Often, when we have to make a choice about adhering to a collective agreement's increases and paying for benefits for our staff, we end up making those cuts—if we can't get it from our municipality—from the collections, from the things that we lend or cutting back on service hours. Those are not choices that any CEO across any public library wants to make.

And our municipalities are counting their dollars, too. They have to make tough decisions, as well. Fortunately, that is not a decision that we have had to make in Ajax. I

just know anecdotally that that is where money comes from. It's from the materials that we have to lend out, which is why the Ontario digital public library is so crucial, because we can have that shared resource and then redirect those monies that people may or may not be spending in their local context elsewhere, where they really need it.

Ms. Stephanie Bowman: Thank you. I think it's a great example of how scale can benefit both the provider as well as the user, so I really hope that you get your funding this year.

I will turn now to Laura. Laura, I know during your presentation you got cut off a little bit, so could you just take a minute—because I have a short amount of time—and just summarize your ask to the committee?

Ms. Laura Elliott: Sure. Through the Chair: In terms of looking at sick leave and other benefits, the ask would be that there needs to be, I think, a re-envisioning of sick leave use in Ontario, a new plan. It is at a huge cost to taxpayers. I think a focus on employee wellness and, perhaps, some sort of incentive for employees, heaven forbid, to go to work, as well as funded benefits for increases to CPP and EI is mandatory. It's costing boards $100 million.

The third request, around executive compensation—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Laura Elliott: —would be to ensure that the freeze is lifted and the legislation is repealed.

Ms. Stephanie Bowman: Great, thank you. Just in my closing minute here: I believe that education funding has fallen about $1,200 per student since this government was elected, in real dollars adjusted for inflation. Could you talk about the impact that this decrease to funding is having on our students?

Ms. Laura Elliott: Overall, the government has put more money into education over the years and, of course, there are stress points in terms of allocations, as I explained, around benefits and around transportation, as well. There are other areas of stress and pressure around capital and school closures to create efficiencies for students. But overall, the government has provided more funding to education—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We go to MPP Coe.

Mr. Lorne Coe: Thank you to all our presenters. Lorrie, I hope you're still there. I can see you on the screen. This question is to Lorrie Hagen from the Charles H. Best Diabetes Centre, which is situated in the top part of my riding.

Lorrie, in the course of discussing the project and the expansion of the Charles H. Best Diabetes Centre, we've often talked about the patient demand doubling over the next five years. I think, for the committee members, there is a need to provide a little bit more context to that statement. Perhaps you can talk about the population growth at one level in the region of Durham, but also talk a little bit more about your broader reach into other parts in proximity to the region of Durham, for example metropolitan Toronto. I think it's an important context point, please.

Ms. Lorrie Hagen: Through the Chair and to respond to MPP Coe, I appreciate that. I'm happy to give the context. Just in terms of actual numbers, we're talking probably about 800 total patients a decade ago, so 10 years ago. We are forecasting, with the understanding of the prevalence of type 1 diabetes and the expected growth of Durham region in the next 10 to 15 years, we're expecting the total number of patients to be in excess of 5,000. Now, although that may seem like a small number to some folks, that 5,000 caseload, if you will, would produce upwards of 50,000 to 55,000 clinical interactions, support sessions, mental health sessions in supporting patients and families living with type 1.

As we gain active patients and they may come or go out of the region, they tend not to want to leave us, so providing this type of care—it is specialized. We are a charity, so it is above and beyond what the provincial programs are able to do. So we don't often have patients who leave. We stay connected virtually. We provide online health care. We're providing phone calls as needed. But again, as long as they are staying and wanting to stay connected with us, that continues to happen.

Then, finally, to share that our referrals are coming from across the GTA, beyond Durham as well. In particular, a lot of our kiddos are transferred or referred to us from the Toronto Hospital for Sick Children, also all of our local partners here, the Lakeridge Health corporation and beyond.

Mr. Lorne Coe: To that, Chair, through you, the region of Durham, in the next two years, is approaching a million people, so the challenge is immense with the work the Charles H. Best is doing and will continue to do.

Lorrie, just an add-on and then I'm going to pass it off to one of my colleagues: The prevalence of type 1 diabetes is touching all age groups, is my understanding; is that correct? So, as your client base potentially grows, so will the number of people requiring services of the type you're servicing.

Ms. Lorrie Hagen: Through the Chair: We are seeing, as expected and evidence-based in the literature, 25% of type 1 diabetes diagnoses is in adulthood, so that leaves 75% in childhood, and because we do keep our patients for as long as we can, that will continue to grow. The adult program gets bigger as the pediatric program expands as well. So there's no discharging or trickling off, if you will, of total numbers of active patients.

Mr. Lorne Coe: Thank you, Lorrie, for that response.

Chair, through you to my colleague, please.

The Chair (Mr. Ernie Hardeman): MPP Kusendova-Bashta.

Ms. Natalia Kusendova-Bashta: I will continue with the Charles H. Best Diabetes Centre. Thank you for also paying tribute to the Canadian roots of the discovery of insulin by Banting and Best. I believe it was the first Canadian Nobel Prize that we received as Canadians as a result of this discovery. Today, millions upon millions of people are being treated thanks to this Canadian discovery. So thank you for keeping that tradition alive.

But my question is actually about the rise of juvenile diabetes. We had Emily, who is a mom, who was greatly impacted by the diagnosis in her daughter, and in my region of Mississauga and in the region of Peel, we're seeing some alarming trends in terms of juvenile diabetes. Can you speak to that a little bit? Are you seeing similar trends in the Durham region as well?

Ms. Lorrie Hagen: Yes, absolutely. Thank you for bringing that up. One of the things we do know is that, with an injury or an insult to the immune system, that can trigger type 1 diabetes diagnosis. So, although we don't understand necessarily the cause, there's obviously a lot of research happening. That's not the focus of Charles Best diabetes, but we do understand that when there is a trigger or an issue that impacts the body's ability to secrete or produce insulin that there therefore would be assessment, diagnosis of type 1.

With the pandemic and with COVID-19, we absolutely did see an increase in number of referrals, number of new diagnoses, both pediatric and adult, so there was most certainly a connection there.

Ms. Natalia Kusendova-Bashta: Thank you. And a follow-up question to that: Another demographic that I'm seeing in my region of Peel are our newcomers. We welcome a lot of new Canadians to our region all the time, and a lot of them are coming from regions where perhaps diabetes education, diabetes awareness and treatment of diabetes are not at the same standard as it is in here in Canada. What ends up happening is that our Canadian health care system has to absorb the cost of treating these chronic conditions that may have not been treated for years or decades previous to this person's arrival to Canada. That's certainly impacting, for example, Brampton Civic Hospital. There are huge rates of untreated diabetes and diabetic ulcers etc. Are you seeing similar trends as well among new Canadians in your region?

1350

Ms. Lorrie Hagen: Yes, we are. Those are what we call an established referral. Although it may not be a new diagnosis, often these folks are coming with limited and/or even incorrect knowledge. And I'll just again remind the committee that type 1 diabetes specialization really is quite unique, so that when we are meeting these new families and newcomers who have been taught living in a certain way, with a certain regime, we might retrain, re-educate and put things in place that they may never have been exposed to. A CGM, as in the question before, is a good example of that. Insulin pumps and CGM are something that we would be able to help them with.

The Chair (Mr. Ernie Hardeman): Fifteen seconds.

Ms. Natalia Kusendova-Bashta: I just wanted to say thank you for the incredible work that you're doing. I think public health awareness and education are a key component of our health care system. Health promotion is a big part of what you do and thank you for doing this important work.

The Chair (Mr. Ernie Hardeman): We'll now go to the official opposition. MPP French.

Ms. Jennifer K. French: Welcome to the three presenters—well, more than three; there are some online—but the three different groups. We appreciate hearing from the different folks who actually do the work.

I'll start out with the Best centre. Thank you for the work that you do. My office is glad to have an emergency kit in case we have a constituent who comes in and they need a pick-me-up. We have our Best centre bag. I think that that also speaks to the broad work that you do across the community for education.

One of the things when I had visited before and we talked a long time ago was about the youth programming. As we know, type 1 patients don't age out of type 1 diabetes. I know that you said that you keep your patients as long as you can. Was there a challenge to the age limits and what you're covered to care for? I'm trying to remember back; it was a while ago. Is there something that the committee needs to be aware of in terms of funding or age cut-offs for different types of programming?

Ms. Lorrie Hagen: Thank you for the question. Through the Chair: I think what you're referring to is the role that we play in connecting those kids who are graduating into our adult program. The Best centre has an adult program where we do continue to provide care. Sometimes the medical coverage, if you will, or the primary care provider for that patient is hard to find, so we take that on and we help those patients navigate. Graduating from a pediatrician to an endocrinologist or diabetes specialist can be challenging. That was something we worked through quite a bit over the pandemic.

If I recall, that may have been the conversation that we had. That had been taking up quite a bit of our time to make sure that our patients did indeed have a medical physician who we could refer and connect with.

Ms. Jennifer K. French: Thank you. We have lots of conversations and I just wanted to make sure that I was remembering that.

Also, I just want to make sure I've written down the numbers correctly. When you talked about the cost of patient care in hospitals being, I think you said, $1,800 a day, comparatively, when you were talking about the care through the Best centre with the interdisciplinary community approach, did you say $3.50 a day, or did I write that down wrong? And could you walk us through a little bit about how important it is economically to provide the right kind of care in the community?

Ms. Lorrie Hagen: Yes, absolutely. So $1,800 is an intensive care bed. Depending, again, on the hospital and the catchment area, somewhere between $1,500 and $1,800 a day is spent on everything related to that bed. If you understand the way that we do cost modelling and health care, it is everything related: It's the bedside nurse, it's the bed, the pump, literally the roof etc.

When we take our total active caseload and we look at our total budget for operations, our capital expenses, our fixed assets etc., and take that total number, we're not a very expensive centre. When we literally look at that per patient, we average out to be $3.50 a day, per patient.

Ms. Jennifer K. French: That sounds like a good deal. Thank you.

Ms. Lorrie Hagen: Thank you.

Ms. Jennifer K. French: I will continue. I wanted to say, Ms. Elliott, thank you and welcome to the committee. I understand that you said that Camille Williams-Taylor is somewhere online, so I'll welcome her, my former director. I was a teacher at the Durham District School Board, so yes, you've got the two former teachers here, and both of us, I think, lived through Bill 115 and what that actually meant and whatnot.

Sick leave conversations are—I'll leave that one for now, because I wanted to actually speak specifically: What do you mean by "smaller vehicles"? When it comes to transportation, I know that every board has different needs and different geographics and whatnot, but am I picturing small school buses? Is this for special-needs students? What isn't covered and what should be covered?

Ms. Laura Elliott: Through the Chair: Some of the special-purpose vehicles would be—some students are transported by taxi and some by van as well. It's sometimes in smaller boards but it is also in areas where there may be smaller communities as well, so it might not be cost-effective to send a large school bus to the child's home for a pickup.

Ms. Jennifer K. French: Thank you.

Time, Chair? I'm going to keep going anyway until you cut me off, but—

The Chair (Mr. Ernie Hardeman): Two point two.

Ms. Jennifer K. French: All right. Here we go.

Ms. Vaisler, I'll ask you about libraries. Having been a teacher in the south end of Oshawa, I know how important the broadband has been. There was a time when students who don't have access to Internet at home, many of them, because of the cost, would sit outside the library after hours. It became a safety concern, actually, to have the kids gathering. There is such a need, I would say in all communities, but certainly in some differently than others.

I know that public libraries are a great equalizer in terms of access, so I don't need to be sold on the digital public library. I'm glad that you're here making that case to the government: not just the cost-effective argument, but also that people deserve access to information in their next steps on that journey, whether that's education, personal interest or personal growth. Certainly the need to invest is well heard and has been for a long time. Sometimes I'm optimistic; I'm not optimistic, necessarily, that the government is going to put money where I think it should go, but I appreciate the case that you have made.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Jennifer K. French: Okay.

What I'd like to ask, though, specifically, is about the First Nation Salary Supplement. You mentioned 39 communities. Is there potential for growth of libraries in First Nations? Also, what are we talking in terms of numbers, dollars and cents?

Ms. Sarah Vaisler: It is a $2-million investment annually that is required. There have also been two First Nations public libraries that have closed within the last six months. If we were able to get those, we would be able to bring those libraries back online.

Ms. Jennifer K. French: Okay. For the 39 communities, how much is it for that salary supplement per library?

Ms. Sarah Vaisler: That is divvied up depending on what the need is, to make sure that we are getting up to that living wage, which is approximately $50,000 per library in each community. It depends on what their current salary is.

Ms. Jennifer K. French: I imagine it would also depend on where they are, because I know the cost of living varies—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We will now go to MPP Hazell.

MPP Andrea Hazell: Thank you, everyone, for your presentations today. I want to go to Laura Elliott. I know sick leave benefits has been—oh my gosh, we've been hearing this since 2020. I know it's depleted; I know it's getting worse. You mentioned that in 2022-23, your funding was around $344 million and the actual cost was $600 million. There's a $200-million variance. How do you make up for that shortfall?

1400

Ms. Laura Elliott: Through the Chair: Boards would need to absorb those costs within their own board budgets. So, you look at the impact of direct resources to students and classrooms. It could impact the students directly. If boards had access to surplus accounts or reserve accounts, that could be another draw as well, but for every unfunded program or service, there is going to be a significant impact, potentially at the school or classroom level.

MPP Andrea Hazell: And how are you sustaining this impact?

Ms. Laura Elliott: Well, sustaining this is very challenging for school boards. A lot of boards are talking about the potential deficits as well, and there needs to be, in my view and with the directors, a re-look at the sick leave plan. It's a very generous and a very rich plan, and I know our Minister of Education is very concerned about the high cost as well. A long time ago, with the retirement gratuity, that was incentive for some teachers to bank sick time and have some sort of a payout upon retirement. I'm not saying that's the answer, but there need to be incentives for employee wellness as well as a plan that's affordable.

MPP Andrea Hazell: We've got to keep pushing the envelope for funding and just continue to go into that direction.

But my second question is for Sarah. Sarah, you talk about $15-million funding, and I just wanted you to detail what's inside of that $15-million funding you're asking for.

Ms. Sarah Vaisler: Through the Chair: The $15-million funding is to bring the Ontario digital public library online. So, that is to cover online tutoring help, LinkedIn Learning, access to language learning, access to online academic research, consumer reports, online magazines. Really, this is a core set of resources that all Ontarians would be able to access through their public libraries that

they cannot, depending on where they live and the municipal library system that they have.

MPP Andrea Hazell: And how will not getting this funding impact the sustainability of the libraries?

Ms. Sarah Vaisler: I think it depends on the size of your library. But, for me, it's not about the libraries; it's about the people, right? As a library, we serve communities—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Sarah Vaisler: —we serve people, and so, if you are somebody who lives in rural Ontario and you don't have access to language learning, how is that fair? How is that equitable? Whereas, if you're somebody who lives in Toronto, you have that access.

MPP Andrea Hazell: Thank you for sharing.

Do I have a minute left?

The Chair (Mr. Ernie Hardeman): Forty-nine seconds.

MPP Andrea Hazell: Okay.

Question for Lorrie—I want to go on the $3.5-million capital expenditure. Is this just for the Durham region services, or is this for the greater Toronto area as well? I didn't pick that up in the conversation. This is for the Charles H. Best Diabetes Centre—not sure if they're still on.

Mr. Serge Babin: Yes, hi. It's Serge Babin here. I'm the chair of the board. I'll respond on behalf of Lorrie, through the Chair.

The $3.5 million is part of an overall capital campaign to expand our current site here in Brooklin, north of Whitby. It basically over doubles our space from about 5,000 square feet of education space to over 11,000 square feet of education space—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for this questioning, and it also concludes the time for this panel, so we want to thank the panel for all the time it prepared for to come here.

I just want to—you know, for equal time for everyone—she was head of my school board too, and my daughter teaches in it. I see everybody else was trying to get in on the act, so we all want to be as famous as you.

But, anyway, thank you, all the presenters, for presenting to us today and helping us in this pre-budget consultation.

RIGHTS 4 VAPERS
COMMUNITY CARE DURHAM
BETHESDA HOUSE

The Chair (Mr. Ernie Hardeman): As we're changing here, the next panel is Rights 4 Vapers, Community Care Durham and Bethesda House.

Okay, as we're coming to the table, again, we will have seven minutes for your presentation. When starting the presentation, we would ask you to introduce yourself to make sure that Hansard gets your names proper. At the six-minute mark, I will say "one minute," and at the seven-minute mark, I will say, "Thank you for your presentation."

With that, we will start in that same order as I said. The first one is Rights 4 Vapers.

Interjection.

The Chair (Mr. Ernie Hardeman): No, you don't have to touch the speakers. Just start speaking and our good folks in the back here will make it all work—most of the time.

Ms. Maria Papaioannoy: Dear esteemed members of this committee, I am sincerely thankful for an opportunity to speak here today. However, during my research on this entire presentation, I was shocked to find that perhaps what I'm going to say means nothing because an order in council was passed on the vape tax, and it's supposed to go through. However, it's not done until it's done, so I'm here to tell everybody that the science that is being followed is incorrect. The science is leading to something else.

My name is Maria Papaioannoy. I am not going to ask any of you to refer to me as Maria Papaioannoy; I will ask you to refer to me as Maria. I live in the province of Ontario. I am born and raised. I am proud of this province. I live in Northumberland county. At 14, I started smoking. At 15, I started trying to figure out, "How the heck am I going to quit smoking?" I tried it all. I tried the pharma-approved products. I put anise in my ears to try and quit smoking. Some of it caused damage to me that took me over a decade to get better.

However, it wasn't until 2010 that I discovered vaping through online, ordered my first package from China, and I've been smoke-free since then. It was that success that led me to open one of the first shops in Canada, and for over 10 years, I helped adults quit smoking in this province. That is thousands of people. It was that connection with those people that led me to advocacy and activism.

I was part of the group Vapor Advocates of Ontario. Those of you that were here, you know we were loud. We had protests. And in 2019, I went bigger. We started Rights 4 Vapers, which is the largest advocacy movement for consumers of vaping products in Canada and around the world. Today, I stand before you not only for myself—because I'm no longer a business owner; I am a consumer. I am a former smoker—but I also stand here for every single person that I have connected with because of vaping.

Upon hearing the budget announcement and this statement, I was profoundly affected by this. The vapour products tax is part of the province's efforts to achieve our long-term goal of becoming one of the healthiest provinces in Canada by 2031. It's challenging to reconcile this with the findings of the science. In 2023, science was released that for every time an e-cigarette tax is placed, e-cigarette sales go down, tobacco sales go up. So trying to figure out who's going to profit—it's the tobacco companies. The science came out in 2023. In your package, you will find all those studies.

For example, a bottle of e-liquid that lasts me three days, in 2022, cost me $24.99; today, it costs me $34.99. With this tax, it's going to cost me $44.99. Three packs of cigarettes—because I was a pack-a-day smoker, and if you know about addiction, you don't start at the beginning, you

start where you left off. It will cost me just as much, if not more, vaping than it does smoking. So how do we do this?

If you also look at the Cochrane review, which, for those of you that don't know, is one of the most esteemed organizations in the world, they identify e-cigarettes as the most effective tool for smoking cessation. Science does not agree with Ontario's goal; contrarily, the science predicts the opposite will happen and more people will begin to smoke. The government, the people who use vaping products and the NGOs that hate vaping products need to carefully get together and share the science, look at the comparative risks associated with these different products. Affordability should not be a barrier to harm reduction. It should not prevent people from stopping smoking.

I want to stress something, and I want to make it very clear: I do not believe, Rights 4 Vapers does not believe and every vape shop in this province that is following the rules do not believe that minors should vape, point blank. I am not going to argue that with anybody.

1410

What I am going to argue with is that we start following the laws. It's illegal to sell a vaping product to a minor in this province; however, they still get them. How do they get them? We need to follow up on enforcing the current regulations instead of trying to add a tax on something that will make it much more difficult for people to have access to this product.

I'm going to quote from Health Canada, but before I do that: Public Health England, in 2014—they have stood firm on the statement of their findings that vaping is 95% safer. It causes 5% of the risk. If it causes 5% of the risk, why are we looking at making the tax greater?

Health Canada also sees the benefits of vaping for those who smoke as a positive tool. Some of the things that they have highlighted on their website: Adults who switch completely to vaping immediately reduce their exposure to toxic chemicals. They experience general health improvements in the short term. They may be more likely to quit smoking, compared to using nicotine replacement therapies. It's crucial to note—and this is from Health Canada—that vaping products do not contain tobacco. Vaping isn't smoking, so why are we currently, in 2023, relying on dated and antiquated tobacco strategies to combat the use of a harm-reduction product? We are currently using fear and misinformation to stop kids from vaping, and all that's doing is stopping adults who smoke from using the product.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Maria Papaioannoy: In 2021, the Angus Reid Institute released a study that people believe vaping does more harm than good. It increased from 35% to 62% in less than a year; that's doubling the negative impact. If we want Ontario to become one of the healthiest provinces by 2031—and let's be very clear that 48,000 people die from tobacco-related illnesses every single year—we need to look at this taxation. We need to open up conversations. We need to pause and include everybody in it. Use the lived experience and find a solution that truly works for every single person who lives in this province.

People who smoke are not second-class citizens, and we need to stop treating them that way. Over 48,000 people died last year because of tobacco-related illness. No one died from vaping since it has come to Canada.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We now go to Community Care Durham.

Mr. James Meloche: I also have copies of my presentation.

The Chair (Mr. Ernie Hardeman): Okay, the Clerk will come and gather. As with the previous, you'll have seven minutes, and I'll let you know when you're at six.

Mr. James Meloche: Okay, thank you.

The Chair (Mr. Ernie Hardeman): The floor is yours.

Mr. James Meloche: Good afternoon, everyone. Thank you for having me here today.

I'm James Meloche. I'm the CEO of Community Care Durham. As you know, over 90% of Ontarians want to live at home and age at home. They want the government to help them to do that.

I'm not going to be here talking about an aging population. We have been talking about that for 20 years. I'm going to talk about the epidemic of loneliness. In 2022, the Canadian Red Cross found that one third of vulnerable older persons were living without the knowledge that they could find the help that they needed. As a result, over half of them felt good about themselves and about their future.

Just this past week, the National Institute on Aging reported that 41% of Canadians had experienced social isolation. Why is this important? I'm here talking about health care. Socialization and loneliness is a health issue. The World Health Organization says its impact is greater than smoking. People who are lonely experience higher rates of hospitalization. They lose their physical and mental health. They have higher rates of dementia, depression, anxiety and suicide.

I'm also here to talk about care partners, or you might refer to them as caregivers. These are children, spouses, family members, friends, relatives who are providing unpaid support to their persons living at home. Last year, care partners provided $5.7 billion of unpaid support to their family and friends. If they don't have the support, they are often taking them to the hospital or premature admission to long-term care.

So what do we do at Community Care Durham? For 47 years, we have provided a wide range of health and social supports to residents across this region. Our 340 staff and our nearly 1,000 volunteers support almost 10,000 clients the ages of 16 to 106. We are enabling every single day for people to live at home where they want to be.

We believe connected communities are resilient. Our mission of strengthening people is to support our community. On the surface, our programs, like Meals on Wheels, transportation, personal support care in the home, are really about helping activities of daily living for older adults, but what we are doing is connecting people to care and to their community.

Last year, we delivered 135,000 meals. That's 135,000 encounters of volunteers with members in their community who are often living alone or isolated. Every encounter is an important opportunity to create meaning. We know we're doing this well. Last year, 96% of our clients told us that we are helping them maintain their independence to live at home, where they wish to be.

I want to give you two examples of why I'm here today about our budget impacts. As I said, we provide a wide range of supports, both health and social supports, to people across this region. I'm going to focus on two. First is assisted living for high-risk seniors, and the second is access to primary care.

Assisted living services: It's one of our most cherished programs and most highly successful. It was actually audited by the provincial auditor about two years ago. We provide active daily living supports to people living at home every single day on a scheduled and unscheduled basis. That's personal support services, homemaking, security checks and care coordination. Currently, we have about 250 clients that receive this service in Durham region.

I'm going to give you an example of a 96-year-old male who lives alone in his apartment. He's developed glaucoma and has a rapid decline in his vision over the last few months. He now lives in darkness and only has the ability to see shadows and outlines. Our staff have increased the supports to him three times a day to ensure he's able to prepare his meals and remain safely at home. His visits, both scheduled and unscheduled, are helping him with both companionship and wellness, and he's good at playing cards. He beats our personal support worker at least once a week. We have 86 clients today waiting for this service in Durham region.

This is a cost-effective solution. Only 17% of our ALS clients visited the hospital last year; 63% of those were persons living over the age of 85. It costs us $7,780 to support an individual in this program per year compared to the $46,000 to $50,000 in long-term care. If you enhance our program, which we have been doing through our own budget by providing community nursing, that annual cost goes up to $8,800 or $51 of care per hour, and we're a non-profit. Every dollar the government sends to us goes to care, not to shareholders.

I want to talk about access to primary care. This is a transportation service that brings personal support workers along to medical appointments. There's no other service like this in Durham region. As of today—well, actually, as of October, we stopped taking new referrals to the program. We take no more clients until April of next year because we are tapped out. We have no more budget.

So here we are. We have clients who are waiting to get access to their cancer treatments, their chemotherapy, their blood treatments and they have no way of getting there except a very expensive Uber.

Gerda is 83 years old and lives at home alone. She has cancer appointments every eight weeks. Her daughter is in her sixties and just had knee surgery and is unable to drive her. We took over her care last year when she was discharged from hospital and the budget that we're allowed to spend to bring her to her cancer appointments ran out last month. She has no way of getting there. We're going to make sure she gets there. Gerda deserves the care she needs, but this revolves on us.

So our ask today is to correct a chronic underinvestment in community support services since 2008. The result of this underfunding has been service attrition, pay inequities across sectors, a widening technology gap and, honestly, the government of Ontario's lost opportunity to take advantage of community support services that are much more cost-effective to support people to age in place.

For every 1% gap of our funding next year, we have to reduce about 1,000 hours of care. Next year, we're looking at a reduction, without any budget increase, of 5% to 10%. For our Meals on Wheels programs and other programs, we're looking at a 10% increase in our client fees to keep pace with inflation.

My recommendation to this committee is a three-year 7% annualized growth fund for the community support services sector. Targeted investments and pay equity and retroactive compensation for employees impacted by—

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The Chair (Mr. Ernie Hardeman): Thank you very much. We'll have to finish the presentation during the question period. That concludes the time. We're now going to Bethesda House. The floor is yours.

Ms. Laura Burch: Good afternoon. I'm Laura Burch, the executive director of Bethesda House, a violence-against-women shelter. As we gather to discuss the 2024 Ontario budget, I am reminded of the profound impact that wise financial decisions can have on the lives of people we serve.

Bethesda House, located in Bowmanville, is more than just a shelter; it is hope for those suffering from the experience of violence and abuse. Our work extends beyond the walls of Bethesda House. Prevention is at the core of our mission, aiming to address the root causes of violence against women.

Today, I urge you to consider the staggering statistics that underscore the urgency of our cause. In Ontario alone, the prevalence of violence against women is alarming. Every number represents a story, a life affected, a person in need. The disproportionate violence experienced by women and children, particularly Indigenous women, demands our attention and action now.

We lost a family in Sault Ste. Marie due to domestic violence. A woman and three children were murdered, ages six, seven and 12, and another woman was murdered in Whitby last weekend due to intimate partner violence. She left behind a young son. In October, in the province of Ontario, we had nine femicides. From November 2022 to November 2023, we have had 62 femicides in 52 weeks: the murder of women and children by male perpetrators because they are women.

In August, there were four femicides; three out of four of those women were Indigenous. It is clear that Indigenous women, girls and two-spirited people continue to be overrepresented in Ontario's femicide statistics. Since

November 26, 2022, Indigenous women have accounted for a staggering 11.9% of femicide victims despite comprising only 3% of Ontario's population. These numbers are alarming and demand our immediate attention.

As a sector, violence against women remains underfunded, and, shockingly, we did not receive the 5% increase in funding dollars that other ministries received in years past.

Bethesda House, in the 2022-23 fiscal year, served 123 emergency shelter clients. We had almost 3,000 crisis calls to our emergency line, all while funding only allowed for one staff member, single-shifted, for each shift. Bethesda House is funded for 18 beds, while the Clarington population is 103,584. Due to capacity, we turned away 1,063 women and children who met our mandate of trying to flee violence and abuse. I'm going to say that number again: 1,063 women and children who met our mandate were turned away.

Intimate partner violence has been deemed an epidemic in Durham region, and yet we are underfunded, understaffed and underpaid. We are saving the lives of women and children in this very community, and we are not funded appropriately for this work; instead, we hustle to raise donation dollars to offset the $200,000 we are required to raise just to run our programming and to staff adequately. In this climate of inflation, a housing crisis and violence against women on the rise, we expect our communities to offset the costs of our programming through donations, but this is futile, as people are struggling to feed their families right now.

We know how to lower the rates of gender-based violence in our communities. We're the experts, and we have been doing this work for decades. But we can't do it without funds to support our efforts. We know prevention is the path to eradicating gender-based violence and abuse by changing the attitudes, ideologies and gender norms of our youth. Bethesda House has exceptional youth programs for male and female youth that we have implemented in schools throughout the region, which have yielded tangible results backed by measurable statistics, yet we find ourselves unable to secure funding for a full-time staff member to spearhead these crucial efforts.

Similarly, in our pursuit of implementing a diversity, equity and inclusion program, we've faced ongoing challenges in securing the necessary funding. Despite our diligent efforts in grant-writing, the saturation of applicants from numerous violence-against-women shelters across Canada place us in direct competition, leading to unmet needs for both our agency and its clients, an unsustainable scenario.

Unlike for-profit entities that allocate substantial resources to overhead costs, ensuring the success of their initiatives, non-profit organizations like ours often are held to a meagre standard for administrative expenses and aren't able to build capacity within changing times. This results in low pay for our front-line staff, many of whom must juggle multiple jobs just to make ends meet, despite their unwavering dedication to our cause. Our team's commitment places them just above the poverty line, underscoring the stark reality of the sacrifices made while endeavouring to save the lives of women and children.

Today, I am asking for:

(1) A new investment of $60 million into the core operating budget of shelters provincially to match inflation and the rising costs of operating, programming, wages, transportation, groceries, insurance, benefits, digitization, IT infrastructure, administration and accountability reporting requirements.

(2) Recruitment, retention and training investments to address our staffing crisis in VAW shelters: Base rates of pay need to be established for the sector, along with ensuring double staffing is available and funded in all shelters. Staff need to be trained in risk assessment across the province.

(3) Continued infection prevention and control investments for shelters: As we look forward, all shelters will need permanent staffing, cleaning and food services employees in place to ensure we remain IPAC compliant.

(4) Investments from the national action plan need to be prioritized for existing gender-based violence services and the establishment of culturally specific programming where it doesn't exist. We need dedicated programs, not projects.

(5) Investments in gender-based-violence-specific prevention work within communities and schools for youth, women and men.

The issue of violence against women is an urgent concern that affects every community, transcending demographic boundaries. The indiscriminate nature of this cruel crime emphasizes the importance of collective action. Your support is crucial in ensuring that our efforts to combat gender-based violence can continue with the impact and effectiveness that this cause demands.

I implore you to recognize the profound impact that funding for organizations like Bethesda House can have on the overall well-being of our society. By investing in preventive measures, emergency shelters and outreach programs, we can begin to dismantle the structures that perpetuate violence and foster a community that prioritizes the safety and well-being of all its members.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation. We now will start the questions with the official opposition. MPP French.

Ms. Jennifer K. French: I'm glad to welcome all of you to the committee. I appreciate that I've had the opportunity to work with some of you before. The work that happens across community, I would say, is immeasurable, but thank you for quantifying it here for us today.

I'll start with James. Certainly, I know the impact that—well, I don't think we can ever actually measure the impact that Community Care Durham has, but you've been working very hard through the years to make the case with this government or with levels of government about the economical value. Whereas, of course, what it means in the lives of seniors and their families is awesome. So I guess my question is, when you gave us the example of Gerda, that you have a budget to take her to her appointments, where is the money coming from now that, as you

said, that budget has run out? I guess what I'm looking for is the humanizing of what those dollars actually look like. You've said, "We're going to make sure" Gerda gets to her appointments. How do you do that? What does that mean for someone else?

Mr. James Meloche: Thank you for the question, and thank you, MPP French, for your advocacy for our sector.

In the case of Gerda, we will rely on our financial reserves that we have established through an organization. As a non-profit, we reinvest in our community through establishing around savings or through fundraising that we're able to obtain. We do this, actually, for almost all of our programs where there's a client fee. In a case, for example, of Meals on Wheels or transportation or adult day programs, there's a client fee that's required to help support the costs that are not funded by government. For some individuals, that's just too much. They can't afford the $32 a day to go to a day program, so we find ways to create subsidies through our fundraising.

What's difficult about the APC program is that this is actually a fully funded program by the province of Ontario. So now—I will say it bluntly—we're subsidizing the lack of funding to a fully funded program. I don't mean to bemoan the other providers in the home care sector, but I don't think you would find any for-profit organization using fundraising dollars to subsidize care for something that the government pays fully 100% for. We very reluctantly will use our fund type 3, which is what we call our reserves, to offset costs or gaps in funding for programs that are actually fully funded by the province of Ontario to service provider organizations that are both for- and not-for-profit.

In the case of Gerda, we care. All of these presenters here today care, not just us at Community Care Durham. How do you turn your back on a Gerda, an 83-year-old woman living alone? None of us would do that. This is what the special part of Community Care Durham is. We don't turn our back. But we need the help of the government of Ontario to do more.

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Ms. Jennifer K. French: I remember back to COVID and, certainly, you guys were instrumental in ensuring that care happened during such an uncertain time. I know that for the for-profits and the not-for-profits, there were different funding channels in terms of reimbursement and investment from the government. Did you ever get your payments? I remember that the for-profits got theirs right out of the gate and not-for-profits had to wait.

Mr. James Meloche: Eventually we received the funding, nine months after it was committed and paid to the other organizations, which meant, as an organization, we were bankrolling the government of Ontario about $380,000. Currently, this government has committed to a 5% increase to the community support services sector, of which to date we've only received 3%, and we've had no word on where the remaining 2% is. If you're going to allocate funding through the financial process—I know I've met with the Minister of Finance and it's frustrating to him. He thinks, with the budget, he makes the decision; why aren't the dollars getting out to the community?

So we still have about a quarter of a million dollars that are waiting from Ontario Health and the provincial government to roll out to our organization. Folks, we're now hitting January. We have three quarters to spend that. So if you're going to commit to funding, get the dollars out to the providers who put the dollars into the community.

As you may know or may not know, I spent 10 or 11 years working with the provincial government in policy, so I speak with some experience when I say now, as a provider organization, that it's very frustrating to see that the commitments are not followed through with when they have been committed to.

Ms. Jennifer K. French: Thank you. We have heard that before today, as well.

Ms. Burch, thank you very much for your presentation. I just want to say to folks that I've had the opportunity—even though I'm not Bowmanville—to see Ms. Burch in action through the human trafficking collaborative initiatives that are happening with TRPS. There's some really awesome innovative work that is happening with the human trafficking division at the unit with the police and community partners working together. I've actually been out spending the day seeing it up close and personally, and the value is immeasurable and the difference is immeasurable. But that's very specific.

What you're talking about today is more the need for funding to do any and all of that work. I was commenting to my colleague here that we're sitting here listening to folks begging for the basics, and that shouldn't be. I've been doing this a while, and the needs that folks are asking for are getting more and more just functional. We're not looking for trimmings.

I guess, when you say the $200,000 per year that you referenced that you would have to fundraise, can you tell me a bit about that money? What is that money for? If that is what you have to fundraise, where does that money go? And as times are getting tougher for the community, as you said, it's impossible for them to donate what you need because they need it as well.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Laura Burch: Yes, thank you. The $200,000 is for our programming. Because we're having over 3,000 crisis calls come in, we're constantly turning people away. We are funded for one staff per shift, and so we've had to bring on a second staff member for the day shift, but we don't have funding for it and so we're pulling out of those donation dollars to pay for that, which we're not going to make this year. It's not happening this year. And so, it's specifically for programming and to serve the people in our shelter and the people calling our shelter who need help. They are not getting the help they need. And it's also unfair for the clients in shelter. If we don't have adequate staffing, they don't get the services they require. They are traumatized, have addiction issues, a numerous amount of issues—

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll have to save the rest of the answer for the next round.

We go to the opposition: MPP Hazell.

MPP Andrea Hazell: Thank you for coming in today and for presenting very well-detailed presentations.

I'm going to start off with Laura Burch. I am very close to the ground on the situation with violence against women. Particularly, I can share what's happening in Scarborough. It's not different from what you have explained. You quoted a number twice; 1,063 women were turned away. I know some of those women in Scarborough are actually living in their cars until a bed becomes available. There are no beds. So how are you mentally coping with that?

And my second question, if you can quickly explain that—you talk about a $60-million budget. What is inside of that? Could you break that down a little bit further?

Ms. Laura Burch: Luckily for me, I'm not on the front line, and so I don't cope with it. I'm on a higher level. It's my front-line staff who cope with it. They're the ones on the phone saying, "I'm sorry I don't have the space," and having to listen to the woman beg or cry or plead. So I think the front-line staff have the hardest job.

For the $60-million investment, it's literally everything. We don't have enough money for, with inflation, our programming, transportation, insurance costs, auditing. Auditing is up 16%. We don't have the funds for transportation. Benefits: For our full-time staff, we pay about $600 a month in benefits for those people, and we can't afford it, but they need it. So it's all of these things.

Like I said, the programming: We want to bring in these specific programs for prevention and getting into schools and diversity and all of the things that we need when Indigenous women and BIPOC women are overrepresented in violence against women. So how do we do this and serve them properly when we don't have the funds?

MPP Andrea Hazell: Thank you for explaining that.

My next question is to James.

Can I get a time check, please?

The Chair (Mr. Ernie Hardeman): It's 2.1.

MPP Andrea Hazell: My next question is to James. James, I just want to say thank you for providing over, I think, 47 years of community service to your clients in Durham region. But what hit me today is you're already down in funding, and yet still, you're going to see a 10% increase in client fees, plus you've got 86 clients waiting to get your services. How are you managing that? Do you just turn them away and don't go back? What's happening there?

Mr. James Meloche: First of all, thank you for your comments. Just by our partners in Scarborough—TransCare, care for seniors and Scarborough Centre for Healthy Communities—you may be—

MPP Andrea Hazell: Yes.

Mr. James Meloche: Those are our partners in the community support services sector. We support them the best way we can. We can't provide them with that service because it's pure cost of labour, and we don't have the ability to support that. But our volunteers will do telephone reassurance checks; we'll provide Meals on Wheels; we'll try and provide them some basic supports until we can get them on the service.

I will say, a lot of these clients are actually getting care from a Home and Community Care Support Services agency—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. James Meloche: —and at a much higher cost. So I'm hoping that we can get some funds from Ontario Health and from the Ministry of Health this year.

MPP Andrea Hazell: Quickly, can you tell us what's on your top wish list for this funding?

Mr. James Meloche: Assisted living services for high-risk seniors. I think that is the most effective program to keep people out of hospital and out of emergency departments.

MPP Andrea Hazell: Thank you.

The Chair (Mr. Ernie Hardeman): We'll now go to MPP Anand.

Mr. Deepak Anand: First of all, thank you to each one of you for coming here. I think shelter community care is very important.

Maria Papaioannoy—

Ms. Maria Papaioannoy: Papaioannoy.

Mr. Deepak Anand: Papaioannoy?

Ms. Maria Papaioannoy: Papaioannoy.

Mr. Deepak Anand: Okay, I'll do that offline. I'm going to practise with you offline on that.

Ms. Maria Papaioannoy: That's okay. But it does spell, "I annoy." Just remember that.

Mr. Deepak Anand: Maria, one of the things which I—when it comes to morals and ethics, we talk about it in one way. We say yes with the vaping. Every time, the vapers we talk to, people will say, "Hey, because of the vaping, the people are not smoking." You said you are one of those examples. Do we have concrete data to support this: How many people left smoking when they went into the vaping?

Ms. Maria Papaioannoy: We don't, because it is very fluid. When you talk about addiction—and I'm sure the Liberal and the NDP parties, who have an incredible harm reduction policy when it comes to everything but tobacco, understand that addiction is a fluid process and that stigmatization tends to bring people back into their addiction over and over and over again. When it comes to addiction to smoking, it's no different than any other drug. So when we talk about numbers, it's very hard.

But what we can talk about is the Canadian Tobacco and Nicotine Survey, and that's published in 2022. Currently, Newfoundland, Nova Scotia, Saskatchewan and BC have a tax. When you look at the numbers of youth that are vaping in Ontario right now, according to the Canadian studies, we have 10.7% of our youth vaping.

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Newfoundland has had the tax, and Nova Scotia has had the tax in play for the longest. Their youth vaping rates are 23.4% and 21.7%, so it looks like a tax doesn't work. Do you want to know why a tax doesn't work? Alibaba

doesn't charge a tax when you buy it online. Our nefarious black market of scary people that we go to downtown in the middle of the night to buy our stuff no longer exists for vaping. It's online. It's on our social media. It is their peers.

So what we need to do is look at how we conquer this. Putting in a tax—if you want numbers, go to the Canadian Tobacco and Nicotine Survey. The numbers are there: Newfoundland, 23.4% youth vaping rates with a tax; Ontario, 10.9% without a tax. There is no need for a bigger black market than we already have. What there is a need for is enforcement.

Mr. Deepak Anand: Thank you. Maria. Another thing which I wanted to ask you, as I was looking at the Heart and Stroke Foundation of Ontario: They praised Ontario's government for implementing a new tax. As per them, the province said it will increase, and it will reduce the number of children—specifically, they talked about reducing the number of children who will be vaping. Because of the cost, they will not be able to buy it. They will not be able to do it. Have you reached out to the Heart and Stroke Foundation?

Ms. Maria Papaioannoy: Unfortunately, the Heart and Stroke Foundation, the cancer society and the smoke-free physicians, who have all lobbied many of your offices, do not talk to me. They hide under the guise of 5.3. They claim that because I owned a vape shop, an independent vape shop, I am a tobacco company, so they don't talk to me. But what I can say is that maybe a question to ask them is, why did they, with the tax, increase their vaping rates in the provinces where they lobbied for the tax and got that tax, before the federal tax? Why did they increase?

Here's the thing: I don't want kids to vape, but it is illegal in this province to sell to a minor. What are we doing? When I owned a shop, I was checked once a year. Do you know how many times I was checked to make sure that the name of my business wasn't on the outside of my business? Seven times. Tell me why adding the name of my business twice will help kids vaping, but not checking to see if I'm selling to kids. Let's get our priorities straight. Where I live in Northumberland county, there is a vape shop that has had over $60,000 in fines because they sold to kids, and kids have come from over 100 kilometres away. Those fines were thrown out of the courts.

Do you know what? Let's be honest: No one cares, because what we're doing right now is not talking to the people who own the vape shops. The people who are there to have conversations. Your offices consistently ignore us. There are policies, spoken and unspoken, that we do not like vaping. We do not treat vaping in the same realm when it comes to harm reduction in this province. That is the problem: ignoring us. We have the solutions. Let's start being honest. Let's start saying who is vaping—

The Chair (Mr. Ernie Hardeman): If we could just answer the questions.

Ms. Maria Papaioannoy: I apologize. I talk a lot.

The Chair (Mr. Ernie Hardeman): MPP Kusendova-Bashta.

Ms. Natalia Kusendova-Bashta: How much time do we have left, Chair?

The Chair (Mr. Ernie Hardeman): You have 2.2.

Ms. Natalia Kusendova-Bashta: Okay, thank you so much. Maria, you're not going to find a friend in me; I'm sorry. As a registered nurse and as someone whose spouse is an avid vaper, I have been fighting with him since we got married to really stop vaping. You're not going to find a friend in me.

However, I did want to state some things on the record so that we are comparing apples and apples. In terms of taxation on cigarette products, from what I understand, currently, a 20-pack of cigarettes would be taxed at $3.70. If we want to compare that to two millimetres of vaping product with our increase, it would bring it up to $2, for a comparison. So we are still taxing the vaping product at a much lesser amount than the cigarettes.

But you know, you said that there currently have been no deaths linked to vaping products. Do you stand by that statement?

Ms. Maria Papaioannoy: I stand by what Health Canada said on their website.

Ms. Natalia Kusendova-Bashta: Okay. Are you familiar with the term "popcorn lung"?

Ms. Maria Papaioannoy: Absolutely. Are you familiar with Health Canada's stand on that, that a single person in Canada—

Ms. Natalia Kusendova-Bashta: I'm the one asking questions today, respectfully.

Ms. Maria Papaioannoy: Oh, sorry. I apologize.

Ms. Natalia Kusendova-Bashta: Are you familiar with the lung injury popcorn lung?

Ms. Maria Papaioannoy: It's bronchiolitis obliterans, yes.

Ms. Natalia Kusendova-Bashta: Are you familiar with how many minors were actually directly linked to deaths in the United States in 2019?

Ms. Maria Papaioannoy: Actually, what I am familiar is with the VALI cases that were based on vitamin E acetate through the illegal market. With popcorn lung, based in Canada, they found two samples when they did there, of over 800, of the diacetyl that is found in popcorn lung, which also happens to be called popcorn lung because the first case study of those that happened were in the popcorn factory in Minnesota. Those lung injuries happened there. There have been no cases in Canada. What has happened in the United States is VALI. In Canada, what they have found is it was from black-market products, and if you go on their site, it actually talks about the clear findings they've had, which is about vitamin E acetate—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We now go to the official opposition. MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to all our presenters today.

I'd like to start off with Mr. Meloche. I think it should be clear to everyone that living at home is where people want to be. It's where they're happiest, healthiest—mind,

body and soul. I think you've outlined, really, the important argument for the financial incentive for people to remain in their home.

I think your comments about CSS subsidizing the government should be ones people take note of. It's very unfortunate the funding has flown and is not actually reaching those folks in our community.

I wondered, would you want to talk about wage parity and how that affects people in the sector?

Mr. James Meloche: Absolutely. First of all, I want to talk about something really positive about our organization and our team. Currently, we enjoy a 96% retention rate, and that's because people are absolutely committed to the mission of what they do at Community Care Durham, and we do our very best to provide them with a competitive wage within the sector.

Before I sing the negatives, I want to talk about the positives of the people who work in the sector and their commitment to it. They also come and work with us at Community Care Durham because we provide stable employment rather than contract work. So they're not spending time in their vehicle, driving from one home to another home, which is unpaid work. They're actually working within community hubs within a five-kilometre radius, able to see more clients and not wasting time commuting from one home to another home. So we have some positives.

The wage imparity between our sector, the community support services sector, long-term care and hospital creates a significant destabilization in both personal support workers, as well as professional staff, so talking about IT, accounting, leadership roles. They can go and make anywhere between 19% to 22% more for the same job in another organization. That's significant. You see people moving laterally across organizations now in the private sector for a 1% to 10% increase, because that's the way they get lateral movement. So it's significant in the health care sector.

I want to refer to nursing. We've implemented a program of community nursing in the last two years, and because of the competitiveness of that role, we have not been able to hold on to a nurse for longer than four or five months because they move on to other jobs where it's higher pay, and that higher pay, by the way, is contract work, working in hospitals rather than full-time employment.

Mr. Terence Kernaghan: Absolutely. We know that it's financially imprudent for much of this over-expended—the way the government is spending far too much money on agency nursing or allowing that to be—

Mr. James Meloche: We don't use a single agency nurse or a PSW in the organization.

Mr. Terence Kernaghan: Good for you. I think as well, from your presentation, you outlined how it costs $103 a day for in-home clients versus $200 per day in long-term care and $730 a day for ALC patients, so I think it's really important that this government takes note of that.

My next questions will be for Ms. Burch. The official opposition has been calling upon this government to follow the lead of many municipalities and regional governments, like Durham county, who have declared intimate partner violence as an epidemic, but as yet this has not happened. Can you tell the government members what this would mean to the families in your sector?

Ms. Laura Burch: Yes, thank you. So, intimate partner violence as an epidemic came out of the Renfrew county inquest, where three women were murdered, and so a lot of the municipalities have done it within Ontario. The province of Ontario will not do it because of the wording and they don't deem it as an epidemic. "Epidemic" is illness. We can argue that it is an epidemic. It's killing our women and children.

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What this would mean to us and their families: When we got Durham region to name IPV as an epidemic, it felt like a huge win, like we were finally being acknowledged. The fact that femicide isn't being acknowledged as an emergency, as an epidemic—we feel disheartened. And behind an epidemic comes money—if you look at COVID, lots of money came through that—and that's what we need. We can't do this without the funds.

There's $18.7 million dollars coming to 400 VAW agencies. That's $18.7 million divided by 400 and divided by however many programs each shelter has. If I even get $20,000 out of that, I'll be lucky. So, yes, there's money coming, but it doesn't do anything for us.

Mr. Terence Kernaghan: Absolutely. Often, folks in the sector have spoken about the overreliance on grants, and I wanted to ask, what kind of difference would multi-year operational funding mean for your organization, rather than having to rely on applying for grants year after year after year?

Ms. Laura Burch: I write the grants. I've written about 25, and I think I've gotten five, and they have all been mediocre in funds. They're not funding the things that I need. They don't want to pay salaries. They don't want to pay overhead. But the people are the ones who are helping, and we're doing the work. If no one's going to fund for our work, we can't help people. Everyone wants a project, and we don't need projects; we need programs. And so I can't get the funds that I need through grant writing.

Mr. Terence Kernaghan: You mentioned specifically about having to turn away 1,063 women. I wanted to ask, how does it affect you and your team when you have to turn away people who are desperate for your help?

Ms. Laura Burch: Yes, it's devastating. MPP Hazell had the same question. It's the front-line staff that have to do that work and they have to tell women with their children who are living in a car or trying to leave that we don't have space because every single shelter is full.

Mr. Terence Kernaghan: How much time do I have, Chair?

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Terence Kernaghan: One minute. Maria, my next question will be for you, in the remaining time that we have. As a former business owner, what should effective

enforcement of regulations look like? What would that look like to you?

Ms. Maria Papaioannoy: Ideally, it would be being examined or getting spot-checked regularly and irregularly. Come in and check us out. Don't come in once a year. We already know you have. I live in Northumberland county. I know the kid. I know how to scare the kid. I literally yell at him, and I yell at the kids that come in there. I'm not the problem. I was never the problem. What we're dealing with is a set of regulations that are hard to enforce, and they're enforcing things that really don't have an effect on kids getting vaping products. When you set the fines, set the fines higher. Make them—if we're going to follow this whole tobacco thing and make it the same as smoking, why don't we fine them the same way?

The Chair (Mr. Ernie Hardeman): Thank you very much. That's the end of the time.

We'll now go to MPP Hazell.

MPP Andrea Hazell: So, I'm back. I want to ask—I forgot your name—is it James?

Mr. James Meloche: Yes.

MPP Andrea Hazell: James, for the record, I want you to tell us more about the isolation that is becoming, I say, an epidemic, because I'm hearing it when I turn on the radio. I hear it when I listen to the news—isolation as a serious health issue for our seniors. The reason I'm pressing on that: These seniors have worked their lives here, they have paid their taxes, and I think we as government need to do more for funding our seniors that are in these programs.

Mr. James Meloche: I'm a 54-year-old adult, and I would say that everyone, in every generation, at this point in time, is feeling a sense of loneliness. It's experienced differently as an adult or an older person or a younger person. And what that comes with is a sense of helplessness or hopelessness. What we want—government can't fix all the problems of the health care system, and much of the problems faced by the health care system aren't health-related at all. If you can't have people who maintain physical activity, maintain their personal decorum, maintain their social interactions with people, maintain their diet, if they feel no sense of self-worth or self-purpose, then why do you take care of yourself? Your diabetes becomes out of control. You lay in your bed too long and develop pressure ulcers on your skin. You feel about suicidal ideation because there's no one there to look after you. These aren't small factors; these are massive.

Have any of you watched the Netflix series Live to 100? The number one factor of all the community blue zones is a connection of individuals to community, whether that's through their church, through social organizations. The value of Community Care Durham is not simply the meal. It's not simply the personal support worker. It's the interaction that we take through volunteers and staff with an individual. We deliver a meal to the door. We knock on the door. We check and see how they're doing. Did they come to the door? If they don't come to the door, we call back the office. We have someone follow up. When the driver picks them up, there's a conversation about how they're dealing with their health today. What has happened with their kids? How are they dealing with their stress level? All of those interactions are an important part for a person to connect with another human in their community, which allows us to respond in ways that are most appropriate.

If you don't do this—and by the way, many of you are care partners or caregivers. The number one issue why people bring their loved ones with dementia to the emergency room isn't because the dementia flared up and something got wrong with them; it's because the care partner is burnt out, because they don't know where to turn and they're looking for the last-minute resort. I had a son with mental health issues. I did the same: I showed up at the emergency department with my son because I didn't know what to do. So you're feeling alone as a care partner; you're feeling alone as a caregiver, as a client. And this is very material. I know it sounds soft. I know it sounds hokey-pokey, but it's real. All of you, I'm sure, have experienced this or seen this with someone whom you've loved, and you wonder what they do all day. Sit on their sofa and watch television and do nothing—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. James Meloche: —and you see their health decline.

So, sorry, MPP Hazell, but that is my response.

MPP Andrea Hazell: Well, thank you for sharing that detailed information with me.

Laura, I want to hear you also talk about what you are hoping, when you leave this room, that we would keep in our thoughts. All of us here, what do you want to leave us with?

Ms. Laura Burch: That we are actively saving lives. Every single day, my staff is doing that. Women and children are literally dying in our province at alarming rates. We just need the funds to do the work, and so I need programming for prevention. We have the program; I don't need to create anything. We have it; I just need a full-time worker—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

MPP Kusendova-Bashta.

Ms. Natalia Kusendova-Bashta: I will direct my questions to James from Community Care Durham. I just wanted to say a huge thank you for the work that you and your staff do taking care of our seniors, our elderly and our vulnerable. I don't think people get into this business for money. They get into this business because they have a passion for helping others.

So in terms of our government supporting the home care sector, we have recently announced a $1-billion investment over three years to help with some of the wage disparities that you have referenced earlier. Are you a member of the home care association of Ontario?

Mr. James Meloche: I'm a member of the Ontario Community Support Association, which you will hear from after me today.

Ms. Natalia Kusendova-Bashta: Excellent, wonderful—because recently I met with the home care associa-

tion of Ontario, and they were presenting some of the similar challenges that you've referenced here. I actually asked them what is the average wage of a PSW working across the sector in Ontario, and I was surprised to hear their answer, which was about $22 to $24 per hour. Would you agree with that assessment?

Mr. James Meloche: That is correct, yes.

Ms. Natalia Kusendova-Bashta: Okay. That's really great to learn, because I think that has certainly gone up since we became elected in 2018. Currently, as a nurse, I work in the hospital. I get paid $34 an hour as a registered nurse working in the emergency room, so I would say when we look at the training required to be a PSW versus a registered nurse and at the level of interventions that are required, I think $22 to $24 an hour is in a place where we want it to be than five years ago or 10 years ago. But my question to you is—

Mr. James Meloche: Can I—sorry.

Ms. Natalia Kusendova-Bashta: Certainly. Go ahead.

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Mr. James Meloche: If there is a question, I'd love to hear it.

Ms. Natalia Kusendova-Bashta: Yes, I'm getting there. Recently our government also announced incentives to get more PSWs into the sector, including a completely free education. To date we have educated 16,000 PSWs completely tuition-free.

Recently we have also announced a grant to encourage more people to go into the PSW profession, wherein PSW graduates and students will receive $25,000 of incentives. My question is whether you have seen an uptick in these programs in your community and whether you think that's an incentive that would work to stabilize your sector in particular.

Mr. James Meloche: I would like to acknowledge the first part and then come to the second part very quickly, because I know it's shortened time.

I want to acknowledge the effort of this government with the personal support wage enhancement brought out with COVID. I think it was long overdue. I'm glad to see that this government has also made that permanent.

What I want to call attention to, though, is that it was a $3 wage enhancement across all sectors evenly, not proportionate. What we are seeing is the inequity continue to grow. Because you are providing a base increase to someone who is making more, the gap continues to go higher. What I am saying is that a personal support worker in the home and community sector should make the same amount in long-term care as they make in a hospital. That is not the case today. You're looking at $22 an hour is about the average on the home care side. It's more in long-term care and it's more in the hospital.

I have yet to see—

Ms. Natalia Kusendova-Bashta: How much is it in the hospital, do you know?

Mr. James Meloche: I think $28.75. There's actually a report that your association—I don't think they've put it out there yet, but they shared it with the government on the wage disparities across the sectors.

The other area that I would call attention to—I have not yet seen the enhancement of the personal support worker bonuses. What we are seeing, though, is the benefits of providing strong health care coverage—health benefits—to staff. Many of these are single moms. They look for that and they're looking for stable work. Those are things that tend to draw people to our organization, not so much those benefits that you've mentioned. But I think it'll just take time.

Ms. Natalia Kusendova-Bashta: Thank you. I just want to be cognizant of time.

The Chair (Mr. Ernie Hardeman): MPP Dowie?

Mr. Andrew Dowie: I thank all the presenters for their remarks today. You've given a great representation of some of the challenges that you face in your sectors.

I'd like to ask my question of Laura. You mentioned the figure of 1,063 who had been turned away from the shelter. Could you describe for me what went into that number? Is that over the course of a year? Where does that figure come from?

Ms. Laura Burch: That's the 2022-23 fiscal year, so April 1 to March 31.

Mr. Andrew Dowie: How many total beds do you have?

Ms. Laura Burch: Eighteen.

Mr. Andrew Dowie: Eighteen. Those 18, is it a six-month program? Sorry, a six-week program?

Ms. Laura Burch: No. Our average stay is roughly—we say about three months. We're in a housing crisis so people literally have nowhere to go. So it could be six months. Some people stay a day. It fluctuates.

Mr. Andrew Dowie: So if someone arrives you do not ask them to leave? Basically, with the absence of transitional housing, someone will stay until they're back on their feet?

Ms. Laura Burch: Someone will stay, if they're working the programming, as long as we can accommodate it. We generally try for three months.

Mr. Andrew Dowie: Okay. With respect to, I will say, the broader housing crisis, I know some of these services in my area—I'm in the Windsor area—their cry to me has always been on this option that transitional housing and giving independence to those who are seeking shelter and not providing them a reason to go back to their abusive relationship. I'm wondering if you could comment on the availability of transitional housing in your neck of the woods and how much the demand would be.

Ms. Laura Burch: There is one transitional house in Oshawa, through Y's WISH. They have cut their beds in half. I think maybe they have six, and that's it.

Mr. Andrew Dowie: I just had a follow-up question on the government's anti-human trafficking strategy. It's been a couple of years now since its implementation. I know it's a multi-faceted, five-year approach—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Andrew Dowie: To date, have you seen any results from that particular strategy and the implementation of it in Durham region?

Ms. Laura Burch: Have we in the violence-against-women sector?

Mr. Andrew Dowie: Well, given that the investments have been made for a couple of years now, have you seen results so far?

Ms. Laura Burch: There's more going into prevention work, but a lot of human trafficking funds go to victim services, and we haven't had specific funds to do that work.

Mr. Andrew Dowie: Okay. All right. Thank you.

Chair, how much time do I have?

The Chair (Mr. Ernie Hardeman): It's 0.2.

Mr. Andrew Dowie: Okay, 0.2. I'll adjourn there.

The Chair (Mr. Ernie Hardeman): That concludes the time for these questions, and it also concludes the time for this panel. I want to thank the panel very much for taking the time to appear and the time to come here and share with us to help us in our deliberations for the next budget.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

ONTARIO PUBLIC SCHOOL BOARDS' ASSOCIATION

The Chair (Mr. Ernie Hardeman): With that, as we're changing, our next panel: The first one on the panel has sent their regrets, so we will only hear two, the Ontario Community Support Association and the Ontario Public School Boards' Association.

As we're coming forward, I will point out again that there will be a seven-minute presentation, and we hope that you will start each presentation with your name to make sure we have that recorded properly for Hansard. At six minutes, I will say, "One minute." That doesn't mean you need to stop; it's just that exactly 60 seconds after that, I will say it's over. So, with that—oh, maybe I could just do that, exactly.

Thank you very much, and we will start with the Ontario Community Support Association. So with that, the floor is yours.

Ms. Deborah Simon: My name is Deborah Simon. I'm the CEO of the Ontario Community Support Association. I'd like to thank you for having me here today to make the case for an increased investment of $533 million for the home and community care sector.

I'm just so pleased to be following my colleague James Meloche on this, because he set the ground for the conversation.

Our association supports the government's goal of ensuring that people get the best care that they need in the most appropriate setting. We also commend the province for the work it has initiated to transform the home and community care sector, which includes significant investments in budget 2023 and the recent passing of Bill 135, the Convenient Care at Home Act.

OCSA represents nearly 230 not-for-profit agencies across the province—just like James's organization—who provide compassionate, high-quality home care, community support and independent living services to over a million Ontarians.

Your ridings are home to many organizations that provide these valuable services to seniors with physical disabilities, services such as in-home nursing and personal support, Meals on Wheels, Alzheimer day programs, transportation to medical appointments or assisted living services. Many of these services, such as friendly visiting and Meals on Wheels, rely on volunteers, who donate over three million hours of service across the province every year. And 85% of seniors who receive home and community care services say that that service helped keep them at home.

Before outlining our recommendations for additional investments, I want to address three key points about our sector. The first is that the persistent wage gap between the home and community care sector and other sectors poses a significant challenge in recruiting and retaining qualified professionals. Skilled professionals who chose to work in this sector will earn considerably less than their peers in other health care domains. Consequently, the sector struggles to recruit a robust workforce. Pre-pandemic, vacancy rates averaged about 7% in the sector. Vacancies for key front-line positions now are around 20%, and the annual turnover of staff is at 25%.

This wage disparity really undervalues the essential work that home and community care workers perform. PSWs in the home and community care sector have the same training yet, on average, earn 19% less than those working in hospitals and 9% less than those working in long-term care. To their credit, in last year's budget, the province invested in wage increases for the sector. Community support service staff have been allocated wage increases of 2% and home care staff were allocated increases of 3% and 4.6%. While we're grateful for these increases, they are still a considerable distance from the 11% increase awarded to hospital nurses and the 8% increase for emergency medical services.

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The second thing to know about the sector is that the perception that providing care in the community is less demanding than in institutional settings is simply incorrect. Over the past decade, there has been a notable increase in the acuity level of clients in the community. Home and community care workers are supporting significantly more clients with complex needs, while providing critical, post-surgical and long-standing, complex, chronic care. Because they work very independently with their clients in socially and environmentally diverse environments and neighbourhoods, they have to execute this with increasingly intricate care plans for clients with serious medical conditions, without the same resources and/or team supports as those working in institutions. It is worth noting that in order to continue to deliver high-quality care, their skill set has expanded to match the growth and complexity of these clients.

The third point I want to make before I discuss our recommendations for investments is that the current service

volumes and organizational capacities are not meeting the needs of seniors and people with disabilities, and I think James talked a little bit about that. A survey of our members found that across 16 different home and community care service categories, most providers said their programs would need to expand by 25% to meet community need.

As the population ages, we will need to make room for an additional 23,000 home and community care clients annually just to keep 76% of people over the age of 75 in their homes and in their communities. Demand will continue to outstrip the province's current investment plan for the sector. The Financial Accountability Office predicts that the most decline in the number of nursing and personal support hours per Ontarian aged 65 and over will go from 20.6 hours in 2019-20 to 19.4 hours in 2025, even with the projected growth in spending of about 5.1% in 2027-29.

So, this brings us to our recommendations. For budget 2024, OCSA recommends the province invest $533 million to build a sustainable home and community care sector. In addition to this investment in 2024, the province should commit to investing an additional $519 million between 2025 and 2029 to eliminate the wage compression gap and compensation gap between home and community care and other health sectors.

The breakdown of the $533 million would be as follows:

—to invest $290 million to increase service providers' operations by 3% and surface volumes by 3% to meet the growing community need, and to build the basket of home and community services in each community;

—invest up to $77 million for retroactive pay increases to wage disparities worsened by Bill 124; and

—address the shortfall in the province's wage enhancement by paying a permanent $3 an hour for PSW wages to cover all hours, not just direct hours.

I want to thank you for your time, and I look forward to discussing with you how these investments can enable us to keep more seniors and people with disabilities living well in their homes and communities. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation.

We'll now hear from the Ontario Public School Boards' Association.

Ms. Jaine Klassen Jeninga: Good afternoon. I chose to shift so I could see each of you a little bit better.

My name is Jaine Klassen Jeninga. I'm the central east regional chair with the Ontario Public School Boards' Association, commonly know as OPSBA, and I'm also the chair of the Kawartha Pine Ridge District School Board.

I want to take the opportunity to thank you for the opportunity to speak with you this afternoon. Thank you for giving me the opportunity to speak with you on behalf of OPSBA, whose member school boards together include more than 1.3 million students, which is nearly 70% of all of Ontario's K-to-12 student population. Our member boards include all 31 English public school boards and 10 school authorities.

As the regional chair, I represent the following school boards and authorities at the OPSBA table: Bloorview School Authority, Campbell Children's School Authority, Durham District School Board, Kawartha Pine Ridge District School Board, the Protestant Separate School Board of the Town of Penetanguishene, Simcoe County District School Board, Toronto District School Board, Trillium Lakelands District School Board and York Region District School Board. As you can see, this is quite the diverse group of school boards with very differing needs.

I think it's important to note that within the central east region at OPSBA and indeed the entire association, no two school boards are the same. So we seek funding that recognizes that every community and school board has its own local context that must be considered.

In early November, OPSBA provided a submission to the government as part of the annual Grants for Student Needs consultation. The submission was shared with all parties in the Legislature, it will be shared with this committee, and it is posted publicly on our website. Our submission reflects feedback from students, trustees and staff in our school boards. I'll begin today with the key items and recommendations that will further improve public education in our province and then spend some time sharing some of our local funding pressures.

Provincial funding areas of advocacy—the areas of focus in our Grants for Student Needs submission included the following: equity, diversity and inclusion; Indigenous education; local school board governance; mental health supports; student transportation; skilled trades and apprenticeships.

For equity, diversity and inclusion, we're looking to the Ministry of Education to support school board staff in building expertise in equity auditing, demographic data collection, research, analysis and policy monitoring and evaluation. We want to ensure our anti-racism and equity policy goals that address racism and oppression are successfully implemented.

With regard to Indigenous education, one of our four strategic priorities is truth and reconciliation. Ontario needs to strengthen its role in supporting the revitalization and resurgence of Indigenous languages. We also continue to support curriculum updates in this area. More details are available in the Grants for Student Needs submission.

Supporting mental health continues to be a huge focus for all boards. OPSBA supports implementation of a comprehensive and coordinated mental health and addictions strategy. According to School Mental Health Ontario, approximately one in five children and youth in Ontario have a mental health challenge. We believe strongly that early investments in school-based mental health and addictions services will yield long-term benefits for the health care system and the wellness of students and future generations.

Student transportation is another area in which boards are still underfunded. The Student Transportation Grant is meant to provide school boards with funding to transport students to and from home and school, including students

with special needs. However, it can also include transport for school field trips, sporting events, other extracurricular activities, experiential learning such as co-operative education and perhaps additional service for before- and after-school care. This requires a coordinated effort involving partners including other boards, different school bus operators, separate consortia and, in many instances, school boards working with our municipalities' local public transport.

The Ministry of Education changed the formula for student transportation recently and provided less funding overall. We are continuing to advocate strongly for immediate funding adjustments needed to address driver shortages and road cancellations; driver recruitment and retention due to compensation, few hours and split shifts; bus safety; increased field maintenance costs exceeding Ministry-funded levels.

OPSBA has also long supported this government's priority in enhancing skilled trades and apprenticeships as a pathway for students for future success. However, we do not support the government's latest proposal that considers adding a new accredited apprenticeship pathway for grade 11 and 12 students. Our recommendation would be for the government to provide more funding and support for the expansion of existing programs like the Ontario Youth Apprenticeship Program, Specialist High Skills Major and co-operative education programs that are working well already.

The other point in our submission was the importance of local school board governance. OPSBA is committed to supporting the role and leadership of local boards in Ontario's English public education system. Trustees are the decision-makers who know their communities best. To bring the focus of my remarks locally to the Kawartha Pine Ridge District School Board, last spring, we completed a difficult and challenging budget process that necessitated some very hard decisions. We have seen funding reductions in critical areas of our board. Most concerning is that we expect these funding gaps between our costs and funding to continue to grow year over year, especially in the areas of transportation and special education.

We are committed to providing a world-class educational experience for our students, but the reality is that current funding is not keeping pace with the on-the-ground impact and the costs of service delivery. We'll continue to be vigilant in finding efficiencies, but the current model is not sustainable. In transportation special funding alone, we are seeing funding gaps of $5 million year over year. We've had to mitigate these gaps by finding efficiencies in other areas, and our work moving forward will be to continue to ensure—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Jaine Klassen Jeninga: —we are providing the resources and supports our students and staff need to be successful, healthy and well.

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In the area of transportation, we have over a $3-million gap between funding and cost, especially in the areas of specialized transportation for high-needs students in passenger vehicles such as minivans and taxis. Some of our most vulnerable students rely on these alternative modes of transportation rather traditional school buses. In our transportation consortium, there were 113 special-needs vehicles where boards did not receive funding for them. Our budget also includes over $68 million to support special education program delivery in schools.

We know that as we continue to move post-pandemic, our students, staff, families and communities are nurturing and rebuilding their mental health and well-being. As a result, we expect our needs in this area to continue to grow though this funding gap grows as we assess school and student needs across the system in-year and seek to have staff in place to meet the urgent student needs. As part of that work, since September, we've added an extra 16 educational assistants requiring approximately an additional $868,000 of investment in staff—

The Chair (Mr. Ernie Hardeman): Thank you. That concludes the time. Maybe we can finish that in the questioning.

We will start that with the independents. MPP Hazell.

MPP Andrea Hazell: Yes. I will start with Jaine. First of all, thank you for coming in, both of you, and presenting to us. You spoke about the equity, diversity and inclusion strategy, along with your mental health and addictions strategy, your truth and reconciliation strategy. How do those strategies relate to your funding ask today?

Ms. Jaine Klassen Jeninga: Those strategies relate to our funding ask in that we are challenged in being able to support those groups. The equity, diversity and inclusion: As you know, and as media reminds us on a daily basis, there are challenges across our school systems with equity, diversity and inclusion, with anti-racism, with anti-Semitism, and we are seeing it, unfortunately, alive and well in our schools as well. So in order to be able to meet the needs of community, which all these individuals live in, and we want them to coexist peacefully, we need to be able to have some of that funding in order to be able to address those issues.

As far as the Indigenous piece is concerned, we spoke about how important the Indigenous part has been. We adopted very much the truth and reconciliation calls to action from our board right in the early days, including the hiring of a superintendent specifically for Indigenous education to take a look at how we can meet the needs of our students, and particularly in Kawartha Pine Ridge we have three Indigenous communities that are represented within our board and a number of urban Indigenous students as well. One of the key challenges we hear is about the loss of language, and one of the comments I made was about the ability to offer languages as a question as well.

I'm sorry, I missed what the third one was. We talked about equity, diversity and inclusion.

MPP Andrea Hazell: Yes. I'm asking you how it relates to—that was the last part of the question—the funding that you're asking? Is there a dollar value, a quantitative amount based on those three areas of diversity that you are discussing?

Ms. Jaine Klassen Jeninga: We're not asking for specific dollar values. We're asking that particularly, for example, in the area of Indigenous education where we were given funding—particularly two or three years ago, we were given funding in order to create particularly Indigenous studied courses. At Kawartha Pine Ridge we adopted a mandatory grade 11 English credit with Indigenous content, and there were others where we were also looking to boost the Indigenous context. Unfortunately, a lot of that funding went away in the last GSN, and so we had to literally rejig our Indigenous education department to be able to support our Indigenous students.

We appreciate the addition of Indigenous grad coaches, which has helped in some areas, but we feel that this is an area that we'd like to have boosted back, at least to the levels they were prior to the last GSN.

MPP Andrea Hazell: Thank you.

Time check for me?

The Chair (Mr. Ernie Hardeman): One minute.

MPP Andrea Hazell: My next question is for Deborah. Thank you so much for your presentation. So many things you talked about, we are experiencing that in my constituency in Scarborough. You've asked for $533 million. It's good that you've got that figure, but can you detail that again on your highest priority part in that $533 million?

Ms. Deborah Simon: Certainly. I think James talked from a program perspective. There are so many demands across the board. But currently, the issue is really wages and really supporting the front-line staff and back office staff. Let me not neglect to raise that issue of keeping and retaining people within the sector. We're one of the few sectors that does not rely on bricks and mortar, so we can mount up services with staff that we have in our home and community care—

The Chair (Mr. Ernie Hardeman): Thank you very much.

That concludes that. We'll go through to MPP Byers.

Mr. Rick Byers: I thank both presenters for being here this afternoon. I very much appreciate it.

Maybe continuing on with you, Deborah, and I noted James's presentation as well. As has been stated, this government has got a funding envelope of a billion dollars, which is a new amount over three years, an important one. You may well have been in the business over—can you give a sense of how the "business," if you will, of home care has evolved? I remember when I was young, which was last millennium—it has been an evolving model over time. Can you give a sense of where we are now and how it fits to where it has travelled, if you wouldn't mind?

Ms. Deborah Simon: Absolutely, and thank you for that question. I think that probably the best analogy to describe how it has evolved is really to take a look at how care across health care has evolved.

When I graduated from nursing, which is kind of dating me, you'd go in for an appendix removal and you'd be in for a week and a half or two weeks. Now that's done in outpatient and you're out. So most clients, most patients, are recovering and getting the majority of their treatment post-surgically in the community. That is totally different than what we were looking at, let's say, even 10 or 15 years ago.

So in order for the community to keep pace with the change that's happening in health care, we've had to take care of sicker and sicker folks in the community. Given the backup of beds in hospitals and ALC numbers climbing, people are having to be retained in community with more and more ailments, more comorbidities. They're more acutely ill.

In addition to that, we've had three years of the pandemic, which has really been an experience for all of us; we know what's happened in hospital and long-term-care settings. People want to stay in the community to receive their care, so we've had to manage and support growing acuity. So all of those experts, whether they be PSWs, nurses, physios or whoever, have had to keep up their expertise to grow in the community.

It hurts me when I hear descriptions of community being light care or easy care. Nothing could be further from the truth on that one.

Mr. Rick Byers: Very interesting perspective; I appreciate that. Before being elected, I was on the board of a community health centre for three years, and so I saw that model. It gave me a sense of the primary care network, if you will, if I can use that phrase. I've noted your point that investments are needed in the sector.

One reaction that I had is that primary care is a network, as opposed to acute care, which is more specific, and it may be different municipality to municipality. Is it an ongoing challenge to make sure home care plays a role, ongoing, in the primary care network? How do we manage that, given the changes in each community, if you know what I mean?

Ms. Deborah Simon: Thank you again for that question. Certainly home and community care is a very strong fabric of the system within the health care system. We connect to primary care on a daily basis, as people who are receiving care in the community need to have a connection with their physician or primary care practitioner, very closely.

Keeping connected has been challenging, because the pace of change has been such that everything has moved electronically. Having a digital connectivity with the entire health care system, whether it be hospitals, primary care physicians etc. has been increasingly important. So I think that when we're looking at the ask for our sector, the increase in funding, the $290 million we're looking for, is really about keeping that infrastructure and keeping pace with the changes that are going on. Our sector has been woefully behind the game in terms of getting the amount of increases that are needed over the years to keep that pace going.

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There's lots of change, as you know, going on in home and community care right now with the transformation that is being planned. Keeping pace with that is critically important. This is what we are here asking for in terms of

funding for our sector to be able to keep pace with what's going on now.

Mr. Rick Byers: Thank you so much. I'll pass it to my colleague.

The Chair (Mr. Ernie Hardeman): There's 2.4 minutes. MPP Barnes.

Ms. Patrice Barnes: I'm going to thank all the presenters for being here and for your time and your passion about the subjects that you speak about.

I'm going to follow up a little bit on the mental health portion in regard to the school boards. The government has done additional funding of $87.7 million that was incorporated in the GSN, which gives a very stable funding formula to students and to school boards in regard to offering mental health supports to students. I just want to talk to that a little bit more because we recognize that mental health has grown a lot in our schools since COVID.

There is an investment of $50.4 million to help school boards meet local priorities when it comes to mental health supports. There is:

—$36.7 million for student mental health allocation;

—$10.5 million for student mental well-being allocation;

—$3.2 million for well-being and positive school climate allocation;

—$26.5 million for mental health workers in secondary schools;

—$10.8 million for mental health leaders for each school board;

—$114 million, which includes the Priorities and Partnerships Fund; and

—$12 million for mental health supports continually over the summer—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Patrice Barnes: Sorry, that went by really fast.

I just want to say, in regard to that amount of money that is flowing to school boards to support student mental health, as well as the grade 7 and 8 curriculum, what are the areas that are being underfunded?

Ms. Jaine Klassen Jeninga: Thank you for that question. I would start by saying that we are thrilled with the addition of the grade 7 and 8 model to be able to be included in the education program. However, the challenge we are seeing is that we need these models and funding for this way earlier. Our mental health challenges and our students are being seen much, much earlier. While we recognize that there will be some challenges in being able to address age-appropriate—

The Chair (Mr. Ernie Hardeman): We'll have to catch the rest of that the next time around. The minute is up.

MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to both our presenters for coming to speak to committee today.

Ms. Simon, I wanted to start my questions with you. I want to first thank you for your comments about wage parity and also for addressing the misconceptions about the ever-growing needs in our community, as well as establishing what these roles are.

In my community of London, our community support services folks do amazing work, but they've warned me that without government attention and government investment they're going to have to withdraw services. It will directly impact seniors who rely on them as a lifeline. It will literally take away support from seniors. They've spoken to me about having to reduce critical back-office positions such as IT, HR.

My question is, have you heard from organizations that are at risk of withdrawing services and expanding their wait-list?

Ms. Deborah Simon: Absolutely. I think what we're seeing today in terms of wait-lists for services is really unprecedented. It's a result, I think, of three years of the pandemic, obviously, that we went through and what health care workers went through during the time frame. Let me just say that workers in home and community care went through the same kinds of challenges in terms of providing care to people in the community during the pandemic, even more so because they were in people's homes and trying to deal with the pandemic then.

But, absolutely, not only are we seeing the wait-lists growing, we are now seeing increasing demand coming on for home and community services, mostly because people's experience of institutional care has been jaded, certainly, by the last few years. But more so, all of us just want to be at home and receive our services as best we can in our own home care setting. So, absolutely, what you have talked about is absolutely accurate.

Mr. Terence Kernaghan: To my mind, many critics of this government have been deeply concerned about greater attention and greater funding being provided to these privatized or for-profit providers, while year after year, there seems to be less concern for the non-profit providers who actually focus on that care. It seems to be a difference between their focus on profit or focus on the actual care that the non-profits provide.

I wanted to ask specifically about the turnover rate that you've mentioned: 25% is a pretty staggering number for an organization to face after a year. Can you explain for the committee what kind of difficulties this causes for an organization that already struggles with low funding?

Ms. Deborah Simon: Well, certainly the biggest impact of that is wait-lists for services and absolutely not having staff and not being able to retain staff just puts added pressure. I know there was a question to James about, "What do you do for people who are looking and waiting for services?" and you do the best you can to provide a little bit of care if you can't provide all of it.

But, absolutely, I think we're way behind the eight ball in terms of other jurisdictions and how much they have invested in home and community care going forward. As I said, we are a sector that is not dependent on building a building, like we do in long-term care, so these services can be enacted as quickly as possible. I think it's just looking at the vacancy rate—one might say, "You have had a lot of investment in home and community care, why do you need more?" I think parity is the issue around making a choice about whether or not I want to stay in a

sector where I'm doing just the same kind of work, and maybe just as hard or even harder as my colleague in another sector, and that, added to the inflation that we've all experienced over the last year since we've come out of the pandemic, has left health care workers trying to make a decision about where they want to work.

James alluded to the fact that people who work in home and community care love what they do, and that's true. We have had their commitment for years and years, but I think as we're moving forward, the cost of living is so expensive that they have to make decisions about compensation, so parity would put us all on a level playing field. It's a big-ticket item and we understand that, so we've suggested strategies for that, but I think it's clearly important.

Mr. Terence Kernaghan: Absolutely. It speaks to the concept of fairness. A nurse is a nurse is a nurse; a PSW is a PSW is a PSW. It should not matter where you are practising; it is the care that you are providing. And, quite frankly, some people prefer being in the community, being in home care, because that is what speaks to them as a care provider, but yet are given short shrift and, quite frankly, have been historically ignored by governments past and present.

My next question will be for Ms. Klassen Jeninga. I want to thank you for your presentation and for your leadership with OPSBA. Recently, in speaking with individuals from OPSBA, I had heard that—we all agree that we need more tradespeople. We need to open up that skills pipeline; we need to make sure that we are getting young people interested in the trades once again—which is curious, considering it was the Mike Harris government that stripped shop classes out of elementary schools, but I am glad that there is that concern. But I had heard about recent suggestions from the government that students in grade 10 could potentially leave school to enter a trade and be completely disconnected from the school itself and not have access to a guidance counsellor, potentially not graduate, rather than further investments in the OYAP. Would you like to discuss that? What are your concerns with that suggestion from this government?

Ms. Jaine Klassen Jeninga: Certainly. A lot of my concerns are concerns from a provincial standpoint around the young age of a number of our students in grade 10. It is almost difficult to imagine a 15-year-old leaving school to head into a grown-up environment where you're going to be having tradespeople and not having a group of your peers for support. Also not having—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Jaine Klassen Jeninga: —a caring adult to be able to speak with, as well. So those are some of the challenges inherent.

Mr. Terence Kernaghan: Most definitely. Severing that young person from their community of support seems as though they would cross a line and never be able to come back. It makes very little sense when the government could invest further in OYAP, a program that is already working. I just want to thank you both for all the work you do and thank you for coming to committee today.

1540

The Chair (Mr. Ernie Hardeman): We'll go to MPP Hazell.

MPP Andrea Hazell: My question is for Deborah. Can we continue where we left off?

Ms. Deborah Simon: Yes.

MPP Andrea Hazell: What I wanted to know is your breakdown of the $533-million funding you're asking for, because that's what you've got to leave us with: exactly what it is for and how it's important for you to receive that funding.

Ms. Deborah Simon: Absolutely. Thank you, and thanks again for that question. So, of the $533 million, what we're asking for is a 3% increase to the operational budget of our home and community providers, which comes to $145 million, and that's on top of the wages that we're talking about. What that money would be used for would be for technology investments, for insurance costs, additional escalation of other operating costs that our organizations would have to look for. With that added to last year's adjustment, it would bring us closer to closing that inflation gap that we're seeing right now as a result of what we've gone through with the economy.

Then, the 3% of that same $290 million would go to service expansion. I talked about the growing need for home and community services and how we're not keeping pace with that. That would be a 3% expansion to existing services, and we think that that would be a reasonable amount in terms of expansion given the current HHR challenges. We can't manufacture health care workers, but we can certainly expand to that capacity to be able to support more services in the community for seniors.

In my ask, we talked about the $77 million to match the award. This is really to—again, we're trying to close the gap in terms of wages. ONA has recently gotten an increase of 11% for all the very deserving hospital nurses in terms of their compensation, and so we're looking for money to help close that, again, add to those retro awards that would have been given to some of our members over the last few years that have been held back with Bill 124.

Lastly, that $50 million is really—I talked about the $3 increase for PSW wages. Surprisingly, those dollars in home and community were only applied to direct hours, so when PSWs are travelling from one home to the next, they were not given the additional $3. So we're looking for that $50 million to just cover that gap in funding for them.

MPP Andrea Hazell: Thank you for detailing that. I want to go back to your $77 million for retroactive salaries. If that is awarded, what impact would that have on staff retention? Because I know you're getting beat up on retaining staff right now.

Ms. Deborah Simon: Absolutely. I think two things. One is the funding is, again, not going to close the gap, but it's certainly going to get us closer. I think that leads to recognition that the home and community care workforce is a valued workforce, that they are equal in terms of work that they do in the community to support people and keep them in their homes and healthy. I think it will help stop the bleed of people leaving our sector wanting to go to

other sectors for increased compensation purposes. So, I think all of those things will make a significant difference.

MPP Andrea Hazell: What's your wish list leaving us here today?

Ms. Deborah Simon: Again, our workers.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Deborah Simon: They're critically important. And I mean all workers, not just our front line—everyone that supports the front line as well.

MPP Andrea Hazell: Thank you.

The Chair (Mr. Ernie Hardeman): MPP Barnes.

Ms. Patrice Barnes: I was just going to take a quick couple of minutes, because it was two, not four, minutes that I had left, to talk a little bit more about the mental health piece. So, we had talked about all these investments that have been made into the boards, and that has been since 2023-24. With the funds that have flown into the boards, can you give me an example of how these funds are being used now to do mental health in a board setting? Because that would have been 2023-24 funding—so, probably, based on your board, where—

Ms. Jaine Klassen Jeninga: Based on our board—so, where we have implemented funding is in mental health leads, particularly in support of both elementary and secondary students because, as I said, we're finding challenges in mental health in much earlier grades. It's just not an availability to imagine that it's in intermediate and older grades.

We recognize the monies that we've received and are focused on continuing that, because one of the things that we've talked about is the ability to reach some of our secondary students in particularly a more detailed factor, such as addictions and programs that we could actually enact within the secondary system. Because we're seeing addictions and challenges in our secondary students a lot, and it goes along with the number of cases of drugs that we are finding in secondary schools—not just in our board, but across the province. It speaks to the addiction issues and the trauma-informed lens. We started with the trauma-informed lens when we talked about our Indigenous partners a number of years ago. It has funnelled down to the trauma that is being experienced with students and their families in our boards on a regular basis.

So how to be able to provide for the mental health of our students that will be able to carry on within their families and support the trauma that they're experiencing at home, and not only our students but our staff? We're also focusing on giving a larger portion to being able—if we don't have mentally healthy staff, then, as you know, across the province, we're struggling with sick time that is not accounted for in our funding, so boards are having to find money for sick days. It's causing challenges. As you know, that even causes challenges for students in the classroom when their teacher is missing on an ongoing basis.

Ms. Patrice Barnes: Thank you. I'll turn it over to MPP Anand.

The Chair (Mr. Ernie Hardeman): MPP Anand.

Mr. Deepak Anand: I'm going to be asking Ontario Public School Boards' Association. Thank you for all of that information. I actually had the opportunity to meet my board chair for Peel—

Ms. Jaine Klassen Jeninga: Mr. Green.

Mr. Deepak Anand: Yes, Mr. Green. And Satpaul Johal, the vice-chair, has been a good friend for the longest time.

Absolutely, I agree with you: We value a lot of what you're doing. My trustee Susan Benjamin has been a big advocate. We work closely with each other. Not every time do we have the same philosophy, but most of the time we come to a negotiation, and we work together on every issue.

I heard loud and clear from you about the government and what we're trying to do with the skilled trades. Being the parliamentary assistant in the Ministry of Labour, I just want to—communicate would be a better word. Every time I speak to a lot of parents, a lot of students who want to go into a skilled trade, one of the challenges they said is that it is sometimes too late to get into it, so they want to start early.

I'll just give you a small example in my riding—I have Malton: 18.3% of the residents have no certificate, diploma or degree; 27% have a high school diploma or equivalent. On one side, we have this; on the other side, we have over 100,000 jobs going unfilled in the skilled trades, and there is a huge demand. So what we're trying to do through this is mitigate this and help those people. It's not mandatory that everybody has to do it. It is only for those who do not want to be an engineer, doctor or lawyer; who do not want to go to college or university. It's not often the money; it is sometimes the choice. That's what we are trying to do: help them, give them a hand and support them at an early age.

But I understand; you're saying, on one side, you're trying to help them; on the other side, you're taking away their childhood, where they're going to go straight into the working environment and may not have the ability to be a youth. I think I would look into something which is more taking the way my trustee and I work: having a negotiation on how we can take care of both sides. What would be your suggestion on that balance?

1550

Ms. Jaine Klassen Jeninga: Thank you for your question. Minister Piccini is my MPP, and we've had numerous conversations around this as well, given that a lot of that is coming from exactly your perspective and taking a look at that. One of the things that I want to talk about too is, I'm not necessarily saying that there are parts of it that don't make sense. I'm concerned about the age. I'm concerned about the grade 10 piece for sure.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Jaine Klassen Jeninga: If this was something that you could consider for an older—but one of the challenges we're having with current programs, like our OYAP etc., is our students are getting into their apprenticeships in year 1, and in year 2 not only is there, as you've said, a shortage of skilled trades, there's also a severe shortage of journeymen. Therefore, we get kids into year 2 and there's nobody to mentor them. What happens is, where they've been

employed, where they've been getting their training from, they're having to let them go because there's nobody to continue the training. So if we put all these students into positions where we're going to have them into these skilled trades, are we going to have enough people to support them?

Again, regardless of the fact that they may not want to be doctors, lawyers and engineers, they are 15-year-old students and a lot of them are lucky if they can get themselves dressed in the morning to go to school. My concern is, do they have the mental and the social capacity to be able to continue in that vein?

The Chair (Mr. Ernie Hardeman): That concludes the time.

MPP French.

Ms. Jennifer K. French: Thank you very much and welcome to both of you. I appreciated the opportunity to learn from you.

I will start with Ms. Simon. We had heard from Mr. Meloche earlier from Community Care Durham, and not just because I'm a New Democrat but as someone who lives in the community, I really appreciate the not-for-profit approach with the focus on care and not having to meet that profit margin where the care from the individuals goes into the community.

My question to you: When the government talks about the investments they've made, $1 billion is not a small amount, but my question is—and please correct my numbers if I'm incorrect, but is it actually the case that $900 million of that is going to the for-profit sector and $100 million of that is going to the not-for-profit? Additionally, is it that the $4 bump is for the for-profit and the $3 bump is for the not-for-profit? That's been my understanding from what I have heard, and I would be glad for the committee to have a clear understanding—I might be way off.

Ms. Deborah Simon: Thank you very much for the question. I don't have the split between the not-for-profit and for-profit of the investment, which I want to just start off by saying has been an incredible support to the home and community care sector—well needed. Organizations in home and community care have not had significant increases in decades, so this was much-needed dollars.

Certainly I can talk about my members that are not-for-profit providers, what they need and what they do with funding that they have. Certainly James talked a little bit about the fact that we get community support services funding from the government, but it's not 100% of the dollars that are provided to our organizations. Organizations that are not-for-profit need to fundraise, as well as there are often client fees to be able to support the 100% of the dollars that are needed to be able to run these services.

Increasingly, what we're seeing when we don't see regular inflationary increases to services is that providers like James have to use more and more of those fundraised dollars and client fees go up. We know, for our seniors, that that increases—their ability to pay for those kinds of services is limited because they are on fixed incomes.

Our role is to advocate to you and to government, to make sure that the dollars that are coming in from fundraising are used for additions to those programs that are not essential staffing dollars, that they're really adjunct dollars to help support the enhancement of some of the services and that client fees don't go up, particularly in this high inflationary period, for those services.

Ms. Jennifer K. French: Thank you very much. I certainly hear what you have said and what we've heard from others about the need for dollars in wages to have to go further out in the broader community. The direct time versus the full time is something that we've been hearing about for a long time: PSWs in the community who aren't reimbursed for their travel time and whatnot, which obviously is, I would say, unfair. So hopefully the government has heard that again today.

I will shift to Ms. Klassen Jeninga. Welcome and thank you. Some of what you have talked about with the broader challenges in society and the need for a trauma-informed lens and an equity-minded approach is actually quite interesting, because we've heard from other presentations today, like the library folks who are saying that in First Nations, two public libraries have just recently closed because there is a need for the government to pay a subsidy to keep those librarians. We're seeing not having equitable access, and I would argue public libraries are part of the broader education system.

But I guess my question is—the government member talked about students having choice. But if students don't have a clear path in front of them with accessing—whether it's higher education or the next steps, specifically the OYAP program and the shortage of journeymen in that second year—if there is no second step to that 15-year-old's plan, if there aren't enough journeymen and there isn't that next step in the training, what choices do they have?

Ms. Jaine Klassen Jeninga: Well, therein lies one of the questions. We have talked about the supporting of the Ontario Youth Apprenticeship Program. The Specialist High Skills Major and other pathways that a lot of our other students have as another pathway of choice, embedding the co-operative education and the experiential learning pieces, as well, into students' pathways, are essential to giving them ideas of what they may want to do in their futures.

The concept of being able to support all of our student needs, all of our students where they're at—sometimes it's a matter of prodding our students and giving them some ideas: "Can you try this? And if this isn't for you, where else can we go? What can we do to ensure that you are going to be the most successful 'you' you are in a post-secondary world?" Having these strong supportive—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Jaine Klassen Jeninga: —programs like this, like the ones I've referenced, is key to making sure that we have options, in addition, of course, to all the options available to our academic students, as well. If we're going to continue to look at creating accelerated apprenticeship pathways, for example, we have to be able to ensure they

are sustainable and it's not just something to bring into a high school program because we have a shortage in a sector, but there is enough support for the students going into it.

We talk about mental health, and it is very daunting for somebody who is 15 or 16—and maybe even 17-year-olds, depending on their age and stage—to take a look at working in an environment where you're focused on adults and where you're missing, again, the peer support and somewhere to go to for—

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes the time. We want to thank the presenters for being here and taking all the time to prepare and coming here to share it with us. I'm sure it's going to be helpful as we move forward to develop the next budget. With that, thank you.

ALS SOCIETY OF CANADA, CENTRAL EAST AND SOUTH EAST REGIONS

MS. JULIA MCCREA

CANADIAN MENTAL HEALTH ASSOCIATION DURHAM

The Chair (Mr. Ernie Hardeman): The next panel is Julia McCrea, the Canadian Mental Health Association Durham and the ALS Society of Canada, Central East and South East regions. I understand that only one is presently here yet, so we will start with the ALS Society of Canada, Central East and South East regions, and hopefully the other two will arrive when we get there. If not, we will proceed with the present one.

1600

As we said—I don't know if you were present for the start of the last one—you have seven minutes to make a presentation. At one minute, I will say, "One minute," and that doesn't mean stop; it means you have one minute. When I say, "Thank you very much," it means you're finished. We do ask that you start by introducing yourself to make sure Hansard has the proper name for the presenter.

With that, the floor is yours.

Ms. Sarah Reedman: Thank you so much. Good afternoon, everyone. Thank you today for this opportunity to share with you the urgent needs of the ALS community. My name is Sarah Reedman, and I'm here today on behalf of the ALS Society of Canada, representing approximately 1,400 Ontarians and their families living with ALS. The ALS Society of Canada is a donor-funded, not-for-profit charity. My role within the ALS Society is to work directly with people and families living with ALS to provide resources and support.

ALS is a terminal disease that gradually paralyzes those diagnosed. It also takes away their ability to talk, eat swallow and breathe. If I may, I would like to take this opportunity to invite you all to experience just a few minutes in the life of somebody living with ALS by staying completely still for the remainder of my presentation. Do not move a single muscle; do not scratch that itch; do not shift in your seats; be completely immobile as if you are indeed paralyzed from head to toe.

This cruel disease can strike anyone, regardless of their sex, ethnic group or socio-economic status. Only 10% of cases are hereditary, meaning that 90% of those diagnosed are completely random. That means that anyone of us in this room can be diagnosed with ALS at any time. In fact, my own brother was diagnosed randomly with ALS at the age of 33, and he died at the age of 36.

With no cure, 80% of people living with ALS will die within three to five years. The progressive nature of ALS results in substantial care needs that increase over time. However, Ontario's health care system is not meeting these needs, leaving people with ALS unable to access the critical care and support that they urgently require. This issue extends beyond the immediate health care concerns. It impacts our communities, our economy and the very fabric of Ontario.

Without dedicated and sustainable funding for ALS care and support, people living with ALS face greater risk, leading to increased strains on our already overstretched health care resources. The five ALS clinics located in Ontario are beyond capacity, unable to meet the unique levels of complex care patients require. ALS Canada addresses the gaps in critical equipment and community support services by providing over 40 different types of mobility equipment and devices in a timely manner as well as direct psycho-social support in communities to more than 8,000 Ontarians affected by the disease.

These vital services should not be funded by donor dollars. This is completely unsustainable, particularly in this current dire economic climate. This puts Ontarians living with ALS and their families in an increasingly dangerous and vulnerable position, where, in fact, we are seeing one out of four people living with ALS choosing to go through with medical assistance in dying. It is completely unacceptable that a person should have to choose to end their life because of a dire lack of support and resources available through the Ontario health care system.

However, between these challenges, there is hope and an opportunity for change. To respond to this urgent need, ALS Canada, in collaboration with the five regional ALS clinics, developed the Ontario Provincial ALS Program, which presents a comprehensive solution to a complex issue. For budget 2024, we are asking the provincial government to implement the recommendations outlined in the Ontario Provincial ALS Program:

(1) investments in ALS clinics to ensure the clinical care needs of the community are met;

(2) sustainable funding for ALS Canada's equipment program and community services, so that people with ALS in Ontario can maximize their quality of life and minimize additional costs to the health care system due to emergency interventions;

(3) formation of a secretariat to ensure the program's effectiveness and value for money; and

(4) development of a regional strategy for people living in northern and rural Ontario to get the care they need.

The total investment required for this transformative program is estimated at $6.6 million, which is a modest figure in comparison to the profound impact it promises. As we consider budget 2024 together with the Ontario government, we can ease the burden of ALS and ensure Ontarians living with ALS and their loved ones receive the care and support that they rightly deserve. Thank you so much, again, for the opportunity to speak here today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I believe we have our other two participants on this panel present now, so we'll start at the top of the list, with Julia McCrea.

As I said when we started this, you'll have seven minutes to make your presentation. At one minute I will say, "One minute," and at seven I will say, "Thank you." With that, if you would start by introducing yourself for Hansard, to make sure that we get the right people attached to the right presentations. With that, the floor is yours.

Ms. Julia McCrea: Good afternoon, Chair, members of the standing committee, staff, MPP French for Oshawa and guests. My name is Julia McCrea. I'm a resident of Oshawa. I'm a qualified teacher and social worker with a combined 45 years of experience in the public sector in health, education, social services and corrections.

I'm an active volunteer in the community, serving on the Oshawa accessibility advisory committee, the Durham Region Labour Council, the Ontario Health Coalition, Durham chapter, and with migrant agricultural workers here in Durham region. I currently work as the president of the Ontario Secondary School Teachers' Federation and as the bargaining unit president for secondary occasional teachers in the Durham District School Board. I have a non-visible disability and I'm a senior.

I welcome this opportunity to participate and provide input to the Ontario budget consultations. I encourage this committee to encourage the government to always include consultation with the public on their actions.

I understand that the committee has already received delegations and submissions from the Ontario Secondary School Teachers' Federation and the Ontario Health Coalition, and I am fully in support of their recommendations.

The matters that I'd like to talk about today that I feel require Ontario government attention in terms of funding or expenditure this year are related to accessibility. The year 2024 is the final year to achieve the goal of the Accessibility for Ontarians with Disabilities Act for universal accessibility for all, or a fully accessible Ontario by January 1, 2025.

Universal accessibility for all is far from achieved here in Oshawa, in Durham region and in Ontario as a whole. The Ontario government needs to step up to this responsibility by increasing funding of accessibility improvements. This is the most important year to make a sincere effort at change, and one that demands funding and action by the government of Ontario.

Statistics show that 2.9 million Ontarians are living with a disability. That is more than one fifth of Ontario's population. In a growing province, with increasing development within its borders and a growing tax or revenue base, it's difficult to understand why Ontario is choosing to balance its budget without addressing the needs of one fifth, or 20%, of the population of residents—plus the visitors—who would benefit from a more accessible Ontario.

The growing number of infrastructure and development applications are the opportunity for Ontario to invest to ensure that health care, education, children's and social services, housing and transportation address the needs of Ontario's disabled residents with the accessible services they require and deserve and demand by that AODA legislation and goal.

Many persons living with disabilities, their caregivers and seniors are on the front lines of the devastation caused by both the COVID pandemic and limited incomes due to inadequate funding of the Ontario Disability Support Program, Ontario Works, workers safety and insurance board payments. Disabled Ontarians are differentially and negatively affected by both rising costs and inflation. These programs have not been adjusted by inflation rates of 3.5% in 2021, 6.8% in 2022 and an estimated 3.5% in 2023.

What we call taxpayer affordability by governments as an excuse for underfunding is experienced as hunger, poverty, homelessness or inadequate housing for many persons in Ontario. At the same time, there is an increasing revenue base that requires investment to address these needs. The purpose of the AODA, as many of you may know, is to develop, implement and enforce standards for accessibility related to goods, services, facilities, employment, accommodation and buildings. The target date for reaching this is no later than January 1. That's only a year and a bit away.

1610

The AODA was originally designed as social justice legislation that's meant to redress the long history of discriminatory exclusions by identifying, removing and preventing discriminatory barriers.

The problems were addressed in 2023 through a legislative review in a report by Rich Donovan. He was appointed by the province in early 2022 to conduct a legislative review of the AODA, and he said little progress has been made since the law was passed in 2005. That's 20 years of inaction that stems from design flaws etc. People with disabilities still consistently face barriers in their everyday lived experiences, from navigating city streets to applying for jobs, to addressing public transit and government services. Our entities serving Ontarians need to change, but as he said, there's no plan that adjusts behaviours to achieve an accessible Ontario.

In addition, in a submission to the same consultation in the Donovan report, Arch Disability Law wrote the following: "Accessibility matters because it is a precondition for persons with disabilities to live independently and participate fully and equally in society. Ten years ago ... Mayo Moran observed that 'an inclusive society of the kind that the AODA aims at will be healthier and more robust along many dimensions.'" It is "the role of govern-

ment to create, strengthen and enforce accessibility standards....”

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Julia McCrea: I just want to talk about a few specific situations with which I’m familiar. In education, special education underfunding in schools—I have worked as inclusive student services staff in six different school boards. We’re seeing gaps, inequities and violence with risks to staff and students that occur due to inadequate funding. Children are at risk due to the COVID pandemic because of the gaps that are being created in literacy and math, and these need further funding as per the Ontario Human Rights Commission’s Right to Read report. This requires an overall school board funding formula change, and that funding formula hasn’t changed for the last 20 years.

Lastly, I believe we need to increase our funding to mental health services. Again, this will address the needs of students with autism and others who require psychologists in school boards and psychiatrists in the community to meet their needs—

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time, and maybe the rest of it will come out in the questions and answers. Thank you very much for your presentation.

We will now go to the Canadian Mental Health Association, and that one is virtual. As the instructions were given to the other presenters, it’s the same for virtual: seven minutes to make your presentation. I will say, “One minute,” at the end of six minutes, and it will be concluded at the end of seven.

So, with that, we ask anybody who’s speaking to identify themselves for Hansard to make sure we have the right conversation attributed. The floor is yours.

Ms. Sheryl Wedderburn: Thank you. And—

Interruption.

The Chair (Mr. Ernie Hardeman): There seems to be somebody else on the line.

Ms. Sheryl Wedderburn: I will pause.

The Chair (Mr. Ernie Hardeman): Okay, let’s try again.

Ms. Sheryl Wedderburn: Does this sound better?

The Chair (Mr. Ernie Hardeman): Here we go. The floor is yours.

Ms. Sheryl Wedderburn: Okay. Thank you so much.

Thank you for the introduction and allowing the Canadian Mental Health Association Durham the opportunity to address the committee. My name is Sheryl Wedderburn and I’m the chief executive officer. My colleague is Kerrie Wriker, and she is the chief operating officer. With 27 CMHAs across Ontario, I hope you hear from several of my colleagues as you continue community consultations.

Last year, the provincial government demonstrated a commitment to community mental health and addictions care by providing a 5% base increase. For this, we thank you. This increase was the first infusion of infrastructure funding for our sector in more than a decade. It came at a critical time, when we were struggling to keep the lights on while continuing to provide the highest quality of care.

As the demand for our services and the complexity of our clients continues to grow, so does the wage gap between our sector and other health sectors. We urge the government to maintain momentum this year by providing another round of stabilization funding for the community mental health and addictions sector.

Municipalities across Ontario are facing complex social issues that intersect with community mental health and addictions care. Durham is of no exception. Take homelessness, for example. Thanks to our relationships with local and provincial partners like the Association of Municipalities of Ontario and the Ontario Municipal Social Services Association, we are well aware of the challenges that municipalities are facing on this issue. More than 400 people are currently experiencing homelessness in Durham region. Over half of those people have been experiencing homelessness for six months or longer. Shelters in our community are struggling to meet that increased demand.

We also know first-hand from our own experience that individuals who are homeless are often the most complex to serve. But it’s difficult to fully support our municipal partners with new or expanded homelessness initiatives when we have such limited resources and are struggling with the health human resource crisis. Providing quality mental health and addictions services and programs for Ontarians requires immensely dedicated staff. Yet my colleagues are among the least-paid health care workers. When compared to others doing the same job in the health care sector, our staff are often paid 20% to 30% less. This means that we’re continuing to lose people to hospitals, public health and other areas of health care that pay more and often have more resources.

To put numbers to story, a comprehensive survey released on behalf of CMHA and our sector partners this morning found that across the province, community health sector workers collectively earn more than $2 billion less annually than their counterparts in hospital and other health sectors. At CMHA Durham, we’re managing a staff vacancy rate of, thankfully, about 10% right now, and that has come down dramatically over the past year.

Now for our formal pre-budget request: The community mental health and addictions sector needs a 7% increase in funding, equal to $143 million annually, to be prepared for the challenges previously mentioned. This includes 5% in stabilization funding to help us bolster services while managing the health human resource crisis. For CMHA Durham, that is least $400,000. The remaining 2% of our ask, or $33 million, comes in the form of a new three-year community services housing innovation fund—more on that in a moment.

We appreciate that the government is focusing on more affordable housing across the province; however, that doesn’t address the need for more supportive housing. Supportive housing is a forgotten segment of the housing continuum. It helps to reduce homelessness and connects service users with wraparound mental health and substance use supports. Evidence shows that supportive housing models can help a person’s journey to recover from

even a severe mental health issue. It is also cheaper than stays in hospital or correctional institutions. But the latest data indicates that the average wait time for supportive housing across the province is 300 days.

The new community supportive housing funding would provide capital and operating dollars for the development of innovative and evidence-based models of housing with supports. This fund will be available exclusively for the community mental health and addictions sector, who are experts in this space and have many collaborative partnerships in place with municipalities, private landlords, civic-minded developers and other social service providers. It would complement the Ministry of Municipal Affairs and Housing's Homelessness Prevention Program, which our municipal partners have indicated is appreciated but not enough to support those in need. The community supportive housing innovative fund and the Homelessness Prevention Program would work in tandem to get more people housed and ensure they have the mental health support they need.

Investing in mental health and addictions care also serves to limit unnecessary hospital visits, which is vital. As a recent Auditor General's report highlighted, hospital emergency departments are facing a crisis with staffing and closures.

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Our sector is proud of the work we do to provide appropriate community care pathways for clients and help reduce the strain on our colleagues in the emergency department. Our work is in line with the AG's report, which recommended strengthening the community care sector in order to support our hospital system. Stabilization funding also allows us to strengthen evidence-based programs like early psychosis intervention, assertive community treatment and step-down care, which help to prevent clients from going to hospital for care.

As you can see, our work helps support many areas in our community. With stabilization funding and more commitment to supportive housing, our sector can help improve outcomes for individuals in our community while also supporting the government in addressing key issues that are impacting our partners within municipalities, hospitals and first responders.

In closing, I would like to thank the committee for making time to hear from CMHA Durham and other stakeholders in our community. We appreciate the opportunity to share the challenges and needs of our community during these dedicated consultations and will be happy to take your questions—

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

With that, we will start the questions with the government. MPP Kusendova-Bashta.

Ms. Natalia Kusendova-Bashta: Thank you to all of our presenters for bringing forward your deputations. I will address my questions to the Canadian Mental Health Association Durham.

First of all, thank you so much for providing vital services that people experiencing mental health challenges rely on in the region of Durham. I, for one, am proud to be a member in the government that since 2018, for the first time in the history of this province, has actually dedicated a ministerial portfolio to mental health and addiction issues in the province of Ontario, because we recognize that mental health is health, and we need a dedicated advocate at that cabinet table to be speaking specifically to the needs of Ontarians who are experiencing mental health challenges. Of course, I'm speaking of Minister Michael Tibollo, who has been doing a phenomenal job since taking over that portfolio.

With that, we have announced a Roadmap to Wellness in 2020 with a $3.8-billion investment to modernize Ontario's system of mental health. So I just wanted to ask, here in the region of Durham, whether this Roadmap to Wellness—have you seen the impact with this dedicated funding?

Ms. Sheryl Wedderburn: Oh, absolutely. I want to say, in terms of the allocation of financial resources to support the homeless population, I want to take the time to at least honour or recognize Minister Tibollo's efforts, particularly in Oshawa, around the homeless population. Over the last three years, we have received—albeit one-time funding, it is appreciated, although annualized funding would be far more supportive for what we need to sustain the work that we're doing within the community. But Minister Tibollo has supported what we call the Mission United, which is a clinic that serves the homeless population in Durham region. So that has been significant, to provide that kind of support for this hard-to-serve population.

Ms. Natalia Kusendova-Bashta: I wanted to also highlight some more recent investments that we've made. This was announced on October the 10th about the Ontario Structured Psychotherapy program, which is connecting adults to more free psychotherapy services. I know that CMHA Durham was not included in this particular announcement, but some of your sister organizations, CMHA York Region and South Simcoe, were specific recipients of this particular program. I was just wondering if you've received any feedback from your chapter organizations specifically around the Ontario Structured Psychotherapy program and the investments our government is making there.

Ms. Kerrie Wriker: Yes, I can speak to that. In terms of what our partnerships are with CMHA Durham, we are partnering with Ontario Shores. So we do have clinicians that are actually placed within CMHA Durham to provide psychotherapy services, and that is embedded within our nurse practitioner clinic, and it's very well received.

Ms. Natalia Kusendova-Bashta: Thank you very much. I'll pass on the rest of my time.

The Chair (Mr. Ernie Hardeman): MPP Anand.

Mr. Deepak Anand: I actually wanted to ask CMHA, but before I ask I just want to acknowledge and thank, Julia, for your work—45 years of experience; that's incredible. I see you are very passionate about and you talked about the people with disability—I actually call them people with a different ability, not a disability.

We did have a program in the recent past where we actually supported some of the organizations with the Skills Development Fund. With that money, there were programs to support the people with different abilities so that they can go into the workforce, and I do see your acknowledgement of talking about a significant increase in expenditure, while expanding innovative programs, such as universal $10-a-day child care, so you believe in these kind of innovative programs.

Any suggestions to the government? Is there any innovative program that we can bring in—another one, maybe—to help support the people with different abilities to get into the workforce, or help and support to have better jobs, incomes in the workforce?

Ms. Julia McCrea: Well, I think in combination with what the CMHA has said—so if you want to have a continuum from students graduating, from perhaps special classes in education into the community, then they need not only the employment supports but often the supportive housing that the CMHA referred to and the staffing that they would require to support the students, once they make the transition from school to the community.

I mean I'm not sure about innovative, but you need to continue to fund high schools to have the funding where students are getting the work experience in some of our PLP programs, other special programs and co-op education, but provide a continuum of support so that they can make the transition either to college-based skills training and/or into the community with the independent living supports and community-based employment supports.

There are programs in this community that are providing some of that support that may need additional funding. I'm thinking of the Durham Region Unemployed Help Centre. There is META community services. YMCA is providing some employment services for persons with disability, but I would imagine they are underfunded to meet the growing demand for that.

Mr. Deepak Anand: My question to the CMHA would be: Durham Regional Police Service and Durham Mental Health Services have a mobile crisis intervention team—we have something similar in Peel as well. What is your feedback on this team and the kind of work they're doing?

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Kerrie Wriker: Sorry, we had a hard time hearing your question. Do you mind to repeat that?

Mr. Deepak Anand: Absolutely. I'm talking about the mobile crisis intervention team in Durham, and we have something similar in Peel. So I just wanted to ask you for feedback on this program, and what would be your suggestion to the budget committee on this?

Ms. Kerrie Wriker: Yes, we actually partner closely with Lakeridge in terms of the mobile crisis unit as well as we have programming embedded within the emergency department, which is called Hospital to Home. That is a linkage program, specifically for people that are coming in to hospital in crisis and need that case management support in the community—

Mr. Deepak Anand: I'm going to be called by Chair as the time is up. So, just quickly, should we need more funding, less funding?

Ms. Sheryl Wedderburn: I'm sorry are you speaking to us?

Mr. Deepak Anand: Yes.

The Chair (Mr. Ernie Hardeman): It doesn't matter who he's speaking to; he's out of time. Thank you very much for that.

We'll now go to the official opposition. MPP French.

Ms. Jennifer K. French: Welcome to all of the presenters. I'm very grateful to have the finance committee stop here in Oshawa, so I'm glad to have some local voices at the table.

I'm going to start first with Ms. McCrea. Thank you for coming and for a very thorough presentation. I know that you got pretty close to the end of your presentation. If there is anything you wanted to highlight, go ahead—but I did have some questions for you.

When we're talking about the AODA, many of us have followed, unfortunately, #AODAFail—that there is a lot of broken trust. I don't think that there's a lot of hope in the disability community for the province to meet its goals, to achieve those goals by January 1. Just over a year from now is not a long runway anymore. And without enforcement, we have seen some real challenges experienced by folks in the broader community.

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One of the things that you had said was that many would benefit from accessibility improvements, the concept of a universal design having universal benefit. What would it look like and feel like to Ontarians living with disabilities if the government actually made a—I think you used the term "sincere effort." What could a sincere effort look like and what would be the impact on members in the community?

Ms. Julia McCrea: Well, I think all government sectors are going to have to identify within their own budgets where they can make the changes. I made reference to income support programs, so that would include the Ontario Disability Support Program, Ontario Works and WSIB. In housing, CMHA made reference to the need for supportive housing, but even as we make developments here in Oshawa and Durham region, any new housing development, if there was a criteria set by the government that 25% or more had to be accessible at the beginning and then affordable on top of that, that would meet a huge housing demand that we have at the moment. So those would be the first two.

Then, if you look at the severe crisis we have with opioid addictions etc., the funding that has been referenced here in terms of funding broad-based services for the homeless, whether it be new shelters in Whitby that are starting to be considered, mission services, or the Back Door Mission in Oshawa, which have been providing—a combination of agencies coming together to serve since COVID.

As well, I can't even begin to think about what senior populations have needed. We saw the crisis during COVID of long-term-care situations that need to be built and need to be funded and need to be staffed, and when those kinds of housing are available with care supports, I think it would have made a huge investment.

Then there's things like transportation. We're still waiting for the GO train to be extended further this way. We're still waiting for Metrolinx to make their developments this way. Public transit—we're underserved in the broader Durham region by even our DRT. So investments in transportation to make them fully accessible—and that's without withdrawing things like specialized transit, which, unfortunately, has been taking place. All of those things would increase accessibility for persons living with disabilities. And I use the term "disability" because that's the term that's used in the government act and hasn't been changed.

Ms. Jennifer K. French: Thank you very much. I appreciate that.

I'm going to switch to Ms. Reedman. I think, probably—this is not a partisan comment, but a lot of us have met with community members about ALS, oftentimes caregivers and surviving loved ones who have talked to us about the impact that an ALS diagnosis and, often, loss of a loved one has. Depending on when they come to talk to us, we've had the opportunity to learn from many people who have lived experience.

One of the things that has been raised repeatedly is around the need for appropriate—I'll say housing, but residential care for those with ALS at different points in their diagnosis. We have heard about challenges in long-term care, whether they accept them or don't, what that care looks like, if hospital care is the most appropriate—all of that. We've heard from a lot of home care providers—I don't know that that's appropriate, depending on where they are in their ALS journey. Is there anything that you would say in terms of government investment or focus around housing, or how to provide the care in community or the best kind of care? What would that look like?

Ms. Sarah Reedman: Absolutely. For the most part, anybody living with ALS wants to stay in their home. They don't want to go into long-term care, regardless of their age, even somebody elderly. I have a whole gamut of people on my caseload—my youngest is actually 24 and my eldest is 92, and none of those want to go into long-term care. Accessibility housing is definitely an issue. One of the biggest things that I notice when I first go to somebody's home and they've had their diagnosis is I'm immediately assessing accessibility in their home: whether they're going to be able to be housebound; whether they're going to be able to get in and out of their home. Other than March of Dimes, there are no other government funding sources for modifications or renovations.

I have a client right now in Ajax, and she and her husband are living in a home that was purchased from their family. It has been in their family for a long, long time—lots of stairs in there. There are either going to have to sell up and move or renovate. They don't have the money for the renovations. Being able to stay in their own home is huge. Nobody wants to go into hospital and nobody wants to go into long-term care, so that is a big issue with that community.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Jennifer K. French: Thank you.

I'm going to shift gears to Sheryl and Kerrie from CMHA. I want to say, I'm glad to be your neighbour. Physically, our offices are nearby, but we have done work in the community and I want to give a shout-out to Stephanie the nurse practitioner, as you had referenced Mission United at the Back Door Mission. Minister Tibollo and lots of us in the community have been working towards that hub model of care.

So, very important work is happening, but when you said supportive housing is a forgotten part of housing—hopefully you'll have more of a chance to elaborate, because I'm running out of time, but tell me what that would look like.

Ms. Sheryl Wedderburn: Yes, I think it's important to—

Failure of sound system.

Ms. Jennifer K. French: Sorry, just a second. We're having feedback—

The Chair (Mr. Ernie Hardeman): Thank you very much. We're out of time, so we'll have to do that answer in the next round.

Ms. Jennifer K. French: We promise.

The Chair (Mr. Ernie Hardeman): We'll now go to the independents. MPP Hazell.

MPP Andrea Hazell: I want to thank everyone for your presentations. My question would be for Sarah. Sarah, thank you so much for educating me today. I didn't know one in four people—is that in Ontario or Canada?—are living with ALS. That is very alarming, and then some of them even want to take their own life, so that kind of took me aback a bit.

I want to ask you about—in your presentation, you mentioned the need for the development of a regional strategy for people living in Ontario to get the care that they need. What does that development strategy look like?

Ms. Sarah Reedman: As I mentioned, this would be in collaboration with ALS clinics. There are five ALS clinics across the province. That is the clinical domain for people living with ALS. They have all the supports there that they need, which is highly under-resourced. As well, I mentioned our organization provides mobility equipment for people living with ALS, and it's all donor-funded dollars. We fundraise and we take donations, and we either purchase or take donations of equipment.

In order to be able to keep somebody in their home, which is where they want to be, they need to have mobility equipment to keep them there safely and to keep their independence. So those are part of the strategy that we are looking at.

MPP Andrea Hazell: Okay. Thank you for that.

I am going to switch to Sheryl and Kerrie. I know you talked about how you received funding and you also explained what the funding did. We also have to realize, all of us sitting here, that we went through a pandemic. We didn't call for the COVID pandemic to happen, but it happened. We all had to figure out how we're going to survive that. Our mental illnesses and people who are experiencing mental illnesses have increased drastically. Then, we're going through an affordability crisis on top of that. We're not out of COVID yet or the post-trauma that we've all been experiencing, and so I understand your ask for new funding.

But when I look at your human resources gap crisis that you are experiencing, what type of funding are you looking for to sustain your important programs?

Ms. Sheryl Wedderburn: First of all, I want to say again that we greatly appreciate the 5% increase to base budget that we've received. I have to tell you that that made a significant difference, particularly to CMHA Durham—right across the CMHAs; I'll speak about us. For us, I have to tell you, what that recent 5% did is really just basically turned on the pilot light, if you will. It enabled us to bring the majority of our salaries to minimum. "Minimum" means that, as a sector, we're still below other health care service providers within the sector, never mind the hospital sector.

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So to answer your question, of the 7% increase that we're asking for, which is equal to $143 million, right now we're asking for a 5% increase to stabilize funding. That will not only just help bolster our services, but it will enable us to at least move some of our salaries. It will help with retention of our employees, and as you know—you said it very well, MPP Hazell. You said it very well just now, that we need to put some strategies in place to retain. We are losing through mass exodus a lot of our very experienced employees to organizations that pay higher. That would be the hospital sector and some other community agencies. So a 5% increase to our base funding is something that we most definitely need.

MPP Andrea Hazell: My next question is, if you continue to, I would say, bleed with not retaining your retentions, how is that going to impact the services that your clients need from you?

The Chair (Mr. Ernie Hardeman): Thank you very much. The question sounds good, and the answer, we won't hear.

We now go to the government and MPP Coe.

Mr. Lorne Coe: Chair, through you to Sheryl and our chief information officer as well: Thank you very much for being here tonight—yes, we are in the evening now. I wanted to have you talk a little bit more broadly about your partnership with Ontario Shores and how that partnership is helping you to effect your delivery of services and programs.

Ms. Kerrie Wriker: Yes, I can speak to that. We have many programs that are linked with Ontario Shores and very specifically in terms of our housing. A lot of clients who are in hospital need to be reintegrated back into the community, and we have made relationships with Ontario Shores to specific programs, like forensic, just in terms of getting them back from hospital and transitioned into community. That comes with a cost as well, because when we're looking at that, those beds are very specifically dedicated to Ontario Shores, and again, then that makes the challenge in terms of providing supportive housing to residents of the community as well.

But the successes of those programs really highlight what Sheryl was referencing, and it kind of speaks to Jennifer's question about what does supportive housing look like. It is more than just bricks and mortar in terms of getting the stock; it's actually having that collaboration of services, so that link between the hospital and the community. So if a person is out in the community, maybe not doing so well, it's an easy link to get them back in, short stay and then come back out to their unit. That's what we're seeing as what supportive housing means. You really need to link the housing with an actual support person to be able to see that recovery journey to its end.

Ms. Sheryl Wedderburn: And that's part of the reason why we're really urging the government to give us the 2% increase, which is about $33 million, for community supportive housing innovative funding, and we're looking for that to be specifically in the community mental health sector.

Mr. Lorne Coe: Thank you, Sheryl and Kerrie, for your answers to my question. You will recall in the last provincial budget that $202 million was announced annually for a Homelessness Prevention Program, right? And part of that funding was devoted towards supportive housing. So in terms of your partnerships, not only with Ontario Shores but also with the Durham health team and others at the region of Durham, can you speak to how the effect of that investment is rolling out? Because that was part of the 2023 budget. So if you could answer that particular question, please.

Ms. Kerrie Wriker: I think in terms of how we're seeing that, CMHA Durham itself has relationships with over 40 landlords in Durham. Because of what we are referencing around providing that support, we are able to work with landlords and building owners to kind of support us and have an understanding of the needs. Once they have determined that that relationship is successful, we have seen really significant buy-in in terms of Durham from those partnerships. That funding supports that, and that's where we're able to kind of build on that with the region of Durham as well as our partnerships with Ontario Shores. Lakeridge Health is another one, and then as you know, Mission United is where some of those clients would flow through some of those supportive housing components.

Mr. Lorne Coe: All right. Thank you for that response. I wanted to get it on the record, because I think it's an important part of the discussion we're having here today about supportive housing, how it is funded by the province and how it continues to be funded by the province.

I want to go back to an investment that was made in 2022. It was $90 million. It was the Addictions Recovery Fund. It was an investment over three years to improve access to addictions treatment services.

Do you find that type of specific investment helpful in affecting the programs and services that you are delivering? I think part of that answer relates to the partnerships with Ontario Shores and others here in the region of Durham. So can you tie that together, please?

Ms. Sheryl Wedderburn: Yes, we most definitely do. So your question was, did we find that helpful? I think the short answer is yes, because we want to appreciate funding at any cost, but I will say that the new community supportive housing initiative funding that we're asking for will provide both capital and operating dollars for the development of innovative and evidence-based models of housing.

I want to just at least mention that CMHA is recognized for the work that we do in housing for the mental health and addictions population. In 2022—I believe it was—the Homes for Special Care was rebranded to Community Homes for Opportunity. Those housing units were transferred from hospital sector to community sector, and I think that that was evidence of something that needed to happen.

I will say that I worked historically at Ontario Shores, so I definitely see the benefits of the mental health hospital sector, but most definitely, I think that that was a pivotal move to move those housing units to the community sector. It's $486 a day—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Sheryl Wedderburn: —to keep a person in a hospital bed versus $72 per day to provide housing to a person in the community health sector.

Mr. Lorne Coe: Thank you for that, and finally—how much time do I have, Chair?

The Chair (Mr. Ernie Hardeman): You have 45 seconds.

Mr. Lorne Coe: Okay. Julia, in response to another question, you were talking about the effect of the extension of the GO Transit system to Bowmanville for people with disabilities. It is happening; it's on schedule. Added to that, we just passed a bill in the Ontario Legislature, an infrastructure bill that has a feature about transit-oriented communities that is going to allow extensive economic development along that whole corridor, create jobs and accomplish all of what the mayors want here in the region of Durham.

The Chair (Mr. Ernie Hardeman): Thank you, and that concludes the time for that.

We'll now go to the official opposition. MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to all our presenters today.

I'd like to start off with you, Ms. Reedman. I just want to thank you for sharing the story of your brother. You do him a distinct honour by your advocacy and by the work that you do. I think of my constituent Matt Brown, who is currently battling ALS, along with his wife, Cathy, and his sons, Jayson and Colin. They had to make many, many different modifications to their home, and as you said, received no funding. It's criminal, quite frankly, that they would be forced to do such a thing just to maintain that quality of life.

I wanted to specifically ask—your organization has asked for a sustainable provincial ALS program with a coordinated and integrated approach to ambulatory care. It ought to be easily supported by anyone who understands this disease. You had mentioned in the presentation that the current model is university-hospital-based in different regional centres. What does that mean for rural and remote communities trying to access ALS care?

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Ms. Sarah Reedman: Yes, that's a really good question. Thank you. One of the things that I did mention was particularly support for northern Ontario. Most of our clinics are centred in southern Ontario: Sunnybrook ALS clinic, Hamilton, London, Ottawa and Kingston. Anybody up in the northern areas has a tremendously difficult time of getting to the clinics to get that support. So they are looking at their regional hospitals that don't necessarily have the expertise in ALS in order to be able to continue to support them.

Access to services, access to PSW supports in the community—I heard the lady earlier speak about PSWs in the community; such a shortage of PSWs, particularly in the rural areas. Certainly, I've had clients and continue to have clients on my caseload who are on wait-lists for PSWs because the PSWs don't get the travel money to be able to get to these rural homes, and so they have to move or they just end up—the reality is that they go for MAID, because they are like, "I can't get the support to stay at home. What's the point in living?" They are more likely to access MAID because they physically don't have that support in the community. In rural areas, it's brutal.

Mr. Terence Kernaghan: It is absolutely a moral horror that is not being faced, that people would have that as what they consider their only option. Thank you very much for your work.

My next questions will be for Sheryl and Kerrie. I think we can all agree that housing is foundational. It is fundamental. Unfortunately, the government has chosen not to support co-ops and non-profits and actually build housing. It seems they would rather leave the construction of affordable units in housing up to for-profit providers. I wanted to ask: Do you think that the for-profit industry will create the supportive housing that Ontario truly needs?

Ms. Kerrie Wriker: That's a good question. We have a relationship with the current landlord that is for-profit, and it actually works out well. I think for that particular situation—it's interesting, because they probably, in some way, as you know, have been touched with mental health, and so they have an understanding of that and are willing to work with us.

I think the success for housing in general would be, again, just to reiterate that housing has to come with supports and a staffing model. Sometimes we see the government gives us the bricks and mortar portion of it or, working with

privatized landlords or social developers, we get the units, but we don't get the staff supports with it, and that becomes a challenge.

Just to go off that comment, I do see that housing has to be explored by all developers and looked at across this province. We have a problem, for sure, and the mental health population has been impacted.

Ms. Sheryl Wedderburn: I'd like to just acknowledge very quickly that we definitely appreciate the government's efforts focused on affordable housing, but that doesn't address the need for supportive housing. At the end of the day, supportive housing, as I've said before, is that forgotten segment of the housing continuum, and that's what we're referencing. We don't want it to be forgotten because it is most definitely needed.

It also helps to reduce homelessness, as I've shared some facts with you earlier. It's most definitely proven. It connects individuals in the mental health community with wraparound services. That's what supportive housing offers, and that's why we are really, really urging the government to look at the three-year community supportive housing innovative funding opportunity for us.

Mr. Terence Kernaghan: I completely understand. It is something that I hope the government will consider, and they ought to look into.

I did want to ask also—I hear from amazing front-line community health sector workers in my community who are also forced to go to food banks. How does wage parity affect morale for folks working in your organization?

Ms. Sheryl Wedderburn: This sector is in a critical staffing crisis shortage right now. We conducted, as I said earlier, a survey across 10 organizations in the community and mental health and addictions survey, and 97% of the respondents claimed that they have a significant staffing shortage. So, right now, right across the CMHAs, we are community sector—not-for-profit—and our salaries are far lower than even some of our other community agencies. So that's why we're in this position of challenges with retention. We're doing the best that we can with what we have to incentivize our employees to stay.

I think someone mentioned earlier, and it is definitely a fact for us, that—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Sheryl Wedderburn: —a lot of our employees thankfully choose to stay in this organization because they feel as though the work that they're doing is meaningful. But, at the end of the day, that doesn't pay their bills, it doesn't put food on the table and—to your question—it sends them to the food bank, which is not necessarily ideal. We appreciate the opportunity that they can go to the food bank, but it's this wage disparity that is a significant contributing factor to causing great challenges for our employees and we're not able to retain them.

Mr. Terence Kernaghan: Most definitely. And when you look at rates of attrition, there is such an impact on organizations when they train someone, only to have that person leave. It's a waste of time and a waste of resources, unfortunately, because that person may be wanting to get paid at a greater rate and it's unfortunate.

Ms. Sheryl Wedderburn: Oh, absolutely. That's a good point. Because the community sector is also seen as a training hub and a part of the reason why is because our salaries are lower. The fortunate side of it is that we're able to—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time and, like they used to say on the Waltons, "Say goodnight, John boy"—that not only concludes that questioning, it concludes this panel.

I do want to, on behalf of the committee and the government, say thank you for taking the time to prepare and to be here and have this discussion with us this afternoon. I'm sure it will be a great benefit to us as we move forward to plan for the 2024 budget.

With that, this concludes our business for today and I thank all the presenters. The committee is now adjourned until 10 a.m. on Wednesday, December 13, 2023, when we will resume public hearings in Markham, Ontario.

With that, the committee stands adjourned.

The committee adjourned at 1657.

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