Modernizing Mental Health Coverage for a Productive Ontario

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Co-sponsored by: North Bay Chamber of Commerce, Sault Ste. Marie Chamber of Commerce, Northern Corridor Chamber of Commerce, Cochrane Board of Trade, Greater Sudbury Chamber of Commerce, Thunder Bay Chamber of Commerce, Muskoka Lakes Chamber of Commerce

Issue

Ontario's workforce stability is threatened by a mental health crisis that current public coverage gaps fail to address. Excluding psychotherapy from OHIP forces a reliance on high-cost crisis care, shifting the burden from proactive community support to expensive hospital systems. A mental health-related Emergency Department (ED) visit costs roughly $423 (more than double the average visit) while related disability leaves cost businesses nearly $18,000.[1,2] This misalignment undermines both healthcare capacity and economic productivity.

Background

The Economic Rationale for Early Intervention

Excluding psychotherapy from OHIP destabilizes Ontario's economy by forcing individuals to face unacceptable choices: paying high out-of-pocket fees, joining lengthy public waitlists, or relying on high-cost emergency departments when needs escalate to crisis.

- Publicly funding psychotherapy yields a net societal return of roughly $2 for every $1 invested through reduced hospitalizations, long-term disability claims, and system savings.[3]
- Productivity loss caused by an employee working while experiencing untreated mental health challenges is estimated to be three times greater than the loss caused by an actual absence.[4]
- Mental illness is now the fastest-growing category of disability claims, accounting for 30% of all claims and 70% of all workplace disability costs.[4]

Hospital Strain and the Cost of Crisis Care

Without access to community psychotherapy, the ED has become the default provider of mental health care. This reliance is fiscally unsustainable and contributes to extreme hospital gridlock.

- A mental health-related ED visit costs $423 on average, more than double the $165 direct cost of a standard ED visit, due to higher resource intensity required for crisis stabilization.[1,5]
- Nearly half of adults presenting to psychiatric EDs had no outpatient mental health care in the two years leading up to their crisis, indicating a systemic lack of timely, community-based access to care.
- Only 40% of psychiatric ED patients receive follow-up care within 14 days, resulting in a scenario where 10% of these patients return to the ED four or more times in a single year.[6,7]
- Proactive support has already proven effective, as 10 CMHA branches diverted over 17,700 ED visits in two years, saving the hospital system roughly $7.5 million.[1]

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[1] Canadian Mental Health Association. (2023, Jan.). *Maintaining the Momentum*. (2024 Pre-Budget Submission).

[2] Centre for Addiction and Mental Health. (2010, Sep. 10). *Mental Health Leaves Most Costly Disability to Canadian Employers*.

[3] Vasiliadis, H. M. et al.. (2017). Insuring Psychological Services as Part of Medicare for Depression. *Psychiatry Services,* 68(9), 899-906.

[4] Conference Board of Canada. (2023, Aug.). *Why Employees Choose Work Over Wellness*.

[5] Office of the Auditor General of Ontario. (2023, Dec.). *Value-for-Money Audit: Emergency Departments*.

[6] Barker L. C. et al.. (2020). Urgent Outpatient Care Following Mental Health ED Visits. *Psychiatric Services,* 71(6), 616-619.

[7] Canadian Institute for Health Information. (2025, Oct.). *Frequent ER Visits for Help with Mental Health and Substance Use*.

The Case for Small Business Support

Ontario's small business owners face significant financial barriers to providing mental health care compared to large corporations, creating an uneven playing field for talent.

- A refundable tax credit would empower roughly 500,000 small businesses in Ontario that employ over 2.5 million people but lack the scale to negotiate affordable private insurance.[8]
- Every $1 an employer spends on mental health yields a median return of $1.62 within a year, rising to $2.18 after three years through reduced turnover and disability claims.[9]
- Only 13% of small businesses (under 50 employees) expanded mental health support compared to 50% of large corporations (over 1,000 employees) during economic shifts, leaving the backbone of Ontario's economy structurally under-resourced.[10]
- Failing to support these businesses forces the province to absorb a share of the $20 billion annual drain on the Canadian economy caused by workplace absenteeism and "presenteeism," which recent data shows now affects 70% of the workforce.[11,12]
- Small businesses that prioritize mental health prevention see a 27% burnout rate compared to 47% for those taking no action, resulting in average savings of $3,400 per employee per year.[13]

Demand, Equity, and Regional Capacity

Ontario's mental health infrastructure is failing to keep pace with demand, particularly in Northern and rural regions where the system is most fragile.

- Over 2.5 million Ontarians lack a family doctor, a figure forecasted to hit 4.4 million residents by 2026.[14] This shortage makes traditional 'gatekeeper' referral models for mental health care impossible for 1 in 4 residents.
- This pilot directly supports the *2025 Primary Care Action Plan* by redirecting appropriate mental health care from family physicians to registered therapists based on clinical assessment.
- These challenges are most acute in Northern Ontario, where just 6.5% of Ontario's family doctors serve a population facing mental health hospitalization rates nearly double the provincial average.[15]
- Rural residents face a 131-day wait for mental health support (versus 41 days in urban centres), a delay that keeps workers sidelined as rural crisis calls for issues like Alcohol Use Disorder rose by 9% last year.[16]
- Currently 28,000 children and youth are waiting for community services, with wait times for intensive programs reaching up to 2.5 years.[17] This lack of timely intervention forces parents to miss work, draining an estimated $421 million from the provincial economy annually in lost productivity.[18]

Operational Implementation

A fiscally responsible OHIP pilot must be anchored in evidence-based care and low-barrier entry to prevent crises before they occur.

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[8] Ontario Ministry of Economic Development, Job Creation and Trade. (2025, Oct. 22). *Ontario Celebrates Small Business Week*. Ontario Newsroom.

[9] Kangasniemi, A., Maxwell, L., & Sereneo, M. (2019, Nov. 4). *The ROI in Workplace Mental Health Programs*. Deloitte Insights.

[10] Canadian Psychological Association & Mental Health Coalition of Canada (MHCC). (2022, May). *Extended Mental Health Benefits in Canadian Workplaces*.

[11] MHCC. (2018, Feb.). *A Clear Business Case for Hiring Aspiring Workers*.

[12] TELUS. (2025). *The State of Mental Health and Wellbeing in Canadian Workplaces*. TELUS Health.

[13] Mental Health Research Canada. (2025, Jun.). *Mental Health in the Workplace 2025*.

[14] Ontario College of Family Physicians. (2023, Nov. 7). *More than Four Million Ontarians Will be Without a Family Doctor by 2026*.

[15] Mandal, A., & Burella, M. (2021). Inadequate Mental Health Supports in Rural and Northern Ontario. *Ontario Medical Students Association.*

[16] Rural Ontario Institute. (2025, Mar.). *Rural Wellbeing: Mental Health Factsheet*.

[17] CMHO. (2020, Jan. 27). *28,000 Ontario Children and Youth Are Waiting for Community Mental Health Services*.

[18] CMHO. (2019). *Annual Report Card: The Burden of Kids Mental Illness on Families and the Economy*.

- 50% of clients experience clinically significant improvements by the eighth session, with the most effective short-term models recommending a range of eight to 12 sessions.[19]
- This pilot adopts a Two-Stream Practice Model, enabling registered practitioners to deliver OHIP-funded care alongside existing private-pay or non-profit services, with participation parameters designed to expand access without displacing existing care and existing programs.
- To comply with the *Commitment to the Future of Medicare Act, 2004*, the pilot strictly prohibits "extra-billing" to ensure patients are never charged additional fees for insured sessions.
- Access would be based on practitioner-led clinical assessment and reassessment, with clear referral pathways for individuals requiring higher-intensity or specialized services.
- To bypass physician waitlists, this model implements a multi-point referral system, including self-referral, schools, and agencies, to bridge service gaps and reduce non-acute ED visits.
- Therapist-led standardized assessments will ensure clinical accuracy and triage resources towards those with the highest need, preventing system strain from low-acuity cases.

Recommendations

The Ontario Chamber of Commerce urges the Government of Ontario to:

1. Establish a three-year Psychotherapy Pilot Program under Section 45 of the Health Insurance Act, 1990 structured as:
   a. Provide up to 12 OHIP-covered psychotherapy and mental health sessions annually delivered by Registered Psychotherapists, Registered Social Workers, and Psychologists, with access guided by clinical assessment and referral pathways to physicians, psychiatrists, or nurse practitioners where medication support is required.
   b. Operate under a Two-Stream Practice Model allowing OHIP-funded care alongside private/non-profit services, with safeguards to prevent displacement of existing community programs and service rates aligned with provincial regulatory college guidance.
   c. Implement a phased rollout, beginning with Northern and rural communities facing the greatest access challenges, then expanding to urban and mid-sized regions, and province-wide as capacity grows. Evaluate expansion rollout based on clinical outcomes, community access improvements, workforce capacity, and system cost performance.
   d. Include investment in awareness and navigation tools to help employers, individuals, practitioners, and system partners understand and promote eligibility, billing procedures, and referral pathways.
2. Finance the pilot through graduated implementation with annual participant caps, Mental Health Social Impact Bonds linking private investor returns to measurable savings in ED visits and disability claims, and federal cost-sharing (50%) under Canada's health accord as an innovative mental health access pilot.
3. Institute a 25% Refundable Mental Health Employer Tax Credit under the Taxation Act, 2007 to enable small- and medium-sized businesses to provide psychotherapy benefits. The credit would provide a maximum annual refund of $500 per employee, incentivizing a total investment of $2,000 per worker in services delivered by Registered Psychotherapists, Registered Social Workers, or Psychologists. Eligibility should be limited to Ontario-based employers with fewer than 500 employees.

[19] Saxon, D., Firth, N., & Barkham, M. (2016). The Relationship Between Therapist Effects and Therapy Delivery Factors. *Administration and Policy in Mental Health*, 44(5), 705-715.